Violence in the Dialysis Setting: Prevention, Immediate Intervention, and Post-Incident Management

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Disclosure

- We have no financial relationships related to this presentation.

- The content will promote quality or improvements in healthcare and does not promote a specific proprietary interest.

- Content for this session will be well-balanced, evidence-based and unbiased.

- We do not have corporate sponsorship or endorsement.
Learning Objectives:

1. Define incidence and parameters of perceived/actual threats or acts of violence in the workplace setting.

2. Identify a decision making framework for preventing and responding to workplace violence.

3. Apply a model of violence management within a continuum of prevention, immediate intervention, and post incident management.
Objective 1

Define incidence and parameters of perceived/actual threats or acts of violence in the workplace setting.
What we did...

✓ National survey facilitated by presenters.

✓ Reviewed data on threats of violence and violence in dialysis, and compared them to Dept. of Justice data on violence in other work settings.
Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide.

https://www.osha.gov/SLTC/workplaceviolence/
According to the Bureau of Labor Statistics (BLS), 27 out of the 100 fatalities in healthcare and social service settings that occurred in 2013 were due to assaults and violent acts.

BLS data show that the majority of injuries from assaults at work that required days away from work occurred in the healthcare and social services settings. Between 2011 and 2013, workplace assaults ranged from 23,540 and 25,630 annually, with 70 to 74% occurring in healthcare and social service settings.

Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
U.S. Department of Labor Occupational Safety and Health Administration
OSHA 3148-04R 2015
Assault Injuries (causing days away from work)

Healthcare Worker: 10-11% of injuries

Private Sector: 3% of injuries

Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
U.S. Department of Labor
Occupational Safety and Health Administration
OSHA 3148-04R 2015
Healthcare workers face significant risks of job-related violence.

While under 20% of all workplace injuries happen to healthcare workers...

Healthcare workers suffer 50% of all assaults.

Source: Bureau of Labor Statistics
The workplace violence rates highlighted in BLS data are corroborated by the NCVS, which estimates that between 1993 and 2009 healthcare workers had a 20% (6.5 per 1,000) overall higher rate of workplace violence than all other workers (5.1 per 1,000).

In addition, workplace violence in the medical occupations represented 10.2% of all workplace violence incidents. It should also be noted that research has found that workplace violence is underreported—suggesting that the actual rates may be much higher.
OSHA: 4 Types of Workplace Violence

**Type 1**
- Acts by criminals with no connection
- Robbery or other crime

**Type 2**
- Violence to staff by persons with a relationship through delivery of services

**Type 3**
- Violence against co-workers, supervisors, managers by current or former employee

**Type 4**
- Violence by non-employee who has a personal relationship with an employee
Types of Violence and Response to Violence

**Types of Violence**
- Physical assault
- Sexual assault
- Stalking by patient or against patient
- Death - targeted
- Assault / property

**Response to Violence**
- Threat / doors locked
- Threat / evacuation
- Threat / law enforcement responds
U.S. Workplace Homicides

2009 = 521  (U.S. Department of Justice)
2011 = 468
2013 = 404
2014 = 403 Preliminary: Extracted 12/29/15

Census of Fatal Occupational Injuries (2011 forward)
Fatal work injuries and hours worked by gender of worker, 2014*

- Fatal work injuries: 4,679
  - Women: 8%
  - Men: 92%
- Hours worked: 272,662,680,000
  - Women: 43%
  - Men: 57%

A disproportionate share of fatal work injuries involved men relative to their hours worked in 2014.
Women experienced a higher proportion of fatal injuries due to homicide relative to men. Men incurred a higher proportion of injuries from roadway incidents, contact with objects and equipment, and exposure to harmful substances or environments. Men and women experienced similar proportions of fatal injuries from falls, slips, and trips and from fires and explosions.

*Data for 2014 are preliminary.
Note: Transportation counts presented in this release are expected to rise when updated 2014 data are released in spring 2016 because key source documentation detailing specific transportation-related incidents has not yet been received. Percentages may not add to 100 due to rounding.
Homicides in Health Care and Social Services

2011: 8
2012: 10
2013: 4
2014: 7
2015: >50

(http://www.bls.gov/iif/oshwc/cfoi/work_homicide.pdf)
(http://timelines.latimes.com/deadliest-shooting-rampages/)

Statistically, you are more likely to be struck by lightning.
2015- San Bernardino, CA - 14 killed
Acts of Violence: Health Care Settings

