ASPR TRACIE Webinar Transcript

Strategies for Healthcare Workplace Violence Prevention: Risk Assessment and De-Escalation

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Shayne Brannman: On behalf of the US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, I'd like to welcome you to ASPR's Technical Resources, Assistance Center, and Information Exchange webinar, titled, Strategies for Healthcare Workplace Violence Prevention: Risk Assessment and De-Escalation. Before we begin, we have a few housekeeping items to note. The webinar is being recorded. To ensure a clear recording everyone has been muted. However, we encourage you to ask questions throughout the webinar. If you have a question, please type it into the question section of the GoToWebinar console. During the Q&A portion of the webinar, we will ask the questions we received through the console. Questions we are unable to answer due to time constraints will be followed up directly via e-mail after the webinar. To help you see the presentation better, you can minimize the GoToWebinar console by clicking on the orange arrow. Today's presentation and speaker bios are provided in the Handout section of the GoToWebinar console and will be posted along with the recording of this webinar within 24 hours on ASPR TRACIE. Next slide.

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To meet the nation's medical needs, ASPR is focused on three key priorities. Extend capabilities to respond well and emerge quickly from the COVID-19 pandemic. Restore resources and capabilities diminished during the pandemic. And third, prepare for future emergencies, whether natural or man-made. Next slide.

My name is Shayne Brannman, I'm the Director of ASPR TRACIE and I want to welcome new and old friends of ASPR TRACIE. I want to thank you for what you do daily to enhance the preparedness, response, and recovery activities of your healthcare entities and communities while facing a myriad of challenges including workplace violence. Your role is so vital to addressing the daily and arduous challenges being presented. So your willingness to spend the next 60 minutes with us to further advance your knowledge is noteworthy. I also want to convey my heartfelt thanks to our awesome lineup of panelists and our moderator for this webinar. Your willingness to lend your precious time and share your substantive expertise so others might

benefit is commendable and generally appreciated. Lastly, many thanks to the ASPR TRACIE crew for coordinating this session, particularly, Corina Solé Brito and Audrey Mazurek.

For our new friends to ASPR TRACIE on the webinar today, this slide depicts the three domains of ASPR TRACIE: Technical Resources, Assistance Center, and Information Exchange. I want to remind each and every one of you that we are very, very sensitive to your time constraints. So if you cannot find the resources you are looking for on the ASPR TRACIE website, simply e-mail, call, or complete an online form and we will respond to your inquiry as soon as possible. Next slide.

It is now my distinct pleasure to introduce one of ASPR's most respected individuals, Dr. Richard Hunt who serves as ASPR's NHPP Senior Medical Advisor. Many of you already are familiar with him as he led the COVID-19 Project ECHO Clinical Webinar efforts, and one of the topics he covered recently was attacks on clinicians. Dr. Hunt, the floor is yours, sir.

Dr. Hunt: Thanks Shayne and thanks to ASPR TRACIE, your leadership and John Hick's leadership and the team for really stepping up and putting this important webinar on. It's a really critical one. As Shayne mentioned, we at HHS will convene -- HHS ASPR Project ECHO COVID-19 Clinical Rounds. Its purpose is to share clinical challenges and successes, both for our patient care and clinical operations perspective. We started those rounds two years ago, we continue to do those rounds. One of the challenges has been certainly the fatigue and burnout of clinicians. When I say the word clinicians, I use that in the broadest sense; all those who care for patients, whether in the EMS arena or at the bedside in a hospital and beyond. So realize when I say the word clinicians, I'm thinking about it and hopefully, you perceive it as the wide range of clinicians.

In the fall of last year, we started to just hear more and more about burnout, fatigue, people leaving the healthcare workforce. I'm sure you've heard about that too and have experienced that challenge in your organizations. Among those conversations started to pop up the concept of, well, you know, it's not just that we're burned out, now we're getting attacked. And as those conversations evolved, when I say conversations, conversations among panelists, participants, we have a wide range of participants from multiple disciplines. From span of rounds, we've had all states represented with a wide range of participants ranging from intensivists from, for example, Bellevue Hospital to an EMT in Alaska caring for a fishing village, so a wide range of participants. As we listened, it was clear that the issue of attacks on clinicians had become just more and more pervasive and there was a little bit of chatter about and chat among participants as well as panelist that this was, you know, just another layer on top of the huge challenges healthcare has experienced.

