

Sixth International Conference on
**Violence in the
Health Sector**
Advancing the delivery of positive practice



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Oud Consultancy

Violence in the Health Sector



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Editors

Violence in the Health Sector

Proceedings of the
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Preface

Welcome all to the vibrant city of Toronto, Canada, for the Sixth International Conference on Violence in the Health Sector. The objective of our meeting is to advance the delivery of positive practice for both the recipients and providers of health care. Some possible ways to advance positive practice is to scrutinize causes of aggression or violence, to research and promote methods to minimize violence and coercion, to promote education and training, to learn how to effectively and collaboratively engage with stakeholders, to share our methodologies, instruments, learning and best practice, and to reflect on policy and safety issues regarding all aspects of aggression and violence in the Health Sector. We do hope that all conference participants will profit from the themes presented during our three day conference.

Just as the wanderer sometimes seeks repose to reflect on their journey, we also would like to trace in a few words the different stages of the voyage of the conference on Violence in the Health Sector to date. In 2006 whilst drinking coffee together in a quiet restaurant in Utrecht, the Netherlands Nico Oud and Ian Needham discussed the possibility of creating the conference. Kevin McKenna was soon invited to help the launching of the first conference entitled *“Together, creating a safe work environment”* held in Amsterdam, the Netherlands in 2008. Following this successful maiden voyage the vessel remained in Amsterdam for the second conference in 2010 which the theme of *“From awareness to sustainable action”*. The vessel in 2012 then embarked on a westward course for the 7697 kilometer journey to set anchor in Vancouver, Canada, where we shared our respective perspectives and enjoyed the great Canadian hospitality. After a southerly journey of 4509 kilometers in 2014 our next port of call was Miami in the United States of America for our conference with the theme of *“Towards safety, security and wellbeing for all”*. The longest haul was to be the record distance of 6689 kilometers to the City of Dublin two years ago in 2016 where, in addition to an excellent scientific exchange, we were treated to an authentic and memorable Irish welcome of *‘Cead Mile Fáilte’*. The final stage of our journey now brings us 5250 kilometers to Toronto at the GPS position of 43.65 latitude and -79.38 longitude in order to *advance the delivery of positive practice*.

The Roman philosopher Seneca once reported that “*every journey has an end*” and it is with heavy hearts, but also with our deep gratitude, that we inform you that our Toronto conference will be the last International Conference on Violence in the Health Sector. The conference organizer, Nico Oud, the chair and co-chair, Ian Needham and Kevin McKenna respectively, have reached or are approaching retirement and looking forward to other life-projects.

We would like to sincerely thank everyone involved for the success enjoyed over our six conferences together, especially the steering committee, the local organization committees in the cities involved, the scientific committee, the supporting organizations, and the contributors to the Waive the Fee Fund. However, our greatest and dearest thanks go to you the speakers and participants of the conference. The conference has been privileged to have had speakers and participants from all corners of the earth, and the inspirations and insights gained have been carried and shared in many countries across the world.

Our vessel will now – symbolically speaking – stay moored in Toronto where we wish you all a great conference. A Chinese Proverb says: “*He who returns from a journey is not the same as he who left.*” In this vein we hope that all will receive some transformational insights which will inspire and inform our quest to advance positive practice long after the conclusion of our time together.

Bon voyage

The organization committee

Ian Needham

Kevin McKenna

Clarisse Delorme

Odile Frank

Nico Oud

Christiane Wiskow

Howard Catton

Baba Aye

Ivan Ivanov

Welcome letters



PRIME MINISTER • PREMIER MINISTRE

October 24-26, 2018

Dear Friends:

I am pleased to extend my warmest greetings to everyone attending the 6th International Conference on Violence in the Health Sector.



This gathering gives participants an opportunity to discuss the phenomenon of violence in the healthcare sector. Under the theme “Advancing the Delivery of Positive Practice”, this year’s conference will explore the multiple facets of work related aggression and violence in the health services, and underscore policies and practices that minimize its prevalence.

I would like to commend the event organizers for increasing awareness about this subject and providing a platform for open dialogue. I am certain that everyone in attendance will leave with renewed enthusiasm to take on the challenges that lie ahead.

Please accept my best wishes for a productive conference.

Yours sincerely,

The Rt. Hon. Justin P.J. Trudeau, P.C., M.P.
Prime Minister of Canada



Premier of Ontario - Premier ministre de l'Ontario

October 24 – 26, 2018

A MESSAGE FROM PREMIER DOUG FORD

I'm delighted to extend greetings to everyone attending the Sixth International Conference on Violence in the Health Sector, organized by Oud Consultancy.

As Premier, I'm pleased that Ontario is hosting this important event. I want to thank everyone who helped to make it a success, including the members of the event's steering group and local organizing committee, the sponsors and speakers, and the people at Oud Consultancy.

Our government is committed to respecting Ontario's doctors, nurses and other health care workers by working with them to make sure we have a system that treats everyone fairly and ensures the safety of all workers.

To all those who made the journey to Toronto, I hope you enjoy your stay in our province's capital, and have the chance to take in some of the city's terrific attractions.

I hope you have a productive and successful conference.

A handwritten signature in black ink, appearing to read "Doug Ford".

Doug Ford
Premier



CITY OF
TORONTO

Message from the Mayor


It gives me great pleasure to extend greetings and a warm welcome to everyone attending the 6th International Conference on Violence in the Health Sector, "Advancing the Delivery of Positive Practice".

Welcome to all attendees who are attending this conference to increase their understanding of the root causes and patterns of violence in the health sector and learn more about resources that are available to them, to proactively respond to it.

As Canada's largest city and the fourth largest in North America, Toronto is a global centre for business, finance, arts and culture and is dedicated to being a model of sustainable development. I welcome everyone to our city and encourage you to enjoy Toronto and learn about our vibrant neighbourhoods.

On behalf of Toronto City Council, please accept my best wishes for an informative and enjoyable event.

Yours truly,



John Tory
Mayor of Toronto

Note on the peer review process of the conference

As a peer reviewed scientific conference, we would like to outline the structure and procedure through which abstracts were selected for inclusion and presentation at the conference. Each submitted abstract was forwarded for peer review to members of the International Scientific Committee and anonymously adjudicated by at least three members of the committee. Abstracts were evaluated according to the following criteria:

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

Following the evaluation of each submission, the Organization Committee assessed the merit of each individual abstract and deliberated on the acceptance, provisional acceptance pending amendment or rejection of abstracts. It was through the consistent of this procedure that the Organization Committee endeavored to do justice to those making submissions, and to the Conference participants, who are entitled to receive state of the art knowledge at the Conference.

Many participants of past conferences have noted that the publication of Conference Proceedings is a valuable complement to the Conference. Here again, the Organization Committee strives for a high quality publication.

Please note, however, that the conference organization will not accept liability for presenters' content. Conference presenters are personally responsible that they have adequate authorization regarding all aspects of their presentations, should such authorization be required, for example from co-authors or financial sponsors.

The conference organization is in no position to negotiate and/or arbitrate any issues of conflict arising from the lack of authorization, copyright disagreements or other such and similar issues of authorship or content.

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Supporting Organisations

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- Australasian Society for Intellectual Disability (ASID)
- BC Government and Service Employees' Union (BCGEU)
- British Columbia Nurses' Union (BCNU)
- British Institute of Learning Disabilities (BILD)
- Canadian Federation of Nurses Unions (CFNU)
- Canadian Nurses Association (CNA)
- Centre of Education and Research, St.Gallische Kantonale Psychiatrische Dienste – Sektor Nord, Switzerland (COEUR)
- Commission on Graduates of Foreign Nursing Schools International
- Dundalk Institute of Technology (DKIT)
- Dutch National Nurses' Organization NU'91
- Health Sciences Association of BC (HSABC)
- Hospital Employees' Union (HEU)
- Institut universitaire de formation et de recherche en soins - IUFRS
- International Association for Healthcare Security & Safety (IAHSS)
- International Confederation of Dietetic Associations (ICDA)
- International Confederation of Midwives (ICM)
- International Council of Nurses (ICN)
- International Hospital Federation (IHF-FIH)
- International Labour Organization
- IntraHealth International
- Manitoba Nurses Union (MNU)
- National Institute for Prevention of Workplace Violence, Inc.
- NGO Forum for Health
- Northern Health (IHANH)
- Ontario Nurses' Association International
- Ontario Public Service Employees Union (OPSEU)
- Oud Consultancy

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- ProActive ReSolutions
 - Providence Health Care (PHC)
 - Provincial Health Services Authority (PHSA)
 - Psychiatric Nurses Association (PNA)
 - Public Services Health & Safety Association (PSHSA)
 - Public Services International (PSI)
 - Registered Nurses' Association of Ontario
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 - Sigma Theta Tau International (STTI)
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 - University of Toronto
 - Vancouver Coastal Health (VCH)
 - Vancouver Island Health Authority (VIHA)
 - Workplace Health at Fraser Health Authority (WHFHA)
 - WorksafeBC
 - World Medical Association (WMA)

The Conference Steering Group

- Ian Needham (Centre of Education & Research (COEUR) (chair)
- Kevin McKenna (Dundalk Institute of Technology) (co-chair)
- Howard Hatton (ICN)
- Clarisse Delorme (WMA)
- Odile Frank (ICSW)
- Christiane Wiskow (ILO)
- Carol Tuttas & Franklin Shaffer (CGFNS)
- Baba Aye (PSI)
- Ivan Ivanov (WHO)
- Nico Oud (Oud Consultancy – Conference Organizer)

Supporting organisations of the “Waive the Fee Fund”

We are also deeply indebted to the following organizations which generously provided financial support for the “*Waive the fee fund*” to help enable conference presenters from financially less wealthy regions to attend the conference:

- Oud Consultancy & Conference Management (Netherlands)
- Public Services Health & Safety Association (PSHSA)

- British Columbia Nurses' Union (BCNU)
- Ontario Public Service Employees Union (OPSEU)
- Canadian Federation of Nurses Unions (CFNU)

The Scientific Committee

Many thanks go also to the members of the scientific committee:

- Ms. Clarisse Delorme (WMA) (France)
- Dr. Odile Frank (PSI) (France)
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- Prof. Stéphane Guay (Canada)
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- Dr. Carol Tuttas (USA)
- Dr. Henrietta Van Hulle (Canada)
- Dr. Lynn Van Male (USA)
- Dr. Babatunde Adebol Olusegun Aiyelabola (PSI)
- Dr. Ivan Ivanov (WHO)

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Chapter 1 – Keynote speeches and special workshops

The International Committee of the Red Cross Health Care in Danger: Updates from the field

Keynote speech

Erin Downey

International Committee of the Red Cross (ICRC), Geneva, Switzerland

Abstract

Dr. Downey's talk will overview the International Committee of the Red Cross (ICRC), Health Care in Danger (HCiD) Initiative, including its current directions for 2018 and beyond. HCiD issues pertaining to targets of violence, prevention strategies, and practical tools for protecting the operational delivery of health care in the field will be discussed. The HCiD Community of Concern, representing a growing global network, will be described in the context of how they can support domestic partners to strengthen national frameworks for the protection of health care.

Learning objectives

Participants will...

1. Understand the structure of the Health Care in Danger program of the International Committee of the Red Cross and its current challenges.
2. Learn about prevention strategies, and practical tools for protecting the operational delivery of health care in the field.
3. Learn how the International Committee of the Red Cross supports domestic partners to strengthen national frameworks for the protection of health care.

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The Ontario Project on Violence Prevention

Keynote speech

Vicki McKenna

Ontario Nurses' Association

Keywords: Violence prevention, workplace safety, stakeholder engagement

Abstract

Ontario Nurses' Association (ONA) President Vicki McKenna, RN, will speak about ONA's successful advocacy work on violence prevention which spurred its 65,000+ members to take steps to improve their workplaces. Hear how ONA constantly advocated and put pressure on the Ontario government to make legislative changes to improve workplace safety. ONA's inspiring advocacy story from point-of-care members to government officials should not be missed.

Learning objectives

Participants will...

1. realize the necessity of engaging with key stakeholders in order to advance workplace safety.
2. appreciate the role of pressure groups to influence legislation.

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Advancing the Delivery of Positive Practices: Addressing the “Patient-Staff” Power Differential in Mental Health Settings

Keynote speech

Kevin Ann Huckshorn

Introduction

Violence in inpatient mental health settings is an international problem that can result in serious injuries to individuals in care the staff that serve them, poor clinical outcomes, lawsuits, high staff turnover, staff burnout, and diminished job satisfaction, and deaths (Huckshorn, et al., 2018). Settings where the most violence occurs include emergency rooms, and inpatient units in both psychiatric hospitals and residential programs (Drori et al., 2017); Muskett, 2014). Violence in healthcare settings has generally been defined as verbal or physical aggression, by either patients or residents, that is directed toward self, property, staff, or other persons occupying the milieu (Papadopoulos et al., 2012). This type of violence occurs on a continuum that includes verbal threats, stalking, bullying, self-harm, property destruction, and physical assaults with or without weapons.

Ensuring safety for patients and staff is most often the primary goal for most psychiatric hospitals and residential programs. As such, the reduction of violence in behavioral health settings has become a significant and international priority over the last two decades with a focus on the demographics of the person who is violent and other causal factors (Fifth International Conference on Violence, 2016). One phenomenon that has not been studied as thoroughly is a subtler form of violence described in the literature as “*disruptive behavior by staff.*” (TJC, 2008). This literature describes “*staff to staff behaviors*” that are characterized as bullying, coercive, and intimidating and that can lead to safety issues for both patients and staff (TJC, 2008).

However, there is another closely related phenomenon, rarely discussed or studied, that comprises the focus of this paper. This phenomenon is related to staff behaviors toward patients that include mostly subtle, but sometimes overt, discrimination and disrespect that can result in escalating emotions and may reflect an abuse of the power that staff have over persons who are being served in that setting (Papadopoulos et al, 2012; Huckshorn, 2013).

The management of violence perpetrated by patients in inpatient psychiatric settings most often includes the use of forced involuntary medication, manual holds, seclusion, and mechanical restraint to manage these behaviors (Huckshorn et al., 2018). These strategies are inherently risky for both persons in care and staff since the behaviors can result in physical injuries, emotional trauma, loss of institutional accreditation, and the imposition of critical oversight by governmental and regulatory agencies alike. , Given these poor outcomes, inpatient violence including the use of seclusion and restraint has been increasingly described and studied over the last two decades (Huckshorn et al., 2018; Lebel et al.,).

Background

To date, there are three violence models portrayed in the literature. The first is the “*Blame the Patient*” model that is predicated upon beliefs that if the person in care would stop being aggressive then violence levels would decrease. In this model, violence is attributed to symptoms of mental illness or substance use and volitional behaviors related to antisocial and other character disorders (Huckshorn et al., 2018). The model is best illustrated by statements from staff including, but not limited to, “*these patients are much more violent these days...*”; “*he knew what he was doing and needs to get consequences*”, and “*I would not let my kids get away with that behavior...*” (Huckshorn, personal notes).

The second model is the “*Environmental Factors Model*” (Huckshorn, et al., 2018). This model holds that the persons receiving care in psychiatric inpatient and residential settings become violent due to “*triggers*” in the care environment itself. These triggers include crowded settings, lack of privacy, poorly managed environmental temperatures, either poor quality or quantities of food... all leading to general physical discomfort and/or feelings of distress. Additional triggers can include institutional rules that make little sense to the person in care and that can feel de-humanizing. Included here are being expected to line up for services, enforced wake-up and sleep times, being forced to receive medications that are unwanted, and having nothing productive to do while in the facility (Huckshorn et al., 2018).

The third model that currently appears to be most useful to those working in the field is one that is informally known as the “*Situational Model*” (Wikstrom & Treiber, 2009; Huckshorn et al., 2018). This model combines the learnings that have emerged from the previously described models resulting in an understanding that violence in inpatient and residential settings is a complex phenomenon and is difficult to study. This model posits that patient, staff, and environmental factors are often inter-related when determining the root causes for adverse events (Wikstrom & Treiber, 2009; Huckshorn, 2013).

During literature reviews that were conducted to develop the *Six Core Strategies to Prevent Conflict and Trauma in Behavioral Health Settings*© (Huckshorn et al., 2018), several studies and articles were found that discussed additional, though not often mentioned, causes of conflict and violence specifically related to the outcomes when human beings are placed in restricted settings (Huckshorn et al., 2018). Several of these studies described typical mental health locked service settings and others portrayed prison settings. More recently, the literature on violence has expanded and more insights have emerged about humans in locked settings, particularly related to the power differential between facility staff and residents.

This article summarizes the key literature on the causes of violence in inpatient mental health settings, as related to staff-- patient relationships that cause and/or perpetuate conflict. This review is informed by the author’s lived experience as the current director of a large forensic hospital in the United States that is being transformed from a prison that houses “*inmates*” to a psychiatric hospital where these same individuals are regarded and receiving clinical services as “*persons served*”. This organizational transformation has been ongoing for less than two years and is focused on changing the mission, values, workforce, institutional rules, policies, and procedures from a correctional setting to a healthcare setting based on evidence-based

practices (Huckshorn, 2018, personal notes). Since early 2017 there has been a dramatic reduction in restraint use (down 96%) and seclusion use (down 84%), to date (Huckshorn, 2018, personal notes). To reduce the use of S/R even further, the hospital's clinical and administrative leaders are currently focused upon determining and ameliorating the specific root causes of all such incidents. Of the five key root causes for the remaining use of S/R, one has been identified as "*problematic staff attitudes and practices.*"

This literature review revisits older findings and incorporates new literature in an attempt to designate factors related to staff actions that increase the probability that violence will ensue due to staffs' use of coercive management methods. The literature, although sparse, has documented staff behaviors that are often uncomfortable to discuss and therefore have taken a back seat to other more understandable and less pejorative findings.

Literature Review: Key Studies in Chronological Order

On Sunday, August 17, 1971 the Stanford Prison Experiment was initiated (Zimbardo, 1971). This study sought to determine how individuals would react to being in a position of powerlessness. Seventy (70) college students applied to participate and subsequently were administered psychological examinations to eliminate anyone with a possible mental health disorder including character disorder traits. Twenty-four (24) students were eventually selected and randomly assigned to be either a guard or an inmate in a fake prison housed in the basement of a Stanford University building. It is important to note that these young male students were living in a time where activism for civil rights and protests against the Vietnam War were the norm for most college campuses (Zimbardo, 1971). The guards were encouraged to think and act like actual guards except that they could not use physical violence. They were instructed to create a prison environment where the inmates felt powerless (Zimbardo, 1971).

Within 24 hours, many of the student guards transformed from typical students to sadistic prison "*guards*" who routinely taunted, debased, and verbally abused the student inmates. The "*inmates*" were forced to strip naked, not allowed to sleep, forced to perform menial chores, had bags placed over their heads, locked in a small closet, and forced to use plastic buckets as toilets. The study, initially expected to run for two weeks, was shut down in six days after several student inmates became violent, depressed, and/or hysterical (Zimbardo, 1971).

In 1973, David Rosenhan conducted a study designed to examine the impact of environment via how being involuntarily admitted and confined to a psychiatric facility might in and of itself change the way an individual patient would be perceived and valued (1973). This study was titled, "*On Being Sane in Insane Places.*" Eight people, heretofore known as "*pseudopatients,*" volunteered to act as if they were mentally ill to gain admission to an inpatient facility. These pseudopatients, comprised of three women and five men, included a graduate student, three psychologists, a pediatrician, a psychiatrist, a housewife, and a painter. Over the length of the study these research subjects got themselves admitted, by alleging psychotic symptoms, to twelve hospitals in five states (Rosenhan, 1973). Other

than the alleged symptoms, and providing false names and vocations, the pseudopatients portrayed the truth about themselves and their life histories.

Once admitted, the pseudopatients immediately reverted to their usually normal behaviors and reported that their symptoms had remitted. Other than being anxious, checking the medications prescribed to them, being bored, and worried about being exposed, these individuals behaved as they had prior to their admission. They demonstrated cooperation with all staff directions, noted they were “*fine*” when asked, interacted with other patients, and devoted their time taking copious notes on their experiences (Rosenhan, 1973). Even so, these eight pseudopatients were never discovered. All were eventually discharged with a diagnosis of schizophrenia, in remission (Rosenhan, 1973).

One finding was particularly significant. In the notes that the pseudopatients kept were many recorded events where actual patients’ distress was misinterpreted by staff. Often a patient was observed to become extremely agitated due to being mistreated by a staff member. Staff rarely asked a patient about the cause of their agitation. Rather, staff would assume that a patient’s distress was due solely to their pathology (Rosenhan, 1973). Never did the staff consider that either the structure of the hospital environment or staff’s behaviors had anything to do with a patient’s behavior.

Rosenhan followed his initial study with another with a slightly reversed methodology. In this study, staff at one psychiatric hospital were informed that there was a high probability that some “*fake*” patients were going to be admitted over the next three months. When asked to identify which, of 193 patients admitted to their hospital in the three months, were “*fake*” patients, at least one staff identified 41 patients who had been admitted were not real patients; 23 were suspect by one psychiatrist, and 19 by a psychiatrist and another staff person (Rosenhan, 1973). In reality, no “*fake*” patients were ever admitted to this hospital.

Rosenhan suggest that when a person is given a psychiatric label, that label assumes a life of its own and exerts a strong influence regardless of any actual behaviors a patient may exhibit. Once such a diagnosis has been bestowed, earned or not, the person is always viewed through that lens and consequently expected to behave in pre-determined ways that are consistent with the diagnoses. Perfectly normal behaviors become distorted through this diagnostic lens and pathologized. Rosenhan believes that, eventually and inevitably, the diagnosis becomes a self-fulfilling prophecy (Rosenhan, 1973).

Rosenhan’s second study also addressed the phenomenon of depersonalization. Rosenhan writes of this experience through the notes taken by his research team. Notes documented the extreme frequency where psychiatric patients were observed to be shamed, humiliated, ignored, and verbally taunted, and physically abused for not following rules that the staff had set. The pseudopatients wrote about the “*overwhelming sense of powerlessness*” they felt when assuming the role as a patient (p. 183). They described the deprivation of basic rights; loss of credibility regarding their complaints and concerns; loss of freedom; and the lack of privacy. At times the pseudopatients reported that they felt invisible and were treated as such (Rosenhan, 1973).

In 1985, Robert Okin, a physician, examined a number of U.S.-based psychiatric hospitals' use of seclusion and restraint (S/R) and in one state alone. He found that even though these hospitals were state-funded and state-operated, the use of S/R varied significantly, and differences could not be explained either by patient pre-admission behaviors or by patient demographics. He concluded that factors related to the individual hospital's practices and conditions were responsible for these different rates of use (Okin, 1985).

In 1989, Eileen Frances Morrison, a nurse researcher, conducted a multi-month ethnographic study on three inpatient units. She titled this study, *"A Tradition of Toughness: A Study of Nonprofessional Nursing Care in Psychiatric Settings."* Morrison defined violence as, *"any verbal, nonverbal or physical behavior that is threatening (to self, others or property), or physical behavior that actually did harm..."* (p. 32). She found that the care environment was characterized by a *"tradition of toughness"* and organizational values that emphasized control and safety (Morrison, 1989, 34). The research documented that both staff and the organization believed that patients *"are sick and must be treated as such"* (p.34). As such, patients' acting-out behaviors were viewed as symptoms of mental illness rather than what the patients told the researcher which was *"to get these people off my back"* (p. 34). While licensed nurses were available, they had rigidly defined roles, which resulted in non-licensed staff interacting with patients most of the time.

Morrison found that the hospital's policies and its enforcement of rules derived from the policies *"inevitably leads to violence through the process of confrontation and escalation of the violent situation"* (p. 35). The defined role of the non-professional staff members (mental health assistants) was called *"enforcing."* The hospital unit enforcers used thematic strategies called *"policing"*, *"supermaning"* and *"putting on a show."* The goal of these strategies included enforcing rules designed to control patient behaviors; sanctioning the physical behaviors of like-minded staff to control patients; protecting the remaining staff; receiving positive reinforcement from other staff members; and being highly skilled in hiding behaviors from facility administrators (p. 35).

Mohr and Anderson (2001) performed a retrospective review on the use of seclusion and restraint in child and adolescent settings. They found that the four most common reasons used to support staff's use of S/R did not meet the minimum criteria required its use as stipulated by federal regulations (2001). Rather, they found that the reasons provided for using S/R were based upon outdated attitudes, disrupting the environment, refusal to obey staff orders, and preventing property damage (2001). None of these reasons met either federal criteria or those identified by the Joint Commission which sets standards required to maintain hospital accreditation (2001).

Another study reviewed 215 assaults in a two-month time frame in one child residential facility (Ryan et al., 2004). This study yielded similar results in that the causal factors for the use of S/R appeared to be the result staff verbal directions, re-directions, and limit-setting. Patient ages, involvement with juvenile justice, diagnoses, and gender were not noted to be significant.

In 2005, the state department of mental health in South Carolina conducted a large-scale study of the state's inpatient's facilities that included service users' perceptions of their experiences in the hospital (Robins, et al., 2005). Patients described a high prevalence of "*sanctuary harm*" in care settings in which they had assumed they would be safe (2005). Specific findings included feeling a constant threat of violence from both peers and staff; staff's idiosyncratic use of the rules; staff not knowing service users as individuals and treating them impersonally; unfair treatment practices; and being embarrassed or disrespected in the treatment setting (2005).

In 2004, O'Brian and Cole conducted a study in an acute psychiatric care unit in Australia to develop an understanding of the experiences of patients, patients' relatives, and nurses (2004). The researchers found that violence in this setting appeared to be related to environmentally driven factors such as forced compliance with rules and not a result of symptoms (2004). They also found that violence management strategies primarily relied on control and containment of escalating patient behaviors and lacked virtually no prevention strategies.

In 2012, a systemic review of the literature was conducted with a goal to identify the types of recorded antecedents of violent events in psychiatric inpatient settings and to estimate the proportion of aggressive incidents related to each antecedent (Papadopoulos et al., 2012). Among many findings, data analyses found that the most frequent antecedent to aggressive and violent incidents was staff-patient interactions (p. 434). A deeper examination of the data found the most common behaviors to be interactions that restricted or denied a patient's request. The researchers' described these findings as "*unsurprising*" and further proof of the need for patients to feel independent and to be treated as an individual (p. 434). They conclude that "*such findings underscore the influence that staff have in making wards safe and efficacious environments*" (p. 434).

The second most common antecedent found were "*behavioral cues*" indicating an escalation of agitation, confusion, increased motor activity, or increased attention-seeking were common and readily observable signs that an event was escalating (Papadopoulos et al., 2012, p. 435). The researchers' conclusions about this antecedent was that these behavioral cues should provide ideal opportunities for staff to intervene in a timely way to avoid such incidents, to do so effectively would require significant attitudinal and clinical skills (p.435). The third finding, mentioned here, was that one of four aggressive events in the data appeared to be triggered by patient-patient interactions that ended poorly. The researchers' noted that this finding was indicative of the importance of staff both noticing, and intervening, before these events escalated to a toxic level (p. 435).

In 2013, another retrospective study was conducted on adult patient records, specifically examining qualitative data that depicted on restraint events, as documented on a *Restraint Event Client-Patient Debriefing and Comments Form* maintained from September 2009 to February 2013. Patient statements about antecedents to staff's use of restraint included feeling angry about loss of personal autonomy and freedom, interpersonal tensions either with staff or other patients, not being heard, and not having one's needs met (2015). These findings included staff not paying attention to what was happening on the unit and/or ignoring other patients who were causing conflicts. The researchers identified a "*clear power*

differential between patients and staff” that, if not managed, could lead to anger, conflicts and subsequent violence (p. 390).

In 2016, Brophy studied barriers to reducing seclusion and restraint use in two types of mental health settings (Brophy et al., 2016). Ten (10) separate focus groups comprised of 66 consumers and supporters were conducted in four cities and one rural setting. Although the reduction of S/R was supported by all participants it was the identified barriers to this goal that were particularly significant. Participants explicitly identified the environment of care as an obstacle, both in the emergency room and the in-patient settings, including poor lighting, substance use, and unwelcoming waiting areas and rooms (Brophy et al., 2016). When asked about implicit barriers, the participants identified the breach of patient rights including the restriction of basic freedoms and the lack of acknowledgement of these breaches by administrators when these concerns were brought to their attention (p. c). The participants also identified the practice of “*paternalism*” as leading to stigmatization and the creation of a culture of fear as key factors in the misuse and overuse of S/R (p. c).

Conclusions

This literature review should command the attention of any individual interested in understanding the violence that occurs in psychiatric inpatient and residential settings. This literature reflects staff behaviors that are reportedly the reason that so many consumers have reported experiences of being treated as an object or “*other*”, having no one to talk with, not feeling cared about as an individual person, feeling belittled, shamed, or treated unfairly (Krieger, et al, 2018; Huckshorn et al., 2018 and Anderson & West, 2011). Staff behaviors that escalate patients can, and do, lead to conflicts and violence that has much to do with a patient’s feelings of losing one’s personal autonomy and being disrespected.

The unequal power base, on one hand, between staff who work in inpatient and residential mental health settings, and, on the other, people they serve, appears to be an important construct for mental health researchers to examine. This power differential appears to be a significant, but under-studied, construct in relatively common staff-patient interactions that lead to conflicts, violence, and the use of coercive interventions anywhere where some human beings have power over other humans. Although it appears that we have had access to literature on this power differential for decades, the mental health field has not done an effective job in highlighting either its importance or its impact on the safety of our treatment settings.

It is also clear that the mental health workforce is different in composition from country to country. For example, some countries strongly rely on unlicensed staff to spend the most time with people in our care systems. This author believes that when we choose to hire relatively uneducated workers to provide care to some of the most ill and vulnerable patients in our systems, we then need to do a better job of recruiting, training and supervising these individuals. However, it is also wise to pay attention to all of our staff’s behaviors as reflected in the recent literature related to staff to staff violence (TJC, 2008).

This author can certainly posit an assumption about the circumstances surrounding our relative silence re: staff-patient interactions. For one, most of the staff that work in psychiatric settings are heroes. They are hard-working and compassionate individuals who provide great care. Another reason is that the issue of staff treating persons in care “poorly” comes uncomfortably close to patient abuse, an extremely serious charge in the US that involves mandatory state and federal reporting. For another, an abuse of power is observed, it remains widely under-reported due to staff and organizational dynamics that take the form of potential intimidation from supervisors and peers. In addition, as noted in a few studies, misuse of power is often extremely subtle, leading the observers to second guess what they actually perceived. Finally, the vast power differential between the organization and its staff, as compared to the patients, renders first-person accounts by patients to be suspect due to the power differential itself; a complicated but real injustice that is steeped in both stigma and discrimination.

If we have even a few staff working in our settings who are treating the people we serve poorly they are doing this either because they have not been well trained; are victims of trauma themselves; have become confused by the power they have over other, more vulnerable people...or a combination of these factors. These issues can be remedied with attention and effort. We need to do more to intently focus on this issue since it appears to be a core factor in violence in inpatient settings and the use of coercive measures such as seclusion and restraint.

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Advancing the delivery of positive practice

Keynote speech

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Keywords: Violence in the health sector, occupational safety and health, labour rights, positive practice, instruments and tools

Abstract

Violence is a threat to the dignity, security, health and well-being of everyone. Violence in the world of work has an impact on workers and employers, on their families, communities, economies and society as a whole. It affects workplace relations, worker engagement, productivity and organizational performance. With the adoption of the 2030 Agenda for Sustainable Development, violence in the world of work has been put in focus at the global level through the call for the achievement of full and productive employment and decent work for all women and men, the reduction of inequalities and the elimination of all forms of violence against all women and girls in the public and private spheres.

In the health sector, violence at work, including harassment, ranging from verbal abuse to physical aggression, is inflicted on health workers by colleagues, the health facility hierarchy, patients and relatives of patients or the general public. Its prevalence is persistently high in the sector in both developed and developing countries. Moreover, health workers are increasingly under attack in emergencies and conflict situations. Violence is a human rights issue and particularly the deliberate targeting of health facilities has drawn attention as it is a violation of international human rights and humanitarian laws.

Informed by a rich body of research, many initiatives worldwide have been developed to address the issue of violence in the health sector using a variety of approaches, methods and tools with the aim to prevent and eliminate violence.

The paper focuses on the aspect of violence at work in the health sector and the protection of health workers from a labour rights perspective. Addressing violence in the world of work in its complexity needs an integrative approach taking into consideration societal, structural, legal, organizational, and individual factors. A broad range of tools and resources have been developed by international organizations, setting standards and guiding the implementation of responses at international, national and organizational levels. It provides an overview on past, present and future developments of resources and instruments available to address violence at work. The importance of intersectoral collaboration and multi-stakeholder involvement further emphasizes social dialogue as a key means to advance responses to violence in the world of work. The paper encourages to look beyond the health sector in order to harness the full potential of the globally available instruments.

Learning objectives

Participants will...

1. become aware of tools and instruments designed to address various aspects of violence at work.
2. gain insight into the importance of intersectoral collaboration and multi-stakeholder involvement in order to handle the challenge of violence in the health sector and beyond.

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The ONA workshop

Special workshop

*Athena Brown, Erna Bujna, Nancy Johnson, Kelly Johnston, Trudy Frank-MacEwen, Carol Gunsch, DJ Sanderson, Karen MacDonald
Ontario Nurses' Association (ONA), Toronto, Canada*

The ONA workshop will be facilitated by Athena Brown, Manager Provincial Service Team and with her will be the Subject Matter Experts Erna Bujna, Labour Relations Officer and Nancy Johnson, Labour Relations Officer and the following ONA Members: Kelly Johnston, H&S rep; Trudy Frank-MacEwen, Bargaining Unit President; Carol Gunsch, Bargaining Unit President; DJ Sanderson, Bargaining Unit President; Karen MacDonald, H&S rep.

A panel of five local ONA leaders will talk about how ONA has worked over the years to protect their members from workplace violence. They'll share challenges they have seen and continue to see on the ground, as well as successes in getting members and the health care sector to understand that no one should accept violence as part of a health care worker's job. ONA training, reporting campaigns, and collaborative work with unions, government and employers have been some of the strategies that have contributed to increasing success in protecting ONA members from violence.

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The Choreography of Catharsis: Recognizing, Responding, and Recovering from Violence in the Health Sector

Special workshop

Patricia P. Capello (USA)

Even before birth, human beings are sensitive to cues from their environment and respond to them on a body level. As we grow, our senses develop and are refined by both our physical surroundings and our emotional and relational connections to others. The “*intuitive self*” can access vital nonverbal cues that can be used to assess the world and people around us.

By practicing the basic constructs of DMT (dance/movement therapy) individuals can begin to hone the natural skills that are present in everyone. DMT exercises in attunement include elements that are fundamental to the health care professional: awareness of body position; body boundaries; engagement and disengagement on a body level; and the non-verbal communication of the physical self.

This experiential workshop will help participants recognize informational sensations in their own bodies and develop a kinesthetic empathy and awareness of those in others. Through practice of the movement elements of flow-weight-time-space, our responses to interpersonal situations (both aggressive and non-aggressive) will be better understood and regulated. Finally, exercising the body’s innate recuperative abilities by exploring the power of breath, tension-relaxation, and strength, participants will learn how to activate their own recovery from incidences of violence.

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Any tolerance on zero tolerance?

Special workshop

Odile Frank, Brodie Paterson, Kevin McKenna

Keywords: Zero tolerance, evidence base, informed decision making

Abstract

While interest in Zero Tolerance approaches and/or policies as responses to aggression and violence within health services has grown very considerably over the last twenty years, the issue remains a hotly '*contentious*' issue.

This '*contentiousness*' reflects both rational and emotive arguments and propositions with very strongly held views on both sides of the debate. This contentiousness is both enhanced and perpetuated by an evidence base which is incomplete, ambiguous, and sometimes conflicting, and potential incongruence or direct conflict between available evidence and the mandates imposed by professional and/or regulatory bodies.

Debates on the subject of Zero Tolerance are often framed dichotomously, with polarised positions characterised by sometimes impassioned arguments and proposals of actions which extend beyond and/or contradict available evidence.

This highly interactive and engaging workshop will explore the issue of Zero Tolerance which emphasis placed on gaining a considered understanding which might, consistent with the theme of this conference, inform and advance positive practice.

The workshop is will be structured in components:

1. The first component will provide a very brief contextual overview of Zero Tolerance.
2. The second component will present a synopsis of both "*proponent*" and "*opponent*" propositions, arguments and evidence delivered by Dr Odile Frank and Dr. Brodie Paterson. Both Odile and Brodie are widely acknowledged and respected international experts, and both are compelling and impassioned orators.
3. The third component will be a facilitated debate involving all workshop participants in the critical evaluation of the proposed "*proponent*" and "*opponent*" positions which will be supported by using interactive technology.
4. The final component will summarise key information with an emphasis on how the learning from the workshop can inspire, inform and advance positive practice.

Learning objectives

Participants will...

1. learn opinions regarding the pros and contras pertaining to zero tolerance.
2. have sufficient information on zero tolerance to form their own informed decision.

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Chapter 2 – Causes of aggression or violence

Organizational Determinants of Bullying and Work Disengagement Due to Bullying Among Hospital Nurses

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Workplace bullying, nurses, hospitals

Abstract

Background and Context

Bullying is endemic to the nursing profession and is a prevalent problem in healthcare settings around the globe. Studies report an association between nurse bullying and intention to leave as well as actual turnover. However, no research to date has examined the degree to which withdrawal from the job/organization is specifically due to bullying. This study aimed to identify organizational determinants of nurse bullying and work disengagement due to bullying.

Methodology

A system-wide electronic questionnaire on workplace bullying was administered to all registered nurses (n=1780) currently employed in a large healthcare system in the Midwestern United States. A total of 432 nurses responded to the questionnaire (20.6% response rate); of these, 331 had complete data and were included in the analysis. The questionnaire measured workplace bullying in the past 6 months, leadership, competence development, psychological safety, relational coordination, work stress, and nurse health. Dichotomous variables (yes/no) were used to measure personal experience, and witnessing of, bullying, respectively. Disengagement due to bullying was measured using 3 items concerning having considered taking time off, changing departments, or quitting because of bullying. Logistic regression was used to identify factors associated with experiencing and witnessing bullying, respectively. Linear regression was conducted to identify organizational predictors of disengagement due to bullying.

Findings

Approximately 37% of respondents had been bullied in the last 6 months, most often by another nurse (21%), physician (11%) or immediate supervisor (10.3%). More than half of the nurses (51%) had witnessed someone else at their workplace being bullied in the last 6 months.

Over 20% of nurses had considered taking a day off because of bullying; 29% had considered changing departments, and 26% had considered quitting their present job. Psychological safety, a measure of team trust and respect, was the only organizational factor significantly, inversely associated with being personally bullied (OR 0.29, 95% CI 0.17-0.50, $p < .001$) and witnessing bullying (OR 0.22, 95% CI 0.12-0.38, $p < .001$). Being personally bullied, but not witnessing bullying, predicted disengagement due to bullying ($\hat{\alpha} = 0.35$, $p < .001$). Psychological safety ($\hat{\alpha} = -0.32$, $P < .001$) and competence development ($\hat{\alpha} = -0.15$, $p < .05$), a measure of opportunities to develop skills and knowledge at work, were both inversely associated with disengagement due to bullying. The final model explained 48% of the variance in disengagement due to bullying.

Implications

Hospital units with work teams marked by trust and respect among nurses are less likely to have a culture of bullying. Both psychological safety and competence development have a protective effect on nurse disengagement from the workplace due to bullying. Interventions to mitigate and prevent bullying and disengagement among nurses should encompass efforts to enhance psychological safety and opportunities for competence development.

Learning objectives

Participants will...

1. be able to identify organizational factors that are associated with being personally bullied and witnessing bullying among hospital nurses.
2. be able to identify the risk and protective factors of work disengagement due to bullying among hospital nurses.

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Violence towards Healthcare Professionals by patient relatives in India: Prevalence, causes and strategies for prevention

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Violence, healthcare professionals, Doctors, Nurses, paramedics, aggression, workplace violence

Abstract

Introduction

In India, the number of violence against medical professionals including doctors, nurses, paramedics and other hospital staff are increasing day by day. Number of incidents of physical attack on healthcare professionals is rising in the recent past. Unlike western countries, it is a unique problem in India because the healthcare professionals have to manage a large population with low health literacy, poor infrastructure, lack of human resource and limited government funding. Even though there are different laws to protect the medical professionals from violence, these are not functioning effectively.

Prevalence

Between 8% and 38% of health workers suffer physical violence at some point in their careers (WHO, 2010). A survey conducted by IMA (Indian Medical Association) states, *“more than 75% of doctors face violence at work specially while dealing with patients in emergency units. The abuse may range from verbal abuses, manhandles physical assaults, threatening and in rare cases murder.”* The Quint reported that two resident doctors, including a woman, were allegedly beaten up by a patient’s relatives at the JJ Hospital in Mumbai on 19 May 2017.

Causes

A number of factors precipitate the violence against health care persons. Some of them are low health literacy of the people, mentality of the mob, increasing cost of healthcare, poor quality of healthcare, insufficient government funds, poor communication between health care professionals and patients which leads to mistrust, inexperienced staff who doesn’t know to tackle the emergency situations and inadequate security in the health care setting.

Interventions

Interventions to prevent violence against health workers include increasing the physical security of the setting, developing a central law for the prevention of violence against health workers and settings, making modifications in the Indian Penal Code to provide stringent punishment to offenders involving in violence, restricting the entry of visitors in the hospital or health care setting and providing training to health care professionals to improve the communication skills.

Conclusion

Healthcare professionals are the roots of health care industry all over the world. It is essential to protect them from violence by taking necessary actions.

Learning objectives

Participants will...

1. be aware of the rising violence towards healthcare workers in India.
2. understand the causes of violence towards healthcare professionals by patient's relatives.
3. be able to analyze the strategies to prevent violence towards healthcare professionals.

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Persistent Negligence of Violence against Health Workers in Nigeria and Call for Action

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Workplace violence, Nigeria, Under-reported, Data collection, lukewarm response, Health workers, Psychological trauma, Service delivery

Abstract

Background

Workplace violence in the health-care sector in Nigeria has for too long been tolerated and largely ignored. Workplace violence is everyday reality, but its persistent occurrence in Nigeria health sector trumps concern.

However, lukewarm response or no response at all deters health workers from reporting incidents, further obscuring the issue. Adding layer of difficulties to the already existing problem can be blamed on religious beliefs, illiteracy, poverty and insurgency especially in the Northern Nigeria where there is poor reputation for violence against health workers.

Nevertheless, prevalence is not restricted to patient-healthworker dispute but growing dispute among health workers that tends to erode health work ethics and water down the quality of health care service delivery.

Violence challenges faced by health workers appears in different forms ranging from physical assault, verbal abuse, bullying, stalking, terrorism, sexual harassment among others.

However, In Nigeria these violence incidents on health workers are grossly under-reported and data collected on them circumscribed, thereby limiting the magnitude of the problem.

Methodology

In this participatory cross-sectional study in an organized self-reported questionnaire distributed to 215 health personnel in three health facilities in Nigeria.

Their experience of workplace violence in line of work reported by 205 respondents is as thus:

Results

Most of the respondents had experience workplace violence with more than (60%) occurring in the clinic and (18%) occurring outside the clinic but work related. Psychological trauma account for (78%) of all abuses and verbal abuse was the most prevalent of (85%), while sexual harassment account for (5%), terrorism was the least on (0.05%).

Patients and their relations were the main perpetrators of physical assault and threats, religious beliefs and terrorism account for some death of health workers in Nigeria, while senior colleagues were the main workplace bullies.

Way Forward in Preventing and Reducing Violence against Health Workers in Nigeria:

One of the best protections employers can offer their workers is to establish a zero-tolerance policy toward workplace violence. This policy should cover all health workers, patients, visitors, contractors, and anyone else who may come in contact with health facility. The risk of assault can be prevented or minimized if government and private employers take appropriate precautions.

Learning objectives

Participants will...

1. learn that violence against health workers can be minimized if robust policies are put in place to arrest trajectory aggression.
2. identify factors responsible for internecine squabble between doctors other health workers and how it affects health care service delivery.

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Horizontal Violence, Psychosocial Work Environments, Burnout, Secondary Traumatic Stress, and Moral Distress Among Hospital Nurses

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Horizontal Violence, Moral Distress, Psychosocial Work Factors, Burnout, Secondary Traumatic Stress, Nursing

Abstract

Background

The purpose of this study was to examine the impact of psychosocial work factors, horizontal violence, burnout, and secondary traumatic stress on moral distress among hospital nurses across departments and roles, specifically including nursing leaders.

Methodology

A cross-sectional design was used to survey all full and part time nurses at three suburban community hospitals in the Western United States. Upon receipt of IRB approval, all staff members at these three facilities with a nursing job code were invited to participate via organizational email including a link to the anonymous survey.

Instrumentation included the Copenhagen Psychosocial Questionnaire, short form, used to measure nineteen dimensions of the psychosocial workplace (National Centre of Workplace, 2007). The Horizontal Violence Survey (Dumont, Riggelman, Meisinger & Lein, 2011) was used to capture frequency of exposure to horizontal violence among nursing colleagues. The Moral Distress Scale – Revised (Hamric, Borchers & Epstein, 2012) is a 21-item instrument assessing the frequency and intensity of moral distress arising from clinical situations, internal and external constraints. The Professional Quality of Life: Compassion Satisfaction and Fatigue v. 5 tool (Stamm, 2010) is a 30-item instrument with subscales designed to measure the three dimensions of Professional Quality of Life: Secondary Trauma, Burnout, and Compassion Satisfaction. Backward linear regression modeling was conducted to determine the effects of the independent variables on moral distress.

Findings

A total of 413 nurses (age $M = 42$ yrs, $SD = 11.7$; 90% female) representing 15 departments and 15 different nursing roles completed the survey. Backward linear regression modeling identified 6 variables explaining 42.1% of the variance in moral distress experienced by these nurses ($R^2 = .421$, $F(2,258)=31.24$, $p < .001$). Of the predictors, exposure to horizontal violence had the greatest negative impact on moral distress ($\beta = .32$, $p < .001$), followed by rapid pace of the job ($\beta = .17$, $p = .001$), secondary traumatic stress ($\beta = .167$, $p = .005$), and increased demands of job skills and knowledge ($\beta = .14$, $p = .007$). Trust in senior management to provide truthful information and trusting employees to do their job had a significant protective effect on moral distress ($\beta = -.24$, $p < .001$),

Implications

Nurses in all departments and in all roles experienced horizontal violence, moral distress, burnout, and secondary traumatic stress to varying degrees. Horizontal violence had the highest negative contribution to the development of moral distress and trust in senior management had a significant protective effect. Interventions designed to address any one of these variables may positively impact the others, however, focusing on issues surrounding horizontal violence and lack of trust in senior management may have the greatest contributions to improve the experience of nurses in their work environment.

Learning objectives

Participants will...

1. be able to differentiate the concepts of moral distress, burnout, and secondary traumatic stress.
2. be able to describe the relationships between horizontal violence, leadership and moral distress among hospital based nurses.
3. understand the connection between psychosocial workplace factors, horizontal violence, burnout, and secondary traumatic stress on moral distress among hospital based nurses.

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MAVAS-R Responses: Healthcare Workers Involved in Workplace Violent Events from Adult and Pediatric Medical Settings

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: MAVAS-R, medical inpatient units, workplace violent events, inpatient aggression, inpatient violence, adult inpatient, pediatric inpatient

Abstract

Background

Healthcare settings are a primary location for exposure to workplace violence. Management of workplace violent events with patients (WVEs) on medical units is an important clinical issue for multidisciplinary teams. Staff attitudes and beliefs influence their management approaches when dealing with violent patient behavior. The purpose of this study was to assess healthcare worker attitudes and beliefs among those involved in WVEs, compared to those who were not, in management of violent patient situations.

Methods

Two samples of healthcare workers one from adult and one from pediatric inpatient medical units were surveyed. Participants completed The Management of Aggression and Violence Attitude Scale (MAVAS-R), identifying attitudes and strategies about inpatient aggression management. The MAVAS-R is a revised 1-5 Likert scale of 27 items, summed for a total score and four subscale scores. Subscales reflect perceived contributions to patient violence: Internal, External, Situational/interactional, and Management. The setting is a large Midwestern academic hospital with a multidisciplinary (Registered Nurses, Patient Care Assistants, Physicians, Social Workers and Security) convenience sample of healthcare workers (N=380) from adult inpatient units and (N=91) from pediatric units

Findings

Participants involved in WVEs (n = 252) on adult inpatient units reported significantly different responses related to three factors: management (n=7), internal (n=4) and situational (n=1). Major management factor items indicated agreement that meds are valuable to treat aggression (p<.0001) and meds could be used more frequently (p<.0001). Disagreement that physical restraint is used more than necessary (p<.0001), alternatives to restraint/sedation could be

used more frequently ($p=.02$), and de-escalation successfully prevents violence ($p=.01$) was reported. Major internal factor items for respondents involved in WVEs on adult inpatient units indicated agreement that patients are aggressive because they are ill ($p=.01$), certain types of patients become aggressive ($p=.01$), and aggressive patients should try to control their feelings ($p=.02$). One situational factor represented disagreement that improved 1:1 staff-patient relationships would reduce aggression incidents ($p<.0001$). Conversely, participants involved in WVEs ($n = 64$) on pediatric units differed on one MAVAS-R management item agreeing that *'patient aggression could be handled more effectively on this unit'* ($p < 0.001$).

Implications

Variation in attitudes and beliefs between healthcare workers on adult versus pediatric units may be related to differences in patient presenting problems in the practice setting, severity of patient violence, or healthcare workers' perception of intentional or unintentional violence by the patient. Developmentally appropriate violence reduction options for specific patient populations or illnesses may be necessary. Further validation studies of the MAVAS-R in medical settings with various disciplines with a qualitative research approach may seek participants' understanding of the MAVAS-R questions.

Learning objectives

Participants will...

1. describe the importance of healthcare workers' attitudes and beliefs for patient aggression management.
2. identify three differences in MAVAS-R responses among healthcare workers involved in WVEs.
3. recognize the four MAVAS-R themes for attitudes and beliefs of management for patient aggression management.

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Nursing student experiences of violence and aggression on clinical placements: an international survey

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Nursing students; Clinical placements

Abstract

Background

Violence and aggression cause significant problems for healthcare staff working in a range of settings; the majority of registered nurses expect to be assaulted at some time in their career. Although there is a large body of evidence describing staff experiences, the prevalence and impact of violence and aggression towards nursing students in clinical placements is less well known. The few studies that have examined this have all found high rates of experienced aggression. Little is known about whether students report violence and aggression; low reporting rates by nurses, particularly of verbal aggression, suggest that rates will be similarly low for nursing students. The aim of this study is to explore nursing students' experiences of violence and aggression on clinical placement.

Methods

This study utilises a cross-sectional survey design with an online survey. The Student Experienced Violence and Aggression Survey (SEVAS) has been adapted from a survey developed by Hopkins et al (2014). The SEVAS comprises one section on demographic details of participants and three sections on violence and aggression: non-physical aggression, physical aggression, and sexual harassment. The SEVAS explores students' experiences of these types of aggression, identifying frequency, form of aggression, reporting, and consequences. The survey has undergone expert review by patients, carers, health professional and researchers, and is currently being piloted with a small group (n=25) of nursing students at one university in the United Kingdom (UK).

Participants will be pre-registration nursing students, recruited from a convenience sample of UK higher education institutions and one Australian university. Data collection will commence in March 2018.

Findings

Descriptive statistics will be used to calculate rates and types of aggression experienced by students on clinical placement, as well as rates for reporting. Chi squared tests of independence and t tests will be used to compare the experiences of students in the UK and Australia.

Implications for practice

The findings from this study will have implications for education and clinical settings. It is expected that this study will demonstrate that students experience similar levels of violence and aggression as staff in clinical settings irrespective of geographic location. If so, action needs to be taken within universities to prepare students. In addition, this study will be able to provide evidence of incident reporting rates of students and compare these with known reporting rates registered nurses. Furthermore this study will identify whether students feel there was any follow-up to their reporting. It is possible that perceived lack of follow-up is one reason for non-reporting. If so, having more transparent processes following reporting of violence and aggression may improve reporting rates.

Learning objectives

Participants will

1. be aware of the types and frequency of violence and aggression as experienced by students on clinical placement.
2. begin to consider whether students report incidences of violence and aggression, and if so, do they identify any follow-up to the reporting.

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Newly Qualified Graduate Nurses' Experiences of Workplace Incivility in Australian Hospital Settings

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Workplace incivility, Co-worker incivility, Graduate nurses, Graduate nurse program, Experiences, Perspectives

Abstract

Background and Context

Workplace incivility is a well-documented issue of concern known to negatively impact on new graduate nurses' confidence, which in turn may affect the quality of patient care. However, there is lack of qualitative research that solely focus on workplace incivility experiences of newly qualified graduate nurses enrolled in graduate nurse programs. Therefore this paper aims to explore newly qualified graduate nurses' experiences of workplace incivility during their graduate year.

Methodology

A descriptive-qualitative method was used to discover the '*who, what, and where*' of events and experiences, - and assist in understanding the perceptions of newly qualified nurses, through face-to-face, in-depth interviews. After transcription, the interviews were analysed by thematic analysis.

Findings

Three major themes emerged: '*realising vulnerability*', '*sensing self actualisation*' and '*changing expectations*', as well as one overarching theme, '*yearning for respect, support & information*'. Findings suggest that workplace incivility is prevalent in nurses' supportive graduate year, with the temporary employment status offered by the graduate nurse program being identified as a major contributing factor. Paradoxically, the relatively short duration of clinical rotation was also found to be a morale booster, as the graduate nurses knew that any conflict experienced would cease, so acted as a decisive factor for their continuation in nursing.

Implications

This study has provided more depth and insight into the experiences of incivility experienced by new graduate nurse. Graduate nurse programs could be strengthened with additional

support provided for each rotation and throughout the graduate year. Initiations of frequent debrief sessions, promoting a culture of open discussion; fostering a culture of respect in the workplace; frontline management of intimidating and disruptive behaviors; conducting a monthly anonymous poll to identify any work-related issues and activation of incident reporting system to report workplace incivility were the main strategies recommended by new graduate nurses to tackle the incivility at the workplace.

Along with conflict resolution strategies, team-building exercises and group assignments where teams collaborate with respect and civil working practices should be inculcated in the curriculum of Bachelor of Nursing. Besides talking about the support with which the nurses are provided, the type of uncivil behaviours that they need to report if encountered needs to be stipulated.

Recommendations for future research include studies on a larger, national sample, to further understand the causes and effects of incivility and to identify whether there are any national uniquenesses, differences or similarities in the support provided in graduate nurse programs. Longitudinal interventional studies, where strategies are implemented to combat incivility and changes are monitored over time, would also be beneficial. Participants will achieve an understanding of the perspectives of a new graduate nurse who experience workplace incivility

Learning objectives

Participants will...

1. learn that the confidence of a new nurse is shattered if the experienced nurses behave uncivilly, and might affect job and career outcomes.
2. learn that even though the new graduate nurses' vulnerability collide with changing expectations, they will sense their own self actualisation and develop motivation to excel in the profession.

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Addressing Disruptive and Unprofessional Behaviors as Quality Improvement Concerns

Subtheme: *Root causes and immediate causes of aggression or violence*

Workshop

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Keywords: Disruptive Behavior, Unprofessional Behavior, Quality Improvement, Reflection-in-Action

Abstract

Background

In 2008, the Joint Commission issued a Sentinel Event Alert requiring hospitals establish codes of conduct and processes for managing disruptive behaviors; “*behaviors that undermine a culture of safety.*” In 2010, the Affordable Care Act was passed in the United States and introduced the concept of on-going quality improvement to the health care system. Some quality improvement initiatives focus on process improvement and problem-solving, yet overlook disruptive behavior as a quality improvement concern. As quality improvement frameworks are structurally similar to those supporting reflective practice, reflective practice, specifically reflection-in-action, is offered as the foundation for future quality improvement initiatives to address disruptive and to improve interpersonal communication.

Methodology

In this workshop, disruptive behavior is framed as a quality improvement concern. Participants will explore a model for reflection-in-action, as well as instruments to identify disruptive and unprofessional behavior, improve their communication skills, and advance evidence-based practice within existing quality improvement frameworks.

Content Outline

- Introduce the concept of reflective practice and reflection-in-action.
- Review of Definitions - reflection, reflection-in-action, reflective practice, quality improvement.
- Reflection in the Moment - What does it look like?
- What’s the frame?
- Using the two-column case and separating impact from intent.
- The Goal - Improving awareness and accountability.
- Expanding this skill to improve personal practice and the practice environment.

Interactive teaching Methods

Evolving Case Studies

Learning objectives

Participants will...

1. Understand the importance of reflection-in-action.
2. Identify barriers to reflection-in-action.
3. Understand how reflection can be used to address problematic human interactions within the health care environment.
4. Incorporate PDSA cycles into their reflective practice to improve communication skills and advance evidence-based practice.

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Where do you think you are? A grounded theory study of the critical factors triggering the existence and fueling the persistence of incivility in nursing

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Incivility in nursing, Charmaz, constructionist grounded theory, theory of self-positioning

Abstract

Background

Incivility in health care settings had been identified in 1976. In 2000 the Institute of Medicine sent a challenge for a safer health care environment and in 2008 the Joint Commission on the Accreditation of Healthcare Organizations emphasized that disruptive behavior continued to compromise patient safety. Incivility in nursing has quickly become a topic of interest yet it had not been studied from a qualitative approach by looking at it as a social process. The purpose of the study was to adopt an abductive process to acquire an in-depth understanding of the critical factors that trigger the existence and fuel the persistence of incivility in nursing and to develop a substantive theory to address the concept of incivility.

Methodology

A constructionist grounded theory approach by Charmaz was utilized. Individual and focus group face-to-face interviews were conducted to collect data from Registered Nurses (RNs). Data analysis involved initial, focused, axial, and theoretical coding alongside memo-writing and reflexive journaling.

Findings

The four main categories that emerged from the voices of RNs were neglecting, alienating, relinquishing, and finding oneself. The theory that developed from these categories is self-positioning.

Implications

The four categories and the theory of self-positioning may serve as a guideline to nursing education, nursing practice, nursing research, and health/public policy in setting realistic and

attainable goals and implementing specific action plans to diminish the incidence of incivility, address the health and well-being of Registered Nurses, contain healthcare costs, and ensure patient/public safety.

Learning objectives

Participants will...

1. identify the critical factors that trigger the existence and fuel the persistence of incivility in nursing.
2. be able to discuss the emergence of the self-positioning theory.
3. encourage a critique of the application of the research process and study findings.
4. apply self-reflection.
5. evaluate their contribution to the current status of incivility in nursing and in health care.

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Workplace Violence among Healthcare Workers in Public Hospitals of East Shoa Zone, Oromia Region, Ethiopia

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Workplace, Violence, Hospitals, Oromia, Ethiopia

Abstract

Background

Workplace violence in the health sector is a worldwide concern with healthcare workers being at high risk of being victims. Although interest in Workplace violence in the health sector has grown considerably within the developed world, it still appears to be an unrecognized issue in many developing countries including Ethiopia. The Objective of this study was to assess the prevalence and associated factors of workplace violence against healthcare workers in public hospitals of East Shoa Zone of Oromia Region, Ethiopia from March to August, 2017.

Methods

Hospital based cross-sectional study was conducted using quantitative data collection method. About 261 healthcare workers who have direct communication with patients/clients were selected from four Public hospitals. Data was collected using self-administered questionnaire. The collected data was double-entered into EPI-INFO version 3.3.1 statistical packages and exported in to SPSS version 21 for analysis. It was principally analysed using logistic regression models after checking all the assumptions to be fulfilled.

Results

The prevalence of workplace violence among healthcare workers was 70.2%. Pphysical violence accounted for 22.5%, verbal abuse for 65.1% and sexual abuse for 4.1%. Types of health institutions (AOR, 6.79; 95%CI: 2.98, 15.45), work experience (AOR, 2.76; 95%CI: 1.31, 5.89), professional category (AOR, 0.32; 95%CI: 0.10, 0.98), frequent interaction with patients (AOR, 3.13; 95%CI: 1.08, 9.04), and wornness about violence (AOR, 2.65; 95%CI: 1.02, 7.08) were predictors of workplace violence among healthcare workers.

Conclusions

A significant proportion of healthcare workers faced workplace violence. Types of health institutions, work experience, professional category, having frequent interaction, and wornness about violence were factors significantly associated with workplace violence among healthcare workers in the study area. Policy makers and stakeholders should focus on workplace violence prevention strategies.

Learning objectives

Participants will...

1. Gain knowledge on the prevalence of workplace violence against healthcare workers in public hospitals of East Shoa Zone of Oromia Region, Ethiopia from March to August, 2017.
2. Appreciate the role associated factors on workplace violence against healthcare workers.

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Domestic Violence factors influencing Womens' Mental Health in Ibadan Metropolis, Nigeria

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Physical abuse, Verbal abuse, Psychological torture, Intimidation and Threats

Abstract

Background

In developing countries such as Nigeria, social and health care systems are the only institutions that interact with almost every woman at some point in her life. However, violence towards women has been demonstrated to increase the risk of other health problems and early intervention can prevent sequel of abuse.

Methodology

The study examined the influence of domestic violence factors on women's mental health in Ibadan Metropolis in Oyo State, Nigeria. A total of five hundred women involved in the study were randomly selected from four different professions constituted the sample for the study. Two validated instruments used for the study were author-constructed questionnaires with 0.71 and 0.76 reliability co-efficient respectively. The data obtained were analysed using frequency counts and percentages, and multiple regression statistics.

Findings

The result obtained from the study indicated that a combination of the five independent variables significantly predicted women's mental health (F-ratio of 239.150 p. < 0.05 alpha level). The results also indicated that significant relationship existed between each of the variables; beating by family (t = 8.495, p. < 0.05), verbal abuse (t = 6.322, p < 0.05), psychological torture (t = 10.633, p. < 0.05), discriminating between sons and daughters (t = 8.844, p. < 0.05), and intimidation/threats (t = 2.284, p. < 0.05) and mental health.

Implications

Based on the results of this finding, it was concluded that domestic violence contributed positively to women's mental health status, therefore, health workers, psychologists, social workers, counsellors and educators should take cognizant of those variables that have been found to influence sound mental health among women of reproductive age The study also

recommended intervention strategy to help families, couples and the individuals for modifying attitudes and behaviors on gender issues.

Learning objectives

Participants will...

1. Recognize factors that contribute to domestic violence and gain ideas on intervention strategies
2. Be able to reflect on the modification of attitudes and behaviours related to gender issues

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Why is Workplace Bullying pervasive in Nursing, and what can be done about it?

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Workplace bullying; nursing; root causes; leadership

Background

Workplace bullying among nurses negatively impacts patient care, is costly to organizations, and contributes to ongoing nursing shortages (Johnson, 2018). While the estimated prevalence of bullying among nurses varies by country, overall about 40% of nurses worldwide may experience workplace bullying at any given time (Spector, Zhou, & Che, 2013). In contrast, the worldwide prevalence of workplace bullying among the general population of workers is estimated to be between 11 and 18% (Nielsen, Matthiesen, & Einarsen, 2010). Given that nurses are charged with taking care of people, a task that is associated with compassion and kindness, the high rates of bullying in this profession are unlikely to be explained by characteristics of individual nurses. The evidence suggests that most nurses enter the profession with a desire to care for others, including their fellow nurses (Phillips et al., 2015). However, experiences with bullying and incivility during nursing school, clinical practicum and as newly practicing nurses can negatively affect their ability to interact compassionately with patients and co-workers (King-Jones, 2011; Laschinger, Grau, Finegan, & Wilk, 2010; Randle, 2003). Thus a negatively reinforcing loop is created whereby new nurses become less compassionate and more prone to bully others.

Furthermore, evidence from a variety of workplaces indicates that the strongest predictors of workplace bullying are characteristics of the workplace and the organization, including weak or ineffective leadership, the presence of violence from people outside the organization, and a generally chaotic workplace environment (Fevre, Lewis, Robinson, & Jones, 2013; Salin & Hoel, 2011). Therefore, to understand the high rates of bullying among nurses, characteristics of the healthcare workplace environment, rather than characteristics of individual nurses, need to be explored. Additionally, interventions to address the issue need to focus on the organizational and departmental level.

Aim

The aim of this paper is to explore system level contributions to workplace bullying among nurses with the goal of offering suggestions for system level interventions to address the issue.

Methodology

This paper is based on results of a review of the literature as well as two qualitative studies by the author. For the first study, managers (n=15) were interviewed about their experiences with workplace bullying. While results of this study have been published elsewhere (Johnson, Boutain, Tsai, Beaton, & de Castro, 2015), aspects of the interviews which have not previously been reported are presented in this paper. The second qualitative study involved interviews with staff nurses (n=13). To date, these findings have not been published.

Findings

The three themes that emerged from the review of the literature and from interviews with nursing unit managers and staff nurses to explain workplace bullying among nurses were: environmental factors, leadership issues, and socialization of nurses.

Environmental factors: In the review of the literature, work-related stressors such as fatigue, experiencing violence from patients and families, organizational change, poor working conditions (e.g. understaffing, lack of resources) and an overwhelming amount of work were specific elements of the workplace environment that have been empirically linked to workplace bullying among nurses (Johnson, 2018). Similarly, managers primarily attributed workplace bullying to stress. As one manager said, *“It’s a really, really stressful job. And I think that bullying sometimes can be an outlet for that.”* Managers also said that nurses are constantly fighting with the organization for more resources, which can lead to bullying between nursing managers.

I think, um, when people get frustrated with not having the things they need to do patient care. If they’re frustrated, then, then it may, you know, lead to a higher level of being able to get angry about something. You know? Um, so when an organization is [in a state of] unrest or in a lot of change and there isn’t clear direction, I think you set things up for bullying to occur.

Staff nurses did not primarily attribute workplace bullying to stress caused by caring for patients. However, stress related to organizational factors, such as being short-staffed, not having enough resources, and organizational change, were mentioned as factors which can lead to bullying.

Everybody was feeling the cuts in staffing, and, um, turmoil, you know. Overturn of people, you know, and managers. And, you know, cutting this and cutting that. You know, everybody was feeling that systemwide. So, you know, our specific things [bullying situation] were, you know just a part of it.

I mentioned that early on, that there was a territorial element to, like the whole clinic. We’re on the phones, they have us in a small space, you know, that’s problematic. Um, so that, that environment issue creates a little stress.

Leadership Issues: The review of the literature indicated that leadership styles and leadership skills are a major contributor to the presence or absence of bullying in nursing units (Johnson, 2018). Research also suggests that nursing managers are not being taught how to be effective leaders and are not given the resources and support they need to do the job properly. In organizations that do not have policies and procedures for handling workplace bullying, managers are left on their own to figure out how to address this issue.

In the interviews with managers, they said organizations need to make sure leaders have the skills they need to deal with bullying and conflict, because they do not get enough of this type of training in nursing school. One manager said in a prior organization *“we would have five days of leadership training quarterly. Um, where they trained us how to-to address and how to deal with these types of things.”* In contrast, in her current organization, *“they don’t give you the training and education. So I think within the organization everybody, um, will handle it differently.”* Staff nurses also recognized that managers needed specific training. As one said, *“But I think if you don’t have a leader to go to, like, school for instance, the whole department was (sic) in shambles. It was known to be in shambles in this regard, you know?”*

Managers and staff also said that nursing unit managers have too many people too directly supervise. One manager said bullying will occur *“if people [the managers] are too far removed from the front-line staff.”* A staff nurse asked, *“How is one nurse who is managing 20 others on a floor plus everyone’s complaints going to focus on something that the hospital doesn’t even talk about?”* This quote exemplifies how organizational support is critical to managerial success.

Staff nurses and managers also mentioned that there is a lot of turnover among nursing unit managers, which can contribute to workplace bullying. As a staff nurse said,

You know, what even made that [bullying] situation even worse was the ---when I first interviewed for the job, the manager of the floor was one person. When I showed up for orientation, it was another manager. When I actually started working it was a third manager, and we are not talking a long period of time. From the end of June until I started in the middle of August.

Managers said it was difficult to manage bullying when they were new to a unit because they didn’t know what previous managers had done. When previous managers had not addressed bullying, the new managers said their efforts to address it were often met with a lot of resistance, and they felt they became the targets of bullying. One manager said that *“if you see a department where managers are constantly leaving, that is where the bullying is.”* Likewise, staff nurses recounted incidents where the manager was the target, and stated that in these situations, it felt like nothing could be done: *“The leadership, the manager we had at that time was afraid to confront this person. And if you have that, if your leaderships even afraid to confront him then there’s not much recourse.”*

Socialization of Nurses

While a common trope in nursing is that “*nurses eat their young*,” there is scant evidence that new nurses are bullied at higher rates than nurses who have been in the profession longer (Johnson, 2018). However, nursing unit managers (Johnson et al., 2015; Lindy & Schaefer, 2010) and staff nurses (Johnson, 2018) report that in their experience, targets of workplace bullying are often perceived to be less competent. Perpetrators of bullying often justify their behaviors by claiming it was done to motivate the targets to improve their care, or to quit. When perpetrated by staff nurses, this type of bullying is a usurpation of legitimate managerial tasks and is a symptom of the absence of real leadership on the unit (laissez-faire leadership). When perpetrated by managers, this type of bullying is an example of dysfunctional or tyrannical leadership.

Both managers and staff nurses indicate that bullying as a disciplinary method is a behavior which is learned in nursing schools and is carried into the workplace (Johnson, 2018; Johnson et al., 2015). The review of the literature also found multiple studies that report bullying occurs in nursing schools and orientation programs worldwide, a problem which the authors of these studies believe contributes to the phenomenon of bullying in healthcare organizations (Johnson, 2018).

Implications for practice

To address workplace bullying among nurses that is related to dysfunctional education, discipline and socialization of nurses, coherent and standardized methods of educating and precepting new nurses, of mentoring and improving the practice of nurses who are struggling, and of disciplining nurses whose practice falls below established standards need to be adopted and maintained. Educators, preceptors, mentors and nursing leaders need to understand the difference between providing constructive and destructive guidance and criticism.

To address leadership issues, leadership training for all nurses needs to be strengthened, both in clinical and academic settings. New leaders should be offered a formal mentorship and continued education. To prevent bullying which occurs in the absence of formal leadership, organizations need to decrease the span of control of managers and give them fewer direct reports.

Addressing systemic issues that contribute to workplace bullying will require a concerted effort on the part of nursing unions, nursing leadership and other advocates for the nursing profession. Given the economic strains on healthcare organizations around the world, it is unlikely that organizations will spontaneously address the environmental factors that contribute to workplace bullying. Organizations need to be convinced that addressing workplace bullying will improve patient outcomes and will ultimately save them money.

Conclusion

Currently most efforts to address workplace bullying among nurses (such as implementing zero tolerance policies, training nurses in conflict management, and expecting targets to confront

perpetrators of bullying) are based the notion that workplace bullying is an individual level problem. These efforts may eliminate a few instances of bullying but will ultimately fail to decrease rates of workplace bullying among nurses as they do not address the root causes of bullying in this profession. To bring about real change, system level interventions and genuine changes in the healthcare workplace environment are needed.

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Learning objectives

Participants will be able to...

1. identify some of the systemic factors which contribute to workplace bullying among nurses.
2. name some organizational and educational initiatives that have the potential for reducing workplace bullying among nurses.

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Safety first, but whose safety? Public Health versus Occupational Health in situation of conflict

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Public Health, Occupational Health, Polio Workers, Pakistan

Abstract

Providing high-quality health care should not be hazardous to the health worker therefore the concept of Occupational Health Safety is becoming prime concern especially for Healthcare workers. Many frontline health workers face a wide range of occupational safety and health hazard including physical, biological, chemical, psychosocial and gender-based violence and discrimination. It is argued regarding the amount acceptable level risk that healthcare workers put on themselves in order to perform their job especially while providing healthcare to communities in a conflict zone. Recently in Pakistan, polio workers have been targeted that has resulted in verbal threat, kidnapping, injuries and more significantly to killing or loss of life of Healthcare workers. The militants has their justified reason for this act that is basically the result of huge mistrust on public health intervention because of fake hepatitis vaccination program that was run by CIA and used Pakistani doctor to obtain DNA from Osama bin Laden's suspected hideout.

The focus of public health intervention is on improving quality of life of population whereas, occupational safety emphasis greater concern on safety of healthcare worker because if healthcare workers are not protected than wellness of society cannot be assured.

This article illustrates the tension that exists between occupational safety and public health measures in the situation of conflict. Developing countries are already facing healthcare workforce shortage and saving lives should not be accomplished by sacrificing provider's own lives. Millennium Development Goals for health cannot be achieved without healthy, well-prepared, motivated healthcare workers that can only be done by ensuring their occupational health safety.

Learning objectives

Participants will...

1. understand scope of the problem.
2. understand the overlap between public health and occupational health safety.

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Violence and threats against forensic mental health staff: Forensic mental healthcare workers' perception of violence and threats against staff and subsequent impact on mental health care

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Mental health, Forensic Psychiatry, workplace violence, staff perceptions, qualitative research

Abstract

Background

On a daily basis Danish mental health staff are the victims of violence and threats as a part of their job. According to national surveys, 59 – 75 % of nurses and nursing assistants, employed in the area of Danish psychiatry, have within a year been subject to one or more types of violence during work hours (Sygeplejeråd, 2015, FOA, 2014). According to the Danish ministry of health, this is in varying ways a very expensive problem regarding both staff and hospitals. Workplace violence increases the number and length of sick leaves, causes higher levels of stress and anxiety (Arbejdsmiljø, 2016, Sygeplejeråd 2015) Existing literature shows an increase in the level of cohesion and suggest an influence on work environment and care provided in psychiatric wards (Sygeplejeråd, 2015, Baby et al., 2014; Itzhaki et al., 2015; Kelly et al., 2015).

However, research on the perceived impact of violence and threats by mental health staff seems sparse but warranted in order to generate a strong theory on the subject that should present a basis for subsequent hypothesis and interventions (not part of this study) to support a reduction in frequency and minimization of impact and aftermath.

Aim

The aims of this study, is to generate knowledge on, how mental health staff and former staff perceive everyday workplace related patient-staff violence and threats, and subsequently to explore how staff perceive the impact thereof on themselves as health care professionals and on daily inpatient care provided in clinical forensic practice.

Method

This study employs an overarching exploratory qualitative research approach rooted in symbolic interactionism (SI). An empirical testing design is adopted to drive the research methods (Blumer 1986; Gildberg and Hounsgaard 2010).

The methods comprise a literature review, in-depth semi-structured individual interviews. Results from a literature review will feed into parts the interviews. The interviews will be analysed and results tested by conducting additional interviews, in an on-going circular process, in order to empirically falsify, validate or refine results with new perspectives on the subject, as part of the testing design.

Semi-structured interviews with staff and former staff have been conducted. Recruitment will be ongoing until data saturation in analysis can be established (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

Inclusion of staff and former staff for in-depth interviews: This study uses purposive sampling (Polit & Beck, 2008) and ongoing volunteer recruitment of forensic mental health staff members and former mental health staff with a high degree of first-hand experience on the subject.

Results

Analysis

Data will be analysed in relation to aims and research questions, using a thematic analysis based on the methodological approach described by Herbert Blumer, stressing the need for careful and disciplined examination of data in regard to relations between categories of data, theory, and the testing of findings against the original data (Gildberg 2012, Blumer, 1986).