- 2004: 14% of all accidents at work were caused by acts of violence. (Zamperion, EDTNA/ERCA Recommendations, March 2010)


- **Nurses** are most likely to become victims of violence, with three times higher risk compared to other professionals. (Zamperion)
71% of 203 dialysis staff experienced disruptive patient situations in the past five years.  
(King and Moss 2004)

49% of 270 dialysis staff experienced disruptive patient situations in the past five years including physical assaults, sexual assaults, stalking, property damage, doors having to be locked, workplace having to be evacuated, and law-enforcement having to respond to the unit.  
(Stricherz, Kwatcher, Kretzner current)
A Detroit Hospital began screening with handheld metal detectors and collected 33 handguns, 1324 knives, and 97 mace type sprays in 6 months. (https://www.osha.gov/SLTC/workplaceviolence/)

A VA in Oregon reduced violent attacks by 91.6% after implementing a database that identified patients with a history of violence. (https://www.osha.gov/SLTC/workplaceviolence/)
Dialysis Specific

- South Carolina: man was hit in head with a large rock at a dialysis center following an argument.

- Florida: woman shot man in the abdomen while he was undergoing dialysis in a spillover of domestic violence.

- New York: an involuntarily discharged patient walked into clinic and opened fire, critically wounding a nurse.

- Kansas: a bomb threat at a clinic required patients undergoing dialysis to be evacuated.

- Kentucky: two 70 year old men had a fist fight in a dialysis clinic.
Experienced Violence in the Dialysis Facility

49% yes
51% no

(Strichcrz, Kwatcher, Kretzner)
Percentage of Respondents answering that threats of Violence were perpetrated by:

- Patient: 75%
- Staff Member: 30%
- Someone known to patient: 30%
- Someone known to staff member: 20%
- Stranger: 10%
Patient / Neighborhood Characteristics

**Patients**

- Alcohol or drug dependent patients
- Patients with severe mental illness
- Combat vets
- Distraught patients, relatives, staff members
- Unemployed
- Gang affiliated

**Neighborhood**

- Shelters/soup kitchens
- Gang area
- Homeless person nearby
Patient / Neighborhood Characteristics

- Parolee's / probationers
- Combat vets
- Homeless
- Patient or family gang affiliated
- Work in gang area
- Patients with severe MI
- Drug dependent pts
- Alcohol dependent pts
- Unemployed
- Distraught relatives or s/o
- Distraught staff
- Distraught relatives or s/o
- Distraught patients

Percentage of Respondents Answering Yes (Stricherz, Kwatcher, Kretzner)
Organizational Risk Factors

- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors.
- Working when understaffed.
- High staff turnover.
- Inadequate security and mental health personnel on site.
Patients dealing with acute or chronic pain are often pre-occupied with their own situation.

Patients on medication for pain may be less inhibited and exhibit inappropriate behavior secondary to delirium.
Displaced Anger

- Anger is a learned feeling or thought response to a process of threat, fear, and often with “hurt” at the base.

- “Safe targets” are the objects of anger.

- People that use displacement as a defense mechanism with their anger often feel they do not have any control. In dialysis settings, caretakers are intricate to their life, family, and health experience.
Patients and Families

- Feel vulnerable and distressed
- Fear of unknown
- Feeling powerless
- May be unfamiliar with and intimidated by the healthcare system
- Not always at their best
- Emotionally raw
How does culture figure in?

Non-verbal
- gestures
- eye contact
- touch
- facial expression
- body movement
- personal space
- gender identification
- family hierarchy
- spiritual resilience
- unspoken / blind biases

Verbal
- tone
- different language
- vocabulary
- formal/informal
Objective 2

Identify a decision making framework for preventing and responding to threats or acts of violence in the workplace.
Increased Risk in Medical Settings

- Accessible, open environment
- High stress circumstances
- Wide range of clientele
- Prolonged waiting times; overcrowding
- Gaps in communication
- Alcohol and drug impairment decreasing impulse control

*Sources regarding slides related to Defusing and De-escalating are gleaned in part from government or state agency documents and are in the public domain, the presenters experience in mental health, hospital and clinic settings, in law-enforcement training and crisis response training. The response plan at Vanderbilt University Medical Center was reviewed and parts of their program are quoted herein (see bibliography note)*
Universal Precautions for Violence

Violence should be expected but can be avoided or mitigated through preparation.

Staff should understand the importance of a culture of respect, dignity, and active mutual engagement in preventing workplace violence.
Developing a Team Culture of Safety

• Is everyone on the same page?