So as we started to fatefully crowdsource that challenge and understand it a little bit, we decided to go ahead and convene one of our rounds titled, Attacks on Clinicians. We held that grand rounds inviting all disciplines to participate. We convened that on October 28th last year. And in the presentations, it was clear that this issue had bubbled to the surface to the point that we needed to do more at HHS ASPR and at rounds in terms of trying to figure out what we could do to actually prevent those attacks. So we followed up with rounds on January 6th, 2022, recently, on protecting clinicians from attacks. And I want to give you essentially a gestalt on our findings

through the polling function plus what we learned through our presenters, one of whom is presenting today, our panelists and our participants.

A first gestalt was that the problem of attacks on clinicians, again, the full span of all those who provide patient care, wherever that is, was a problem long before COVID-19. So, this is sort of like, okay, it was already there, but, wow, now, it's come to the forefront and it's really there. Additionally, another concept that that came forth was that training by organizations for clinicians and how to protect themselves from attacks is extremely variable. In one polling question we did on whether or not your -- the polling question was, the essence of it was, "Does your organization provide training to protect you from attacks?" It was pretty blunt to the point. 49% of participants who responded said yes, 51% said, no. So in some instances, actually in many instances, any support in terms of training has been lacking.

Another nuance to that, that I think is really important to put out there was that there wasn't much being done in terms of training for the specific nuances related to COVID-19 attacks on clinicians. For example, in the polling we saw the issue of treatment as in, for example, Ivermectin, the challenges around those discussions prompted many, many attached. There was not training that suddenly pivoted to get really specific around the COVID-19 specific prompted attacks. And then the other thing that I think many, certainly myself, was surprised by, in a polling result, we asked about the kinds of training, "If indeed you had training to support protection from attacks on clinicians, what was it that was lacking and needed the most?" And it wasn't the physical piece, as in how to protect yourself from a physical attack, it was the issue of being able to deescalate. That one absolutely rose to the forefront of, "We need to know how to de-escalate better."

And then the last thing, I think many people knew it, but when you saw the polling and the discussion in the chat, it came home, really profoundly. The enormity of the consequences of attacks on clinicians. Frivolously, I put in one of the polling questions like, you know, "Where did people who were attacked, clinicians attacked, get cared for?" And indeed, there were a few responses, they went to surgery. Alarming.

So there are certainly physical, but a large number of mental health consequences to clinicians that rose to the surface, it has been a huge one, the mental health consequence, but also consequences to the healthcare system and its workforce. With many, either like being on leave of absence for a period of time, for sure after an attack, and then the other, many not just left their organizations, but left healthcare altogether. So there the consequences for our entire healthcare system and the individuals involved are profound.

And with that, I think that that summarizes at least some of the highlights of what we learned in these two rounds. And again, I'm just really appreciative of TRACIE taking this up and going further with it. Thanks. Over to you, John.

John: Thanks so much, Rick. You know, I think we're all used to the transference that occurs, especially in emergency and acute care settings. But the level of anger and the willingness to act in a matter of violence towards healthcare providers is something novel here. So, next slide, please. I want to introduce our first speaker today, Jim Kendig is a Field Director and Surveyor

Management and Support in the Division of Accreditation and Certification Operations for the Joint Commission. Joint Commission has a huge interest in providing both support and accountability for a safe environment of care in healthcare facilities, and that includes safety for healthcare workers. So Jim, I am so pleased you could be with us today and take it away.

Jim Kendig: Thanks very much for that introduction. Yeah. The Joint Commission has taken on the topic of workplace violence. We understand that we're kind of behind the eight-ball. This was a journey that the Joint Commission had to undertake. Being former law enforcement, I've been an advocate of this for some time. I've been with the Joint Commission approximately 11 years now, and I've asked to consider workplace violence and our standards and EPs are elements of performance.