Presentation

Preliminary results will be presented at the conference.

Learning objectives

Participants will...

1. be able to identify mental health staffs' perceptions of situations and subjects associated with violence and threats, as a part of their everyday work.
2. will be able to identify factors, that from staffs' perspectives, may reduce incidents of violence and threats, or improve handling aggression that leads to violence or aggression.
3. be able to identify Staff's perceptions of impact and aftermath from workplace violence and threats

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Aggression at work is a prominent feature of nursing and midwifery practice in Australia

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Federation University, Berwick, Australia*

Keywords: Workplace, aggression, experience, nurse, midwives, patients, well-being, health, safety, prevention, harm minimization, nursing, research

Background and context

Workplace aggression in health care is a major work health and safety concern. Nurses and midwives are at high risk of exposure to aggression from patients, patients' relatives or carers, co-workers and others. There has been limited investigation of population-level exposure and responses to workplace aggression from all sources, however, in Australia.

Methodology

This component of a broader study of Australian nurses, midwives and other care staff in the State of Victoria investigated levels of exposure to workplace aggression from external sources (patients, patients' relatives or carers and other persons) and internal sources (co-workers) in the previous 12 months. Information on responses to workplace aggression and the range of supports accessed (including legal redress) were also investigated. A self-report, online survey was initiated in collaboration with the Australian Nursing and Midwifery Federation (Victorian Branch) and 1300 nurses, midwives and other care staff consented to participate in the study.

Findings

Over 95% of respondents reported experiencing one or more forms of aggression from any source. More than 80% of respondents reported experiencing verbal or written aggression and more than 70% reported experiencing physical aggression from patients in the previous 12 months. Almost 78% reported experiencing verbal or written aggression and 35% reported experiencing physical aggression from co-workers in the previous 12 months. Nurses, midwives and carers responded in numerous ways, but rates of incidents reported and engaging psychological, medical, industrial and legal supports were relatively low.

Implications

Victorian nurses, midwives and carers experience staggering levels of workplace aggression, with a disturbing level of acceptance apparent when considering rates of reporting and engaging a range of supports and redress options. Despite widespread media reporting and the

introduction of strengthened policy initiatives in the State of Victoria, this major work health and safety concern remains a depressingly unsolved problem for the health care professions. There is a desperate need for a major breakthrough in the prevention and minimisation of workplace aggression in Australia.

Learning objectives

Participants will...

1. appreciate the extent of and consequences of workplace aggression in Victorian nursing and midwifery practice settings.
2. learn the levels of exposure to workplace aggression from internal sources (co-workers) and external sources (patients, patients' relatives or carers and other persons) responses to workplace aggression and the range of supports accessed; the presence or otherwise of workplace aggression prevention and minimisation measures; and the extent to which a range of personal and work-related factors are associated with aggression exposure.

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“I only report when I am bleeding”. Australian nurses, midwives and carers feelings about reporting workplace aggression

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Workplace, aggression, experience, nurse, midwives, patients, well-being, health, safety, prevention, harm minimization, nursing, research

Background and Context

Workplace aggression in health care is a major and seemingly intractable work health and safety concern. In the Australian State of Victoria, nurses, midwives and carers have been found to experience staggering levels of workplace aggression, despite widespread media reporting and the recent introduction of strengthened policy initiatives. This major work health and safety concern remains a disturbingly unresolved issue for the health care industry across the country.

Methodology

As part of a broader study of Australian nurses, midwives and other care staff in the State of Victoria, Australia, almost 25% of 1300 respondents who completed a self-report, online survey opted in to be interviewed by a researcher about their experiences of and responses to workplace aggression. Respondents were members of the Australian Nursing and Midwifery Federation (Victorian Branch). Thirty study participants were interviewed at the completion of the online survey data collection, commencing in July 2017. Respondent commentaries on aggression incident reporting behaviours, collected during the in-depth interviews, were interrogated in an attempt to gain an understanding of the barriers to reporting across a range of health care settings.

Findings

Respondents gave often harrowing accounts of their experiences of aggression and violence, but the majority indicated that only the more serious incidents of aggression, primarily physical aggression, were reported. *“I only report when it is bleeding and it needs to be dressed.”* (C15)

Despite the seriousness of the incidents that the nurses experienced, however, many did not report at all. The basis for non-reporting included:

- Lack of knowledge about the scope of the reporting systems – “*VHIMS [Victorian Health Incident Management System], that’s for patient safety isn’t it? I wouldn’t report incidents – I feel it is a nurse’s job to just absorb it ... I feel like we need to be a bit thick skinned.*” (C20)
- The onerousness of reporting using current systems – “*We don’t do incident reports unless the aggression is getting really serious, it takes too long – 40 minutes.*” (C17, C13)
- The recurrence and frequency of aggressive behaviours experienced – “*You don’t always report, I get jaded ... there are a couple of things that I tolerate, that I shouldn’t.*” (C27)
- A belief that there was no point in reporting due to inaction – “*... nothing is ever done.*” (C28)
- Disillusionment with the lack of follow-up following an incident – “*I filled out an incident form of cases of patient aggression and it seems to have gone into a big black hole, never to be heard of again.*” (C12)

For nurses working in regional and rural areas, they had significant concerns about the impact of raising ‘unpleasant’ issues in the workplace. For example, as C2 indicated, “*... the hospital is the largest public employer in the area, so there is not much ability to move around to get away from potentially toxic people.*” C11 stated that, “*I have not reported incidents of ... aggression from fellow staff members because I live in the rural area that I work in. If things became really difficult at work then that limits my choice if I had to leave ... I’m too scared*”. For C25, reporting bullying just makes the whole situation worse, resulting in being labelled, “*... a dobber, and then nobody talks to you.*”

Implications

Without a full account of the extent of workplace aggression experienced by Australian nurses, midwives and carers, there is unlikely to be an adequate understanding of the pressing need to address this serious work health and safety issue. But the current systems of reporting in Victoria (and almost certainly all Australian States) seem quite well designed to prevent routine reporting, something that desperately needs to be addressed for the sake of health care and the health care professions. In the long-run, the safety and well-being of clinicians is a public health concern, as there is a growing body of evidence linking exposure to workplace aggression with adverse well-being and workforce participation outcomes. Ultimately this can lead to reduced patient access to care and a loss of trained health professionals from the industry.

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Learning objectives

Participants will...

1. have an in-depth understanding and insights from the health care workers' perspectives into the experience, the consequences of, and their responses to workplace aggression from internal and external sources.
2. analyze the key risk and protective factors for workplace aggression and its impact, both personally and professionally, and to determine what efforts are required to prevent or minimize the likelihood and consequences of workplace aggression in Victorian nursing and midwifery practice settings.

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Trauma among psychiatric workers: A research and knowledge translation project

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Trauma, psychiatric workers, PTSD, patient violence, help seeking behaviour, barriers to accepting support

Abstract

Background

The Mental Health Commission of Canada has identified workplace mental health as a strategic priority, and recognizes that sometimes traumatic events occur in the workplace and have an impact on workers' mental health. On-the-job post-traumatic stress disorder (PTSD) is especially prevalent for workers in occupations where they can be exposed to violence or other traumatic events. Psychiatric workers are exposed to not only acute and potentially life-threatening events such as violence, but also chronic stressors related to providing health care which can lead to compassion fatigue, lower healthcare quality, and lost work time. This project aims to identify prevalence of trauma and related disorders among psychiatric unit staff, investigate help-seeking behaviors and examine barriers to accessing support.

MethodologyA pilot survey was completed at Waypoint with 219 participants (30% response rate). This poster will report on a cross-sectional survey of more than 500 inpatient staff at two large psychiatric hospitals in Ontario.

Findings

In the pilot study, 24% of participants endorsed trauma symptoms at the level of probable PTSD. Interim results will be presented describing initial findings among the new survey participants from both hospitals, including the prevalence of exposure to patient violence and the prevalence of reported symptoms indicating PTSD. Next steps for research and knowledge translation activities will also be described.

Implications

Our research fills knowledge gaps about the prevalence of trauma-related disorders among psychiatric workers. We are using an integrated knowledge user model to guide practices at psychiatric hospitals that maximize best strategies for workplace prevention and intervention.

Learning objectives

Participants will...

1. gain an understanding of prevalence of trauma-related disorders among psychiatric workers.
2. understand help-seeking behavior and barriers to accessing support.

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Mental health and security professionals create strong partnerships with patients and families to ensure a safer workplace for all

Subtheme: Root causes and immediate causes of aggression or violence

Workshop

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Security Risk Management Consultants, Columbus, United States of America

Keywords: Patient and Family-Centered Care, psychological predictive models, Risk assessment and mitigation, Healthcare violence, Managing cultural expectations

Abstract

Context

Occupational hazards continue to plague health care. Verbal and physical violence takes its toll on the health and mental health of staff. Understanding how to prevent work-related injuries and encourage de-escalation strategies is critical to ensuring a safer workplace. Collaborative relationships between mental health and law enforcement professionals has been extremely productive as a deterrent to work-related injuries. Better communication, trusting relationships, and shared information and skills has created a strong alliance. Utilizing each other's special skills led to thorough clinical assessments, increased team communications, and greater consistency for patients. The addition of Patient and Family-Centered Care (PFCC) into our hospital-wide operations played an essential role in the prevention of threatening behavior and violence. Applying the basic tenets of PFCC has enabled the voice of patients and families to emerge reducing misunderstandings that could escalate into hostile behaviors. This was especially true in high acuity areas, i.e. Emergency Services, Psychiatric Services.

Methodology

The findings were developed as a single case study. The commitment of our staff and faculty, in unison with patients and families, helped to make positive changes to the organizational culture. Several programs were developed using data from security logs, adverse event reviews and safety rounds. Stakeholders collaborated to provide creative solutions to reduce further incidents. Presenters will discuss lessons learned to assist other health care organizations in creating a culture of safety.

Findings

An academic tertiary care hospital engaged patients and families throughout the health system. PFCC guiding principles of respect, information- sharing, participation, and collaboration

(IPFCC) were integrated into core operations, engaging patients as partners in care. Understanding the patient experience provided a greater appreciation for behaviors that can evolve into a crisis. PFCC advisors were trained and incorporated into key committees, adverse event reviews, safety meetings, ethics reviews, etc. to better understand all perspectives. Although Social Work and Security had a previously established partnership, the inclusion of the patient-family perspective created additional value. High stress and acuity areas were the focus for retrospective data review and analysis to prevent future adverse events. Early intervention via reporting of disruptive and aggressive behaviors monitored by a mental health/security response team, was adopted as a best practice.

Implications

Collaborative programming and strategic problem-solving demonstrated positive outcomes. One concern identified was during end of life care when stress levels were high and fraught with communication difficulties and cultural misunderstandings. A family-activated response team allowed family access to an immediate team response to prevent untoward events. Cross training staff in de-escalation techniques and cultural competencies helped the teams become even more effective in averting violence.

Learning objectives

Participants will...

1. understand the basic principles of applying Patient and Family-Centered Care to reducing risk and preventing an escalation of violence in healthcare.
2. learn best practice models when applying mental health and security/law enforcement professionals to help mitigate health care violence.
3. learn ways to add value to adverse event review and root cause analysis in managing high risk areas.

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Staff Perceptions of Risk Factors for Violence and Aggression in Ambulatory Care

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Workplace violence, safety, outpatient clinics

Abstract

Background

Management of violent acts of patients and their visitors in psychiatric and hospital settings has been studied, however violence has not yet been addressed in the ambulatory care environment.

Objective

To identify potential risk factors for patient and visitor violence and staff perceptions of the impact of these risk factors in ambulatory care.

Methods

A review of psychiatric inpatient research was conducted examining violence and aggression including risk factors for patient and visitor violence (PVV). Identified risk factors for violence were incorporated into a survey tool and distributed to staff in a community clinic asking for their perception of the impact of these risk factors on aggression in their work environment.

Results

Risk factors for violence and aggression were categorized as static or dynamic or as related to characteristics of staff or the environment of care. All of the risk factors were identified as possible contributors to PVV by the staff while items related to substance abuse and the clinic environment were selected by the staff as “*highly likely*” to contribute to PVV in their setting.

Conclusions

Continued research is needed in this area to better understand risk factors for PVV and develop appropriate safety interventions and crisis training for ambulatory care settings.

Learning objectives

Participants will...

1. identify risk factors for PVV present in ambulatory care clinics.
2. understand the importance of time patients and visitors spent outside of the clinical encounter in the escalation of aggression.
3. identify potential interventions to reduce occurrences of PVV in ambulatory care clinics.

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Patient aggression as a response to psychiatric power and social control

Subtheme: *Root causes and immediate causes of aggression or violence*

Workshop

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Keywords: Power dynamics, aggression, societal pressure, Foucault, psychiatry

Abstract

The deprivation of liberty is part of the societal role of psychiatry. Patients wonder about the reasons that justify such a loss of freedom. The explanations vary between the fear aroused and the incapacitation. Foucault (2003) was one of the first to question the notion of psychiatric power. In an anti-psychiatric context he rethinks the function of asylum. It introduces the idea that this type of institution is not part of the medical and therapeutic system but is based on disciplinary principles, especially with the figure of the psychiatrist. Why focus on asylum? The reorganization of psychiatry and the abandonment of the absolute power of the doctor did not result in a reduction of psychiatric power, but quite the opposite. Indeed, despite the assertion of the rights of patients in recent decades, the psychiatric institution remains a nucleus in which this power is exercised. Foucault's work poses a fundamental and radical challenge to the theoretical and practical foundations of diagnostics and therapeutics in psychiatry.

Foucault thus defines the psychiatric power as the supplement of power by which the real is imposed on madness in the name of a truth held once and for all by this power under the name of medical science (psychiatry). The patient must be docile and submissive to access healing. On the one hand there is the savage force and on the other the disciplined force of the servants. The latter applies to meet the requirements and necessities of the patient's condition. Disciplinary power is a discrete, distributed power; it is a power that functions in a network and whose visibility is only found in the docility and submission of those on whom in silence it is exercised.

In psychiatry power is constantly exercised at all levels by a surveillance game set up to control the patient. Today the tone of speech has become more humanist but what about the reality? Disciplinary power implies a whole dynamic of pressure amongst actors in the psychiatric system. The pressure undergone by the patient under stress is to *'fit into the societal mold'* or risk suffering punishment. The *"balance of power"* in the psychiatric team is often against patients who are expected to what is asked. From this point of view the therapeutic dimension disappears in favor of the analysis of the stake of power. Disciplinary power in institutions still exists but is no longer questioned in the same way: While nowadays the care will be centered on the individuality of the patient the question of the interweaving of care with the power dynamics of psychiatry often goes unquestioned.

In this paper excerpts from a recent grounded theory study on the situation of patients involuntarily referred to psychiatry will be employed to illustrate the power dynamics of psychiatry and to plea for the case that psychiatry may provoke aggression.

Learning objectives

Participants will...

1. understand the power dynamics of psychiatry as outlined by Foucault and other critical thinkers.
2. be able to reflect on the power dynamics of their own health care institution and its possible role in the genesis of aggressive behavior.

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Measuring sexual harassment and sexual violence in healthcare and welfare: A gender-sensitive investigation

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Sexual harassment, questionnaire, health and welfare worker

Abstract

Background and context

Sexual harassment at the workplace is still a relevant research topic in work psychology. However, sexual harassment by patients and clients has been widely ignored. Although studies show similar detrimental effects of sexual harassment by patients and clients on workers' mental and physical health, little is known about sexual harassment and sexual violence by patients, clients or residents in the healthcare and welfare sector. Furthermore, gender differences in prevalence rates are ambiguous and differential effects of sexual harassment on men and women have not yet been investigated. One reason for this lack of research is that instruments measuring sexual harassment/violence experienced by employees working with patients, clients, and residents are missing. Therefore, the aim of this study is to develop and validate an instrument that measures sexual harassment/violence by patients, clients, and residents in the healthcare and welfare sector.

Methodology

First, we developed items based on an extensive literature research in the context of healthcare and welfare that assess different forms of sexual harassment/violence: non-verbal, verbal, and physical sexual harassment/violence. Subsequently, several experts working in different areas of healthcare and welfare (e.g., care for the elderly, nursing, care for the disabled, youth welfare) rated and discussed the items according to their relevance and comprehensibility to assess face validity. Finally, we validated the questionnaire with 345 employees working in the healthcare and welfare sector and assessed construct validity, criterion validity, and incremental validity.

Findings

The scales show good psychometric properties and substantial correlations with indicators of employees' well-being (esp., depression, psychosomatic complaints and emotional exhaustion). Hierarchical regression analyses show that the sexual harassment/violence scales

explain an incremental amount of variance compared to general violence. Thus, the results indicate that the questionnaire validly measures sexual harassment/violence in the work with patients, clients, and residents.

An additional analysis of gender differences revealed that the correlations of sexual harassment/violence with employee well-being are significantly higher for men than for women. Thus, the health-impairing effect of sexual harassment/violence is stronger for male than for female healthcare and welfare workers.

Implications

To keep healthcare and welfare workers safe and healthy, it is important to provide knowledge about prevalence rates of various forms of sexual harassment/violence in order to derive appropriate prevention and rehabilitation strategies. This study advances the understanding of the impact of sexual harassment/violence on employees' health and paves the way for future investigations of antecedents and consequences. This knowledge should be integrated in prevention and rehabilitation programs. Based on the results, a promising approach may also be to analyze gender differences and to address them in work design, education and training.

Learning objectives

Participants will...

1. gain knowledge regarding a validated instrument for assessing sexual harassment and violence.
2. understand that sexual harassment and violence at the workplace occur often in healthcare and welfare.

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Differences in the Experience of Violence between High-Risk Healthcare Settings

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Healthcare, Patient-on-Patient Violence, Behavior Management, Violence Prevention, Risk Reduction

Background

The preponderance of disruptive behavior in healthcare environments is generated by patients and in most of those events, employees are the primary experiencers or targets of such behavior. According to the United States National Institute of Occupational Health and Safety (NIOSH), violence generated by clients/patients, termed Type II violence, is the most common type of violence in healthcare settings (DHHS(NIOSH) 2002-101). The United States Bureau of Labor Statistics also found in a study of significant incidents of workplace violence events over a 12-year period that healthcare workers are four times more likely to encounter workplace violence than workers in other private industries (U.S Department of Labor Occupational Safety and Health Administration, 2015). The most common employee targets of healthcare violence are nursing professionals, particularly registered nurses and nursing assistants, as well as psychiatric technicians. In many cases, staff with the least experience and training who work in high risk areas are more likely to experience both verbal and physical violence generated by their patients (Hamdan & Abu Hamra, 2015; U.S Department of Labor, 2015). Additionally, studies have suggested rates as high as 78% of emergency room physicians reporting exposure to violent incidents (Kowalenko, Walters, Khare, & Compton, 2005) and 40% of psychiatrists reporting physical assault by patients (Privitera, Weisman, Cerulli, Tu, & Groman, 2005).

While the clear majority of current workplace violence in healthcare research has examined patient-on-employee violence, studies looking specifically at high risk inpatient psychiatric and nursing home environments show that patients in such settings are frequently targets of disruptive behavior and in many cases staff only become targets once they attempt to intervene (Staggs, 2015; Staggs, 2016; Prabhu & Valdiya, 1994). Another study, which used focus groups with nurses working on an acute inpatient psychiatry unit, revealed more verbally aggressive behavior between patients over property with some events escalating to physical violence, all of which negatively impacted the unit climate (Lantta, Anttila, Konito, Adams, & Valimaki, 2016). Aside from employees, patients are the second group most likely to experience violence while accessing healthcare. For this reason, workplace violence in healthcare cannot be viewed only as an occupational safety issue, but also an issue of patient safety.

In addition to considering both occupational and patient safety, data analysis and prevention planning must differentiate between individual types of healthcare workplaces because not all healthcare settings will be similar regarding the amount and type of patient-on-patient violence that occurs. A 2016 study of the differences in workplace violence between types of healthcare settings found that violence was more common in psychiatry departments, emergency departments, and geriatric units (Ferri, Silvestri, Artoni, & Di Lorenzo, 2016). Research suggests that patient-specific factors contributing to physically violent behaviors in high risk healthcare workplaces include altered mental status related to intoxication, delirium, or dementia; mental retardation or other psychiatric disorders; and higher levels of physical and emotional distress, all of which are more common in more acute medical settings (Harwood, 2017; Ferri, Silvestri, Artoni, & Di Lorenzo, 2016).

Furthermore, comparisons of violence in various medical settings show that physical violence in particular has a significant presence on psychiatric, post-acute extensive phase rehabilitation, metabolic medicine, and neurological/post-surgery intensive care units. The physically aggressive incidents studied were often related to changes in sensorium stemming from underlying medical conditions. Non-physical violence was more often observed on geriatrics and post-acute geriatric treatment units, metabolic medicine, and emergency departments. In addition to patients, non-physical violence was also more likely to be engaged in by visitors, family members, and caregivers frustrated by long wait times, anxiety about prognosis, and communication challenges (Ferri, Silvestri, Artoni, & Di Lorenzo, 2016). These differences indicate the necessity for healthcare workplaces to take patient safety into consideration in addition to occupational safety when evaluating data and developing prevention interventions, training, and protocols. Safety plans and protocols must plan for the safety of patients in the care environment. (U.S Department of Labor Occupational Safety and Health Administration, 2015; Stene, Larson, Levy, & Dohlman, 2015; Richmond, et al., 2012). To do that, more information is needed about the differences in care environments. This study begins the work of discerning key differences in healthcare workplaces to inform violence prevention planning.

Methodology

Since December 2013, Veterans Health Administration (VHA) has collected workplace violence data specific to twenty-two different types of healthcare workplaces as well as types of violence. Data regarding workplace violence events are collected from multiple sources, including police reports, patient safety reports, and an electronic reporting system available to all employees, among others. These data are organized by Fiscal Year (FY) annually to conduct workplace risk assessments for the purposes of informing prevention plans and mitigation strategies and then submitted to the national Workplace Violence Prevention Program office for collation and further analysis. An analysis of these assessment data from (FY) 2012 through 2016 was conducted to determine what differences in workplace violence exist between high and low risk healthcare workplaces. Following this analysis, a second analysis was conducted to look for differences in types of violence between the high risk workplaces, specifically looking at patient-generated violence and differences between types of violence and targets of violence.

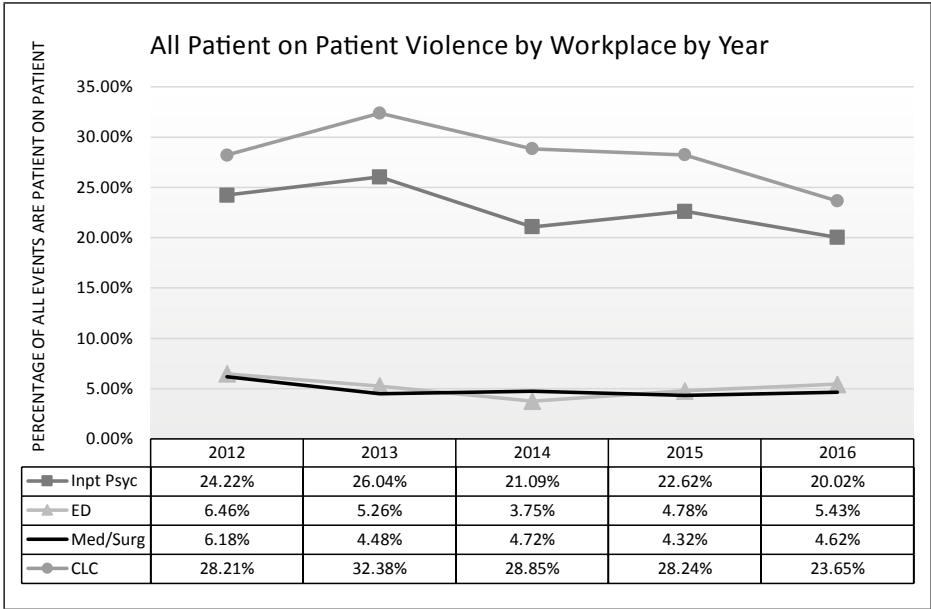
Out of 142 VHA medical facilities, 132 have emergency departments, 115 have acute psychiatric units, 124 have inpatient medical and surgical units, and 124 have rehabilitative/extended nursing care/nursing home units. The data from each workplace type was collated and standardized into four groups by workplace type for comparison.

Based upon initial descriptive statistics, the four high risk workplace groups were combined into two groups: inpatient psychiatric units with nursing home units and emergency departments with medical/surgical units. This pairing was based upon similarities found between psychiatric units and nursing homes, as well as similarities between emergency departments and medical units to be described in the results section. The resulting two groups were compared using a two sample t-test assuming unequal variances looking for differences among the groups related to the amount of patient-on-patient violence in each group.

Results

Data from the United States VHA have shown over several years that four healthcare environments (inpatient psychiatric units, nursing home care, emergency departments, and medical surgical units) out of twenty-two identified types of healthcare workplaces account for approximately half of all disruptive behavior reports and almost three quarters of all physical violence events (48% and 70% respectively). Because of these findings, these four settings have been identified consistently as higher risk workplaces in VHA.

Figure 1 Percentage of all events that are patient-on-patient violence

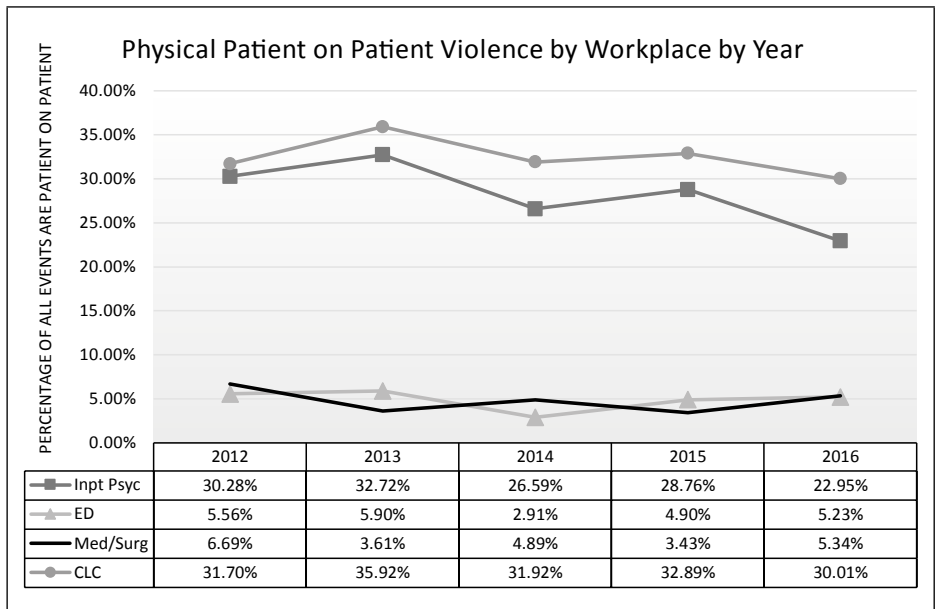


The initial descriptive statistics between the four high risk workplaces demonstrated notable similarities between inpatient psychiatry and nursing home units, as well as between emergency

department and medical/surgical units in regard to the number of events that included patient-on-patient violence. Over the five years of reporting, the percentage of all disruptive behavior events that included patient-on-patient violence averaged 22.8% in inpatient psychiatry units and 28.3% in nursing home units, while emergency departments and inpatient medical/surgical units only averaged 5.1% and 4.9% respectively (figure 1). Due to these similarities, the inpatient psychiatric unit data was combined with the nursing home data and the emergency department data was combined with the medical surgical unit data for purposes of statistical analysis, which demonstrated a statistically significant difference ($t=24.04$ $p<.001$) between the two groups. Within the groups themselves, there was not a statistically significant difference between inpatient psychiatric units and nursing homes ($t=3.02$ $p=.03$) or between emergency departments and medical surgical units ($t=2.70$ $p=.04$).

Similarly, descriptive statistics of only those events that included physical violence, showed the average percentage of all physically violent events that were patient-on-patient violence was 28.3% for inpatient psychiatry units, 32.5% for nursing homes, 4.9% for emergency departments and 4.8% for inpatient medical surgical units (figure 2). There was a statistically significant difference ($t=18.78$ $p<.001$) between the inpatient psychiatric unit and nursing home group and the emergency departments and inpatient medical surgical unit group. There was not a statistically significant difference between inpatient psychiatric units and nursing homes ($t=1.47$ $p=.2$) or between emergency departments and medical surgical units ($t=.5$ $p=.63$).

Figure 2 Percentage of physical events that are patient-on-patient violence



For purposes of comparison, descriptive statistics of the average percent of all events that were patient-on-employee for the same time period were 60.4% for inpatient psychiatry, 58.1% for nursing homes, 78.7% for emergency departments, and 77.3% for medical/surgical inpatient

units. There was not a statistically significant difference between all patient-on-employee violence for these groups. ($t=-.81$ $p=.43$) and in fact the emergency department and medical surgical units had higher mean number of incidents of patient-on-employee violence (2909.6 and 2265.6 respectively) than the nursing home units (2087).

Discussion

Data support statistically significant differences between high risk clinical settings regarding risk of patient-on-patient violence, with both inpatient psychiatric units and nursing home units demonstrating higher risk than emergency departments or medical/surgical units. Factors that may contribute to these differences include longer periods of exposure (higher average number of bed days) on inpatient psychiatry units and nursing home units compared to emergency departments and medical/surgical units, as well as higher number of patients with acute or chronic conditions (e.g., dementia, substance dependence/withdrawal, psychiatric illness, etc.) that can increase risk for violence. Other factors to consider are longer periods of psychiatric hospitalization or nursing home rehabilitation due to the difficulties surrounding discharge of patients with violent behavior to long-term care settings. Though comparisons of bed days of care were not made in this analysis, the data generated in this study are a starting point for further research regarding comparison of bed days of care across settings, establishing a base rate for rate of patient-generated violence in high risk workplaces per bed days of care per year, and examination of differences between clinical settings when the inflation created by single individuals engaging in multiple events is considered as a potential confounding factor.

While such future research will help clarify details that may be beneficial in contributing to mitigation plans, this research reveals the absolute need to include patient safety protocols when developing violence prevention plans in high risk environments, particularly in inpatient psychiatric units and nursing home units. Patient safety planning should pay special attention to environmental and milieu factors, patient access to other patients, thorough history taking and assessment for violence risk on admission, and inclusion of patients in the development of safety plans as well as debriefing of any violent event. Best practices should also include employee training specific to identifying factors of aggression between patients and protocols to mitigate patient-on-patient violence risk.

Limitations

The primary limitation in this study was the exclusion of a relatively small number of events in which multiple types of people experienced workplace violence in high risk healthcare workplaces. Examples include situations in which the targets of violence included both patients and employees, employees and visitors, patients and visitors, or all three (patients, employees, and visitors). These events were not included due to the inability to delineate which events included patients and which did not. Though it is possible that the inclusion of these events would change the analysis, it is unlikely due to the magnitude of the differences between groups and the relatively low number of events excluded.

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Learning objectives

Participants will...

1. be able to critically analyze the differences between healthcare settings when evaluating safety practices and plans.
2. be able to develop safety practices and plans that take both staff and patient safety into consideration in settings that have increased risk for patient on patient violence.
3. be able to implement environmental and milieu interventions to reduce patient on patient violence.

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Incident and Claims Profile for BC healthcare industry

Subtheme: Root causes and immediate causes of aggression or violence

Paper

Waqar Mughal, Dave Keen

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Keywords: Incident data, analysis, violence, healthcare, comparison

Abstract

Incidents involving violence against workers is a great concern in the healthcare industry. This presentation provides contextual information regarding the burden and proportional representation of incidents of violence against healthcare workers in comparison to all other types of incidents that occur in the healthcare workplace. Data were extracted from the 6 BC health authority databases and anonymized. Descriptive statistics were calculated and comparative analyses were performed. Of all incidents recorded in the databases, incidents involving violence represented 15% of all types of incidents. Patient handling injuries represented 14%. When only claims were included in the analyses, incidents involving violence dropped to 7%, while patient handling injuries were 23%. In all analysis including counts of claims and total costs of claims, incidents involving violence ranged from 7-11%, while patient handling injuries varied from 23%-30%. However, when average claims costs were examined, incidents involving violence had the highest average cost of all types of incidents. The same finding was seen when the average days lost per claim were examined; claims involving violence had the highest average days lost per claim. From this analysis, it can be said that while violence represents a relatively constant, and relatively low, proportion of incident counts and claims cost, their high relative severity, as demonstrated by their highest average claims cost and days lost per claim, makes them a priority for organizational attention. Further analysis is required to determine if there are differences in where the costs occur in the claims management process for these types of incidents. Additional analyses examining the types of workers involved in the different types of claims will be presented and discussed in the presentation.

Learning objectives

Participants will...

1. appreciate the context within which incidents of violence occur among other types of workplace incident in healthcare.
2. be able to describe the similarities and differences in the characteristics of violence incidents versus other workplace incidents in the healthcare industry.

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Root Cause Analysis of Health Sector Violence in Nepal: a qualitative exploration of stakeholders' views

Subtheme: *Root causes and immediate causes of aggression or violence*

Workshop

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Helping Hands Community Hospital, Kathmandu, Nepal

Keywords: Patient, Quality, Health Professional, Violence, quack

Abstract

In recent years attack on health care professionals and health care institution had been rapidly increasing in the name of medical negligence in Nepal. Many regulatory policies had adopted by the government to overcome these issues but the magnitude of the problem is in same ground. This study was designed to identify the causative factor for the act of violence against health professionals and facility along with address these issues which is vital to ensure healthy working environment with the health care professionals and patient prospective.

To analyze the root cause of violence against health care professional, a multidisciplinary task force was developed which include all the stakeholder of the health care. The task force undertook the in depth interview with the key informants who are the key stakeholders of the health services and patient representatives about the mapping of health sector violence act causality and possible copping mechanism to make violence free environment for health care professionals and health care facilities.

The health care professionals are continuously targeted by the patient and their groups, the cause remains in the vicious cycle of complexity. However the main reasons behind the act of episodes were poor medical services delivery and increased awareness among the population about their right and their wiliness to seek the justice from court or crowd. The trusts on the medical services were worsened by the quack medical professionals. The other reasons behind the scene were negative media influence on the medical education and services, catastrophic out-of-pocket medical expenses, poor quality of care and commercialization of health services, poor monitoring of medical services, along with lack of professional ethics in some of quack medical professionals.

With the sociopolitical development of Nepal, the violence against health care professional is still in increasing trend due to awareness of the patient about their right and trustworthiness of medical professionals. Health professionals, health facility, government and media remain the causal factor for the medical disputes but the poor quality of care; out of pocket payment and negative media influence remain in the top of the vicious cycle of complexity. The government,

health professionals, social actor of the society and health facilities should have strong policy and mechanism to cope the problem raised by the crowd. Trustworthiness and cost effective treatment approach by the health professional and health facilities are crucial for the prevention of health sector violence in limit resource settings.

Learning objectives

Participants will...

1. understand the social determinants of health sector violence in Nepal.
2. understand the root cause of violence against health care professionals by patient or their relatives.
3. understand the role of media to stimulate the act of episodes repeatedly in health facility.
4. gain knowledge into how to provide the recommendation to policy makers and hospital authority to cope with the act of episodes.

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Understanding systems-level factors contributing to physical, emotional, and cognitive overload in the nursing workforce

Subtheme: Root causes and immediate causes of aggression or violence

Paper

Rosemary Taylor, Karla Armenti

University of New Hampshire, Durham, United States of America

Keywords: Nursing, Workload, Quality Improvement, Burnout

Abstract

Background and Context

We currently have an overburdened health care workforce. Studies document growing despondency and resignation among nurses and other providers. The recent physician literature suggests clerical burden is one of the biggest drivers of burnout in medicine. High demands and low control at work are causal factors in work stress. Heavy workloads, large emotional demands, and limited resources are important sources of stress for the general nursing population. Chronic, cumulative and incremental stress created by short staffing and increasing administrative burdens must be differentiated from the acute temporary situations of high stress that are an expected part of nursing work. We propose the persistence of unaddressed chronic stressors, many of them modifiable conditions of work, contribute to cognitive, emotional and physical overload which erode providers' mental and physical health. The aim of this study is to understand systems-level contributing factors affecting physical, emotional, and cognitive overload in nursing and contributing to provider burnout.

Methodology

The proposed study will investigate systems-level contributions to burnout through the review and collection of empirical evidence on nurses' experiences with job overload and burnout. Phase 1 focuses on reviewing current literature and existing instruments. Phase 2 includes a survey of nurses from area hospitals. Survey questions will be drawn from existing validated questionnaires used to measure workplace stress, (with a focus on job demands and controls) and work-life balance, including the Job Content Questionnaire (Karesek 1998), the NIOSH Quality of Work Life Questionnaire, the Maslach Burnout Inventory, and other national surveys that measure factors leading to employee overload, stress, and burnout.

Findings

The study is currently in Phase 1. Findings to date will be presented.

Implications

Understanding and measuring factors within the work environment that contribute to employee overload will assist healthcare facilities to build appropriate interventions targeted toward systems improvement to reduce employee burnout.

Learning objectives

Participants will...

1. identify modifiable systems-level contributions to provider burnout.
2. have a basic understanding of strategies to identify overload in the the nursing work environment.

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Workplace Violence Directed Upwards at Nurse Managers and Leaders

Subtheme: Root causes and immediate causes of aggression or violence

Paper

Linda Patrick, Alice Gaudine, Lorraine Busby
University of Windsor, Windsor, Ontario, Canada

Keywords: Upwards Violence, Nursing, Workplace Negative Behavior, Leadership, Management, Scoping Review

Abstract

Background and Context

Research exploring negative workplace behavior has existed for decades under many names including, but not limited to incivility; bullying; horizontal violence, lateral violence and vertical violence (Budin, Brewer, Chao, & Kovner, 2013; Chen, Ku & Yang, 2012). Findings reported in the literature have primarily focused on lateral relationships and workplace violence directed downwards towards subordinates. Upwards violence is the negative behavior that a nursing student may direct towards their instructor, that staff nurses direct at a manager, or that nursing faculty direct upwards at their director or dean. It exists mainly under the radar and is excused as being the result of incompetent leadership skills and poor management ability. The assumption is that nurse managers and instructors are in a position of authority and are the ones with the 'tools' to cause harm to their subordinates.

Methodolog

A scoping review of the literature was used to describe the phenomenon of upwards violence directed at nurses in positions of authority. The search strategy included literature on workplace violence and workplace conflict from 2006 to the present.

Findings

This presentation focuses on antecedent themes including the unrealistic expectations upon leaders and a workplace environment that is toxic with high levels of stress, conflict and decreased productivity. Negative outcomes include the possibility of group mobbing, sabotage and a negative spiral of disrespect for a leader's decisions.

Implications for Practice

Recognition that upwards violence is not simply the by-product of poor management and leadership ability is the first step towards developing education and training to support

managers and leaders. Nurses in leadership positions who are not given the tools, organizational support and policies to navigate the negative workplace environment may exit the workplace, leadership positions or the profession altogether. The findings from this scoping review add to what is known about workplace/organizational culture and the negative impact of aggression and violence in the workplace.

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Learning objectives

Participants will be able to...

1. define and describe upwards violence in the workplace.
2. describe the implications of upwards violence for nursing practice, education and research.
3. explain the financial, organizational, legal and societal implications of not addressing upwards violence in the workplace.

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Relationships between violence in healthcare and work environment factors

Subtheme: *Root causes and immediate causes of aggression or violence*

Paper

Suzanne Hrynyk, Gregory Ekland, Michele Chase
BC Nurses Union, Burnaby, Canada

Keywords: Workplace violence, organizational factors, practice environment, workplace climate, violence, healthcare, policy and initiatives

Abstract

Background and Context

The purpose of this work was to explore what work environment factors are associated with violence in healthcare, to identify relevant knowledge gaps in this area, and to identify how this information could inform policy efforts in violence prevention in British Columbia (BC).

Methodology

A scan of relevant literature was conducted from 1995 forward and the results synthesized. Original search terms used were “*workplace climate*”, “*practice environment*”, “*organizational factors*”, “*violence*”, and “*healthcare*”. The results of this literature scan were then analyzed in relation to existing policy and practices in nursing workplaces across BC, and the ongoing work in this area being undertaken by the BC Nurses’ Union (BCNU).

Findings

The underlying causes of violence in healthcare are complex, and often the methods used to characterize violence are overly simplistic. Current theories and interventions tend to focus on individual-level measures, where our findings indicate that work environment factors should be used more to inform violence prevention strategies. Many workplace factors are associated with violence including organizational factors (e.g., patient wait times), workplace stressors (e.g. staffing shortages), and workplace culture (e.g., leadership engagement)

Implications

Identifying gaps in our understanding of the complex interrelations of factors affecting violence in healthcare workplaces could not only guide future research efforts, but allows us to better address contributors to this violence at both policy and practice levels. In this presentation, we will discuss how the findings of the literature scan can influence the BCNU’s policy work.

Learning Objectives:

Participants will...

1. have an understanding of the environmental factors that are related to violence in nursing workplaces.
2. learn about how workplace environmental factors associated with violence can be addressed through policy change.

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Violence experienced on the job by NSW nurses and midwives: preliminary results of a survey of Australian survey

Subtheme: Root causes and immediate causes of aggression or violence

Paper

Jacqueline Pich

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Keywords: Violence, aggression, nursing, midwifery

Abstract

Background

Violence in healthcare is a significant issue globally and nurses have been identified as the profession most vulnerable to patient-related violence. Much of the focus of research and government action has been centred on the emergency department; however it is only the first port of call for most patients. As patients are transferred to various wards for ongoing treatment and care, the risk of patient-related violence can also be transferred. There has been minimal research into the experience of nurses in these areas with such violence, and this is particularly the case with midwives. In addition nurses in smaller and often isolated remote hospitals face unique challenges in managing patient-related violence and are often ill equipped to do so leaving them especially vulnerable.

Aim

The aim of the research is to investigate the experiences of the members of the New South Wales Nurses and Midwives Association (NSWNMA) with violence from patients and/or friends or relatives in their workplace. To enable the NSWNMA to get a snapshot of the experiences of their members with violence in the workplace.

Method

A cross sectional survey was designed in consultation with the NSWNMA. It will be distributed to all NSWNMA members (which in 2017 was approximately 63 000 nurses and midwives) in April/May 2018, to uncover their experiences with violence from patients and/or friends and relatives.

Results

The results to be discussed at the conference are the preliminary results from this survey. The survey data will be entered onto an excel spread sheet, checked for accuracy and completeness and preliminary analysis conducted using excel and descriptive statistics. This analysis will enable the characteristics of the study population to be summarised through measures of central tendency, including means, median and mode.

If time permits the results of statistical analysis will also be discussed. This will include comparisons using Pearson's chi-square analysis with p-values of <0.05 considered significant and the use of Fishers exact test for comparisons involving cell counts that are less than five. Uni- and multivariable Logistic regression analysis will be performed to estimate odds ratios for associations (both crude and adjusted) between variables of interest.

Implications for practice/significance of the research

This is the first study to survey both nurses and midwives working in both the public and private sector. There are some areas that tend not to attract research and it is hoped the results of this survey will provide insight into the experiences of nurses and midwives working there. These results will help inform future dialogue with the NSW government in upcoming round house discussions on violence in healthcare.

Learning objectives

Participants will...

1. receive a snapshot of the experiences of NSW (Australian) nurses and midwives and their experiences with violence in the workplace.
2. have a comparison between the public and private health care sector in terms of the experiences of nurses and midwives with workplace violence.
3. have a comparison between metropolitan, regional and remote areas in terms of the experiences of nurses and midwives with workplace violence.
4. have a snapshot of different clinical areas and the experience of the nurses and midwives working there with violence.

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Intimate partner violence and child development: The evaluation of applications to the pediatric emergency units

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Intimate partner violence, child, pediatric unit

Background

Intimate Partner Violence (IPV) is one of the most common forms of violence against women (WHO 2012, Chai et al., 2016). Negative consequences of IPV against women can be extended and may also affect their children's health both via direct and indirect pathways. (Ziaei et al. 2014). Various negative health problems such as diarrhea, respiratory tract infections, nutritional deficiencies, growth and developmental retardation could be seen in children of mothers who are exposed to IPV (Pallito et al 2013, Ziaei et al 2014, Chai et al. 2016). In addition, children who are witnessed in IPV events are suffered from emotional impacts being characterized with stress and strain. Children's metabolic rates, physical growth and cognitive functions are decreasing.

Women exposed to IPV can be physically, psychologically and economically are precluded from meeting their children's health needs (Ziaei et al. 2014). Restrictions on maintaining children's health care, not paying attention to their health because of maternal stress and depression even if they have adequate food, restrictions by partner on nutrition expenses and inadequate fulfil children's health care needs effect on the child's development (Chai et al 2014). Because emergency units are the first place for urgent application of such cases, emergency unit data are often needed for the relevant analysis.

Objective

This descriptive and correlational study is conducted with the aim of evaluation of applications to the pediatric emergency unit within the scope of medical diagnosis, growth-development and mother's exposure to violence in child patients.

Material and method

The data are collected from all the patients who are applied to the pediatric emergency unit of a Medical Faculty Hospital during April-May. Information form is consisted of 36 questions

under five divisions. In the analysis of the data, descriptive statistics (percentage and frequency distribution, mean, median), chi-square test will be used.

Results

Data collection is still ongoing.

Conclusion

Evidence gained will provide an important knowledge for the identification of prioritized areas in the healthy development of children being witnessed and direct or indirect victimized of domestic violence. It will also reveal the destruction based on dreadful dimension of interpersonal violence in the direction of child-mother association.

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Learning objectives

Participants will...

1. have deeper understanding on the negative impact of the IPV from the most vulnerable part of the violence circle.
2. be induced to formulate the efficient and multidimensional cautions on the IPV subject.

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Violence in Healthcare: The Precipitating Factors

Subtheme: Root causes and immediate causes of aggression or violence

Paper

Sam Asselstine

International Association of Healthcare Security and Safety, Ottawa, Canada

Keywords: Precipitating Factors, Indicators of Crisis, Non-Verbal Danger Cues, Situational Factors that contribute to violence, Managing Resistant Behaviour, Verbal De-Escalation Techniques, Profiled Behaviors, Cooperative, Passive Resistant, Active Resistant, Assaultive, Grevious Bodily Harm

Abstract

Imagine a Healthcare Environment that could Pro-Actively Respond to violence, Predict Code-Whites and ultimately Prevent Acting Out Episodes before they occur. Violence In Healthcare - The Precipitating Factors will discuss how organizations can move toward that very environment through employing fantastically common principles that focus on Watching, Listening and Speaking in an environment that has become riddled with violence.

Acting Out Episodes happen more frequently in hospitals than in other areas. The presentation will discuss why this happens, and perhaps more importantly why staff miss the indicators of violence over and over again.

Violence in Healthcare - The Precipitating Factors will discuss the Risk accepted by hospitals including relevant legislation including the Occupiers Liability Act (1991), The Patient Minimization Restraint Act(2001), The Criminal Code of Canada, and how Healthcare Security Programs can help to minimize that risk. This presentation will examine the difference between Risk Mitigation and Risk Transfer to contract allied healthcare workers.

This presentation will touch on the social response to violence in healthcare and ask difficult questions as to what is acceptable and what is not, who is routinely victimized, helping others to understand why reporting incidents of violence is critical. Communicating and Dealing with Policing agencies while respecting and balancing Patient Confidentiality will be discussed, likely generating lively discussion and debate.

Finally, the presentation will discuss the differences between Certified Healthcare Security Officer and the rest of the Private Security Industry. A snapshot of training requirements, Ministry of Labour recommendations, standardized pre-requisites and contemporary Healthcare Security Training Programs will be discussed.

Learning objectives

Participants will...

1. gain an understanding of safe work practice.
2. learn to approach daily tasks through the lens of a Healthcare Security Professional.
3. better understand precipitating factors of patient crisis.
4. better understand non-verbal indicators of patient crisis.
5. understand and articulate difference between Risk Mitigation and Risk Transfer.
6. understand and articulate.
7. understand the relevance of a Healthcare Security Program.

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Violence. Not part of the Job

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Violence Prevention; Survey Methods; Healthy Workplace

Introduction and background

Workplace violence is on the rise in healthcare. In British Columbia, 26 nurses per month suffer a violent injury at work of sufficient severity to receive compensation through WorkSafe BC, the province's workers' compensation body (1). Even more common are the daily hits, bites, kicks, threats and other violent incidents that don't make it through formal reporting processes, in part because violence has become accepted by many employers and staff as *'part of the job'*.

The impacts of experiencing violence at work are varied and long-lasting for healthcare workers. A systematic review conducted by Canadian researchers found that workplace violence affects workers physically, psychologically, emotionally, vocationally, socially, and financially. The effects of violence reach into patient care as well, damaging workers' abilities to relate effectively with their patients and deliver high quality care (2). In particular, this review found that healthcare workers exposed to violence most often experience difficulties related to work functioning, including difficulty returning to work; in the context of a worsening nursing shortage in Canada (3), employers would be well advised to take this matter seriously, as one way to retain staff. While measures to mitigate the impacts of violence are necessary, the ultimate goal should be violence prevention wherever possible.

While there are many studies on the prevalence of violence in healthcare (4,5,6,7,8) and the potential impacts on healthcare providers (9,10) and patients (11), there is a lack of research looking at the effectiveness of specific violence prevention strategies.

Methods

The BC Nurses' Union collaborated with academic researchers to examine direct care nurses' experiences of violence, perceptions of safety, and suggestions for violence prevention. Using a mixed methods design, with two province-wide surveys and a set of focus groups across the province, the team endeavored to understand nurses' experiences of violence, describe the scope of the problem in BC, and link specific violence prevention strategies with nurses' self-reported perceptions of safety.

Survey 1: Stratified Random Sample (n=1,600)

The first survey was conducted by telephone and email, using a contracted survey company. In total, 1,600 respondents were engaged, 1,051 of whom were nurses (registered nurses, licensed practical nurses and registered psychiatric nurses) working in acute care, long-term care and community care settings across BC.

Survey 2: Convenience Sample (n=2,881)

The second survey was conducted in-house by BCNU researchers, with analysis conducted by UBC researchers. The questions were developed in collaboration with occupational health and safety professionals, designed to elicit quantitative and qualitative data in seven key areas of interest: Code White protocols, security personnel, fixed alarms, personal alarms, violence prevention education, employer support, and perception of safety. Perception of safety was used in this survey based on research demonstrating that nurses' intent to stay depends on how safe they feel rather than the objective level of risk for violence in their workplace (12).

The survey link was e-mailed out to members of the BC Nurses' Union, and a link was made available and advertised through union e-communications. 2,881 responses were received and analyzed jointly by BCNU and UBC researchers.

Focus Groups

In concert with the first survey, the same contracted company conducted six focus groups including acute care, long-term care, and community nurses in BC. The purpose of this arm of the project was to explore perceptions of and protocols for dealing with violence against direct care nurses in the workplace. The stated objectives of the focus groups were:

- To develop a deeper understanding of workplace violence that stems from direct patient care, including any gender issues around Code White and sector differences in terms of the levels and types of violence in the workplace;
- To better understand the protocols that are in place for the various sectors and training that is available to nurses; and
- To gain a sense of what protocols might be seen as valuable in diminishing the frequency of violent incidents and what protocols might be best for dealing with violent situations when they arise.

A series of six focus groups were conducted. Four were in-person groups conducted in the city of Vancouver. Each of these groups ran for approximately 1.5 hours and consisted of 7-8 respondents. In addition, two telephone groups were conducted amongst participants residing outside of the Lower Mainland. Each of these groups consisted of 5 individuals and ran for approximately one hour. The groups, with permission of the participants, were captured electronically.

Results

Survey 1: Stratified Random Sample (n=1,600)

Of the members of the public surveyed, 77% said they were aware of the issue of violence against nurses, and 49% said that the problem is increasing. Fewer than half (46%) believe that security in hospitals is adequate to protect health care workers. 48% support tougher sentencing for people convicted of assaulting health care workers.

Among nurses, 79% reported experiencing some form of physical or verbal violence at work, and only 55% said that violence is taken seriously by their employers. 65% of nurses said that violence in health care is increasing, and 87% support tougher sentences for people convicted of assaulting health care workers. There was no difference in the proportion of nurses who said that security is adequate to protect health care workers compared to the general public (46%).

More than half of nurses (57%) said they had experienced or witnessed a violent incident, but not reported it; reasons for not reporting included lack of time (55%), apathy (18%), not warranted (18%), part of the job (18%), lack of support (16%), and patient empathy (9%). Of those who did report, only 22% said they reported to the Workplace Health Call Centre, which is the official reporting mechanism for the province.

When asked for suggestions on measures to prevent violent incidents, the most common response was better security (37%), followed by zero tolerance policies (21%), better staffing (20%), improved Code White protocols (15%), public education (14%), screening (13%), reducing overcrowding (12%), and nurse education (7%).

Nearly one in four (39%) of nurses said that violence was a deterrent to staying in their current job, and 40% stated that violence was a deterrent to remaining in the nursing profession.

Survey 2: Convenience Sample (n=2,881)

Perception of safety was assessed with the question “*do you feel safe at work*”. Overall 27% of respondents said always, 65% said sometimes, and 8% said not at all. Perception of safety was analyzed in relation to each of the identified key areas of interest: Code White protocols, security personnel, fixed alarms, personal alarms, violence prevention education, and employer support.

Code White protocols

Respondents were more likely to say they always feel safe at work when they had enough properly trained Code White responders on each shift (39% vs. 24%); when they reported that Code White incidents were reviewed on their units (42% vs. 17%); and when they reported that behavioural care plans were created or updated based on Code White incident reviews (39% vs. 20%).

Security personnel, fixed alarms & personal alarms

Not surprisingly, quicker response times to fixed and personal alarms were related to increased feelings of safety at work. Nurses who said that security responds “*right away*” were more likely to say they always feel safe compared to nurses who said that the security response was “*not quick enough*” (38% vs. 11%).

Having access to security personnel did not automatically increase feelings of safety; the quality of security personnel made a difference. Those who said that security personnel were helpful in Code White situations were more likely to say they always feel safe compared to those who said their security detail was unhelpful (27% vs. 11%).

Similarly, having fixed and personal alarms in inpatient units did not automatically increase feelings of safety; accessibility and proper functioning made a difference. Those who said they had fixed alarms that are easily accessible were more likely to say they always feel safe compared to those who reported having fixed alarms that are not easily accessible (33% vs. 16%), and those who said they had personal alarms that work properly were more likely to feel always safe compared to those whose alarms do not work properly (28% vs. 7%).

Violence prevention education & employer support

Training and education did not emerge as predictors of nurses’ perceptions of safety in this research, perhaps because of a lack of variation in training experience. The vast majority of respondents (93%) reported having completed the online violence prevention modules required for their work areas, making it difficult to assess whether there were any differences between those with and without the relevant education. Respondents were more likely to say they feel always safe when their employer listens to their suggestions about violence prevention (36% vs. 9%).

Focus Groups

The six focus groups included nurses from across BC, working in acute, long-term care and community settings. A common thread was that violent events in the workplace are fairly common across all nursing sectors, and the majority of nurses involved indicated that violence or threatening situations are occurring more often than in the past.

Some participants felt their situations or the aftermath were poorly handled. Everyone agreed the appropriate response from a supervisor or manager is to support the nurse’s actions both in and after the event. However, in some cases, neither appeared to be the case. Although a few nurses thought they had handled a violent event less capably than they might have, more nurses felt that their supervisors were unsupportive and sometimes accusatory.

Regarding reporting, most agreed that filing an incident report is expected, but some nurses said they were encouraged by their supervisors to avoid filing such a report. Some indicated they minimize the event themselves and do not file a report, because of the time involved in doing so. And, since the majority had no idea what happens with a report after it is filed, there was a sense that filing one has little impact. The Workplace Health Call Centre was mentioned, but it does not appear to be very helpful, according to some.

As for training, everyone had taken the online training, and most had taken the half-day, in-person associated training. Everyone agreed this training was valuable, especially the in-person training, and that all nurses should have to take the training at least once a year.

When asked what they would change in their workplace, there were common responses. All sectors felt that additional staffing is necessary to allow nurses to give their patients the attention they need, and to allow them to file the above-noted reports as needed. Some, from all sectors, also said that supervisors should be more supportive and less accusatory, and suggested offering training for supervisors in how to do so.

Discussion

A common thread in this research is that violence is a common experience for nurses in BC. However, this is not new information; as stated previously, there is an abundance of research documenting the prevalence of violence in healthcare. What is new and notable about this work is the linking of common violence strategies with nurses' perceptions of safety. Across both surveys and each of the focus groups, the following solutions were offered up by participants:

- Security professionals in acute settings, trained to go 'hands on' in Code White situations, leaving nurses to perform their clinical roles
- Enough security personnel so that calls can be responded to quickly
- Code White incident reviews that result in new or updated behavioural care plans
- Front-line staff engagement in violence prevention planning
- Safe staffing and better workload management
- Reduction or elimination of hallway nursing and patient overcrowding
- Enforcement of zero-tolerance violence policies
- Regular, active nurse education (e.g. Code White drills versus passive education only)
- Simplified reporting systems (e.g. one number to call) and dedicated employer-paid time for filing reports
- Attention to the unique needs of long-term care and community nurses (e.g. appropriate screening procedures and working-alone policies)

Preventing workplace violence and bolstering the perception of safety of front-line staff has the potential to reduce costs, improve staff retention, and improve patient care. This collaboration between the BCNU and academic researchers has added rigor to our search for effective solutions. What is needed now is employer commitment to move this work forward through implementation and evaluation of evidence-informed preventive policies and practices.

Acknowledgement

We thank the nurses of BC for lending their voices and sharing their experiences.

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Learning objectives

1. To identify violence prevention strategies that contribute to nurses' perceptions of safety at work.
2. To demonstrate understand the impact of workplace culture on nurses' perceptions of safety at work.
3. To name the need for collaborative work in violence prevention, including government, employers, worker representatives and front-line staff in designing, implementing and evaluating violence prevention strategies in health care.

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Mistreatment of older adults and associated psychological distress in rural north India

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Elder mistreatment, elder abuse

Abstract

Introduction

Elder mistreatment is an important public health problem that exists in both developing and developed countries yet is typically underreported globally. Mistreatment refers to abuse, neglect, exploitation and abandonment of elderly by family members, spouse, relatives or any other formal or informal caregivers.

Aim of the study

To determine the prevalence of mistreatment among older persons and find out association between mistreatment and psychological distress.

Materials and methods

Quantitative approach, cross-sectional survey design was used for the study of older persons selected from seven villages of Haldwani rural block of Uttarakhand state, India by convenient sampling technique. Total of 381 subjects who fulfilled inclusion criteria were enrolled in the study using total enumeration sampling method out of total population of 7405 living in the selected area.

Tools and techniques

Proforma for socio-demographic and selected variables, Kessler Psychological Distress Scale (K10), Geriatric Anxiety Inventory (GAI)-Hindi Version, Geriatric Depression Scale (GDS)-Hindi Version, Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) and Elder Assessment Instrument (EAI) were used for collecting data from older persons. Validity and reliability of the tools were established. MOS-SSS, K10 and H-S/EAST were translated to Hindi besides availability of standardized Hindi version of GAI and GDS.

Data collection

Seven villages were selected using convenient sampling method for selection of setting. All houses in each village were visited and examined for presence of older persons (subjects) and 383 enrolled.

Results

The mean age of the study subjects is 68.17 years (SD±7.64), ranging between 60 and 98 years. Sixty out of 381 older persons reported at least any one sub-type of mistreatment and the prevalence of elder mistreatment is 15.7% (95% CI, 12.05%-19.35%). Nineteen subjects reported abuse and the prevalence of elder abuse is 5.0% (95% CI, 2.81%-7.19%). Forty eight subjects reported neglect and the prevalence of neglect is 12.6% (95% CI, 9.27%-15.93%). Twenty two subjects reported exploitation and the prevalence of exploitation is 5.8% (95% CI, 3.45%-8.15%). Fourteen subjects reported abandonment and the prevalence of abandonment of subjects is 3.7% (95% CI, 1.80%-5.60%). Older persons who reported mistreatment have significantly higher psychological distress score than those who did not report mistreatment ($P<0.05$). Anxiety level of older persons who reported mistreatment, abuse, neglect or exploitation is significantly ($p<0.05$) higher than those who did not report. Depression level of older persons who reported mistreatment, abuse, neglect or exploitation is significantly ($P<0.05$) higher than those who did not report. Older persons who reported mistreatment, neglect or exploitation are likely to have poor social support that those who did not report ($p<0.05$).

Conclusion

The findings emphasize the need of screening for mistreatment of older persons during home visit of nurses to find out the cases of abuse otherwise most often it go unreported.

Learning objectives

At the end of the presentation the participants will be able

1. to know the meaning of elder mistreatment.
2. to be aware of the extend of elder mistreatment in India.
3. to discuss the health and psychological consequences of elder mistreatment.
4. to analyse the factors associated with elder mistreatment.

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Addressing Violence Faced By Women In The Health Sector During Delivery, Nakuru County, Kenya

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Ambassadors of Change, Nakuru, Kenya*

Keywords: Language, words usage in communication, Equipment, Skills, Confidentiality (Patient's Rights), Information, Systems strengthening, Innovation

Abstract

Background

Cases of violence carried out by nurses and midwives in maternity wards reported by patients during delivery are on the rise. Violence against women and adolescent girls are in form of physical and emotional abuses.

Methods

Visits to 5 maternity wards between March- December 2017 to discuss with both nurses, midwives, hospital managers and women at delivery on reported violence cases in the media , social workers and former clients and contributing factors.

Findings

Poor training curriculum for mid-wives lacking human rights aspect. Mid-wives and nurses take advantage of patients ignorance on Patient Rights Charter and ethical procedures. Lack of proper supervision especially at night and weekends. Fatigue among health providers due to overworking (30 needy patients per shift by 1 attendant), poorly equipped hospitals. lack of motivation and incentives. Poor mechanisms to address and remedy cases of violence reported . lack of protection (e.g. insurance cover) for health providers and families. Poor referral systems for emergencies

Conclusion

Address shortage of human resource for health caused by migration for better pastures. Provide essential equipment and supplies for effective health care delivery. Transform health services, policies, systems through research, education ,innovation, and partnership.

Main study

Violence meted against women and girls during delivery is on the rise from mid-wives , nurses and gynecologists in public hospitals ranging from use of derogatory language and words , physical violence , sexual harassment and medical negligence e.g pair of scissors left in the stomach, and unwarranted caesarian operations even when women can deliver the normal way.

Reports indicate women undergo unnecessary pains , heavy bleeding and deaths of both the mother and the young baby following the unethical and lack of professionalism in the manner caesarian operations are carried out. This has led to majority of expectant women opting to deliver either in private hospitals despite the high costs or at home attended by traditional mid-wives to escape the violations and possible deaths. However this has resulted to increase of HIV transmission from mother to child.

The study noted women prefer being attended to by male doctors rather than fellow women reported to be notorious in using abusive and humiliating language in labor wards. Women living with HIV and those with disabilities suffer double tragedy during delivery due to their status and stigma associated with the disease in the community and among health care workers in both private and public hospitals.

Women with disabilities either blind, or physical impairment experience violence in public hospitals during pregnancy and during delivery being blamed for engaging in sex unlike the normal women a misconception that they are not sexually active and have no reproductive rights. Efforts have been made by both the government and non-governmental organizations to promote community participation as provided in the constitution to shape and influence their own health within the county hospitals including sexual reproductive health , access to affordable and quality treatment and care , patient's rights , insurance health policy and professionalism in hospitals.

Health advocates are demanding a multi- sectoral approach to improve and expand the health sector to ensure quality, dignified health care delivery . Health management in sector have been provided by the Ministry of Public Health an updated rules and regulations document to guide on best practices , reporting and disciplinary measures on violence cases detected or reported.

Health managers have been accused by nurses and clinicians for subjecting them to violence and unfair treatments during promotion , transfers , and trainings for self career development after refusing to comply to their demands for sex.

It becomes imperative for the government to establish a regulatory board to deal with complaints on violence as an autonomous authority in the health sector to deliver justice , reduce cases of violence and whenever considered necessary the culprits be subjected to disciplinary measures such as dismissed , deployed to other hospitals ,charged in courts of law and imprisoned depending on the magnitude of the matter.

It is equally important to ensure all cadres of health providers in the sector sign code of conduct as guide on matters of integrity and ethics while on duty properly trained on patients' rights .A patient –centered approach is key in the efforts to reduce violence in the health sector.

Learning objectives

Participants will...

1. Learn how motivation and incentives are key for retention of health workers and delivery of quality health care violence
2. Understand the necessity of funding by governments and donors.

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Strategic interventions to minimize violence in the health sector: Nakuru level five hospital, Kenya

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Patient-centred approach, ethics, information sharing, gender-equality, culture, mental disorder, innovation

Abstract

Background

Violence in the health sector is reported by the Ministry of Health in Kenya to be increasing impeding effective delivery of treatment and care services manifesting itself in abuse and physical violence from the health providers, senior staff on the juniors, co-workers as well as the patients.

Methods

Study was carried out between March and October 2017 to establish key root causes of aggression and bring together stakeholders to provide and implement solutions for positive practice, policy guidance. Questionnaires and interviews were designed and carried out engaging 24 nurses, 2 health managers, 2 policy makers, 2 psychiatrists, 35 patients, 2 security personnel by a trained duo observing confidentiality. Literature review. Data analysis.

Findings

Study show bullying of junior staff by health managers is common. Disclosure of terminal illnesses e.g. HIV by co-workers, to families, friends create conflict and violence. Patients experiencing mental dysfunctions when poorly handled in the health sector are aggressive and cause physical violence to other patients and health providers Poor working environment create tension, stress promoting aggression. Manner in which information is shared on illnesses to family and friends on patients in hospital is a major factor of violence. Male patients are biased towards female health providers based on gender factors deeply rooted in cultures values, attitudes and practices physically abusing them.

Conclusion

Innovative approaches and policy change to reduce violence is critical in the health sector for positive practice. Increased research is needed for evidence-based information to guide policy,

systems and implementation of solutions by all stakeholders. Promote ethical practices in the health sector. Address the stigma on HIV and associated diseases among health providers.

Learning objectives

Participants will...

1. Learn how a health sector free of aggression/violence is an assurance of effective health care delivery system.
2. Realize that all stakeholders must be involved to develop information to guide policy, systems and implementation of solutions.

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Before anger is an opportunity

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Aggression, violence, prevention, mental health

Abstract

Violence towards health care staff continues to be a serious problem in emergency rooms and other healthcare settings nationwide. Medical professionals have emphasized an importance of developing communication or techniques to handle aggressive or violent patients. Using online educational materials to develop new and evaluate existing communication styles with patients can help in identifying and preventing aggressive or violent patients.

It has been found that the first step in decreasing workplace violence is having a well-written policy in place for reporting, responding to, and debriefing from a violent experience. Additionally, a mix in text, videos, and graphics create an interactive online learning space, which can promote engagement in training videos. This presentation is aimed to assist health care providers to recognize and identify escalation in patients, identify healthy de-escalation techniques, and gain awareness of education methods that are beneficial in addressing workplace violence.

Learning objectives

Participants will...

1. Identify preventative verbal and nonverbal communication skills to avoid escalation.
2. Identify factors that can cause escalation and aggression in clients.
3. Evaluate their own personal prevention and communication style with clients.

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Nurses Expertise and Recommendations for Anti-Workplace Violence Program

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Aggression, Bullying, Safety, Workplace Violence

Abstract

Background & Context:

Workplace bullying is one of the major difficulties in the nursing administration today, which really calls for an immediate action to stopover (Lindy & Schaefer, 2010). Although, there were widespread campaigns and interventions were done to decrease the case reports of workplace bullying among nurses. However, it continually increases in number (Karatuna, 2015). Every nurse can experience workplace bullying. The most identified workplace bullying victims were the newly registered and licensed nurses (Simons, 2006).

However, some studies from Yildirim (2009), Efe & Ayaz, (2010), and Ovayolu et.al (2014) revealed that older generations of nurses had also experienced mistreatment, discriminations and harassments from co-nurses, other health care professionals, patients and patient's significant others. Some reasons of workplace bullying are socio-cultural diversity, gender specification and preferences (third sex), religious orders, race and nationality and personal indifferences. Therefore, experienced or inexperienced nurses can be subjects of workplace bullying, thus, it does not target specific population of nurses and it can happen at any time and place (Ovayolu et.al, 2014).

Methodology

This qualitative study would like to investigate on the lived experiences of the nurses who were victimized by workplace bullying in a selected government hospital situated in Saudi Arabia. It aims to provide information on how to eliminate workplace bullying by understanding the underlying causes, issues and mechanisms of this nursing issue and phenomenon. Likewise, this can be a way of ascertaining action plans on how to promote awareness and education among the concerned professionals.

The data will be collected through qualitative methods like interview and observation with utilization of field notes. Data analysis will be utilizing qualitative content analysis.

Furthermore, emergent themes will be generated from the rich contextual descriptions of the narrations, which later be used as constructs in the anti-workplace violence program.

Findings

The findings of this study will be determine after analyzing the data collected from the qualitative investigation that will shed light in creation of anti-workplace violence program.

Implication

This phenomenon of workplace bullying among nurses required a motivation to the advocates of the study to explore, analyze and understand the nurses' who experienced this phenomenon to provide insights that shed light in discovering foundations justifying problems of workplace bullying, thus, this body of knowledge can serve as an awareness to all nurses around the world on how to eradicate and overcome the aftermath of workplace bullying, which is timely and relevant in the profession in this country. Salvador (2016) mentioned that an anti-bullying program should be initiated by the administration of any institution to monitor and conduct surveillance in the occurrences of this phenomenon, thus, these activities should be included in the program promoting anti-bullying among the nurses in the hospital.

Learning objectives

Participants will...

1. have awareness of workplace violence.
2. be able to distinguish various types of workplace violence.
3. be knowledgeable of the assortment lived experiences of the participants.
4. to serve as body of knowledge towards creation of their specific anti-workplace violence program.
5. be able to create robust policies to eradicate workplace violence especially to countries who do not implement actions about this social phenomenon.

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Violence experienced by the prehospital emergency care providers: point of situation

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Workplace violence, Prehospital emergency, Emergency physicians, Paramedics, Emergency medical technicians

Abstract

Context

Workplace violence is a serious and increasing problem in the health care sector. Prehospital emergency services are particularly at risk. They are regularly confronted with violence. Nevertheless, only few studies have been carried out about this topic, and mainly in English-speaking countries. There are limited epidemiological data concerning violence against prehospital emergency care providers (PECP) in Europe and specifically in Switzerland.

Objective and methodology

The aim of this study was to describe the acts of violence experienced by PECP in the Canton of Vaud between 01/2016 and 12/2016. This Swiss Canton is located in the French-speaking part of Switzerland and has a population of about 780'000. Trained paramedics or emergency medical technicians constitute the initial response on site. Emergency physicians may be dispatched on scene in the case of life-threatening emergencies, or secondarily at the request of the paramedics on site. For this observational transverse study, we used an online survey, sent to all Canton of Vaud PECP (n=416).

Findings

273 (65.6%) PECP participated to the survey. In 2016, workplace violence was experienced by 229 survey participants (83.9%). Most of them declared to be victim of violence between one and three times a year. Among all cases of violence, the patient and/or a relative initiated the aggressive behaviour in 96% of cases. Verbal assaults were the most common violence (99.2% of all acts of violence). They were followed by intimidations (72.8%), physical assaults (69.6%) and sexual harassment (16.3%). Concerning physical assaults, the PECP were predominantly victims of spits and/or jostling (50%). In 50%, PECP modified their behaviour due to workplace violence, 82% of them wear protective vests and 16% carry a weapon, such as a pepper spray. In 75%, PECP changed their strategy of intervention, acting more carefully

and using verbal de-escalation techniques or physical restraints for violent patients. Finally, only 22% declared having systematically reported the episodes of violence, resulting in an under-estimation of violence.

Implications for practice

Workplace violence has significant consequences for PECP. In order to increase their own security, PECP changed their behaviour: they sometimes wear protective vests and some even carry weapons. Although these modifications potentially increase their security, they can lead to confusion with police forces and are not without risks for the patients. Furthermore, these results illustrate the feeling of insecurity experienced by PECP, which can lead to negative effects over the years, by reducing their satisfaction as well as their motivation at work.

The identification of violence plays an important role in the prevention and management of these situations. As these acts of violence are widely underestimated, systematic registration of the acts should be improved for a better evaluation of the problematic. In addition, further studies should be initiated in order to better evaluate the context, promoting factors and therefore the potential mitigating strategies that could be introduced in education and operational process.

Learning objectives

Participants will...

1. understand the situation of the pre-hospital emergency care providers in Switzerland about violence.
2. understand long-term consequences of workplace violence and their implication on the daily practice.
3. identify the factors that make the violence underestimated.
4. understand why the formation is important to prevent violence.

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Prevalence and Experience of Bullying Directed Toward Clinical Nursing Faculty

Subtheme: *Root causes and immediate causes of aggression or violence*

Poster

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Keywords: Bullying; nursing; clinical nursing faculty; academia

Abstract

Background and Context

The purpose of this study is to explore clinical nursing faculty's (CNF) experiences with bullying directed at them in their clinical sites and their strategies used to deal with this behavior. Clinical placements are a critical component of nursing education, providing students with opportunities to put classroom knowledge, and skills into practice. (CNF) play a crucial role in facilitating necessary skill acquisition. This study defines CNF as full or part-time, or adjunct faculty hired to instruct and supervise students in their clinical placements in Baccalaureate and Associate degree nursing programs. We are also interested in the effects of exposure to bullying on CNF health, job satisfaction, and retention. Due to the paucity of research focused on this population, the prevalence of bullying and its impact on the educational environment, recruitment, and retention of CNF is unknown.

There are not enough nurses taking positions of CNF to meet the increasing demand of the nursing workforce. In 2014, the American Association of Colleges of Nursing (AACN) reported that the schools of nursing in the U.S denied admission to over 68,000 qualified applicants because of an inability to attract sufficient numbers of qualified faculty to teach student nurses. The clinical nursing faculty shortage is documented as a reason for nursing programs nationwide turning away qualified applicants. Bullying directed toward CNF, in particular, is a potential stressor that hinders effective teaching. Bullying in this case refers to psychological and interactional mistreatment. It is well documented that the targets of bullying have high levels of stress, sleep disturbance, post-traumatic stress disorder, lower self confidence and self-esteem, as well as decreased job satisfaction and increased intention to leave the job.

Methodology

This study adopted a cross-sectional web-based survey using Qualtrics. The survey is currently being distributed to CNF working in New England states using a convenience sampling approach. The survey was composed of 44 items from the Negative Acts Questionnaire-Revised, Michigan Organizational Assessment Questionnaire, and demographic questions. Data analysis will use descriptive and inferential statistics. The study was approved by the

Institutional Review Boards of the University of Massachusetts Lowell and University of New Hampshire.

Preliminary Results:

The data collection is currently ongoing with a current sample size of 60 CNF. One third have reported exposure to bullying in the last 6 months. Majority of the participants (85%) find their job as CNF stressful. Ten percent of the participants are not satisfied with their current job as CNF, and 21% of the participants are likely to leave their current job as CNF to find a new job within the next year.