  *Everyone within the chain of command must value safety and understand it requires 100% participation.*

• Is the prevention plan disseminated and empowered?

• Are personal biases suspended when a plan is implemented?

• Consequences are in place for violation of plan.
Model of Violence Prevention
Behavior Targeted to Perpetrator Type

Source of Aggression
- Early identification – Empowering disclosure about potential perpetrators
- Stranger / Active shooter (preparation for survival)

Individual Action
- Empowering individual preparation - Rehearsal of response
- Staff and administration must be on the “same page”

Agency Policy & Procedure
- Empowering and embracing survival
- Empowering and embracing successful prevention
- Empowering accurate inter-unit debriefing / victim support

Stricherz and Kwatcher, 2015 series
Staff Abuse = Staff Violence
It is NEVER Right or Justified

• A healthy culture makes verbal or physical threatening unacceptable.

• This applies to both staff and patients. Families and visitors must be reminded of their role as “guests” of the facility.

• Must be stated in company policy.
Primary Prevention: Employee Perpetration

- Bullying
- Supervisor
- The troubled employee

Policy
- Policy - empowerment
- Non-punitive reporting

Consequences
## Risk Factors Identified

<table>
<thead>
<tr>
<th>Static</th>
<th>Dynamic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gender</td>
<td>• Stress/Frustration</td>
</tr>
<tr>
<td>• Age</td>
<td>• Relational conflict</td>
</tr>
<tr>
<td>• Major mental illness</td>
<td>• Substance abuse</td>
</tr>
<tr>
<td>• Hx violent/criminal behavior</td>
<td>• Organic brain trauma</td>
</tr>
<tr>
<td>• Age at first offense</td>
<td>• Chronic physical problem</td>
</tr>
<tr>
<td>• Low intelligence</td>
<td>• Effects of post-op anesthesia</td>
</tr>
<tr>
<td>• Neurologic impairment</td>
<td>• Septicemia - High levels of toxins, glucose,</td>
</tr>
<tr>
<td>• Hostile/aggressive manner</td>
<td>electrolytes, oxygen, bacteria</td>
</tr>
</tbody>
</table>
Other Identified Risk Factors

- Presence of pain
- Fatigue/hyper-stimulation
- Tension/anxiety/fear
- Confusion/disorientation
- Feeling not understood or believed regarding illness
- Hx of violent behavior do to aggressive or anti-social personality, poor impulse control
- Difficulties with communication (pathological or related to linguistic or cultural habits)
- Poor coping skills
- Social problems
Acute and Chronic Psychiatric Disorders

Nearly 40% of adults with "severe" mental illness, such as schizophrenia or bipolar disorder, anti-social personality with aggression (Rau 1999) received no treatment in the previous year, according to the 2012 National Survey on Drug Use and Health. Among adults with any mental illness, 60% were untreated.
The Medically Ill Person

- Persons who can’t seem to cope with their new illness (Rau 1999).

- The medically ill (physical or mental illness) person may pose a risk to others due to an illness (acute or chronic). This could be the patient, family, visitor, or staff.

- Cognitive problems due to delirium (which may be secondary to medications or aging), delusions (a misperceived thought process), or paranoid thinking may alter the person’s sense of reality.
Objective 3

Apply a model of violence management within a continuum of prevention, immediate intervention, and post incident management.
Reducing Violence Risk

Three Step Plan:

1) Treatment and environmental interventions
2) Target hardening
3) Incapacitation
General Screening Questions

1. What kinds of people or things get you mad? What do you usually do when you get mad?
2. What is your temper like? Do you usually act out against people or objects? Do you tell people with whom you are angry that you are angry?
3. Do you ever just explode?
4. What is the most violent thing you have ever done?
5. Weapon or hands?
6. Do you know when you get to your breaking point?

7. Do you just explode?
8. Do you own a weapon like guns or knives? Where are they now?
Incident Specific Questions

1. What kind of harm occurred?
2. Who were the victims/targets?
3. Where did the incident take place?
4. What do you think caused the violence?
5. What were you thinking and feeling before/during/after the violent incident?
6. Were you using alcohol/drugs around the time of the altercation?
7. Were you taking psychoactive medications at the time of the incident?
Tips for Staff Protection

- Neckties and scarves are risky
- Don’t wear hanging jewelry
- Give yourself access to exit
- Do not work in an isolated area/let others know where you are.
Identify objects that can be used as weapons, especially with persons that are high risk for or known for violence!
Environmental Controls

• physical barriers
• metal detectors
• safe room
• panic buttons, smart phone apps
• better or additional lighting
• more accessible exits
Model of Violence Prevention
Behavior Targeted to Perpetrator Type

- Lower end agitation – stop the acting out
- Patient / Co-worker / Person known to staff
- Defusing / De-escalating / Communicating

- Empowering individual preparation / Rehearsal of response
- Attention to the environment with agency scan and individual scan
- Preparing for the physical response, preparing the team response

- The greatest risk of harm
- Emergency Response Plan for the agency and also individual response plan
- Facility Plan, Facility Direction, Facility Training

Stricherz and Kwatcher, 2015
What Tactics?