So I'm glad to say we are starting that journey. This journey has not ended. At the conclusion of my presentation, I'll add some of the things that were not made to the standards and EPs that were on the table. It gives you some idea in what direction we're taking. But we also want to make sure that you understand that this is for our hospital and critical access hospitals programs right now. So our accreditation manuals were updated in January of 2022. We intend to take this to home health, laboratory standards, ambulatory standards as applicable, and as appropriate.

Next slide, please. Couple of objectives here, as far as our standards and elements, and again the standards and elements of performance, give the organization great latitude in developing their program that fits the organization's needs accordingly. Next slide, please.

Next slide. This is not a new problem, and we recognize that early on, with our subject matter expert panel, including members from the International Association for Security and Safety, as well as others. We even had on our panel the army nurse that was set ablaze by a co-worker, was on our panel, as well as many from the Veterans Administration, who've done a phenomenal job taking care of our veterans throughout the country. So we had considerable input from those folks as well. So as I noted this is not a new program. We understand that the many organizations, large and small that we accredit have programs in place already, have been very much on top of the situation and moving forward with their program. So we are new to this arena, but again we have not stopped. We will not stop as far as providing additional information, resources and standards and guidance activities. Next slide, please.

As Dr. Hunt mentioned, as far as education training I was surprised to hear the numbers, that 49% said yes, they had been trained and 51% no. And again, this is just some of the comments from our folks in the field and some issues tended to. So we have a nurse stabbed by a patient, pleads for more hospital security, top left. A police officer and two employees killed in a Chicago hospital shooting. We have some comments relative too at RN, Maryland Emergency Nurses Association. As well as I mentioned, the army nurse set on fire by a colleague, noting that she knew this would happen. And, again, if you haven't had the opportunity, I would take the opportunity to visit her website and look at the video that they've created. Next slide, please.

Next slide. We had on the books several elements of performance and standards updates, I would say, 10, 15, 20. We had a big debate in the very beginning, do we create its own chapter, workplace violence chapter, or do we put it in the environment of care chapter or otherwise? So,

it ended up in three distinct chapters, the Environment of Care that Dr. Hick talked about, as well as leadership, as well as HR. So you'll see it across three main chapters: The environment of care, human resources, and leadership. And you will see the existing language in blue, and the new language in orange and I'll talk a little bit about survey process. Next slide please.

This is a new EP in an existing standard. So the hospital is conducting an annual worksite analysis as it's related to the workplace file and standards. And the hospital, we expect them to take action to mitigate or resolve workplace violence, safety and security risk, based upon the findings from their annual worksite analysis. And it talks, the note provides some guidance as far as what we believe a proactive worksite analysis includes, and that's looking at existing incidents through, perhaps a security reporting and training. And again, maybe there's additional laws and regulations in your state that would also be applicable. And we just found out yesterday that OSHA is looking at this again from their standpoint as well. Next slide, please.

This standard under EC.04.01.01 EP1, we've added a little comment there in the fourth bullet point, safety and security incidents involving patients, staff, or others within the facilities and those related to workplace violence. So again we're going to collect the information about these workplace violence events during your annual assessment, whether you're doing an OSHA 3148 assessment, guidelines put out by IHSS a number of years ago, the Emergency Nurses Association risk assessment that came out several years ago or any other risk assessments, perhaps, that you have through your professional organizations. Next slide, please.

The next standard with a revised GP is EC.04.01.01 EP6. And again, what we're looking at is reporting and investigating safety and security incidents, involving patients, staff, and others within the facilities, including those related to workplace violence. So again, an aggregation of these particular incidents and reports and investigation as well. Next slide, please.