Relevance and Implications

This study will help to describe the prevalence of bullying toward CNF and inform interventions to reduce exposure to bullying, promote health and well-being, and positively affect recruitment and retention of CNF. This research will help to formulate evidence-based interventions to better support CNF in the important work they do.

Learning objectives

Participants will...

1. understand the prevalence of bullying on clinical nursing faculty and the effects on health.
2. Understand the importance of well-being and intent to stay in their job.

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Why has workplace violence increased so rapidly? A structural analysis offers answers—and opportunities for employer prevention

Subtheme: Root causes and immediate causes of aggression or violence

Paper

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Keywords: Workplace Violence; Nurses; Hospitals; Root causes; Restructuring

Abstract

The U.S. healthcare industry periodically changes how it is structured (“*restructuring*”) in the name of cutting costs or making service delivery more efficient. These changes often include, among many other things, decreasing staff and consolidating jobs, outsourcing work to contractors, discharging patients more quickly, and increasing use of technology. The result is that, in general, nurses are caring for more acutely ill patients with fewer staff, fewer resources, and a requirement to spend more and more of their time interfacing with technology.

Paralleling these trends are the rapidly increasing rates of workplace violence experienced by registered nurses and other healthcare workers in the U.S. The U.S. Bureau of Labor Statistics reports that healthcare workers are 5 to 12 times more likely to report a workplace violence injury than all workers in general industry. While the overall occupational injury and illness rates have been declining for decades, workplace violence injury rates have climbed rapidly since the early 2000’s (AFL-CIO Death on the Job Report, 2017).

Many would suggest this increase is due to increased awareness and more frequent reporting. However, this view does not take into account significant structural changes that have been occurring during a similar time period. This presentation will examine ways that healthcare industry restructuring has directly impacted workplace violence through increasing risk factors and not implementing prevention measures. We will examine the effects on an industry wide level using nationally gathered data and peer reviewed literature as well as on a facility level through direct care registered nurses’ experiences of workplace violence.

Understanding this context reveals the importance of seeking structural solutions to health and safety issues, which are too often held apart as technical. This presentation will touch briefly on ways that the largest labor union and professional association for registered nurses in the U.S. is developing—and winning—structural solutions to workplace violence, including organizing nurses, sponsoring landmark legislation and regulation mandating employer prevention, and winning strong collective bargaining contract language around workplace violence.

Learning objectives

Participants will...

1. be able to discuss the connection between healthcare industry restructuring and workplace violence.
2. be able to describe the importance of structural solutions to employer workplace violence prevention.

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Workplace bullying and horizontal violence among nurses in India: A National Survey

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Workplace bullying, Nursing, violence, horizontal violence

Abstract

Introduction

Workplace bullying is a persistent pattern of mistreatment from others in the workplace that causes either physical or emotional harm. It includes but not limited to verbal, emotional, physical abuse and humiliation. Workplace bullying is common in nursing profession and it obviously results in poor productivity and decreased quality of care provided to the patient (RNnetwork, 2017). This study was planned to conduct a National survey among nurses on their experiences of workplace bullying.

Methods and Materials

One hundred and fifty six (n=156) nurses working in 15 different states of India have responded to this cross sectional descriptive survey. A self-developed and validated online questionnaire was sent to Registered Nurses and 156 nurses responded to the questionnaire.

Results

The mean age of nurses was 31.9 (SD=7.4) and ranged from 22 to 56 years. Majority (57%) of the nurses were females and 80% were working as staff nurses. The highest number of responses was received from the nurses working in south Indian state of Tamilnadu (44.2%), followed by Delhi (30.8%). Nearly half (48.1%) of the nurses were working State government hospitals followed by 23.1% in central government hospitals and Private hospitals (19.2%). The mean years of experience in nursing was 21.9 years. Nearly one fifth (19%) of the respondents were Post Graduates in Nursing. Three fourth (75%) of nurses reported that they were harshly criticized by someone without listening to both side out of which 18% reported that this happens very frequently or almost always. Two thirds of the respondents reported hurtful remarks about self or coworkers in presence of others. Complaining about coworker instead of solving the conflict (68%) and pretending not to notice the workload of fellow nurses (72%) were also commonly reported. Sixty one percent of staffs reported about threatening non-verbal communication by supervisors, doctors and in-charge nurses. Association of workplace violence with age, gender, experience and education were analysed.

Conclusion

Study revealed that workplace bullying is omnipresent in nursing profession. A healthy and non-threatening work environment is essential for delivering quality health care to the patients. Strategies need to be developed to curb workplace violence in nursing to ensure physical and mental health of nurses and delivery of quality healthcare to clients.

Learning objectives

Participants will...

1. be aware of the prevalence of workplace bullying in nursing.
2. be able to understand the circumstances in which the bullying occurs in nursing.
3. be able to analyse the factors associated with workplace bullying in nursing.

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Emerging Safety concerns of Healthcare providers, patients and attendants; Shout out to newer challenges

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Violence, harassment, physical abuse, healthcare providers, Pakistan

Abstract

Introduction

The status of mental and physical health and well-being is overall declining in Pakistan. There is an epidemic of behavioral disorders and distorted mental health due to stress and anxieties induced by variety of triggers like lack of basic necessities, religious extremism, social hardships, low income, illiteracy etc. Along with these confronting threats of all types of violence is not only prevailing but also the exaggeration has been noted in health care sectors on both healthcare provider's and patient's end.

Objectives

The main aim of the investigative report was to identify the emerging Safety concerns of Healthcare providers, patients and attendants. In addition to that the secondary objective was to find out the core reasons, triggers and sufferings.

Methodology

Selected reported Incidents of violence in health sectors across Rural and urban areas from April 2016- March 2018 were gathered and the case scenarios were documented with qualitative analysis done based on insights, reported proofs and interviews.

Results

The cases that are documented in this report included almost all levels of violence from bullying, harassment, physical and mental abuse. Victimization of doctors, security guards and ambulance drivers by patients, attendants and public were reported by hospital staff. On the other hand there are cases of victimization of patients' attendant by doctors and associated staff even result in death of attendant.

Conclusion

Focusing on root cause(s) few of cases showed the violence trends that followed ethnic lines hence pointed out towards the ethnic inequality. However, we have also observed that in both rural and urban areas there is a huge impact of social, economic, political and religious gaps as well as inequality in cost-effective opportunities and communal resources. These restrictions sustain the patterns of marginalization within cities and vicinities, making it difficult for both healthcare providers and patients to escape the environments associated with high rates of violence.

Learning objectives

Participants will...

1. Learn about new emerging triggers that stimulate violence in healthcare facilities.
2. Be able to compare the intensities and patterns of incidents happened and to identify break points where there are possibilities to improve scenarios.

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Post-traumatic stress as an emergent threat to mental health of Health Care Providers (HCPs)

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Traumatic stress, Stress, Sadaf Stress Scale, mental health, Health Care Providers

Abstract

Background

Since past tow decades Pakistan has become unstable by certain overstressing factors like terrorism, sociopolitical constraints, violence, and media war as well as burden of chronic and infectious diseases as well. All of such instances imposed emergency conditions as well as enormous amount of chaos that has extreme effects on the psychosocial and mental wellbeing of Health Care Providers (HCPs) through direct and indirect mechanisms. In addition these traumatic experiences have tendency to become more severe among HCPs who attended victims of terrorist attacks and other extremism related situations and might develop Post traumatic stress disorder (PTSD).

Method

In this cross-sectional observational study data was collected from 200 selected health care providers those were supposed to be affected by traumatic events from Karachi, Hyderabad, Peshawar and Quetta. The severity of traumatic stress, as well as the relationship of severity with the duration of the incident or cause, was also determined in study subjects using Sadaf Stress Scale (SSS). The Traumatic stress was scored according to scale as mild, moderate and severe and reasons were investigated with the help of pre-designed questionnaire. Subjects were also asked about the individual experiences and suggestions to improve the emergent situations.

Results

The results showed that there was a moderate to mild level of stress reported by the middle career doctors but severity of traumatic stress was intense among young doctors and paramedical staff including ambulance drivers who were first to attend victims. However, there was also a difference among male and female subjects as female subjects were found to be more traumatized and reported more severity in symptoms like fear, anxiety, flash backs, mental and physical discomfort when reminded of the traumatic event. Almost all of the subjects in moderate to severe category stated down the triggers and their effects as

significant factor to affecting quality of life and service. Many subjects reports their own burnouts and traumatic episodes.

Conclusion

It was observed that the medical workforce in such situations should be considered as second victims and severity of traumatic episodes must be identified before development of serious mental and related health issues. The indirect exposure to traumatic events and its chronic effects have potential to threaten the professional and personal progress of these HCPs that can be also be a strong part of chaos. It is recommended that HCPs in high risk areas should be trained on community and professional level and can be on high alert and well trained to reduce Post-trauma stress and anxiety in any catastrophic situation, otherwise it will increase more trauma in affectees if mishandled. In Pakistan, we have to prepare and establish interventions/precautions in the state of emergency measure more specific for our own region and culture with all social and psychological individuality.

Learning objectives

Participants will...

1. learn about the sorts and sources of traumatic and post- traumatic conditions and their acute and chronic effects.
2. be able to compare the severity and impact among diverse groups of HCPs within similar and different agitated situations.

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Exploring the dynamics inducing initiatives to manage violence and aggression against healthcare workers

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Dynamics, Inducing, Initiatives, Violence, Aggression, Healthcare workers

Abstract

Background

The study sought to explore the dynamics inducing initiatives to manage violence and aggression against healthcare workers, using social support theory, and also to encourage healthcare organisations and the larger society to offer greater support to healthcare workers.

Methods

A cross-sectional survey of healthcare professionals from 19 hospitals in six districts in Uganda was conducted.

Results

The respondents exposed to workplace violence expected to receive organisational and social support. Those exposed to psychological violence had a strong opinion of the need for target training to strengthen their competence in responding to violence (OR = 1.319, 95% CI: 1.034–1.658) and enacting workplace violence legislation (OR = 1.968, 95% CI: 1.523–2.543). Those exposed to physical violence thought it might be useful to reinforce staff with back-up support (OR = 3.101, 95% CI: 1.085–8.860).

Conclusion

Those exposed to both types of violence and those with high anxiety levels need greater support at both the organisational and societal levels.

Learning objectives

Participants will...

1. Appreciate the role of social support theory in managing violence.
2. Learn of persons most vulnerable to violence in the health sector.

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Victims of verbal or physical violence: any differences in their impact on mental health?

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Verbal violence, physical violence, post-traumatic stress disorder, psychological distress

Abstract

Background

The Montreal Mental Health Hospital is one of the largest psychiatric institution in Montreal. It employs approximately 2,000 people and counts more than 3,000 emergency room visits per year. Due to the nature of their job, employees are at-risk of being exposed to verbal or physical violence from patients. This longitudinal study aimed to assess 1) the psychological consequences after a serious violent act, and 2) the potential differences in these consequences depending on the type of violence experienced (verbal vs. physical).

Method

Between 2012 and 2015, employees who reported incidents of verbal or physical violence to the hospital's safety board were presented the study. Seventy-four participants completed four questionnaires that evaluated their state of mental health over a 12-month period. The Kessler Psychological Distress Scale (K6) was used to measure psychological distress, the Posttraumatic stress disorder checklist – civilian version (PCL-C) was used to measure post-traumatic stress disorder, and the Confidence in Coping with Patient Aggression Instrument (CCPAI) was used to measure the employees' ability to deal with aggressive patient behavior.

Results

The types of violence (physical or verbal) had different consequences on the psychological distress score. A two-way interaction ANOVA was performed to explain the evolution of the psychological distress score (T1 to T4) according to the type of violence. The interaction effect between time and type of violence was found to be significant ($p = 0.026$). The psychological distress score decreased over time for both victims of verbal and physical violence, though it decreased more rapidly for victims of verbal violence. For the post-traumatic stress disorder score, it was found that only the two main effects (time and type of violence) were significant. The average post-traumatic stress score (regardless of time) was higher for victims of verbal violence than for victims of physical violence ($p = 0.030$).

Additionally, victims of verbal violence had greater confidence in their ability to deal with aggressive patient behavior than victims of physical violence.

Conclusion

The findings emphasize the need to consider victims of verbal violence as much as victims of physical violence. Health and Safety boards, as well as unions, supervisors, and employees should be made aware of the risk of mental health problems that can arise following a serious violent act and that can persist for up to 12 months.

Learning objectives

Participants will...

1. be able to discuss in depth about verbal violence, which will render it less taboo.
2. be sensitized to the consequences of verbal and physical violence.

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Mobbing exposure status of the nurses working at hospitals and influencing factors

Subtheme: Root causes and immediate causes of aggression or violence

Poster

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Keywords: Nursing, mobbing, violence

Abstract

Introduction

Since most of the time is spent in the workplace by the employed people, it is important that the working environment is healthy, comfortable and that the person can feel himself/herself psychologically comfortable there. Where there is mobbing, the working environment for the victim is stressful and difficult to work with. In this case, one's relatives may be lack of help. The need for the psychological support of the person gradually increases. Exposure to mobbing is high in the field of education and health where power imbalances are seen intensively. According to ICN, women and nurses are at more risk than men in terms of exposure to violence both in their workplace and at home. Nurses are exposed to mobbing by doctors, administrators, colleagues, patients and relatives. Based upon all these, it has become necessary to deal with the mobbing phenomenon which threatens health workers. Hospitals are stressful places with difficult working conditions. Night shifts, inefficiency in wages, low availability trigger mobbing.

Study aim

The purpose of this study is to determine the mobbing exposure status of the nurses working at hospitals and the influencing factors.

Materials and Methods

The study has been conducted by scanning Pubmed, Google Academic, Google Scholar, EBSCO Host, data bases of Kocaeli University Library and Trakya University Library. In this study, English and Turkish articles published between the years 2007 and 2017 have been utilized.

Findings

When literature is examined, mobbing exposure of the nurses is higher than other occupations. Psychological violence in the nursing profession has also been found to be seen more often than

in other professions by various studies. However, although some institutions have mobbing problems, these problems are not seen as a disease. Neither actions to prevent this situation nor necessary precautions are taken.

Results

Nurses work under difficult working conditions and they are exposed to mobbing. Exposure to mobbing reduces the quality of patient care. For this reason, it is necessary to determine whether the nurses are exposed to mobbing and to find a solution for this situation.

Learning objectives

Participants will...

1. Appreciate that nurses work under difficult working conditions and that exposure to mobbing reduces the quality of patient care.
2. Learn of possible solutions to the mobbing problem.

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Chapter 3 – Mininizing violence and coercion

Creating a culture to reduce and prevent violence; through the eyes of Australian paramedics

Subtheme: Creating cultures that minimize aggression and violence

Poster

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Keywords: Violence, healthcare, paramedic, pre-hospital care, interventions, culture

Background

In the Australian state of Victoria, there are 13 incidents of abuse or violence towards paramedics every day. Despite this high incidence, there have been very few studies exploring paramedics' experiences of occupational violence. The aim of this study was to improve the delivery of positive practice by exploring the experience of paramedics and highlighting appropriate interventions to prevent and reduce violence in their workplace.

Methodology

Ten Victorian paramedics who had experienced occupational violence were interviewed about their experiences of violence. Interview transcripts were transcribed verbatim and underwent thematic analysis based on an interpretive phenomenology methodology.

Findings

Stakeholders

Three key stakeholders that contribute to a safer work culture were identified: paramedics, ambulance services and communities.

- The participants in this study recognised that a hero mentality has placed them in dangerous situations. This happens when paramedics sacrifice scene safety for patient management.
- Ambulance services lack clear procedures for reporting violent incidents and often do not follow up reported incidents.
- The participants have observed an apathetic culture and a normalisation of violence in the communities they work in.

Justice

The main finding of this study is that safety centres on justice. The participants stated that a sense of justice following a violent incident discourages further violent behaviour, shows commitment from ambulance services and assists paramedics in their recovery.

In order to achieve this sense of justice, people need to be held accountable for their actions. This culture of accountability applies to the perpetrators of violence, paramedics and ambulance

services. In the experience of the participants of this study, very few perpetrators of violence are held accountable for their actions. Harsh penalties such as jail time for perpetrators are not always appropriate and there are no less severe, educational interventions that maintain accountability for perpetrators.

Implications

- Engaging with multiple stakeholders to develop interventions that improve the accountability for perpetrators may reduce the prevalence of violence.
- Acknowledging and overcoming the cultural issues for paramedics, ambulance services and communities could help prevent and minimise violent incidents.

Learning objectives

Participants will...

1. understand the importance of justice and including the perpetrators of violence in planning interventions.
2. be able to discuss the cultural issues associated with occupational violence in paramedic practice.

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Fraser Health “Stop Violence” public and staff education and communications campaign

Subtheme: *Creating cultures that minimize aggression and violence*

Paper

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Keywords: Stop, Violence, communications, campaign, engagement, staff, physicians, public, perception, value, matters

Abstract

A communications campaign to improve morale and feelings of organizational support while increasing uptake with violence prevention tools and training for employees and physicians in emergency departments frequently experiencing violence or the risk of violence from patients and the public. Additionally, the campaign strived to educate the public about violence against health care workers. Fraser Health holds its leadership accountable to provide employees with a safe work environment that is free from violence through its site-based violence prevention program and mandatory violence prevention training and orientation for all employees, and; we care about our employees and physicians and are educating the public, patients and visitors that we do not tolerate violence and that caregivers must be treated with respect. Our proposal was to develop the campaign and promote it under the popular ‘*What I Do Matters*’ brand to embrace employees in our Fraser Health family. We would use a strong visual and message to convey the story at a glance, i.e. ‘*Stop violence because Carly Matters*’. The stories would increase employee and physician engagement by sharing personal experiences that resonate for fellow employees. The stories along with training links, tools, resources, statistics and a description of violence would be posted on our Pulse employee’s intranet ‘*hub*’. Recognizing staff feedback and the increasing scrutiny over Fraser Health’s ability to provide a safe environment for employees, our campaign messages were:

Internal: 1) Our people matter to us; 2) We are taking a stand against violence; 3) We are taking immediate actions to make our sites safer and address our people’s concerns for feeling safe at work; 4) We have a Violence Prevention policy and program, including mandatory employee education, tools and resources to help keep you safe against the threat of violence by patients

External: 1) Our people matter to us; 2) We do not tolerate violence against our health care providers; 3) Respect our people: No foul language, spitting, slapping, kicking, hitting, shoving, punching or weapons; 4) Tell staff if you see problem behaviour or if your loved one has the potential for violence. 82 percent of employees who completed a site assessment survey feel the stop violence campaign helps to raise awareness of the issue of health care violence (Survey date: June 1 to August 31, 2016.) 860 members of the public and/or health

care agencies have read, followed, liked, shared, or retweeted our stop violence stories on social, web and media, between August 11-31, 2016.

Participants will be informed as to the impact of campaign messages on the perceptions of our front line emergency department teams that they are cared for and are respected as important members of our Fraser Health family. They matter to us.

Learning objectives

Participants will...

1. learn how employee feedback informed campaign materials.
2. learn how the campaign was integrated into existing staff engagement campaigns and strategies.
3. learn how and to what extent a strong visual and message to convey the story at a glance, and by sharing personal experiences that resonate for fellow employees to increase employee engagement and change perceptions. The stories along with training links, tools, resources, statistics and a description of our experience of violence will be provided as a context to the campaign.

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100 Percent Mindfulness instead of 0-Tolerance – the NOW-Model

Subtheme: *Creating cultures that minimize aggression and violence*

Workshop

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Keywords: Aggression management, environmental factors, interaction, personal factors, problem solving, sense of security and equilibrium

Abstract

Background and Context

The concept of zero-tolerance may support the creation of a good-bad dichotomy with an upper-lower-difference (Ilkiw-Lavalle et al. 2003; Middleby-Clements et al. 2007). In fact, aggressive behavior is a challenge which needs answers or – better – prevention (Mental Welfare Commission for Scotland 2017; National Institute for Health and Care Excellence (NICE) 2015). Therefore, we think, the emphasis should be on advancing 100%-mindfulness. That means 100%-mindfulness regarding all the contributing factors, which will help a client (and staff) to stay calm despite a distressing situation e. g. in an emergency department, psychiatry, nursing home etc. Therefore, and for didactical reasons the NOW-Model was developed to emphasize the actual present situation of client or staff (“*here and now*”). The view is especially not only on flaws but the resources for all involved persons and circumstances in order to enable them for an integrating respectful interactionist and situational approach.

Methodology

After face validity was attested by research fellows, a grid was derived and the applicability of the model in multiple settings was tested by asking experts of the field to complete the grid (Box 2).

Results

Finally, we received completed grids from Accident and emergency department, Ambulance paramedics, Children and adolescent psychiatric inpatient care, Community nursing, Drug and alcohol dependency treatment and detox, Forensic care, General hospitals, Gerontology and dementia care, Homes for people with learning disability, Nursing homes, Nursing students, Pediatric care, Psychiatric inpatient care (Walter et al., 2012).

By this applicability was accredited. Users of the grid reported that it was easy to complete the part which asks for elements which promote aggression. And they reported that it was

more difficult to complete the sections of resources (inhibiting factors). But the latter was perceived as the most enriching part of the exercise. Interestingly, many adaptations towards strengthening the sense of security and equilibrium which were derived from the grid were rather easy and cheap to implement.

Implications

The criticism regarding zero-tolerance of violence should not be reduced to zero tolerance regarding perpetrators. But instead 100%-mindfulness should be the catchphrase regarding internal, interactive and environmental conditions which may enable to keep in balance or to regain balance. The model highlights interaction, behaviors and organizational processes, their interferences and correlations as well. It helps for primary, secondary and tertiary prevention.

The NOW-Model is a valuable instrument for identifying crucial factors and achieving these aims.

The model is suitable for analyzing aggressive episodes, team-supervision, counselling, clients, relatives and is convenient as a checklist for self-supervision. It may be used by colleagues and other people who have experienced violence.

(Workshop schedule: Explaining the model, work in groups using the grid, discussion)

Learning objectives

Participants will...

1. be sensitised for an integrating respectful interactionist and situational approach which considers not only flaws but abilities of clients, staff and environment for maintaining or promoting a sense of security and equilibrium.
2. be able to discuss aggressive episodes within a team should have more emphasis on elements which promote sense of security and equilibrium.

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Development and evaluation of a nurse-based intervention to prevent elder abuse in nursing home care

Subtheme: *Creating cultures that minimize aggression and violence*

Poster

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Keywords: Prevention, elder abuse, complex intervention, long-term care, nursing homes

Abstract

Background and Context

Prevalence of elder abuse in nursing home care in Germany remains high despite current efforts to raise awareness concerning this important issue. A recent systematic review showed good evidence for the effectiveness of reducing physical restraints in nursing home residents, while evidence for prevention of other forms of elder abuse is weak. It seems that multi-faceted approaches including nurse education and counseling and establishing a “*culture of awareness*” are most promising. On this basis, we have developed a program aiming to prevent elder abuse against nursing home residents, but also against nurses and among residents. The program aims to sensitize nurses, therapists, caregiver, nursing home residents and their relatives and to develop sustainable concepts in a participative structure.

Methodology

A complex intervention consisting of implementation, education and training of all employees, implementing a reporting-system and monthly exchanges has been developed based on the current best evidence and adapted in cooperation with practitioners. Development followed the MRC framework on complex interventions. Currently, the intervention is piloted in two nursing homes with 230 residents. Here, we will assess nurses’ assessment of prevalence of elder abuse and their attitude and knowledge concerning avoidance of abuse. Qualitative data from interviews and focus groups with nurses and other employees, nurse managers, residents and relatives will complement these results and will be used to adapt the program.

Findings

The feasibility and pilot study has recently started and will provide valuable insights for further refinement of the intervention. In a next step the revised intervention program will be implemented in 12 nursing homes in Northern Germany and assessed using a mixed-methods before-after study with 18 months follow-up. Results will be presented.

Implications

Because of the participative structure and the focus on the development of mutual interventions with the aim of sustainability, we are confident to reduce barriers for prevention of elder abuse in participating nursing homes. If the program proves to be feasible, we plan a randomized-controlled trial to assess the efficacy of such a complex intervention to prevent elder abuse.

Learning objectives

Participants will...

1. have a basic understanding of the participative structure and the focus on the development of mutual interventions of the program.
2. understand how to reduce barriers for prevention of elder abuse in nursing homes in Germany for the first months the program is implemented.

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Implementing a No Force First Safety Culture in UK Mental Health Services

Subtheme: Creating cultures that minimize aggression and violence

Paper

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Keywords: Staff Assault Reduction, Restraint Reduction, Reducing Restrictive Practice, Safety Culture, Quality Improvement

Abstract

Background and Context

Aggression in mental health settings is rising and there is also increased scrutiny and guidance to reduce restrictive practices on mental health wards, as they are often traumatising for both service users and staff and limit recovery and wellbeing. Previously many mental health settings have attempted to manage aggression by increasing restrictions and security, however research (Ashcraft and Anthony 2008 & Bowers 2014) in this area suggest that safety cultures are enhanced by staff and service users working together to improve services and outcomes. The aim of this presentation is to provide an overview of the critical factors of a reducing restrictive practice implementation programme which contribute to improvements in service user and staff safety, ward culture and clinical practice across inpatient services including secure services.

Methodology

To implement the strategy we focused on a number of key areas: improving safety; enhancing quality, ensuring consistency; developing innovation and leadership. Culture change was driven by co-produced engagement sessions and integrated positive handovers on wards. Safety was improved by predictive assessments and through analysis of incidents of conflict. Service improvement methodology (Plan Do Study Act) cycles were applied to analyse the impact of the interventions to reduce conflict. Consistency was supported by the development of a Reducing Restrictive Practice guide of core ward approaches and a tool box of evidence based interventions for clinical teams. Skills in compassionate leadership were developed by a range of training initiatives and engaging leaders across all levels of the organisation from the board to the wards.

Findings

The outcomes of implementing the approach were positive for both staff and service users with a reduction of physical restraint of 29% as a quarterly average. Last year there was a

23% reduction in assaults on staff and out of these assaults there was a 50% reduction in the percentage of assaults which resulted in harm. Subsequently there was a reduction of staff work related sickness linked to physical restraint. The approach also had associated benefits including improved staff morale, more positive ward atmosphere, increased service user satisfaction and enhanced ward safety. As a result of these outcomes the programme has been awarded a number of national awards in 2017 for improving quality and safety and has been cited by the Care Quality Commission as a good practice exemplar in reducing restrictive practice.

Implications for practice

This approach has been used with a range of service users and at all levels of security both in health and justice settings. The guide developed provides a comprehensive package of interventions and systemic change to develop a safety culture based on least restrictive principles. As part of the package we have also developed the HOPE(S) Clinical Model of Care to reduce long term segregation and this is being adopted nationally in the UK.

Learning objectives

Participants will...

1. obtain an understanding of the key factors which contribute to improving safety in ward environments.
2. learn about how to implement quality improvement methodology to improve clinical engagement and culture.

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Extraordinary possibilities: Using appreciative inquiry to enhance positive practice

Subtheme: Creating cultures that minimize aggression and violence

Workshop

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Keywords: Appreciative inquiry, positive practice, minimizing violence, nursing education

Background

Nursing academic institutions have a responsibility to promote healthy environments, where openness and respect flourish, and students and faculty share knowledge and feel valued for their contributions (Altmiller, 2012, Clark & Kenaley, 2011; Del Prato, 2013; Peters, 2014). However, the current reality in nursing academia is much different (Berquist, St-Pierre & Holmes, 2017; Clark et al. 2012). Incivility, encompassing lack of respect, poor communication, insulting remarks and verbal abuse is commonly reported, resulting in significant negative psychological and physiological consequences for faculty and students (Clarke, 2013). Incivility is also found in the clinical environment, with students experiencing trauma, distress and disengagement (Levitt-Jones, Lathlean, Higgins & McMillan, 2007). Unprofessional behavior, power struggles and hostile environments have been reported within schools of nursing, with participants expressing feelings of being belittled, intimidated and unsupported (Berquist, St-Pierre & Holmes, 2017; Peters, 2014). Bowllan (2015) has described incidences of horizontal violence experienced by students in clinical and academic settings, specifically negative comments regarding their suitability to the profession and being assigned tasks and grades in the form of punishment rather than as opportunities for growth. Furthermore, Allen (2006) asserted that nursing education systems integrate whiteness, reinforcing middle class norms, Christianity, and heterosexuality, contributing to student reports of high levels of discrimination (Kermode, 2006). Students are required to conform their behaviors in order to be successful (Le Blanc, 2016; Love, 2010; O'Lynn, 2009; Ierardi, Dinine, Fitzgerald & Holland, 2010), with no regard to any resultant personal conflicts which ensue, leading to student feelings of isolation (Love, 2010).

Negative behaviors have been found at all levels (Matt, 2012), contributing to the adage that *"nurses eat their young"* (Egues, A. & Leinung; 2013; Olender-Russo, 2009; Thomas & Burk, 2009). Coping mechanisms have been identified as essential for survival, including physical and mental avoidance strategies (Le Blanc, 2015; Weiland & Beitz, 2015), nurturing and mending dysfunctional relationships (Heinrich, 2010), and development of supportive peer relationships for students (McIntosh, Gidman & Smith, 2014). Unfortunately, there has been limited progress in addressing the organizational and systemic factors contributing to these challenges, with overemphasis on shortfalls and malfunction. As a result, what is not clearly understood is the underlying positive potential. Use of an appreciative inquiry

approach provides a mechanism for shifting the focus from the negative to the positive. Using an exemplar in nursing education, built on three independent research studies in Canada, this paper will present appreciative inquiry as a method of research and practice which can elevate community strengths and support the advancement of positive practice.

Appreciative Inquiry

Appreciative inquiry is an organizational development theory and social research method. Oppressed individuals and departments are commonly found within most organizations (Whitney & Trosten-Bloom, 2010). The strength of appreciative inquiry lies in its ability to empower and liberate employees at all levels of an organization. Appreciative inquiry distinguishes “*problem-centric from opportunity centric-approaches*”, redefining organizational potential (Boyd & Bright, 2007, p. 1019). Negative experiences inherently take precedence in people’s consciousness (Williams, 2014). Appreciative inquiry utilizes a strength based approach that focuses on what works. It is oriented toward discovering, elevating and extending strengths as opposed to simply a focus on solving problems (Boyd & Bright, 2007). Use of the appreciative inquiry **4D cycle discover, dream, design and destiny** can assist in uncovering the human potential and organizational strengths to reveal the extraordinary possibilities for growth and change which can emerge. It allows people to envisage the future, creates optimism, and shapes the way images of the future are created (Meier & Geldenhuys, 2017).

Methodology

Using an appreciative inquiry approach, the findings of three research studies were examined in order to **discover** existing organizational strengths, and to **dream** of the transformation and **destiny** that could be. The first study used the principles of critical ethnography to examine violence in nursing academia. The second study explored lived experiences of male baccalaureate nursing students in relation to gender performativity in nursing. The third study analyzed internationally educated nurses’ digital stories about being in a bridging education program.

Findings

The findings of these studies illuminated negative experiences within the nursing education system. The secondary analysis of these findings informed a transformation of the experiences into positive possibilities for change in nursing academia. Although each of these studies uncovered violations in nursing education from a different perspective, three common principles of: embracing diversity, empowering, and esteeming emerged (3E’s for nursing education), forming a foundation for education transformation. These principles will now be presented.

Principle 1: Embracing Diversity

The Canadian Nursing Association (CNA)(2009a) reported that if current trends persist, Canada will have a shortfall of registered nurses in the range of 60,000 full time

equivalents by 2022. Canada receives 200,000 new immigrants per year, and its visible minority population is reported to be approximately 20% of the population (CNA, 2009b). Unfortunately, the diversity of the population, including race, culture, language, religion, gender, and sexual preferences is not reflected in nursing or among nursing faculty (CNA, 2009b). For example, in 2006 there were 252,948 registered nurses employed in Canada, yet only 5.6% were men, and 7.9% were internationally educated (CNA, 2009b). In order for nursing to be sustainable, it must reflect the diversity of the population. Unfortunately, current nursing education forces students who are different to adapt and adjust to conform to the expectations of the predominantly Euro-white female faculty (Le Blanc, 2015; Paterson, Osborne & Gregory, 2004).

I found a lot of the visible minorities seemed like they were targeted, the males seemed like they were targeted and the girls that weren't quite, I guess, stereotypically pretty were targeted (Jessica).

Recognition of the need for change at all levels of nursing academia is necessary and this awareness is evident in the following quotes:

I mean, it is a very feminist, very hard core culture, the nursing professional world and academia world. And it is very female geared and female oriented. And I do think it's dismissive of men, really, if you think about it (Cameron).

One thing that tends to bother me in almost all of our classes or our textbooks is they always "she" the nurse and I always notice these things, because they personally bother me so much. It should be a completely gender neutral thing if we're trying to introduce more men into our program (Lisa).

To promote inclusivity, schools of nursing must provide culturally sensitive environments, promote diversity within the profession and create programs that embrace difference (Pitkajarvi, Eriksson & Pitkala, 2013; Tabi, Thornton, Garno & Rushing, 2013). The need for structures to support greater diversity was identified.

Whereas I think here, people believe that we're this inclusive place....we believe we need the structures in place to facilitate that (Ellen).

Statistics providing a full description of the health care population in Canada, including sexual orientation, race, and ethnicity are not available (CNA, 2009b). However, what is known is that the healthcare workforce does not reflect the diversity of the population (CNA, 2009b). Recognition of the need for greater diversity and understanding is the first step towards change.

Principle 2: Empowering

A culture of bullying has been said to have existed in nursing and nursing academia for over seventy-five years (Stevens, 2002). Historically, oppressed group behavior has been used to explain this culture (Weinand, 2010). While other explanations have been posited to explain this phenomenon, it is important to recognize that while oppressed individuals and departments are commonly found within most organizations (Whitney & Trosten-Bloom, 2010), powerful, committed and hardworking individuals also exist.

Academics are all type A's, even if they're AAA or AAAA and some are A's, but they are all really in that range of high achievers (June).

My experience has been so bad, I want to go back and be a role model. I want to say “Hey, like, look what I did as a nurse. I didn’t follow the path. I deviated and I succeeded (Brad).

Identification of their qualities and characteristics, as well as the organizational systems and supports which have enabled their strength can assist in designing organizational change. Individuals who exhibit confidence and feel they have something to contribute are well suited and able to become part of the solution.

I know that I’ve been able to make an important contribution (Jesse).

(I’m) very confident. And I’m not afraid to put people on the spot and challenge their idea if I can back up my argument (Brad).

I felt like I was one of the strongest in my group and she made me feel that way. So that was a really positive experience. It was like, “Okay, I’ve got this. Then I started working with Tom and having that whole group of people and very supportive environment. I guess since then I really have been attached to the school and wanting to continue, pursue my studies and feeling really supported, academically and personally. (Jeremy).

Additionally, the strength gained from supportive supervisors was evident, as were the benefits of inclusion in academic decisions.

I feel very supported by the dean. I mean, I can always go to the dean with anything (Kelly, 271-272). ...And the dean, she’s very collaborative (Kelly).

A good professor will encourage and get the majority of their students to success and will turn around and go, “We had a bad test here. Why did we have a bad test?” and ask that question as opposed to, “It’s your fault, it’s your fault” (Doug).

Ultimately, successful organizational change requires empowered employees, those with confidence in management and their decisions. Building on these existing strengths can provide the support required to enable schools of nursing to reduce feelings of belittlement, intimidation and increase feelings of support, creating more positive cultures within the schools of nursing.

Principle 3: Esteeming

Workload for nursing faculty and students is significant. For students, the pressures of the program, courses and clinical was seen as daunting. To successfully navigate the pressures, an environment that was supportive and built on the student’s self-esteem was required.

From a volume perspective and especially with clinicals and the amount of hours you have to put in, I can barely hold down a part-time job with this degree (Dave).

Glass (2003) identified a ‘disease’ of nursing academia as a result of the overtime and competing priorities. The pressure to publish and the search for grants to secure funding for research to be successful is substantial (Morrissette, 2011). Open mindedness and understanding builds respect and can assist in increasing team cohesiveness. Although the following quote highlights poor communication skills, recognition of the need for benevolence is demonstrated and is a strength which can be built upon.

I’ve seen the good in what people say. Sometimes what they say is clouded by their delivery method but often time, if you get passed the delivery method, what you find is what they’re telling you has some merit and some value. Some people don’t have that internal monologue that says you shouldn’t say that that way (Courtney).

Further to this is the benefit of trust as demonstrated in the following quote:

People aren't malicious, really. People come to work to do good. They don't come to work to be horrid and do nasty things to you. But people can be very hurtful without really meaning to do it. And if you go off the deep end every time somebody's hurtful, you'll just end up having a heart attack or a stroke (Ainsley).

Respecting the job each has to do and supporting each other will assist in increasing team cohesiveness. Past choices had resulted in problems within this school of nursing. However, this faculty member demonstrated respect for management's previous choices, believing and appreciating that at the time there had been sound reasons for these.

The history and those..... why... Because I think you have to be respectful of the decision, whether you look at the decision right now and say, "What the hell were they thinking? They weren't thinking." The reality is they were. And I think before we change something, it's really important to understand what they were thinking about (Melissa).

Organizations have a role to play in the creation of respectful work campaigns. One participant explained their school had supported this. "We did a respectful workplace campaign a number of years ago" (Justin), providing a foundation for them to build upon.

Conclusion

Workplace violence has been a topic of interest and inquiry for decades. In nursing education, we know more about problems, issues and concerns than we do about how faculty and students demonstrate and live with strength, openness, and hope. Examination of previous organizational successes, assumptions and experiences can aid in the identification of existing strengths. An appreciative inquiry approach may assist in adjusting assumptions and expectations about the cultural norms in existence in nursing education, moving in an upward direction towards more positive possibilities. This may allow the highest dreams, passions and aspirations to emerge, supporting the development and deployment of concrete actionable ideas.

Acknowledgements

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Learning objectives

Participants will...

1. identify how the strength-based approach of appreciative inquiry can be utilized to support positive change.
2. critique the three principles of embracing diversity, empowering and esteeming as a foundation for positive practice.

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100 Percent Mindfulness instead of 0-Tolerance – the NOW-Model

Subtheme: Creating cultures that minimize aggression and violence

Workshop and Poster

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Keywords: Aggression management, environmental factors, interaction, personal factors, problem solving, sense of security and equilibrium

Background and Context

As ICN in its latest position statement in 2017 (International Council of Nurses 2017) emphasized, there must be a zero-tolerance policy against violence. However, there is a risk that the concept of zero-tolerance may support the creation of a good-bad dichotomy (Ilkiw-Lavalle et al. 2003; Middleby-Clements et al. 2007). We have to distinguish between violence, which should not be accepted as an inevitable part of workplace conditions on the one side and violence as a symptom or expression of

- perceived threat against justice (e. g. the one who came later was the one who was seemingly first to be called),
- well-being (e. g. the instrument for mouthcare looks like a scissor), or
- freedom (“*how could they dare to say I have to stay*”) on the other side.

We know nowadays that aggression must be differentiated as pro-active (criminal, planned) and re-active (impulsive, defensive) aggression (Wahl, K. as cited in the preface of the Proceedings of the Fifth International Conference on Violence in the Health Sector) (Needham et al. 2016, 5). However, the most common sort of aggression in Healthcare-settings is the defensive sort. In fact, aggressive behavior is a challenge which needs an preparation or – better – calls for prevention (Mental Welfare Commission for Scotland 2017; National Institute for Health and Care Excellence (NICE) 2015). Therefore, the emphasis should be on advancing 100%-mindfulness. That means 100%-mindfulness regarding all the contributing factors, which will help a person (client and staff) to stay calm despite a distressing situation e. g. in an emergency department, psychiatry, nursing home etc. For a better understanding as well as for didactical reasons the NOW-Model was developed to emphasize the actual current situation of client or staff (“*here and now*”). Emphasizing the current moment means to accept that we are not able to change anything which went wrong in the past. But alternatively we have to consider what our options are in the present situation. To succeed one has to become aware of the resources. The key point is to reflect how it could happen that a person which is per se not violent gets in a situation where she has no more access to her developed communication skills. Therefore, the view has to be especially on the resources of all involved persons and circumstances. It is important to enable them for an integrating respectful interactionist and

situational approach. This approach considers not only flaws but abilities of clients, staff and environment for maintaining or promoting a sense of security and equilibrium.

Method

After face validity was attested by research fellows, a grid was derived and the applicability of the model in multiple settings was tested by asking experts of the field to complete the grid (Box 2).

Results

Finally, we received completed grids from

- Accident and emergency department
- Community nursing
- Drug and alcohol dependency treatment and detox
- Forensic care
- General hospitals
- Gerontology and dementia care
- Ambulance paramedics
- Nursing students
- Nursing homes
- Pediatric care
- Psychiatric inpatient care
- Children and adolescent psychiatric inpatient care
- Homes for people with learning disability

(Walter et al., 2012)

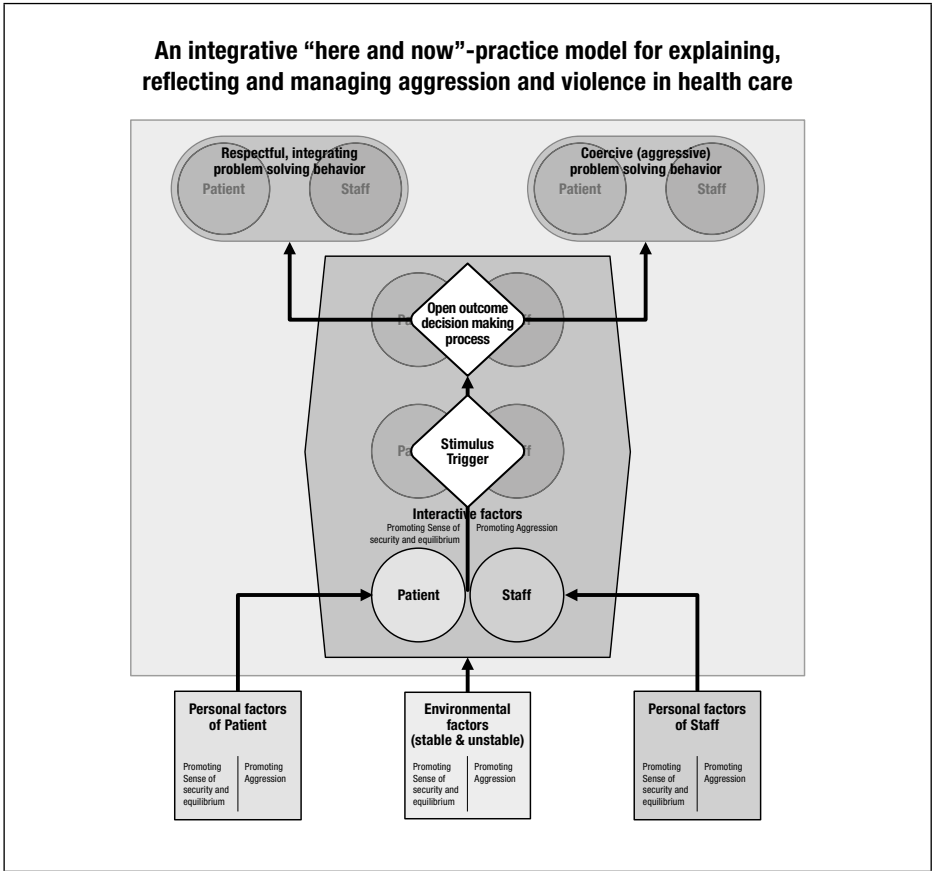
By this applicability was accredited. Users of the grid reported that it was easy to complete the part which asks for elements which promote aggression. And they reported that it was more difficult to complete the sections of resources (inhibiting factors). But the latter was perceived as the most enriching part of the exercise. Interestingly, many adaptations towards strengthening the sense of security and equilibrium which were derived from the grid were rather easy and cheap to implement.

Implications

Zero-tolerance against violence should not be reduced to zero tolerance against problematic service-users. But instead 100%-mindfulness should be the catchphrase regarding internal, interactive and environmental conditions which may enable to keep in balance or to regain balance. The model highlights interaction, behaviors and organizational processes, their interferences and correlations as well. It helps for primary, secondary and tertiary prevention.

The NOW-Model is a valuable instrument for identifying crucial factors and achieving these aims. The model is suitable for analyzing aggressive episodes, team-supervision, counselling, clients, and relatives and is convenient as a checklist for self-supervision. It may be used by colleagues and other people who have experienced violence.

Box 1: The NOW-Model



Box 2: Check-Grid to determine influencing factors:

	Promoting Sense of security and equilibrium	Promoting aggression
Personal factors of patient		
Personal factors of staff		
Environmental factors (stable and variable)		
Interactive factors		
Examples of Triggers		

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Learning objectives

Participants will....

1. be sensitised for an integrating respectful interactionist and situational approach which considers not only flaws but abilities of clients, staff and environment for maintaining or promoting a sense of security and equilibrium.
2. be able to discuss aggressive episodes within a team should have more emphasis on elements which promote sense of security and equilibrium.

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Internal Responsibility system in a Violence Prevention Program

Subtheme: *Creating cultures that minimize aggression and violence*

Paper

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Keywords: Internal Responsibility, Violence Prevention Program

Introduction

Integral to the success and sustainability of a Violence Prevention Program (VPP) and the reduction of violence related injuries are s a health safety management system (HSMS), due diligence and an internal responsibility system (IRS). Chris Mazurkewich, Interior Health (IH) President & Chief Executive Officer, stated in an all employee May 1, 2018 memo.

We are on a journey to embed a culture of health and safety in IH. To help us achieve that, we have made this one of our key strategies going forward.

The goal is to empower each of us to take responsibility for safety, be mindful of our physical and mental health, and remain engaged and psychologically resilient to the pressures of everyday work and life. Health and safety must be part of our everyday practice – with each one of us taking ownership for it, wherever we are in the organization – because every person matters.

To guide us in moving beyond basic health and safety compliance to embracing a culture of health and safety, where it becomes an intrinsic part of the way we work, we are using the proactive and coordinated approach offered through a Health and Safety Management System (HSMS). With the HSMS, we have a proven model with effective tools to move us forward on our journey.

Through the implementation of a HSMS, demonstrated due diligence by the employer and the understanding of the IRS by all can result in the reduction of violence in the workplace. Preventative investment sustained by a culture of health and safety will find realizations of the reduction of direct and indirect costs.

This will be explored in the following paper by illustrating the journey of Interior Health as it moves from in-compliance to compliance and beyond as the result of a WorkSafe BC (WSBC) corporate order.

Background

Interior Health Authority Quick Facts and Leadership (2019)

The Interior Health Authority (IHA) is located in the southern interior region of British Columbia covering over 215,000 square kilometers, serving a population of over 730,000 citizens. The IHA worker composition includes over 19,000 staff, over 1,400 physicians and over 4,800 volunteers. The health authority includes hundreds of facilities which include 2 tertiary hospitals, 4 regional hospitals, 16 community hospitals with over 1400 hospital beds, 43 residential care facilities with over 6500 residential care and assisted living beds and 24 health care centers.

The IHA organizational structure includes a board of directors who is responsible for creating the policy and direction for the organization to meet government expectations. The Senior Executive Team (SET) is responsible for putting the Board's policies and directions into action with the help of both managers and staff.

WorkSafe BC Occupational Health & Safety Corporate Order

On November 1, 2016 WorkSafeBC (WSBC) issued a corporate order requiring IH to demonstrate actions taken to ensure compliance with the sections of the Workers Compensation Act and the Occupational Health and Safety Regulation specific to: violence prevention, minimizing the risk of injury from violence, violence prevention training, supervisor training, conducting incident investigations and implementing corrective actions following the investigation of violence related incidents. A compliance date of September 30, 2017 was identified.

In response the following objectives were identified to meet and provide evidence of full compliance:

- Complete Violence Prevention Risk Assessments for every IH work site with the following targets: High Risk Sites (Residential Care, Mental Health, and Emergency Departments) by March 30, 2017 and all other sites by September 30 2017.
- Ensure 70 to 75% of employees in all high-risk areas complete violence prevention training courses by March 30, 2017 and 90 to 95% by June 30, 2017. (High risk areas include: residential, emergency departments, and mental health and substance use.)
- Ensure 100% of supervisors and managers receive Occupational Health and Safety (OHS) training by March 30, 2017.
- Update Code White procedures at each work location. Commit to Code White training, refresher training, debriefing following a Code White response and conducting Code White drills where required.
- Complete 100% of preliminary incident investigations within 48 hours, implement corrective actions to prevent similar incidents without delay, and complete 100% of final incident investigation reports within 30 days.
- Minimize risk of violence through policies, procedures and work environment arrangements, if the risk cannot be eliminated.

Interior Health achieved and demonstrated compliance through the following success indicators:

- Leadership commitment and oversight
 - Senior executive team meetings, director/manager meeting, board reports
- Manager accountability
- Monitoring and tracking methods
 - Daily electronic data reports, weekly report cards to SET, bi-weekly board reports, monthly project status reports
- Communications
 - IH wide memos, posters, website updates, website polls, publications/good news stories, payroll reminders, webinars, FAQs, presentations
- OHS regulation compliance

Occupational Health & Safety Compliance Activity	Total Number of Workers	November 2016 Compliance % Complete	March 2017 Compliance % Complete	July 2018 Compliance % Complete
Provincial Violence Prevention Curriculum Training (PVPC)-High Risk Training	4,035	36	91	92
Provincial Violence Prevention Curriculum Training (PVPC)-Medium Risk Training *not part of corporate order	8,299	32	92	95
Provincial Violence Prevention Curriculum Training (PVPC)-Low Risk Training *not part of corporate order	5,1877	9	87	97

Additionally, 30% of medium and low risk employees have taken the PVPC classroom component (above baseline education requirements and outside of corporate order)

Occupational Health & Safety Compliance Activity	Total Number	November 2016 Compliance % Complete	September 2017 Compliance % Complete	July 2018 Compliance % Complete
Violence Prevention Risk Assessments	265	Unsure as there was no central tracking system prior	100	100

Occupational Health & Safety Compliance Activity	Total Number of Workers	November 2016 Compliance % Complete	March 2017 Compliance % Complete	July 2018 Compliance % Complete
Occupational Health & Safety Supervisory Training-Manager	1,263	21	95	96
Occupational Health & Safety Supervisory Training-In Charge	3,133	1	94	95

Occupational Health & Safety Compliance Activity	November 2016 Compliance % Complete	March 2017 Compliance % Complete	July 2018 Compliance % Complete
Incident Investigation Completions with 30 Days	Unsure as there was no central tracking system prior	95	96

In a compliance summary sent to WSBC it was stated that the plan was not only to continue the work started through the WorkSafeBC Corporate Order but for it to expand and lay the foundation for the implementation of a Health and Safety Management System (HSMS). A HSMS is a proactive and systemic approach to achieving defined occupational health and safety goals and objectives based on accountabilities of all workplace parties for health and safety.

Health Safety Management System CAN/CSA-Z1000-14 (2015)

The HSMS consists of five pillars or phases; leadership and commitment, hazard identification, risk management and control, evaluation and corrective action and strategic review and improvement. Each of these pillars includes an assessment which guides an organization in moving beyond basic compliance into enhancement of the safety culture and improvement in occupational health and safety performance. Each assessment follows an audit format, with requirements for documentation, observable safety behavior, and validation through interviews with workers (usually frontline). WH&S advisors trained in auditing procedures facilitate the assessments.

Implementation of the HSMS was intended to shift the culture of “*thinking about safety*” to the “*presence of safety*” (measuring through leading indicators; for example, completion of regular workplace inspections, completion of violence workplace risk assessments, timely completion of incident investigations and implementation of corrective actions, completion of occupational health and safety orientation for all new workers), rather than viewing safety as the absence of accidents and incidents (or as an acceptable level of risk) where ‘*human error*’ is seen as a near-universal cause of incidents. Another significant shift is the integration of occupational health and safety practices into “*the way we do business*” rather than viewing it as a separate program.

While improvement in lagging indicators such as injury rates is an expectation, results would not be immediate. However, there should be near term improvement in measures such as basic regulatory compliance; proactive safety behaviors; improved diligence and documentation by managers/supervisors; and a reduction in WorkSafe BC orders and sanctions.

Interior Health Journey through to a Health and Safety Management System

Current state

An initial step was to educate senior leadership to HSMS and to obtain their agreement and support for;

- Corporate adoption of a systems approach to health and safety (HSMS)
- Participation in the Health and Safety Management System Core Requirements Assessment, based on the Canadian Standards Association Standard “*Occupational Health and Safety Management*”
- Commitment to the journey required to enable and achieve regulatory compliance
- Health and safety investments which includes
 - Assignment of a Senior Executive Team Member Lead to oversee the adoption of the HSMS.
 - Management time and named resources to ensure occupational health and safety is given appropriate attention, and integrated into decision-making and work priorities.

- IMIT resources to support the adoption of the electronic Health and Safety Management System tracking tool.

Health Safety Management System Phase 1- Leadership Commitment

Interior Health began the implementation of an HSMS in November 2016 with the formal acceptance by the Senior Executive Team. This initial pillar/phase also included a core requirements assessment interview of senior leadership to help inform the action plan. Over the next year leadership demonstrated its leadership commitment to the rest of the organization through;

- Approval of HSMS governance structure
- Approval of an HSMS Steering Committee
- Organization wide communications
- Embedding safety language into its strategic goal “*cultivate an engages workforce and healthy workplace*”
- Promoting and support site HSMS adoption and engagement
- Adding health and safety to performance plan objectives

Health Safety Management System Phase 2- Organizational Hazard Identification

Interior Health’s has identified the following IH wide target areas;

1. Musculoskeletal Injuries (MSI) – improvement on preventing and reducing physical injuries in the workplace (e.g., patient handling injuries, equipment-related injuries).
2. Psychological Health & Safety in the Workplace – actively working to promote psychological health and prevent psychological harm due to workplace factors (as identified in the Canadians Standards Association National Standard)
3. Creating a Health & Safety Culture – embedding safety into everyday practice as everyone’s responsibility.

Future State

Health Safety Management System Phase 3 – Risk Management and Control

The following 2018/19 action items have been determined to support the identified hazard and are to be actioned upon by operations;

1. Provide tools for leaders, staff, and physicians to support regular safety huddles/conversations
2. Increase support for Joint Occupational Health & Safety Committees (JOHSCs) to help improve day-to-day site safety
3. Add health and safety as a regular topic on meeting agendas (e.g., leadership team meetings, departmental staff meetings and handovers and huddles)
4. Support completion of quality incident investigations
5. Review of incident and claims data to identify common themes and develop action plans to reduce incident/injury rate by 50% over 3 years

Health Safety Management System Phase 4- Evaluation and Corrective Action

An evaluation benchmark of has been agreed to that organizationally there will be a 15% reduction in time loss and medical aid injuries over the next 3 years. Electronic data reports have been developed for monitoring purposes at the manager level along with senior level data

dashboards. SET will be following up with leadership on target achievements. Each level is expected to report progress towards the 5 action items to the HSMS steering committee.

Health Safety Management System Phase 5- Strategic Review & Improvement

HSMS steering committee will evaluate data and controls and make recommendations for improvements.

Conclusion

Interior Health has struggled with violence prevention occupational health and safety (OHS) regulation compliance for years which culminated in a WorkSafe BC corporate order in November 2016. The corporate order included the key compliance areas of violence prevention training, violence prevention risk assessments, supervisory training and incident investigation completions. Not only did IH achieve compliance but grew the safety understanding of the organization and nudged them closer to a safety culture which included both patient and worker. Building upon this momentum the organizational agreement and support that in order to ensure violence prevention compliance sustainability and the compliance to other OHS areas there was a need to embark on an creating an IH health safety management system. It is through the HSMS implementation we are steps forward towards an Interior Health safety culture.

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Learning objectives

Participants will...

1. appreciate the necessity of Internal Responsibility in Violence Prevention Programs.
2. gain an understanding that Preventative investment sustained by a culture of health and safety will find realizations of the reduction of direct, indirect and hidden costs and gains.

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Safewards at the Centre for Addiction and Mental Health: Reducing conflict and containment by making mental health units more peaceful places

Subtheme: Creating cultures that minimize aggression and violence

Paper

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Keywords: Safewards, Conflict, Containment, CAMH, Forensic, Canada

Background & Context

Abstract

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital as well as one of the world's leading research centres in its field. It combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues.

The safety of clients and staff has long been a concern for hospitals (Gadon, et al., 2006; Bowers et al., 1999). At CAMH, the highest strategic priority is the "Safe and Well" initiative, two of its key aims being the elimination of avoidable client death and physical injury to staff and clients. To that end, CAMH piloted Safewards on three Forensic inpatient units with a view to organization-wide adoption.

Safewards is an evidence-based, open source, model developed by Len Bowers in the United Kingdom which evolved from significant research seeking to explain varying degrees of conflict and containment, and the domains that interact to produce this variation, on psychiatric inpatient units (Bowers, 2014). In a randomized controlled trial, Bowers et al. (2015) identified 10 clinical interventions that reduced conflict events by 15% and containment incidents by 26.4%.

Methodology

CAMH selected 3 forensic units, with relatively high levels of violence, as pilot sites to assess the impact of the Safewards model over a twelve-month period. The project was carried out as a quality improvement initiative with the support of the hospital's Project Management Office.

A front line Registered Nurse was appointed to the role of Safewards Coordinator. The Coordinator acted as an organizational champion for the Safewards model, including developing and adapting education materials from Safewards as well as the delivery of comprehensive

introductory training and facilitating weekly staff education sessions, “*Safewards councils*”, on the pilot units. The Coordinator also spent considerable time getting to know the unit communities through various clinical conversations and unit meetings. Unit leadership (Managers and Advanced Practice Clinical Leaders) championed the model and assisted in the delivery of training and weekly councils and participated in regular meetings, guiding the project approach and resolving ongoing challenges. The primary desired outcome for the pilot was the reduction of the severity and number of total conflict and containment incidences on the pilot units. Data did not demonstrate a statistically significant reduction in total conflict or containment. However, a downward trend in conflict severity was observed. Findings also noted an opportunity to identify gaps in service provision.

Implications

Greater acceptance and use of the interventions is required to determine whether outcomes can be meaningfully replicated in Forensic settings. The recovery-oriented philosophy that underlies Safewards represents a change in practice in Forensic services at CAMH. CAMH is implementing Safewards across all inpatient units commencing in 2018 by aligning with the organization’s mandatory safety and prevention training. Policies are being reviewed to support adherence.

Learning objectives

Participants will...

1. will be able to demonstrate a high-level understanding of the Safewards model.
2. be able to cite key challenges in translating a highly evidence based, flexible, open-source model for reduction of conflict and containment developed in the United Kingdom in a general mental health setting to a Forensic setting in Canada.

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Facilitators and barriers of a peer mediation program to reduce coworker conflict among correctional registered nurses

Subtheme: Creating cultures that minimize aggression and violence

Paper

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Keywords: Correctional nursing, bullying, co-worker conflict, peer mediation

Abstract

Background and Context

The correctional environment exposes registered nurses (RNs) to unique occupational health hazards including co-worker bullying and conflict. In 2006, the Bureau of Labor Statistics reported that half of the employers surveyed reported at least one incident of workplace violence. The results showed that 34% of employers reported an incident reported a coworker-related event. The prevalence of bullying has varied between 5% and 30%. Because co-worker conflict is associated with adverse physical and psychological health consequences for nurses, which in turn could negatively impact patient safety and staff retention, a state correctional system developed and implemented “EMPOWER”, a peer-based mediation program. Based on established principles and techniques of mediation, “EMPOWER” was developed to assist healthcare staff in resolving coworker conflicts that might contribute to tension and discord. This program provides an opportunity for workers to pursue conflict resolution through effective communication, problem solving strategies, and consensus building. Despite expressed staff interest in “EMPOWER”, utilization has lagged. The purpose of this study was to examine facilitators and barriers to improve the utilization of EMPOWER as a peer mediation program for addressing co-worker conflict and bullying.

Methodology

Using a participatory action research approach, the study adopted a mixed method, combining a web-based survey of correctional nurses (response rate of 71%, n=107), and individual interviews (n=7 correctional nurses) was utilized. Quantitative data was analyzed using Cross-tabulation and Fisher’s exact test for categorical variables, and t-test and Mann-Whitney U test for continuous variables. Qualitative data was analyzed using thematic analysis.

Findings

The sample was 75% females with a mean age of 44 years (+/- 9.7), a mean tenure in the current job of 8 years (+/- 6.5), and an average weekly work of 32 hours (+/-15.46). More females worked on the first shift while more males worked on the second and third shifts. Female nurses reported more frequent bullying by a co-worker than male nurses. The majority of correctional nurses (71%) felt they knew how to deal with co-worker conflict. However, few nurses (9%) felt very comfortable working directly with a co-worker to determine a resolution, with 15% feeling not comfortable and 40% a little comfortable. A minority (40%) indicated they would report co-worker conflict. Only 1% of nurses felt very confident and 18% felt confident that management would make a good-faith attempt to manage a conflict. Though 86% were willing to use available peer mediation tools and programs, only 38% were familiar with the organization's EMPOWER program. Of those who may have had an experience of co-worker conflict within the last 6 months (45%), approximately a quarter attempted to access the program.

Implications

Our results will facilitate improved utilization of the “EMPOWER” program. The findings will provide evidence to develop a larger-scope project using participatory action research to improve the work environment by reducing co-worker conflict.

Learning objectives

Participants will...

1. identify key barriers for the utilization of the Empower peer mediation program.
2. identify key facilitators for the utilization of the Empower peer mediation program.

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Advancing the Delivery of Positive Practice – University Health Network (UHN)’s Journey to Eliminating Workplace Violence

Subtheme: Creating cultures that minimize aggression and violence

Paper

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Keywords: Workplace violence, strategic transformation, zero preventable harm, incident reporting culture, prevention strategies, proactive organizational approach, early detection and correction, education program, behavioural management strategies, building a safety culture, building resilience

Introduction

University Health Network (UHN), Canada’s largest Academic Health Sciences Centre located in the Greater Toronto Area, recognizes that most acts of violence are preventable within the workplace. Creating a culture that supports this philosophy will inevitably reduce and eliminate preventable harm experienced by violent acts. We believe that understanding why these events occur is key to preventing future events. It is important to understand the experience of individuals when encountering a person exhibiting disruptive behaviours and address system failures that contribute to causation in order to prevent reoccurrence. At UHN, we are transforming our culture, embarking on a strategic transformation in which “*safety*” is embedded in every aspect of what we do and how we do it. This signifies our commitment to zero preventable harm for both our patients and our staff.

UHN has implemented a workplace violence prevention strategy that outlines our approach to eliminating preventable harm caused by workplace violence. By building a system with a series of multifaceted prevention strategies aimed at early detection and correction that is led by the Workplace Safety Team, leadership, and key stakeholders both internal to UHN and our community partners, our efforts will focus on reducing preventable harm experienced by workers from acts of violence. Understandably, we need to learn more about *what* happens during incidents of violence, but also *why* these incidents occur. To accomplish this, we put forth four key objectives:

- Analyze data and review details of reported safety events to determine how violence is experienced and to understand why these events occur, measure the effectiveness of current preventative measures, and establish performance metrics to measure improvement efforts
- Apply a validated risk methodology that quantifies level of risk related to violence based on probability and severity of harm
- Implement a multi-tiered approach to education which includes situational learning to mitigate risks related to violence, aggression and responsive behaviours

- Develop and implement behavioural management strategies that include how to recognize, communicate, and manage those individuals who demonstrate disruptive behaviours that have potential to cause harm.

When healthcare workers are injured, it leads to a loss of experience and knowledgeable staff, which impacts the quality of care and the safety of our patients. Patient and worker safety are inextricably linked and grounded in similar science and principles. The same system factors (workplace culture, system/device design, physical environment and human factors) contribute to both worker and patient safety. We must continually identify and implement preventative measures and strategies to protect the health, safety, and wellness of all healthcare providers and overall reduce the risk of injury related to violence.

Background

At UHN, workplace violence is defined as:

- a) the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker,
- b) an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker,
- c) a statement or behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

The four types of workplace violence, consistent with the literature, are:

- **Type 1** = External perpetrator (i.e., a person with no current relationship to the workplace)
- **Type 2** = Patient/Client/Customer (i.e., a patient, client, family member, visitor, or customer)
- **Type 3** = Worker to Worker (i.e., employees, physicians, contractors, students, volunteers)
- **Type 4** = Domestic violence (personal relationship)

Although the definition of workplace violence is broad enough to include acts that would constitute offences under Canada's Criminal Code, we recognize a person does not need to have the capacity to appreciate that their actions could cause physical harm. In healthcare, a paradigm shift in thinking is required as healthcare workers often excuse harmful behaviours exhibited by patients. Few people come into a healthcare environment with intent to cause harm. However, violence is real in healthcare settings and according to UHN data, is experienced everyday by our staff.

Current UHN Data/Measurements

Workplace violence incidents can result in serious physical and psychological harm that affect the workers' ability to perform his/her duties. In 2016, UHN adopted the Healthcare Performance Improvement (HPI)'s Serious Safety Event Classification system, which categorizes events that are preventable and reach the worker as Serious Safety Events (SSE) with five distinct levels of harm. For workers, these range from death (SSE1) to moderate temporary disability (SSE5).

UHN's Safety Scorecard displays both the total number of SSEs and the Serious Safety Event rate (SSER). The Workplace Violence (WPV) Worker Serious Safety Event Rate is calculated as follows:

Serious Safety Event Rate (SSER) = (12-Month Rolling Average of the # of WPV SSE Incidents) X 200,000 (12-Month Rolling Average of Hours Worked)

Details of UHN's workplace violence serious safety event rate is incorporated into UHN's Safety Scorecard. UHN's leadership team reviews each serious safety event on a monthly basis. In addition, the workplace violence data is shared with the Joint Health and Safety Committees and/or Health and Safety Representatives as well as the UHN Safety and Quality Committee of the Board. The UHN Safety Scorecard is posted and available on UHN's corporate intranet site for all leaders and staff.

External Reporting

To ensure UHN meets all provincial reporting requirements, we maintain the Ontario Workplace Safety Insurance Board (WSIB) incident classification criteria to enable benchmarking with other provincial hospitals. Standardized incident rates are used to allow for comparison of statistically significant data. However, we recognize that lagging indicators indicate past performances and do not predict what will happen in future performances. UHN participates each year in the Ontario Hospital Association (OHA) Human Resources Benchmarking Survey. Workplace violence data is submitted to OHA for provincial comparability with other hospitals of similar size.

UHN's fiscal year runs from March to April. For the F2018/19 year, UHN Quality Improvement Plan will include two indicators that relate to workplace violence: 1. Total Number of Workplace Violence Incidents and 2. Percent of Lost Time Due to Workplace Violence.

The total number of workplace violence incidents reported by workers at UHN is the mandatory indicator selected by HealthCare Quality Ontario. The percent of lost time due to workplace violence indicator is one of thirteen indicators that comprise UHN's balanced scorecard and is linked to UHN's compensation for executives. Included in our quality improvement plan is a detailed narrative outlining UHN's workplace violence prevention strategy.

Progress to date

In an effort to understand UHN's current state and the effectiveness of existing prevention strategies, a data analysis of the current performance indicators was conducted. A review of all reported incidents of workplace violence was completed looking for trends and reoccurring themes to understand:

- Where and how violence was experienced, and by whom
- Evaluation and prioritizing of risks related to violence and harmful behaviours (including aggression and responsive behaviours), and the
- Determination of the effectiveness of current preventative measures and recommendations for improvements.

Data Analysis

Since 2010, year over year, UHN has seen a significant increase in the number of incidents related to workplace violence. This is a positive trend and demonstrates a strong reporting culture made possible by our continued efforts to emphasize the importance of reporting situations when violence is experienced. In 2016, UHN introduced an electronic incident reporting system that enables any person providing service at UHN, who has access to the intranet, to submit an incident.

Through an in-depth analysis of UHN's workplace violence data from F2013/14 to F2016/17, there has been a 238% increase in the number of reported workplace violence incidents (196 to 663). Although the number of incidents reported continue to rise, the ratio (percent) of harm decreased from 14% to 5% during the same period (this includes incidents that result in healthcare and lost-time). This demonstrates an improved reporting culture and suggests a positive correlation to preventative measures, resulting in fewer incidents of harm to workers. When examining the data specific to the percent lost-time due to workplace violence, we observed a similar trend. In F2014/15, the percent lost-time was 1.55%. In the following F2015/16, we experienced a 33% reduction (percent lost-time reported as 1.04%). In F2016/17, we saw a further decrease of 45% (percent lost-time reported as 0.57%).

Upon further review, 35% of all reported incidents by type were workplace violence related. Of those incidents, the majority were reported by professional staff (e.g. nurses, physicians, social workers) with 97% involving a patient and/or a person connected to a patient (visitor, family member). In areas with fewer reported incidents, focused group discussions and individual interviews occurred and identified barriers to reporting, a lack of standardized and validated methods to assess risk related to violence, an acceptance of violence as being a part of the job, and variations in the interpretation of violence. A further analysis into workplace violence events is needed to understand contributing factors and to identify the root causes of *how* and more importantly, *why* these events occur.

Internal Alignment

UHN's workplace violence prevention strategy aligns with UHN's strategic themes of our commitment to zero preventable harm at all our hospitals. This includes the delivery of the greatest value for our patients, the empowerment of patients to participate in their own healthcare, and the enablement of our staff to do their best work. Each priority is cultivated in four foundational elements:

1. **Caring Safely** represents our work to create a culture where staff and patients embrace safety. It begins with a commitment to safety, for each other, our patients, and their caregivers. The overall plan incorporates principles of high reliability by anticipating failure and always thinking about what could go wrong. This includes not jumping to simple solutions but taking the time to understand all aspects of a situation while including different perspectives, experience and opinions. Caring Safely also means being mindful of what is happening at the point of care, in the environment, and the potential impact of violence on our people, patients and the rest of the organization. To minimize risk related to

violence means planning for the unexpected and building the capacity to recognize or defer to expertise in such situations.

2. **Patient Experience** represents our work to engage patients and family caregivers in organizational decision-making. UHN's patient partners were actively engaged in the development of UHN's workplace violence prevention strategy, including the policies and processes for flagging those with a history of violence, and the behavioural management planning.
3. **Operational Excellence** represents our work to find safer, simpler and smarter ways of providing exceptional care. The workplace violence prevention strategy is a framework that guides decision making to enable our workforce to deliver exceptional care in all circumstances.
4. **People and Culture** represents our work to ensure our staff feel respected and valued. It outlines UHN's commitment to providing a high-quality work experience because we believe our people are our greatest asset. The workplace violence prevention strategy is an example of how UHN is building trusting and productive relationships as well as strengthening partnerships with union affiliates.

Lastly, the workplace violence prevention strategy aligns with UHN's purpose, values and principles, which include safety, compassion, teamwork, integrity, and stewardship as core values.

External Alignment

UHN's workplace violence prevention strategy incorporates change ideas adopted from the recommendations of the joint Ministry of Health and Long-term Care/Ministry of Labour: Workplace Violence Prevention in Health Care Leadership Table's report, "*Preventing workplace violence in the healthcare sector*" (Health Quality Ontario, 2017). It meets and, in most cases, exceeds all legal requirements that are applicable in the healthcare sector, as outlined in the Occupational Health and Safety Act and Ont. Regulation 67/93, Healthcare and Residential Facilities. UHN works closely with community partners such as the Public Services Health Safety Association to ensure our prevention plans align with the Ontario Ministry of Labour Health Care Sector Plan and Safe at Work Ontario mandate.

Conclusion

Looking ahead

Key Interventions Achieved in 2017/2018:

In 2017/18, UHN introduced the High Reliability Leadership Methods training for all leaders (approx. 500 completed) and the Caring Safely Behaviours and Error Prevention Tools training for all staff and physicians (approx. 11, 000 completed). This is the first time at UHN that all staff, physicians and leaders have been educated together in a common language about safety to support the way teams function together operationally. Additionally, approximately 200 units/departments across all UHN sites have implemented daily safety huddles to help identify, communicate, and anticipate safety issues.

In consultation with the Joint Health and Safety Committees and leaders across UHN, the organizational workplace violence risk assessment tool was revised using a validated risk methodology, incorporating elements of the Public Services Health Safety Association Guideline document and WPV Risk Assessment Toolkit for Acute Care, to quantify risk based on probability and severity of harm. To date, more than 105 workplace violence risk assessments were completed with input from frontline staff and physicians.

In January 2017, a multi-tiered education program that incorporates situational learning and UHN specific workplace violence measures and procedures, was developed in collaboration with Safe Management Group. Since inception, 89% of staff in all high-risk areas completed Crisis Intervention Training (approx. 1,100 people); 90% of all staff & physicians have completed Safety Culture at UHN – Workplace Violence, Domestic Violence and Harassment in the Workplace education (approx. 15,000 people).

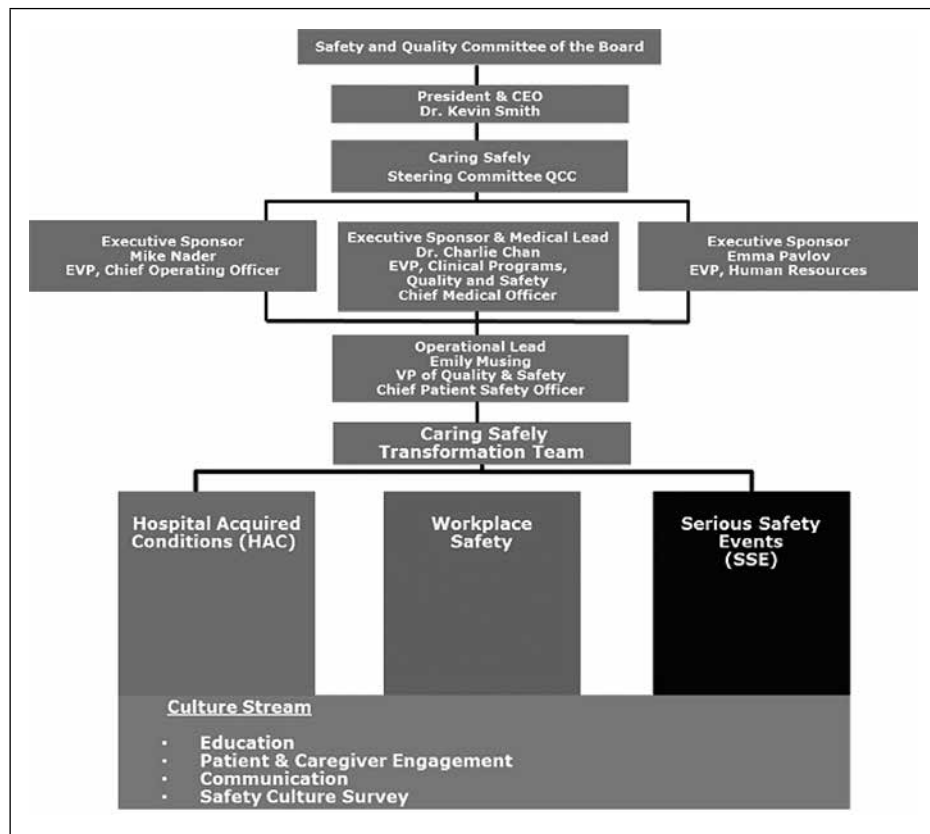
Consistent with other industries who incorporated high reliability principles into practice, UHN has collectively emphasized safety with leaders and individuals over competing goals to ensure the protection of patients and staff. For example, a collaboration from the organization's departments including Legal, Public Relations, Human Resources, Operational Leadership, Security, Emergency Preparedness, Occupational Health and Safety, Patient Relations, Professional Practice and Risk Management departments, created a standardized process for managing threats of physical and psychological harm.