Workplace types of violence

- Bullying – supervisor-peer
- Patient acting out
- Staff acting out
- Threats of physical or sexual assault
- Relative / Significant Other acting out
- Stalking

Communication / De-escalating / Defusing
What Perpetrator?

Intruder types of violence

- Run
- * Hide
- * Fight for your life
Security Plan When Person is Identified as Target

- Identify risk to alleged victim: terror, tissue damage, death
- Decide if the plan will be a protection for a victim or deterrence for perpetrator
- Brainstorm, use policy, set plan of action (specific)
- Implement plan (victim/target must know plan and not disclose to others)
- Follow-through regarding all actors
- Debrief when plan is over
Prevention When There is a Target

- Locked treatment area/staff work areas
- Security cameras
- Personal alarm systems for staff who have been targeted
- Room arrangement
- Co-workers aware of your presence
Defuse
De-escalate
Communicate

Bullying Supervisor Peer

Agitating Anger Angst

Threats of Physical or Sexual Acting Out

Patient, Staff, “Relative” acting out

Stalking
Determine Etiology of the Hostility and Anger

Which of these are present?

- Pain
- Stress
- Fear
- Grief
- Depression

Suggested Response:

Listen...Reframe...Empathize

Consider social worker or psychiatric consult
If these are the factors:

Personality problems / Behavioral problems

Suggested response:

Confront with manager or physician (person in position of perceived power) defining acceptable behavior.
 Violence Reduction Strategies

If there is a trusted person that can be identified, consider suggesting that the person be present in treatment room to calm patient, family or visitor.
Communicate the “Process”

- **Identify** yourself and role.
- **Anticipate** their questions using your (collective team) experience. People want to know what to expect.
- **Explain** the process and procedures in plain terms. “Think them” in plain terms.
- **Acknowledge** their emotional pain, feelings of helplessness and fears.
- **Empathize**
Tips: Verbal Strategies

- Listen
- Set limits
- Restate common goals

**DO NOT**
- Argue
- Challenge
- Order
- Threaten
- Shame
Defusing Techniques

- Avoid arguing or defending previous actions.
- Avoid threatening body language (don’t stand with arms crossed).
- Calmly but firmly outline limits of the setting.
Defusing Techniques

- Allow a frustrated patient some time to vent.
- Ignore personal verbal “attacks.”
Defusing a Situation

• Be aware of the anxiety level
• Note when situation first escalates:
  • Louder voice
  • Fidgeting, verbal sounds
  • Build up of energy
• Be **PROACTIVE** not **REACTIVE**. Attend to person before things get out of hand.
• The staff needs to be in control by actively defusing the patient, family or visitor.
Listening is an Action that Defuses

- Listen to the person’s frustration.
- Empathize with their “plight.”
- Understand how they perceive the situation.
- What do they want that they are not getting?
- Address their concerns.
- Offer a solution or an alternative.
Defusing a Situation

• Watch for the Defense Phase

• If situation continues to escalate, patient will give more physical cues (louder, more agitated verbalizations, etc).

• Staff needs to intervene to defuse.
  • Reduce stimulation from setting...e.g. bring from waiting room to exam room or office.
  • Communicate information about any delays etc.
  • Give some choices.

• As emotions increase, auditory processing abilities decrease.

