ASPR TRACIE Technical Assistance

On March 2, 2022, ASPR TRACIE hosted the webinar Strategies for Healthcare Workplace Violence Prevention: Risk Assessment and De-Escalation. During this webinar, presenters highlighted the issue, explained recent changes in The Joint Commission's workplace violence standards, and demonstrated some examples that can be used in real-world situations.

Due to the large number of questions received during the question-and-answer session, speakers were not able to respond to all the questions during the webinar. These questions were sent to panelists and their answers are provided in this document.

For more information, access ASPR TRACIE's Exchange Issue 14: The Impact of Civil Unrest and Workplace Violence on Healthcare which includes the article Trends, Policies, and Protocols Related to Healthcare Workplace Violence.

Question: In general, is there a common definition of WPV vs struck by a patient, for example, experiencing a seizure?

> **Answer:** The Joint Commission (2021), which evaluates and accredits healthcare organizations and programs in the U.S., defines workplace violence as "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors." OHSA 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. It can affect and involve employees, clients, customers and visitors." OSHA defines "serious workplace violence" as an incident in which the victim needs time off to recover.

Question: How do you measure workplace violence at a hospital (e.g., incidents per patient days, incidents per FTE, etc.)?

> **Answer:** The Joint Commission does not stipulate on mandate any method or model so it is up to the organization to determine. However, you may want to reach out to IAHSS or its members to see what many are doing or what is recommended. Industry experts can also be contacted, such as Tony York (tyork@palamerican.com) or Bryan Warren (bryan.warren@warsecsecurity.com).

Question: In extreme circumstances is it allowable for security staff to use law enforcement restraints until CMS authorized (soft or leather) restraints can be applied to a patient?

Answer: If there is an imminent danger to staff then appropriate restraint techniques should be used that are available until the most appropriate, least restrictive types of restraints can be applied.

According to 42 CFR 482.13 - Condition of participation: Patient's rights: "CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term 'weapon' includes, but is not limited to, pepper spray, mace, nightsticks, tasers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion. If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement."

Question: Are there training videos of Do's and Don'ts when working with an agitated patient?

Answer: De-escalation training is gaining in popularity, as ED staff find themselves having to manage patients and visitors who may be aggressive, violent, and/or experiencing severe stress. In this short video, Dr. Scott Zeller demonstrates how to speak with an agitated patient to reassure and comfort him. He also compares the level of time and other resources needed to de-escalate versus restrain (and sedate) a patient, highlighting that many assaults could be avoided by using de-escalation techniques. The Joint Commission (2021) encourages leadership to ensure that all staff be trained in escalation and self-defense, citing OSHA's 2015 guidance that training include a hands-on component.

Question: Can you provide additional information the SAFER Matrix Scoring?

Answer: The Joint Commission uses the "Survey Analysis for Evaluating Risk®" or SAFER Matrix to "provide health care organizations with the information they need to prioritize resources and focus corrective action plans in areas that are most in need of compliance activities and interventions." Post-survey issues of noncompliance are notes as "Requirements for Improvement" noted in final reports and each one is plotted on the SAFER matrix based on its potential harm to patients, staff, and/or visitors.

Reminder – SAFER definition (*Perspectives* Jan 2017)

REMINDER: SAFER™ Matrix Effective January 1, 2017 (continued)

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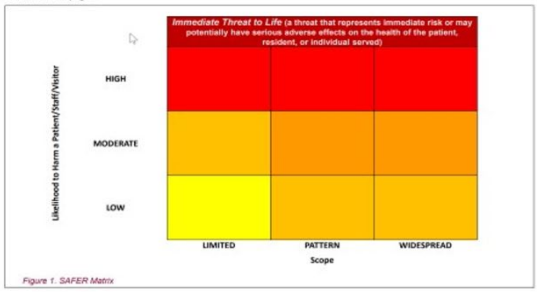

Figure 1. SAFER Matrix

The Joint Commission

- **High**—Occurrence of harm is likely; that is, the finding could directly lead to harm without the need for other significant circumstances or failures.
- **Moderate**—Occurrence of harm is possible; that is, the finding could cause harm directly but is more likely to cause harm as a contributing factor in the presence of special circumstances or additional failures.
- **Low**—Occurrence of harm is rare; that is, the finding undermines safety/quality or contributes to an unsafe environment is but very unlikely to directly contribute to harm.

Operational definitions along the *x* axis—"Scope"—are as follows:

- **Widespread**—Issue is described as "pervasive at the organization"; that is, the finding is the result of a process or systemic failure and could impact a majority of patients.
- **Pattern**—Issue is described as having the potential to "impact more than a limited number of patients impacted"; that is, the finding involves process variation.
- **Limited**—Issue is described as a "unique occurrence"; that is, the finding is considered an outlier and not representative of routine or regular practice.