As we continue to implement our workplace violence prevention strategy, our focus will be on creating a joint approach to analyzing both patient and worker serious safety events as well as developing the processes for disseminating findings. This approach is uncommon in Canadian hospitals; however, UHN believes this novel approach to having a paralleled focus is crucial in preventing harm to both workers and patients. Our team understands if we fail to share the learnings that occur in different contexts (within various groups and in various sites) that this will compromise our ability to efficiently and effectively improve safety for all those within the organization. In 2018/19, a panel of key stakeholders consisting of members from UHN's (21) Joint Health and Safety Committees and (11) Health and Safety Representatives will provide a comprehensive approach to examine stratified data analysis beyond a review of the overall number of incidents of workplace violence. As we finalize our cause analysis framework, UHN's operations and practice leads will guide the analysis of the root and contributing causes of workplace violence. The failure modes identified, and the resulting effects analysis will inform the organization of future priorities for improvement.

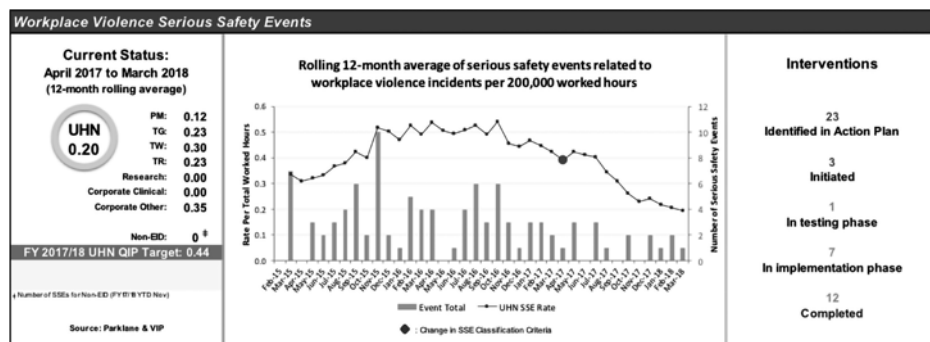
With the support from UHN's Leadership and Operations team, UHN will continue to transform how we deliver exceptional care and integrate workplace violence preventative measures into standardized organizational practices as part of our workplace violence prevention strategy.

Appendix

Appendix A. UHN Caring Safely Structure



Appendix B. UHN Safety Scorecard for Workplace Violence – Release 10



Acknowledgements

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UHN's Caring Safely Transformation Team

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- Wing-Si Luk, Director of Patient Safety & Quality Improvement, Lead for Hospital Acquired Conditions/Serious Safety Events, University Health Network
- Brenda Perkins-Meingast, Director of Practice Based Education – Collaborative Academic Practice, Lead for Caring Safely Education, University Health Network
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Learning objectives

Participants will...

1. have an understanding regarding building a “*safety culture*” where staff and patients embrace safety as a core value.
2. have an understanding regarding developing a comprehensive strategy to reduce workplace violence preventable harm to zero.
3. have an understanding regarding building resilience by incorporating harm reduction and prevention strategies into daily practice.

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Call to Action: Need for an Inpatient Assessment to Reduce Aggression/Violence in Healthcare

Subtheme: Creating cultures that minimize aggression and violence

Paper

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Keywords: Positive Practice, Healthcare, Aggression Prevention, Violence Prevention, Risk reduction initiatives

Introduction

Threat assessment as a discipline is actively evolving and has witnessed impressive changes over the last 30 years. Most of the increased use of threat assessment tools and techniques in healthcare has focused on management of outpatients, while the prevention of disruptive behavior by hospitalized patients has gone comparatively unnoticed. This problem was originally identified by Drummond, Sparr and Gordon [1], in which an interdisciplinary team created specific threat management strategies and notifications to the care team of those strategies primarily for outpatients. However, a growing body of evidence suggests more workplace violence occurs in inpatient setting rather than outpatient settings. The disparity between higher use of interdisciplinary threat management strategies in outpatient settings with lower overall violence risk than inpatient settings demonstrates an opportunity to explore the complex interplay among prevention methods and management strategies across clinical areas.

Background

Drummond et al [1] identified that many patients who have multiple incidents of disruptive behavior, most of which occurred in outpatient/ambulatory care areas, benefit from an interdisciplinary team threat assessment process, and prospective threat management strategies which are communicated to staff. Within Veterans Health Administration (VHA), these interdisciplinary threat management strategies are communicated to providers via a notice in the computerized medical record called an electronic health record alert (EHRA). Drummond et al. [1] showed this interdisciplinary team approach significantly reduced the number of disruptive incidents, resulting in a moderation of the patients' use of care services, from overuse of various services, to levels of use more consistent with age-matched peers. This efficacy for outpatient care is one of the driving factors for continued use of the interdisciplinary threat management strategies for outpatient areas, yet few of the incidents that came to the attention of Drummond et al. [1] were inpatient incidents.

Wyatt, Anderson-Dreves and Van Male [2] laid out a comprehensive workplace violence prevention program including education, awareness, threat assessment, management plans,

and communication strategies. This model is the most comprehensive model for violence prevention in healthcare found in the literature, and suggests that threat assessment must take into consideration the unique set of variables found in each type of healthcare setting. Predictably, tools developed for purposes of threat assessment and violence prevention focus on specific populations and are informed by the environment in which care is provided.

Methods

To compare inpatient versus outpatient disruptive behavior events and violence prevention efforts, data were reviewed from 142 healthcare systems within VHA looking at numbers of EHRA and disruptive behavior reports in various workplace settings. To provide a more robust understanding of the phenomenon of threat management efforts, these data were collected from both the Workplace Behavioral Risk Assessment, which collects and analyzes disruptive behavior reports from all VHA facilities annually, [3] and the Disruptive Behavior Reporting System, a real time democratized reporting system used by front line staff within VHA to report disruptive behavior. For the purposes of this study, inpatient care settings were defined as emergency rooms, inpatient mental health, inpatient medical and surgical units, inpatient intensive care units, inpatient other (e.g., traumatic brain injury, spinal cord injury, etc.), and nursing home care units. Outpatient care settings included all other areas where ambulatory care is delivered, but did not include administrative areas such as human resources, parking lots, hallways etc. Reports from administrative and facility support service areas were tabulated under non-clinical work areas.

A literature review was conducted to assess the current state of the science for threat assessment in inpatient care settings, looking for risk assessment and threat management opportunities. Further, the literature review was expanded in search of risk factors associated with violence across multiple inpatient unit settings.

Finally, due to a lack of literature on key protective factors for impromptu violence in healthcare, the authors spoke with national threat assessment experts, clinical experts on workplace violence, and front line clinical staff as part of a focus group discussion. This discussion focused on the current state of threat assessment in inpatient settings, the state of the science of evidenced-based risk factors, risk factors from their clinical experience, and protective factors which prevent inpatients from resorting to violence.

Results

The data revealed at the time of the index incident identified only 154 of 638 threat managements plans placed between 2013 and 2016 were related to inpatient encounters. However, disruptive behavior reports occurring between Fiscal Year (FY) 2012 and FY 2016 demonstrated a disproportionate number came from inpatient care settings. See Table 1 for breakdown of reports by area, by year.

Table 1. Disruptive Behavior Event Reports by Clinical Area by Year

AREA	TOTAL EVENTS	2012	2013	2014	2015	2016
Inpatient	80,945 (53%)	16,985 (57%)	14,872 (54%)	16,054 (56%)	16,903 (53%)	16,131 (47%)
Outpatient	43,980 (29%)	7,344 (25%)	6,835 (25%)	7,815 (27%)	9,780 (31%)	12,206 (36%)
Nonclinical	27,014 (18%)	5,380 (18%)	5,735 (21%)	4,948 (17%)	5,239 (16%)	5,712 (17%)
TOTAL	151,939	29,709	27,442	28,817	31,922	34,049

A review of the literature showed current tools for threat assessment on inpatient units tend to be used at the point of discharge, normalized around mental health/ forensic populations, and for those who are legally committed to care. Because of that, many of the tools had mixed results for predicting violence and lacked generalizability to other inpatient settings. Tools where specific literature was able to be found included Historical Clinical Risk Management-20 [4, 5, 6, 7, 8, 9, 10], Psychopathy Checklist Revised [11, 12, 5], and the Violence Risk Appraisal Guide [13, 14, 15, 16, 17, 15, 18, 19], which have been found to have mixed outcomes with respect to violence prediction in forensic and psychiatric settings. Hamilton Anatomy of Risk Management Forensic Version(HARM-FV) [20] is a structured clinical tool which includes both historic risk factors and dynamic risk factors. The HARM-FV was found to be predictive in forensic settings, however, no literature was found validating this finding in other settings. Classification of Violence Risk is a computer-based actuarial tool which has been developed to assess forensic patient’s risk for violence after completion of treatment [21]. It did have some ability to detect violence in the short run, however, the setting was not compatible with the short length of stay associated with acute hospitalization.

Review of the literature surrounding risk factors for violence across multiple settings, cross-referenced with the risk factors in the assessment instruments, demonstrated that key risk factors associated with violence in inpatient settings included confusion [22], history of violence within the past month [23, 24, 25], surrogate decision-makers, (court ordered or guardian) [26, 27], treatment resistance (not participating in treatment planning) [20], and impulsivity [5].

The group discussion with the national threat assessment experts, clinical experts on workplace violence, and front line clinical staff suggested the addition of acute withdrawal (including nicotine) and history of need for physical restraint as risk factors. The former, due to the frequency with which withdrawal symptoms co-occur with agitation, and the latter, because restraint often marks an inability or failure to maintain a disruptive patient in treatment safely. Further, the group discussion suggested three areas of focus for protective factors. First is sensory awareness or the ability to see/ hear caregivers in the environment. Experts and staff hypothesize this improves safety by allowing communication between the patient and the care giver. Second is the presence of positive and involved family members, which can improve safety by creating a bridge between the patient and the care team, as well as increasing historical awareness of treatment. Third is insight into current level of illness, need for treatment or assistance, and perceived benefit of treatment. This last factor is protective because it empowers the patient to be an equal and active member of the treatment team and engenders more pro-social approaches to get needs met, rather than the use of violence.

Discussion

The data reinforce the Drummond et al [1] article that the majority of interdisciplinary threat management plans occur in the medical records of outpatients with multiple incidents of disruptive behavior. However, the number of disruptive behavior events reported in inpatient settings in VHA consistently exceeds the number reported in outpatient settings, suggesting the need for regular and consistent use of a general threat assessment when patients are admitted to inpatient units. Since formalized threat management plans appear less utilized as a management strategy in inpatient care settings, and because these settings have a higher incident of disruptive behavior, other management strategies such as threat assessment instruments are clearly needed. However, the available threat assessment instruments demonstrate several significant gaps. First, the tools most commonly described in the literature were standardized on mental health/forensic patients and have questionable generalizability to a more general mental health population in inpatient settings, much less those patients on medical/surgical, intensive care, and nursing home care units. Second, there is little agreement on what represents risk factors in the inpatient setting. Lastly, there was no available literature on protective factors among this population. It is also of note that this is only the first part of threat assessment and management in inpatient care environments. After there is a viable assessment tool there is then a need for a management strategy through just-in-time consultations with an interdisciplinary threat management team.

Future Research

In light of these gaps there is a need to create and validate a threat assessment tool for workplace violence in inpatient healthcare settings. Inclusion of this assessment tool as early in the admission process as possible, along with a co-created risk management plan for the patient, is a model of assessment which is not new in healthcare. Most healthcare providers are already familiar with doing in-depth assessment at the point of admission for other risk factors such as fall risk, skin issues, and other general health factors. The thought scaffolding already exists, creating a ready-made spot to deploy an inpatient violence risk assessment. Similarly, healthcare professionals already use inter-multidisciplinary treatment plans which are a natural structure upon which to build threat management plans.

Limitations

There are significant limitations in this review and call to action. First, there is very little data both domestically and internationally on risk factors for violence in healthcare outside of mental health care units. The literature which is available is normalized to the forensic population and may not generalize to the medical surgical population. Due to this limitation, it could be that the proposed factors are not predictive of violence in inpatient settings.

Conclusion

There is a gap in the threat assessment continuum within healthcare. This is a critical issue due to the focus of regulatory bodies and professional organizations on reducing both the use of restraints and the frequency of workplace violence. The only way to move these metrics at the

same time is to increase prevention of violent incidents from happening. These efforts could be greatly enhanced by an inpatient violence risk assessment and management plan.

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Learning objectives

Participants will be able to...

1. recognize the difference between reducing aggression/violence in inpatient versus outpatient care.
2. identify key risk and protective factors associated with preventing aggression/violence in inpatient care.
3. implement structured assessment tools in inpatient care to prevent/reduce aggression/violence.

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The Development and Validation of a Clinical Decision Making Tool Measuring Implicit Bias During Aggressive Events

Subtheme: Creating cultures that minimize aggression and violence

Poster

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Keywords: Bias, implicit bias, explicit bias, unconscious bias, psychiatric emergency departments, Implicit Association Test (IAT), disparities, minorities, treatment, aggressive events, clinical decision making

Abstract

Background

Implicit bias is a bias in judgment and/or behavior resulting from subtle cognitive processes often operating at a level below conscious awareness and without intentional control. These biases are the result of unconscious cognitive processes and are present among all. There is ample evidence that implicit bias is present among health care providers and impacts clinical decision-making. Unaddressed bias can negatively affect patient care and is thought to be a major contributor to health disparities.

To date, the most widely used way to measure implicit bias at the individual level is the Implicit Association Test (IAT) measuring automatic associations of objects in memory. Despite the IAT's well-established consequential validity, it has attracted much scholarly criticism for failure to connect to meaningful events such as clinical decision-making.

Initial focus groups suggested that implicit bias might be a factor influencing decision making during aggressive events in the Psychiatric Emergency Department (PED). A research team developed, with IRB exemption, an anonymous online simulation survey using scenarios within a simulated clinical setting to measure clinical decision-making based on patients' race within the PED.

Methodology

Twenty-seven different clinical scenarios were created for the purpose of this tool, depicting events that have the potential for escalation or are aggressive within the PED. For each scenario, a picture of a male patient appearing to be White or Black will appear from the shoulders up with similar clothing. Of note, the apparent patient race in the picture is designed so that scenarios judged by an outside expert panel to depict low, moderate and high patient

aggression each have equal numbers from both races. This assignment of pictures is based on an already conducted face-validity exercise. In order to maximize power for the study we have kept all variables constant with exception of race selecting just one comparison group (White vs. Black). Participants consisted of all RNs, nursing technicians, and security staff who rotate to the PED. At the end of each scenario, our participants were asked to choose one of five possible recommended courses of action they deem most appropriate, which are: 1. Do nothing, 2. Verbal intervention/ redirection, 3. Offer medication, but do not force patient to take it, 4. Administer medication even if patient declines, 5. Seclude and/or physically restrain patient.

Findings will be presented for the first phase of the study; testing the newly developed simulation exercise designed to measure possible bias in clinical decision making in the Psych ED.

Implications

Disparities in diagnosis and treatment of racial minorities exist in psychiatric emergency departments. Developing a tool that will potentially measure implicit bias within the context of this clinical healthcare setting can assist healthcare educators in developing and evaluating interventions aimed at decreasing implicit bias, thereby increasing the equity and quality of care.

Learning objectives

Participants will...

1. will gain an understanding of implicit bias and its impact on clinical decision making.
2. have the opportunity to participate in the simulation exercise, and if they choose to, critique this tool with an iPad supplied by the writers.

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Experience of Psychiatric Violence at the Katouabi Neuropsychiatric Center in Kananga, the Democratic Republic of Congo

Subtheme: Creating cultures that minimize aggression and violence

Paper

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Keywords: Violence, Psychiatry, Hypervigilance Fear

Abstract

Neuropsychiatric Center of Katouambi, is located in the province of Central Kasai 70 km from the Kananga city in the Democratic Republic of the Congo since 1985. It takes care of the person with the disease suffering from dullness. Exposure to violence in the health sector affects employees and also has implications for the quality of care provided. Workplace assaults can lead to different emotions or behaviors in caregivers, such as fear and avoidance of patients.

The phenomenological approach allows to take a new look at this problem by plunging into the universe of each speaker, to understand the interpretation given to the act of violence experienced. The use of this approach gives access to more content and allows to specify how their daily lives are altered by this phenomenon. Thirty semi-structured interviews were conducted, two for each of the 15 participants (11 women) from various professional fields working in a psychiatric center. The analyzes are based on the technique.

Particular attention was paid to the possibility of different experiences depending on the sex of the workers. The analysis revealed four main themes that are present regardless of the gender of the responders, namely: hypervigilance, caring, specific fear of the aggressor patient, then generalized fear to all health professionals. A state of hypervigilance is found in all participants who have been victims of aggression from a patient. Compared to the responders who witnessed the escalation of aggressiveness of a patient, those who were attacked by surprise report repercussions of this vigilance that extend to their personal lives.

A caring approach is present in the majority of the participants. This implies a kindness and authenticity towards the patient treated. Putting the patient at the heart of his intervention, the 'caregiver' worker develops a bond of trust and acts as an agent of change. A feeling of fear is also expressed among participants.

This is modulated by the presence or absence of caring. Intervenors demonstrating caring developed a specific fear for their abuser, while those demonstrating little or no caring developed a widespread fear of the clientele.

Following an event of violence, caring stakeholders remain, while those with little or no caring would be more likely to disinvest and disengage from relationships with patients. Generated by the violence experienced in a psychiatric hospital, hypervigilance and fear, whether specific or generalized, both have an impact on the quality of care offered.

Considerable interest should be given to caring, which modulates this fear and the resulting effects. Research could shed light on the origin of caring - is caring learned or is it a vocation? Finally, these studies could establish ways to strengthen or develop caring.

Learning objectives

Participants will...

1. take a new look at this issue by plunging into the universe of each speaker.
2. understand the interpretation given to the act of violence experienced.

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Workplace Innovation; Island Health Integrating Violence Prevention Policies into Practice

Subtheme: Creating cultures that minimize aggression and violence

Workshop

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Keywords: Best Practices, Coaching Model, Code White, Innovation, Interdisciplinary Collaboration, Successful Implementation, Training, Violence Prevention Policies

Abstract

Background and Context

WorkSafeBC (British Columbia, Canada) regulatory requirements inform the development of employer policies and industry practice. During 2012, WorkSafeBC identified gaps in Island Health's Violence Prevention Program. Island Health's Occupational Health and Safety department worked collaboratively with clinical stakeholders and union partners to develop seven system-wide violence prevention policies. Violence Prevention Advisors provided health authority-wide information sessions and guidance to program areas and Joint Occupational Health and Safety committees to support the implementation and integration of the new Violence Prevention (VP) policies and the Provincial Violence Prevention Curriculum (PVPC). During this time, an innovative staff training model, that includes a Violence Prevention Coaching Model and Code White drills, was developed to best integrate safety into the clinical world. This innovative approach supports collaboration across all clinical/support programs with the timely application of violence prevention theory to practice.

Methodology

Six staff members (PVPC Facilitators) were trained and scheduled to work shifts as a Violence Prevention (VP) Coach. In this role they:

1. informed their clinical work environment with in-the-moment violence prevention coaching and helped frontline staff understand and follow relevant violence prevention policies and procedures;
2. focused on communicating and assessing the risk of violence and developing effective behavioural care plans to manage and prevent violent behaviour;
3. reinforced skills taught in the Provincial Violence Prevention Curriculum by supporting staff directly at the bedside in implementing VP best practices into their clinical practice and care of patients;
4. conducted Code White drills to further reinforce education competencies and support team responses in their facility; and
5. ensured violence prevention policies were integrated into practice.

Findings

Preliminary evaluation results of the original 2012 implementation indicated a significant increase in staff use of communicating both a risk and history of violence as well as formulating patient specific behavioural care plans. VP processes are actively integrated into new quality improvement work. For example, VP processes have been recently incorporated into unit structured team report and discharge planning boards, and care planning work. Data compilation from Health Authority Protection Services department (In-house organization security officers) demonstrates a four year downward trend in high level response calls.

Implications

This innovative program helped inform Provincial Violence Prevention Curriculum development and Educational standards for all high risk staff.

Workshop activity

- Facilitated PVPC refresher and Code White drills with participants
- Inclusion of observer roles for feedback and debrief purposes
- Questions and answers

Learning objectives

Participants will...

1. have a basic understanding of how policy and clinical procedures can effectively be implemented into clinical practice.
2. be aware of a progressive use of a coaching model in clinical practice.
3. explore various Code White implementation tools.
4. have an understanding of the facets of a Code White drill.

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The “Sigmaringen model” to reduce seclusion and restraint in psychiatry - the first adaptation of the Six Core Strategies in Germany

Subtheme: Reducing seclusion, restraint and coercive measures

Paper

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Keywords: Six Core Strategies, Safewards, Aggression and Violence management, Preventive Measures, Coercive Measures, Seclusion, Restraint, Acute Psychiatric Care

Abstract

During the past years, a vast number of activities both in research and clinical practice to reduce seclusion and restraint in psychiatry can be noted. Numerous interventions have been described in the literature and were tested in psychiatric hospitals. Nevertheless, it has been shown that the sole unsystematic propagation of these solitary successful interventions undoubtedly does not show through in the clinical practices. Measureable effects still remained low.

Based on this background the idea of creating a practically relevant manual came up. We planned to combine already successful concepts in reducing seclusion and restraint in psychiatry and developed a multimodal intervention program that was evaluated in the Clinic of Psychiatry, Psychotherapy and Psychosomatic Medicine at the SRH Hospital in Sigmaringen from August 2016 to July 2017.

Our clinic that consists of 88 beds spread to five wards and a day clinic has the public service obligation for the district of Sigmaringen (Germany) We treat approximately 1.400 cases in an inpatient and day-patient setting. One of the wards counting 18 beds is a mixed gender acute / closed ward, the others are open mixed gender wards. Coercive interventions almost sole take place at the closed ward that is considered an intensive care psychiatric unit. 20,4% of the cases (n=538) that were treated on this ward in 2015 underwent coercive measurements. We are a member of a nationwide consortium to reduce seclusion and restraint in psychiatry and share out numerical data with the other participants in terms of a benchmarking. Although, our official figures reflect the average among German psychiatric clinics, we felt that we have to improve our ratings as on obligation to our patients and clients.

The “Sigmaringen model“ connects the scaffolding of American “six core strategies” with the British “safewards model” as well as the German “DGPPN guidelines regarding measurements concerning aggressive behavior”. These concepts were adapted to the conditions of a typical psychiatric clinic at a general hospital in Germany. The newly developed manual that was then introduced to our doctors, psychologists, nurses, social workers, community care givers,

local judges, the hospital management as well as patient representatives in July 2016. After training our staff the implementation of the “*Sigmaringen model*” guidelines came into action in August 2017.

During the period from August 2016 to July 2017, a significant reduction in cases of seclusion and restraint was observed.

Altogether, 565 cases (+27 compared to 2015) were treated at the acute closed psychiatric ward of which only 14,4% compared to previously 20,4% of the cases had undergone restraint or seclusion using the structured proceedings of the “*Sigmaringen model*” manual. In total, it translates to a reduction of coercive interventions by 29,4%.

Learning objectives

1. The participants shall learn about the first adaptation of the Six Core Strategies in Germany. However, the ‘*Sigmaringen model*’ is more than just an adaptation, it combines different approaches to reduce coercive measures on an acute psychiatric ward.
2. The audience will be shown that the structured combination of already established and successful strategies to reduce seclusion and restraint is an effective method to reduce coercive measures. It shall also be shown that preventive measurements on one hand as well as debriefings at different levels on the other hand are capable of reducing coercive incidents significantly if combined stringently.

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Enhancing safety and supporting recovery: the impact of Safewards on a forensic program

Subtheme: Reducing seclusion, restraint and coercive measures

Paper

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Keywords: Seclusion and restraint, Aggression, Forensic mental health, Safewards

Abstract

Background and Context

Violence is considered one of the most dangerous occupational hazards facing mental health workers and injuries resulting from aggression by patients are worryingly common. Violence is a highly complex problem in mental health facilities that requires multi-faceted conflict-reduction strategies (Cutcliffe & Riahi, 2013). Safewards is an evidence-informed model made up of 10 core interventions. Grounded in recovery principles, the main goal of Safewards is decreasing rates of conflict (violence) and containment (use of seclusion and restraints) by improving staff and patient relationships through positivity and engagement. A 15% reduction in the rate of conflict and 26.4% reduction in containment has been reported in acute psychiatric settings (Bowers et al., 2015). Less is known about the impact of Safewards in forensic settings where fidelity to the model has proven difficult (Price et al. 2016). Safewards was implemented on 6 forensic inpatient units in a tertiary mental health facility in Ontario at a time where incidents of violence and aggression were increasing.

Methodology

This study is part of a larger mixed-methods evaluation of the implementation of Safewards in a forensic program. A co-creation approach to implementation was utilized and fidelity to the Safewards model was assessed. Quantitative data was collected three months pre and post implementation. The number of aggressive incidents, use of seclusion and restraints (incidents and time in seclusion) and how staff responded to aggressive incidents pre and post implementation were examined.

Findings

Fidelity to the Safewards model was found to be high indicating a successful implementation. After the implementation of Safewards the number of incidents of aggression reduced by almost 20%. Seclusion incidents and the average number of hours spent in seclusion also decreased. After implementation, staff were more likely to use a positive recovery aligned intervention and less likely to use seclusion or restraints as the first response to an aggressive incident.

Implications

We have demonstrated that Safewards can be successfully implemented in a forensic setting. Our results indicate that the use of Safewards is effective in reducing incidents of aggression in forensic inpatient settings. Implementation of Safewards can transform how staff responds to aggressive incidents. The outcomes of this study and the implementation strategies utilized can be used to inform future implementations of Safewards.

Learning objectives

Participants will...

1. have an understanding of how the Safewards model can be effectively implemented in a forensic setting.
2. be aware of how Safewards can reduce reliance on seclusion and restraints.

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Identifying factors influencing the use of restraints and seclusions in youth residential treatment centers: a mixed method study

Subtheme: *Reducing seclusion, restraint and coercive measures*

Paper

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Keywords: Restraints and seclusions, youth residential treatment centers, factors underlying decision, mixed-method

Abstract

Background and Context

About 12% of youth involved in Quebec's child protection services are placed in residential treatment centers. Restraints and seclusions (R&S) are often seen as "last resort" strategies for educators in these settings to manage youth aggression. These interventions are likely to lead to an escalation of violence, which undermines the safety and health of educators and youth. Yet, studies assessing the R&S use in these settings are very scarce and few have investigated the factors underlying educators' decision to use R&S. Nevertheless, studies in psychiatric hospital settings have documented this practice and shown that the decision of healthcare workers to use R&S depends on their personal characteristics (e.g., sex, attitudes, psychological functioning) and their environment (e.g., institutional contingencies). Relying mostly on objective measures and cross-sectional data, these studies have not captured the longitudinal effects of cognitions, affect and institutional norms on R&S use. This study aims to identify individual and contextual factors influencing R&S use to manage aggression in youth residential treatment centers.

Methods

A prospective mixed method design was used. The first goal was to identify micro-interactional factors leading to R&S during violent events in Montreal youth rehabilitation centers using archival data prospectively on a 12-month period. Discourse analysis of R&S reports written by educators allowed for exploring the 'lived experience' of educators. The second goal was to identify the characteristics of educators and their environment associated with R&S use. Using a convenience sample, 158 educators completed weekly diaries composed of instruments measuring individual and contextual factors underlying R&S use during a 2-month period (i.e., 8 diaries). Generalized estimated equation models and cross-lagged models were used. Results were discussed with educators through focus groups.

Findings

Twelve micro-interactional factors emerged from R&S reports (e.g., non-compliance, aggressive behaviors, by preventive measures, by lack of staff). Results from weekly diaries indicated that verbal violence experienced by the educators was positively associated to R&S. Some social climate's characteristics, namely order and organization (positive team functioning in terms of tasks and their execution), as well as negative climate (conflict between team members as well as the pressure they felt) were negatively associated with their decision to use R&S. Poor recuperation from work was also found to lead to chronic fatigue that led to higher stress and then less R&S use. Acute fatigue was positively associated with R&S.

Implications

In addition to enriching scientific knowledge so far lacking, this study provided a better understanding of the decision-making process of educators in residential treatment centers when using R&S to manage youths' violent behaviors. The findings foster the development of intervention strategies aimed at reducing the use of R&S based on subjective bias (i.e., reflective practice). Findings may also benefit other settings using R&S to manage aggression (e.g., hospitals).

Learning objectives

Participants will...

1. appreciate that micro-interactional factors influence the decision of educators to use R&S. These micro-interactional factors can be used to develop reflective practice that could lead to a reduction of R&S use.
2. learn how individual and contextual factors influence R&S use and can be monitor through organizational as well as individual intervention. These efforts could lead to a reduction of R&S use.
3. learn that the reduction of R&S has been associated with fewer youth and staff injuries, less staff turnover, higher staff satisfaction and higher success in rehabilitating youth.

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Effectiveness of a guideline-based intervention to reduce physical restraints in nursing homes – pragmatic cluster-randomized-controlled trial (NCT02341898)

Subtheme: Reducing seclusion, restraint and coercive measures

Paper

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Keywords: Physical restraints, nursing homes, clinical practice guideline, implementation, cluster-randomized trial

Abstract

Background and Context

Physical restraints (PR) are regularly used in older persons in need of nursing care, despite the lack of evidence of their effectiveness and safety. In an earlier study, we could show that an own guideline-based intervention significantly reduces the use of PR in nursing home residents in Germany. We aimed to examine the effectiveness of the previously tested intervention and a short version in comparison to optimized usual care in a pragmatic intervention study and to identify facilitators and barriers of the implementation of the intervention.

Methodology

The guideline-based intervention was updated (intervention group (IG) 1) and a concise version (IG2) developed and piloted and compared to a control group receiving only written information. A three-arm cluster randomized trial with 120 nursing homes in four regions throughout Germany (Saxony-Anhalt, Hamburg, Schleswig-Holstein, Ruhr) was carried out. All nursing homes in the participating regions with all residents were eligible for participation. Apart from the evidence-based guideline, the intervention consisted of written information for nurses, residents, relatives and other health care staff, 2-day training and subsequent counseling of nominated nurses in all IG nursing homes and further supporting materials. In IG1, all nurses received a short educational session on PR use, while in IG2 this was optionally performed by nominated nurses. The primary endpoint was the number of residents with at least one PR at 12 months assessed using direct observation by blinded assessors. Secondary endpoints included fall rates and fall-related fractures. Also a comprehensive process evaluation was carried out. The trial was funded by the German federal ministry of education and research.

Findings

Overall 12,245 residents took part during the 12-months study period. Baseline PR prevalence was 17.4% (IG1), 19.6% (IG2) and 18.8% (CG) (n = 8,800 residents); after 12-month, PR prevalence had decreased in all groups to 14.6%, 15.7%, and 17.6% respectively (n = 8,841 residents). Although reduction of PR prevalence was higher in the IGs, cluster-adjusted differences between IGs and the CG were not statistically significant: IG1 vs. CG -2.0% (97.5% confidence interval (CI) -5.8 to 1.9), IG2 vs. CG -2.5% (97.5% CI -6.4 to 1.4). PR were mostly bedrails (IG1: 11.1%, IG2: 12.6, CG: 13.8% after 12 months) while other PR like belts and fixed tables were rare. There were pronounced PR prevalence differences between facilities in all groups. Initial analysis of the process data indicates differences in the level of implementation of the intervention. Numbers of falls and fall-related fractures after 12 months did not differ significantly between the groups (falls: IG1 34.0%, IG2 32.9%, CG 31.8%, fractures 2.4%, 2.0%, 1.8%).

Implications

Both interventions showed no clear advantage over optimized usual care. The prevalence at baseline was lower than in the previous intervention study. Therefore, it may not be possible to achieve a relevant reduction of PR under the given features of nursing homes. Implementation of the guideline in high prevalence facilities could still help to reduce PR.

Learning objectives

Participants will...

1. learn that a multi-faceted guideline-based intervention program reduces physical restraints in nursing home residents.
2. identify structural and personal aspects that determine the success of implementing restraint reduction programs.

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Dangerous discourses: Masculinity, coercion and psychiatry

Subtheme: Reducing seclusion, restraint and coercive measures

Paper

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Keywords: Masculinity, psychiatry, community mental health practices, Assertive Community Treatment, Mental Health Act

Introduction

Coercive psychiatric practices as sanctioned through mental health law, policy and protocol have been shown to contravene Canada's commitment to the UN Convention on the Rights of Peoples with Disabilities (Chammartin, Ogaranko & Froese, 2011), and yet, these practices continue to pervade emerging interventions with significant repercussions for the lives of people with mental health and substance use challenges.

Although coercive practices are most often associated with institutional and inpatient forms of care, they are routinely used in community-based mental health care. The use of involuntary committals and of restrictive and controlling interventions are disproportionately shown to impact men (Mah, Hirdes, Heckman & Stolee, 2015). In British Columbia, data collected by the Ministry of Health illustrates that the incidence of involuntary psychiatric committals and community treatment orders under the Mental Health Act have been significantly increasing over the past decade, with a high of over 3,000 incidents in 2015, only declining in the wake of the dramatic rise in overdose deaths (Lupick, 2017, 2015a, 2015b) which undoubtedly affected a population with concurrent mental health struggles.

These worrying statistics coincide with the introduction of modified Assertive Community Treatment models (ACT) in BC. The ACT model is a form of inter-disciplinary community-based treatment. The way ACT is currently implemented in BC is a departure from the model's original intent and best practices from other jurisdictions. Typically, ACT is paired with housing supports and does not involve police personnel on teams. ACT has essentially replaced hospitalization and become the de-facto outpatient mechanism for enforcing treatment.

Using available statistics, an examination of public and policy discourse, and the professional experiences of the authors, this paper explores the intersections of masculinity, psychiatric diagnosis and discourses of dangerousness as they play out in coercive practices in community-based settings. The intent of our work is to expose the ways in which damaging psychiatric practices continue to crop up in community-based mental health, giving lie to the promise of recovery and person-centred models of mental health care and violating the rights of

psychiatrized people. We use the term discourse, following Foucault, to describe knowledge(s) that are historically contingent and central to the construction of subjects like *'the mad'* or *'addicts'*, situations like a *'crisis'*, and practices such as forced treatment (Foucault 1991). We suggest that mental illness and substance use for men is often constructed through the lens of violence, which justifies coercive practices in the mental health system and at the same time pathologizes violence in a way that undermines a discussion of its social causes. Although our focus is recent developments in BC, we contextualize our discussion through an historical examination of discursive practices of psychiatric confinement in Canada and its links to colonialism and intersecting forms of oppression.

The tools of psychiatry—assessment, stabilization, psychopharmacology, and confinement—along with the lives of racialized *'patients'*—are historically bound to “*political institutions such as slavery, scientific racism, and eugenicist discourses*” (Kanani 2011, 1). Any examination of the intersection of madness and race must thus consider that psychiatry is bound to scientific rationalism and colonial roots. Particularly relevant for our work in BC is the history of colonialization of Indigenous Peoples and its impact on Indigenous men, who are disproportionately represented among those living in poverty on the streets of the Downtown East Side (DTES) of Vancouver—a neighbourhood intensely targeted for psychiatric outreach programs and policing—and in prisons throughout the province (Lewis, 2008).

Our analysis shows how mental health and substance use policy and practice has come to carve out new populations to monitor, contain, and control through apprehension under the *British Columbia Mental Health Act*, involuntary treatment orders, and growing use of police officers in ACT teams. The increased use of the Act as an apprehension tool has been significantly influenced by Vancouver Police Department (VPD) reports on mental illness, violence, and safety with a strong focus on the city's poorest and most marginalized neighborhood, the DTES (Wilson-Bates, 2008; VPD, 2010; VPD, 2013; Lee, 2013). Here we raise the alarm at how ACT teams and their locally-specific coercive practices have been enabled by the BC Mental Health Act and increasingly rely on the police to enforce compliance.

ACT in Vancouver: Research, Policy Development, and Practice

ACT models emerged as a result of the de-institutionalization era in the United States and are intended to care for individuals with *'severe mental illnesses'* and sometimes co-occurring substance use and are regarded as an evidence-based community mental health intervention (Udechuku, et al, 2005; Philips et al, 2001). Teams operating under a *'Housing First'* model, where participants are offered immediate access to rent supplemented market-apartments, have been particularly endorsed by researchers and policy makers. Fidelity measures hold that Housing First ACT programs should not require clients to maintain sobriety or engage in psychopharmaceutical treatment. The Housing First ACT model, has been extensively studied in Canada as part of the federally funded randomized control trial, At Home/Chez Soi conducted across five cities from the Maritimes to BC (Currie 2014). Despite heavy criticism levelled at the At Home/Chez Soi project for assigning a control condition where people would continue to live in unacceptable circumstances while the government was providing funds for housing for other participants (Patton 2012), researchers have gone on to advocate for ACT models based on their study results (Currie 2014). Findings largely focused on *'success'* defined

as cost savings to government and biomedical management of study participants in the form of *'improved adherence to antipsychotic medication'* (Rezansoff et al., 2016). Absent from the discussion on these supposed *'successes'* is reference to the political contexts of poverty, colonization, and the simple fact that many study participants were forced to take medication involuntarily through Extended Leave provisions under the Mental Health Act—practices that fly in the face of recovery oriented care and *'Housing First'*.

It is important to note that the *At Home/Chez Soi* study did not include police involvement as part of its ACT model, yet, following the completion of the study, the Ministry of Health mobilized the enthusiasm of the researchers and their emerging evidence and began to establish several ACT teams with police departments in Vancouver and Victoria, BC. Critical researchers in Vancouver have pointed to a decade of increasing security discourses connected to mental health policy as setting the context to make this departure from the original model possible (Van Veen, Teghtsoonian, and Morrow, 2018) and others direct us to the unusual position of the Vancouver Police Department (VPD) as a dominant claims maker on issues related to mental health and substance use policy and practice (Boyd and Kerr, 2015). Indeed, over the past decade the VPD have self-published a number of policy reports with recommendations on health policy changes to the mental health and substance use system and have strongly advocated for more defined roles for their officers (Wilson-Bates, 2008; VPD, 2010; VPD, 2013; Lee, 2013).

From their onset Vancouver ACT teams were modified to include police in a way inconsistent with *'the evidence'* and in contradiction with established fidelity rules of the ACT and Housing First models. With fidelity scales focused on client autonomy and choice, formalized roles for officers and aggressive forced medication regimes represent, at best, a significant departure from the evidence base, and at worst, the deliberate on-going criminalization of individuals, mostly men, who are said to be *'ill'* and structurally vulnerable to homelessness. Many men with mental health struggles have extensive exposure to the use of force by police, a practice that has historical intersections with colonialism, racism, homelessness, and poverty. Indeed, a report published by the BC Civil Liberties Association details high rates of police contact amongst Indigenous people and police in BC, and highlights the disproportionate number of Indigenous deaths that occur while in police custody in comparison to the deaths in custody of non-Indigenous Peoples (MacAlister 2012). What is particularly distressing about this new police and health services collaboration is that it may be operating outside the boundaries of the *Mental Health Act*, which clearly stipulates the criteria of certification and detention and the respective roles of service providers who are regulated through the *BC Health Professions Act*, of which the police are not accountable to.

Contesting Confinement and Coercion

The *BC Mental Health Act* is an outlier in the context of mental health laws across Canada (Nunnelle 2015; Dhand and Grant, 2016). The fact that the Act is now facing a constitutional court challenge at the BC Supreme Court reflects concerns that advocates have been raising about its coercive reach (Community Legal Assistance Society, 2016; Woo, 2016). Although there have been civil and legal resistance to the lack of patient rights in the *Act* over the years, more critical attention must be focused on its legislative intersection with emerging forms

of community-based psychiatric control. ACT, and other methods of policing marginalized populations under the pretext of mental health 'care', requires coalitions of psychiatrized people, critical researchers, policy makers and practitioners to jointly, and in their own ways, work to offer critical challenges. These challenges can come in the form of court cases, critiques of the effectiveness of interventions and the problematic discourses that research evidence relies upon, and through appeals to policy makers to consider the human rights of those encountering the mental health system.

BC has a strong history of resistance to psychiatric discourses with the formation of the Mental Patients Association (MPA) in the early 1970s; the MPA consisted of individuals who were discharged from Riverview Hospital and formed Canada's first organization led by people with experiences of the psychiatric system. The MPA gained international attention in the 1970s and 80s for its innovations in providing social support and housing and its challenges to psychiatry. The MPA was the antithesis of institutionalized care prevalent at the time and proved the power, resiliency, ingenuity and resourcefulness of psychiatrized people (Davies et al. 2016; Beckman and Davies 2013). The legacy of the MPA has lived on in contemporary organizations like the West Coast Mental Health Network and Unity Housing in BC, where the leadership and activism of people who have experienced the psychiatric system informs responses to people struggling with mental health and substance use difficulties.

However, paths to carve out resistance to dominant discourses and practices are not easy. Drawing on findings regarding cost efficiency and medication adherence from the *At Home/ Chez Soi* study, and the BC Ministry of Health's continued endorsement of ACT as a 'best-practice', City Council in Victoria, BC recently approved funds to embed two police officers in the regions four ACT teams. However, contestation also worked its way into debate on the new policy. Advocates from the Mad activism community and critical social service workers organized, through a closed Facebook group, to strategize how to keep officers off the teams. When the new funding for police was debated in council chambers, activists lined up to point out that the proposal "*sends the message that people with mental illnesses are dangerous*" and that the new configurations of police-involved 'care' could actually make some people apprehensive to reach out for help (Derosa 2017). In response, activists in Vancouver set up a 'Warm Line' for people who want help but are fearful of apprehension and subsequent Extended Leave orders under the *BC Mental Health Act*. Although recently deactivated, the Warm Line functioned as '*a peer run support line that anyone in the (psychiatrized) community is welcome to call*' (Mad Society of Canada 2017). As further evidence of the ways in which the *BC Mental Health Act* is preventing people from accessing care, are media reports that one of the plaintiffs in the current Supreme Court case in BC has moved to Ontario to avoid the reach of the legislation (Brown 2016). Emerging research on the experiences of Somali immigrants suggests that leaving BC to avoid the coercive reach of the *Act* is occurring in other instances (Ibrahim, 2018).

The efforts of activists to wage nimble expressions of resistance should not go unrecognized. The lengths that those resisting psychiatrization are willing to take to avoid confinement and loss of control over their lives reflects the severity of the violations taking place, but it also reminds us that subjects are not passive recipients of new politics in mental health and substance use policy. In non-ideal situations, many activists perform practices that counter the

discourses that connect mental illnesses to dangerousness or criminality. Indeed, the resistance to the *BC Mental Health Act* and other coercive psychiatric practices is multi-dimensional, with diverse scholars also challenging human rights abuses and the ‘*science*’ that underlies coercive interventions (see Patton, 2012; Dhand and Grant 2016; Boyd and Kerr 2015; Van Veen, Tegtsoonian and Morrow 2018). Taken together, expressions of resistance have the potential to counter psychiatric control and foster human rights.

Post script

There have been several shifts in the context of BC’s mental health landscape since the composition of this paper. Most notably, the province finds itself in the midst of one of the most significant public health challenges in its history. In April of 2016, the Minister of Health declared a public health emergency in response to a dramatic rise in overdose deaths, most of which involved contamination of the illegal opioid supply with fentanyl. In 2017 the BC Coroners Service reported 1,449 overdose deaths in a province with a population of just 4.6 million people (BC Coroners Service, 2018). Noteworthy for a chapter about the intersection of violence and masculinity, men accounted for over 80% of these deaths (BC Coroners Service, 2018) and overdose is now the leading cause of death amongst men aged 30-39 (Canadian Press, 2018).

Drug policy advocates have called for a national inquiry into the federal government’s actions in the decades leading up to this emergency (Lupick, 2018). Many recall the long years of court battles that Vancouver’s activist non-profits and drug user groups waged against then Prime Minister Stephen Harper’s Conservative government to ensure that basic, life-saving harm reduction services be available to those at risk of overdose and infectious disease transmission. Many of these same advocates point to the fact that the solution to the present crisis is simple: if the overdose emergency is a result of an illegal drug supply that is contaminated, the situation could be improved through providing drug users accessed to a regulated supply of ‘*clean*’ prescription opioids. Every day that the state refuses to implement a public health regulatory approach to opioids is a day with more unnecessary and avoidable deaths. In this context, choosing not to pursue this regulatory approach might rightly be called state sanctioned structural violence against mostly male drug users, resulting in untold grief and trauma for their families and loved ones.

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Learning objectives

Participants will...

1. learn about how Assertive Community Treatment is evolving in the province of British Columbia.
2. better appreciate the intersections of masculinity, psychiatric diagnosis and discourses of dangerousness as they play out in coercive practices in community-based mental health settings.
3. be challenged to think about how to eliminate harmful practices in community mental health.

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Personal protective equipment (PPE) and restraint alternatives in the management of challenging behaviors in inpatients with autism and intellectual disability

Subtheme: *Reducing seclusion, restraint and coercive measures*

Paper

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Keywords: Autism, intellectual disability, challenging behavior, self-injury, violence, caregivers, nursing, restraints, childhood ethics

Abstract

Background

In intensive and emergency psychiatry units, caregivers are often faced with severe behavioral disturbance, including self-injury, aggression and extreme psychomotor agitation. The associated risk of harm is highly problematic. While the use of restrictive measures is common, it optimally should be limited.

Objectives

To review the myriad forms of personal protective equipment in current use, including helmets, gloves, sleeves, jackets, bodysuits, mattresses, splints, padded shields, papoose boards, etc. and describe their usage through caregiver experience.

Methods

A focused ethnography based on the observation, justification and formalization of personal protective equipment and procedures used as an alternative to restraint, focusing on caregivers' representations of violent patient encounters. The research was a multi-centered study in three psychiatric inpatient units in Canada, the USA and France dedicated to the assessment and treatment of challenging behaviors in individuals with autism and intellectual disability.

Results

Innumerable forms of personal protective equipment (PPE) exist, and their usage confers a safe alternative to the containment of behavioral crises. Appropriate handling of challenging,

recurring behaviors is imperative to the preservation of physical and moral integrity in both patient and caregiver.

Conclusions

Personal protective equipment (PPE) decreases harm associated with the management of challenging behaviors, and promotes respect of individual integrity and fundamental moral rights. The usage of PPE further assists understanding of behavioral etiologies, and subsequent provision of personalized and efficacious therapy.

Learning objectives

Participants will...

1. Learn about special needs of persons with intellectual disability and challenging behavior pertaining to the management of aggression.
2. learn how the personal protective equipment (PPE) and their usage renders a safe alternative to the containment of behavioral crises in inpatients with autism and intellectual disability.

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Reduction of Patient and Staff Exposure to Violence by Implementing a Psychiatric Nurse Rounder

Subtheme: Creating cultures that minimize aggression and violence

Poster

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Keywords: Violence, Psychiatric Nurse Rounder

Abstract

Background

Individuals with severe mental illness pose unique challenges, resulting in a care experience that is stressful for patients and health care team. Between 2007 and 2010, our hospital initiated and refined a program to implement patient-centered culture change on our psychiatric medical unit (PMU). We initiated training and policies to improve patient safety and teamwork among unit co-workers. We also modified unit rules and routines to be more patient-centered. Around 2010, we identified an increase in the number of patients exhibiting challenging behaviors across the hospital. Frontline nurses were ill equipped to handle these complex behaviors, resulting in an unsafe work environment for staff and patients.

Study Objective

We sought to expand the reach of our positive behavioral health model more broadly across the hospital. We implemented a novel psychiatric nurse rounder model to increase collaboration among the health care team, spread our behavioral health patient-centered culture, and improve safety for patients and nurses.

Intervention

A psychiatric resource team (PRT), of Psychiatric Mental Health certified nurses, worked collaboratively with the psychiatry consultation service to determine the patients with greatest need. This service was available 24 hours per day, 7 days per week. The PRT rounded proactively throughout the hospital providing guidance and consultation. The PRT collaborated with and coached the assigned nurse in development and implementation of plans of care using evidenced-based strategies. During implementation of the PRT, we used data to continuously improve our practices and policies.

Metrics

Data included restraint use, sitter use, and harm to staff from patient violence.

Results

Following the implementation of PRT rounding in FY14: 1) restraint orders per 1000 patient days were reduced in hospital by 32% (FY14 21.18 to FY18 YTD May 14.34), 2) number of patients restrained per 1000 patient days decreased by 24% (FY14 9.33 to FY18 YTD May 7.11), and 3) staff reports of injuries due to patient violence decreased in FY15 (5%) and FY16 (16%). Although reported violent event rates have increased in FY17 and FY18, this coincides with timing of increases in drug-related deaths across the US. Future analyses will include data from control sites to better understand the impact of our efforts in light of national trends associated with violent patients.

Conclusions

By proactively identifying patients with challenging behaviors and working with nurses collaboratively, reported staff injuries, restraint rates, and patient companion usage have decreased. Further research is needed regarding the effectiveness of this model in other health care settings. There is an opportunity for advocacy at the state and federal level to incentivize replication of the model. The PRT model has resulted in an organizational culture change, where violence in the workplace is no longer viewed as a part of the job. Constant management of the change will be necessary to assure sustainability.

Learning objectives

Participants will...

1. have a basic understanding of a strategy for reducing restraints, patient companions, and staff injuries.
2. have a basic understanding of the role of a psychiatric rounder.
3. identify factors that contribute to workplace violence related staff injuries.

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A Study of Leading Indicators for Occupational Health and Safety Management Systems in Healthcare

Subtheme: Creating cultures that minimize aggression and violence

Poster

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Keywords: Workplace violence, occupational health, leading indicators, safety management, health and safety, risk management

Abstract

Background and Context

Healthcare workers face many occupational health and safety hazards every day, including workplace violence. The cost of violence in Ontario hospitals is .8 million annually, making up 10% of lost-time injuries (Government of Ontario, 2015). While the awareness of the problem is growing, policies and practices have lagged behind (CFNU, 2017). An approach to changing this trend is the utilization of leading indicators within Occupational Health and Safety Management Systems (OHSMSs). In contrast to lagging indicators, which focus on outcomes retrospectively, leading indicators are associated with proactive activities. Using leading indicators is common in other industries; however, this shift has not occurred in healthcare. The purpose of this study was to evaluate the feasibility of implementing interventions guided by six leading indicators (senior management commitment, continuous improvement, communication, competence, employee involvement, occupational health management), and the effectiveness on improving selected health and safety workplace indicators.

Methodology

A quasi-experimental longitudinal design was used within 2 acute care hospitals. Phase I focused on assessing current OHSMSs using the leading indicators, identifying possible leading indicators to be added or changed, and determining potential facilitators and barriers. Phase I concluded with developing tailored interventions based on identified gaps and in collaboration with each site. Phase II pilot tested and evaluated the interventions. Data was collected pre- and post-intervention with interviews to assess feasibility, and surveys to assess effectiveness.

Findings

The interventions focused on improving elements related to 3 leading indicators: employee involvement, senior management commitment, and communication. Regular ‘*Safety Rounds*’ were implemented to engage staff in discussions with senior management related to health and safety (including workplace violence), areas needing improvement and possible solutions. Communication was bolstered through newsletters and bulletins focusing on leading indicators. At Site 1, pre- and post-survey data showed employees’ perceptions of safety culture decreased, while at Site 2, employees’ perceptions improved. Data from the post-interviews provided positive feedback about using leading indicators as a proactive lens to assess OHSMSs. The interventions also provided a framework for ‘*safe*’ discussions about workplace safety (including workplace violence), encouraged senior leaders to obtain first-hand experience of issues, and strengthened the support for health and safety as a strategic priority. Barriers during the interventions included competing priorities, workload, and organizational culture.

Implications

Healthcare workers have a right to work in safe workplaces, free from all forms of violence. It is the responsibility of employers to try to mitigate, and ultimately eliminate, workplace violence hazards (CFNU, 2017). Our study examined one promising approach to creating safe workplaces and the results will inform employers on the feasibility of implementing leading indicators into current OHSMSs.

Learning objectives

1. have an understanding of the assessment and utilization of leading indicators associated with proactive activities within occupational health and safety management systems.
2. be aware of potential barriers and facilitators to implementing interventions to increase the use of leading indicators in health care organizations.
3. be able to discuss the feasibility of implementing leading indicators to support a safety culture across health care organizations.

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Cognitive Milieu Therapy contributes to a decrease in mechanical restraint

Subtheme: Reducing seclusion, restraint and coercive measures

Poster

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Keywords: Cognitive Milieu Therapy (CMT), mechanical restraint, dual diagnosis, Denmark

Abstract

Background and context

In 2014 it became a national goal in Denmark to reduce the use of mechanical restraint by 50% before 2020. I work in the Psychiatric Center Sct Hans, department M, which is part of the Mental Health Services at the Capital Region of Denmark. Our department has space for 74 in-patients with dual diagnosis and is regionally specialized within the area. We experienced a significant decline in the use of mechanical restraint after we changed the philosophy of treatment from one that was based on psychodynamic theory to strictly applying cognitive behavioral therapy, which is also called Cognitive Milieu Therapy (CMT).

The purpose of the change was solely to provide better treatment. However, the adoption of CMT resulted in a change of culture at the department, which diminished the use of mechanical restraint. According to the former research published within the area, the decline in restraint cannot be explained by a change in the patient category or human resources. The new data presented on my poster demonstrates similar results. Thus, I consider CMT to explain the decrease in the use of restraint.

In my poster, I propose which elements of CMT have resulted in the decrease of mechanical restraints at department M.

Methodology

The data is based on a quantitative study of the transition to CMT, on the literature on CMT and is informed by clinical experience both before and after the shift to CMT.

Findings

CMT is composed of several different techniques, e.g. restructuring of negative automatic ways of thinking, techniques of exposure and use of schemas. Nevertheless, it is not the techniques and the schemas but rather the spirit within CMT, which is the most important. The spirit is comprised by the opinions and ways of thinking of the personnel, which is the critical part of CMT.

The introduction of CMT entailed a shift in the relation between patients and professionals, which can be considered the spirit of CMT. Central to this is collaboration, starting from the patient's experiences and allowing different perspectives to exist simultaneously.

Communication

There is an emphasis on engaging the patient with questions instead of providing the patient with answers.

Approach to the patient

There is a change in the basic understanding of the patient, emphasizing the patient as an independent agent with the ability to help him/herself.

What is the patients' opinion of CMT?

The ongoing feedback we have received from our patients confirms that they experience a great deal of respect, involvement, and freedom in the therapy they receive at department M.

Implications for practice

I believe the implementation of CMT at other psychiatric departments can result in decrease of restraint. However, to achieve this result it is necessary to dedicate economic resources to educate the personnel in CMT. In our department, all professionals are educated in CMT. In addition, it also requires a change in basic assumptions about the relation between patient and professionals to be facilitated and supported institutionally.

Learning objectives

Participants will...

1. learn about synergies created by all the different elements in Cognitive Milieu Therapy on a ward with persons with dual diagnosis.
2. learn of the affinity and similarities between Motivational Interviewing and Cognitive Milieu Therapy.

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Chapter 4 – Engaging with stakeholders

A Collaborative Partnership: Preventing Workplace Violence in Health Care in Ontario

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Paper

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Keywords: Collaboration, partnerships, workplace violence prevention, nurses, hospitals

Background

Workplace violence in Ontario's health care sector is a complex issue that affects workers, their families and communities. In order to reduce the risk of workplace violence, a collaborative, multi-faceted response is required to change workplace culture, provide more support for prevention, and make health care workplaces safer and more responsive to incidents of violence. There must be zero tolerance for workplace violence; one incident of workplace violence is one too many. Hence the creation of a joint provincial initiative: The Workplace Violence Prevention in Health Care Leadership Table.

Methodology

The Ontario Ministry of Labour (MOL) and the Ontario Ministry of Health and Long-term Care (MOHLTC) established the Leadership Table in 2015. Over 100 members of a committed group of unions, hospital representatives, health professional associations, nursing and patient advocates, researchers, front-line staff, and safety associations were brought together for the very first time to share leading practices, experiences, and ideas. Collaboration is key in making workplace violence prevention a priority.

Outcomes

As a result of the work of the Leadership Table and its 4 working groups (leadership and accountability; hazard prevention and control; indicators, evaluation and reporting; and communication and knowledge translation), a progress report from phase 1 was released in May 2017. With the focus on the prevention of violence towards nurses in hospitals, the Leadership Table members endorsed 23 recommendations and 13 products created through the project which encompassed system enhancements, development of standards, increased training and standardized reporting (i.e. Quality Improvement Plans). The 13 products created enhance communication between patients and providers, public and sector awareness, positive workplace culture, accountability from top to bottom, assessment of risk and standardized data collection. The MOL has used these products to enhance its enforcement strategy and compliance expectations within the health care sector.

Two recommendations already implemented involve two of the Leadership Table's key partners: Health Quality Ontario (HQO), an agency of the MOHLTC and the Public Services Health and Safety Association (PSHSA), a funded partner of the MOL.

The recommendation directed to HQO was related to including workplace violence prevention as a key component of the Quality Improvement Plan (QIP) process for hospitals. QIPs are submitted annually to HQO by hospitals, inter-professional primary care organizations, long-term care homes and local health integration networks (which oversee home and community care) to describe how the organization will address its quality improvement goals. The goal of including workplace violence prevention in the QIPs was to address this important issue using a quality improvement approach, incorporating employee safety as an element of safety (one of the six dimensions of quality) (HQO, n.d). Addressing workplace violence using a quality improvement lens should reflect a thoughtful, proactive, and non-punitive approach.

The approach to implementing workplace violence prevention into the QIPs and the development of guidance for hospitals was conducted in collaboration with HQO's Quality Improvement Plan Workplace Violence Prevention Guidance Task Group. This Task Group included representatives from the Ontario Hospital Association, the PSHSA, the Institute for Work and Health, the Cross-Sector QIP Advisory Committee, the Ontario Nurses' Association, the Ontario Public Service Employees Union, the Canadian Union of Public Employees, and representatives from several Ontario hospitals.

Based on the recommendation from the Leadership Table, workplace violence prevention was incorporated into the 2018/19 QIPs in two ways:

1. Organizations in all four sectors were asked to complete a free-text statement in the QIP Narrative describing how workplace violence prevention is a strategic priority for their organization. The prompt was as follows: Please describe how workplace violence prevention is a strategic priority for your organization. For example, is it included in your strategic plan or do you report on it to your board?
2. Hospitals were required to include an indicator measuring the number of workplace violence incidents reported by hospital workers within a 12-month period in the Workplan of their QIP. As part of this indicator, hospitals were asked to describe what they were planning to work on to improve on this issue.

Specific guidance and training was developed in collaboration with the Task Group to help hospitals apply quality improvement science and change management principles to workplace violence prevention. This included a guidance document as well as a set of webinars hosted with members of the Task Group. The guidance and training emphasized the importance of reporting and highlighted the fact that the number of incidents may increase as reporting improves, and that this should be encouraged (HQO, 2017). The technical specifications for the measurement of the indicator are included in the guidance document.

The 2018/19 QIPs were submitted in April 2018. A brief overview of our observations from the QIPs submitted by 137 hospitals is presented here.

QIP Narrative

- 95% of hospitals described specific activities demonstrating how workplace violence prevention is a strategic priority for their organization.

Indicator

- 100% of hospitals completed the indicator measuring the number of workplace violence incidents. Of these:
 - Just under half reported that they are collecting baseline data
 - Approximately half included numeric current performance values
- Of the hospitals who reported a numeric current performance value, the majority set targets to increase the number of reported workplace violence incidents – that is, they are aiming to improve the reporting culture in their organization
- There was a wide range in reported current performance values, indicating that there is room for improvement in the consistency of measurement of incidents and reporting systems

Improvement initiatives

- Hospitals described many ways in which they plan to address workplace violence in both the QIP Narrative and indicator. These included initiatives such as risk assessments, flagging, collaboration with the Joint Health and Safety Committee, changes to their physical environment, and training
- There were also examples of regional and collaborative efforts to address workplace violence, including collaborations among organizations in multiple sectors, collaborations at the local health integration network (LHIN) level, and collaborations among hospitals in different LHINs
- Many hospitals also described using the tools developed by the PSHSA.

Overall, HQO observations reveal that hospitals are taking this issue seriously and expanding their practices to prevent workplace violence. Many have demonstrated leadership in transparently reporting their numbers and addressing workplace violence.

Another recommendation from the progress report that has been completed was for the promotion of all existing and future PSHSA Violence, Aggression and Responsive Behaviour (VARB) tools in all Ontario hospitals by the MOL and the MOHLTC. PSHSA has led the workplace violence prevention in health care toolkit initiative by developing five toolkits: Workplace Violence Risk Assessment (WVRAT); Individual Client Risk Assessment (ICRA); Communicating the Risk of Violence (Flagging); Security and Personal Safety Response Systems (PSRS).

The toolkits were developed collaboratively with 22 stakeholders representing Ministries and employer, labour and professional association. A literature review, jurisdictional scan, focus group, experiential working groups and pilot sites helped to round out the content of the toolkits which can be used on their own to fill a specific need or gap in a healthcare organizations workplace violence prevention program, or used together in a 5 step program implementation process.

The toolkits were promoted by the MOHLTC in a letter from the Minister, and by the MOL in a letter from the Chief Prevention Officer and Director of the Occupational Health and Safety Branch. They were also referenced by HQO in the Technical specifications and Guide for QIPs.

PSHSA has also launched a healthcare awareness campaign drawing attention to the issue of workplace violence and directing traffic to the website that houses the tools and Ontario's Leadership table resources: workplace-violence.ca. Since the release of the toolkits in August 2017 until March 31, 2018, the website has been accessed over 7000 times by unique users with the WVRAT being accessed the most at 3048 times.

As part of our toolkit evaluation, an inventory survey was sent to individuals responsible for workplace safety at 125 of Ontario's 138 public hospitals in May 2018. The goal of this step was to gather information about hospitals' awareness and use of four of the five toolkits (the ICRA toolkit is not included in this evaluation), their perceptions of the toolkits, and implementation challenges and facilitators. The hospital inventory was completed by 74 hospitals. In addition, a single-question follow-up poll was sent to non-respondents in June 2018. This poll yielded information about awareness and use for another 21 hospitals.

Combining the poll and the inventory, PSHSA has information from 95 hospitals (76% of those queried, and 69% of all Ontario public hospitals) about whether hospitals were aware of and/or had used any of the toolkits. Of these, 92 (97%) of responding hospitals were aware of the VARB toolkits and 79 (83%) had used at least one of the five toolkits.

Together, these findings tell us that there is awareness of the VARB toolkits in at least 67% of Ontario's 138 public hospitals, and the toolkits are being used in at least 57% of these hospitals. Respondents to a recent survey are most aware of the WVRAT and Flagging Program toolkits, with 95% and 94% awareness, respectively. Fewer respondents are aware of the ICRA (90%), Security (82%), and PSRS (81%) toolkits, but it is important to note that at least 81% of respondents are aware of each toolkit (see Figure 1).

Some comments about the toolkits usefulness are captured below:

Workplace Violence Risk Assessment;

The majority of respondents found the WVRAT toolkit very or extremely useful for identifying what changes were needed (72%) and determining how to implement the changes (53%).

Five hospitals provided comments about the usefulness of the WVRAT toolkit. Some found the toolkit useful because it provided "*clear indicators for enhanced safety and means to decrease risk due to WPV*" and allowed them to "*compare current tools to those in the toolkit in order to identify opportunities to improve prevention program tools*". Other hospitals found aspects of the toolkit '*tricky to use*'.

Communicating the Risk of Violence (Flagging);

The majority of respondents found the Flagging Program toolkit very or extremely useful for identifying what changes were needed (70%) and determining how to implement the changes (50%). Five hospitals provided comments about the usefulness of the Flagging Program toolkit. One hospital "*loved all aspects of this part of the program*", and several others found the tool to be a great resource and reference. These hospitals either used the toolkit to improve their existing flagging programs, or as a starting point for developing a new flagging program. For other hospitals, the toolkit was not as useful. Hospitals with a large number of confused

patients or patients with a history of violence required flagging policies that meet their unique needs and fit with existing policies and procedures.

Security

The majority of respondents found the Security toolkit very useful for identifying what changes were needed (50%) and determining how to implement the changes (36%).

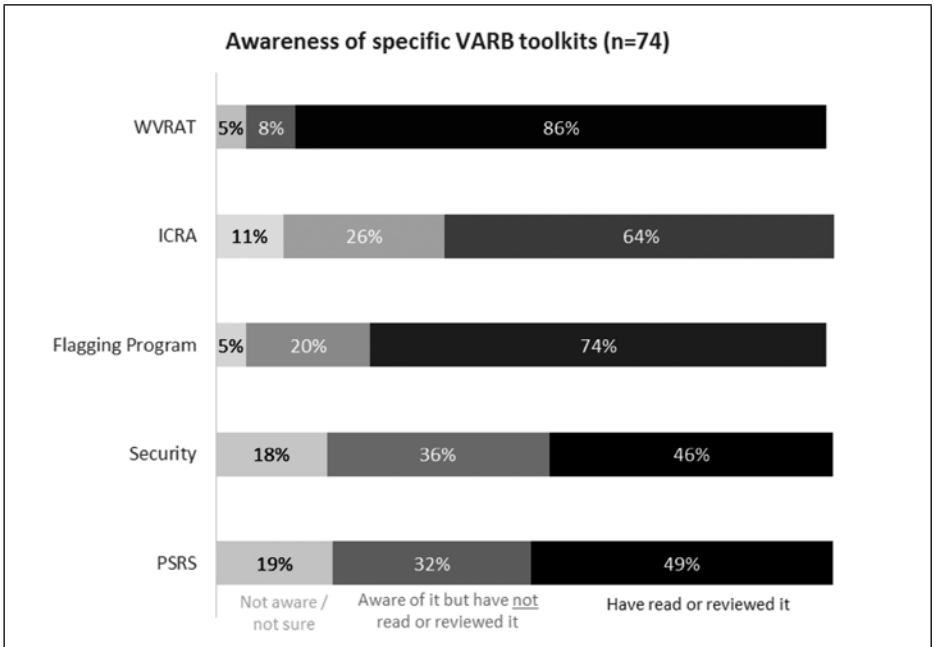
Four hospitals provided comments about the usefulness of the Security toolkit. Several hospitals used the toolkit to identify important security criteria for their hospital, or as a reference for onboarding new security staff and identifying facility improvements.

Hospitals who found the toolkit less useful identified technical and functionality issues with the toolkit (e.g., issues with information extraction and templates), or felt that their hospital was already meeting toolkit criteria and had no current issues with their security program.

Personal Safety Response Systems

Five respondents provided feedback about the usefulness of the toolkit. While hospitals found that there was duplication, repetition and it was overcomplicated in nature given its purpose (i.e., identifying appropriate noise-making or signal sending devices), one hospital did find that the toolkit provided good ideas about protections for staff on home visits.

Figure 1: Awareness of specific PSHSA VARB toolkits.



Conclusion

The achievements of the Leadership Table have been far reaching within health care and beyond. For example, the experience of the Workplace Violence Prevention in Health

Care Leadership Table including the project framework, logic model, approach, structure, management, collaboration model, development and review process and reporting has been valuable to the development of a roundtable for violence prevention in schools. There has also been national attention with the project in other provinces helping to draw attention to the issue of violence in health care. Other provinces have reached out to the MOL requesting to replicate the project framework.

It is expected that this collaborative effort, through the continuing work of the Leadership Table in phase 2, will not only improve patient care but ultimately reduce violence against all workers in Ontario's hospitals, long-term care homes, and home care. It will accomplish this by strengthening policy, legislation, standards, physical environments, measures and procedures, programs and training.

Acknowledgements

We wish to thank the members of the Executive Committee, Leadership Table, and Co-Chairs of the Working Groups for their guidance, support and dedication during phase 1 of the Workplace Violence Prevention in Health Care Leadership Table project.

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Learning objectives

Participants will...

1. gain an understanding of how the work of key partners is making a difference in workplace violence prevention in Ontario.
2. gain an overview of Ontario's Quality Improvement Plan and prevention toolkits to address workplace violence in the hospital sector.

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Commitment + Collaboration = Success for Workplace Violence Prevention in a Mental Health Hospital

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Paper

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Keywords: Commitment, Collaboration, Unions, Management, Mental Health, Violence prevention, Trust Relationships

CAMH, located in Toronto, Ontario, is Canada's largest academic health science centre dedicated to mental health. In early 2017, the hospital faced increasing concerns about staff safety and workplace violence. Tension between unions and management surrounding workplace violence was at an all-time high. Although work was underway to address the concerns, there was a lack of engagement, trust and authentic communication between management and the hospital's two unions, Ontario Nurses Association (ONA) and Ontario Public Service Employees Union (OPSEU). It was clear that no resolution could be achieved without a reset of union and management relationships. All parties realized that we needed to address the very real issue of workplace violence together, toward the end of both staff and patient safety.

An initial meeting between the hospital's executive leadership and both local and central union leadership was set. The outcome of the meeting was a commitment to work together using the vehicle of a Workplace Violence Prevention (WVP) Committee, a subcommittee of the Joint Health and Safety (JHSC) committee, to begin relationship repair, while simultaneously creating and implementing focused initiatives to address the structural, process and human resources issues to improve safety in the workplace. The newly formed WVP committee was chaired by the President and CEO signaling the priority the organization and most senior leadership was putting on this work.

The Committee was struck with representation from: union leadership – both local and central, senior leadership, frontline staff, frontline management, physicians, patient voice, human resources, risk, patient quality and safety, and communications. Terms of Reference clearly articulated the purpose, aims and function of the committee. Rules of engagement were agreed upon to ensure effective committee function that enabled safe sharing of perspectives and meaningful discourse toward consensus decision-making on the path forward.

While a strong commitment toward a goal of authentic collaboration between unions and management was articulated, conversations were tentative at initial meetings. Building trusting personal relationships created an inflection point that became the key success factor for the

committee and its work. For example, the simple act of the sharing mobile phone numbers between the CAMH president and CEO, and union leadership spoke to the confidence that communications would be respectful and substantive. Texts or calls could be used to address specific concerns, or to simply ensure that there was timely sharing of pertinent information. In addition a meeting between the committee chair and union leadership is held prior to every WVP committee to further cement open lines of communication, and build strong relationships.

Another critical success factor was a focused structure that organized timely follow-through on commitments and ensured communication with committee members. Comprehensive meeting agenda packages sent out well in advance of meetings to allow review of materials. Action logs that track status of actions, and assign accountabilities and timelines for follow-up with a standing agenda item to provide updates on action items. Meeting minutes being sent out for review and edits within one week of a meeting. Update emails to the committee as required. Although simple, these committee communication techniques have ensured clear and transparent communications on committee work and have been another vehicle to build a trusting relationship.

It was also integral to the success of the committee to share the work broadly across the organization. In addition to each WVP committee initiative having a communication plan, following each WVP committee meeting, a president and CEO blog '*Call me Catherine*' highlights the work of the committee for all staff. It further concretizes the commitment of the most senior leader to this work and shares her enthusiasm and passion to shift the culture of safety at CAMH. The work of the WVP and JHSC committees, along with the implementation of multiple safety and wellness initiatives were celebrated at a joint ONA/OPSEU/management barbecue in July 2018. A one page document outlining all the accomplishments was shared with over 1000 staff, management, and central union attendees. Frontline staff were astounded at all that we had achieved, working together in such a short amount of time. The positive relationship shift was palpable at this event reinforcing the importance of the work, and reinvigorating everyone to continue to move the work forward.

The initial action items for the Committee were: 1) executing an external risk assessment on 3 high acuity units, 2) developing and implementing a supervisor competency training program, 3) implementing zero tolerance signage, and 4) reviewing and implementing applicable recommendations from a provincial leadership table document '*Preventing Workplace Violence in the Healthcare Sector*.' These action items were all addressed in a systematic way with WVP committee working groups made up of union and CAMH management tackling each action item and coming back to the broader committee for updates and input on work.

Details of the original action items and our progress include:

1) Executing an external risk assessment on 3 high acuity units

- Joint union and management subcommittee engaged in a competitive process to select a vendor to conduct the external risk assessment.
- External risk assessor conducted the risk assessment over a 3 month period which included:
 - Full site tours and 2 primary CAMH sites
 - Tours of units to be assessed

- Employee and Physician Risk Assessment Survey was completed with a 70% response rate
 - Joint union and management messaging and in person visits to units and support services was felt to positively impact the response rate for the survey
- Unit observations – day, evening/overnight, weekend shifts
- 70 individual or small group interviews including: ONA/OPSEU frontline staff (clinical and support services), physicians, and management
- Attendance at WVP and JHSC meetings
- Comprehensive data and information provided including: relevant policies and procedures, training materials, code white (psychiatric emergency) data, employee incident reporting data, and WVP and JHSC agendas and minutes.
- The risk assessment led to a final report with 49 unit specific recommendations and 90 organization recommendations.
- Work is now underway to implement recommendations. Within 2 months of receiving the final report, 80% of unit specific recommendations, and 35% of the organization wide recommendations have been completed or are in progress. Progress on implementation of recommendations is being tracked with regular updates to the WVP committee.

2) Developing and implementing a supervisor competency training program

- Joint union management subcommittee with both WVP committee members and non-committee members from Health Safety and Wellness and Education.
- 3 day Supervisor competency training – 2 days led by the Public Services Health and Safety Association (PSHSA) and a 1 day CAMH specific training titled '*Lead the Way to Safety*'.
- CAMH specific training translates the concepts taught at PSHSA to the CAMH environment.
- CAMH specific training was piloted with over 30 participants and audited by 4 WVP committee members.
- Training updated based on pilot participant and auditors feedback.
- Roll out of training will commence in October 2018 for all CAMH supervisors.
- '*Lead the Way to Safety*' framework is now influencing provincial workplace violence toolkit for supervisor competency training.

3) Implementing zero tolerance signage

- Draft posters prepared by CAMH Public Affairs and shared with WVP committee.
- WVP Committee chair and local union president's met to finalize the posters and shared result back with committee.
- Zero tolerance posters are now at the entrance to all CAMH buildings and are in all elevators across 3 campuses.
- CAMH's Zero Tolerance posters are now part of PSHSA's Violence Aggression and Responsive Behaviour (VARB) toolkit.

4) Reviewing and implementing applicable recommendations from a provincial leadership table document 'Preventing Workplace Violence in the Healthcare Sector.'

- Joint union management subcommittee reviewed the 23 recommendations to identify applicable recommendations for CAMH to action
- Action log with applicable recommendations developed

- Work now underway to implement recommendations and build recommendations in to work across the organization.

Simultaneously, initiatives external to the Committee, such as a refresh of (JHSC), amplified the general goodwill and the impact of the Committee work. With the WVP being a subcommittee of JHSC, the two committees work together to broaden the reach of work around workplace violence and overall staff health and safety. WVP committee updates are provided at JHSC meetings and issues pertaining to workplace violence that get raised at JHSC are brought to the WVP committee agenda for discussion and resolution. The hospital furthered its commitment to health and safety by supporting all JHSC members to receive full JHSC certification. This is a 5 day training program facilitated through PSHSA. We wanted to create '6-packs' where a minimum of 6 worker representatives from both ONA and OPSEU are certified to share the work of the JHSC and further permeate health and safety knowledge at CAMH amongst frontline staff.