Response: simple and clear
Managing Agitation

• Isolate the person who is agitated (patient, family member or visitor) if possible.
• If there is a pattern of agitation, use a private or quieter area.
• Position yourself between the patient and the exit.
• Call for help: alarm, alert, voice, group cell text.
• Offer simple statements.
Responses to Acting Out

• Staff behavior: always professional and in control
• Staff thought: it is not personal
• Staff verbal behavior: Use calm voice; Use simple statements; Go slow as perpetrator may not be able to process cause and effect or action and consequences as well as normal
• Staff aid the perpetrator to get control. The aim of interaction, “I want to hear what you have to say.” which results in person to person communication
Relative Threat of Violence

Possible perpetrators

Acting out/threat of assault

Non-active shooter violence

Active intruder/shooter
Active Shooter/Stranger on Premises
Active Shooter
Stranger on premises

- HIDE
- FIGHT
- RUN
Physical Environment Tactics

- Locks
- Doors
- Buzzers / Alarms
- Loudspeakers/Intercom (Code, Dr. Winchester, Code Silver)
- Opportunistic objects (water, chairs, clipboards)
- Windows and shades
- Cell phone alert
Physical Environment Tactics
Active Shooter Survival

- RUN
- HIDE
- FIGHT

- Know escape routes
- Safe and secure place
- How far will you go in the fight? Are you ready? Have you visualized?
66% of active shooting incidents end in 5 minutes or less / many ended in less than 2 minutes.
UP CLOSE AND PERSONAL: When Physical Response is All That’s Left

Agency training e.g. Non-Violent Crisis Intervention (NVCI) Possibly designed for the highest risk population

Body Target Points
- Eyes, Nose, Ears, Neck, Groin, Knees, Instep, Toes
- How to strike
- Inner rehearsal

Escape points (Physical Routes, Barriers to Escape)
- Thumbs, Weak Joints, The PAUSE
Debriefing Staff

• Few people like to deal with conflict or confrontation.

• It is very stressful to deal with threatening, volatile or out of control patients.

• The art of conflict management is a skill that can be developed.

• The staff may need to debrief after such an incident.
Consequences for Staff Victims

- Short- and long-term psychological trauma
- Fear of returning to workplace
- Changes in relationships with co-workers and family
- Feelings of incompetence, guilt, powerlessness;
- Fear of criticism by supervisors or managers
Post-Incident Management

- Medical attention if needed; Follow-up, Follow-up, Follow-up
- Reporting: police, manager, medical director, risk manager, Network
- Patient/visitor debriefing
- Questioning? Are there unseen or hidden victims?
- Critical incident staff debriefing
- Public relations
Case Example 1

A woman runs into the dialysis center for help, stating that her ex-husband is chasing her with a gun.
Case Example 2

Patient is a retired correctional officer with minimal social support, severe depression, and PTSD. He is on PD, but managing it poorly. During PD clinic, the social worker asks him if he has thoughts of suicide. He calls a day later, very upset, states the question was inappropriate and he is threatening.
Case Example 3

A straight patient starts belittling a gay male patient while both are getting their dialysis, and things escalate....
Case Example 4

A few staff members like to leave the back door open when they go out for a smoke. Another employee objects regularly, stating she has concerns about her former boyfriend and has a restraining order in place.
Case Example 5

A patient is a young gang member, heavily tattooed, and often has foul language. He gets angry when a staff member talks to him about the risks of constantly being fluid overloaded and cutting his treatments short. When another staff member tries to calm him down, he calls her a “#@***!” throws a full water bottle at her, and threatens to “shut her up for good.”
Case Example 6

A team member seems to be having difficulty functioning at work. He makes some bad judgement calls, gets written up several times, and is finally fired. He says “you’ll be sorry...”
Bibliography

• Hospital Code Silver Activation; Active Shooter Planning Checklist, CA Hospital Association, Rev. Version: 12-19-12
• Zamperion, A, Saraiva, M, Pranovi, R “EDTNA/ERCA Recommendations for Prevention and Management of Violence and Aggression in Renal Units” March 2010
• Hospital Code Silver Activation; Active Shooter Planning Checklist, California Hospital Association, Rev. Version: 12-19-12
• Universal Behavioral Precautions, PowerPoint, Vandebilt Medical Center, January 2004.
Government and Agency Publications

- FBI, active_shooter_educational_booklet_508
- FBI. Active_shooter_pamphlet_508
- FBI. a-study –of-active-shooter-incidents-in-the-u.s.
- CPI Setting Limits, Crisis Prevention Institute, reprinted with permission
- EC News-Jan-2012 OSHA ISSUES DIRECTIVES ON WORKPLACE VIOLENCE
- FBI Study (2013) – Lessons Learned (brief results)
- DOL Workplace Violence Program OSHA “Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers” 3148-01R, 2004
- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, OSHA 3148-04R 2015
Renal Publications

- Decreasing Dialysis Patient-Provider Conflict, NTF Position Statement on Involuntary Discharge, Executive Summary 2006
- Tip_Sheet-4-Abuse-Behaviors, ERSD Network 15