The HR chapter. We added a new EP in the HR 153 standard, and making sure that pretty much like we see under the global harmonizing system, that training is occurring at the time of hire perhaps and annually and when the program changes and you make changes to the program. And it's up to the hospital to determine what aspects of training are appropriate for each individual group of employees. There could be different training for nurses in the ER versus nurses in the Oncology Department perhaps or greeters or patient business service representatives and, of course, security representatives. So it's up to the organization, the hospital, to determine what training is most appropriate for those different jobs at a particular hospital, accordingly. So we give you wide flexibility establishing those particular training programs and education programs. Next slide, please.

New EP under HR 153, training and education, address, prevention recognition, response, reporting, definition of what constitutes workplace violence; that could be physician bullying, for example. Educational and the roles, responsibilities of leadership, and all other staff within the organization. Training and de-escalation, nonphysical intervention skills, physical intervention techniques and response to emergency incidents and the reporting processes for workplace violence incidents. Again, that ranges from domestic violence to patient-on-patient violence, patient on staff, staff on patient, whatever comes across, and as I mentioned, it could be verbal abuse as well. Next slide, please.

Existing standard with a new EP under Leadership 03.01.01 EP9. The hospital workplace violence prevention program led by a designated individual and developed by a multi-disciplinary team. We didn't add as well with Legionella and other opportunistic waterborne pathogens standard as well. So we're looking for that designated individual, but working with a team at the organization. That may include human resources, risk management, certainly security, nursing, nursing leadership and others that work through the hospital program. We're looking at policies and procedures to prevent and respond to workplace violence, a process to report incidents, and a process for follow-up and support. And again, I think a couple of our physicians mentioned earlier in their introductory remarks about the follow-up care of those people that are victims of workplace violence, and the retention rates and people leaving the hospital organizations as a result of these events.

Now of course, reporting of workplace violence incidents to the governing body, that could be the Board of Trustees. So when we sit down that leadership session, we're going to ask leaders of the organization about the workplace violence prevention program. Next slide, please.

Some implementation strategies and survey process and education training. We've defined workplace violence so that we have a common core definition. We want to tailor our education to roles and responsibilities and response expectations and we want that training to keep up to date as the program changes. Training and education resources based on who gets what training, de-escalation, non-physical and physical intervention, emergency response and the reporting process.

Our survey process will look into this and identify through your policies or procedures, what training is being developed and applied to what group of individuals at your organization for their job. Again using your policies and procedures, we will do that during the HR competency review. So if you identified a particular job classification of folks, and they will receive this level of training, we're going to make sure that level of training is provided in the file jacket, the HR jacket of that individual. So again, just matching up your policy procedure, making sure individuals get the level of training that you've identified.

Again completed education based on the job requirements. Interview with staff, when the life safety code surveyors and clinicians are touring through the building. They're going to ask individuals of various jobs from environmental, nursing, CNAs, physicians, licensed independent practitioners, “What type of training have you received, and how do you report workplace violence at this organization?” And how is this information provided back to you in summary fashion? And what data are you collecting that designated individual in that multi-disciplinary team?

So we're going to look at those aspects accordingly to make sure that your program is effective. And, of course, during the leadership session, typically held on the second to the last day or last day, what board members, physician leaders, as well as the C-suite, we're going to ask them about the workplace violence prevention program and how they are overseeing that and what results have they seen. Have they seen an increase, decrease, or has it maintain the same?

And again that's the capstone of the program and making sure that leaders are aware and are involved in the program up including the Board of Trustees or the folks that are ultimately responsible for oversight of the hospital. So couple of things I want to talk about just quickly, some of the things that did not make it to the standards and EPs is, previously we had a standard on forensic patient management HR 01.04.01 EP7. And you can see this from time to time at hospitals where a inmate or a prisoner has gained control, or overcome the guard, jailer or police officer, and secured their weapon and may have shot others, used it in attempt to escape, or committed suicide. That did not make it back onto the program, but again, perhaps in the future. Also, we have a requirement for 100% preventive maintenance for utility and medical equipment, biomedical equipment. And we proposed that 100% of security equipment needs to be 100% as well. Whether it be panic alarms, CCTV, or other security devices. So that did not make it.