14 months since the inception of the Committee, the organization is in a very different place. We are more vigilant about engaging in '*early and often*' communications between our unions and management. More and more, management and unions talk about working toward a common goal or being on the same team. We go jointly to our unit and program staff to learn from them, and share information with them. This partnership process has been the central outcome of the work. There is a nascent shift at CAMH to a culture and climate of safety and an a priori assumption of good will in our interactions. Our work is now being shared locally, provincially and nationally. It is informing provincial toolkits addressing violence in the health sector. The practical learning's from CAMH's journey are broadly relevant – across any sector or geography.

Learning objectives

Participants will...

1. have an understanding of how to implement a successful workplace violence prevention program at their organization.
2. learn the critical role relationships and trust play when bringing multiple stakeholders together when developing a workplace violence prevention program.
3. learn a successful formula for developing a workplace violence prevention program - including building relationships and trust, and clearly articulating initiatives and outcomes.

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Implementation of a Violence Prevention Framework in Saskatchewan

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Workshop

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Keywords: Prevention, Non-reporting, provincial unions, employers, partnerships

Introduction and Background

Workplace violence, whether physical or psychological, is a global issue crossing borders, work settings and occupational groups. Once an unreported issue, violence at work is now a priority concern in all workplaces in Canada. Health care workers are impacted by the increasing violence in health care settings (CFNU, 2017), in fact according to CFNU rates of violence and injury correlate to patient contact time. Research has also established that regulated nurses and nursing assistants are among the most at-risk for workplace violence (CFNU, 2017).

Health care workers in Saskatchewan sustain 14% of overall injuries resulting from violence, the highest in the province (WCB, 2016). While the Saskatchewan health care sector overall has made some progress to address violence, evidence of escalation remains (WCB, 2016). In particular, three health care areas in Saskatchewan were identified to require immediate attention; acute care (emergency rooms), inpatient mental health facilities, and long term care facilities.

Despite recent escalation of violence in the workplace, the lack of reporting and under reporting of incidents of such violence and acts of aggression in health care is attributed to the notion that care providers put the “*duty of care*” ahead of their own safety (CFNU, 2017). Literature and research findings indicate that under reporting is also associated with the normalization of violence among health care workers (CFNU, 2017). The under reporting of violence and aggression in health care is attributed, in part, to health care workers viewing such regular occurrences as “*just part of the job*” (CFNU, 2017).

Unlike other jurisdictions in Canada, Saskatchewan has not adopted a province wide violence prevention strategy. Rather, each employer is obligated through legislation to develop and implement a strategy of its own. The Saskatchewan Workers’ Compensation Board (WCB), through WorkSafe Saskatchewan, recently provided funding support to the Saskatchewan Association for Safe Workplaces in Health (SASWH) to implement and evaluate a strategy to provide a consistent approach to standardize the identification of risk and controls to address this situation. Identified as a best practice developed by the Public Services Health & Safety Association of Ontario (PSHSA), the Workplace Violence Risk Assessment Toolkit for Acute Care (WPVRA) was chosen for implementation and evaluation in Saskatchewan.

Highlights

The purpose of this project was to evaluate a model of violence prevention that supports workplaces to meet legislative requirements in Saskatchewan and can be applied across other sectors (e.g. social services, education, hospitality, policing and corrections). In addition, by implementing this toolkit, health care providers would become aware of the need to report incidents of violence.

The PSHSA of Ontario created five tool kits to help health care organizations and staff assess workplace violence and meet legal responsibilities for ensuring safe workplaces. The tool kits comprise: Workplace Violence Risk Assessment (acute care, long term care, community); Individual Client Risk Assessment; Flagging; Security; and Personal Safety Response System (PSHSA, 2016).

The SASWH in partnership with the PSHSA evaluated the WPVRA Toolkit for acute care in Saskatchewan. The evaluation showed that legislative requirements are similar in both provinces and that the tool kit met these requirements. Each toolkit includes a detailed hazard assessment designed to identify hazards particular to violence, establish a risk rating, identify controls and implement an action plan.

Implementation

A Provincial Steering Committee was formed with broad representation from unions, government, and employers. The Committee provided advice about the design, implementation and evaluation of a strategy that would work in Saskatchewan's health care sector.

The SASWH released a request for partners to implement the PSHSA WPVRA Toolkit. Two facilities made the decision to implement this Toolkit between January and November 2017. The facilities were the La Loche Health Centre, in La Loche, Saskatchewan, and the Saskatchewan Hospital, North Battleford, Unit Rehab 2. La Loche is a community in northern Saskatchewan with a population of approximately 3,000 including Métis, First Nations (Cree, Dene) and non-Aboriginal people. In 2016, La Loche experienced a highly publicized violent event. A school shooting claimed the lives of four people and injured seven others. The Saskatchewan Hospital was the first mental health hospital to be built in Saskatchewan. Unit Rehab 2 is a secure unit which provides care for individuals experiencing various forms of mental illness.

The Five Steps of Workplace Violence Risk Assessment

There are five steps to workplace violence risk assessment: plan the assessment; identify hazards and determine risk rating; develop an action plan to control hazards; implement the action plan; and evaluation (PSHSA, 2016). A hazard is commonly thought of as a risk, danger or peril to a person's safety.

Workplace Safety Specialists with the SASWH worked with employers and facilitated the working groups based in La Loche and North Battleford. The working groups engaged in the first three steps of the workplace violence risk assessment. The employer and working

groups are currently working on the implementation and evaluation steps. Membership in these working groups included regulated nurses (Registered Nurses, Registered Psychiatric Nurses, and Licensed Practical Nurses), environment, dietary, security and management staff.

Results

A survey was completed by both working groups to better understand the settings and their respective knowledge of the legislation affecting workplace safety. Findings were consistent across both working groups and included regular exposure to violent incidents, differing interpretation of what constitutes a violent incident, varying levels of training/education in violence prevention, and unawareness of processes in place to support reporting and follow up of a violent incident.

Hazards were identified in three areas; the physical environment (exterior and general worksite); the work setting and conditions; and direct patient interaction. Both working groups determined high risk hazards in three main areas; security, training, and structure (the design of the facility and signage posted for public notification). The WPVRA tool provides best practice controls with each hazard that if implemented will mitigate the hazard.

Each working group then developed an action plan which prioritized controls that need to be put in place. This action plan was shared with the respective employers and was adopted as part of the ongoing violence prevention strategy for each facility.

The Provincial Steering Committee reviewed the process and outcomes of the implementation of the WPVRA Toolkit. After deliberation, the Committee concluded that the WPVRA Toolkit met Saskatchewan legislative requirements and recommended further implementation in the province.

Many of the health care providers who participated in the working groups had difficulty understanding the need to report violent incidents and the processes in place to support this reporting. It was found that violence has been normalized in both settings. Participants involved in the project stated that it helped clarify both the need to report violent incidents, and the existing supports that are in place or need to be established. This work highlighted the importance of involving direct care staff in the work of violence assessment and mitigation.

This implementation took place during an administrative restructuring of health care in Saskatchewan that would see administration of health care moving to one provincial health authority. In light of this imminent change, the leadership in the various health regions was reluctant to take on additional projects. In addition, the Saskatchewan Hospital in North Battleford is in the midst of construction of a new hospital. Therefore, the assessment results are based on findings for the existing (old) building and will need to be updated when the move to the new building occurs.

With these system changes underway, it is not surprising that employers commented on the difficulty in releasing staff to participate in the working groups and finding replacement staff. As this was the initial trial of the WPVRA tool, it was understood that more time would be

needed. Going forward, the PSHSA has recently released an electronic version of the WPVRA tool that will decrease the time required for hazard assessment and risk determination.

Next Steps

The SASWH is negotiating a license agreement with the PSHSA so that this tool can be used throughout Saskatchewan. Workshops are being designed to help employers and health care providers implement this tool kit and develop their action plans. Workplace Safety Specialists will be available for consultation purposes to any employer/employee groups who want to assess their workplace.

Acknowledgements

The SASWH would like to acknowledge the assistance provided by the Public Services Health and Safety Association of Ontario for the generous sharing of their experience, knowledge and of course the Tool kit that allowed us to proceed with this work. The SASWH also acknowledges the cooperation and effort put forth by the staff and management of the LaLoche Health Centre and Unit Rehab 2 in the Saskatchewan Hospital North Battleford. The Tool kit was validated for use in Saskatchewan through the work of these groups. Members of the Provincial Steering Committee provided ongoing feedback and guidance as the Tool kit was implemented in both settings. The experience held by members of this group allowed for validation of a tool that will meet the needs of Saskatchewan workplaces.

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In this presentation, we will provide an overview of the implementation of the Toolkit and how learnings translated to a Violence Prevention Framework for Saskatchewan. We will also outline ongoing efforts to support reporting of incidents at work and a plan to provide further support for violence assessment in workplaces.

Workshop participants will be encouraged to ask questions and provide comments during and after the presentation.

Learning objectives

Participants will...

1. engage with presenters to understand the design and implementation of a violence prevention framework in Saskatchewan.
2. gain understanding of how to implement a violence prevention initiative in their workplace.

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The ABC's of Identifying and Communicating Risks for Violence

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Workshop

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Keywords: Workplace Violence Prevention, Reducing Violence , Health care, Collaboration, Workplace Violence Prevention tools, Identification, Risk mitigation

Introduction

Workplace violence prevention (WVP) requires a collaborative, multi-faceted approach (Ministry of Labour and Ministry of Health and Long-Term Care, 2017). As system leaders, the Joint Centres for Transformative Health Care Innovation (Joint Centres) understands how to leverage the synergy between system change and collaboration. The consortium of seven community hospitals in the Greater Toronto Area is working together to reduce the incidence of workplace violence across the system. Members include Mackenzie Health, Markham Stouffville Hospital, Michael Garron Hospital (formerly known as Toronto East General Hospital), North York General Hospital, Southlake Regional Health Centre, St. Joseph's Health Centre – Toronto, and Humber River Regional Hospital. Over two years, the partners actively collaborated and worked together to reduce the incidence of workplace violence across the system. A “*best practices*” playbook was developed that reflects the essential components of a comprehensive workplace violence reduction and prevention program. The playbook was followed up by an “*Alert for Behavioural Care*” (ABC) protocol which includes a set of tools designed to help prevent, identify, manage and communicate risk within and between health care settings.

The need for improved processes to identify patients at risk for violence is a shared issue among health care institutions including the Joint Centres. Work was initiated to develop a collaborative approach to what is currently referred to as “*patient flagging*.” Given language concerns and the potential for patient stigma, a new term was proposed and adopted by the Joint Centres – ABC, a terminology and process intended to provide consistent notification to support the safety of workers while signaling the importance of care planning to respond to patient-centred care needs. The components comprise a set of tools and processes encompassed within a comprehensive joint policy statement. The ABC protocol was disseminated to the Joint Centre hospitals in May 2018 for customization and spread to meet local needs including the engagement of patient and family advisors and a formal evaluation.

Methods

A committee with representation from each Joint Centre hospital was formed with the aim of exploring and selecting an appropriate validated risk of violence assessment tool to be implemented across all sites. A usability/fit scoring sheet was developed to evaluate appropriateness of tools that were already being used in Ontario. Criteria included: if the tool had been researched or validated; was intuitive and considered human factors practicality; was currently being used in acute care hospitals; and if use of the tool could create opportunities to engage in research. A scan of existing tools currently being utilized in Ontario was then conducted to which the usability tool was applied. Four tools were identified in the scan:

- 1) Violence And Aggression Checklist from Southlake Regional Health Centre (Southlake, 2016)
- 2) Acute Risk of Violence Scale from Waypoint Centre for Mental Health Care (Marshall, 2016)
- 3) Hamilton Anatomy of Risk Management/Aggressive Incidents Scale from St Joseph's Healthcare Hamilton (Hamilton, 2016)
- 4) Violence Assessment Tool from the Public Service Health and Safety Association (PSHSA, 2016)

Members of the committee visited the three sites identified in the scan to witness the tools in use and gain context on their development. Participants in the site visit scored each tool using the criteria mentioned earlier and against their hospital and clinical settings. Three post site visit meetings were conducted to review the observations and collect scoring data. During this time, it was determined that due to the limited use of violence risk assessment tools in Ontario hospitals, assessing the usability and fit would be challenging. Both the Waypoint and Hamilton tools were validated in forensics settings but had not yet been implemented in acute care hospitals. Additionally, the committee appreciated having tools that included both static and dynamic information about the patient but had concerns about workload for nursing in some acute care clinical settings. Processes for documentation electronically versus on paper were also discussed.

The committee concluded that because the tools were all validated, any of the tools could be effectively used in acute hospital settings. Ultimately for the committee, the top priorities for safety in the clinical setting were: the alertness to potential risks, the process of identifying the risk, and developing and acting on a safety plan. This thinking led to the universal precautions approach and development of behavioural care plans as well as a visual management and communication strategy.

Results

Universal Precautions and Behavioural Care Plans

It is well understood that care plans are essential for providing safe, consistent, reliable care based on the best available evidence for a given condition or type of patient. Unfortunately, many staff struggle to create behavioural care plans consistently, especially for patients at risk of violence. A care planning group consisting of three clinical leaders and one patient

advisor was struck to develop a resource with care planning strategies based on best practices to prevent violence from occurring.

In group discussions, it was agreed that care planning strategies are dependent on context and setting. For instance, what can be implemented on an inpatient unit may not be possible in the Emergency Department or in an Outpatient Clinic. As such, multiple strategies were developed for Triage/Admission; Inpatient units; Outpatient/Community. The strategies were further sorted for each area by level of risk.

The low risk category includes strategies that everyone should adopt for safe care, even if a patient initially presents as low risk or has an unknown history (Studer, 2013; A-HEART, 2018). These strategies are meant to ensure patients are receiving sensitive care which could mitigate the risk of someone escalating. These are understood as Universal Precautions, captured in the acronym S.C.A.N.

S = Scan (apply safety strategies in relation to self, environment, others)

C = Communicate (use hospital-specific service recovery protocols such as AIDET® or A-HEART)

A = Act to Alert (follow standard protocols to inform others of risks especially at transfer points)

N = Non-judgmental (use approaches based on needs of patient and family)

Medium risk strategies were created for patients who may be displaying behaviours that could further escalate; whose individual circumstances automatically categorize them as a medium risk that requires precaution (e.g. patients escorted by police/corrections; patients with dementia); or who are identified by a formal risk assessment tool as a medium risk (Public Service Health and Safety Association, 2017).

High risk strategies are for those patients who have a known history of aggressive behavior, who display indicators of aggression, or who are identified as high risk by a formal risk assessment tool. The group decided to create care planning strategies for each level of risk based on observed behaviours, circumstances or presentation. These strategies can be adopted in the absence of a formal risk assessment (e.g. at triage) and be put in place as an interim strategy until a full assessment can be completed. This enables staff to put precautions in place, in the absence of data, to ensure care is being offered safely. The adoption of medium or high risk care planning strategies is a useful signal that a formal assessment is required and should be initiated.

The care planning strategies offer a template of how to provide care to a patient at possible risk for violence, and are not meant to replace any effective care planning strategies that may be suggested by the patient or their family. Care planning should be created with patient and family involvement and include known triggers, patient preferences around care, de-escalation strategies, self-soothing techniques and any cultural or personal sensitivities. Training on the use of care planning strategies will emphasize that care planning is not a static process and it may evolve as the patient's presentation and level of acuity/risk changes.

Visual Management and Communication

Visual management and communication tools are part of the larger toolbox used to help reduce and prevent workplace violence. A working group, with fresh perspectives and knowledge from Joint Centres hospitals, was formed to examine and select WVP communication tools for staff, physicians, patients and families. The goal was to create consistency across the Joint Centres, with the recognition that staff and patients may work at, or seek treatment at multiple facilities.

The group explored options for standardization including an alerting acronym, electronic notifications, colour, symbol, signage and a patient and family information pamphlet. The acronym ABC (Alert for Behavioural Care) was selected with the aim of directing staff's focus towards how best to deliver care rather than simply focusing on the challenging behaviours. The acronym may be printed on admission face sheets or be put on staff whiteboards and huddle boards. Some Joint Centre hospitals were able to have a printout or electronic image of a symbol, such as a white bell, for visual management but due to differing technology platforms, a standard electronic symbol was not feasible to implement.

A standard colour, purple, was agreed upon to symbolize the potential for aggressive or responsive behaviour across all Joint Centre hospitals. Purple will be used on identifying wristbands and signage, so that all staff interacting with the patient, not just clinicians, will be aware of the need to review the patient's behavioural care plan. The purple signage was modeled after infection control signs that alert people to necessary precautions but do not disclose any private or stigmatizing information. The precaution is simply to check in with a staff member who knows the individual patient, and their behaviour care plan, before proceeding to interact with them. The purple lettering is the visual indication there is a potential safety risk with regards to aggressive or responsive behaviour. Ideally, electronic charts and printouts for paper charts would feature purple as the colour, however technological limitations prevented Joint Centres hospitals from creating a standardized electronic format.

The working group elected to use the same information pamphlet for patients and families across Joint Centre hospitals and engaged patient and family advisors and clinical ethics representatives as partners in its development. The pamphlet delivers a uniform, unambiguous message of what can be expected at every hospital in response to challenging behaviours. It works to set limits and expectations of those coming for care while offering understanding and empathy towards individuals with the ultimate goal of providing safe, quality care. The pamphlet accompanies a script for staff to ensure proper communication of the ABC protocol. The script provides a clear explanation and allows for the engagement of patients and families in a two-way conversation that includes their involvement in their care plan.

Policy Document

To support implementation of the ABC protocol, the committee felt it was important to identify and communicate a common policy statement. The development of the Alert for Behavioural Care - Identification, Communication and Care Planning for Patients Who Pose a Risk of Violence/Aggression Behaviour Policy is a Joint Centres collaborative approach to outline the purpose, guidelines and roles and responsibilities of all workplace stakeholder in each organization using common language. The policy outlines expectations with regards to

establishing and maintaining an identification and communication system for at-risk patients. It aims, in accordance with legislative and regulatory requirements, to prevent occupational injury and to ensure safe and appropriate patient care and behaviour management while respectfully maintaining the dignity of the patient.

Education, training, review and evaluation are essential to successful implementation and sustainability. The application of the policy and its elements will be determined by each hospital in accordance with their overarching corporate policies.

Conclusion

The Joint Centres was successful in developing an approach to that leveraged their collective expertise and shared commitment to reducing violence in the workplace while supporting and involving at-risk patients and families in behaviour management. The ABC protocol to identify, manage and communicate risk within and between health care settings provides a standard of care that supports the safety of staff as well as patients and families while allowing individual hospitals to customize implementation to their local context.

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Learning objectives

Participants will...

1. acquire an overview of the context of the collaboration between the member hospitals of the Joint Centres.
2. identify key successes and challenges that will further increase the understanding of management and mitigation strategies related to workplace violence prevention, specifically those related to identification and assessment of patients at-risk for violent behaviours.
3. be able to facilitate useful discussion and potential spread of tactics such as the ABC protocol that help to identify and assess patients at-risk for violent behaviours.

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Experiences of crisis management in a child mental health setting: Engaging stakeholders in finding solutions

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Paper

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Keywords: Child, mental health, violence, inpatient, experiences, participatory research

Abstract

Background

The rates of restraints and seclusion episodes on child mental health inpatient units are of particular concern, as they have been reported to be 5 to 6 times higher than on adult units, with 25% of child inpatients having at least one seclusion episode during the hospitalization period and 29% at least one restraint episode. An increasing body of literature is highlighting the harms resulting from using these practices, including physical and psychological trauma. This situation, which raises significant ethical and moral concerns, calls for an in-depth examination of the use of control measures with children in mental health settings and how crises are managed, to implement more collaborative care practices.

Methodology

Using a participatory hermeneutic ethnographic framework, we studied conflict and crisis management in a child mental health setting offering care to children aged 6-12 years old in Quebec, Canada. The use of this framework allowed for an in-depth examination of the local imaginaries, of what is morally meaningful to the people in the setting, in addition to institutional norms, structures and practices. Data collection involved participant observation, interviews, and documentation review, with an interpretive framework for data analysis.

Findings

We argue that the prevalent view of children shared by staff members as “*incomplete human becomings*” led to the adoption and legitimization of authoritative norms, structures and practices guided largely by a behavioral approach, which sometimes led to an increased use of control measures (i.e. seclusion and restraints) for reasons other than imminent harm. Children experienced these controlling practices as abusive and hindering the development of trusting relationships, which impeded the implementation of more collaborative approaches staff members sought to put in place to prevent the use of control measures.

Implications

Following the conduct of this study, we are now engaging with stakeholders in the setting to reduce the use of control measures with children and implement more collaborative approaches, including children's perspectives in the process. This knowledge translation process is guided by a reflective and participatory approach. Similar processes to practice change involving key stakeholders – including patients themselves – could be applied to other inpatient settings that aim to implement more collaborative approaches and reduce the use of restraints and seclusion.

Learning objectives

Participants will...

1. have a better understand of the experiences of children, family members and staff members of conflict and crisis management in a child mental health inpatient setting.
2. be aware of strategies to engage key stakeholders, including patients, in the research and knowledge translation process to prevent the use of restraints and seclusion.

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Interventions for Change: Driving best practices for workplace violence prevention through constructive stakeholder engagement and coalition building

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Workshop

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Canadian Federation of Nurses Unions, Ottawa, Canada*

Keywords: Violence prevention; coalition building; best practices; jurisdictional approaches; legislation, regulations and policies

Abstract

Background

Over the past decade in Canada, violence in the health sector has increased impacting the health of nurses and all front-line health care workers. Both the numbers and severity of violent incidents appear to have risen. Violence is particularly prevalent in long term care facilities, emergency rooms and mental health facilities. As the costs of violence-related lost-time claims continue to rise, governments and other health care stakeholders have taken notice, catalyzing a response to workplace violence.

Methods

Nurses' unions in Nova Scotia, New Brunswick, Ontario and Alberta, as well as the Canadian Federation of Nurses Unions (CFNU), are building coalitions to address violence in the health care sector. Working together across jurisdictions, they are uniting in their commitment to breaking down the silos when it comes to the issue of violence, towards integrating and disseminating best practice interventions across all health care settings, learning from both domestic and international violence prevention efforts.

Findings

Workplace-related violence is growing at an alarming rate, with the number of reported incidents rising year-over-year. Violence correlates to patient contact time so front-line health care workers are most at risk: CFNU's recent research notes that the number of violence-related lost-time claims for front-line health care workers has increased by almost 66% over a decade, exceeding the rate of increase for police and correctional officers combined. CFNU's national poll found that 61% of nurses have had a "serious" problem with some form of violence during a 12-month period, and significantly, two thirds (66%) of those polled have thought

about leaving their jobs. National polling numbers reflect similar findings in jurisdictions across Canada. While the costs to our health care system are enormous, including increased absenteeism and higher turnover, there are also personal costs to nurses who may suffer from both the physical and mental health consequences of traumatic violent incidents. And there are costs to patients, whose quality of care suffers. Violent workplaces are dangerous for everyone and impact patient outcomes. Increasingly, governments, employers, unions and other stakeholders are recognizing this reality and building coalitions in the health care workplace to address violence through the systemic implementation of multi-pronged approaches to address the factors that lead to violence. The fundamental premise underlying this work is that violence cannot be tolerated as *'just part of the job'*.

Implications

This workshop will provide stakeholders with an overview of the jurisdictional efforts being undertaken to address violence in the health care sector through stakeholder engagement and coalition building. It will identify some of the keys to successful coalition building leading to positive change, as well as highlighting some of the challenges in engaging with stakeholders to address violence.

Participant Engagement

- Handout materials, including recommendations, policies, etc.
- Seek guidance to address challenges in coalition building
- Share national/international best practices

Learning objectives

Participants will...

1. compare/contrast the different approaches to violence prevention in the healthcare sector across various jurisdictions and nationally in Canada.
2. develop a better understanding of the process involved in stakeholder engagement and coalition building nationally and within several jurisdictions in Canada.
3. be able to identify both the enablers and the barriers to change in implementing violence prevention measures in the healthcare sector through stakeholder engagement.
4. learn how to engage with stakeholders to bring about meaningful, sustainable top-to-bottom changes within organizations in order to implement best practices in violence prevention.

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The Impact of Security Services on a Positive Patient Experience and Staff Safety

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Paper

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Keywords: Security, Protection Services, intervention and prevention, reducing violence, healthcare, collaboration, partnerships, patient centred care

Abstract

At Michael Garron Hospital (MGH), proprietary security has played a significant role in establishing and sustaining the comprehensive Workplace Violence Prevention (WVP) program. During the program's development, MGH benefitted from detailed data provided by the security team. Over the last 15 years, as the program matured, the security department has partnered with clinicians and has become a member of the circle of care. It is the collaboration between health professions and security that has positively impacted both culture and day-to-day safety by greatly reducing staff, physician and patient injury severity and creating a safe environment for patients and their care team. In 2003, the proprietary security department at MGH committed to improving the quality of service delivery through the application of a new training curriculum. Given the large role security plays in the care and services provided to patients, a stringent annual training curriculum for all security agents was mandated. The curriculum is consistent with patient centered care values and the legal, ethical and moral delivery of security services in a health care environment. Training has been instrumental in developing the confidence of security and clinicians in the quality of services related to workplace violence prevention and intervention. Clinical providers in the organization have come to rely on the expertise of the security department in ensuring, not only safe verbal and physical management of aggression, but also in providing preventative presence and support for the care team in both care planning and implementation. The utilization of security in care planning and risk analysis has greatly benefited patients, as the care environment is assessed to reduce triggers for violent behaviour and the risk of injury to patients and clinical staff is significantly reduced. Security continues to be engaged in the care planning process with clinical staff on a daily basis to ensure a safe environment for all.

Background

Violence is an unfortunate reality in healthcare. As a full service, urban, community teaching hospital, Michael Garron Hospital (MGH)| Toronto East Health Network, is located in East Toronto, one of the most diverse neighbourhoods in the country. Situated in a vibrant community of 400,000 people within 22 distinct neighbourhoods, it holds some of the highest needs and most culturally varied areas in the city, adjacent to those of privilege

and wealth. The population is comprised of a high percentage of newcomers to Canada, children, and a growing number of seniors. It is also a thriving, dynamic, and changing community subject to emerging issues, such as gentrification. Some of the challenges with serving such a unique patient demographic include populations with low incomes and low levels of education (Murphy et al., 2012). The catchment area of the hospital 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). The Hospital has seen an elevated number, over the years, of incidents including, criminal offences, threats, thefts, and disturbances, including incidents involving weapons, police, and the management of aggressive and violent behaviour. Even with a proprietary security team, insufficient training, a traditional model of security patrol and increased use of force when responding to calls of aggression created an immediate need to address the prevalence of workplace violence growing at MGH. In 2003, the Protection Services department, along with senior leadership, committed to improving the quality of service delivery with a particular focus on reducing the use of force and improving the overall interactions between Protection Services agents, clinicians and patients. Over the last 15 years, as the program matured, the Protection Services department has moved away from a traditional security model to partnering with clinicians in the delivery of care. This collaboration has positively impacted the culture at MGH creating a safe environment for patients and their care team while greatly reducing staff, physician and patient injury severity.

Context

Workplace safety and wellness has always been a key driver at Michael Garron Hospital. MGH recognizes that a component of being mentally well at work is associated with an individual's feeling of being physically safe and secure while on the job. Feeling safe at work is highly linked to overall engagement which correlates to higher quality care and patient satisfaction. As a strategic priority, workplace violence prevention evolved to become a well-rounded program consisting of a blend of training and non-training solutions. The program currently covers all elements of worker safety from policies, procedures, risk assessments and staff training. As the breadth of violence prevention strategies at Michael Garron Hospital became more comprehensive, the organization and other key stakeholders relied on detailed data provided by security to ground the work and look for opportunities. Through this data it became increasingly evident that security played a vital role in the overall response and prevention of incidents of aggression and/or violence. At the time of review, security was in-house, patrolling at random and therefore not present on the unit when an incident occurred and primarily focused on aspects of building security, such as; doors, surveillance footage, lighting, etc. Through a detailed analysis of existing policies and procedures, and a review of newly tracked metrics, such as the use of force during patient interactions, it became clear that a new direction and commitment to patient and staff safety was required. As the program expanded and matured, the security department began to develop its own proactive practices and tools to support a safe environment for all.

Methodology

Detailed data was collected and analyzed related to all security services delivered over the course of the program redesign. This allowed for focussed review of opportunities. Data included location of incident, incident type, incident severity, injury rates and use of force application by Protection Services agents. Data indicated the use of force application was in excess of 50% during interactions involving patients. To substantiate the data, observation of security interactions were conducted to assess how Protection Services agents were responding to calls of aggression. Observation and data confirmed the high use of force application. Following observations of security responses and subsequent debriefs, it was noted that clinical staff's perception of security lacked trust and confidence. This information established that Protection Services agents required a more appropriate toolkit of skills to manage escalating behaviours and crisis effectively and to improve the patient experience, staff safety and confidence. The gap analysis led to the determination that the training received to date was not effective enough when interacting with a vulnerable patient population which, compounded the lack of confidence from clinical staff. To address the first identified gap, training was procured from an external expert and was rolled out initially and continues to be offered annually as a mandatory refresher. The focus of the curriculum is on crisis management, effective communication, Criminal Code applications and resistance management techniques designed to ensure physical safety and to reduce the risk of injury to participants in a violent encounter. The curriculum is consistent with patient-centered care values at MGH and the legal, ethical and moral delivery of security services in a health care environment. Over the course of the training rollout, an immediate correlation was made between quality of training and the reduction of force and improved verbal management of escalating behaviours. The development of detailed procedures for security to follow, such as restraint application, search methodology, and patrol standards were implemented as a result of the training received. Patrol standards, in particular were modified to focus on visibility related to safety and to promote relationship building. As part of the new patrolling standards, Protection Services agents were to round on patient units. Agents were to initiate focused check-ins with the charge nurse or manager; thereby proactively identifying staff concerns and potential safety risks. Any identified risks were documented throughout their shift and compiled prior to shift change. All details are documented through an electronic pass-on log and information is disseminated to all clinical staff and leadership across the hospital to maintain transparency on the risks within the organization.

Data substantiated the effectiveness of training, improving trust for Protection Services, and the operational data to support ongoing prevention of workplace violence. The shift then began at the bedside and how best to integrate Protection Services at stages of care planning. Clinicians review care plans on a regular basis and additional safety plans are implemented to manage individuals with a higher risk of aggression. As a result of the effectiveness of training and overall confidence in Protection Services, the team became involved in elements of the care planning process for at risk individuals. This integration allowed for the Protection Services team to provide a level of expertise on strategies and intervention techniques available to support clinical staff in providing high quality, patient centered care in a safe way. Where care plans and safety plans were not pre-established, lunch and learn sessions were, and continue to be conducted, between Protection Services

agents and clinical staff in the Emergency department. The sessions have allowed for communicating lessons learned during security training and effectively how best to integrate security during patient interactions. This has led to an understanding on scope of practice and more effective utilization of security in a preventative role rather than a reactive one. The clear understanding by clinical staff of what processes and skills were now available from Protection Services agents has caused a measurable increase in the utilization of security in a preventative role.

Findings and Discussion

The combination of enhanced training and the collaborative relationship between Protection Services and clinicians has directly impacted both staff satisfaction and patient satisfaction throughout the organization. The rigorous training curriculum has been instrumental in developing the confidence of security and clinicians in the quality of services related to workplace violence intervention and prevention. Data used previously to assess the current state of the organization was used to measure the impact of the training program. Results showed an increase in effectiveness in Protection Services agent's verbal de-escalation and physical intervention skills through a notable reduction in use of force application. MGH has seen the application force during patient interaction reduced from over 50% in 2003 to less than 5% in 2017. The confidence of staff in Security for preventative measures is evident with the ratio of prevention-related patient services to intervention in violent incidents 8 to 1. Injury rates for clinical staff have reduced with lost time incidents related to workplace violence at a minimum. In the old model, when Protection Services was involved in a patient interaction there was a negative perception on the interaction and was sometimes referred to patient relations. With the integrated model, the number of complaints regarding the performance of security personnel tracked by patient relations has reduced with an increase in positive feedback from both patients and staff on security interactions.

De-escalation of potentially violent situations and the safe management of physical violence occurring in the facility has shifted organizational culture around to the use of Protection Services. Rounding Protection Service agents target units with high-risk patients or where staff express concern. Protection Services are integrated into daily safety huddles and provide input on patient management during the care planning process. Examples include clinical staff calling pre-emptively for security assistance to stand-by during medication administration for high-risk patients. With the newly developed skill set, Protection Service agents are seen as a valued part of the team changing the dynamic in which they interact with patients, fostering a sense of concern for the patients' well-being and safety rather than a previous focus on building safety. Based on a research study conducted by the Institute of Work and Health, 83% of staff at MGH feel that workplace violence is a strategic priority and 77% feel that the organization takes effective action to prevent workplace violence (Institute for Work and Health, 2018). This change alone has increased the level of satisfaction in their role as Protection Service agent. This has positively impacted managing responsive or violent behaviour and as a result patients are often more cooperative with security. According to annual staff engagement results, conducted by National Research Corporation of Canada (NRC), 67.5% of staff feel they are able to meet the individual needs of the patients which has a direct correlation to patient satisfaction scores. The integration of security in care

planning and risk analysis has greatly benefited patients, as the care environment is assessed to reduce triggers for violent behaviour and the risk of injury to patients and clinical staff is significantly reduced.

Staff engagement scores have shown that a culture of teamwork and safety is prevalent in the culture at MGH with 83.7% of the staff population experiencing no physical violence from patients, clients and public. Of those who unfortunately experience workplace violence, 77.1% felt appropriate action was taken. Anecdotally, clinical staff express the appreciation and value of teamwork with security. That sense of team is also fostered through security's preventative presence and support for the care team in both care planning and implementation. When a code white does occur, the security team are involved in the debrief with the clinical team on the unit. This practice is carried over when mock code whites are conducted around the hospital. This demonstrates and continues to build a sense of team.

Michael Garron Hospital has a well-entrenched and recognized workplace violence prevention program that has earned the hospital accolades within the hospital community and recognition from government bodies. The trust and confidence of our clinical providers in the services provide has directly impacted not only our organization but our external partners as well. MGH has partnered with other community hospitals to help share and spread this initiative across the healthcare industry. Our contribution in healthcare security provision has had positive impacts with the Toronto Police Service, our union partners and allowed us to contribute effectively on the development of workplace violence prevention tools externally. The establishment, development, maturity and, most importantly, the integration of security into daily operations with clinical partners, has improved both patient and staff safety.

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Learning objectives

Participants will...

1. appreciate that security inclusion in all aspects of patient care has a positive impact on WVP culture and both patient and positive staff safety
2. learn that strategic partnerships and collaboration are keys to instilling clinical confidence in the provision of security services and providing early preventative strategies.
3. understand that security services can have a significant impact upon patient safety and developing a positive patient centered care environment.

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The Long Road: Building a Violence Prevention Program in a large Provincial Health System

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Paper

*Norma Wood
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Keywords: Violence, Workplace violence prevention program, Collaboration, Types of violence, Violence alerts, Reporting and Tracking violence, Communications, Psychologically Safe workplace

Abstract

The audience for this international conference may be well aware that 33% of incidents of workplace violence in Canada occur in social services and the health care environments (Statistics Canada), and that health care workers rank third behind police officers and first responders as victims of violence. Over many decades, acceptance of aggression and violence is a cultural norm in some health care environments.

Alberta Health Services (AHS) is a Canada's first and largest province wide, fully-integrated health system, responsible for delivering health services to the over four million people living in Alberta, as well as to some residents of Saskatchewan, B.C., and the Northwest Territories. AHS has over 108,000 employees, and 8,000 physicians are affiliated with the organization across more than 650 sites. Preventing workplace violence in such a large and complex provincial health system is a daunting prospect.

AHS started on this journey in 2011 when Accreditation Canada put in place a Required Organizational Practice for Preventing Violence in the Workplace: AHS' foundational program was accredited in 2014. Since that time, as part of Our People Strategy, efforts have focused on making resources more visible and accessible, building toward an electronic patient violence alert system, establish a comprehensive, sustainable training program for 30,000 at risk workers and strengthening violence reporting through the provincial health and safety reporting system – MySafetyNet.

Alberta Health Services recognizes that workplace violence prevention is much larger than an "initiative"—it is part of a cultural transformation in a workplace that fosters psychological safety and recognizes that quality patient care is enabled by people who feel safe and supported. AHS would love to share successes and challenges with you as the organization continues its journey toward a safe, healthy and inclusive place to work.

In this presentation AHS will:

- share the work the organization has completed to date across four categories of violence, including successes, learnings and next steps;
- provide an overview of the resources and supports for front line staff, including policies, violence alerts, incident reporting, training strategies and communications materials;
- talk about the importance of shared ownership with various stakeholders such as unions, workplace health and safety, frontline employees, leaders and contractors;
- share successful communication tools, co-developed with Union partners, that have been used to create awareness of violence in the workplace; and
- share the key struggles, hardships and “*dead ends*”.

Key messages: policy and program development and culture change related to violence prevention in a large public sector organization are complex and take time, but are both worthwhile and necessary.

Learning objectives

Participants will...

1. Gain an awareness of Alberta Health Services’ approach to workplace violence, including successes, failures and learnings.
2. Have a deepened understanding of the ways in which the size and complexity of large systems have an impact on program implementation, and discuss strategies for success.
3. Receive impulses to prompt dialogue about the need for extensive and committed collaboration to mitigate this significant risk in health care environments.

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Pediatric Behavioral Emergency Response Team

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Poster

Reginald Bannerman, Michael Ruiz, Maggie Finke, Laura Welch, Theresa Wavra, Susanna Oley Smith, Brenda McNeely, Ram Oula, Linda Talley
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Keywords: Aggressive, Disruptive Patient, Behavioral Emergency Response Team (BERT), Crisis Prevention Intervention (CPI), De-escalation, Acting Out, Restraints, Acute Agitation

Abstract

Our organization began to see an increasing number of patients who exhibited aggressive and violent tendencies, particularly behaviorally complex patients, requiring extensive care and resources. Our noble goal was to decrease the number of violent acts or threats against employees and improve the care of the patient using an interdisciplinary team that could rapidly respond to assist and/or take the lead in de-escalating these patients. A collaborative interdisciplinary taskforce came together from psychiatry, nursing, medicine, security, social work, and performance improvement to address this challenge.

The solution implemented by the taskforce was the Behavioral Emergency Response Team (BERT). The BERT is an integrated team from Psychiatry, Emergency Department, Social Work, Unit Charge Nurse, Security, and Medicine. It was piloted on a small scale. A special code “BERT” was created. Equipment bags with mechanical restraints were made. A BERT Debrief Form is used for each BERT response. Psychiatry, attending physicians, pharmacy, hospitalists, information technology, and hospital committees created medication order sets for acute agitation for the electronic health system. The medications were added to the medical units Pyxis machines. The BERT members completed CPI and simulation training, and front-line staff also completed CPI training. The CPI mythology was to ensure a shared mental model during emergencies. The BERT works collaboratively with the bedside care team to devise a plan to manage an emergent behavioral health crisis using interventions that go from least restrictive to most restrictive and include effective verbal de-escalation techniques, medication recommendations, and therapeutic holds and mechanical restraints as a last resort.

There were 14 BERT calls during the pilot period between April 2017 and January 2018. The outcomes were 85% of the time no mechanical restraints were used, 93% of the time no staff injury reported, 100% members of the BERT team responded during emergency, and feedback from post call evaluations was positive. Over 700 staff was trained in CPI. There was a noted increase in the competency and confidence of staff in caring for this difficult patient population. A 51% decrease in the rate of disruptive, violent or threatening acts from patients to employees (3.264 events/ 100 incident reports to 1.591 events/100 incident reports). There was also a 63% decrease in the absolute number of disruptive, violent or threatening acts from

patients to employees (25.91 events per month to 9.44 events per month). The success of the pilot is attributed to the involvement of many stakeholders but most especially the outstanding engagement of our executive sponsors.

Engaging employees with little to no experience working with psychiatric patients is critical to developing the skills, confidence and competence to care for the wide spectrum of patients presenting to pediatric facilities. This CPI training, coinciding with the BERT Response team have decreased harm events and improved employee satisfaction regarding a safe work environment. It is expected that we will continue to implement BERT hospital wide.

Learning objectives

Participants will...

1. be able to identify a method for improving how pediatric patients with aggressive and violent behavior can be managed.
2. be able to evaluate their readiness to implement a practice change such as Crisis Prevention Intervention (CPI) combined with a Behavioral Emergency Response Team (BERT).

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Understanding Patient-to-Staff Violence and the Path Forward to Reduce Staff Harm

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Paper

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Keywords: Patient to Staff Violence, Workplace Violence, Skilled Staff, Interviews, Survey, Critical Decision Method, Qualitative Research, Quality Improvement

Abstract

Background/Context

Patient-to-staff violence is a significant and increasing problem across most health systems, and post-incident online reporting systems provide an incomplete picture of these events. Typical reporting systems yield limited information on the variables influencing outcomes and give no indication of why some approaches work and others do not. We are conducting a combined qualitative research and quality improvement project to investigate more deeply the specific circumstances of individual events as well as the perspectives and approaches used by staff considered adept at managing violent patients and de-escalating potentially violent situations. Our approach uses the Critical Decision method of interviewing (CDM), a guided technique for exploring experts' insights about subtle cues they perceive and that influence their decisions in those moments. Findings from these interviews and from a survey of health system leaders' opinions regarding activities in place to reduce workplace violence will lead to recommendations for actions to prevent patient-to-staff violence.

Methodology

This project is being implemented at Trinity Health, a large health care system encompassing 94 hospitals in 22 states. Up to 120 leaders across Trinity Health will be asked to respond to a survey about existing activities in their organizations designed to reduce patient violence and staff harm and their perspectives on those activities' effectiveness. Researchers will use the CDM, a cognitive task analysis technique, to interview a total of 24 staff from four Trinity Health hospitals involved in incidents with violent patients within one week of the event and approximately 18 staff from those hospitals who are perceived as particularly skilled in managing violent or potentially violent patients. The CDM interview is an iterative process that begins with the individual describing the event (or a past event they recall, in the case of the expert staff); the interviewer repeats back the description to verify understanding. The individual is asked to describe the event again, but with deeper questioning and probing by the interviewer for timeline details, decision points, and situational cues that might have been

considered only subconsciously during the event. Analysis draws out themes and identifies experts' unique insights that allow them to succeed in these situations.

Findings

The survey and interviews begin in March. We anticipate findings will be available in late summer.

Implications

We expect the results to provide insight into: 1) the breadth and relevance of prevention activities currently underway across Trinity Health; 2) situational factors influencing specific violent events as interpreted immediately after those events by those involved; and 3) subtle cues perceived by skilled staff and the insights and techniques used by those staff to mitigate violent events. We plan to use these findings to guide development of new or revised practice standards, policies, education and training within Trinity Health and to inform future research on preventing, de-escalating, or mitigating staff harm from patient violence.

Learning objectives

Participants will...

1. identify at least two cues or approaches skilled staff use when interacting with potentially violent and/or violent patients to de-escalate the situation and reduce staff harm.
2. identify two highly regarded violence prevention activities reported in a survey of leaders throughout Trinity Health.

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Skills Enhancement for Aggression Management (SEAM) in Inpatient Medical Settings

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Paper

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Keywords: Medical settings; inpatient hospital, aggression, education, needs assessment

Abstract

Background and Context

Disruptive behavior is difficult for medical nurses to manage on busy inpatient medical units. Increasing numbers of individuals are hospitalized with concomitant disruptive behavior including delirium, dementia, substance intoxication or withdrawal, mood instability, or psychosis. A needs assessment was developed to identify needs of managers, nursing staff, and individuals with disruptive behaviors and to collaboratively develop interventions and educational supports to deliver high quality care to this population in inpatient medical settings.

Objective

To develop a needs assessment to identify and implement intervention for disruptive behavior in inpatient medical units.

Methodology

Assessments of needs of managers and staff members were completed, and other resources in the hospital system were included to identify resources, strengths, and needs for education and intervention in 2 inpatient medical units. Meetings were held with managers and staff to discuss results of the assessment and obtain feedback to prioritize implementation of educational interventions.

Findings

Results of the initial needs assessment indicated that the inpatient medical units had many similarities and important differences that could be used in planning to address the educational and development needs on each unit.

ImplicationsPlans were identified to address the following priorities:

- Proactive behavioral assessment paired with preventive intervention as a foundation for planning behavioral intervention.

- A need to better understand how and when to use resources, and how to collaborate on care when resources arrive on the unit.
- Develop ‘*Behavioral Health Leads*’ on each unit, to integrate and translate programs on each unit.
- Provide an Advanced Practice Psychiatric Nurse to role model and problem solve related to care will address the specific needs to integrate physical and mental health care.
- Develop criteria for admission and patient mix on each unit and adaptive models to provide resources and support for staffing needs to assure patient safety and improve behavioral health outcomes.
- Development of adaptations to provide a therapeutic environment and manage the context and environment of behavioral care on each unit.
- Nursing staff are often in the middle of patient, family and providers in providing information on changes in care or treatment. Develop interventions to improve the interdisciplinary model of caregiving and communication on each unit.
- Develop daily structure and activity on each unit to assist in managing behavior and providing distraction and diversion.
- Integrate a proactive, preventive approach to managing behavioral health patients that involves the patient in daily identification of goals and activities to accomplish them.
- Utilize existing behavioral care plans and develop algorithms for difficult to care for patients that can guide nursing care.
- Interest was identified to evaluate for changes in rates of patient aggression and worker exposure to aggression, and worker related criteria such as turnover and absenteeism.

Learning objectives

Participants will...

1. discuss construction of a needs assessment to identify nursing staff perceptions of needs for education, intervention and planning for behaviorally disruptive patients.
2. identify priority needs for education and intervention identified by managers and nursing staff related to disruptive behavior in inpatient medical patients.
3. describe methods to collaborate with managers and nursing staff to develop a plan for positive proactive practices to intervene with and support staff related to disruptive behavior.

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Violence against health care workers: putting the perpetrator in the picture

Subtheme: Engaging with multiple stakeholders in seeking an implementing solutions

Poster

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Keywords: Violence, aggression, perpetrator, intervention, emergency health care

Background

The recent 'It's never OK' campaign in Australia has re-emphasised the high incidence of violence against health care workers. The key message is that violence against health care workers is unacceptable, which is also evident from the numerous interventions in this area.

Many anti-violence interventions focus on the victim (health care worker) by offering self-defence and de-escalation training and education. Another group of interventions is organisation-focused, such as more security personnel, mandatory reporting, or new legislation. For example in rural and remote areas, new Australian legislation ('*Gayle's Law*') prohibits nurses from working solo in remote areas.

A consequence of both these approaches is that they contribute to a normalisation process for the worker. Violence has become an unavoidable, normal part of their job. In the triad of worker, organisation, and perpetrator, the perpetrator is more often than not invisible. When attention is given to the perpetrator, a punitive approach is frequently taken without any evidence that this helps to reduce violence.

There is a need for co-designed interventions focused on the perpetrator and taking a positive rather than a punitive approach in order to curtail violence and aggression against health care worker. In this contribution we present our integrated research program in progress that will inform the development of an intervention. We aim to design and trial a perpetrator-focused intervention to reduce violence against health care workers.

Methodology

Preliminary Studies

- A Cochrane review on organisational interventions for the prevention of aggression against health care workers by patients and patient-advocates;
- A study on Code Grey/Black security alerts in the Emergency Departments (ED) of rural Australian hospitals;
- Interviews with rural paramedics about their experience of aggression and violence.

Intervention Study

- Focus on selected perpetrator populations;
- Non-punitive approach;
- Rigorous analysis and consideration of application to practice.

Findings**Violence and interventions**

- Health care workers are more vulnerable in uncontrolled settings (e.g. paramedics and others working in rural and remote areas).
- Organisations invest heavily in many different interventions such as body cams, campaigns, courses, policies and protocols, Location of Interest (LOI) systems, and on-site security staff.
- There are very few published evaluations of the impact of these interventions on violence reduction.

The perpetrator

- The majority of incidents appear to involve patients with mental health issues or under the influence of alcohol and/or drugs;
- A large proportion of incidents involve repeat offenders;
- Health care workers express frustration at the lack of follow-up or consequences for the perpetrator;
- Perpetrators appear not to be part of the picture.

Implications for practice

- A focus on the perpetrator of violence in a positive way might contribute to a safer workplace.
- Acknowledging the importance of including the perpetrator in the picture might help to counterbalance the trend to accept violence at work as '*normal*'.

Learning objectives

Participants will...

1. understand the importance of a focus on the perpetrator to tackle violence and aggression against health care workers.
2. identify the need to develop evidence based interventions to reduce and prevent violence against health care workers.

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Chapter 5 – Education and training

Workplace Violence among Healthcare Workers in Public Hospitals of East Shoa Zone, Oromia Region, Ethiopia

Subtheme: Providing education and training

Poster

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Keywords: Workplace, Violence, Hospitals, Oromia, Ethiopia

Abstract

Introduction

Workplace violence in the health sector is a worldwide concern with healthcare workers being at high risk of being victims. Although interest in Workplace violence in the health sector has grown considerably within the developed world, it still appears to be an unrecognized issue in many developing countries including Ethiopia.

Objective

To assess the prevalence and associated factors of workplace violence against healthcare workers in public hospitals of East Shoa Zone of the Oromia Region, Ethiopia from March to August, 2017.

Methods and Materials

Hospital based cross-sectional study was conducted using quantitative data collection method. About 261 healthcare workers who have direct communication with patients/clients were selected from four Public hospitals. Data was collected using self-administered questionnaire. The collected data was double-entered into EPI-INFO version 3.3.1 statistical packages and exported in to SPSS version 21 for analysis. It was principally analyzed using logistic regression models after checking all the assumptions to be fulfilled.

Results

The prevalence of workplace violence among healthcare workers was 70.2%. Physical violence accounted for 22.5%, verbal abuse for 65.1% and sexual abuse for 4.1%. Types of health institutions (AOR, 6.79; 95%CI: 2.98, 15.45), work experience (AOR, 2.76; 95%CI: 1.31, 5.89), professional category (AOR, 0.32; 95%CI: 0.10, 0.98), frequent interaction with patients

(AOR, 3.13; 95%CI: 1.08, 9.04), and wornness about violence (AOR, 2.65; 95%CI: 1.02, 7.08) were predictors of workplace violence among healthcare workers.

Conclusion and recommendations

A significant proportion of healthcare workers faced workplace violence. Types of health institutions, work experience, professional category, having frequent interaction, and wornness about violence were factors significantly associated with workplace violence among healthcare workers in the study area. Policy makers and stakeholders should focus on workplace violence prevention strategies.

Learning objectives

Participants will...

1. Learn about the prevalence and associated factors of workplace violence against healthcare workers in public hospitals of Ethiopia.
2. Realize the necessity for education, training and policy issues.

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De-escalation: The Assault Cycle revisited

Subtheme: Providing education and training

Paper

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Keywords: De-escalation; Assault cycle

Abstract

Background

Multiple sources of regulatory standards and practice guidance for the health care sector stress the important role that de-escalation may play in averting violence and in reducing the potential for the use of restrictive interventions. The evidence supporting the effectiveness, or otherwise, of de-escalation as an intervention is actually notably weak. There is no consensus on the processes involved and considerable disagreement regarding what the core skills are.

While training in de-escalation is now increasingly widespread, there is significant diversity in the focus, content, duration in the skills taught. Nonetheless, in terms of underpinning theory, the Assault Cycle in a number of iterations appears a common source reference.

While the assault cycle has provided some educational and clinical utility, the thirty five years since its initial description have witnessed major advances in our understanding of the neurological, psychological and sociological implications of trauma in contributing to behavioural escalation. In the context of such advanced knowledge, and this ongoing paradigm shift, the degree to which the assault cycle serves as a contemporary and comprehensive model of aggressive incidents, and therefore its continuing appropriateness, have not been critically explored.

Methodology

A non systematic review of the literature on the use of the assault cycle identified multiple expositions of the model and its relevance to de-escalation in particular. Evolution in its interpretation and application was identified. The original phases of escalation have over time have been added to and stage specific staff interventions suggested.

Findings

No references to the potential significance of trauma in either the patient or staff were identified.

Implications

A novel iteration of the assault cycle was developed incorporating explicit acknowledgment of the neurological and psychological implications of trauma for the assault cycle. The implications of this development for policy, training and practice are significant in providing an updated interpretation of a widely used conceptual model that increases its relevance to populations where the incidence of complex trauma may be notably high.

Learning objectives

Participants will have the opportunity to...

1. Consider the assault cycle in the context of recent major advances in neurological, psychological and sociological knowledge.
2. Consider a reformed iteration of the assault cycle which acknowledges the neurological, psychological and sociological factors which influence behavioural escalation.
3. Consider the implications of this revised model from policy, training and practice perspectives.

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An Education Protocol for Responding to Violent Behavioral Emergencies

Subtheme: Providing education and training

Poster

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Keywords: Behavioral Emergencies, Education, Protocol

Abstract

Background

Violent behavioral emergencies are a common occurrence on inpatient psychiatry units, leading to workplace hazards for staff members and patients. The key to safely controlling such situations is the seamless coordination between interdisciplinary staff. There are many different education models that outline responses to violent situations, each with particular strengths, which could be combined to create an ideal model.

Aims/Methods

Using the information gained from our previous review assessing the different education models on violent behavioral emergencies/codes provided for interdisciplinary staff a detailed protocol for management of violent behavioral instances and aggression on the inpatient units will be developed. This detailed protocol will outline the important roles of each member of the interdisciplinary team (including attending physicians, resident physicians, nurses, occupational therapy, and social workers). Through literature review, the effect of such protocols in different hospitals will be examined.

Results

The implementation of such a protocol, with appropriate education of staff regarding its logistics, is expected to improve the response to behavioral emergencies, decrease risk for staff injury, and avoid behavioral escalation.

Conclusions

Behavioral emergencies, especially violent ones, place interdisciplinary staff at risk for injury, if improperly managed. Not only is it important for interdisciplinary staff to be trained and educated properly, but having a detailed, protocolized response to these situations is expected to decrease injury and further escalation.

Learning objectives

Participants will...

1. learn in depth about a proposed protocol for responding to violent behavioral emergencies.
2. examine how implementation of similar protocols at other institutions has affected staff safety, violence and response.

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Prepared and competent: outcomes of competence development within Norwegian community mental health and substance abuse services

Subtheme: Providing education and training

Paper

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Keywords: Mental health work, substance abuse services, education, phenomenography, recovery-oriented services, person-centred healthcare

Abstract

Since late 2010 the Municipality of Oslo, Norway has made available a range of competence endeavors aimed at staff working in home based mental health/substance abuse services. The main aim of the specific education and training afforded has been to provide both practical and theoretical knowledge about prevention and management of violence during the provision of home based services to service users with mental health and/or substance abuse challenges. Footed within a framework of decentralized, recovery-oriented and person-centred healthcare and social work, the various education and courses promotes attitudes and values of acceptance and emphatic presence with personnel in mental health and substance use services. Our approach also recognizes the importance of qualified risk assessment and management, and aspire to make tools for this available both for participating services. The education and training thus seeks to advance positive practice and a safe and competent underpinning for the management and prevention of staff-directed violence in municipal services.

The Municipality of Oslo offers education and courses in prevention and management on both more general levels, as well as more specialized and advanced levels, involving different strata of the organization. Acknowledging favorable management and prevention of violence toward staff as contingent on the quality of cooperation of different levels and parts within the organization, the competence endeavors have been tailored to meet organizational needs such as intra-and-extra-organizational cooperation and the transfer and sustainability of competence within practice. This have been sought by involving managers as well as employees in our different educational endeavors, and equipping select staff with in-depth competence in principles and strategies of risk and violence prevention and management, as well as the educational skills and abilities to transfer and perpetuate competence within own services.

We have since 2017 conducted a research project in an effort to gauge the outcomes of the various competence endeavors on practice in mental health and substance use work. The project-design is from within a descriptive, phenomenographic research tradition, informed by variation theory's view of competence as the individual – yet socially constructed - understanding of

one's work, and focuses on the participants' varying conceptualizations of the phenomena of practice in threatening or violent situations. Changes in the conceptualizations of the phenomena – following participation in education and courses – are assessed by applying interview data from participants from both personnel, managers and service users. In this presentation we wish to present our findings from two of our current substudies. These are the outcomes as identified in participants from general, non-specialized courses and managers' conceptualizations of competence-development and practice change in own services following participation in education and courses on prevention and management of violence and violent threats.

Learning objectives

Participants will...

1. learn of examples of conducting education and training for practice development within the field of violence prevention and management.
2. Gain an introductory understanding into the in phenenomenographic assessment methodology and explication of practical usage of variation theory in practice change and competence development.

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Decreasing Workplace Violence By Responding To Factors And Behaviors That Precede Aggression

Subtheme: Providing education and training

Paper

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Keywords: Type II workplace violence, disruptive behavior, registered nurse, intervention, prevention and evidence-based practice

Introduction

There is little debate that violence in hospitals is a growing problem where incidents are reported in the media almost daily, and many more likely go uncovered by news outlets (Crafton, 2015). The Joint Commission (2010) points out that hospitals are open to the public around the clock every day of the year and securing the building and grounds presents specific challenges since it would be difficult to thoroughly screen every person entering the facility. Nater (2012) points out that violence in hospitals is both an institutional threat and contentious reality facing governing bodies, leadership and security directors throughout the healthcare industry.

The Occupational Safety and Health Administration (OSHA, 2015) defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide.

McPhaul, London and Lipscomb (2013) stated that workplace violence is a dangerous and complex occupational hazard in the modern health care work environment, presenting challenges for nurses, other health care employees, management, labor unions and regulators. Blando, Ridenour, Hartley and Casteel (2015) point out that nurses and allied health care professionals are at an increased risk of workplace violence compared to other professionals.

The United States Bureau of Labor Statistics (USDOL [2013]) reported that healthcare workers are nearly four times more likely to be injured as a result of workplace violence and require time away from work (15.1 per 10,000 workers) as compared to all workers in the private sector (4.0 per 10,000/workers). A 2011 study with 7,169 emergency nurse participants, completed by the Emergency Nurses Association Institute for Emergency Nursing Research revealed 54.5% of the participants experienced physical violence and/or verbal abuse during a seven-day period (during which the participants worked an average of 36.9 hours in an emergency department).

Methods and Results

A convenience sample, one group, pre-post-intervention methodology was used for this project. The pre-test/post-test design is commonly used for the purposes of comparing groups and measuring change resulting from a treatment or intervention. The educational program focused on the recognition of escalating patient aggression and implementation of interventions to minimize assaultive behaviors. Staff's knowledge was measured prior to and immediately following the program. A program evaluation tool was also distributed to the participants following the educational session to secure the learner's feedback regarding the program content, environment, materials and trainer. The skill lab session was held 6 weeks following the program to measure the application of knowledge to performance.

The educational program, lasting 60 minutes was held on October 10, 11, 12 and 13, 2016 at various times to accommodate all 3 shifts. The educational program entailed the administration of a pre-test, slide presentation, group discussion and the administration of a post-test. The test and slides are adapted from the Emergency Nurses Association (ENA) "*Workplace Violence Prevention: Know Your Way Out*" program materials. Permission was obtained from the Emergency Nurses Association to utilize program materials. Eight RNs and 6 unlicensed assistive personnel participated in the program. In addition to the pre and post-test, participants completed a program evaluation tool following post-test completion.

Post Education

Six weeks following the intervention, a skills assessment session was conducted. The skill session gauges knowledge applied to performance and is assessed through simulation.

Three RNs and 2 unlicensed assistive personnel participated in the skills assessment session. The skill assessment session utilized volunteer actors as "*patients*" in various stages of aggressive behavior. Actors were nurse colleagues of the project coordinator and were briefed prior to the simulation and provided with written descriptions of the emergency room environment and "*patient's*" temperament. Staff were also briefed for the simulation and provided with written descriptions of the emergency room environment and the "*patient*" condition and behavior. Individual staff interacted with the "*patient*" in the simulated experience to identify the level of environmental and patient behavioral risk (low, moderate, or high) and implement applicable risk-level interventions to minimize assaultive behaviors.

Conclusion and Discussion

This evidence-based project increased the emergency department personnel's knowledge to recognize escalating patient aggression and identify appropriate interventions to minimize assaultive behaviors as evidenced by improved post-test scores in 11 of 12 questions. The emergency staff also believed that the educational program helped them to identify appropriate responses to low, medium, and high risk levels to de-escalate/prevent workplace violence.

The increased post-test scores correlate with Gillespie et al. (2013) in their 2013 study of workplace violence prevention interventions. The researchers found that the workplace violence prevention education program led to increases in workplace violence prevention knowledge as well as the staff's belief that the classroom training could help them translate the content to their clinical practice. OSHA (2015) points out that education is a key element of a workplace violence prevention program that helps raise the overall safety and health knowledge across the workforce.

The simulation skill assessment demonstrated mixed results in the staffs' ability to implement appropriate interventions to minimize assaultive behaviors. Participants were able to implement the appropriate interventions at both the low and moderate risk levels. However, at the high risk level, there was a gap in the staff's ability to apply knowledge in the simulated exercise. Staff did not utilize the buddy system, communicate/alert co-workers, manager and security to the need for assistance, and remove patient objects that could be used as weapons.

High risk level situations are most challenging as the environment and patient are chaotic and unpredictable which requires the staff to communicate and request assistance. Staff may be reluctant to ask for needed help or it may have been difficult for staff to ask for help from team members during the simulation exercise as team members were not present.

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Learning objectives

Participants will...

1. identify components of a workplace violence prevention program that increases the knowledge and skill to recognize escalating patient aggression that precedes Type II violence.
2. evaluate the effectiveness of a workplace violence prevention program utilizing Kirkpatrick's Four Level Evaluation Model.

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Duration Reduction of Violent WSBC Claims Concomitant to Completion Rate Increase of Violence Prevention Education

Subtheme: Providing education and training

Paper

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Keywords: Violence Prevention Education, WSBC Claims, Claim Duration

Abstract

To reduce the risk and impact of violence in Healthcare in the province of British Columbia, Canada an initiative was started in 2014 to raise the completion rate of violence prevention education. Previously, the Violence Education Curriculum was available but reporting on it did not include completion rate. Additionally, the completion of the Curriculum was not a requirement to work at that time. Initially the focus of reporting was on the completion rate for the programs deemed “*High Risk*” for violent incidents, Mental Health and Addictions, Emergency and Residential Care. The curriculum for these programs included 8 online courses and two class room courses. Within Fraser Health, the completion rate of this curriculum increased from 25 to 65 for these three programs to close to 100 between 2014 and July 2017. During this period there was a significant reduction in the length of the WSBC claims due to violence. There was also a similar decrease in length of violent claims for all the programs within Fraser Health. This may be because much of the violent injuries occur in these three programs and there was also an increase in the education completion in other programs during this time. Analysis also showed that other types of injury causes were not all affected the same, such as slips/trips and falls. The rate of injuries due to violence did not decrease during this period.

Further study will be done to confirm a correlation between increased education completion rates and reduced WSBC Claim duration. If this correlation can be confirmed it would suggest that high levels of completion of such a comprehensive Violence Prevention Curriculum may not reduce the number of incidents as the patients we serve remain, but the severity of these incidents may be reduced. This would fulfill the goal of the original initiative.

Expanded abstract

To reduce the risk and impact of violence in Healthcare in the province of British Columbia, Canada a province wide Violence Prevention Education Curriculum was created. Previously, many disparate Violence Education courses were created throughout the province by BC's six Health Authorities. In order to ensure consistent outcomes throughout the province, a

curriculum was agreed to and made available to the entire province. High risk areas were determined and these areas were the initial focus of the provincial initiative. Additionally, the reporting of the curriculum was significantly improved and standardized. As the percent of staff with completed Violence Prevention Education Curriculum approached 100% a concomitant reduction the length of Work Safe BC Claim was observed within Fraser Health.

Courses on Violence Prevention had been in use in various health authorities since 2010 but the education was not provincially consistent or available. A standardized Violence Prevention Education Curriculum was agreed to with both online and classroom and made provincially available in 2014. Some changes and content updates were made to the program in July 2016. Employees were required to complete their entire curriculum prior to July 31, 2016 in order to retain the credit for the courses taken, otherwise they had to start again with the new curriculum.

	Online		Classroom	
	Pre July 31, 2016	Post July 31, 2016	Pre September 26, 2016	Post September 26, 2016
Low	1,2,4,6	1,2,3,5,6,7,8	N/A	N/A
Medium	1-8	1-8	or 4 hour class or ATR	
High	1-8	1-8	4 hour class or ATR	PVPC
High + ATR	1-8	1-8	4 hour class + ATR	PVPC + ATR

Note: ATR= Advanced Team Response and PVPC = Provincial Violence Prevention Curriculum

Course Number	Violence prevention module	Course Length
1	Overview (online)	20-30 min
2	Recognizing and Responding to Risk (online)	20-30 min
3a	Interventions in Acute Care (online)	20-30 min
3b	Interventions in Residential Care (online)	20-30 min
3c	Interventions in Community Care (online)	20-30 min
4	Communication Basics (online)	20-30 min
5	De-escalation (online)	20-30 min
6	Responding to Physical Violence (online)	20-30 min
7	Post Incident Response (online)	20-30 min
8	Behavioural Care Planning for Violence Prevention (online)	20-30 min
Classroom	4-8 Hour Course	4-8 Hour
ATR	Advanced Team Response	8 Hour

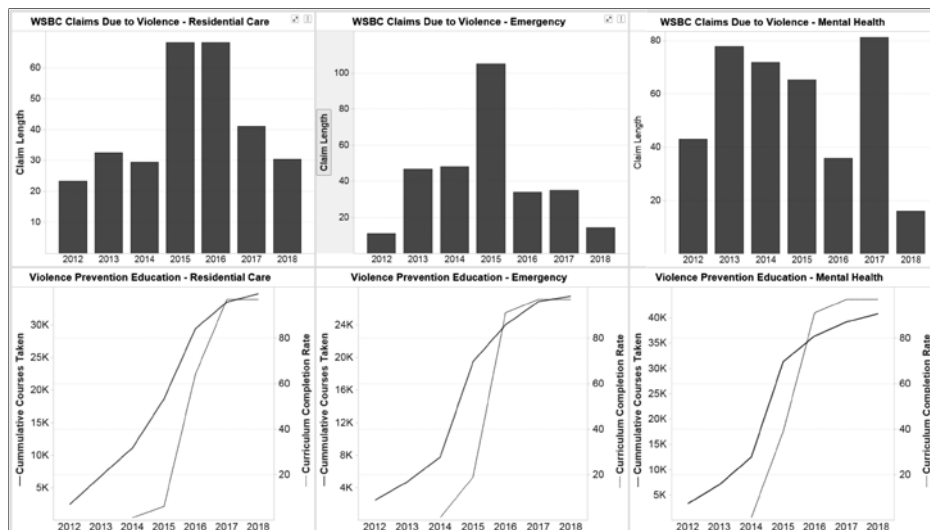
Courses Post July 2016 on Violence Prevention		
1	Introduction to Violence Prevention	20-30 min
2	Recognize Risks and Behaviours	20-30 min
3	Assess and Plan: Part 1 - Complete Point-of-Care Risk Assessments	20-30 min
4	Assess and Plan: Part 2 - Develop Behavioural Care Plans	20-30 min
5	Respond to the Risk: Part 1 - Perform De-escalation Communication	20-30 min
6	Respond to the Risk: Part 2 - Perform De-escalation Strategies	20-30 min
7	Respond to the Risk: Part 3 - Determine When and How to Get Help	20-30 min
8	Report and Communicate Post-Incident	20-30 min
PVPC	Provincial Violence Prevention Curriculum	8 Hour
ATR	Advanced Team Response	8 Hour

Initially it was agreed that focus would be on areas of highest risk to violence. Due to a history of higher claim rates and more significant injuries, Mental Health and Substance Abuse/Addictions (MSHU) and Emergency (ER) were chosen as areas of focus but Residential Care was added shortly after. The departments within these three programs were listed for all health authorities and with time, all the departments within the province were classified into one of four risk levels. This highest level was required to complete 8 online courses, a 4-8 hour classroom course and another 8 hour classroom course.

Fraser Health produced manager authenticated reporting on Violence Prevention Education since 2012 and continued to use this format. Other health authorities had differing reporting infrastructures and abilities and so reporting of curriculum completion was produced provincially by OHS Solutions, IMITS. This permitted standardized and near real time reporting across the province to aid health authorities in their efforts to increase their curriculum completion rates.

In 2014, a contract with WSBC and the subsequent Nurses Bargaining Association Collective Agreement required 100% completion of the PVPC classroom courses for employees working in high risk departments by June 30th 2017. In Fraser Health, employees in the high risk areas needed to complete their Violence Prevention Education Curriculum in order to continue to work after that time. These mandates and the support of the management, unions and others fostered an environment that resulted in over 290,000 courses being taken by Fraser Health Staff by the end of 2017. This significant accomplishment resulted in each the high risk programs approaching a near 100% completion rate for the curriculum. These completions were the result of the thousands of hours of instruction across the health authorities.

In each of the three high risk areas: Emergency, Residential Care and Mental Health and Substance Abuse/Addictions, and overall in Fraser Health (FH), there was an increase in the length and frequency of WSBC claims as the result of violent incidents between 2012 and 2016. The rate of WorkSafeBC (WSBC) claims was not reduced during this increase in Violence Education completions. However, as was hoped, the length and significance of these claims was reduced concurrently with the increased education. This may be because the patients in health care may continue to be violent due to their circumstance and health but through training we may be able to reduce their impact. As the number of course completions across FH approached 300,000 and the curriculum completion rate approached 100% within high risk areas, the FH, ER and Residential Care average WSBC claim length decreased.



The MHSU claims rate did decrease in 2016 in conjunction with completion rates approaching 90% about a year before the other programs. Unfortunately the length of WSBC claims in MHSU increased in 2017 before again decreasing in 2018. This change in 2017 in MHSU is likely due to an observed increase in overtime. Other 2017 research completed in conjunction with the University of British Columbia, but not yet published, has shown that increases in overtime in MHSU is related to an increase in Violent WSBC claims.

Although not all the WSBC claims from 2016, 2017 and 2018 have returned to work it appears the difference in claim length is due a reduction in number of longer claims. More investigation on this detail will be undertaken. Further analysis will continue over the next few years to determine if the positive effects of Violence Continuing Education will persist or even improve. Other analysis continues on the outcomes, including a time series analysis to determine further links between education and reduced claim length.

All employees in High Risk Level areas that completed their Violence Prevention Curriculum are now required to complete a refresher course each year. All new employees are required to complete the entire curriculum. This refresher course will hopefully ensure the positive effects of the education will continue for the healthcare employee in BC.

A multifaceted Violence Prevention Education initiative has had positive effects on the risk and impact of violence in Healthcare in the province of British Columbia. This included the adoption of a comprehensive Violence Prevention Education Curriculum with both online and classroom courses that was provincially available and reported on. Provincial mandates and the support of staff, management, union and other stakeholders facilitated almost every staff within high risk areas being educated on how to reduce the risk and impact of violence. The industry leading program and the analysis of the results will continue to progress to ensure the risk and significance of violence in healthcare is optimally mitigated.

Learning objectives

Participants will...

1. understand the stages involved in the development of the initiative.
2. learn how high completion rates of a comprehensive violence prevention education curriculum may reduce the impact of violent patients in the workplace.

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A training approach to augment healthcare provider's knowledge, attitude and practice to address child sexual abuse

Subtheme: Providing education and training

Workshop

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Keywords: Child sexual abuse, training, care-giver child communication.

Abstract

Background

Child sexual abuse is a pessimistic and intimidating issue for the health care providers to address children and their families. Pain from sexual abuse ameliorates with time however; the psychological and traumatic effects endure till adulthood. Literature highlights that with the help of health care providers child sexual abuse can be prevented and treated in the best manner. To discern child sexual abuse and constitute the most appropriate interventions is a complex task. Henceforth, this workshop is designed to introduce health care providers about child sexual abuse, promote caregiver-child communication and help caregiver create molester-free environment.

Aim

The aim of the workshop is to enhance the knowledge, attitude, and practice of the health care providers to approach and elucidate child sexual abuse issues and to enhance the knowledge and positive experiences of the community while addressing the child sexual abuse issues.

Procedure

Power point presentation with interactive activities and case studies.

Participants

This workshop is proposed for healthcare professionals from diversified line of work including physicians, professional nurses and midwives, nursing faculty, nursing students and social health workers.

Learning objectives

Participants will...

1. Be able to create genuine interest, sensitivity, and capacity in healthcare providers to distinguish and oversee child sexual abuse issues.
2. Be able to help prepare health care providers to replicate the contextually relevant teaching tools and modules in the community and clinical setting related to child sexual abuse issues.

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Effectiveness of organizational training programs for workplace violence, harassment, and bullying on the safety of patients and health-care workers

Subtheme: Providing education and training

Poster

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Keywords: Education, patient injury, restraints, health-care providers, attitudes, values, staff injury, staff turnover, systematic review, best practice guideline

Abstract

Background and Context

Workplace violence, harassment, and bullying are pervasive problems in the health-care environment that negatively impact the physical and psychological wellbeing of health-care workers, and compromise patient care. Consequences for providers can include post-traumatic stress disorder, depression, anxiety, decreased work productivity, and leaving the workforce. Moreover, providers can become fearful of patients, which affects the quality of, and time spent in, patient interactions. Education and training programs for health-care providers addressing workplace violence are crucial to prevent, manage, and recover from violence, harassment, and bullying. Thus, a systematic review was conducted to examine the effectiveness of workplace violence education and training programs for health-care workers. The results were used to develop evidence-informed recommendations for a best practice guideline.

Methodology

A comprehensive literature search was conducted in 8 academic databases. The search was limited to peer-reviewed studies published in English between January 2012 and August 2017 focusing on education for health-care providers and students on workplace violence, harassment and bullying initiated by patients and/or caregivers. Studies that implemented education on violence, harassment, and bullying between health-care providers also were included. All records were independently screened for inclusion by two reviewers, and discrepancies resolved by consensus. Following data extraction and quality appraisal, the body of evidence was evaluated using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology.

Findings

Twenty-four articles were included. Overall, certainty in evidence was graded as low, but there were benefits across several outcomes. Staff education focusing on de-escalation techniques was found to reduce rates of restraint use in patients. Education addressing communication and re-direction techniques (including risk factors and triggers for violence) not only was shown to positively change provider attitudes about patients and/or caregivers, but also was associated with a decrease in staff injuries. In one study, perceived safety of health-care providers appeared to increase after staff was trained in break-away techniques. In terms of bullying, staff education about lateral violence led to reductions in staff turnover, and qualitative studies suggest interactive educational courses in undergraduate nursing programs may increase the perception of confidence to handle bullying situations.

Implication

Although the certainty in the body of evidence was low across outcomes, the overall direction of the effect was consistent. Organizations that implemented education and training programs for workplace violence, harassment and bullying demonstrated improvements in health-care provider and patient outcomes. Specifically, research suggests education and training for health-care providers implemented by an organization should: highlight the issue of workplace violence, harassment and bullying; and focus on communication strategies, and de-escalation and re-direction techniques.

Learning objectives

Participants will...