And also, some other things, as well. So we're going to continue our journey with this particular chapter or these particular standards and updates and you may see additional standards and EPs in the future. Next slide, please. Some resources I want to provide to you, next slide. Some workplace violence prevention website, you can access at your leisure. Next slide.

Next slide. Our requirements, rationale and references, as well. And there's the website above. Next slide. And some resources through our Sentinel Event Alerts, quick safety, environment of care, news, and perspective. So all those are available to you to make you successful if you do not have a program. Again, we acknowledge that we're kind of late in the game here, and that many, many organizations have a very robust and very effective program. Some of the folks I've talked to, they're actually seeing a declination of the number of events, because of their programs.

Next slide, please. Some additional resources as well. Next slide. And, lastly, our Compendium of Resources. And the web URL link is above. Next slide, please. Some safer matrix data that I was able to pull from last year, as far as scoring under this EC chapter. We did not have the workplace violence chapter. You can see the majority are at the moderate level; moderate compared to low and high. So I just wanted to pull that. I hope to pull this for future events. So I'm speaking at the IHSS conference in Reno, Nevada I think, coming up in the next couple of months. I hope to pull some scoring data on the new workplace violence prevention standards as well. Next slide.

And some opportunities, if you'd like to provide input or otherwise. Dr. John Hick please, it's all yours.

John: Thanks so much Jim. I really appreciate that, and just a couple of quick questions. And again, if our viewers have questions they should type them into the questions section of the GoTo Webinar console here. Again we'll try to get to those during the Q&A, but I'll just take a couple of quick ones since we have an opportunity here. It seems like there's a great opportunity to standardize site assessments, as well as data collections for these type of events, Jim. So as part of the rationale portion of the R3, do you expect Joint Commission to, or do they already have templates for facilities doing that?

Jim Kendig: Not yet, because I think there's some other professional membership groups, such as, as is IHSS that would come with their membership, because they have the driving expertise. I'm former law enforcement from a long, long, long, long time ago putting myself through college. So I don't think we would be able to convene a group, as well as some of the professional organizations out there. So we would lean towards them to look at some of these opportunities. But again there's already many that existed that I used when I was still a hospital administrator in Florida. So they're out there currently, and I think using them, again I think using them would provide some consistency of what our servers would see on site.

John: Great. It seems like if we could standardize some of the data collection too, it would be a very robust and interesting dataset. So you mentioned OSHA and we got a question about the applicability of these standards to, right now, which specific facilities. There was a question about whether or not they applied to skilled nursing. But also, just a reminder to people that I think you touched on with mentioning OSHA, that there are other regulatory and potential, civil liability is here, that facilities need to take into account based on their specific threats and their specific geographic location.

Jim Kendig: Absolutely. These particular standards only apply currently to a hospital accreditation program and critical access hospitals. It has not gone to the MCC program or skilled nursing, ambulatory lab, or behavioral health at this time. It is our intent to move along as applicable and appropriate to apply some of these concepts to those programs, again, depending on the program itself. OSHA- we just received a fact sheet from the other day. We are in alliance with OSHA. As you know, currently, they use the general duty clause to cite folks for workplace violence. And again, some states have robust programs of themselves, as well as academic medical centers, as you know, have to deal with the Clery Act.

So again, there are many things out there to consider when you're taking a look at this, but we didn't necessarily partner with OSHA, but OSHA has been made aware of our standards and EPs. So we are collaborating consistently with them and sharing our information as well, so they can make use of whatever they find useful as they continue their path in addressing workplace violence.

John: Great. Excellent. Very important for facilities to be aware of any state specific things that their surveyors are looking for or requirements the state has in addition to other accreditation bodies. But Joint Commission certainly has been a key driver in this area and much appreciate the review Jim, and your time and commitment to this issue.

Thanks and I'll be back with you in the Q&A section. We're going to move on now to Austin Akervik who actually, I've had the privilege of working with at Hennepin Healthcare where I work as an emergency physician and he's one of the talented team that do their best to keep us safe in the emergency department. And Austin, you know, we get you guys involved when things are starting to fall apart a little bit more. But there's a lot of things that healthcare providers get told to do as far as de-escalation, but a lot of times, it's not a lot of practical instruction on how to do that. So we're going to try something a little different with the webinar today, and you're going to provide us a little bit of show and tell, I believe, so, thank you for doing this.