1. Be able to discuss evidence-based education and training components that can lead to the prevention, management, and recovery from workplace violence, harassment, and bullying.
2. Identify training strategies to address workplace violence from patients, caregivers, and/or colleagues.

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A Realist Literature Review: How, Why and For Whom Does Violence Prevention Education Work?

Subtheme: Providing education and training

Paper

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Keywords: Healthcare; violence prevention education; evaluation; realist review

Background

As recipients of violence from patients, residents, and visitors, healthcare workers have higher rates of injuries due to violence than workers in other occupations (Canadian Centre for Occupational Health and Safety, 2018). The main intervention to address violence in healthcare has been educating employees in the prevention, management and reporting of violence and aggression (Tölli, Partanen, Kontio, & Häggman-Laitila, 2017). Despite the number of studies that have been conducted on the effectiveness of violence education, systematic reviews have reached similar conclusions: with the variability of study types, settings, metrics, definitions, and violence education programmes being evaluated, there is little definitive evidence as to the effectiveness of violence prevention training for healthcare workers (Beech & Leather, 2006; Tölli, Partanen, Kontio, & Häggman-Laitila, 2017; Wassell, 2009). Although previous reviews have focussed on violence prevention program effectiveness, to the researchers' knowledge none have explored the contexts and conditions under which violence prevention education may or may not be effective and why. This review addressed this gap by utilizing an alternative, realist approach to reviewing and synthesizing evidence from existing literature to identify how, why and for whom and in what contexts violence prevention education is likely to be effective. This realist approach provides practical information for decision makers on educational interventions to prevent violence.

Methods

This review used a realist methodology to synthesize evidence from existing literature to understand how, why, for whom and in what circumstances violence education is effective in decreasing violence and related injuries in healthcare. A realist approach is founded on a belief that reality is stratified: a real world that exists, and perceptions of that world filtered through individual senses and experiences (Greenhalgh et al., 2017). Realist researchers believe that social reality is manifested in regular patterns of behaviour that are observable, produced by underlying generative forces such as reasoning and beliefs that we can't see (Mark, Henry, & Julnes, 1998; Pawson & Tilley, 1997). The realist perspective enables evaluators to iteratively utilize a wide range of quantitative and qualitative literature to develop theories that explain how a programme or policy "works" through configurations of contexts, underlying generative mechanisms and resulting outcomes that explain why an intervention works in some

circumstances and for some people but not for others (Pawson & Tilley, 1997). Within realist theory an individual may or may not act on a supplied resource, such as skills or knowledge from education, depending on how their internal reasoning mechanisms are influenced or triggered by the characteristics of the circumstances and context they are in (Kontos & Poland, 2009). In contrast to a systematic review that seeks to summarize all evidence and concentrates on study characteristics and findings (Greenhalgh et al., 2017), a realist review focuses on key literature to build an understanding of generative causation, utilizing theory as the unit of measure (Wong, Westhorp, Pawson, & Greenhalgh, 2013). Applying a realist approach to the review of violence prevention education in healthcare enabled identification of theoretical explanations that account for social complexity at a mid-range level of abstraction that is transferrable across settings (Pawson, 2006).

To identify patterns of outcome-mechanism-context combinations, over 400 articles were screened and 183 articles reviewed in full to identify a set of key sources. Explanatory theories from expert consultations provided initial programme theories that were built upon -and added to- by analysis of the literature. Data was coded using NVivo[®] software focussed on context, mechanism and outcome configurations related to workplace violence prevention in healthcare. Data was sorted and analyzed by outcomes to seek inter and intra variation. Through the analysis of the data the original program theories were refined and several new areas identified. The refined explanatory configurations were tested back against the evidence identified in the literature, resulting in a final set of explanations of how, why, when and for whom violence prevention programs are likely to be effective.

Results

Although the goal of this review was to assess the effectiveness of violence prevention education, findings focussed very little on the education program and more on workplace contexts and how they are experienced and perceived by individual employees. Confidence in applying new skills and knowledge such as de-escalation was influenced by whether an individual trusted that peers and supervisors could be counted on for support if things went wrong. Feeling overwhelmed with workload or feeling cynical that violence is inevitable influenced whether assessment and reporting protocols were followed. Previous experiences of violent events going poorly and inadequate follow-up by leaders that resulted in individuals feeling blamed or shamed for the violence, increased fear and decreased individuals' ability and agency to manage violent situations.

Conclusion

This review demonstrates the practical contribution of a realist approach and illustrates how workplace contexts- and how they are experienced and interpreted by healthcare workers- influence the effectiveness of violence prevention education. This review provides explanatory theories that can inform decisions regarding violence prevention education and provides direction for healthcare decision makers by positioning violence prevention education as one component of a comprehensive violence prevention organizational strategy.

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Learning objectives

Participants will...

1. understand why evaluation of violence prevention education has been challenging.
2. gain an understanding of the realist approach and why and how it is useful.
3. gain practical knowledge to inform program and policy decisions from theories of how and why violence prevention education is likely to work, for whom and in what contexts.

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Cinemeducation as a positive pedagogical approach for aggression and violence education: An international perspective

Subtheme: Providing education and training

Paper

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Keywords: Education, Cinemeducation, Positive Psychology, Nursing Students

Abstract

Background

It is recommended that undergraduate nursing students need education in aggression and violence, but agreement on the correct methodology to facilitate this remains unresolved. The concept of using positive psychology in education is a relatively new one but it has been identified that positivity can have an effect on individual's mood and outlook when faced with adversity. Educators seek new and innovative methods to promote learning and the inclusion of movies into the traditional classroom setting to enhance learning and encourage student discussion is becoming more commonplace. The positive psychology literature has suggested that many commercial movies are of great benefit to human wellbeing and can be integrated into the pedagogic setting in the form of cinemeducation.

Methods

Educational interventions including didactic and cinemeducation sessions were designed using a humanistic approach to assist nursing students to learn to cope with aggression and violence in practice. The cinemeducation intervention employed positive psychology to identify movie clips highlighting character strengths and virtues that promote resilience. These clips were incorporated into a specially designed education intervention: Building Resilience to Aggressive and Violent Events (BRAVE). The BRAVE education sessions were initially delivered in the Australian context to second (N=48) and third year (N=71) nursing students and based on its success, the cinemeducation session will be delivered in the United Kingdom context in March 2018 to first year nursing students n=(132). Written qualitative evaluations were collected from Australian nursing students (n = 119) and will be collected from UK nursing students, and data analysed using thematic analysis to ascertain the international viability of cinemeducation as a positive pedagogical approach to aggression and violence education.

Results

Qualitative data was collected immediately following the intervention in the Australian context for individual themes and will be further analysed for similarities and differences between the Australian and UK context, once UK data has been collected. This analysis identified an overall theme of being a *'Positive educational experience designed to enhance and develop their learning of aggression and violence in healthcare'*. Analysis further revealed that no negative responses to the education with all students embracing the learning opportunity. Furthermore, analysis identified that the students found the cinemeducation enhanced application of knowledge to real life situations in their clinical practice.

Implications for practice

Cinemeducation was well received by nursing students in the Australian context with students feeling that the movies enhanced their learning and allowed them to experience situations through the eyes of others. Following the introduction of cinemeducation in the UK, it may be plausible that cinemeducation enhanced by positive psychology is an appropriate pedagogic design in a global nursing context to aid students in addressing the confusing and potentially damaging feelings, generated through exposure to aggression and violence.

Learning Objectives

Participants will...

1. have an understanding of positive psychology and cinemeducation as a pedagogical approach to aggression and violence education.
2. be able to appreciate the international application of cinemeducation for enhancing education for nursing students.

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Before Anger is an Option: Violence Towards Health Care Professionals

Subtheme: Providing education and training

Paper

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Keywords: Aggression, violence, education, prevention

Abstract

Violence towards health care staff continues to be a serious problem in emergency rooms and other health care settings nationwide. Medical professionals have emphasized an importance of developing communication or techniques to handle aggressive or violent patients. Using online educational materials to develop new and evaluate existing communication styles with patients can help in identifying and preventing aggressive or violent patients.

It has been found that the first step in decreasing workplace violence is having a well-written policy in place for reporting, responding to, and debriefing from a violent experience. Additionally, a mix in text, videos, and graphics create an interactive online learning space, which can promote engagement in training videos. This presentation is aimed to assist health care providers to recognize and identify escalation in patients, identify healthy de-escalation techniques, and gain awareness of education methods that are beneficial in addressing workplace violence.

Learning objectives

Participants will be able to...

1. identify preventative verbal and nonverbal communication skills to avoid escalation.
2. identify factors that can cause escalation and aggression in clients.
3. evaluate their own personal prevention and communication style with clients.

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National Study to Refine an Anti-bullying Tool for Canadian Nursing Students: Preliminary Findings

Subtheme: Providing education and training

Poster

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Keywords: Cognitive Rehearsal Training, Canadian Nursing Students, Bullying, Communication, Education, Tool Kit

Abstract

Background and Context

The purpose of this qualitative national study was to further examine the effectiveness of an anti-bullying intervention called Cognitive Rehearsal Training (CRT) using a workshop format to increase third year nursing students' knowledge and confidence to address bullying behaviours. A lanyard card identifying common nurse bullying behaviours, used in a previous pilot study, was included as part of the intervention to encourage participants to Stop! Reflect! and Respond! (Griffin, 2004; Griffin & Clark, 2014) when experiencing bullying. Although similar bullying interventions have been studied among practicing nurses, few studies exist that involve students within their pre-licensure training program (Iheduru-Anderson, 2014; Thomas, 2010) and none in Canada.

Methodology

This qualitative national study involved 340 nursing students at five undergraduate nursing school sites across Canada. Participants took part in an anti-bullying workshop/research project using CRT as a tool to address bullying behaviours. Data was collected during the workshops via group and individual surveys. The student participants provided feedback regarding the utility of the CRT tool. Research sites were chosen through interested faculty members volunteering their school to participate. Ethics approval from all participant sites was obtained.

Findings

Themes identified included a need to update the types of bullying identified on the lanyard tool, as well as increasing its visual appeal. Participants stated that faculty require training in providing learner-centered feedback and role modeling more confidence in managing conflict. The findings overwhelmingly support the CRT tool and a need to integrate the intervention throughout the undergraduate nursing curricula. A review of Canadian schools of nursing websites reveals that training around bullying is not a discrete in the curriculum, yet participants almost without exception stated that they had experienced bullying within their program.

Implications for Education, Training, and Practice

Student-Participants have overwhelmingly shared experiences of being bullied or witnessing bullying while in nursing school. There are currently little to no training sessions preparing nursing students for the workforce environment and bullying situations in Canada. They have expressed a need for this type of training throughout their education program. They have also expressed a need for faculty to understand their role in supporting students and having the skill and confidence to address bullying. This study suggests simple and practical way for educators to initiate and sustain open discussion on bullying and better preparing students for the workplace during and after graduation.

Learning objectives

Participants will...

1. Have raised awareness of bullying behaviors and its consequences while in nursing school.
2. Learn of a pragmatic method to deal with bullying situations in the healthcare workplace.
3. Be able to identify ways to practice self-care while maintaining professionalism.

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Safety and security: a training programme for employees working in youth residential care in Norway

Subtheme: Providing education and training

Workshop

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Keywords: De-escalation, communication skills, Understanding anger, Safety for staff and youths, Physical intervention, Ethics, Preventing and managing conflicts.

Introduction

In 2015 the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) established an expert panel consisting of experts on different fields in regard to youth in residential care. The purpose of this was to begin the work to develop a training programme for employees in youth residential care. The intention of the training programme is to give the employees tools to prevent, and handle, situations involving aggression and physical interventions. Hopefully this will result in less re-traumatization for the youths living in residential care, and fewer reports from employees considering physical and psychological violence at work. The work of the expert panel resulted in a knowledge base report, and 13 specific national recommendations for working in youth residential care.

In 2016 an expertise group based in the Office for Children, Youth and Family Affairs (Bufetat), all of them have experience in working with youth and children, began developing a basic training programme. The name of the group is Expertise Group of Safety and Security, from now on referred to as SKM-TS. The programme was based on the 13 recommendations and the knowledge base from the expert group. In Norway Bufetat is divided into five regions north, middle, west, south and east. SKM-TS visited each region and presented a pilot-programme. The pilot was strictly evaluated by the participants, and the programme was finished and a national implementation began fall 2017, in the eastern region, and then onto the other regions. By 2019 a total of 3500 employees in Bufetat will have received the training programme, and continue training at their own facilities.

The programme: Theory, physical interventions and scenario

The programme is based on three different components, and one programme is four days of lectures and practical training. One part of the programme is theory, second is physical interventions, and the third part is scenario training. All three components are connected to models on rollups, which we refer to during the entire programme. We will bring rollups to the workshop in Toronto.

The **theory** includes subjects as:

- aggression as phenomenon: how can we prevent aggressive incidents? How we understand aggression, and the different phases of aggression. Understanding powerlessness and understanding anger.
- Stress and coping with stress: how does stress affect me and my abilities as a therapist?
- Physical interventions: what are the risks and limitations in physical interventions? When do we use it, and why do we do it like this? Communication while we use physical interventions.
- Basic security: how should we furnish our residents, how should we dress at work to minimize risk? Risk assessments, personal and structural routines, STOP and the “no action action” «No action action» is a principle that we want our employees to use in high risk situations. The intention is to give them something purposeful to do, instead of intervening in a situation that is clearly out of control and with high risk for all involved. An example of a “no action action” routine is to STOP, get help/call the police, observe the situation from a safe distance, remove dangerous objects, make a plan for evacuation, or evacuate people at risk.
- De-escalating: verbal skills, and de-escalations of aggressive situations. Green/red-communication.
- Scenario: what is scenario training, and why should we practice on difficult and challenging situations? And how do we practice?
- Law: rights regulations, in child welfare, in a security perspective.
- Reflection on practices: why do we do the things we do, what should we do more of, and what should we do differently?
- debrief of adults: why do we need debriefing, and how can we do it?
- debrief of youths: what can we, as adults, and the youths, learn from conflicts?

The **physical interventions** consist of four steps, and are approved by the Norwegian Forensic Institute. When we need to use physical interventions, there should always be at least two adults.

- Catch an arm: two adults catch the arms of the youth, one arm each. The purpose is to secure the youth, and help him/her calm down. Sometimes this step is enough, and the situation calms down.
- Catch the body: when two adults are holding the arms of the youth, but the situation continues to escalate, one of the adults grab the youth by the hips, and they go down on the floor.
- Down to the floor: two adults are holding the arms of the youth, with the youth’s torso lightly pushed forwards. The youth is now sitting on the floor, and the adults sitting on their knees at the sides.
- Down on the floor: if the situation continues to escalate, and there is much aggression, sometimes laying the youth all the way down on the back is necessary. In this position the youth is laid down on the back, with two adults securing the arms, and sometimes a third adult is securing the legs. In this position, one of the adults has the responsibility to focus on the youths breathing.

Scenario training starts with the introduction of verbal communication skills. We have green and red paper, which simulates green and red communication. The participants are told to divide into

the roles of youths and adults, and practice verbal communication skills. They stand on the paper, red or green, and move according to whether they are using green or red strategies. The youth moves between the papers as a response to how they emotionally respond to the communication. The purpose of the scenario is to practice the use of green/red-communication strategies, and how it feels to have your commands met with the different strategies.

The next stage of scenario is the STOP-principle. STOP is an abbreviation for Stop-Think-Observe-Plan. We arrange situations that are similar to those we meet at work and one of the participants have the role of the employee, and another has the role of the youth. The scenario is directed by SKM-TS instructors. The purpose of scenario training is that the participants should see the connections between the theory that we present and their own practice. The scenarios are directed in such a way that the participants should experience mastery, and they have the opportunity to try again, if they would like to try a different solution. After we present the scenario, the adult is asked to set the situation in accordance to the aggression curve, to specify their goal, and what they will do to achieve their goal. The instructor stops the scenario when it is starting to escalate, to give the adult the opportunity to change ones goal, and have a different outcome.

At the end of the week we take the participants through what we call “*full-scale*” scenario, which is as similar as possible to real life situations. Here we include the “*no action action*” principle. “*No action action*” is an alternative for the employees in high risk situations. We give the employees tools to handle high risk situations without physical intervention. We have a strict structure that we use in debrief and summary of the scenario, and we also connect the situation to the rollups we have, to help the participants see connections between theory and practice.

- In the debrief we use the following structure
- The one that had the role as adult, always gets the opportunity to say for themselves how they experienced the scenario, connect it to stress and communication, what they did and why, and if they, in retrospect, would like to something different. If there are multiple adults in the scenario, the other ones may say how she/he experienced the scenario, according to their role in the scenario.
- Then the one, or those, who had the role as youths get to say how they experienced the scenario. How the adults met their needs and their communication skills.
- The observers. Sometimes the observers are given specific tasks to look for in the scenario, if not they are allowed to say something about the scenario, as long as it’s not already mentioned by one of the above.
- Then the instructor sums up the scenario, and connects what happened to the models at the rollup.

What would we like to present in Toronto 2018

We are presenting a workshop where we introduce our models, and how we use them to connect theory and practice. We want to present STOP and “*no action action*”, as methods to reduce the risk of physical intervention, and how they contribute in increasing safety for both youths and employees in residential care. We also want to present our physical intervention techniques, and the green/red- scenario exercise.

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Learning objectives

1. Participants will be aware of how staff behavior effects safety and security for both staff and youths in residential care.
2. Participants will have a basic understanding of how scenario training with staff may effect safety and security in residential care.

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Cognitive Rehearsal Training: A Strategy for Undergraduate Nursing Students to Address Bullying

Subtheme: Providing education and training

Poster

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Keywords: Cognitive Rehearsal Training, Nursing Students, Bullying, Nursing Education

Abstract

Background and Context

The effects of bullying on nursing students raise a threat to the future of nursing practice and the quality of care provided. Bullying reduces nurse productivity (Berry, Gillespie, Gates, & Schafer, 2011; Yildirim, 2009) and when nurses are unable to adequately cope with bullying, nurse turnover increases (Laws, 2016). Strategies for recognizing and addressing bullying behaviours should be addressed as soon as students begin their nursing education. Without educating and supporting nursing students to deal with bullying behaviors, these effects will carry on to future generations (Cooper, 2009; Curtis, Bowen, Reid, 2007; Delez, 2003). Cognitive Rehearsal Training (CRT) is a strategy that helps people reduce impulsive actions through training/education (Griffin, 2004). The purpose of this research was to provide CRT to second year nursing students so that they would be better prepared to handle bullying behavior effectively in the clinical setting.

Methodology

Prior to second year clinical experiences, a workshop was presented to second year nursing students about bullying. The content included a definition of bullying and the impact it has on nurses and the quality of care delivered. Following this senior nursing students' role-played scenarios of bullying interactions; student to faculty member, student to registered nurse, and student to student. While the scenarios were being performed, students were asked to raise their hand when they recognized the bullying and how they would address this behavior. At the end of the workshop they received lanyard cards that outlined how to deal with bullying. At the completion of their clinical experience two focus groups (N=23) were conducted at a University in South-Western Ontario asking students about their experiences implementing the strategies taught during the workshop.

Findings

The majority of students voiced that the CRT workshop helped them to recognize bullying situations, however, they did not have the confidence to respond to the behavior when experienced or witnessed. Students indicated that they now recognize why they do not speak up and related this to the power differential in the workplace between nurses and students. They expressed that more education on this topic should be included within the nursing curriculum, beginning in first year.

Implications for Education

CRT workshops present effective strategies that can be used to assist students become more confident in recognizing and addressing bullying behaviours. Workshops should be initiated in the first year of the nursing curriculum and should be continued throughout their education. This proactive approach will provide students with the education needed for them to assume a leadership role in dealing with bullying behaviours.

Learning objectives

Participants will...

1. gain knowledge of a strategy to prepare nursing students to confidently address bullying behaviors.
2. become familiar with the benefits of implementing cognitive rehearsal training to respond to bullying behaviors.

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Changing attitudes to the use of Coercion through education

Subtheme: Providing education and training

Poster

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Keywords: Coercion, Mechanical Restraint, Education, Prevention

Abstract

Background

When trying to reduce or eliminate the use of coercion e.g. mechanical restraint in Mental Health Care, one of the key elements is to change the staff attitudes and beliefs towards coercion as a phenomenon. Then it later would be possible, for them, to change their behavior and actions towards the psychiatric patients. To change staff attitudes, many organizations offers education to staff, but can education change staff attitudes, even though the teaching is activating, diverse, and involving (1-4)?

Objectives

This study explores, if it is possible to change staff attitudes towards the use of coercion, e.g. mechanical restraint, through activating, diverse, and involving teaching.

Methods

An investigation on attitudes towards the use of coercion and mechanical restraint, was performed using Poll's (Poll Everywhere), on 122 staff (six classes), before and after 6 hours of education, in how to prevent physical coercive interventions. The questions used to describe the attitudes was translated to Danish and back-translated. One question were developed by Colton (5), Cronbach's Alpha (between .6 to .8) indicated strong reliability of each construct. The other were derived from "*A Snapshot of Six Core Strategies...*" (6). Trends will be analyzed using Wilcoxon Signed-Ranks Test. The analyses were performed using IBM SPSS Statistics for Windows, Version 22.

Results

In Table 1. the Wilcoxon Signed-Ranks Test indicated that two of the three, median pre-tests ranked were statistically different in a positive way, than the median post-test ranked ($Z = -0.41, p > 0.05$, $Z = -2.00, p < 0.05$, and $Z = -2.20, p < 0.05$).

In Table 2. the Wilcoxon Signed-Ranks Test indicated that one of the five, median pre-tests ranked were statistically different in a positive way, than the median post-test ranked ($Z = -2.21$, $p < 0.05$, $Z = -0.74$, $p > 0.05$, $Z = -1.57$, $p > 0.05$, $Z = -1.58$, $p > 0.05$, and $Z = -1.22$, $p > 0.05$).

Conclusions

The data could point in the direction that it is possible to change staff attitudes towards the use of coercion, e.g. mechanical restraint, through activating, diverse, and involving teaching.

Discussion

The method used, fitted the research question, the statistical model fitted the data. The results showed three significant differences from the pre-test to the post-test and the others pointed in the same positive direction. The conclusion is not very strong, because the design is not adequate. Probably many factors (confounders) influence the change in staff attitudes in “*the real world*”, as the culture they come from, and return to after the education, the quality of planning the education, the qualifications of the teacher, etc.

The end-goal is to change staff, patients, and relative’s attitudes and beliefs, towards each other. Change the culture of the Mental Health Community in the direction of empowerment, resilience, and recovery. But we must start “*little by little*” by changing the individual’s beliefs and attitudes, and hopefully they subsequently change their behaviour and actions.

Learning objectives

Participants will...

1. achieve knowledge on the possibility of changing staff attitudes towards coercion.
2. take confounding factors into consideration in interpreting the results.

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Confrontational teaching vs e-learning program

Subtheme: Providing education and training

Poster

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Keywords: Education, confrontational teaching, E-learning program

Abstract

Background

Mental Health services in the Capital Region of Denmark have decided that the Risk Assessment Instrument, the Brøset Violence Checklist (BVC) should be applied to all adult psychiatric wards across the region. The course that is designed to train the staff in using the BVC is only intended for new employees in psychiatry and no other systematic teaching is given in the use of BVC in the region. To meet this challenge a Danish e-learning program have been developed to train or re-train experienced staff members. This study was conducted to determine 1) can a e-learning program help raise staffs understanding of how to use the BVC? and 2) can the e-learning program improve the quality of the way the BVC is used?

Methods

All participants were after they had attended the regular 3 hours course (confrontational teaching) or after they had taken the e-learning program, giving a multiple-choice test (MCQ-test) and an evaluation form. The result of the MCQ-test and the evaluation-form from the course and e-learning program was compared to see if there were differences between the results of the MCQ-test and satisfaction with the course and e-learning program.

Results

257 people have completed the MCQ test. Of these, 147 people participated in confrontational education and 110 people have completed the e-learning program. The results show that for six questions out of 13 there was a significantly higher proportion of wrong answers in the group of test takers who had completed the e-learning program.

In total, 140 (54%) respondents answered the evaluation-form. For confrontation teaching, 55% of participants responded and for the e-learning program it was 58%. For the confrontational education, a higher proportion of participants generally report their satisfaction with the academic benefits, the academic level and the knowledge they have acquired through the module compared with the participant who has evaluated the e-learning program.

Conclusions

There were a higher proportion of wrong answers in the MCQ test for participants in the e-learning program compared to participants in the confrontational education. The participants in the e-learning program had a generally lower satisfaction than participants in the confrontational education course.

Learning objectives

Participants will...

1. Appreciate the importance of the use of the right e-learning activity at the right time. It is about finding the right blend.
2. Learn of advantages and disadvantages of confrontational education and what is best suited for a e-learning program.

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Chapter 6 – Enhancing safety and positive practice

Recommendations to Redesign the Emergency Department Physical Environment for Workplace Violence Risk Reduction

Subtheme: Designing quality safety and risk reduction initiatives

Paper

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Keywords: Workplace aggression; nursing; threats; assaults; environmental assessment

Abstract

Background and context

Emergency department (ED) workers have among the highest rates of workplace violence (WPV) of all hospital units. Negative consequences of WPV have been linked to employee injuries, mental health disorders, and decreased productivity. The physical environment is believed to be a factor to prevent or permit WPV occurrences; therefore, the purpose of this research was to assess the physical environment of multiple ED settings and make recommendations for environmental redesign to increase protections against WPV.

Methods

Ethnographic methods were used to assess environments of 7 EDs in Ohio and Kentucky (U.S.). ED walkthroughs were conducted by 2 researchers. During walkthroughs, the team documented field notes from interviews with ED workers and observations of negative and positive WPV factors in parking areas, entrances, lobbies, registration, triage, nursing station(s), treatment rooms, and medication room(s). Digital images were taken to provide supportive evidence for poor and exemplary environmental designs. Security and ED staff collaborators for each site completed a survey detailing staffing, training, and perceptions of safety for WPV. Two researchers then reviewed accumulated data and came to consensus on ED scores based on an investigator-developed environmental assessment tool. The 44-item tool was based on the Crime Prevention through Environmental Design framework constructs: natural surveillance, territoriality, image management, access control, activity support, and target hardening. Each item was Likert-rated from 0 (poor) to 3 (optimal). Items were summed to yield a site environmental assessment score.

Findings

Environmental assessment scores ranged 85 to 103 (median 96) indicating overall positive environments for WPV prevention. Characteristics needing improvement included reducing

blind spots (natural surveillance), providing portable alarms for ED workers (activity support), establishing violence notification procedures (target hardening), establishing complaint management program (image/management), and preventing workers from working alone (activity support). Characteristics deemed exemplary included having adequate staffing and providing frequent WPV training (territoriality), having locked EMS entrances (access control), and keeping entrances litter free and having emergency exits available and identifiable (image/management).

Implications

Immediate efforts can focus on implementing complaint management and violence notification procedures developed collaboratively with interprofessional team of nursing, medicine, registration, security, risk management, and administration. Short terms efforts can focus on providing portable alarms to all workers and assuring no employee works alone. Training will be needed on proper use and response to alarm activation. ED workers need to periodically check on safety of colleagues working in isolated areas (e.g., registration, triage). Long term efforts can focus on redesign of EDs for reducing blind spots which can be accomplished through ceiling mounted mirrors. Future research is needed to determine if environmental changes lead to decreased WPV.

Learning objectives

Participants will be able to...

1. describe the Community Assessment through Environmental Design (CPTED) framework.
2. compare characteristics of emergency departments with poor and exemplary environmental designs.
3. discuss strategies to strengthen the environmental design of emergency departments for the prevention of workplace violence.

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Use of Vignettes to Explore the Relationship Between Bullying and Affect

Subtheme: Designing quality safety and risk reduction initiatives

Paper

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Keywords: Bullying, Vignettes, Negative Affect, Transportation

Abstract

Workplace bullying in health care affects both workers and patients. Bullying has been negatively associated with workers' psychological and physiological well-being. Studies show that health providers associate bullying exposure with errors, adverse events, and patient deaths. Cause and effect research is lacking due to difficulties in securing error data and the ethical implications of such studies. Bullying has been negatively correlated with productivity, but findings were based on participant recall. Simulation has also been used to show a relationship between incivility, a low-level type of bullying, and diagnostic and procedural performance suggesting that cognitive tasks can be impaired when exposed to bullying. Workplace bullying may evoke negative emotions. While negative affect have been associated with less accurate performance and low levels of attention and motivation, it is not known how negative affect due to being bullied influences cognitive performance.

We conducted a three-phase study using a within-subjects descriptive design. The primary objectives were to: develop a set of bullying vignettes, evaluate the content validity of the vignettes, and evaluate the relationship between the severity of the bullying vignettes and negative affect. To meet objectives 1 and 2, a set of 21 written bullying vignettes were created based upon a conceptual framework of inappropriate workplace behavior. To test content validity, a panel of experts reviewed the vignettes for relevance, severity and realism. The vignettes were then revised and constructed in a manner to depict a continuous narrative of bullying. To meet objective 3, the vignettes were built into an online survey platform, and participants ($n=51$) were recruited from a college of nursing. The participants completed the negative affect (NA) scale of the Positive and Negative Affect Schedule (PANAS) after reading each vignette. One concern when trying to cause a mood induction would be the level of immersion in the vignette. If the reader is not immersed in the vignette, mood may not be affected. A way to conceptualize immersion is through the Transportation Theory which stipulates that when individuals become transported into a narrative, vivid mental images are formed, and cognitive and affective engagement can be experienced. After reading the 11 vignettes and completing the negative affect scale of the PANAS, the participants completed the Transportation Narrative Questionnaire. Results demonstrated that the vignettes elicited statistically significant changes in Negative Affect over time, $F(5.716, 234.371) = 24.770$, $p < .000$, partial $\eta^2 = .377$, with Negative Affect increasing from 17.47 ($SD = 4.702$) after the first

vignette to 30.79 (SD = 6.58) after the 11th vignette (13.310) (95% CI, 9.788 to 16.831), $p < .000$). The average score on the Transportation Narrative Questionnaire was 54.67 (SD=10.5) (range 11-77) suggesting that the participants were immersed in the vignettes. In future research the bullying vignettes can be used to understand how psychological outcomes of bullying can impact cognitive performance.

Learning objectives

Participants will...

1. be able to describe the development and testing of bullying vignettes.
2. be able to describe the relationship between the reading of bullying vignettes and negative affect.

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“U.P. with Safety”: A Universal Precautions approach to reducing Aggressive Behaviour Risk in Acute Care

Subtheme: Designing quality safety and risk reduction initiatives

Paper

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Keywords: Acute care, Aggression, Program, Education, Process, Risk reduction, Visual alerts, Care planning, Tool-kit, Skills, Staff experience, Medical, Surgical, Multi-disciplinary

Abstract

Given the high rates of workplace violence experienced by our staff, at Sinai Health System we developed a program to standardize practices for identifying and managing hospitalized patients with aggressive behaviour. Our multidisciplinary team included nursing leadership, frontline nursing, medical imaging, support services, allied health, risk management, Human Rights and Health Equity, Occupational Health and Safety, security and patient support specialists. An extensive literature review and environmental scan were conducted. Though leading practices were identified, there was little literature regarding best practices for implementation. Our team developed a pilot program, called the Safe Patients/Safe Staff Universal Precautions (SP/SS-UP) program, which included:

1. Screening patients for risk of aggressive behaviour.
2. Use of visual alerts/flags in the health record to alert staff of high-risk patients.
3. Evidence-based algorithms and care plans for the prevention of patient aggressive behaviour.
4. Training to support building skills and self-efficacy among all staff to identify and manage patient aggressive behaviour.

The SP/SS-UP Program is unique in that it targets both clinician and support staff (such as housekeeping) and explicitly includes worker safety and risk management processes rather than relying solely on education/training. It combines training with evidence-based strategies of individual client risk assessment, flagging and patient-specific care plans to address patient aggressive behaviour.

Our team led a pilot of the program on one medical unit in 2015. Feedback from the pilot was positive. Currently, a research study is underway to evaluate whether the program will improve worker safety with staff feeling better prepared and safer in caring for high-risk patients. This is a prospective randomized two group (SP/SS-UP program versus control) matched field intervention study. Six units from Mount Sinai Hospital (2 medical, 4 surgical) are participating.

The outcomes being evaluated are: (1) After implementation what proportion of staff trained in the Safe Patient/Safe Staff-Universal Precautions program understand and know this protocol? (2) Does the program increase staff knowledge and confidence, and improve attitudes, in managing patient aggressive behaviour? (3) Does the program decrease staff experiences of aggression?

All staff on the units are being asked to participate in the research study, which will involve staff completing questionnaires pre- and two times post-implementation. To ensure that the SP/SS-UP program is delivered as intended, research personnel will engage in weekly observations on the units to determine if SP/SS-UP protocols are followed.

Implementation began in November 2017. This presentation will give an overview of the baseline and preliminary follow up results. The results of this research study will provide insight into the implementation of best practices and experience of staff members in using the best practices approach. If results are positive, the comprehensive and portable nature of this program will facilitate adoption by other institutions.

Learning objectives

Participants will...

1. understand the Safe Patient/Safe Staff-Universal Precautions program for the prevention and management of patient aggressive behavior.
2. be able to explain the real-world implementation strategies used to successfully implement the Safe Patient/Safe Staff-Universal Precautions program on multiple acute care units and involving multiple hospital departments.
3. appreciate the research study outcomes in terms of staff knowledge, confidence, attitudes and experience and, thus, be able to evaluate the effectiveness of the Safe Patient/Safe Staff-Universal Precautions program.

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Transforming a Culture - A Collaborative Approach to Violence Prevention

Subtheme: Designing quality safety and risk reduction initiatives

Workshop

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Safe Management Group Inc. and Windsor Regional Health, Oakville, Canada

Keywords: Collaboration, Cultural Change, Prevention of risk, Reduction of Violence, Staff Competence, Staff Confidence, Systemic Change, Training

Abstract

Safe Management Group Inc. and Windsor Regional Hospital (WRH) have partnered to actively address and reduce violence in the workplace in an acute care hospital setting. The two-day Crisis Intervention Training for high intensity areas and a one-day comprehensive training for all hospital areas has been launched which provides clinical staff with preventative and direct intervention skills. This training both grounded and supported a bundle of corporate initiatives to reduce the risk of violence in an acute care hospital setting. These initiatives include high-risk joint health and safety huddles, safety screening using metal detectors, revised patient pass protocols for acute mental health, revised patient pass protocols for acute mental health, corporate use of a specially trained canine unit to detect illicit substances, corporate weekly reporting of incidents of violence with corrective measures, a revised Code White Police and a refresh strategy for violence prevention screening tool and violence prevention care plans.

The training and bundle of interventions have been implemented with close collaboration with Joint Health and Safety Committee, Union Groups, physician leadership, and front-line staff. Outcome measures to demonstrate effectiveness to date include reported incidents of violence, harm due to violence, and code whites in the acute mental health unit. Cumulatively, this work has resulted in a culture shift where patient and staff safety are equally valued, violence is not acceptable, and reporting is encouraged in a transparent process.

This Workshop will focus on how Windsor Regional Hospital and Safe Management Group Inc. have been successful in reducing the risk of violence in the workplace. We will walk the audience through our journey from a place where staff morale was low, violence and risk was high to our current work environment that we feel has significantly addressed the issue of violence in the workplace; resulting in what we will demonstrate improved staff confidence and competence in preventing and managing potential violence in the workplace.

Learning objectives

Participants will...

1. Understand assessing and addressing violence prevention and management from a systems level.
2. learn about interventions and practices that have had a significant positive impact on violence prevention.
3. learn how to collaborate with stakeholders in addressing risk from many levels.

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Multidisciplinary Management of Behavioral Emergencies at the University of Maryland Medical Center, Baltimore, Maryland, USA

Subtheme: Designing quality safety and risk reduction initiatives

Poster

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Keywords: Behavioral emergencies, security officers, behavioral de-escalation, psychiatric emergency services, seclusion and restraint

Abstract

Background

With healthcare settings having a particularly high incidence of workplace violence, the University of Maryland Medical Center (UMMC) has developed initiatives to manage behavioral emergencies with the goal of reducing violence. UMMC hospital security has a specific Behavioral Emergency Response Team (BERT), skilled in de-escalating conflict. BERT aims to assist with patients and visitors showing disruptive or threatening behaviors in the hospital setting. Additionally, the collaborative work of the multidisciplinary staff in the Psychiatric Emergency Services (PES) has led to a significantly decreased use of seclusion and restraint at our facility. Our relationship with security has continued to evolve in an effort to reduce violent outcomes. The Solutions Team is a set of officers with unique skills in conflict de-escalation and threat neutralization. These officers have been incorporated in the response to behavioral crises throughout the hospital, including on BERT calls. As of 2018, efforts have been made to establish a permanent security officer in PES, which is in the process of being finalized. A Solutions Team member is assigned to the main emergency room, with ready access to PES, and security officers routinely round in PES.

Methodology

Data from the BERT calls were reviewed, from July 2015 to June 2017 (fiscal years 2016 and 2017), including: reason and length of the call, safety risks involved, and the unit that placed the call. Data from the PES starting in July 2016 were also retrieved to determine the rate of seclusion and restraint use.

Findings

There were 96 BERT calls with retrievable documentation in FY2016 and 113 calls in FY2017. Most calls were for patients attempting to leave against medical advice (52%), followed by patients who were upset with their medical care (16%). The majority of safety risks identified during BERT calls was for aggression/violence towards staff (49%). The Medical Intensive Care Units placed the most calls (45%), followed by the surgical units (25%). Seclusion and restraint data for PES in FY2017 showed a total of 53 seclusion and restraint events out of 3,335 patient visits (rate of 1.6%). The FY2018 seclusion and restraint data, including pre- and post- security presence in PES, will be compiled and presented.

Implications

In recent years, the importance of behavioral health training for both clinical staff and security officers to maintain individual and public safety has been recognized. Several multidisciplinary efforts have been made at UMMC to better manage behavioral crises. Our PES de-escalation protocols have led to lower rates of seclusion and restraint compared to national averages for psychiatric emergency settings, which range from 8.5-24%. Our collaborative approach to behavioral crises has been implemented on a hospital-wide level through BERT. Utilizing mental health providers in an acute liaison capacity and providing support staff and security officers with behavioral health training is integral to maintaining patient, visitor, and staff safety. We hope our guiding principles and models will inform similar initiatives in other healthcare facilities.

Learning objectives

Participants will...

1. be able to explain the importance of collaboration between clinical staff and security officers in de-escalating agitation/aggression in behavioral emergencies.
2. be able to demonstrate the impact of a multidisciplinary team approach in decreasing violent events and the use of seclusion and restraint.

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Communication of Violence Risk Across a Large Health Authority: Fraser Health's ALERT Policy and Procedure Implementation, Updates, Improvements and Learnings

Subtheme: Designing quality safety and risk reduction initiatives

Paper

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Keywords: Violence, communication systems, ALERT policy, ALERT procedure

Abstract

Background and Context

In 2008 a policy and procedure for a mandated system to communicate risk of potential for violence towards workers was initiated and developed. Following extensive stakeholder feedback, a policy and procedure was approved by the Health Authority's Clinical Senior Executive in 2010 and implemented. (ALERT SYSTEM: Designation, identification and Review of Clients at Risk for Aggressive Behaviour, Fraser Health Authority, Feb 2010) This included the development and implementation of a clinical screening tool and a communication system which included both an electronic and visual component. In 2016 a process which included multiple program collaborations and stakeholder feedback was initiated to review and update the policy and processes.

In 2017 an updated policy draft was completed and procedural updates have been initiated. Specific procedural updates have been made pertaining to identified gaps and challenges of the original system. This included improvements to ALERT tools and forms to meet the requirements of the policy and procedure within newly implemented and updated clinical electronic data systems, initiation of a new Behaviour and Safety Care Plan template and the addition of the ability to communicate risk of violence not only from patients but risk of violence also or potentially only from the family, friends and relations of the patient.

Methodology

An ALERT Shared Working Team was initiated which included representatives from identified key stakeholder, programs and clinical practice experts. This working group initially met monthly and then quarterly with ongoing work and development by the Violence Prevention Program representatives between meetings while incorporating ongoing feedback from key stakeholders and user groups. Key components resulting from the ongoing work to update

the ALERT policy and procedure are being communicated and stakeholder feedback and evaluation is ongoing until all key components have been updated and fully implemented.

Findings

Ongoing review of the effectiveness and implementation of the ALERT policy and procedure is required. Data system upgrades, changes in work practice, and ongoing implementation and system feedback informed the development of much needed updates and will continue to do so in the future. Multi-program collaborations, ongoing stakeholder feedback and ongoing system evaluations and audits are required to ensure adequate communications amongst all workers that may be at risk of exposure to violence from patients and their relations.

Implications

The ongoing work in the Fraser Health towards the improvement of its communication system for risk of violence will continue to decrease potential risk to all of its workers by fine tuning the sharing of information leading to an increase in preventative practices. Violence Prevention continues to be a priority for the best health and safety of its 35,000+ employees, physicians and volunteers. This includes ongoing work towards policy and procedure improvements and incorporation of current best practices, health authority-wide violence prevention education and training, and violence risk assessment standardization and completion across all of the Fraser Health's acute and community programs.

Learning objectives

Participants will...

1. Learn about improved practices for the communication of risk of violence from patients and their relations towards workers.
2. Learn about improved tools used in the assessment and communication of risk of violence from patients.

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PTSD and Occupational Stress Injuries Among Nurses: advocating for national recognition of workplace impacts

Subtheme: Development of positive practice

Workshop

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Keywords: Post-traumatic stress disorder (PTSD); violence, psycho-social hazards; occupational health and safety; legislation, regulations & policies

Abstract

Background

Over the past five years, the issue of violence and its impact on nurses' mental health has become a flash point for Canadian nurses. PTSD in nurses is a gender issue: 90% of nurses are women and epidemiological surveys have found that PTSD prevalence rates are twice as high in women as in men. There are gender differences in the type of trauma exposure, presentation of the illness, and the co-morbidities. Hence, PTSD symptoms may be misdiagnosed or go unrecognized and this failure to act means the toll of workplace trauma and violence continues to rise. Rising absenteeism rates and mental health lost-time claims in line with those for police and correctional services officers are the symptoms of a growing workplace health issue.

Methods

Groundbreaking research was conducted by the Manitoba Nurses Union (MNU), in 2013-2014, on the impact of violence, or the threat of violence, on the mental health of its membership. Similarly, the Canadian Federation of Nurses Unions, MNU, Ontario Nurses' Association and Nova Scotia Nurses' Union have identified the impact of violence on nurses' mental health nationally and provincially.

Findings

Manitoba's research concluded that violence, or the threat of violence, plays the largest role in PTSD development in nurses. MNU found that one in four Manitoba nurses consistently experiences PTSD symptoms; more than half have experienced critical incident stress, a precursor to the development of PTSD. Research suggests that partial syndrome can be as disabling and hard to treat as full-blown PTSD. Coupled with MNU's previous research which found high rates of violence among nurses, with the majority having experienced physical and verbal abuse, the psychological impact of workplace violence and trauma in the nursing profession is undeniable.

Subsequent campaigns in Manitoba, in Ontario, and Nova Scotia have resulted in significant awareness of the impact of violence on nurses as first responders, as well as significant legal gains in addressing PTSD. These legal gains have provided the foundation for the campaign to include nurses in the federal framework on PTSD, currently being reviewed by Parliament, so they may be part of formulating a national strategy on the issue (in its current form the federal legislation appears to arbitrarily exclude nurses and other impacted health care workers from the federal framework and any subsequent strategy).

Implications

This workshop will provide stakeholders with an overview of the jurisdictional efforts being undertaken to address PTSD and other occupational stress hazards related to violence in the healthcare sector. It will identify some of the keys to successfully advocating for positive change, as well as highlighting some of the challenges in engaging on this issue.

Participant Engagement

- Engage on how violence impacts the psychological health and wellbeing of nurses.
- Provide handouts of materials, including recommendations, policies, legislation.
- Seek guidance on how best to mitigate the effects of violence to safeguard the mental health and well being of nurses.
- Discuss strategies for enabling a collaborative response to this issue.

Learning objectives

Participants will...

1. acquire an understanding of the psychological impacts of violence as it relates to PTSD and other occupational stress injuries.
2. learn about how gender impacts PTSD development in nurses in relation to their unique work environments.
3. learn about campaigns to influence provincial, federal legislation, regulations and policies to effectively address workplace violence impacts.
4. develop an understanding of the enablers and barriers to addressing the mental health impacts of violence.

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Mental Health nurses' job content and its correlation with their management attitudes for patient aggression

Subtheme: Development of positive practice

Poster

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Keywords: Psychiatric nurse, job content, aggression management, attitude

Abstract

Background

Aggression management is an important issue in psychiatry care. Professional attitudes to deal with patient aggression among mental health nurses need to be concerned. Their job content and its correlation with their aggression management attitudes were still unclear.

Methods

A cross-sectional self-reported survey was designed. A sample was recruited of 246 mental health nurses who care for adult psychiatric patients on three hospital-based mental health centres in Taiwan. After the approvable process of the relevant research ethics committees and to get the inform consent from participants, the Chinese version of the Job Content Questionnaire (JCQ-C), including three categories of job control (JC: skill discretion and decision authority), psychological demand (PD), and workplace support (WS: supervisor and coworker support); and, the Chinese version of Management of Aggression and Violence Attitude Scale (MAVAS-C), including three causative factors (internal, external, and situational cause) and three management factors (traditional, alternative, and de-escalating management); were administered to measure. Those relationships were examined and analyzed.

Results

Their job content and management attitudes for patient aggression were significantly correlated with each other ($r=.200\sim.383$, $p<.01$). The "job control" and "workplace support" sub-scales of the job content had respectively positive correlations with the six sub-scales of the management attitudes ($r=.137\sim.312$ and $r=.144\sim.307$, $p<.05$). Whereas, the "psychological demand" sub-scale of the job content had respectively positive correlations with only three sub-scales of the management attitudes, including the internal cause, traditional management, and de-escalating management ($r=.189$, $.220$, and $.181$, $p<.01$).

Conclusion

Mental health nurses' job content relates to their aggression management attitudes. Especially, they tend to hold more attitudes with internal cause, traditional management and de-escalating management for patient aggression among whom has job content with higher psychological demand. These findings could be discussed and applied in development of a less coercive practice for patient aggression by offering organizational support and training for mental health staffs.

Learning objectives

Participants will...

1. understand mental health nurses' job content and its correlation with their management attitudes for patient aggression.
2. indicate possible directions in development of a positive practice for patient aggression and psychiatry care.

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Creating the indomitable spirit: Integrating resilience theory into healthcare practice

Subtheme: Development of positive practice

Workshop

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Keywords: Resilience, firefighters, first responders, nursing, healthcare

Abstract

Background, context, and methodology

Resilience is a contributor to mental health and a protective factor against adversity such as violence in healthcare. This presentation provides a constructivist grounded theory of resilience which was developed in collaboration with volunteer firefighters in conjunction with a PhD thesis at Nottingham Trent University. The research, conducted in 2015 with a fire rescue service (FRS) on Vancouver Island, Canada, provided unique insight into the capacities, strengths, and resilience of firefighters, and demonstrates that resilience is multidimensional, complex, dynamic, and contextual. The theory has subsequently been utilized and integrated into healthcare organizations with multidisciplinary healthcare teams. An education program has evolved from the theory and is being evaluated for its effectiveness in increasing and maintaining resilience scores in healthcare providers.

Findings

Unlike other studies that focus on pathological, developmental, and/or ecological perspectives of resilience in children, this theory evolved from a health promotion lens and provides evidence that six concepts inter-relate to construct resilience: relationships, personal resources, meaning-making, leadership, culture, and education. Although a number of resilience theories note relationships between concepts such as social support, adaptive health strategies, etc. and resilience, and some are recognizing cultural influences on resilience, there is a dearth of literature linking these six components together within a middle range theory of resilience in high-risk professions such as healthcare. As well, many of the extant theories/models are linear whereas this model is multidimensional requiring novel methods that visually represent the complex nature of resilience in volunteer firefighters and healthcare providers.

Implications

Along with discussion on the theory's development, the presentation will offer concrete strategies for practical integration of resilience theory into policies and actions to mitigate risks and enhance resilience in high risk professions such as healthcare. There are global

implications for healthcare providers such as nurses, emergency service providers such as firefighters, disaster and humanitarian aid workers, military personnel, and any organization or business that responds to and is exposed to the trauma associated with human suffering.

Workshop

Healthcare is rife with adversity from violence, exposure to human suffering, and numerous pressures such as finite human and financial resources. Resilience is the most common outcome following adversity however continuing exposure to trauma requires that organizations and individuals are actively engaged in building and maintaining resilience in healthcare practice. The first 40 minutes of this presentation will be an interactive discussion and critique of the current theory of resilience, followed by 30 minutes of small group activities that allow participants to articulate one's own vision of healthcare resilience; the final 20 minutes will be a *'gallery walk'* to explore participants' perspectives.

Leraning objectives

Participants will...

1. critique the current theory of resilience in the context of healthcare practice.
2. synthesize knowledge about resilience and integrate select resilience categories into own healthcare practice.
3. participate in a *'gallery walk'* to compare and contrast perspectives on resilience in healthcare.

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Assertive Empathy – Striking the Balance

Subtheme: Development of positive practice

Paper

Melanie Dodds

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Keywords: Assertive Empathy, Verbal abuse of nurses, Therapeutic Relationship, Permission, Expectation, Assertiveness, Courage, Empowerment

Abstract

Nurses in every area of every hospital struggle to deal with difficult patients and family members. Although hospitals work to make our place of work safe through violence training, panic alarms and code white teams, there is little to no education about how we can be our own solution in these situations. At the same time, current literature focuses on describing the problem, while providing few concrete, practical solutions for nurses to employ in their day to day practice.

Recently, our unit had a shift in staffing toward younger, less experienced nurses. The seasoned nurses noticed that they were consistently being asked to care for the most behaviourally difficult patients and when our novice nurses were met with this challenge, they either avoided the room, engaged in ineffective verbal sparring or over pleased to the point of tears.

An informal survey was sent to the other floors of our hospital to determine if they were experiencing a similar trend. The results suggested that in every corner of the hospital, young nurses were working in fear and seasoned nurses were feeling frustrated and angry about the ongoing abuse and lack of support around this issue.

From our own experience and the survey results, it became clear that our novice nurses lacked a very specific skill set that allowed the more experienced nurses to meet the needs of the most challenging patients, while maintaining their sanity and safety. We knew that we needed a method to teach our young staff how to manage these situations. After reflection and discussion, a specific, teachable method to handle challenging verbal interactions was developed, called Assertive Empathy.

Assertive Empathy is caring with boundaries. It holds both the nurse and the patient accountable within the therapeutic relationship. The practical skills of permission, expectation, assertiveness, courage and empowerment (PEACE) will be demonstrated through a case study.

Learning objectives

Participants will...

1. be able to describe the results and comments of the survey performed at University Hospital with regards to the nurses' experience of verbal and physical aggression.
2. be able to define Assertive Empathy as the balance achieved when nurses maintain their physical, emotional safety while meeting the patients' needs for support, care and advocacy.
3. understand the skills of assertive empathy which can be broken down into five areas of focus: Permission, Expectation, Assertiveness, Courage, Empowerment.

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Restraints alternatives in the management of challenging behaviors in inpatients with autism and intellectual disability

Subtheme: *Development of positive practice*

Poster

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Keywords: Personal protective equipment (PPE), autism, intellectual disability, challenging behaviors, self-injuries behaviors (SIB), restraints, ethics

Abstract

Context

In intensive and emergency psychiatry units, caregivers are often faced with severe behavioral disturbances, including self-injury, aggression and extreme psychomotor agitation. The associated risk of harm is highly problematic. While the use of restrictive measures is common, it optimally should be limited.

Objectives

To review the myriad forms of personal protective equipment in current use, including helmets, gloves, sleeves, jackets, bodysuits, mats, splints, padded shields, papoose boards, etc. and describe their usage through caregiver experiences.

Methods

A focused ethnography based on the observation, justification and formalization of personal protective equipment and procedures used as an alternative to restraint, focusing on caregivers' representations of violent patient encounters. The research was a multi-centered study in three psychiatric inpatient units in Canada, the USA and France dedicated to the assessment and treatment of challenging behaviors in individuals with autism and intellectual disability.

Results

Numerous forms of personal protective equipment (PPE) exist, and their usage can confer a safe alternative to the containment of behavioral crises. Appropriate handling of challenging, recurring behaviors is imperative to the preservation of physical and moral integrity in both patient and caregiver.

Conclusion

Personal protective equipment decreases harm associated with the management of challenging behaviors, and can promote respect for individual integrity and fundamental rights. The usage of PPE can be extremely helpful in challenging and dangerous behaviors, and subsequent provision of personalized and efficacious therapy.

Learning objectives

Participants will...

1. Be able to evaluate advantages and disadvantages of personal protective equipment in the given setting.
2. Appreciate the positive effects of personal protective equipment.

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The Effects of Work Excitement and Workplace Violence among Hospital Nurses in Taiwan: A Cross-Sectional Multi-Center Study

Subtheme: Development of positive practice

Poster

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Keywords: Intention to resign, Professional commitment, Violence prevention climate, Work excitement, Workplace violence

Abstract

Background

Workplace violence creates a crucial crisis that could lead to the intention to resign for hospital nurses. However, work excitement and a sound violence prevention climate can facilitate the professional commitment of clinical nurses.

Objectives

This study aims to determine the effects of work excitement, workplace violence, and a violence prevention climate on professional commitment and intention to resign.

Design

A cross-sectional multi-center study with a convenience sample was adopted. Participants were nurses from three hospitals in Taiwan. Of 900 questionnaires, 696 were valid for analysis (77.33%).

Settings

Three regional teaching hospitals in southern Taiwan.

Participants

Nursing staff with more than three months in non-emergency and psychiatry departments were chosen as the research subjects.

Measures

This study used a structured questionnaire to collect data on sociodemographic information, workplace violence experience, professional commitment, work excitement, violence prevention climate, and intention to resign.

Results

Professional commitment has a significant negative impact on intention to resign. Professional commitment positively impacts work excitement, especially when the work is challenging and varied, and simultaneously indirectly influences the intention to resign through work excitement. At certain times, workplace violence leads to an interactive moderating effect in the relationship between professional commitment and work excitement. A violence prevention climate changes the interactive moderating effect of workplace violence on the influence of professional commitment on the intention to resign.

Conclusions

Nursing staff's personal positive work experience and the institution's organizational policy and support systems are the mediating and moderating factors of the relationship between professional commitment and the intention to resign. Nurses expect organizations to strengthen nursing expertise and human resources management to establish a friendly partnership, provide a workplace with a positive working environment and learning opportunities, and strengthen interpersonal interactions and communication channels. They also expect to obtain the support of executives and peers. All of these expectations are important factors that influence nursing staff's thoughts regarding whether they should remain in the profession.

Learning objectives

Participants will...

1. learn how a positive work affect, such as work excitement, has an overall mediating effect on nurses' professional commitment and intention to resign.
2. Realize how a person who has witnessed the suffering of someone else due to workplace violence is more likely to have the intention to resign than an individual who has been directly exposed to workplace violence.

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Assessing the incidences and consequences of aggression and violence in Uganda health sector

Subtheme: Development of positive practice

Poster

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Keywords: Incidences, Consequences, Aggression, Violence, Uganda, Health sector

Abstract

Study objectives

In this study, the incidences and consequences of aggression and violence in Uganda health sector.

Methods

A retrospective cross-sectional study was done and health care workers in the Ugandan healthcare sector and their experiences of violence and aggression were assessed in this study. The sample consisted of 1973 health care workers from 39 health facilities (6 facilities for the disabled, 6 hospitals and 27 outpatient and inpatient geriatric care facilities) who have regular contact with patients or clients. The incidences of physical and verbal violence towards health care workers and the consequences of aggressive assaults were analysed.

Results

56% of respondents had experienced physical violence and 78% verbal aggression. The highest incidences of physical violence was in inpatient geriatric care (63%) ($p=0.000$). Younger health care workers run a higher risk of being affected by physical violence than older colleagues (OR 1.8, 95% CI 1.3 to 2.4). There is also an increased risk of experiencing physical violence in inpatient geriatric care (OR 1.6, 95% CI 1.2 to 2.0). Around a third of workers feel seriously stressed by the violence experienced. The better the facility trained employees for dealing with aggressive and violent clients, the less risk employees ran of experiencing either verbal aggression (OR 0.5, 95% CI 0.4 to 0.7) or physical violence (OR 0.7, 95% CI 0.6 to 0.9). Training by the facility has a positive effect on experienced stress (OR 0.6, 95% CI 0.4 to 0.8).

Conclusions

Violence towards nursing and health care workers occurs frequently. Every third respondent feels severely stressed by violence and aggression. Occupational support provisions to prevent and provide aftercare for cases of violence and aggression reduce the risk of incidents and of

perceived stress. Research is needed on occupational support provisions that reduce the risk of staff experiencing verbal and physical violence and the stress that is associated with it.

Learning objectives

Participants will...

1. Learn about the incidences and consequences of aggression and violence in the Ugandan health sector.
2. Learn about gaps being experienced by health care workers regarding the management of aggression in the context of the health sector.

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Applying intelligent technology to enhance safety and prevent violence in acute care hospitals

Subtheme: Designing quality safety and risk reduction initiatives

Poster

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Keywords: Intelligent technology, real-time information, risk flagging, violence assessment, safety

Abstract

According to the World Health Organization, healthcare workers are at high risk of violence all over the world. Between 8% and 38% of health workers suffer physical violence at some point in their careers. In Ontario, up to 30% of reported violent incidences originate from health care settings. Having prompt assessment of patients and access to real-time information regarding risk level is important in the prevention of violence and to enhance safety. With advanced use of technology, three processes were developed whereby staff are now able to obtain real-time information about their patients' level of aggression and violence.

An environmental scan and a literature review was conducted to determine the best way to identify and flag patients that are potentially aggressive or violent, and how to best utilize our technology to inform staff of the flagged patients.

Other healthcare organizations were consulted for feedback on determining the best tool to use in collaboration with internal stakeholders. The outcome of the review and consultations determined the Violence Assessment Tool (VAT) was the most appropriate. The VAT was integrated into our intelligent technology system. Clinical practice leaders collaborated with the information technology team to build an algorithm and flagging system that interfaces with our electronic health record (EHR) in three different ways:

1. A "*Behaviour Risk Alert*" flagging is generated on the emergency department tracker, identifying patients with risk of violence. The tracker is visible by all staff and provides up to date real-time data on patients' risk levels.
2. "*Known history of violence & patient demonstrating Agitated/Aggressive Behaviour*" is assessed at each shift for every patient. When a positive response is documented, our new intelligent technology will generate a symbol on the digital room sign monitor located outside of the patient's room that alerts staff of the risk.
3. The VAT is completed every shift which determines the violence risk level as low, moderate or high. The level of risk is displayed in the EHR and on the patient status board located in all team stations.

Once the patient is identified as a risk for violence, our technology enables this violence risk information to be accessible to all staff and physicians during the patient's hospitalization. After 6 months of its implementation, a survey was conducted on select in-patient units to identify the effectiveness of the VAT. Overall, 86% of nurses found the VAT was effective in identifying and flagging patients. This violence prevention program could be used provincially, Canada wide or globally to prevent violence in all healthcare settings. Utilizing this international conference as a platform allows us to present the effectiveness of this system in preventing violence.

Merging technology in healthcare offers a distinct opportunity to have to access to real-time pervasive information, achieve excellence in patient care by being a high reliability hospital, keep our patients and staff safe, and addresses health care needs as they arise.

Learning objectives

Participants will...

1. be aware of the role technology plays in preventing violence and enhancing safety.
2. identify potential opportunities to integrate technology into their own safety programs to prevent violence.

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“U.P. with Safety”: A Universal Precautions approach to reducing Aggressive Behaviour Risk in Acute Care

Subtheme: Designing quality safety and risk reduction initiatives

Paper

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Keywords: Acute care, Aggression, Program, Education, Process, Risk reduction, Visual alerts, Care planning, Tool-kit, Skills, Staff experience, Medical, Surgical, Multi-disciplinary

Introduction

The healthcare sector has one of the highest levels of workplace violence (1, 2). In 2013 the Workers Safety and Insurance Board of Ontario reported that more than 30% of all violence-related lost-time injuries in Ontario occurred in the healthcare sector (3). Data from the Ontario Hospital Association demonstrates that violence from patients is widespread, with 16.8% of hospital employees reporting being the victim of patient violence (3). An Ontario Nurses Association survey showed that 54% of member respondents had experienced physical violence or abuse in the workplace (4).

Patients are the most common source of aggressive behaviour, defined as verbal/emotional abuse, physical assault, and/or threats of physical abuse (5,6). Under-managed behavioural symptoms contribute to poorer patient and staff outcomes. Patients with aggression may have deferred clinical care and/or be treated with excessive chemical or physical restraints (7, 8).

Violent behaviour is especially challenging to address in the healthcare sector as healthcare workers typically feel a duty to provide care, with appreciation that patient aggression is often due to conditions that are beyond the patient’s control (e.g. dementia, delirium, psychosis) (5,9); this contributes to a culture of tolerance. However, the effects of aggression on healthcare staff can be considerable and include physical injuries, psychological trauma (3), increased sick leave (10), and the development of post-traumatic stress and substance abuse disorders (11). There are significant programmatic gaps in current systems for preventing and managing aggressive patient behaviour; innovative effective solutions are needed.

In collaboration with clinical experts, frontline workers, security, health equity experts, patient advisors, Occupational Health and Safety, and research experts from the Institute for Work & Health, we have developed the “*Safe Patient/Safe Staff (SP/SS) Universal Precautions (UP) Program*”. First, an extensive literature review and environmental scan

were conducted. Though leading practices were identified, there was little literature regarding best practices for implementation. Unlike other programs, we chose to target both clinician and support staff (such as housekeeping) and to include worker safety and risk management processes rather than relying solely on education/training. The 'Universal Precautions' approach leverages best practices established for hospital infection control and translates key components into a behaviourally focused adaptation. In addition to training, the evidence-based strategies of individual client risk assessment, flagging and patient-specific care plans are included in order to address patient aggressive behaviour. The SP/SS-UP program contains similar elements as the Public Services Health and Safety Association Individual Client Risk Assessment toolkit, which was developed during a similar timeframe (12).

Currently, a research project is underway to evaluate the following outcomes: (a) after implementation what proportion of staff trained in the Safe Patient/Safe Staff-Universal Precautions program understand and know this protocol? (b) Does the program increase staff knowledge and confidence, and improve attitudes, in managing patient aggressive behaviour? (c) Does the program decrease staff experiences of aggression?

Methods

Currently, a research study is underway to evaluate whether the program will improve worker safety with staff feeling better prepared and safer in caring for high-risk patients. This is a prospective randomized two group (SP/SS-UP program versus control) matched field intervention study. Six units from Sinai Health System (2 medical, 4 surgical) are participating. To account for inter-unit differences, the units were matched on type of unit (e.g., surgical, medical), unit staffing level, patient type per unit and average age (+/-10 years), and approximate level of aggression for the unit and one from each match was randomly assigned via an online randomization program (Research Randomizer) to receive the SP/SS-UP program and one will receive the program after the study is complete (control unit). Staff members are completing questionnaires that assess understanding of SP/SS-UP protocols, attitudes/knowledge toward patient aggression, confidence in dealing with aggressive patients, perception of skill in managing aggressive patients, experience of patient aggression and demographics. These questionnaires are completed before implementation, immediately after the implementation of the SP/SS program is complete and six months after implementation. To ensure that the SP/SS-UP program is delivered as intended, research personnel unknown to staff engage in weekly observations of staff behaviour in order to verify that staff on units where SP/SS-UP is implemented are adhering to SP/SS-UP protocols (i.e. spot checks).

OUTCOMES: (a) Staff adherence to SP/SS-UP protocols; (b) change over time and compared to the control units in staff knowledge, attitude and confidence in managing patient aggressive behaviour; (c) change over time and compared to the control units in staff experience of aggression and emotional abuse.

INTERVENTION: Staff received training on knowledge, safety and behavioural skills related to the management of patient aggressive behavior. Managers and clinical leads from each unit also received training on delivering reinforcement/auditing strategies to their staff to ensure sustained training impact. A system for screening all in-patients, and flagging and care-planning

for high risk-patients was implemented. Participants received training on the program elements (flagging, visual management, care algorithm development).

CONTROL: The current protocols for managing patient aggression on the control units include standard general hospital approaches: clinical screening, code white policies and access to behavioural and psychiatric consultation. As well, proactive consultation is available for patients meeting high risk criteria. All control units have continued with these protocols; they will not receive the SP/SS-UP program training or interventions until the study is complete and the results support implementation.

Results

Implementation began in November 2017. The program has been implemented on the three intervention units. To date, over 400 staff have been trained in didactic sessions. Weekly spot checks demonstrate variable compliance with each of the processes related to the program, however, based on the spot checks, the screening tool is completed for 73.4% of admissions. At the conference, baseline and preliminary survey results about staff knowledge, attitude and confidence in managing patient aggressive behaviour; and staff experience of aggression and emotional abuse will be provided.

Conclusions

The program has been successfully implemented on the 3 intervention units. Follow up data collection will end in August, September and November 2018. Thus, at the October 2018 conference the baseline and follow up data for two pairs will be shared. The results of this research study will provide insight into the implementation of best practices and experience of staff members in using the best practices approach. If results are positive, the comprehensive and portable nature of this program will facilitate adoption by other institutions.

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Learning objectives

Participants will...

1. understand the Safe Patient/Safe Staff-Universal Precautions program for the prevention and management of patient aggressive behavior.
2. be able to explain the real-world implementation strategies used to successfully implement the Safe Patient/Safe Staff-Universal Precautions program on multiple acute care units and involving multiple hospital departments.
3. appreciate the research study outcomes in terms of staff knowledge, confidence, attitudes and experience and, thus, be able to evaluate the effectiveness of the Safe Patient/Safe Staff-Universal Precautions program.

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Chapter 7 – Policy and practice

Unveiling Oppression: Addressing Horizontal Violence among Nurses

Subtheme: Developing policy and guidance based on good practice

Paper

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Keywords: Horizontal Violence, Policy, Integrative Review and management

Background and context

Horizontal Violence (HV) is sustained under a veil of deeply enculturated oppression within healthcare organizations' hierarchical organizational structures that keep nursing leader's decision-making authority constrained, and ultimately impact nursing practice environments. An Integrative Review (IR) explored the organizational antecedents related to HV among nurses and the extent to which policy initiatives reduce its incidence. Findings of the IR inform a hypothesized model of incivility experiences of new graduate nurses for testing. There is a disconnect between organizational roles and anti HV policies. To be effective anti-HV policies must have internal consistency among three elements: problem definition, goals and instruments. The results of the IR reveal that focus on the problem definition statement which is the first, central element; the problem must be recognizable and easily defined. The irony of problem definition is that while it is central to understanding policy, it is rarely articulated in a manner that is congruent with the realities of nursing practice within a policy statement.

Methodology

The IR explored the organizational antecedents related to HV among nurses and the extent to which policy initiatives reduce its incidence. Which organizational antecedents are related to HV among nurses? What are the policy implications of these organizational antecedents? An IR methodology that involved identification, analysis and synthesis of research findings from both qualitative and quantitative studies to determine current knowledge in relation to HV among Registered Nurses (RNs) was employed.

Findings

Health care organizations sustain oppression and power inequity which is deeply enculturated and entrenched within nurses' everyday practice yet remains seemingly protected or guarded by health care organization executives and administrators. For example: a) nurses being placed lower within health care organizations' reporting hierarchy as employees, while other professionals with privileges to the hospital are placed higher; b) nurses having many authorities

to which they report to and are accountable—nurse managers, administrators, patients, and physicians; and c) nurse managers are not being given formal decision-making authority.

Implications for practice

The next steps are to assist health care organizations to understand the impacts of organizational structural hierarchies in sustaining nursing in an oppressed position. If nurse managers understand the impacts of organizational antecedents and climate on RN roles, they can advocate for the breakdown of hierarchies and power inequalities that keep RNs in oppressed positions. This awareness and advocacy facilitates a new understanding of the roots of HV, beginning with incivility should include the organizational roles and the creation of effective anti-HV policies.

Conclusion

Regarding a new conceptualization of incivility experiences of new graduate nurses in the organizational context the following factors seem important: Internationally reported incidences of horizontal violence (HV) are widespread among RNs (Hutchinson et al., 2010). This preponderance initially appears to be a paradox, given the historical under reporting of HV acts (Vessey et al., 2010). However, research findings indicate that 65% - 80% of the nurses surveyed reported to have witnessed or experienced HV (Vessey, Gaffney & Budin, 2009; Wilson, Diedrich, Phleps & Choi, 2011). HV causes nurses to experience increased stress, communication barriers, and concentration difficulties (Yildirim, 2009), and the potential impact on the quality of patient care is notable (Purpora & Blegen, 2012; Vessey, DeMarco & DiFazio, 2010).

Important contextual factors of nursing practice environments (i.e., organizational culture and climate) contributing to HV may be the very factors that are fueling HV; yet contextual factors remain hidden under a veil due to being enculturated through hierarchical organizational processes within health care organizations. Organizational culture refers to the values, beliefs, customs, and norms shared by organizational members or a distinctive subculture within an organization (Pilsch & Turska, 2015). Organizational climate reflects perceptions of organizational features like decision making, leadership and norms about work (Stone, Harrison, Feldman, Linzer, Peng et al., 2005). Researchers have sometimes used the terms '*culture*' and '*climate*' interchangeably.

Organizational antecedents related to work environments, structures, and processes lead to escalation of incivility to bullying and HV (Einarsen et al., 2003). Escalation of behaviors to HV is problematic for policy makers to discern behaviors to target in HV problem identification. Further, it is difficult to distinguish what HV is and is not due to competing terms and definitions. Moreover, organizational leaders continue to grapple with the etiology of HV and its impact on the nursing profession (Clarke et al., 2012). Competing definitions adds complexities for researchers/policy makers to clarify and define the problem of HV (Griffin, 2004; Harlos & Axelrod, 2008).

The focus of the IR was problem definition of the policy statement—the first, central element; the problem must be recognizable and easily defined (Pal, 2014). The irony of problem definition is that while it is central to understanding the policy, it is rarely articulated in great detail in a policy statement (Pal, 2014). An IR was conducted to discern the factors that contribute to the problem of HV among nurses to obtain clarity in deriving anti-HV policies that accurately reflect the realities of the nursing practice environment. The assumption of the negative impact of multiple terms defining HV affecting the problem definition of HV and internal consistency of anti HV policy statements were confirmed. When problem statements within anti HV policies are not clear then we question whether anti-HV policies are making a difference to mitigate HV.

Defining the Problem of HV

Research findings show that environmental factors such as laissez-faire leadership style, oppressive working conditions and low job control contribute to the presence of incivility, bullying and HV in health care organizations (Hutchinson et al., 2010; Purpora & Blegen, 2012; Rodwell & Demir, 2012). Historically, oppressive work environments have been enculturated into the nursing profession, and sustained, as evidenced today by nurse leaders, without any formal decision-making authority (Croft & Cash, 2012).

Anti-HV Workplace Policy

Regardless of the anti HV workplace policy, HV remains prevalent among nurses (Vessey, De Marco & Gaffney et al. 2009; Wilson et al., 2011). Therefore, understanding the role of anti-HV policies as a health care organizational antecedent presents an opportunity to address HV (Ma, Wang & Chen, 2011; Coetti, Davis, Guessferd et al., 2012). Anti-HV policies may play a role in the creation of power imbalances when it comes to rank structure, leading to authoritarian leadership styles, and a strong emphasis on conformity of RNs to particular institutional norms of behavior. Anti-HV policy in the IR are workplace policies meant to curtail incidences of HV; for example, policies such as anti-HV, zero tolerance, workplace respect, and code pink (ANA, 2015; 2017). Ultimately, addressing incivility along the negative workplace behaviors continuum is optimal for health care organizations to curtail progression to HV.

Aim

A high level review of an IR (Blackstock et al, 2018) to analyze organizational antecedent factors related to HV among RNs assists in problem identification, clarifying policy development, and next steps in the first author's research. Two questions guided the IR: 1) Which organizational antecedents are related to HV among nurses? 2) Have anti-HV policy initiatives reduced the incidence of horizontal workplace violence among nurses?

Methods

Design

An IR methodology that followed the steps outlined by Burns, Grove and Gray (2011) was used. Steps included “*identification, analysis and synthesis of research findings from independent studies to determine the current knowledge (what is known and not known) in a particular area*” (Burns et al., 2011, p. 24). The IR included identification, analysis and synthesis of research findings from qualitative and quantitative studies determining current knowledge of HV. Steps to achieve standards of clarity, rigor and replication for primary research were well documented in the IR. The rigor of the IR followed the integrative stages and methods outlines by Soares’ et al. (2014). Once the aim of the study and associated questions, the inclusion criteria, and key search terms were formulated, the next steps were: systematic literature search, review of results using inclusion criteria, screening, data assessment, quality review, data synthesis, and reporting of results.

Results

Search Results

The electronic data base search resulted in over 1,423 titles and abstracts. The final list included a total of 22 studies, featuring 16 quantitative studies and six qualitative studies met the inclusion criteria. High level results are reviewed to provide context to subsequent conceptual model of incivility development.

Research Question 1: Which organizational antecedents are related to HV?

In total, 19 different organizational antecedents were found across the 22 studies. Organizational factors of labor environment (i.e., working conditions, tasks and teamwork) and demographics (Ariza-Montes et al., 2013); workplace environmental factors (i.e., nursing role in quality of care/hospital affairs, staffing resources, and manager’s ability); practice environment (Yokohama et al, 2016); and organizational culture (An & Kang, 2016; Yeun, & Han, 2016) were important constructs for understanding incidences of HV. The most relevant constructs used to explore organizational antecedent factors were categorized as: influential working conditions, relational aspects of teams and leadership, organizational culture, climate and the role of structural process. Two categories were :a) Influential working conditions, relational aspects of teams and leadership; and, b) organizational culture, climate, and the role of structural processes.

Research Question 2: Have anti-HV policy initiatives reduced the incidence of horizontal workplace violence among nurses?

While we were unable to conclusively answer the question, we identified leadership roles, decision-making authority, and organizational structures’ relationship with anti-HV policy. We analyzed and synthesized study results related to the second question, which provided two themes: 1) leadership role and decision-making authority and 2) organizational structures’ relationship with anti-HV policy. Reconceptualizing HV by understanding the role of politics within health care organizational structures show promise to reposition workplace policies and laws; beginning with addressing incivility within health care organizational structures to mitigate HV.

Discussion

Organizational Antecedents, Policy and HV

Problem definition is key, yet rarely articulated in a cogent manner, reflecting the realities of nursing practice within a policy statement. The studies included in the IR (Blackstock et al., 2018) explore organizational factors related to HV, offering important insights into its conceptualization and understanding for policy makers, analysts, and nurse leaders. The relationship between reporting structures and the position of nurses within the organization informs the anti-HV policy. The hierarchical and horizontal axes of reporting and management structures are important to be articulated within anti-HV policies; most of the included studies did not indicate the nature of the anti-HV policies and the reporting structures. A political analysis of HV can offer insights into the problem by understanding organizational antecedents in relation to promotion/career advancement and the interplay within health care administrative structures. Politics has special meaning from a meta perspective as well as within groups and social networks; the interplay of relationships, influence, co-operation, and loyalty combine as powerful forces, shaping and molding the behaviors of individuals within the group (Stone, 2011). It has been argued that HV is rationalized by perpetrators to serve their self-interest (Katrinli et al. 2010). However, researchers have found several potential political reasons: the influence of promotion, assignments, recruitment, and dismissal, allocation of equipment, and organizational structure decisions, all of which may be related to rationalization of HV by nurse perpetrators (Katrinli et al. 2010). Some studies included in the IR did not mention politics explicitly, however, measures and themes that examined social networks impacting promotion, allocation and organization of RN work, were present in the research.

Research Implications

Further research should explore anti-HV policies to discern the effectiveness of anti-HV policies. The discourses of anti-HV policies should be congruent with the workplace and system-level issues that contribute to the problem of HV (Johnson, 2015). Exploring the role of administrative structures, giving authentic decision-making power, and authority to nursing leaders is a first step in stopping oppression in nursing. Secondly, zero tolerance policies in the workplace are remiss in conceptualizing the problem of HV; an assumption persists that bullying occurs only at individual level rather than through alliances or at the group level, thereby ensuring reports are minimized if they are reported at all (Hutchinson et al., 2010). Future researchers will determine whether the implementation of policy initiatives has reduced the incidence of HV among nurses once nurse leaders are given the decisional authority to mitigate antecedents contributing to HV and to deal with HV incidents.

Making the Case for proposing a new model

Researchers have looked at the role of authentic leadership focusing on cognitive (i.e., attitudes of employees) and emotional (i.e., trust) aspects in relation to organizational outcomes, commitment, satisfaction with leaders and intention to stay (Alvolio et al. 2004). The influence of authentic leadership has been postulated to extend beyond bottom-line success, because of leadership initiatives tackling public policy issues and addressing organizational problems (George, 2003). Authentic leadership has a role in counteracting the negative impacts of

reengineering of organizational structures on frontline health care professionals to restore confidence, hope, resiliency and meaningfulness (Aiken et al., 2001; Aiken et al., 2002; Avolio et al., 2004).

Health care organizational leaders have embraced and relied on this notion of exceptional nursing leaders countering the impacts of reengineering rather than dismantling organizational hierarchies that sustain nursing in positions of oppression and lack of formal decision making authority and power as it relates to incivility in nursing. Organizational, patriarchal structures and hierarchies within the nursing work environment have remained constant therefore so is the lack of power of nurses and nurse leaders; a lack of power act as antecedents in a chain of factors contributing to incivility with the potential to escalate to HV. Nursing has evolved since Florence Nightingale's era however, the lower ranking of role of nurses within the hierarchical structure of health care organizations remains constant. The author's future research looks at the indirect causal effects along a chain to the constructs of empowerment, authentic leadership with decision making authority to impact job demands and resources are inter related in the causal world of horizontal incivility experiences of new graduate nurses.

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Learning objectives

Participants will...

1. Reflect that it is time to dismantle and unveil historical organizational hierarchies within healthcare organizations that inadvertently propagate oppressive nursing work conditions that may act as organizational antecedents to HV.
2. Understand that the findings of the integrative review are a step to expand the in-depth understanding of the relationship of organizational antecedents to incivility and clarify the interrelationships of workplace culture and climate to incivility experiences.
3. Realize that the mitigation of incivility stops the progression to HV and will impact the attrition of RNs and foster a healthy work climate for student nurses, new graduates, and clinical educators.

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Appropriate guideline for preventing workplace violence in health sector using a participatory action research

Subtheme: Developing policy and guidance based on good practice

Poster

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Keywords: Sorkplace violence, healthcare workers, health sector, participatory action research

Abstract

Background

Workplace violence is known as a global health problem, especially in health sector for a quarter of all. Most studies aimed to determine prevalence and risk factors, leading to knowledge that proportion of non-physical violence is higher than physical violence. Major well-established guidelines were known to prepare and manage this problem which mostly focused on many training programs which mostly focus on hardware, for examples, facility design, and workplace procedures. The recent study (2018) of a tertiary hospital's setting in northeastern Thailand showed that health care workers (HCW) in the high risk groups of workplace violence agree to the OSHA's guideline content between range 59.2-100%, whereas the hospital situation regarding OSHA'S guideline were rated between 1-88.9%. In addition, such study showed 81.4% were experienced in workplace violence, which is more verbal violence than physical violence, therefore OSHA's guidelines may not be appropriated to Thailand healthcare setting.

Objective

To develop and apply a practical form of preventing workplace violence system in health sector by using a participatory action research.

Methodology

A participatory action research will be performed. Study population will widely include stakeholders, hospital executives, occupational health and safety management, health personnel, and researcher. Current situation regarding workplace violence will be analyzed in terms of types of incident and probable causes. The system for preventing workplace violence in health sectors, adapted from major international guidelines, are contemplated by researchers and health personnel, as co-researchers, initiative to a practical form of system. Implementation will be evaluated while conducting and after action reviews. Data collection will spend 8 months.

Results

An initial result will be ready before October 2018.

Learning objectives

Participants will...

1. learn how we practically adapted major guidelines in our setting and situation.

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Psychiatric Emergency Unit Introduces A New Model Of Care Using LEAN Methodology

Subtheme: Practice initiatives

Paper

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Keywords: Lean Methodology, Violence Assessment, Quality Improvement, Model Change

Abstract

This presentation will outline an improved model of care introduced in 2017 in the Psychiatric Emergency Service Unit at a large urban acute care hospital in Toronto. Over eight weeks, the team organized 5 Quality Improvement Days to identify opportunities for improvement, establishing 4 interprofessional working groups. Applying the principles of LEAN methodology, each group addressed the identified opportunities and implemented improved evidence-based standard work processes.

One group developed a standard operating procedure to improve communication and safety between patients and staff when transitioning a patient from the Emergency Department triage into the Psychiatric Emergency Unit. The second and third groups updated the nursing assessment protocol to include comprehensive and current best practice assessments and care-planning tools. These best practice assessments included introducing the Dynamic Assessment of Situational Aggression (DASA), and an updated search of property protocol.

The last group applied the principles of “*See It Shine*” to declutter the PESU area thus eliminating time and motion waste of team members. Changes to the layout of the unit including calming posters, new furniture have created a more welcoming environment for patients and staff.

The model reflects the unique, complex and changing needs of patients and has reduced the incidence of code whites in the unit.

Learning objectives

Participants will...

1. understand how to apply Lean Methodology to improve practice.
2. have increased knowledge of using the DASA to assess for violence.

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The Nurses' Campaign for Workplace Violence Prevention in California and the United States

Subtheme: Policy initiatives

Paper

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Keywords: Nurses; Workplace Violence; Regulation; Enforcement

Abstract

This presentation will look closely at the landmark California Workplace Violence Prevention in Health Care Standard and the role the enforceable standard has played in reducing workplace violence in hospitals and other healthcare settings in California. This standard, won by union nurses, marks not only a significant achievement in improving healthcare worker safety, but also an important lesson about the centrality of direct care workers' testimony and expertise to improving workplace health and safety.

The California Nurses Association (CNA) is a state-based arm of National Nurses United (NNU), which is the largest labor union and professional association for registered nurses in the United States. CNA/NNU accelerated its campaign for workplace violence protections after a union member died as a result of a preventable workplace violence incident in 2010. CNA/NNU sponsored legislation, which was developed based on direct care registered nurses' experiences and expertise, passed in 2014. This legislation was a crucial element leading to one of the fastest regulatory projects of the state program responsible for enforcing the federal Occupational Safety and Health Act (known as Cal/OSHA). CNA/NNU members' testimony and expertise was essential to the formation of the standard. Cal/OSHA's Workplace Violence Prevention in Health Care Standard (Calif. Code of Regulations Title 8 Section 3342) is one of the most comprehensive workplace violence standards in the world, and has a final implementation date of April 1, 2018. The Cal/OSHA Standard requires that employers develop comprehensive, facility- and unit-specific prevention plans, obtaining the active involvement of employees regarding hazards, prevention measures, and training. CNA/NNU has implemented a robust enforcement program, including member and staff education, shop floor organizing, contract bargaining, and interfacing with the enforcement agency, Cal/OSHA.

This presentation will describe CNA/NNU's grassroots campaign to win legislation and an enforceable standard, the significant protections won in the standard, as well as barriers to and successes of nurses' enforcement efforts. CNA/NNU has also led the push for workplace violence protections nationally and in other U.S. states.

This closer study of the California Nurses Association/National Nurses United's (CNA/NNU) campaign to win and leverage one of the most comprehensive workplace violence standards in

the world offers insights and lessons for maintaining and growing workers' collective power during the current era of de-regulation and attacks on unions, and the central role that direct care workers' expertise could—and should—play in developing workplace violence prevention programs.

Learning objectives

Participants will...

1. be able to describe the development and content of the California Workplace Violence Prevention in Health Care Standard.
2. be able to discuss the importance of employers gaining direct care registered nurses' input and expertise when developing effective workplace violence prevention plans.

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The Flagging Policy and the Challenges Hospitals Face

Subtheme: Policy initiatives

Paper

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Keywords: Flagging policy, patient violence, hospitals, stigmatization, patient privacy

Introduction

Violence towards healthcare workers is a significant health and safety concern. When compared to other service providers such as police officers and prison guards, healthcare workers are at the highest risk for workplace violence (Kingma, 2001). As high as 85% of healthcare workers experience workplace violence at least once in their career (Hahn et al., 2012). In Ontario, Canada, 12% of lost-time injuries in the healthcare sector in 2015 were due to violence (Workplace Safety and Insurance Board, 2016). To protect workers from violence and harassment in the workplace, Bill 168, an Act to amend the Occupational Health and Safety Act was enacted in 2010, which outlines employers' roles and responsibilities, including developing and implementing policies and programs. Flagging, a standardized method of communicating safety-related concerns to workers (Public Services Health & Safety Association, 2017), is one such policy that hospitals are implementing to meet their legislated responsibilities. However, flagging is a contentious issue and hospitals face challenges impacting successful implementation and the safety of staff.

Methods

A case-study was conducted with five acute care hospitals in Southwestern Ontario, Canada. An exploratory qualitative research approach was used to examine the underlying mechanisms and contextual influences that support or limit the successful implementation of the flagging policy. Data were collected in the following ways: 1) hospital documents related to their violence prevention program; 2) interviews with external key informants, and; 3) focus groups and/or interviews with frontline staff, management staff, and management representatives (e.g., health and safety consultant). Ethical approval was granted by the University of Toronto Research Ethics Board and the four hospitals that had an internal research ethics board.

Recruitment and Sampling

Purposive sampling was used to recruit hospitals and staff. Of the 11 hospitals that were shortlisted, 8 were contacted, and 5 participated. Hospitals ranged in size and were located in urban, semi-urban, and rural areas. A total of 157 frontline clinical and non-clinical staff, and management from the 5 hospitals participated (Table 1). Eight external key informants were

interviewed prior to hospital data collection. They included senior leadership from health and safety associations, unions, training organizations, and policymakers. Key informants were members of our advisory committee or were referred by members of the advisory committee or scientists from the Institute for Work & Health.

Table 1: Hospitals and Hospital Staff Participants

Site	Hospital Characteristics	Focus Groups /Focus Group Participants	Interview Participants	Frontline Clinical Staff	Frontline Non-clinical Staff	Management Staff*
1	Large (500+ beds); multi-site	3 / 16	17	19	6	8
2	Medium (300-500 beds); single-site	4 / 33	7	19	11	10
3	Medium (300-500 beds); single-site	3 / 20	8	12	7	9
4	Small (<100 beds); single-site	3 / 20	6	6	13	7
5	Large (500+ beds); multi-site	5 / 19	11	8	7	15
Total		18 / 108	49	64	44	49

Note. Some management participants had dual roles. Participants who had dual roles were counted as management representatives.

Data Collection

Focus groups were conducted in a private room at the hospital site; interviews were held in person or via telephone depending on the participant's work schedule and preference. Consent to participate in the audio-recorded sessions was obtained from all participants. At their discretion, hospitals shared documents related to their violence prevention program, such as: codes of conduct; policies and procedures on incident reporting, risk assessment, panic alarms, flagging alerts, and; training materials including new staff orientation. Documentation review allowed us to gain knowledge of each hospital's program and to customize the interview and focus group questions for rich interview and focus group discussions.

Data Analysis

The audio-recorded interviews and focus groups were transcribed verbatim and de-identified. Data were analysed using thematic content analysis. First, a manual of codes and definitions was established by members of the research team. Next, transcripts were coded in two rounds by two researchers; common themes and concepts were identified. Discrepancies in coding and interpretative differences were discussed and resolved. Data pertaining to each code was reviewed and common themes identified. Analysis and interpretation examined core experiences, underlying assumptions, shared and divergent perspectives, contradictions, silences and gaps (Poland & Pederson, 1998).

Findings

Four of the five hospitals had a flagging policy in place. In addition to the similarities in policy components, procedures, and communication methods, hospitals experience four main challenges:

Flagging is an Act of Stigmatization

Several participants contend that flagging patients is an act of stigmatization. It is believed that a worker's knowledge of a patient's potential for violence will lead to poor patient care delivery. However, participants did not provide examples of themselves or colleagues treating patients sub-optimally because of patients' flag status. Flagging mental health patients is also a concern as this population is already at risk for stigmatization. *I think it [flagging] is enormously stigmatizing. For an illness that the symptoms make people do things that they wouldn't normally do, to flag them in that way I think is doubly stigmatizing* (Mabel, Director, site 5). On the other hand, participants are concerned that failing to use visual alerts, such as wristbands, to flag potentially violent mental health patients jeopardizes the safety of others: *... but the issue with the wristband that we're fighting with the hospital on is they're not going to put them on mental patients because it stigmatizes them. Well, now you're stigmatizing everyone that's not [a] mental [health patient]* (Focus group participant, site 5). Participants also talked about the difficulty with discharging flagged patients to other institutions because they may not be accepted. This practice discourages staff from reporting violent behaviours on patient charts or transfer forms.

Patient Privacy and Staff Safety - a Balancing Act

Several participants believe that hospital leadership focuses on patient privacy above staff safety. Dorit, a registered nurse (RN) who was badly injured by a patient several years prior to the study, remained in conflict with her employer over return-to-work accommodations. From Dorit's perspective, the conflict continues because of her employer's stance that patient privacy takes precedence over employees' access to patients' behaviour related information. Dorit explains: *In Bill 168 it's very clear. It's very clear. There's a clause even in PHIPA [Personal Health Information Protection Act], and they [employer] said no. They are hiding behind PHIPA. I've been off work for two years because they were saying PHIPA trumps your safety* (Dorit, RN, site 1). Emily, an external key informant who works for a union echoes Dorit's claim that employers focus more on patient privacy than staff safety and doing so implies that privacy acts outweigh the Occupational Health and Safety Act in cases of flagging violent patients: *Flagging violent clients is something that places don't do well, and we're still having the argument with places, that they have a duty to do it and they hide behind privacy and say we can't do it. And, Section 2 of the Health and Safety Act says that it prevails* (Tamara, union employee key informant).

Policy and Procedural Clarity is Key to Communication

Hospitals have a number of communication methods in place, however, gaps in policy and procedures prevents successful implementation of their flagging policy. For instance, hospitals use signage to direct non-clinical staff who are not authorized to access patient charts, to locate a flagged patient's nurse. Once the nurse has been located, the nurse provides instructions about how or if the flagged patient should be engaged. Repeatedly, participants are unable to locate

the nurse or another clinician who can provide further instruction: ... *you spend half your time looking for that person's nurse to say, can I go in there? They might be on break and the other people are like, well, I don't know. [...] We don't know whether we can actually enter this room* (Focus group participant, site 3). At another site, only managers are authorized to initiate flags, thus clinical staff or acting supervisors place temporary flags in the system for managers to review and initiate when back on duty. This practice results in delayed flagging decisions, putting the safety of others at risk.

Procedures to communicate about flagged patients during patient transfer between units or facilities are not always clearly outlined and/or implemented, preventing information about a patient's behaviour from being shared. Contributing to this issue is the relative lack of control a receiving unit or hospital has in the information provided by the transferring unit or facility. One participant discusses this issue and provides a recommendation to improve staff safety: *Let's say you're coming from [neighbouring city]. You move down here. You had to leave [neighbouring city] because you're a violent person. You're down here. Nobody knows anything ... But if that could travel with you, like someone suggested, with your OHIP [Ontario Health Insurance Plan] card, it's not the greatest thing to ever have on your [personal hospital record], but it saves us* (Focus group participant, site 5).

Non-compliance with the Flagging Policy

Findings show that staff who do not agree with the practice of flagging implement only parts of the flagging policy. Although a patient may act out violently, participants evaluate the patient's intentions behind the behaviour before deciding to implement the flagging policy. For instance, if a nurse has determined that a patient's violent behaviour toward the nurse was not intentional, the nurse may not report the incident counter to the hospital's flagging policy.

Jade discusses the lack of sensitivity in flagging procedures as a reason why staff may not comply with the flagging policy: *If patients are identified as violent or with a history of violence, they're flagged permanently. You could have somebody who is upset about the loss of a child and swears, and somebody who lashes out with a weapon and hurts somebody, or kills somebody even, and they're flagged in the same way. There's no gradation. That's the biggest problem, I think. What ends up happening is it doesn't work for staff, so they sort of pick and choose how to apply it. So, they're in the position of not following their own policy. That's an issue. Staff will develop work-arounds* (Jade, Director, site 2).

Discussion and Conclusion

Hospitals have developed and implemented flagging practices to meet their Ontario Health and Safety Act (OHSA) legislated requirements. However, flagging patients for violent behaviours is a contentious issue with several challenges. Findings show that hospitals experience policy and procedural gaps and a widespread belief among frontline and management staff that flagging is an act of stigmatization, all of which may contribute to non-compliance. These challenges perhaps indicate a lack of knowledge of the OHSA and the purpose of flagging, and a rooted belief that certain types of violence are part of the job. Misinformation, policy and procedural gaps, and non-compliance threaten the safety of staff and others. It is recommended that hospitals: regularly educate and train all hospital staff of the OHSA and flagging policy;

regularly review and revise the flagging policy and procedures to meet the unique needs of individual hospital units, and; establish a hospital culture of zero tolerance.

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Learning objectives

Participants will...

1. learn about four challenges some hospitals encounter when implementing a flagging policy.
2. have a basic understanding that a hospital's safety culture and flagging procedures impact the success and sustainability of the flagging policy.

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Evaluation of Zero Tolerance Policy Effectiveness in Health Care: Systematic Review

Subtheme: Policy initiatives

Poster

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Keywords: Zero tolerance, policy, health care, violence

Introduction

The incidents of violence and aggression continue to exist today in the healthcare system (Middleby-Clements & Grenyer 2007). Various country studies show that doctors and nurses are at significant risk for threats and assaults in the workplace (Gabe & Elston 2008, Di Martino 2003, Kaplan et al. 2013). Di Martino (2003) stated that violence in the health sector constitutes 25% of the violence cases in the workplace. When the causes of violence towards healthcare professionals are examined in the literature, the absences observed in the conduct of regulations regarding poor communication, high levels of stress, heavy workload, gaps in the judicial system, lack of security precautions and protection of healthcare professionals come into prominence (Kaplan et al. 2013). In a growing number of countries, various violence prevention programs have been developed to prevent the emergence of violence incidents and to tackle concerns about increased violence in the health sector (Cvitkovich 2005). “Zero tolerance” is the most comprehensive in the programs to reduce the risk of violence and prevent violence in health sector (Middleby-Clements & Grenyer 2007, Cvitkovich 2005). This document describes the actions required to establish and maintain a culture of zero tolerance against violence (Middleby-Clements & Grenyer 2007, Bond et al. 2009). On the other hand, with ‘zero tolerance’ approach, the document aims to assure employees that normalization of violence towards healthcare staff working in the UK National Health System is no longer possible by stating that violence is unacceptable (Bond et al., 2009).

Method

Aim

It was aimed to systematically investigate the studies that assess the effectiveness of the ‘zero tolerance’ policy approach through a systematic point of view.

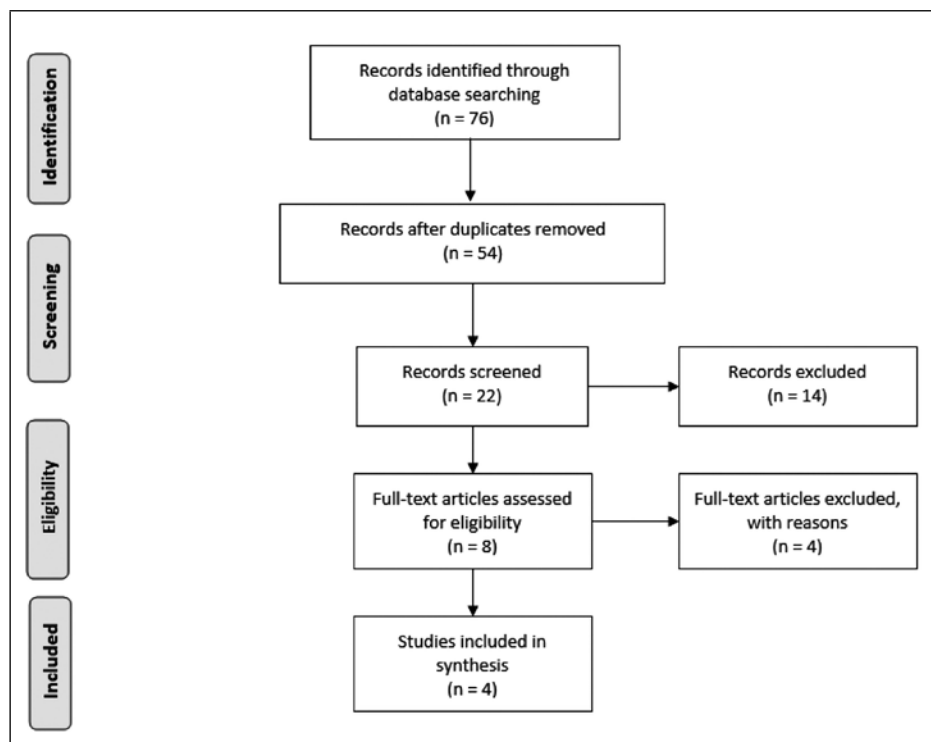
Electronic search process: We conducted a search in the following databases: PUBMED, Wiley Online Library, Cochrane Library, Google Scholar and reference lists of articles. A systematic search strategy was conducted.

Search methods for identification of studies: The search strategy consisted of key words, including 'zero tolerance', health care, violence, aggression. Search words could be in title, keywords/text word. The specified databases were scanned without time limitation. Following the electronic search, manual searches were also conducted by searching the reference lists of included studies. The search was limited to articles in English. Studies with full text access were included.

Types of studies: We included all studies that evaluated the effectiveness of zero tolerance approach in the health care system.

Types of outcome measures: The primary outcome of this study is the effectiveness of zero tolerance approach on the healthcare system.

Fig. 1. PRISMA flow diagram (Moher et al. 2009)



Data extraction: All duplicate publications of studies were extracted. In order to determine the appropriate studies in terms of content, 2 authors independently scanned all titles and abstracts. Irrelevant studies were excluded. The method and the result sections of the studies determined at the end of the scanning were read and the reference lists were examined one by one. Those who provided full text access from the related articles were evaluated through the same process for their suitability to the study.

Results

Overview of the literature search results

A total of 76 studies were reached as a result of systematic scanning in the databases. Of these, 22 related studies with full text access were determined. Following the detailed review, it was determined that 8 studies including 4 original research and 4 reviews were appropriate. 4 original studies were included in this study. A schematic diagram of the literature search procedure used in this review is shown in Fig.1. An overview about the included studies is presented in Table 1.

Whittington (2002), a descriptive study in England, examined whether the tolerance of aggression varied among mental health workers and determined the occupational and stress factors affecting the tolerance level in the zero tolerance era. Thirty-seven staff completed a Tolerance Scale (from the Perceptions of Aggression Scale) and the Maslach Burnout Inventory. In this study, which was carried out in the UK National Health System where zero tolerance against violence towards healthcare staff is officially implemented, tolerance levels of employees' for attitudes towards violence were determined. The result is that tolerance for aggression and violence is higher in those with more professional experience and that higher tolerance is found to be associated with low emotional exhaustion and high personal accomplishment. Tolerance tendency was found to be strongly related to burnout level and duration of experience from occupational factors. Some employees made positive statements that support aggressive behavior of patients. Such complex attitudes of nurses related to patient aggression are stated to create dilemma within the framework of zero tolerance against violence approach.

Table 1. Overview of studies in this review reporting about zero tolerance approach

Study	Subject characteristics	Number of enrolled subjects	Study outcome parameters
Whittington 2002	Nursing staff	77	Tolerance Occupational stress
Middleby-Clements&Grenyer 2007	Health care staff	117	Rigidity Tolerance Confidence and skills
Meloni&Austin 2011	Health care staff	Three phase study n:421 (2005) n:660 (2007) n:710 (2008)	Employee satisfaction
Pam 2013	Health care staff	103	Workplace violence

Middleby-Clements and Grenyer (2007), an experimental study in Australia, included zero tolerance approach in a training program regarding prevention of aggression and violence towards healthcare staff, divided staff into 2 groups, applied the original program on one group and information about zero tolerance policy added form (manual which determines 6 zero tolerance attitudes and behaviors) on the other group. Rigidity, tolerance, confidence and skills toward the management of aggression were the main outcomes of the study. When the outcomes were examined separately in terms of groups, both interventions were seen effective on improving the skills to cope with violence and aggression. However, it was seen that the healthcare staff, who know the zero tolerance policy, increased their rigid attitudes and their

tolerance towards violence decreased. In this study, undesired results as zero tolerance training makes attitudes in healthcare staff strict were observed.

Meloni and Austin (2011), a case study in Australia, collected data with '*employee satisfaction survey*' in 2005, 2007 and 2008 in the study they applied the program of zero tolerance against bullying and harassment in workplace. At the beginning, employee satisfaction was low, and employees' rates of encountering with bullying were high. For this reason, the application of the program was introduced and it was seen that the program has positive effects on the measurements made after 3 years and the employee satisfaction was increased.

In Nigeria, a descriptive study conducted to observe the effectiveness and cost of zero tolerance policy for reducing the workplace violence, Pam (2013) determined the opinions of the employees on the basis of the responses given to the 16-item questionnaire. The results indicated that zero tolerance policy was not effective on reducing workplace violence and that the cost of applying zero tolerance interventions was greater than the benefits of the practice.

Discussion

In this systematic review was formed by examining four original research studies. Violence in the health system has been a real part of the life since the first years of organized health services, but recently governments have begun to acknowledge the existence of this problem and looked for ways to fight. The '*zero tolerance*' policy among the fighting methods is the latest developed approach (Holmes 2006). The basis of zero tolerance policy was laid in the UK and then started to be used and developed among the countries of the world (Meloni and Austin 2011, Pam 2013). Although zero tolerance against violence approach is adopted by governments, the effectiveness of this approach to prevent violence is limited (Middleby-Clements and Grenyer 2007) and even in Australia the authorities refused to adapt it to the system. Yet another study in Australia (Meloni and Austin 2011) found that zero tolerance approach is effective on increasing employee satisfaction. It is seen that in literature, studies on '*zero tolerance against violence*' approach focus generally on employee satisfaction and attitudes towards violence (Whittington 2002, Meloni and Austin 2011), and studies on the incidence of violence only show the conclusions reached from employees' attitudes (Holmes 2006, Pam 2013).

It is also clearly stated in the literature that the zero tolerance approach for prevention of violence in the healthcare system is useless for employees (Holmes 2006), and even employees have positive statements about patient aggression (Whittington 2002). These results may explain the limited effect of zero tolerance policy determined by research. It has been emphasized in the literature that rather than the adoption of zero tolerance approach, willingness to listen and to discuss and the problem solver attitude will improve the therapeutic relationship and that these are the main components in healthcare professionals' practices (Wand and Coulson 2006). Along with stating that zero tolerance approach is effective on increasing the employee satisfaction (Meloni and Austin 2011), it is also indicated that tolerance against violence is reduced and rigid attitudes are increased (Middleby-Clements and Grenyer 2007) in those who adopt zero tolerance approach. In other words, on one hand, the zero tolerance approach can be interpreted as a way of increasing job satisfaction by allowing healthcare employees to feel

safe, and on the other hand, it can be interpreted as indirect contribution of the employees to violence with their one-sided viewpoints or effect potential that interrupts empathy skills, which are counted as the basis of the healthcare. The lack of similar studies in terms of methodology is a limitation in this review which is conducted to evaluate the effectiveness of zero tolerance approach on prevention of violence.

Conflict of interests

The authors declare no conflict of interests.

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Learning objectives

Participants will...

1. understand the pros and cons of zero tolerance policy.
2. be aware of the effectiveness of zero tolerance policy to prevent violence in health care.

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Reporting and consequences of workplace violence in six Ontario hospitals

Subtheme: Policy initiatives

Paper

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Keywords: Surveillance, reporting, consequences

Abstract

Understanding trends in workplace violence in health care or other sectors relies, in part, on the collection of reliable and valid indicators of the incidence of workplace violence gathered in a consistent way over time. In 2018, the Province of Ontario will start collecting the number of workplace violence events (annually) as a new mandatory indicator within each hospital's quality improvement plan. However, we currently do not know what proportion of workplace violence incidents (as defined under the Occupational Health and Safety Act) are captured by each hospital's reporting system. We also lack information on reasons for not reporting workplace violence incidents, which could be integrated into approaches to improve overall workplace violence reporting in the health-care sector.

In this presentation, we will provide findings from a survey in late 2017 of over 1,000 workers in six Ontario hospitals. The survey focused on the incidence, reporting and consequences of workplace violence. Among the sample 41% experienced some type of workplace violence in the previous 12 months, with 22% experiencing a physical assault, 24% experiencing an attempted assault, and 31% experiencing a threat. Among respondents who experienced one or more assaults, 45% did not report any of these assaults to their hospital system, while the same numbers for attempted assaults and threats being 51% and 64% respectively. The presentation will discuss reporting across other aspects of workplace violence, and common reasons for not reporting workplace violence to a hospital system.

Learning objectives

Participants will...

1. gain an understanding of hospital reporting systems as a source of workplace violence surveillance.
2. appreciate the consequences of workplace violence among health care workers.
3. identify targets to improve workplace violence reporting in Ontario hospitals.

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Caring Communities as positive interventions to enhance inclusion, empowerment, and civic engagement

Practice initiatives

Paper

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Keywords: Caring Communities, mutual support, basic needs, Positive Peer Culture

Introduction

Caring Communities (CC) stand for a cross-sectoral and cross-thematic concept for coping with individual and social tasks, for the bundling and cooperation of support services in the community, and for strengthening individual co-responsibility in public space. CC also stands for pro social attitudes and values. From a systemic point of view, CCs are an expression of a culture of mutual concern and help. In organizations and in the residential quarter, they counterpoint exclusion, abuse, and bullying. The group's dialogue offers the possibility of an appreciative confrontation against bullying. However, they also offer the ideal opportunity to address experiences of violence and abuse in the group and to receive support in the search for solutions. The group's dialogue thus makes it possible to take responsibility, to confront problems in an attitude of concern, and to reframe deadlocked patterns of thought.

Caring Communities to support acute and the chronically ill people

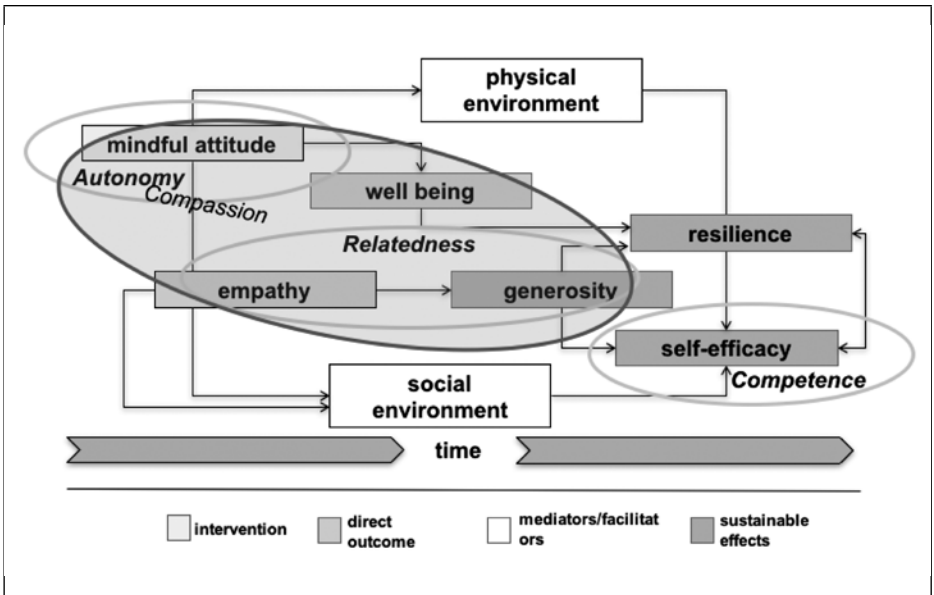
Inclusive offers have to meet the needs of people in their special circumstances. On the other hand, however, people e.g. with chronic diseases should not be reduced to their disease and their special needs. Members of inclusive "*caring communities*" themselves will profit from the diversity of interests, problems, competencies, etc. At the same time, the experience of being able to help others, regardless of one's own problems, promotes empowerment and self-esteem.

Motivational and social aspects

We understand "*caring communities*" as groups of actors whose main concern is to help others. We assume that the groups will be reliable and sustainable if the group meetings serve the basic needs of their participants. According to Self-Determination Theory (Ryan & Deci, 2017), we see belonging, autonomy, and experiences of competence as central basic needs. Following the Circle of Courage we add "*generosity*" as a fourth basic need (Steinebach et al., 2018). In a comprehensive conditional model, the factors "*mindfulness*", "*empathy*", "*generosity*", "*compassion*", and "*well-being*" are put into composition (Steinebach et al., 2018).

Prosocial behaviour is proposed to be one of the mediators through which compassion exerts its positive effect on psychological health, by increasing social connection and self-efficacy (Goetz et al., 2010; Lim & DeSteno, 2016). In models of human affiliation, compassion is seen as an emotional state that enables the individual to act prosocial (Brown & Brown, 2015; Depue & Morrone-Strupinsky, 2005; Keltner et al., 2014).

Figure 1: Model of mindfulness related interventions in positive environments (Steinebach et al., 2018, p., 152, translation by the authors)



Research and transfer

We were particularly interested in two research questions: (1) Does helpfulness really play a key role when it comes to preventing violence and bullying and building and maintaining well-being and resilience? (2) Which factors support the transfer of positive experiences with caring communities into everyday life and into the living environment of the group members? To answer these questions, two examples of groups of mutual support were examined more in detail:

(1) Over a year we implemented groups following the Positive Peer Culture (PPC) approach in a school (N=482 with 295 adolescents in the intervention group). During group meetings the young people were taught and encouraged to help each other within their class. Regardless of their own problems young people made the experience that they can be helpful for others. In this longitudinal study 295 students in the intervention group and 187 in the control group were questioned. After the project started, the young people were asked about the class climate, attitudes, and selected personality traits. The survey was repeated at the end of the project (10 months). In the quantitative cross-sectional as well as in the longitudinal comparison, there are differences between the intervention and control group, which validate statements on the effects of PPC.

To evaluate the intervention in different school classes we asked questions regarding the evaluation of the meetings and the assessment of the effects. In addition, standardized questionnaires were used: The Landau Scales for Social Climate in School Classes (von Saldern & Littig, 1996), the WHO Questionnaire on well-being (Psychiatric Research Unit, 1998), a scale to measure resilience (Schumacher et al., 2005), and a scale to measure Self-efficacy (Schwarzer & Jerusalem, 1999).

The results first show that classroom aggression is associated with cliques, and discrimination. However, while helpfulness is negatively correlated to aggression, there are significant positive correlations to well-being, resilience and empathy (Table 1).

Table 1: Positive Peer Culture. Different aspects of attitudes and personality (478 < N < 482)

	Forming cliques, total, t1	Helpfulness, total, t1	Aggression vs. others, total, t1	Discrimination of others, total, t1	Satisfaction with others, total, t1	Well-being, total, t1	Resilience, t1	Empathy, t1	Self-efficacy, t1
Forming cliques, total, t1	1	-.075	.534**	.597**	.401**	-.140**	.003	.046	.097*
Helpfulness, total, t1	-.075	1	-.139**	-.225**	.220**	.301**	.352**	.313**	.245**
Aggression vs. others, total, t1	.534**	-.139**	1	.724**	.348**	-.170**	-.036	.039	.073
Discrimination of others, total, T1	.597**	-.225**	.724**	1	.346**	-.232**	-.070	.059	.009
Satisfaction with others, total, t1	.401**	.220**	.348**	.346**	1	.084	.221**	.248**	.205**
Well-being, total, t1	-.140**	.301**	-.170**	-.232**	.084	1	.436**	.308**	.332**
Resilience, total, t1	.003	.352**	-.036	-.070	.221**	.436**	1	.460**	.453**
Empathy, total	.046	.313**	.039	.059	.248**	.308**	.460**	1	.435**
Self-efficacy, total, t1	.097*	.245**	.073	.009	.205**	.332**	.453**	.435**	1

** . Significance of 0.01 (2-tailed). * . Significance of 0.05 (2-tailed).

(2) In a second study we evaluated “Tavolata”-groups. These table communities following the Swiss “Tavolata” concept, have been developed as small self-organizing supportive networks. Members of a “Tavolata” meet because they like to eat together. But they also learned to organize themselves. In particular, they have developed a suitable organizational form for the group, who contributes what to the meal preparation, so that “give and take” is balanced for all. It is optimal for group cohesion, if everyone can contribute his strengths as much as possible. Depending on the group process Tavolata table communities turn out to create integrated health-promoting settings that enable social activation through civil and social engagement.

Similar to the above mentioned questions and standardized questionnaires to evaluate the effects of table communities we measured generosity using a scale developed by Smith and Hill (2009). In addition, organizational citizenship behavior was measured by a scale developed by Singh and Kolekar (2015).

A scale for quality of leader-member exchange (Janssen & Van Ypern, 2004) was used to learn about the relationship between the group members and the organizers of the groups. The importance of the residential quarter for the development of the offer was recorded in a questionnaire that was published by Wiegandt (2015). First of all, the correlations confirm the network of key variables designed in the model (Figure 1). In addition there are two variables that ensure to a larger amount the transfer into everyday life: Commitment and generosity (table 2).

Table 2: Tavolata Table Communities. Different aspects of attitudes and personality (128<N<142)

		Well-being	Resilience	Generosity	Self-efficacy	Commitment	Relation leader/group	Tavolata transfer
Well-being	Pearson Correlation	1	.600**	.340**	.464**	.291**	.161	.202*
	N	138	138	137	136	136	123	130
Resilience	Pearson Correlation	.600**	1	.543**	.589**	.398**	.251**	.250**
	N	138	141	138	137	137	126	132
Generosity	Pearson Correlation	.340**	.543**	1	.346**	.542**	.189*	.301**
	N	137	138	138	137	137	124	129
Self-efficacy	Pearson Correlation	.464**	.589**	.346**	1	.324**	.105	.228**
	N	136	139	137	137	137	126	131
Commitment	Pearson Correlation	.291**	.398**	.542**	.324**	1	.190*	.448**
	N	136	137	137	137	137	124	129
Relation leader/group	Pearson Correlation	.161	.251**	.189*	.105	.190*	1	.138
	N	123	126	124	124	124	126	119
Tavolata transfer	Pearson Correlation	.202*	.250**	.301**	.228**	.448**	.138	1
	N	130	132	129	129	129	119	141

** . Significance of 0.01 (2-tailed). * . Significance of 0.05 (2-tailed).

There are probably three characteristics of the quarter that are particularly related to resilience and generosity (table 3): the journey time to the next motorway access, the travel time to the city center by bus and or train, the travel time to the city center by car. These features of the quarter might be mediated by the experience of mastery in the sense of self-efficacy. All this also offers the opportunity to participate more easily in the groups and to get actively involved.

Table 3: Different features of the quarter

		bus and train connections	the parking situation	the journey time to the nearest station	the journey time to the next motorway access	the travel time to the city center by bus and or train	the travel time to the city center by car	the range of shops for daily shopping	childcare services (kindergartens, primary schools)	medical infrastructure (pharmacies, family doctors)	with leisure and sports fields (halls and playgrounds)	with the gastronomy offer
Resilience (general)	Pearson Correlation	.076	.111	.084	.394**	.328**	.294**	.096	.287*	.200*	.166	.057
	N	118	106	115	93	112	95	125	69	120	103	120
Generosity (general)	Pearson Correlation	.085	.122	.019	.421**	.303**	.382**	.055	.194	.083	.126	.012
	N	118	106	115	93	112	95	125	69	120	103	120

** . Significance of 0.01 (2-tailed). * . Significance of 0.05 (2-tailed).

Conclusion

In order for group members to become permanently involved, group meetings should address the basic needs of group members. As the results show, generosity can certainly be understood as a basic need, at least as a relevant key variable. In addition, the results show that generosity as a characteristic of group culture counteracts aggression and exclusion. Being committed and helpful also promotes the transfer of positive experiences with Caring Communities into everyday life. This transfer into everyday life is also supported by certain characteristics of the neighbourhood's living environment.

From our point of view, PPC-groups and table communities are a model for caring communities. There is much evidence that these groups provide help and support for their members, even in difficult situations. On the other hand, we find a comprehensive transfer into everyday life and into the living environment of the quarter. This again highlights the importance of caring communities for civil society. At the same time, however, the importance of the social and physical environment for development of positive groups as well as for individual resilience and well-being becomes clear.

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Learning objectives

Participants will...

1. learn about the different concepts and practice of “Caring Communities” as positive practice in health prevention and health care.
2. identify different basic needs which are important for the sustainable implementation of such groups.
3. will be able to compare “Tavolata”-Groups and Positive Peer Culture (PPC-) Groups as positive examples for groups of mutual support across the life span in health care.
4. will discuss and identify best practices to support relevant group processes.

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Risk Aware: Enhancing students' clinical competence in risky environments through a blended simulation-based learning program

Subtheme: Practice initiatives

Paper

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Keywords: Risk, Simulation-based education, Clinical placement

Abstract

Rationale

Students across the healthcare field engage in clinical placement as a component of their education. Unfortunately, there are a number of physical, psychological and environmental risks associated with clinical placement. Risk Aware is a simulation-based education program designed to address the risks associated with clinical placement, enhancing students' clinical awareness and competence.

Approach

Risk Aware is an online learning package that provides students with theory and context in managing risk; quizzes and activities with real time feedback to enhance learning; and, interactive virtual and filmed simulations to shape students' skill development and competence when managing risky situations such as violence and aggression. This presentation will describe and discuss the development and implementation of Risk Aware across seven Australian universities and a major health service.

Results

157 first year clinical psychology students across Australia completed Risk Aware as a compulsory component of their pre-placement training. A mixed methods evaluation of the program followed with student participants, healthcare managers and placement supervisors. The evaluation suggested that Risk Aware improves students confidence in environments of risk, improves students ability to identify risk and also improves students competence in managing risk.

Summary

Students face a number of risks, such as violence and aggression, within the clinical placement environment. They require training and support to better identify and manage these risks. A blended simulation-based education program like Risk Aware is ideally suited to this task as it allows for dissemination across a broad student group and communication of theoretical and contextual information while also focusing on competence and clinical skill development. Future iterations of the program will focus on modification for use across an interdisciplinary healthcare cohort.

Acknowledgement

Support for this project has been provided by the Australian Government Office for Learning and Teaching.

Learning objectives

Participants will...

1. be able to outline key elements of Risk Aware, a simulation-based program designed to aid healthcare students to better identify and manage the risks associated with the healthcare environment.
2. be able to discuss important design features of Risk Aware for inclusion in their own training packages.
3. be able to access Risk Aware for possible use amongst their own cohorts.

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What do student paramedics know about workplace violence?

Subtheme: Practice initiatives

Paper

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Keywords: workplace violence, student, paramedic

Abstract

Background and Context

Previous research into paramedic student exposure to workplace violence during ambulance clinical placements has demonstrated exposure to various acts of workplace violence. Furthermore, paramedic students are hesitant to report acts of workplace violence against them due to several reasons, “*don’t want to upset chance of getting a job*”, “*fear of backlash*”, and “*don’t want name tarnished*”. For the students to report an incident the process; “*needs to be anonymous*”, “*done through the university*”, and “*confidential with follow up support*” with a “*phone app*” the best way to report an incident. The objective of this study was to identify paramedic student understanding of workplace violence acts and their thoughts on reporting.

Methodology

Paramedic students at Griffith University who were yet to undertake an ambulance clinical placement or an educational workshop on health and wellbeing, including workplace violence, were eligible to participate. The study used a cross-sectional methodology in the form of a paper-based questionnaire to elicit demographic data; students’ definition of six acts of workplace violence; bullying, verbal abuse, threat, physical abuse, sexual harassment, sexual abuse, and three questions about reporting incidents. The students were asked to complete the survey at the beginning a health and wellbeing workshop.

Findings

There were 112 students who completed the survey, a response rate of 84%. There were 60 (53.6%) females with a majority, 68 (60.7%), of all students less than 21 years of age. When asking students to write their definition of the six acts of workplace violence these varied considerably when compared to the definitions published by Boyle and Wallis. For bullying, the views varied from “*being mean to someone*” to “*The act of repetitively annoying and/ or personally attacking an individual*”. For verbal abuse, views varied from “*abuse that comes from the mouth*” to “*The use of speech to negatively impact another being directly, e.g. name calling, shouting*”. For threat, views varied from “*I’ll punch you*” to “*Comments that are used*”.

to intimidate or scare another person by suggesting violence or abuse will occur if they do not do what you say". For physical abuse, views varied from "punching someone" to "Using physical means, such as hitting, punching, kicking or slapping to hurt another person". For sexual harassment, views varied from "being harassed sexually" to "Inappropriate sexual actions or even suggestions/language against an individual". For sexual abuse, the views varied from "molestation" to "Physically inappropriate contact that the participant does not approve of".

A majority of students would definitely report an incident to the appropriate contact person at their university. A majority of students would probably report an incident to an ambulance service manager. A small group of students, less than 26 years of age and predominately male, would not report any incident.

Implications for Education

Paramedic students need to be educated about the definitions of workplace violence acts and the necessity of reporting it to appropriate staff for health and wellbeing follow up.

Learning objectives

Participants will...

1. identify the understanding paramedic students have for the definitions of workplace violence acts.
2. identify the paramedic student thoughts on reporting acts of workplace violence against them.

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A best practice guideline on the prevention and management of workplace violence, harassment, and bullying in health-care: Implementing GRADE and CERQual methodologies

Subtheme: Practice initiatives

Paper

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Registered Nurses' Association of Ontario, Toronto, Canada*

Keywords: Systematic review, nursing, organization, initiatives, safety, well being, workplace aggression, workplace bullying

Abstract

Background

Workplace violence, harassment, and bullying are internationally pervasive problems that exist across professions and sectors in health-care workplaces and academic environments. Although many comprehensive guides, reports, and recommendations exist on addressing these issues, there remains a paucity of evidence-based best practice guidelines for health-care providers and students, specifically those using the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology. Our guideline development team at the Registered Nurses' Association of Ontario sought to fill this gap by developing the second edition of a guideline on preventing and managing workplace violence using GRADE and Confidence in the Evidence from Reviews of Qualitative Research (CERQual) methodology.

Methodology

Three comprehensive systematic reviews were conducted between August 2017 and February 2018. The systematic reviews sought to answer specific research questions on education, organizational initiatives, and risk assessment tools, and summarize the impact of various interventions on 11 key provider and patient outcomes. Upon completing the systematic reviews and determining the certainty and confidence of evidence using the GRADE and CERQual methodologies, recommendations were drafted and brought to 18 members who comprised the expert panel for discussion. The expert panel reviewed key considerations, including benefits, harms, values/preferences, and equity to determine the overall strength of each recommendation (either strong or conditional).

Findings

There were 19 recommendations developed for the best practice guideline. The recommendations include those specific to the organization or academic institution, as well as those for the individual health-care provider or student. The recommendations provide guidance on using risk assessment tools to detect behaviours indicative of violence or aggressive behaviours, as well as incivility or disruptive behaviours from colleagues. There also are recommendations to provide guidance on which components should be included within larger organizational initiatives to address violence, harassment, and bullying. Finally, there are recommendations that provide guidance on what content should be included in educational programs used to inform providers and students on the prevention and management of workplace violence.

Implications

To our knowledge, this is the first evidence-based best practice guideline to use GRADE and CERQual methodologies on the topic of preventing and managing workplace violence, harassment, and bullying in health-care. Although the overall certainty and confidence in the evidence supporting the recommendations was identified as low or very low, the strength of the recommendations varied based on the expert panel's considerations of benefits, harms, values/preferences, and equity. The recommendations provide important guidance to health-care providers and organizational leaders on taking a structured and consistent approach to prevent and manage workplace violence, harassment, and bullying within their workplace.

Learning objectives

Participants will...

1. be able to describe how GRADE and CERQual methodologies are used in the development of a best practice guideline on workplace violence prevention and management.
2. be able to discuss evidence-based recommendations to influence practice at the individual and organizational levels.

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How to meet verbal aggression at work: Understanding the emotional dynamics of conflicts and problem solving. Practical workshop

Subtheme: Practice initiatives

Workshop

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Keywords: practical techniques, challenging verbal behavior

The workshop presents practical techniques in talking to a patient who presents challenging verbal behavior.

Topics presented

Understanding the emotional dynamics of conflicts and problem solving.

1. Basic communication skills and techniques in talking to a patient who is angry, confused, anxious.
2. Basic communication skills and techniques in talking to a patient who has a disturbing, provocative and challenging behavior.
3. Basic communication skills and techniques in talking to a patient who is verbally aggressive, yelling and screaming.

Models which are presented are collected by the Estonian Verge team and used in practical training of health care personnel in Estonia. The focus is preventing an aggressive episode to escalate and thereby reducing the risk of violent behavior.

At the workshop there will also be given an brief overview of the situation in Estonian health care institutions concerning perception of violence at work. The research concerning this topic is not finished yet but will be before October 2018.

Learning objectives

Participants will...

1. understand basic communication skills and techniques in talking to a patient who is angry, confused, anxious.
2. understand basic communication skills and techniques in talking to a patient presenting disturbing, provocative and challenging behavior.
3. understand basic communication skills and techniques in talking to a patient who is verbally aggressive, yelling and screaming.

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Comprehensive Workplace Violence Prevention Program: Model and Process Success in a National Health Care System

Subtheme: Practice initiatives

Paper

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Keywords: Practice initiatives, Evidence-based practice, Multidisciplinary threat assessment, National program model, Policy initiatives, Positive practice, Program implementation, Violence prevention

Abstract

Background

The U.S. Veterans Health Administration (VHA) Workplace Violence Prevention Program (WVPP) has developed evidence-based, data-driven initiatives to promote a standardized culture of safety. Serving over 9 million beneficiaries, VHA employs >300,000 people across 170 medical centers and >1,000 community-based outpatient clinics. VHA is the largest integrated healthcare system in the United States. VHA's WVPP operates on the foundation that access to healthcare promotes the protective factors that reduce violence risk. Comprehensive violence prevention programs must engage employees, have full leadership support, and support the on-going and iterative nature of threat assessment best practices.

Methodology

The following five elements comprise VHA's WVPP model that meets the published standard for preventing violence in health care (IAHSS, 2018).

Employee Education. Relevant knowledge empowers employees to identify situations that have the potential to escalate toward violence and address them effectively at the lowest possible level of disruption. Training is customized to provide verbal management, personal safety, and/or therapeutic containment skills that do not involve pain-based or tissue-damage compliance.

Event Reporting. Education relevance is informed by disruptive behavior event data obtained through an user-friendly event reporting system that allows for anonymous reporting. This secure, web-based system notifies both the reporter and the assessment team immediately that an event has been entered.

Report Assessment. Reported events are assessed by a multi-disciplinary team trained in violence risk and threat assessment best practice. Operating under the facility's chief medical officer and chaired by a senior clinician trained in evidence-based, data-driven threat assessment and management practice, the team includes representatives from security/law enforcement and labor union safety representative(s).

Treatment/Management Plan. If the behavior reported to the threat assessment team is determined to pose a true safety or security threat, then a customized treatment/management plan is developed and implemented. At no time may a plan incorporate permanently barring individuals from health care access.

Communicate. Safety/treatment plans are communicated to personnel effectively and ethically via electronic health record (EHR) alerts that provide a 1-2 sentence summary each of the problem behavior and a description of actions personnel should take to promote safety. EHR alerts are known to be part of an effective strategy for reducing health care violence (Drummond, 1989).

Findings

Process improvement and program implementation data for each WVPP model element are reported and demonstrate the feasibility and challenges of deploying a standardized, comprehensive WVPP in a very large national healthcare system.

Implications

VHA's WVPP model and process are exportable to healthcare systems of varying sizes and complexities. Standardizing the elements of comprehensive violence prevention programs across all healthcare agencies and organizations represents the next major challenge of violence prevention at a systems level.

Learning objectives

Participants will be able to...

1. identify critical elements of a successful comprehensive national violence prevention program in healthcare.
2. articulate operational implementation requirements and strategies for overcoming implementation challenges of a successful national violence prevention program in healthcare.
3. apply published healthcare workplace violence prevention standards to evidence-based program development.

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Creating a positive treatment environment by reducing restrictions in care: an analysis of psychiatric ward rules

Subtheme: Practice initiatives

Paper

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Keywords: Ward rules, patient restrictions, violence prevention, psychiatric hospital

Abstract

Background and Context

In traditional psychiatric inpatient care, patient treatment has been supported by restrictive rules. Current modern psychiatric care emphasises patient autonomy, responsibility and positive encouragement to support recovery in psychiatric care. There is still a lack of understanding on whether current ward guidelines and written rules for patients or family members represent a positive treatment environment in inpatient care. As a part of a large-scale educational intervention, we assessed the content and language used in the rules of psychiatric wards.

Methodology

A content analysis using quantification was used to analyse collected rules presented in written format on the wards (e.g., leaflets, posters, written information on the walls). The data were collected (2016) from 12 psychiatric wards (closed, acute or rehabilitative wards with patient seclusion and/or a mechanical restraint room). The rules were first categorised based on themes derived from previous research (Andersen et al. 2012): language (commanding, threatening, appealing, expressing community solidarity, precisely formulated, unclear, argumentative) and content (order, cleanliness, substance abuse, social life, atmosphere). The frequency of each theme was then calculated to indicate how often ward rules contained certain language and contents.

Findings

A total of 26 ward rule documents containing 300 individual rules existed on the 12 wards (M2 documents/ward, range 1–11). The language of the rules was mostly commanding (n=118, 34%), precisely formulated (n=110, 31%) but unclear (n=38, 11%). Ward rules were rarely threatening (n=22, 7%). A few of the rules included a reason for setting the rule, e.g., based on law, so only 4% were classified as argumentative (n=12). The content of the rules focused on

order (n=150, 50%), social life (n=97, 32%) and atmosphere (n=25, 8%). Least common were rules related to cleanliness (n=8, 3%) and substance abuse (n=20, 7%).

Implications

Reducing the use of coercive measures in care and connected violent behaviour of patients is a complex issue. The analysis of written ward rules provides one useful tool for exploring the restrictive practices underlying the daily practices of psychiatric wards. By analysing the rules critically, it is possible to work with patients and their families to modify the language towards more positive, encouraging and argumentative expressions, and rethink the need for restrictive contents. There is a need for future research to explore if changing the language and content of ward rules could reduce patient violence and the need for coercive measures.

Learning objectives

Participants will...

1. learn that the rules of psychiatric wards may include language and contents that are restrictive to patients.
2. have a basic understanding of how to use ward rules analysis as part of changing care practices regarding psychiatric wards.

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Rethinking Debriefing: A structure for integrated post occurrence review

Subtheme: Practice initiatives

Paper

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Keywords: Debriefing, Post occurrence review

Abstract

Debriefing following any adverse event, including episodes of aggression and/or violence, provides potent learning and support opportunities for all involved. While there are many regulatory and professional mandates to conduct effective debriefing, there remains some confusion as to its specific role purpose and function. Debriefing in this context includes four distinct but associated processes all of which aim to effectively use learning from occurrences to prevent future occurrences.

Service users should be provided with the opportunity to debrief following an occurrence of aggression and/or violence, especially where coercive interventions have been employed, in order that they can discuss the episode with members of the multidisciplinary team involved in their care and treatment. Critically the key function of this debriefing is to reconnect the service user and treatment team so that their collaborative working toward recovery can continue unhindered.

Personnel involved in the occurrence equally require the opportunity to debrief. While the opportunity for reflective learning is the core of staff debriefing, a key function of personnel debriefing is to provide a safe and supportive environment in which staff have the opportunity to work through issues and/or feelings which may have emerged during an occurrence.

From an organisational perspective each occurrence of aggression and/or violence should prompt a review which identifies either preventive or remedial measures, or broader quality improvements. Circumstances surrounding each occurrence should be reviewed in order to identify immediate measures which might prevent re-occurrence, and/or service wide opportunities for improvement. A contextual understanding should inform organisational reviews with an emphasis placed on '*fact finding*' rather than '*fault finding*'.

Bearing witness to occurrences of aggression and/or violence can impact negatively, both from the perspectives of individual experience, and/or on the therapeutic functioning of the broader milieu. Those witnessing occurrences therefore require the opportunity to debrief in order that they can reality test their experience and in order that all are reassured of their individual and collective safety.

This paper will present a debriefing matrix which aligns the purpose, constituents, rationale and outputs of each of these four components.

Learning objectives

Participants will have the opportunity to...

1. consider a reformed integrated organisational approach to debriefing which structures four inter-related components, each of which has a specific role purpose and function.
2. consider the implications of this revised approach to debriefing from policy, training and practice perspectives.

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Chapter 8 – Tools and instruments

Communicating the Risk of Violence: A Paradigm Shift for Flagging

Subtheme: *Tool-kits*

Workshop

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Keywords: Communicating risk of violence, Flagging, Behavioural Alert System, Prevention for everyone, Patient Centred Care, Program Development, Toolkit, Paradigm shift

Abstract

Background

Employers have a key responsibility to provide all workers at risk of exposure to violence with information, including personal information, about a person with a history of violence so they can be protected. Healthcare workplaces must also develop and implement effective measures and procedures to keep both patients and workers safe when providing person-centred care. A proactive approach that can meet these requirements and communicate the risk of violence involving patients is the implementation of a flagging alert system.

Methodology

PSHSA, a funded partner of the Ontario Ministry of Labour, developed an evidence informed Flagging Handbook to assist healthcare organizations in the development of effective flagging alert systems. This initiative was 1 of 5 resources developed as part of a Violence, Aggression, and Responsive Behaviours (VARB) project, funded by the Ontario Ministry of Labour. Toolkits were developed through multi-stakeholder engagement and expert consultation. Flagging was identified by the VARB steering committee as a key issue for healthcare organizations noting that minimal knowledge and guidance existed. A multi-stakeholder working group reviewed literature, best practices and collaboratively developed the flagging toolkit.

Findings

To implement successful behavioural alert systems a fundamental shift in thinking about flagging is required. Misconceptions must be demystified and perceptions of flagging must shift from the labelling and stigmatization of patients to that of a proactive safety practice approach where visual or other cues are used to communicate the potential risk of violence to caregivers. In addition, healthcare organizations need additional resources regarding what flagging is and is not, the benefits, types, legal and ethical considerations, program development steps, and implementation tools. The PSHSA Flagging Handbook Toolkit provides this necessary information and is presented.

Implications

Adopting and implementing a flagging alert system as a workplace violence prevention practice has the profound ability to keep both patients and workers safe. This can be accomplished with a change in thinking and attitude coupled with knowledge and tools on how to effectively communicate risk of violence. However, healthcare workplaces must carefully consider: patient experience and care needs; patient safety; patient privacy; worker safety and related legislative requirements. A well-developed flagging alert system has the potential for adaptation in many community and healthcare environments.

Workshop

- Presentation 45 minutes
- Presenter 1: 25 minutes – Overview of flagging concepts, legal & ethical considerations, program development and tools
- Presenter 2: 20 minutes – Hotel-Dieu Grace Healthcare’s experience developing a flagging program e.g. successes, challenges and barriers
- Active Participation 45 minutes
- Polling questions - 5 minutes flagging issues
- Small group table discussions on 3 major issues to improve insights and overcome challenges - 10 minutes each e.g. preventing stigmatization, flag permanency, flagging visitor violence risks
- Final Remarks/Questions 10 minutes

Learning objectives

Participants will...

1. have a basic understanding of the critical components of an effective flagging alert system structure and implementation.
2. be aware of the delicate balancing of multiple and sometimes competing legislative considerations related to privacy and safety when implementing a flagging alert system.

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Person centred restraint reduction plans - auditing peoples lives and turning reduction plans into actions

Subtheme: Tool-kits

Workshop

Sarah Leitch

BILD, Birmingham, United Kingdom

Keywords: Person centred, restraint reduction plans and actions, restrictive practice audit tool, quality of life

Abstract

People who live or spend time in services and rely on others for care and support are vulnerable to the overuse of a whole range of restrictive practices. These may range from physical restraint and seclusion to what are often referred as minor restrictions. In fact these restrictions are not minor if they are experienced on a daily basis. Access to food, cigarettes, personal possessions and activities are often restricted by staff or need to be earned.

Sometimes restrictions are implemented under the justification of health and safety or duty of care. It is unlikely that these types of restrictions are always recorded and it is likely that staff do not always recognise that they are applying restrictions – it becomes part to the model of care that can lead to toxic environments where it is easier for high levels of coercion, restraint and seclusion to exist. There is an obvious correlation between quality of life / positive emotions and the presentations of challenging behaviours. Restrictive practices are often used to manage the risk or presentation of aggression. In such cultures the environment itself becomes the trigger for challenging behaviour which are then managed by more restriction.

Many authors have talked of this ‘slippery slope’ – one of the ways of addressing this is to pay careful attention to all restrictive practices and understand the impact they have and examine the justification for each of them.

This workshop first describes how a whole organisational audit was undertaken of individual people’s lives to ascertain what restrictions were in place. This process needs to be managed sensitively and I will describe barriers and solutions.

A tool kit was developed to engage with services and will be shared with the group who will be able to practice using it. Many different restrictions were found during this restrictive practice amnesty. Some of which were completely unnecessary. I will describe some of the restrictions that were found and invite participants to relate it to their own practices and generate lists.

I will then describe the process of introducing a system of governance, review and action planning for individual reduction.

In the UK much guidance is available to aid organisations to reduce unnecessary use but few resources are available to support the development of reduction on an individual basis. I will share a person centred restraint reduction plan format with the group and elicit any other examples that are being used . Participants will test this plan out with a case study. For restraint reduction to be sustainable and cultural change to be effective practice leaders are needed. Plans can be developed by everyone under the guidance of practice leaders who can role model, support competence and monitor success.

A service that is focused on reduction and promotion of quality of life restraint focused is likely to be a good place to work and live.

This audit was conducted in services for people with IDD but it has been used successfully in mental health, children's services and forensic services.

Learning objectives

Participants will...

1. develop an understanding of the range of restrictions that people are subjected to and how that impacts on quality of life and service culture.
2. learn to use an auditing tool to identify a range of restrictive practices.
3. understand how to develop a process for review and monitoring of restrictive practices.
4. explore the development of person-centred reduction plans and actions.
5. develop their understanding the importance of practice leaders in implementing person centred reduction plans.

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Preventing workplace violence and training with virtual reality simulation

Subtheme: *Tool-kits*

Poster

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Keywords: Virtual reality simulation. low arousal approach. computer simulation

Abstract

With the aim of reducing violence and threats of violence in workplaces, research has identified a number of areas in which conventional education and training may be improved. The areas examined in this study are workplace violence, low arousal approach, and they have been integrated with research in the field of computer simulation, virtual reality (VR) simulation for training and teaching.

Methodology

The study will compare traditional education for managing workplace violence using low arousal approach, with a virtual reality (VR) simulation training. Interactive VR simulation will be applied to one group of staff, while the control group will receive traditional education.

Findings

Expected results based on answer from 50 participants in a pilot survey. The interactive (VR) simulation tools have been found to be acceptable by all study groups. Significant differences between the groups could be detected. Those educated in a traditional way lacked knowledge of their own affects and reactions when exposed to stress or aggression. Those who underwent training in VR estimated lower on a scale of stress compared to the control group. The study also showed that after completion of the education the VR trained group consistently had a lower pulse during the training.

Implications for education and training

We believe that several similar projects can benefit from our results, as they can be generalized to other VR-based educators.

Demonstration

We will offer a number of participants to experience our VR simulation. Although not all participants will be able to actually try the VR due to time constraints, while one colleague tries

the technique, the other colleagues can observe the event on a computer screen. We believe that several similar projects can benefit from our results, as they can be generalized to other VR-based educators.

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Structuring nursing interventions to reduce aggression and linking these interventions to risk assessment using the Dynamic Appraisal of Situational Aggression

Subtheme: Instruments

Paper

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Keywords: Aggression, risk assessment, nursing intervention

Abstract

Aggression remains a concern in mental health inpatient settings. Frameworks and strategies have been designed to reduce the risk of inpatient aggression and restrictive interventions (Bowers et al., 2015; Huskshorn, 2004). The Dynamic Appraisal of Situational Aggression (DASA) is designed to assess the risk of imminent inpatient aggression, and is most commonly used by nurses. While the predictive validity of DASA has been established (Maguire et al., 2017) there is currently no structured advice for nursing interventions following the DASA assessment. Against this background, our study examined the impact on aggression and restrictive interventions of structured nursing interventions, as suggested by an aggression prevention protocol according to the level of risk as assessed by the DASA.

An archival audit was conducted to gather information on commonly used nursing interventions to reduce aggression. Findings were used in conjunction with a literature review to develop an aggression prevention protocol. The protocol was then piloted on an acute female forensic mental health unit in Melbourne, Australia. Baseline data was collected for 60 days using an electronic version of the DASA (eDASA), following this phase all nursing staff were provided with training on specific nursing interventions as outlined in the protocol.

Following training, nurses were asked to implement the protocol following the level of risk as assessed by the eDASA for 60 days. Data were collected for all eDASA ratings, aggression and interventions provided. Nurses were also surveyed about the eDASA and protocol pre and post implementation. This presentation will focus on findings from the survey. Prior to implementation of the protocol, nursing staff selected interventions in various ways including their assessment and knowledge of the patient and existing documentation. The majority of nurses considered a protocol would have a positive impact on guiding their practice. Following the implementation phase of the protocol, 88% of staff who attended the training completed the survey. When asked about the effect the protocol had on their practice, 69% of nurses surveyed felt the effect was positive to very positive. When asked

to compare use of the eDASA and associated intervention protocol with previous DASA (without recommended structured interventions), 93% of nurses responded that it was somewhat better to much better. In regards to continued use of the eDASA and protocol, 88% of nurses responded they were likely/very likely to continue using the protocol.

In practice, the ward continues to use the eDASA and protocol. Overall the nurses responded positively to structured recommendations for interventions following a DASA assessment. Some of the difficulties encountered in this study included documentation of interventions. At times nursing interventions were not clearly documented, making it difficult for others reading the notes to gather details about what was effective. It may be more effective for nurses to rate and document interventions as they occur rather than retrospectively. Contemporaneous documentation may also enhance interventions and experience of care.

Background and Context

Aggression remains a concern in mental health inpatient settings. A number of frameworks and strategies have been designed to reduce the risk of inpatient aggression and the use of restrictive interventions (see Abderhalden et al., 2008; Bowers, 2014; Huckshorn, 2004). The Dynamic Appraisal of Situational Aggression (DASA) is designed to assess the risk of imminent inpatient aggression, and is most commonly used by nurses. While the predictive validity of DASA has been established (e.g., Maguire, Daffern, Bowe, & McKenna, 2017), there is currently no structured advice provided for nursing interventions following the DASA assessment. Against this background, our study examined the impact on aggression and restrictive interventions of structured nursing interventions, as suggested by an aggression prevention protocol according to the level of risk (low, moderate, high) as assessed by the DASA.

Methodology

An archival audit was conducted to gather information on commonly used nursing interventions to reduce aggression. Findings were used in conjunction with a literature review to develop an aggression prevention protocol. The protocol was then piloted on an acute female forensic mental health unit in Melbourne, Australia. Baseline data was collected for 60 days using an electronic version of the DASA (eDASA), and following this phase all unit nursing staff were provided with training on specific nursing interventions as outlined in the protocol. Following training the nurses were asked to implement the protocol following the level of risk as assessed by the eDASA for 60 days. Data were collected for all eDASA ratings, acts of aggression and interventions provided. Nurses were also surveyed about the use of the eDASA and the protocol.

Findings

This presentation will focus on the finding gathered from a pre- and post-staff survey on the use of the eDASA and intervention protocol. Prior to the implementation of the protocol nursing staff selected interventions in a variety of ways including knowledge of patient, following their assessment and use of documentation. The majority of nurses considered

that a protocol would have a positive impact on guiding their practice. Following the implementation phase of the protocol, 88% of staff who attended the training completed the survey. When asked about the effect the protocol had on their practice, 69% of nurses surveyed felt the effect was positive or very positive. When asked to compare the use of the eDASA and associated intervention protocol with previous use of the DASA (without recommended structured interventions), 93% of nurses responded that it was somewhat better to much better. In regard to continued use of the eDASA and the protocol, 88% of nurses responded they were likely to very likely to continue using the protocol, and in practice the ward continues to use the eDASA and protocol.

Implications for practice

Overall the nurses responded positively to structured recommendations for intervention following DASA assessment. Some of the difficulties encountered in this study included documentation of interventions. Often nursing interventions were not clearly documented, making it difficult for others reading the notes to gather details about what was effective (or not effective). It may prove more effective for nurses to rate and document interventions used to reduce/manage aggression as they occur, rather than retrospectively by another nurse on another shift. Contemporaneous documentation may also enhance interventions and the experience of care.

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Learning objectives

Participants will...

1. learn that the eDASA is risk assessment tool that can be used by nurses to assess risk and prompt interventions to reduce the risk of aggression.
2. be able to identify key nursing interventions suitable for each of the DASA risk bands.
3. identify some of the advantages of providing structure to nursing interventions following risk assessment.

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User-friendly system (a smartphone app) for reporting violent incidents in the Emergency Department: a multicenter study

Subtheme: Instruments

Paper

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Keywords: Type II Violence, Emergency Nurses, Smartphone App, under reporting, report-keeping, report-system

Abstract

Violence towards health workers is worldwide spread. Emergency nurses are the most exposed. Despite recording systems (report-keeping) and monitoring of the workplace violence (WPV) are becoming more common, the under-reporting of violent incidents, widely described in the literature and estimated at around 80%, remains today a major obstacle to the knowledge of the problem and a limit for the actual verification of the effectiveness of interventions to prevent, counter or minimize the phenomenon. Studies suggest that the use of simple and easy registration systems could facilitate the reporting of violent events. Our pilot study, presented at the 5th International Congress on Violence in Health Setting (October 2016 - Dublin Ireland) on the effectiveness of an app for reporting aggressions showed a decrease in under-reporting. This further and extended multi-center study wants to verify its effectiveness on a representative sample by resorting at an informative system based on a smartphone app.

Introduction

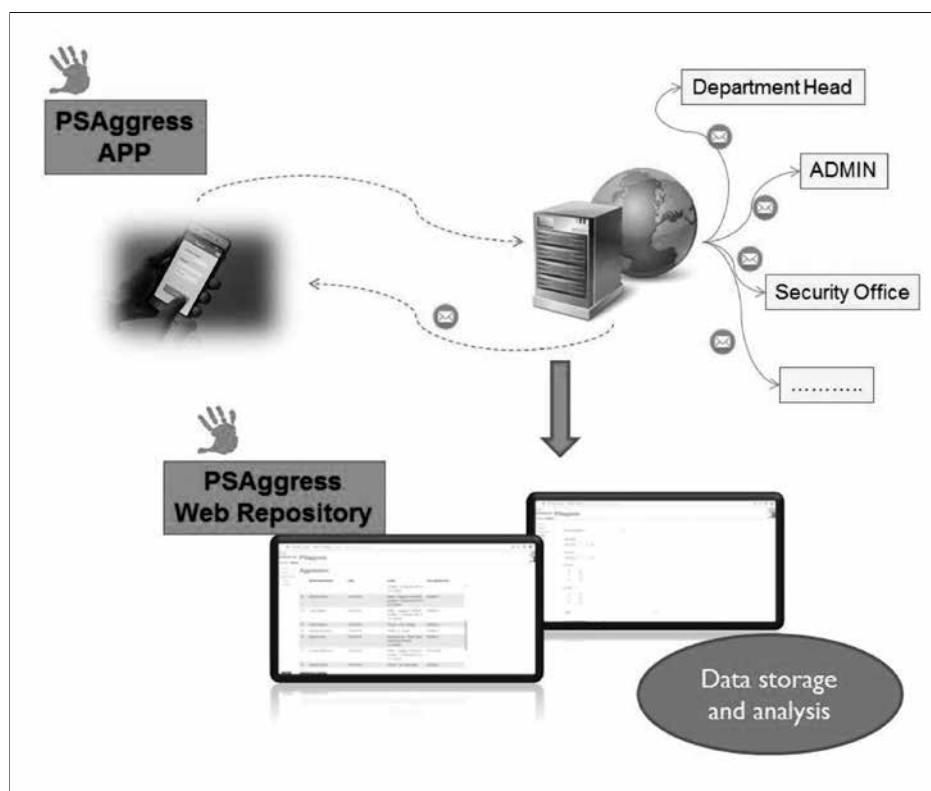
Violence against health professionals is a severe and widespread phenomenon. Nurses, in particular, those ones belonging to the emergency department, especially if engaged in the triage activity, are the most exposed workers [1]. Italy is not immune to this issue, so much that the Ministry of Health issued in November 2007 a specific Recommendation to prevent acts of violence towards health workers.[2] Despite the recording systems (report-keeping) [3,4] and monitoring of the WPV are increasingly widespread, [5,6] the under-reporting phenomenon widely described in the literature and estimated at around 80%, [7] remains today a severe obstacle to the knowledge of the problem and a limit for the verification of the real effectiveness of the interventions implemented to prevent, counteract or minimize the phenomenon itself [8]. Recent studies suggest that the use of simple and easy registration systems could facilitate the reporting of violent events [9]. In particular the one conducted by the University of Florence at the Hospital of Perugia, whose preliminary results were presented at the 35th Aniarti National Congress [10] and at the 5th International Conference on Violence in Health Sector in Dublin. [11] has demonstrated that under-reporting can be strongly reduced.

The paper is organized as follows: after having introduced the underlying problem in Section 1, Section 2 presents the system and the different steps of the procedure to signal a violence event, while Section 3 proposes some preliminary results of the study and finally, Section 4 draws conclusions.

The system and the procedure

The whole developed system, named PSAggress (in Italian PS means Emergency Department), is composed by a back-end server and a web application for data storage and a smartphone app (both for iOS and Android), as pictured in Figure 1.

Figure 1 The PSAggress system



The study has started on March 1st and will last for 6 months; it will involve at least 700 nurses and more than 25 Italian emergency departments. All the nurses participating to the study have been registered to the system after their consensus, and they have automatically received a registration e-mail containing the links to Play Store and Apple store (according to their smartphone) to download the app and their credentials to log in for reporting episodes of violence.

The smartphone app is straightforward and usable; it has been developed in React Native technology. [12] After the log in phase (username and password are required only the first time and then are stored within the app), the user access to the reporting form and is asked to select some basic and pre-defined required fields such as date, hour, kind of aggression, kind of aggressor (e.g. the patient, a relative, etc.) and other optional fields such as aggression motivation and specific notes. Then the nurse clicks on the “*submit*” button to send the form; all the data are received by the web server which registers them and consequently sends an e-mail to the nurse him/herself (as a receipt) and to all the interested persons/offices (administrators) that have to be informed of the event and eventually are in charge of intervening.

All the data concerning each violence event are accessible and manageable through the web application by all the staff persons with an “*administrator*” profile; the system also provides a “*viewer*” profile that can be conceded to users allowed only to read data.

The PSAggress system is endowed of a “*search*” functionality to perform data analysis, and it permits to export the obtained results as a Microsoft Excel file for in-depth statistical studies of the violence phenomenon.

Results

The basic idea of PSAggress system is to provide to the nurses a user-friendly and handy application to better monitoring the violence events and, above all, to significantly reduce the phenomenon of under-reporting, in line with the results of our single-center study, which had already shown a significant increase (from 8% to 65%) of nurses who had reported episodes of violence (both verbal and physical).

At the time of writing the study is still on-going. So far, we have enrolled 305 emergency nurses of 21 Emergency Departments (ED) distributed all over Italy. During July we hope to finish the recruitment phase both by incrementing the number of EDs and of nurses. At present, 60.1% of nurses participating in the study are male, 39.9% female, of which 57.0% single, 43.0% married. The average age is 40 ± 19 years. Work experience 15 ± 11 years, as Emergency Nurses 10 ± 10 years. This sample is composed of Registered Nurses (94.1%), Head Nurses (2.2%), and Specialist Nurses (3.7%). Mainly shift workers (83.2%) and minority employed in day shift (16.8%). When asked whether, in the last six months, there have been acts of violence by patients or relatives, 38.4% said none, 52.9% verbal violence and 8.9% physical aggression or both. In case of violence, only 15.1% always reported or some (23.1%) episodes, while the remaining 61.8% did not. Soon, a six months retest will be performed to verify the hypothesis that the App can favour the reports.

Conclusions

The multicenter study based on the PSAggress system would demonstrate that the adoption of an easy-to-access instrument can both permit to better monitor the events of violence in the Emergency Department and, at the same time, to reduce the phenomenon of under-reporting. The PSAggress system has been used only for nurses, but it could be extended merely to other users of the health sector.

Acknowledgements

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Learning objectives

Participants will...

1. appreciate how user friendly the reporting system is.
2. learn that the system can reduce the under-reporting phenomenon.

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Aggression Prevention: It Takes All of Us!

Subtheme: Tool-kits

Poster

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Keywords: Aggression prevention tool, Violence prevention tool, Staff education

Abstract

Methodology, findings and implications

In 2015, the State of Minnesota, United States, amended hospital licensing requirements and mandated that hospitals design and implement preparedness and incidence response plans for acts of violence that occur on their premises (Minnesota Statutes, Section 144.566). The legislation also required hospitals to provide training to their staff about “*safety guidelines for response to and de-escalation of an act of violence; ways to identify potentially violent or abusive situations; and the hospitals response reaction plan and violence prevention plan.*” (Minnesota Department of Health, 2015).

A Fairview Health Services system wide work group was formed to develop a tool which would be utilized across the health system to identify aggression risk levels, risk behaviors, and linked interventions. Utilizing Gjere’s doctoral dissertation literature review and dissertation findings, the “*Traffic Light for Aggression Prevention*” was developed and tested with nursing staff. Once the testing was completed, the Tool was modified and finalized. Feedback about the tool was that it provides a quick reference for staff members to identify behaviors and apply interventions to reduce risk for aggression.

One consideration for development of this tool was to assure access for all staff. If an aggression prevention tool is embedded into the electronic health record (EHR), many staff who interact with patients and visitors are excluded from information vital to assuring safety. This consideration was especially important to assure all staff who interact with patients and visitors can recognize and intervene in aggression prevention. The tool is utilized for hand-off communication and supports communication within the full interdisciplinary team including physicians, nurses, station secretaries, environmental services, nutrition services, security officers, and others.

In late 2017 and 2018, education interventions have included required learning modules, case discussions, in-person competencies, and retrospective reviews of aggression incidents. Formal evaluation is in process of the effectiveness of the tool in supporting staff competency with aggression prevention.

Since this tool has been developed, it has been adopted by another major health system in Minnesota, has been reviewed by the Violence Prevention subgroup of the Minnesota Department of Health, and presented at a statewide conference.

Learning objectives

Participants will...

1. will identify aggression risk behaviors and linked interventions for the behaviors.
2. Be able to explain the importance of hand off communication in preventing aggression.

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EASI-ltc[®]: A step towards identifying suspected cases of abuse in long-term care facilities

Subtheme: Instruments

Poster

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Keywords: Elder Abuse, Screening, Long-Term Care, Instrument

Abstract

Background and Context

Elderly individuals living in long-term care facilities (LTCFs) are at high risk for elder abuse (EA) and its related health consequences. LTC residents are vulnerable due to their increased physical and mental frailty, dependency, and social isolation. Yet, studies of elder abuse detection and prevalence in LTC are scarce, as EA detection and identification tools generally have limitations for this population. To respond to this problem, our team has adapted the Elder Abuse Suspicion Index[®] (EASI) (a six question suspicion tool previously validated for use in the ambulatory setting) into a nine question index, the EASI-ltc. This new tool better reflects the LTC setting and population, and is designed to be administered to seniors with MMSE scores of 24 or greater. We have also begun to explore the practical implications of administering such a tool within the complex domain of institutional care. This presentation will address some of those considerations.

Methodology

The creation of the EASI-ltc was accomplished using a mixed methods study, sequentially integrating quantitative cross-sectional and qualitative descriptive methodologies. This included a structured literature review, an internet-based consultation with EA experts across Canada, and purposively selected focus groups comprised of experienced front-line LTC clinicians and local EA specialists.

Findings

A common theme that emerged is that it is not sufficient to merely have access to a tool to help with EA detection; a thorough understanding of the possible barriers and facilitators of tool utilization is also paramount. Further, protocols need to be in place that include an examination of the goals of tool utilization, a process for how such a tool should be implemented, the implications of the results for staff and families, and standardized institutional response strategies. Our presentation will provide examples of the types of issues that might benefit from

institutional discussions in order to achieve consensus and buy-in to address the challenging problem of elder abuse in LTC.

Implications

It is expected that the EASI-ltc will advance understanding of abuse experienced by LTC residents. For successful and ethical implementation of this tool, LTCFs will need to engage in complex organizational, ethical, and legal considerations, including a determination of how to distinguish between abuse that is systemic and mistreatment that is specifically resident-directed.

Learning objectives

Participants will...

1. learn how to introduce the EASI-ltc, a new nine-question tool designed to raise suspicion of elder abuse in older adults residing in long-term care facilities.
2. appreciate the institutional issues that should form standardized and institutionally sanctioned utilization protocols and reporting procedures.

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Organizational work regarding the reduction of mechanical restraints at the Psychiatric Center Copenhagen

Subtheme: Tool-kits

Poster

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Keywords: Reduction of mechanical restraints, data driven management, plan of action for every department in large organisation, cultural change, interdisciplinary, development and attention

Abstract

Background

The National Health services in Denmark aim to reduce the use of mechanical restraints in psychiatric inpatient treatment. The Psychiatric Center Copenhagen wants to address and change the culture in the intensive care units to prevent situations, that can lead to the use of mechanical restraint.

The Psychiatric Center Copenhagen is placed on 4 locations in the Danish capital. The center has 7 closed wards, 3 intensive care units and an emergency ward. Also, the center Copenhagen has 256 beds, 5000 admissions a year, and serves 454.000 people in Copenhagen

To work with each of the intensive and closed wards regarding reduction of mechanical restraints, the center has set up a taskforce that works across the 4 locations with representatives from all professions, to ensure optimal cooperation between different professions and cultures. The taskforce is composed of experts with different levels of experience in the direct patient contact in closed sections.

A culture with use of coercion, with patient participation and professional staff evaluations, shall contribute to a decline number in use of mechanical restraints.

Process

The taskforce meets once a month, where data can be reviewed, challenges can be discussed and initiatives for further examinations can be decided. The taskforce will look enquiringly and critically at the available data, and from the data produce knowledge to a further common action.

The Taskforce has made an action plan, guidelines and tools for all the intensive and closed wards in the center that will be used to admit patients, for the staff evaluation and to promote dialogue with the patient about prevention, handling of externalizing behavior and learning from episode to secondary prevention.

First the material is used in intensive and closed wards, and then the next day will be reviewed by the management of wards and management of center, so that shared learning and further communication of initiatives and challenges will be addressed.

Goals

1. Continued reduction of mechanical restraints
2. Working with common tools to reduce the use of mechanical restraints in every intensive and closed ward.
3. To change the culture in intensive and closed wards, with the use of Safe Ward, to gain knowledge about the patient experience and staff evaluations on mechanical restraints, to prevent mechanical restraints by early and faster action, and handling of uneasy episodes.

Findings

The number of mechanical restraints has dropped substantially from 349 in 2017 to 105, 1.7 in 2018. Likewise, the number of mechanical restraints has dropped from 199 persons in 2017 to 73 persons, 1.7 2018.

Every intensive and closed ward has implemented the initiatives of Safe Wards, which has contributed to a changed culture regarding patients' cooperation. The caretaker has become more aware of initiatives to handle uneasy episodes, so that the use of mechanical restraints can be avoided.

The staff and patients are collaboratively making a co-working agreement where they are planning how to handle difficult situations and that the staff members are making themselves available for assistance in handling such situations.

If it had been necessary to use mechanical restraints the staff on duty will gather and analyses the episode. This is to obtain knowledge about potential prevention efforts that will need to be mediated, and the management of the Center will participate in dialogue with the patient regarding prevention on the next day. A dialogue between patient/staff and management about the same situation, gives a varied insight and understanding of why and how caretakers can assist each other in an intervention so future mechanical restraint can be prevented

Learning objectives

Participants will...

1. Learn of organizational aspects which may reduce the incidence of mechanical restraint.
2. Appreciate the necessity of the communication interface between patient, staff members, and management in reducing restraint.

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Chapter 9 – Other themes

Nursing practitioners' opinions on international guideline for preventing workplace violence

Subtheme: Other themes

Poster

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Abstract

Background

Workplace violence is surprisingly found in health sector especially in the Asian culture like Thailand. Majority of hospitals in Thailand have no specific guideline for violence prevention although Thailand patient and personnel (2P) have launched since September 17, 2018. To start making an operational guideline for a hospital setting, learning from a well internationally established guideline (OSHA) is worth doing. Therefore the aim of this study was to find out the nursing practitioners' opinions on OSHA guideline for preventing workplace violence.

Methods

The descriptive study was performed in the study population of 135 nursing practitioners who worked in the psychiatric ward, accident & emergency unit and waiting areas in outpatient departments. The self-administered questionnaire was constructed according to OSHA guideline together with detail of nursing practitioners' experience in workplace violence. Data were analyzed for proportion and 95%CI.

Findings

Response rate was 76.3 % (103 /135). Nursing practitioners agreed to each items of guideline in the range of 59.2-100%. The lower proportions were the items of security hardware such as convex mirror or alarm bell. Considering the current situation among those studied sites, there were a range of 1.0-88.9% followed the OSHA guideline. The samples reported that they ever had experience of workplace violence as high as 81.4% and the psychiatric ward showed the highest percent in both physical and verbal. Looking the OSHA guideline, the majority contents are mostly dealing with physical environment for security. Training in non-technical skill for personnel was not documented whereas workplace violence in verbal is more prevalent in this setting.

Conclusion

The majority of nursing practitioners' agreed to the OSHA guideline for preventing workplace violence. About 4 in 5 nursing practitioners' experienced both physical and verbal workplace violence.

Implication

OSHA guideline contains mostly in physical environment and security system management, however, items of training regarding non-technical skill for health professional is important for preventing workplace violence. Therefore, the appropriate guideline for Thailand hospital setting should include a training of non-technical skill for hospital personnel since this skill will prevent the action-reaction between person and person and that prevention of workplace violence.

Learning objectives

Participants will...

1. appreciate the value of the OSHA guideline on prevention of workplace violence is a good standard for all hospital setting but in some countries where verbal violence is more prevalent
2. recognize the need for additional non-technical skills (soft science).

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The horrific murder of a remote area nurse and how it has changed Remote Health in Australia

Subtheme: Other themes

Paper

Christopher Cliffe

CRANApplus, Cairns, Australia

Keywords: CRANApplus, Gayle Woodford, Remote Area Nurse, Remote Health, Safety and Security Guidelines for Remote & Isolated Health, Safety and Security Training, Working Safe in Remote and Isolated Health Handbook

Introduction and/or background

CRANApplus is a non-government, not-for-profit professional body for the remote and isolated health workforce in Australia. Our members make up the workforce that provides services to mostly remote Aboriginal & Torres Strait Islander communities but also cattle stations, remote mine sites, oil rigs, tourist resorts, Islands, ships at sea and small country hospitals across the nation. Remote Health serve some of the most disadvantaged people in Australia with many of the countries worst health outcomes. Given the small populations and extreme geographical and environmental barriers, the model of care in remote Australia tends to consist of a resident nursing & health workers workforce supported by Fly-In Fly-out Medical and Allied Health. Historically CRANApplus was a solely nursing organisations, however we are now inclusive of all disciplines and have for the last 35 years been providing education, support and professional services to the most hard to access parts of the health workforce in Australia.

Findings

Over Easter in 2016 a remote area nurse was called out in the middle of the night to attend to an alleged emergency call in the remote Aboriginal Community of Fregon. Three remote area nurses live in the community, with the nearest Hospital in Alice Springs a 12-hour drive away. Gayle Woodford the remote area nurse was abducted, raped and murdered with her body buried in a shallow grave in the outback. The result was a spot-light shone on the unconscious tolerance of risk in remote health, resulting in calls for the Federal Health Minister to be sacked, the nursing workforce in uproar, media and social media confusion and the ability to continue to provide healthcare to Australia's most remote populations at imminent risk of catastrophic failure.

The workforce, the industry and the government looked for solutions and CRANApplus, as the only agency in Australia with remote health as its core function, came to help overcome this harrowing period in remote health history. CRANApplus undertook a project that included a literature review, facilitation of a national conversation, convening of a national expert advisory group, development of national guidelines for safety & security, development of a working

safe in remote handbook, creation and delivery of a 1-day '*Staying Safe & Secure*' workshop along with a free on-line learning package, a free Safety & Security App & additional tools such as audits, risk assessment, decision making flow charts, and an anti-violence poster.

Conclusion/Discussion

The project has fundamentally changed the way remote health is delivered and continues to remain a highly political and emotional subject, currently changing legislation in one State and the topic of a TV documentary on our national broadcaster. The new national safety & security guidelines are routinely being adapted into the policies and procedures of health service providers, while the free resources are being utilised by the health workforce.

One of the challenges has been CRANApplus and our staff being thrust into the political, media, social media and broader general population spotlight, despite having very little control over the employment conditions of the remote health workforce. The impact of social media as a disseminator of inaccurate information, a call to arms of the broader population and the impact of social media trolls that spread fear, aggression, hate, racism and intolerance were unexpected and a monumental challenge for a small organisation like CRANApplus to overcome.

Acknowledgements

Australian Government Department of Health, Safety & Security Expert Advisory Group, Rod Menere – CRANApplus Safety & Security Project Officer, Brenda Birch – CRANApplus Remote Safety & Security Educator, The Aboriginal & Torres Strait Islander Peoples whose land on which we work.

Resources

www.crana.org.au (Website)

www.crana.org.au/resources/safety-security-in-remote-healthcare/ (Resources)

www.youtube.com/watch?v=EL7KDDkkHLk (Short Course Video)

Learning objectives

Participants will...

1. have an understanding of a unique incident of safety & security that has fundamentally changed the Australian Remote Health Context.
2. have an understanding of how industry led national guidelines on safety & security can drive reform.
3. learn of a suite of tools and resources that are freely available for consideration in their own contexts.
4. gain an insight into the barriers to change and the significant impact of social media and community mobilization when calm heads must to prevail.

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Body Image Perceptions of Veterans who have Suffered Military Sexual Trauma

Subtheme: *Other themes*

Paper

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Keywords: Veterans, Military sexual trauma, Body image

Abstract

Background

The Armed Forces is a service offered by our Governments to ensure the safety of all citizens. Within the military is a type of violence that is called military sexual trauma (MST). MST is the “*physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment...while serving on active duty, active duty for training, or inactive duty training*” (U.S. Government Publishing Office, 2006, 38 U.S.C. 1720D). In Canada and the United States, the actual number of military who have experienced MST is unknown. In Canada, reports have indicated that as many as 2% of the Armed Forces have reported sexual assault, with women being four times more likely than men to experience MST. In the United States, the prevalence of MST has been reported to be as high as 41% of female veterans in the 2009-2011 National Health Study of U.S. Veterans. MST is associated with adverse physical and mental health outcomes, homelessness, and suicide. This study provides a novel perspective on the effects of MST and provides a foundation for future interventions.

Methods

The researchers were invited to a transitional home for homeless woman veterans to help improve “*body image issues.*” Convenience sampling was used to recruit 12 veterans who perceived they had a physical difference due to military service. Data were obtained in focus groups where the veterans were invited to share stories. Ricoeur’s hermeneutic phenomenology guided the study. The research team learned early in the data collection stage that 11 of the 12 participants suffered from MST. The transcripts were analyzed by three researchers. A validation meeting was held with four participants.

Findings

Three structures emerged in the data: 1) to speak up or not to speak, 2) from military pride to shameful anguish and, 3) invisible scars versus visible scars. The participants discussed the reasons that made it difficult to report the abuse, and for those who did report, the repercussions

that followed. The military pride that they felt in body, mind, and spirit when entering the military dissipated into shameful anguish after MST. The internal scars of MST were far worse than physical injuries and left lasting body image issues that were felt in the mirror, in society, and in intimacy. Finding and sharing words for these body image experiences that had been for the most part lived in silence, allowed the participants to realize that their experiences were not unique but universal.

Implications

The participants had suggestions for healthcare professionals including sensitivity training to prevent MST, separate MST from post-traumatic stress syndrome (PTSD) to improve reporting, women-only clinics, and interventions focused on enhancing body image. Healthcare professionals working with woman veterans with MST should know that there may be embodied effects of MST. In other words, the impact of MST may go beyond cognitive functioning to the level of body, mind, and spirit. Before this study, there are no studies that suggest body image is related to MST. In addition to studies that capture statistics, reporting, and effects of MST, correlational studies are needed to discern whether body image is associated with MST. Interventional studies are required for those with MST, including interventions aimed at enhancing body image. Research is also needed to determine if body image may be affected by other types of sexual abuse.

Learning objectives

The participants will be able to...

1. Review known statistics and effects of military sexual trauma (MST).
2. Assess the methodology used to capture the experience of veterans who had suffered MST.
3. Develop strategies for caring for victims of MST.
4. Discuss the possibility of impaired body image in other types of sexual abuse.

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Incivility in Health Care: Original Research

Subtheme: *Other themes*

Poster

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Keywords: Registered Nurse, Nurse, Incivility, Healthcare, Incivility in Health Care: Original Research

Abstract

Reports have shown that nurse bullying occurs in 40 to 90% of working nurses worldwide. Nurse bullying, also known as horizontal violence, lateral violence, and nurse hostility, create a significant impact for the victim and the organization. Organizational symptoms of nurse bullying include: poor nurse retention, increased burnout, absenteeism, financial cost of nurse turnover, poor morale, increased medical errors, compromised patient safety, and poor patient outcomes (Embree & White, 2010; Higgins & MacIntosh, 2010; Katrinli, Atabay, Gunary, & Cangarli, 2010; Sellers, Millenbach, Kovach, & Yingling, 2010).

There is empirical evidence that reveals how disruptive behavior in the workplace affects the healthcare workforce, victim's health, and patient's lives (American Nurses Association, 2015; Joint Commission, 2008). Among new nurses, 60% leave their first RN position within the first six months due to disruptive behavior in the workplace, which directly effects the nursing shortage. Such a shortage has projected to cause 260,000 open RN positions in the US alone (Castronovo, Pullizzi, & Evans, 2015). Furthermore, the cost of nurse turnover can be expensive; the estimated cost of replacing one specialty RN can be over 0,000 (Embree & White, 2010; Castronovo et al., 2015).

One study revealed that over 70% of new nurses reported being a victim of some type of bullying in the previous month (Berry, Gillespie, Gates & Schafer, 2012). In addition to new nurses, any newly hired nurse, even with significant work experience, is highly targeted in the workplace. Special focus has been placed on nurses either who challenge the current system or who are seen as threats to higher-level employees (Castronovo et al., 2015).

Victims of bullying suffer greatly from psychological and physical trauma including lower job satisfaction, burnout, absenteeism, job turnover, anxiety, poor work performance, decreased self-esteem, post-traumatic stress, depression, and increased intention to leave nursing (American Nurses Association, 2015). Perhaps the most disturbing report came from The Workplace Bullying Institute (2012) that reported 29% of surveyed victims of workplace bullying contemplated suicide and over half of those had a plan to carry it through.

Cultures where bullying is occurring, have a detrimental impact on patients; increased medical errors, compromised patient safety, and increased patient morbidity (The Joint Commission, 2008; Sellers et al., 2010).

The purpose of this IRB-approved study was to determine if senior RN to BSN nursing students had witnessed or been a recipient of bullying behavior in the workplace. The qualitative study utilized three focus groups (n=14) to collect data on the incidence of bullying in the workplace. The participants included senior RN to BSN students during their final semester in the program.

Study findings indicated that uncivil behavior occurs between all members of the health care team. Another phase of the study aimed at delving deeper and looking at the specific uncivil behaviors that RN to BSN students encounter in the workplace.

Learning objectives

Participants will...

1. be aware of the harm that uncivil behavior causes nurses and to patients.
2. be able to the uncivil behavior.

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Use of Body-Worn Cameras on Healthcare Security Personnel Increases Accountability, Transparency, and Accuracy

Subtheme: Other themes

Paper

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Keywords: Body-Worn Camera, Healthcare Security, Patient Violence, Agitation, De-escalation

Abstract

Background

Healthcare security officers respond to incidents where patients have become agitated, violent and out of control. These incidents are documented after the fact, most often from memory. Memory is a fallible reconstructive process that is negatively affected by stress. This may lead to inaccurate recall, inadequate documentation, and misleading root-cause analyses of the event. The use of Body-Worn Cameras (BWCs) by security officers is hypothesized to assist in improving accuracy in this process.

Methods

We placed BWCs on 10 healthcare security officers and put them into an agitated, violent patient simulation. They were asked to document their interaction with the patient upon completion of the simulation by standard written report. They were then allowed to view their BWC video and edit their report as needed. The number and type of edits to their reports were tabulated for descriptive analysis.

Findings

All officers had significant alterations of their reports upon viewing their videos, some greater than 50%. Many edits were for incorrect sequencing of events, incorrect statements made, or poor descriptions of patient or staff behavior. This indicates that typical report review of high-risk incidents is an inaccurate and potentially misleading process and development of prevention programs and policies based on traditional documentation is likely to be flawed.

Implications

Care of agitated, violent patients can be improved through the strategic use of BWCs. Review of BWC data would allow for accurate root cause analyses, accountability of behavior on both sides of the camera, and transparent care practices.

Learning objectives

Participants will...

1. be aware of the inaccuracies in the way that we currently analyze violent patient events.
2. gain an understanding of how current video technology can aid in caring for violent patients and how this technology can lead to more transparent and patient-oriented practices.

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Home-visit nurses' violent experiences from patients with mental illnesses: The possibilities of under-reporting about experiences

Subtheme: Other themes

Poster

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Keywords: Occupational violence, home-visit nurse, patient with mental illness, under-reporting

Background

Home-visit nurses (hvns) in Japan play a crucial role in the provision of medical services for community-living individuals with mental illnesses. However, hvns' violent experiences from patients with mental illnesses were not fully investigated. No survey was found on the state of their reporting of the violent experiences or on the organizational supports for hvns.

Aim

The purpose of the present study is to clarify the current situation of hvns' exposure to violence from patients with mental illnesses, their reports after exposure to violence, and the provision of organizational supports to prevent re-exposure for the violence-experienced hvns.

Method

This study employed a cross-sectional design. All home-visit nursing stations established in the Kinki area of Japan were approached; 219 of 408 stations agreed to participate in this study. Hvns affiliated with these stations were sent the questionnaire and a return envelope, along with documentation explaining the research purpose, voluntary participation, and strict protection of information. Descriptive statistics were performed. The ethics review board of the affiliate university approved this study.

Results

Over 90% of the 184 participants were females, with an average age of 45.4 (sd 9.3). Eighty-four participants (47.3%) had experienced at least one form of violence during their career as a home-visit nurse. Forty-four hvns (23.9%) had experienced physical assault, 53 (29.8%) had experienced verbal abuse, and 27 (14.8%) had experienced sexual harassment.

Regarding the most stressful episode of physical assault during a visit, 42 of 44 participants who had experienced physical assault reported their experience while two did not report their experience to anyone. After this exposure, 33 of 44 participants obtained at least one type of organizational support from their affiliated stations, while 11 participants obtained no organizational support.

When it came to verbal abuse, 50 of 53 participants reported their exposure, while three did not report their experience to anyone. After this exposure, 45 of the 53 participants obtained at least one type of organizational support while eight participants did not obtain any organizational support. Regarding sexual harassment, 25 of 27 participants reported their exposure, while two did not report their experience to anyone. After this exposure, 24 of 27 participants obtained at least one type of organizational support, while three participants did not.

Discussion

Most hvns reported their most stressful experience of violence exposure to their manager, administrator, or colleagues, and they obtained support from their affiliated stations. In some HVNs who experienced violence, there was no organizational support from their affiliated stations. This situation might be accelerated via the less report and under-reporting on violence exposures. To take appropriate measures, it is important to investigate the backgrounds and mechanisms of the less report and under-reporting.

Learning objectives

Participants will...

1. have an understanding of current situation of violence exposure of hvns from patients with mental illnesses in Japan.
2. understand the role under-reporting may play on the violence in the provision of organizational support to prevent re-exposure.

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How to deal with anger? The effectiveness of anger regulation strategies

Subtheme: *Other themes*

Paper

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Keywords: Aggression, anger, anger regulation

Abstract

Anger often causes aggressive behavior, which makes it an emotion in most situations socially unacceptable. But according to the state of the art on emotion regulation, aggression is only one form of regulation of anger. The subject of the research was to test the effectiveness of seven anger regulation strategies: rumination, submission, feedback, downplaying humor, venting and distraction.

The study was conducted using the experimental procedure with psychological (self-report) and psychophysiological measurement (GSR, EMG). Sample (N=350) consists of health men and women (age 18-35 years old).

The research fills the gap associated with testing the effectiveness of different anger regulation strategies within one experimental procedure. Moreover, it will show which anger regulation strategies should be mainly promoted as a way of decreasing aggression in social life.

Learning objectives

Participants will...

1. learn how aggression can be decreased by implementing functional anger regulation strategies in the behavioral repertoire of people.
2. appreciate the social benefits of the regulation strategies.

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Maledictology: the science of swearing

Subtheme: *Other themes*

Workshop

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Keywords: Swearing, terse language, verbal abuse, speech act theory

Abstract

In many societies politeness is seen as a virtue whilst swearing and the use of crude or offensive language is deemed a vice. Growing children are often fascinated by the use of offensive words and their parents' task is to guide and instruct them on how to social navigate deal with such utterances. It is also well known that some of the first words acquired in a foreign language are terse or offensive terms for use or for avoidance.

Current day political correctness demands social actors to use utterances of the least offensive nature and even to revert to artificially constructed euphemisms. This would seem to be the antithesis to language use in "*protected*" settings such as locker rooms, in-groups, or perhaps the staff-room in a health setting. In the health care system the use of strong language is often associated with the labels of "*toxic language*", "*verbal abuse*", or "*verbal aggression*" and personnel is prompted to report such behavior as an aggressive incident.

In this paper we view the use of terse, offensive, or strong language from the vantage point of maledictology. Maledictology as a branch of psychology researches the usage of cursing and swearing as an integral part of human social interaction.

In this paper (workshop or both) we will review various forms of strong language – e.g. insults or curses – and explain the functions – e.g. power or social acceptance – these utterances serve. We will also highlight some situations in which swearing and cursing is appropriate and non-appropriate. The issue of trans-culturalism regarding swearing and cursing will be addressed.

Learning objectives

Participants will...

1. be able to reflect the use and functions of swearing and cursing related to the patients in their own setting.
2. be prompted to reflect whether patients' swearing and cursing may be positively interpreted.

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Violence in acute psychiatry care through the camera lens: How much has changed since the 1960s?

Subtheme: Other themes

Workshop

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Keywords: Oppression, somatic therapies, Hollywood, development, recovery, empowerment, cultural sensitivity

Background

Although sociologists frequently identify and discuss the effect of film/movies on culture, the reverse of this is also true, if less discussed in the professional literature. “*The relationship between movies and culture involves a complicated dynamic; while American movies certainly influence the mass culture that consumes them, they are also an integral part of that culture, a product of it, and therefore a reflection of prevailing concerns, attitudes, and beliefs*” (Movies and Culture in Mass Communication, Media and Culture, vol 10). The concept that film can be an integral part of a culture, reflecting its concerns, attitudes and beliefs is the subject of this paper in relation to the depiction of conditions in psychiatric institutions over the last 50 years. Keri de Carlo (2007) states that “*film reflects a society’s conception of mental health nursing, the hospital and the people they nurse*” (de Carlo, 2007).

Against this background we consider the contribution of cinema films to detect and trace some developments over the last 50 years in handling aggression in the health care systems with a special focus on the mental health hospital and its treatment and ideological regimen.

Early psychiatric treatments leading up to the 1950s and beyond

Physicians as far back as Hippocrates (c. 460 – c. 370 BCE) had observed that somatic stress such as convulsions or high fever may alleviate disturbing mental conditions (cf. Sabbatini 2018). Prior to the development of the modern psychotropic substances – especially the first generation of major tranquillizers with both anti-psychotic sedative effects developed in the early 1950s in Europe – the principle of inducing somatic stress was used in a number of “*somatic therapies*” for producing physiological shock developed between 1917 and 1935 (Table 1) in Europe (cf. Sabbatini 2018).

By 1941 42% of American Psychiatric Hospitals utilized electroconvulsive shock therapy in an attempt to “*try anything for many of their famously chronic patients*” (Sadowsky 2006, P.

10). Electroconvulsive shock therapy and Cardiazol therapy aimed at producing convulsions similar to epileptic seizures. Mccrae (2006) reports the following application of Cardiazol (known in the USA as Metrazol) convulsion therapy: After intravenous application of the substance the patients face immediately loses its color. The seizure begins with a cry and tonic contractions begin. A gag is applied to evade jaw dislocation. At the onset of clonic jerking (around 40 seconds) pupils widen and the patient is manually restrained to avoid injury. The patient then falls into a comatose sleep (about 10 minutes) prior to recovery. Incontinence was common (cf. Mccrae 2006, 71-72).

Table 1: Overview of some somatic therapies (cf. Sabbatini 2018)

Date	Place	Discoverers	Somatic therapy
1917	Vienna	Julius Wagner-Jauregg	Malaria-induced fever, to treat neurosyphilitic paresis
1927	Berlin	Manfred J. Sakel	Insulin-induced coma and convulsions, to treat schizophrenia
1934	Budapest	Ladislav J. von Meduna	Cardiazol-induced convulsions, to treat schizophrenia and affective psychoses
1937	Rome	Ugo Cerletti and Lucio Bini	Electroconvulsive shock therapy
1936	Rome, Lisbon	Mario Fiamberti and António Egas Moniz	Lobotomy/leucotomy, psychosurgery severing connections in the brain's prefrontal cortex to regulate (often aggressive) mental disorder

Depending on the somatic therapy serious effects were observed such as irreversible coma (insulin shock) or in the case of Cardiazol embolism, cardiovascular accidents, status epilepticus or even death have been reported (Mccrae 2006). By the early 1950s (in America) the somatic therapies were in decline due to the risks involved, the growing critique by the antipsychiatry movement voiced by persons such as Szasz (1960), Goffman (1961), and Foucault (1961) (cf. Sadowsky 2006), and possibly by the advent of the new antipsychotic agents such as chlorpromazine. However, the application of e.g. electroconvulsive therapy continued after the 1950s. This therapy – as Hollywood films show – seems to be a “*typical*” psychiatric treatment in the perception of the public eye fifty years ago.

Advances in psychiatric treatment

Throughout the ages, care of the mentally ill was a challenge in all cultures. In reading about the history of the management of those with serious psychiatric conditions, containment and behavioral control – especially in the case of violent or hostile behavior – of those afflicted was the major goal of those responsible for their care. Often the conditions under which the mentally ill were maintained were brutal and horrific (cite). In the best of cases, the care was custodial rather than therapeutic. As more knowledge was gained about the mind and its workings, changes in institutional practices were made. However, it was the discovery of Chlorpromazine in 1950, the first neuroleptic having some degree of efficacy in controlling symptoms, that rapid advances were made.

Recent developments in psychiatric treatments

More recent developments in mental health have witnessed a welcome and refreshing paradigm shift from exclusive reliance on institutional, somatic and psychopharmacological

treatments which firmly located mental illness within the agency of 'patient' alone, 'cure' within the agency of the psychiatrist alone and the asylum as a structure of social order which potentially assigned nurses the function of custodian rather than clinician. The evolution of 'recovery' has seen the relocation of treatment shift from institution to community, the role of custodian shift to clinician, the engagement shift from either paternalism and/or coercive control to one of empowerment, and the outlook shift from despair to hope. While the definition of recovery varies geographically and between constituents, Anthony (1993) describes the essence of recovery as a "*deeply personal unique process of changing... a way of living a satisfying, hopeful and contributing life even with limitations caused by illness... [including] the development of new meaning and purpose in life as one grows beyond the catastrophic effects of mental illness*" (p.11).

Enlightened contemporary mental health care provides multidisciplinary community based recovery oriented services which place greater emphasis on the legitimacy of the unique knowledge of lived experience, and much less on the curative power of either the institution or medical practitioner. Within such settings recovery is 'done by' rather than 'done to' the person with a mental illness, resulting in a transformational shift in the location of power within the therapeutic encounter, to one which relies on a collaborative engagement that respects the centrality of the person's life choices. In the context of this paper, personal stories of recovery have played a major part in this paradigm shift, fostering core messages of hope, empowerment meaning, and pursuit of a life of one's own choosing (WHO 2010; Australian Health Ministry 2013; HSE Ireland 2017).

Advances in patients' rights

Prior to ca. 1950 patients' legal and civil rights were relatively non-existent, and patients could be subjected to invasive treatments such as ECT and psychosurgery against their will. In most western cultures at this time, people were more accepting of control and restrictions of personalized freedom as evidenced by the lack of rights granted to racial groups, the indigent, the disabled, women and others who were looked upon as inferior in any way. During the decade of the 1960s, social attitudes began to change rapidly in western society. Political activism was occurring, achieving more and more success at securing rights and freedom for those who had previously been denied them. Among these were those with mental illness, whose rights were expanded by court decisions, charitable organizations and by the support of healthcare professionals as well who were becoming more knowledgeable and enlightened about psychiatry. A 1971 legal finding in the case of Wyatt v Stickney found that not only did patients have a constitutional right to receive treatment, but they had a right to refuse electroshock, psychosurgery and other major intrusive procedures (Brown 1981). Simon and Shuman (2007), in the Clinical Manual of Psychiatry and Law, provide a detailed discussion of the development of patient rights relating to refusal of any/all treatment including concepts of competency, informed consent and exceptions to these. Such power transitions may have led to a reduction of aggressive behavior in psychiatry.

Indeed, the emergence of 'recovery' can be considered as one manifestation of these advances in human rights, being attributed initially to US service mental health consumer activists,

and readily and rapidly embraced in Australia, New Zealand and Europe (Australian Health Ministry 2013; HSE Ireland 2017).

Discussion

The authors of this paper performed a review of select films in which conditions in psychiatric hospitals were depicted in order to analyze whether the sociocultural changes occurring in psychiatry pertaining to aggressive behavior were reflected in the films of the period. The films selected were assessed by experienced, credentialed psychiatric professionals to either realistically present a picture of conditions in acute care psychiatry or they were films that, although not accurate in their general presentation of hospital conditions, did present the location of power within the existing hierarchy of psychiatric institutions and the treatment modalities in use at the time, accurately.

Transitions in power and authority

The handling of violence in the health sector is necessarily linked with the treatment regimen and the social and political movements at any given time. Beginning in the 1950's and continuing to the present day, we can identify a theme of a power shift in society with power beginning to be extended to vulnerable populations from the previously exclusive location of power within dominant controlling authorities having recognized legitimate social status. The decades of the 1960's and 70's gave rise to a resurgence of political activism such as the civil rights movement, the antiwar movement and the women's movement where those social groups who had been relatively powerless before, began to demand a share of influence and control. These cultural changes "*spurred new criticism of psychiatry's role in preserving the status quo*" (Brown 1981).

Violence in psychiatry: What do the camera lens show us?

The film clips utilized in the workshop reveal how psychiatric treatments and regimens influence violence and its handling. In the early films (starting from about 1960) demonstrate examples of treatment – both somatic and interactional – which on the one hand aimed at handling violence in patients but on the other hand were by way of their oppressive nature may have been instrumental in provoking violence. In these early films we see examples of somatic therapy such as electroconvulsive therapy or even lobotomy utilized as punishment for aggressive behavior. On the other hand more recent films demonstrate therapeutic encounters of collaborative engagement which respect the person's life choices, in which the helper is often framed as the '*good other*' rather than clinician, and occurrences of aggression are contextually located rather than being purely a function of illness alone.

Conclusion

Datta (2009) identifies the opportunity to compare and contrast the presentation of mental illness, psychiatry, and psychiatrists in cinema from different times and cultures, and to critically appreciate the influence of psychiatry on cinema from different times and cultures.

In spite of some of the film editors inaccurate portrayals of treatment in psychiatry, we have good reasons to believe that significant advances have occurred over the past 50 or so years. However, few would contest that the issue of aggression and violence remains a challenge within all health care settings. Popular movies, and indeed the humanities in general, can assist clinicians in their critical reflection on how we frame both the challenge and our responses.

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Workshop activity

During the workshop participants will...

1. receive theoretical (historical) input on some major somatic therapies used from ca. 1930 till 1990.
2. be invited/prompted to help develop emerging discussions on the film material.
3. be invited/prompted to detect and discuss the material in the light of their own cultural background.
4. be invited/prompted to use the material presented to reflect on developments pertaining to the handling of violence and aggression in their own culture and setting.

Learning objectives

Participants will...

1. reflect on developments pertaining to the handling of violence and aggression in their own culture and setting over the last years.
2. use their "ethical compass" in the discussions and for their own personal take-home message from the workshop.

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Non-harmonious harmony – aggressive outbursts in concert halls

Subtheme: *Other themes*

Paper

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Keywords: Aggression, “musical deviance”, scandal, classical music, deviance

Introduction

Usually the world of classical music is associated with civilized and well-mannered behavior. However, even before the student revolts in Paris and other European countries and the – at least – partially violent behavior at the legendary festival in Woodstock in 1969 the Austrian capital of Vienna was shaken - more than 50 years earlier - by a riot in a Concert Hall in Vienna on the 31th of March 1913 during the first performance of the “*Altenberg Songs*” of the Austrian composer Alban Berg (1885 – 1935). A few weeks later the Théâtre des Champs-élysées in Paris witnessed a similar scandal on May the 29th 1913: After only a few bars of the ballet “*Le sacre du printemps*” (the Rite of Spring) by Igor Stravinsky (1882 – 1971) tumult broke out in the auditorium and the orchestra could not be heard under the jeers and whistles of the rioters. However, we will start this journey of musical aggression with Ludwig van Beethoven.

Beethoven’s Eroica Symphony

Beethoven’s (1770 – 1827) first two symphonies were composed in a similar vein to the symphonic tradition created by Josef Haydn (1732 – 1809) and Wolfgang Amadeus Mozart (1756 – 1791). However, Beethoven’s third “*Eroica*” symphony Opus 55, which premiered on the 7th of April 1805, investigated new musical territory in terms of style, length and harmonics. Jurik (2018) remarks on the oeuvre: “*While few championed Beethoven’s accomplishment, the Eroica was generally understood as a troubled symphony of harmonic advancements clashing against structural deviations*”. Wegeler and Ries (1838) refer to a particular part in the first movement of the symphony which caused considerable discomfort to the listeners: “*Beethoven has a wicked trick for the horn; a few bars before the theme comes in again complete, Beethoven lets the horn indicate the theme where the two violins still play the chord of the second. For someone who is not familiar with the score this always gives the impression that the horn player has counted wrong and come in at the wrong place. During the first rehearsal of this symphony, which went appallingly, the horn player, however, came in correctly. I was standing next to Beethoven and, thinking it was wrong, I said, ‘That damned horn player! Can’t he count properly? It sounds infamously wrong!’ I think I nearly had my ears boxed – Beethoven did not forgive me for a long time*” (Wegeler/Ries 1838).

The “*corpus delicti*” – sometimes referred to as the “*cumulus*” – is demonstrated in the following excerpt from the piano reduction of the score:

The image shows a musical score excerpt. The top staff is the vocal line, with lyrics "Pw." and "Pw." written below it. The bottom staff is the piano accompaniment. Dynamics include *ppp* (pianissimo), *pp* (pianissimo), *f* (forte), and *ff* (fortissimo). A "*" symbol is placed at the end of the piano part.

According to Sipe (1998) later conductors such as François-Joseph Fétis (1784 – 1871) and Richard Wagner (1813 – 1883) are reported to have made amendments to the “*cumulus*” passage to render the two bars “*harmonious*”.

Berg’s Altenberg Songs

Ninety eight years later on the 31st of March 1913 another concert occurred which shocked the public. It was the famous “*scandal concert*” held at the Grosser Musikvereinssaal in Vienna. The following works were advertised:

- Anton Webern: Six Pieces for Orchestra, Op. 6
- Alexander von Zemlinsky: Four Orchestral Songs on poems by Maeterlinck
- Arnold Schoenberg: Chamber Symphony No. 1, Op. 9.
- Alban Berg: Two of the Five Orchestral Songs on Picture-Postcard Texts by Peter Altenberg, Op. 4 Nos. 2 and 3.
- Gustav Mahler: Kindertotenlieder.

Here are the texts of the two poems Berg set to music:

<i>German original</i>	<i>English translation</i>
Sahst du nach dem Gewitterregen den Wald? Alles rastet, blinkt und ist schöner als zuvor. Siehe, Frau, auch du brauchst Gewitterregen!	Did you see the forest after the rainy thunderstorm? Everything rests, twinkles, and is more beautiful than before. See, woman, you too need rainy thunderstorms!

Über die Grenzen des All blicktest du sinnend hinaus; Hastest nie Sorge um Hof und Haus! Leben und Traum vom Leben, plötzlich ist alles aus Über die Grenzen des All blickst du noch sinnend hinaus!	Beyond the limits of the universe you thoughtfully looked, You never had worries about courtyard or house! Life and life's dream, suddenly have gone Beyond the limits of the universe you still thoughtfully looked!
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At the concert it was during Berg's songs that the fighting began and audience called for both poet and composer to be committed to a local psychiatric hospital, despite it being public knowledge that Altenberg was already committed to an asylum at the time (cf. Skandalkonzert, 2018). Due to the fighting the final work of the concert – Kindertotenlieder by Gustav Mahler – was not performed. Press reports of that time speak of tumultuous riots: “*The followers of Schoenberg, his students and opponents shouted at each other, threw objects at them, disturbed the performance, destroyed the furniture, etc. Several times outraged conservatives from the audience climbed the stage cursing to slap Arnold Schoenberg. When the latter threatened that order would be created with the help of the public authority, the turmoil really started properly*” (Skandalkonzert 1913).

The Rite of Spring - Pictures of Pagan Russia in Two Parts

Barely two months later – the 29th of May 29 1913 – the premiere of Igor Stravinsky's (1882 –1971) ballet “*Le sacre du printemps*” (the Rite of Spring) caused rioting in the Théâtre des Champs-Élysées in Paris. Before the “*Rite*” the following familiar ballet favorites were performed: Les Sylphides, Le Spectre de la Rose and the Polovstian Dances from Borodin's opera Prince Igor. The “*Rite of Spring*” is structured in the following manner:

Part 1: Adoration of the Earth

1. Introduction 2. Augurs of Spring 3. Ritual of Abduction 4. Spring Rounds 5. Ritual of the Rival Tribes 6. Procession of the Sage: The Sage 7. Kiss of the Earth 8. Dance of the Earth)

Part 2: The Sacrifice)

9. Introduction 10. Mystic Circles of the Young Girls 11. Glorification of the Chosen One 12. Evocation of the Ancestors 13. Ritual Action of the Ancestors 14. Sacrificial Dance.

Morton (1979) quotes Stravinsky's own conception of his creation: “*I had a fleeting vision which came to me as a complete surprise, my mind at the moment being full of other things. I saw in my imagination a solemn pagan rite: sage elders, seated in a circle, watched a young girl dance herself to death. They were sacrificing her to propitiate the god of spring*”.

Gittleman (2013) reports on what happened at the venue: “*After a few moments of relative calm, the curtain went up and the dancers started jumping and stomping. Audience decorum quickly broke down: grumbling, hissing, whistling, catcalls, arguments, even fist fights! Stravinsky escaped to the lobby, horrified. Nijinsky [the choreographer] ran backstage and stood in the wings shouting counts to his dancers, who couldn't hear the music over the din of the audience.*

Only one person in the building seems to have kept his cool: Monteux [the conductor], who calmly and efficiently led the orchestra through the score from beginning to end”.

The following unorthodox musical and dancing techniques may have contributed to the extreme response of the public: Pulsating visceral rhythms, perverse dissonance, unorthodox treatment of the instruments (bassoon set in an extremely high register, the use of the strings as percussion instruments) (cf. Hewitt (2013)). Some analysts maintain, however, that Nijinskys choreography the dancing consisting of stomping, the inturned feet of the dancers (diametrically opposed to the classical ballet tradition).

Today – more than one hundred years later the “*Rite of Spring*” is considered by many to be one of the greatest masterpieces of the 20th century.

Discussion

As the concept class has a strong influence on the musical taste of listeners (cf. Ashwood/Bell, 2017) it is reasonable to assume that the audience hearing the works of Beethoven, Berg and Stravinski had had access to concert halls and were thus persons of higher class. It also seems reasonable to assume that visitors of classical concerts have been socialized to the musical taste they are generally exposed to and thus cherish. This would especially be the case at the scandalous Stravinsky concert: The works performed before the “*Rite of Spring*” were all well-loved, popular and “*non dangerous*” pieces in the standard repertoire (Les Sylphides, Le Spectre de la Rose and the Polovstian Dances from Borodin’s opera Prince Igor).

Expanding on the idea of – in this case – higher class as a key mediator in the development of the “*classical*” musical taste it is noteworthy that the connoisseurs of classical music had probably invested hundreds of hours in their humanistic education and lots of money in accessing the concerts they frequented (please recall that there no radios or television sets at that time). So the resources invested would have led to a vested interest in the perpetuation of the ideology of “*classical*” music and the emotional basis for its defense. Ashwood and Bell state that “taste also results from complex relationships formed by affections that develop through distinct and relative experiences, bonds, and friendships, all of which are situated in particular places (2017, p. 626).

Possibly Stravinsky’s musical style – with the “*Rite’s*” archaic rhythms, the “*unfiltered*” presentation of dark and uncanny impulses, the associative outpour of the ID – may be tentatively compared to the novel of the French writer Marcel Proust regarding his novel “*À la recherche du temps perdu*” (1913–1927) (In Search of Lost Time) which makes use of the literary device of the “*stream of consciousness*”. It is also noteworthy that some years after the scandal concerts in Vienna and Paris new literary works appeared which shook the fundamentals of many readers, namely the modernist novel “*Ulysses*” by the Irish writer James Joyce (published in parts from 1918 onwards) or “*The Waste Land*” by T.S. Eliot (1922).

Conclusion

In the instances mentioned the acts of aggression all seem to occur as a defense of one's own personal taste. Personal taste is developed in a long process probably unconscious to the defender of the taste. Changes in tradition – be they small (the two bars in the Beethoven symphony) or large (the shocking score of Stravinsky's "*Rite of Spring*") – may have posed a threat to the persons' cherished habitat and may – as in the case of other types of aggression – have provoked flight or fight modes.

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Learning objectives

Participants will...

1. realize that "*musical deviance*" was one of the major forces of the development of classical music.
2. be invited to reflect on possible parallels between aggressive outburst in concert halls and in health care settings.

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The influence of the first two standard exercises of Autogenic Training

Subtheme: *Other themes*

Poster

Helene Lytwyn

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Keywords: Autogenic Training, heaviness of limbs, warmth of limbs, coping with stress, mental and somatic symptoms, anger, aggression and depression

Case study

Background

Autogenic Training (AT) as a systematic relaxation method devised by I. H. Schultz has been able to show that it is a very good procedure to master mental and somatic symptoms. Also, AT has a good track record as regards its impact on managing stress in both healthy and depressed adults. For example, aggressive behavior on stress could be significantly reduced in healthy people. Even with the use of the first two standard exercises of the AT heaviness of limbs and warmth of limbs alone, good exercise results could be found within a very short time in depressed patients. Since depression often involves repressed anger as well as aggression against one's own person, this should be given special attention in this case study.

Material and Methods

One inpatient depressive woman, who had multiple childhood and adolescent traumas and got antidepressant medication, wanted to learn AT voluntarily, was tested with five psychological tests before and after completing the first two standard AT exercises over five days. These tests were: AT-Sym (Änderungssensitive Symptomliste, a subset of Diagnostisches und Evaluatives Instrumentarium zum Autogenen Training (AT-EVA)), SVF-120 (Streßverarbeitungsfragebogen 120), FAF (Fragebogen zur Erfassung von Aggressivitätsfaktoren), STAXI (Das State-Trait Ärgerausdrucksinventar) and BDI II-R (Beck-Depressions-Inventar Revision).

Results

In the AT-Sym, clear improvements were seen in decreasing above-average scores to the average for performance and behavioral difficulties, painfulness, self-determination and control issues, and the overall value of problem burden and discomfort. The SVF 120 saw a reduction in above-average levels of trivialization, social isolation, resignation, self-pity and self-incrimination at normal median value. The mental retention, substitute satisfaction

and the situation control attempts fell to below-average values during the course. Aggression as a stress-processing mechanism was already below average at the first measurement. It continued to decline below average at the second time of measurement. In general, negative stress-reduction strategies clearly decreased. The values in the FAF showed only a clear decrease in the excitability scale. The scale of self-aggression or depression remained consistently slightly above average. In the below-average range, the value for openness also remained unchanged. In the STAXI, the S-A value rose from a below-average to a median value, indicating a slight increase in the sensation of anger. The values of the AO scale remained significantly below average, which indicated that the patient remained below average as regards open aggressive behaviors. This unequivocally high value above average of the AI scale at the second measurement suggests the increasing experience of anger, which, however, is not shown to the outside world or is suppressed. The BDI II-R showed a clear decline during the course in depression.

Conclusion

A short form of the AT has already shown a positive effect repeatedly on different mental and somatic symptoms as well as on different stress-processing strategies such as aggression. There is also an increase in activating the experience of anger, which is often severely suppressed in depressives. However, this study also shows that for good postgraduate psychotherapy, gaining the trust of the depressed patient is very important for helping the patient experience the anger he has experienced, showing the anger appropriately to process it. Thus, the probability would be less that the person would set uncontrolled aggressive actions against himself or others due to his anger. In summary, this study shows that parts of the AT could already serve as the first entry point for depressed patients, enabling them to devote themselves to further psychotherapy in a relaxed state, especially to work on their anger.

Learning objectives

Participants will...

1. appreciate the role that Autogenic Training may play in modulating aggression and violence.
2. learn about associations between violence and other mental health states.

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The implementation of violence prevention policies and programs in hospitals

Subtheme: *Other themes*

Poster

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Keywords: workplace violence, hospitals, healthcare, flagging, incident reporting, security, alarms, risk assessment, training

Abstract

Background & Context

Violence in hospitals is a serious occupational health and safety issue affecting the physical and mental health of front line staff and the quality of patient care. In 2010, the province of Ontario (Canada) introduced legislation which directs hospitals to put into place violence prevention and management systems. Our study examined how five Ontario hospitals have developed and implemented their violence prevention programs.

Methodology

Semi-structured interviews were conducted with 8 key informants external to hospitals (legislators, union leaders, hospital associations) and 40 management and occupational health and safety specialists in hospitals. Eighteen focus groups (n=108) and one-on-one interviews (n=9) were conducted with front line workers. Five hospitals participated in the study. Interview and focus group questions focused on the effect of the legislation on the development of violence prevention programs and how they were implemented across departments. Once data were collected, a code list was developed by reviewing the transcripts. Each transcript was coded by two researchers and then a thematic, inductive analysis was carried out. The constant comparative method was used to identify differences and similarities across hospitals and to understand factors that shape hospital violence prevention and management policies and practices.

Findings

Study findings suggest that while legislation sets parameters for the development of policies, serious violence-related events and the presence of a violence prevention “*champion*” bolster long-term commitment to violence prevention and the development of sustainable programs. The following key components related to the prevention and management of violence in hospitals were discussed: security teams, patient ‘*flagging*’, codes and alarms, training, organizational risk assessment, and incident reporting.

Implications

Our findings detail how management commitment, workplace culture and broader structural factors can shape the implementation of hospital policies around violence prevention and reporting. Considerations for decision-makers focus on long-term sustainability of violence prevention practices in the acute care sector and the implications this can have on worker health.

Learning objectives

Participants will...

1. learn about the challenges five hospitals have faced in implementing their violence prevention programs.
2. have a basic understanding of how workplace safety culture can impact the success and sustainability of violence prevention practices.

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College Student Awareness of Physical and Psychological Dating Violence

Subtheme: Other themes

Poster

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Keywords: College student, awareness, physical, psychological, dating violence

Abstract

Objectives

To help prevent dating violence among college students, it is essential to first raise general awareness of dating violence. The aim of this study was to reveal associations between awareness of physical dating violence and psychological dating violence, and associations between each type of awareness and gender.

Methods

(1) Participants: 344 college students at University X in Japan; (2) Methods: Anonymous self-administered questionnaire; (3) Survey period: from July to August 2017; (4) Question items: demographics, awareness of physical dating violence (10 items from the Attitudes About Aggression in Dating Situations), and awareness of psychological dating violence (12 items from the Justification of Verbal/Coercive Tactics Scale). A 6-point Likert response scale was used to assess awareness of physical dating violence, and a 5-point Likert response scale was used to assess each of a number of psychological dating violence situations against a female and against a male. On both of the scales, a greater number of points indicates a higher level of awareness; (5) Analysis: Associations between physical and psychological dating violence awareness scores, and between each type of awareness scores and gender, were examined statistically using SPSS vers.19, with p

Results

Valid responses were obtained from 45 males and 204 females, with a mean age of 20.2 years. The scores of awareness of psychological dating violence against a female were 49.2 for females and 47.4 for males ($p=.045$); and the scores of awareness of psychological dating violence against a male were 49.8 for females and 46.4 for males ($p=.002$), which demonstrated that males had significantly lower levels of awareness of both types of dating violence. Awareness of physical dating violence appeared to have significant positive correlations with both psychological dating violence against a male ($r = .184, p = .004$) and psychological dating violence against a female ($r = .212, p=.001$). In addition, a significant positive correlation was

observed between psychological dating violence against a female and psychological dating violence against a male.

Discussion

Given the results that male awareness of psychological dating violence is lower than that of females, and that there are significant positive correlations between physical and psychological dating violence and between awareness of psychological dating violence against a female and that against a male, efforts to raise awareness of psychological dating violence should be strengthened. Koizumi et al. (2008) states that encouraging men to think about women being subjected to dating violence may contribute to raising their levels of awareness. Educational programs using role play where men take the role of women may be helpful.

Conclusion

Findings of this study suggest that support to raise male student awareness of psychological dating violence is needed.

Learning objectives

Participants will...

1. have an understanding of the Japanese college student awareness of dating violence.
2. identify factors that influence college students' awareness of physical and psychological dating violence.

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Body Image Perceptions of Veterans who have Suffered Military Sexual Trauma

Subtheme: *Other themes*

Paper

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Keywords: Veterans, Military sexual trauma, Body image

Background

The Armed Forces is a service offered by our Governments to ensure the safety of all citizens. Within the military is a type of violence that is called military sexual trauma (MST). MST is the “*physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment... while serving on active duty, active duty for training, or inactive duty training*” (U.S. Government Publishing Office, 2006, 38 U.S.C. 1720D). In Canada and the United States, the actual number of military who have experienced MST is unknown. In Canada, reports have indicated that as many as 2% of the Armed Forces have reported sexual assault, with women being four times more likely than men to experience MST. In the United States, the prevalence of MST has been reported to be as high as 41% of female veterans in the 2009-2011 National Health Study of U.S. Veterans. MST is thought to cause adverse physical and mental health outcomes, homelessness, and suicide. This study provides a novel perspective on the effects of MST and provides a foundation for future interventions.

The invitation

The researchers were invited to a transitional home for homeless woman veterans to help improve “*body image issues.*” As the principal investigator had previously studied body image in individuals with terminal illness, mastectomy, and amputation, she made the inaccurate assumption that the body image issues may stem from physical disfigurement or disease attributed to military duty. The researchers learned early in the study that the inner wounds of military sexual trauma had more of an effect on body image than physical issues.

Methodology

The study had institutional review board approval. The setting for the study was a transitional shelter for homeless woman veterans in a large city in the southern USA. Convenience sampling was used to recruit woman veterans (n=12) between 25 and 63 years of age who perceived they had a physical difference due to military service. Ten of the participants were African American. Data were obtained in focus groups where the veterans were invited to share stories about viewing self in the mirror and being with others. When the participants

disclosed MST as being the reason for their body image issues, the principal investigator reminded them of the study objectives (stories about viewing self in the mirror and being in society). All participants wanted to proceed with the study of body image. Ricoeur's hermeneutic phenomenology guided the study. Three researchers analyzed the transcripts. Two researchers and four participants discussed the findings in a validation meeting.

Findings

Eleven of the participants reported MST. Six participants shared that they had suffered rape. These assaults were brutal: one participant had a gun held to her head. Another participant required a hysterectomy following the rape. Eleven participants had suffered sexual harassment. This form of assault consisted of frequent public demeaning, derogatory sexual comments directed at the female body. Some participants indicated comrades would expose their genitals or mimic the sexual act. Four participants witnessed the after-effects of MST on their colleagues. One veteran told this story. *"We were very close ...She was a medic, very young and she killed herself after the deployment because somebody raped her. She shot herself in the head"* (Freysteinson et al., 2018, p. 4).

A structural explanation to the text typically consists of up to three structures that contain opposing themes. Three structures emerged in the data: 1) to speak up or not to speak, 2) from military pride to shameful anguish and, 3) invisible scars versus visible scars. The participants discussed the reasons that made it difficult to report the abuse, and for those who did report, the repercussions that followed. The military pride that they felt in body, mind, and spirit when entering the military dissipated into shameful anguish after MST. The internal scars of MST were far worse than the visible scars of physical injuries and left lasting body image issues.

The phenomenological interpretation provided an understanding of these internal scars of MST in 1) viewing self in the mirror, 2) being with others, and 3) intimacy. The reflection in the mirror was described as a stranger. One participant had not looked in a mirror in four years. Others avoided mirrors. In society, including one's family, one always wore a mask. *"It is just like you have to take and put on this mask. You still do your job because you have to fake the face. At the same time on the inside, you still go through a lot. ...I have to do it for my kids. We have to put the mask on and look strong for them"*. (Freysteinson et al., p. 5). Although the study objectives did focus on intimacy, the topic arose spontaneously. *"I am broken"* (Freysteinson et al., p. 5) was the phrase that best-described intimacy for these veterans. For some, intimacy had been nonexistent since the attacks. For others, intimacy was strained.

Implications

The participants had suggestions for healthcare professionals including sensitivity training to prevent MST, separate MST from post-traumatic stress syndrome (PTSD) to improve reporting, women-only clinics, and interventions focused on enhancing body image. Finding and sharing words for these body image experiences that had been for the most part lived in silence, allowed the participants to realize that their experiences were not unique but universal. Healthcare professionals working with woman veterans with MST should know that that there

are embodied effects of MST. In other words, the impact of MST may go beyond cognitive functioning to the level of body, mind, and spirit.

Discussion

Before this study, there are no studies that suggest body image is related to MST. In addition to studies that capture statistics, reporting, and effects of MST, correlational studies are needed to discern whether body image is associated with MST. Interventional studies are required for those with MST, including interventions aimed at enhancing body image. Research is also needed to determine if body image may be affected by other types of sexual abuse. Currently, the research team is working with an agency to design a peer-led intervention aimed at MST and body image.

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Learning objectives

Participants will be able to...

1. review known statistics and effects of military sexual trauma (MST).
2. assess the methodology used to capture the experience of veterans who had suffered MST.
3. develop strategies for caring for victims of MST.
4. discuss the possibility of impaired body image in other types of sexual abuse.

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Addendum

Erratum: The following full-text was due to an unfortunate mistake of the editor erroneously not included in the Conference Proceedings. This full text is thus an addendum to the PDF-version of the book to replace pages 396 through 398.

Comprehensive Workplace Violence Prevention Program: Model and Process Success in a National Healthcare System

Subtheme: Practice initiatives

Paper

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Keywords: Violence prevention in healthcare, Multidisciplinary threat assessment teams, National program model, Evidence-based practice, Program implementation

Background

The U.S. Veterans Health Administration (VHA) Workplace Violence Prevention Program (WVPP) has developed evidence-based, data-driven initiatives to promote a standardized culture of safety. Serving over 9 million beneficiaries, VHA employs greater than 300,000 people across 142 healthcare systems and more than 1,000 community-based outpatient clinics. VHA is the largest integrated healthcare system in the United States. Although the urge may be strong to bar individuals from healthcare whose behaviors undermine a culture of safety, VHA's WVPP operates on the foundation that full engagement in the resources available through healthcare access promotes the protective factors that reduce violence risk [1]. Comprehensive violence prevention programs must engage employees, have full leadership support, meet national regulatory requirements [2, 3], and support the on-going and iterative nature of threat assessment best practices [4, 5].

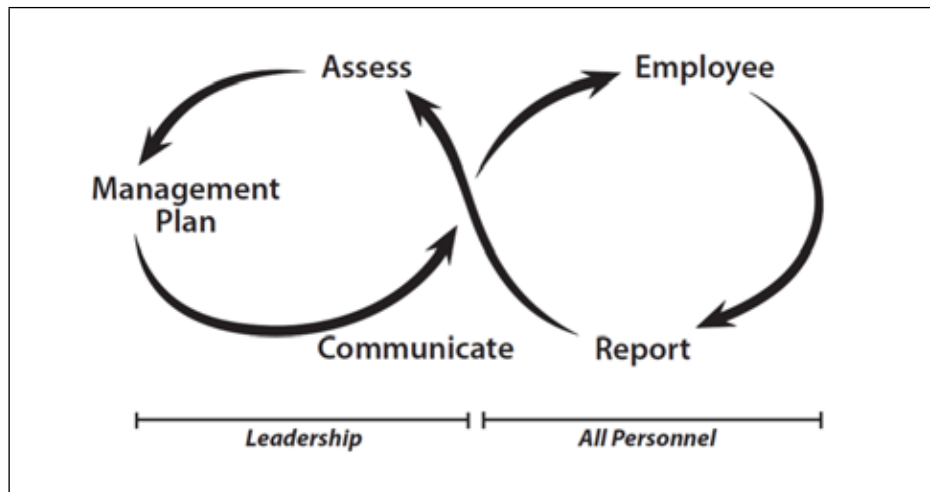
It is understood that comprehensive violence prevention involves physical security measures that address environmental realities of healthcare delivery venues. It is within that context that VHA's WVPP model emphasizes a data-driven, evidence-based approach to the early identification, clinical assessment and individualized management of behaviors that undermine a culture of safety. The five elements of VHA's WVPP model (see Figure 1) meet the International Association of Hospital Security and Safety (IAHSS) published standard for preventing violence in healthcare [6].

Program Description and Rationale

Policy and program design for comprehensive workplace violence prevention in healthcare should support promulgation of state-of-the science best practices. Utilization of multidisciplinary teams are the current published standard for threat assessment and management in healthcare [6]. Such an approach is not new, having been promoted as best practice in education [7, 8] and general workplaces [4, 5]. VHA adapted these models for ethical and appropriate use in healthcare venues, requiring their national implementation in

2003. VHA's WVPP model includes threat assessment and management teams as the essential "Assess" and "Management Plan" components of the 5-element model [9].

Figure 1. Healthcare Workplace Violence Prevention Program Model



Employee. The personnel populating healthcare environments are our greatest safety asset. Employee education and training is most successful when relevant to the violence-related hazards personnel experience in their respective and unique workplaces [10]. VHA's premier education program, Prevention and Management of Disruptive Behavior (PMDDB), emphasizes knowledge and skills necessary for employees to successfully identify situations that have the potential to escalate toward violence and address them verbally at the earliest levels of disruption. If healthcare personnel will experience situations during the course of their duties that are not ameliorated by verbal de-escalation, then they also should be trained in personal safety skills and therapeutic containment techniques that do not leverage pain-based or tissue-damage compliance. By being prepared to address disruptive behaviors spanning a spectrum of severity, employees report increased willingness to intervene at the earliest stages of escalation [11].

Report. Data about type, location, severity, and frequency of disruptive behavior inform WVPP improvements and relevance of employee education. In VHA, these data are obtained through the Disruptive Behavior Reporting System (DBRS). Underreporting of potentially dangerous behavioral events in healthcare is a well-documented concern [12, 13]. Additionally, healthcare administrators and leaders are challenged by receiving disruptive behavior event reports via numerous different reporting systems that do not integrate all information into a comprehensive database [14, 15, 16, 12]. One successful strategy for overcoming the underreporting challenge is use of secure, web-based, user-friendly event reporting systems that allow for anonymous reporting. DBRS is one such system, specifically designed for healthcare. It is short and easily accessed by all VHA employees via any computer terminal across the entire healthcare system. DBRS has five reporting pages with a total of 32 questions, comprised primarily of radio button and check-box responses, that elicit data regarding the time and location of the disruptive behavior event (e.g., night shift in the emergency department, day shift in the

outpatient behavioral health clinic, etc.), the person who experienced the event (e.g., a direct care nurse, another patient, an administrative support worker, etc.), the person who reported the event (e.g., the person experiencing the event, a person witnessing the event, etc.), the person involved in creating the event (e.g., a patient, a visitor, another staff member, etc.), and a description of the event itself (e.g., involved verbal behavior only, involved physically disruptive behavior, involved behavior with weapons resulting in injury, etc.). DBRS automatically and immediately delivers an electronic event entry notification to both the reporter and the threat assessment team.

Assess. Leadership's credibility that violence prevention matters hinges largely upon its ability to demonstrate action in response to event reports. Every incident reported should be assessed by a multidisciplinary team trained in violence risk and threat assessment. The current state of the science involves the use of Structured Professional Judgment (SPJ) guides [17, 18] to ensure that assessment teams focus on evidence-based risk and protective factors. Threat assessment in healthcare exists to determine whether a reported behavior poses a threat to the delivery of safe and effective healthcare. As such, they operate under the authority of the facility's chief medical officer and are chaired by senior clinicians trained in evidence-based, data-driven threat assessment practice. Members of these teams also include, but are not limited to, professionals from security/law enforcement, documented high-risk workplaces, legal counsel, and labor union safety representative(s).

Management (Treatment) Plan. If the behavior reported to the threat assessment team is determined to pose a threat, then a customized management plan must be developed and implemented. Employing a continuum approach to graded levels of invasiveness [19] permits such plans to range from non-confrontational interventions (e.g., special appointment to determine the patient's understanding of why his/her behavior became disruptive, change of healthcare provider, etc.), to more direct interventions (e.g., written letters expressing behavioral expectations, redirection of communication with the healthcare system through a personalized point of contact, etc.), to more restrictive interventions (e.g., placing limitations upon the time, place, and/or manner of healthcare service delivery). At no time may a behavioral threat management/treatment plan in VHA permanently bar individuals from healthcare access [20].

Communicate. Violence prevention programs must include mechanisms for ensuring the safety/treatment plan developed by the multidisciplinary threat assessment team is communicated to personnel effectively and ethically. Electronic health record alerts (EHRA) that provide a 1-2 sentence summary of the problem behavior and a 1-2 sentence description of actions personnel should take to promote safety are known to be part of an effective strategy for reducing violence in healthcare [21]. EHRAs convey information about customized interventions; that said, they are communication tools, and placing an EHRA per se is not an intervention in and of itself. The value of using EHRAs to convey information necessary to know at the initial moments of a patient encounter to promote safety must be balanced carefully with potential for inadvertently stigmatizing patients. Signal-to-noise value of EHRAs must be maintained, thus over-use of EHRAs should be avoided.

The on-going and iterative capacity of the WVPP model is thus manifest. Employees learn of the safety/treatment plan, implement the actions described in the EHRAs, and safely provide

healthcare. Through continued reporting, assessing, and safety/treatment plan evolution, healthcare systems are empowered to retain even the most behaviorally challenging patients, thus promoting access to risk-reducing protective factors [1].

Program Implementation Success

VHA's WVPP model evolved over time, with some elements introduced in the Administration over forty years ago and some elements currently in the deployment phase of implementation. VHA offers the following program metrics to illustrate that comprehensive programs take years of investment and ongoing institutional commitment to become manifest.

Employee education in VHA takes many forms and has evolved over time to adjust to resource realities and the changing needs of employees. Although the core PMDB program has a robust, greater than 40-year history in VHA, it was in 2013 that behavioral event data were used to align employee training assignments with actual behavioral hazard exposure by workplace [22]. This process enabled data-driven improvements in employee training plan creation and completion, with a 16% increase in employee training plan completions from 2016 (67%) to 2017 (83%).

Event reporting, an essential element to data-driven workplace violence prevention programs, is a long-standing requirement in healthcare systems. The 2015 implementation in VHA of the DBRS, a new national standardized, secure, web-based reporting system, has facilitated a significant refinement in the quality and quantity of available event data informing appropriate violence prevention initiatives and employee training assignments. One of the most remarkable impacts of implementing the DBRS is a greater than 300% increase in event reporting rates at many sites, and as much as a 764% reporting rate increase at one site, over the past 3 years. By enabling all employees to have a voice regarding safety concerns, VHA captures increased information on "*just in time*" and "*near miss*" events. At this early phase of reporting system national adoption, VHA has observed a trend toward increased reports of verbally disruptive behaviors. This shift in the disruptive behavior event data suggests proactive identification of potentially injurious events that are resolved without physical harm to patients or personnel. As DBRS reports increase over time, additional analyses will be possible to better understand these encouraging preliminary trends in disruptive behavior data.

Fifteen years ago, VHA required implementation of a facility-level multidisciplinary threat assessment and management team, the Disruptive Behavior Committee (DBC), to support the ethically appropriate implementation of the EHRA communication tool. The 91.6% decrease in mean number of violent incidents, with an accompanying 85.4% decrease in number of violent events per healthcare visit reported by Drummond et al. [21] stand as evidence that the process required prior to placing an EHRA, not the EHRA itself, is successful in reducing healthcare violence. An EHRA should not exist unless the comprehensive process of doing a data-driven threat assessment, which informs an individualized threat management plan, which in turn is communicated during the immediate moments of a patient encounter to promote safety via the EHRA, has been utilized. Satisfaction in VHA with this comprehensive approach to assessing and managing behavioral threats is high, with 84% of VHA healthcare system leadership teams endorsing DBCs as being "*very effective*" at addressing behaviors causing safety concerns,

and the remaining 14% of leadership teams reporting DBCs as being “*somewhat effective*” [23] . Furthermore, findings not previously published from a 2014 survey of DBC Chairs [24] indicate 76% of DBC Chairs reporting being “*satisfied*” or “*very satisfied*” with the overall function of their DBCs. There is variability in satisfaction ratings among DBC Chairs, however, with a minority feeling “*neither satisfied nor dissatisfied*” (20%) or “*dissatisfied*” (4%), reportedly due primarily to experienced resource shortages and/or inadequate amount of time available to do threat assessment and management work.

Discussion

VHA’s WVPP model and process are exportable to healthcare systems of varying sizes and complexities. Optimal violence prevention program results are achieved within healthcare agencies making a complete commitment to resource all program elements. Different program elements, however, may be resourced internally or externally across the spectrum of healthcare agencies based upon agency size and complexity and availability of in-house expertise. For example, larger, more complex healthcare systems may have access to expertise amongst their existing employees to populate all roles on a DBC, whereas smaller healthcare systems may retain external consultative agreements with various professional resources to ensure availability of expertise on an as-needed basis (e.g., legal and/or behavioral sciences consultation role for DBC, etc.).

Standardizing the elements of comprehensive violence prevention programs across all healthcare agencies and organizations represents the next major challenge in violence prevention at a national and international systems level. Healthcare consumers often transition across providers and systems. For all healthcare systems across regions within countries, countries within continents, and even continents around the globe, to embrace violence prevention programs that allow for a coordinated transition of plans for providing safe and effective healthcare creates a collaborative network that benefits patients and the professionals who provide them care. Such an integrated system would make it possible for behavioral safety and violence prevention management plans to move with patients as patients move within and between healthcare delivery systems.

Acknowledgments

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Learning objectives

Participants will be able to...

1. identify critical elements of a successful comprehensive national violence prevention program in healthcare.
2. articulate operational implementation requirements and strategies for overcoming implementation challenges of a successful national violence prevention program in healthcare.

3. apply published healthcare workplace violence prevention standards to evidence-based program development.

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Advancing the delivery of positive practice

Work-related aggression and violence within the health and social care sector pose a major challenge and diminish the quality of working life for staff, compromise organizational effectiveness, threaten workers' health and ultimately impact negatively on the provision and quality of care. These problems pervade both service settings and occupational groups.

The specific aims of this sixth conference are:

1. To enhance the understanding of facets of violence in the health sector – such as its root causes and patterns, the impact and consequences, successful strategies and initiatives – which can help advance the delivery of positive practice.
2. To learn more about resources such as policy and/or practice initiatives, tool-kits, and instruments which can help advance the delivery of positive practice.

The key theme of this sixth conference is to advance the delivery of positive practice. In order to structure our exploration of positive practice, the following subthemes of the conference have been defined: the investigation of causes of aggression or violence, methods to minimize violence and coercion, the promotion of education and training, engagement with stakeholders, the exchange of tools and instruments, reflection on policy and safety issues regarding all aspects of aggression and violence in the Health Sector.

We hope that you enjoy our exploration together and continue to explore these proceedings long after the conference in our individual and collective quest to advance positive practice and enhance the care experience for both recipients and providers.

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