Austin Akervik: Yes, absolutely. So I'm here in our simulation center, which is a really great place that we have here. I've got a room set up for us, and I'm going to kind of give you an overview of a couple of classes that we offer to our staff here at the hospital. And I'm going to go through some of the highlights of that to give you some tools to bring back to your work, and hopefully your teams to help. Just some nice tips to keep yourself safe, prevent assaults, because I'm sure, much like our hospital, we had a 68% increase in assaults that were reported to security this year. A lot of those were security officers, as well. We had a record high year of assaults. It's a dangerous world we live in these days, so hopefully I can give you something to help keep yourself safe.

We offer at our hospital for our staff, two classes that really do go hand in hand. We try to get people to take them together, because you know one feeds off the other, but we offer a personal safety class and a de-escalation class. We do an hour and a half for each or three hours total if we can do them together. We like to do scenarios with them and do some hands-on practice. The hands-on portion really helps people get comfortable with the defensive maneuvers and blocks that we teach. COVID really hurt momentum we had. We're going outside the local, their hospitals in the state that are requesting this training during these classes all over the area and we're hosting them regularly at our hospital. Then COVID hit and also training kind of halted. The in-person training halted, which makes it very challenging for the personal safety.

I'm going to do my best here to show you guys this stuff. But I guess, and when you get to do them in-person, have somebody from security helping guide you through it. It's a lot easier to learn it than trying to do it over a virtual setting. The de-escalation is a little easier, we can do those virtually, you know, we've done them through teams here after COVID, but COVID really made it a big challenge for us to figure out how to keep going with these trainings.

First thing I want to talk about, go through here, is positioning. In the security law enforcement world, that's a big part of our training is how you position yourself safely to handle whatever happens. I don't think you guys get as much of that training. So I'm going to go through a couple of things here. In our room here, this is pretty accurate for one of our hospital rooms, we got our patient in the bed. The computer's usually on the side for our inpatient rooms. And there's a nice lovely wall or a window over here. It doesn't take much. You're working out your computer here. This patient is set up, and now you're trapped in a corner. You may have to get around the patient somehow, or you have to try to climb over the bed, which is not very easy to do. If there's another option for you, another computer, you can use, if this person is agitated, or aggressive, or has a violent history, it'd be a good option to try to use something else, rather than put yourself in a position where you can get trapped in that corner.

Another thing that you can do, we move over to this side here. It's a couple of other things that we typically see in the rooms here. This food tray that patients use, these work as really good barriers that you can put between yourself when you're talking to the patient if they're aggressive. It gives you a little something to buffer to get yourself out of the way, create distance, kind of block them. A lot of criminals are opportunists, if you take that opportunity away, the less likelihood of them trying to assault you or hurt you. So another option if you are in that, have to get blocked in is bringing a second person with you, if that patient has that a history. Bringing that second person in makes them think twice and has a lot better chance of making them think

twice about doing anything. This allows them to call for help if you need it, or physically help you if they get closer over here, that I like to look at when I come into a patient room is, what's out here. Is there a food tray on this tray, that's got metal silverware, a fork or a butter knife or anything like that, that they can use against you? If they do, I just grab it when I walk in, as I'm introducing myself, hand it to somebody else or we'll put it on a chair, a table in the back and put it out of arm's reach.

Other thing is often these, the tables or trays or desks that they have in there. What's on there? Pens? We've had people get stabbed here by pens or scissors that are left out. Like, if you use any tubes. Was there anything else that can be used to choke or grab you as -- loose chords, chords that aren't being used, stethoscopes, whatever it may be. This is one of the chords where nurses have them, patient took off one of the leads and wrapped it around the staff member's neck. Or something that's missing, where is that, why is it gone? Be a little cautious about that if you see things missing. But if there's things that aren't being used that can be removed from the situations as you're talking to the patient, trying to calm them down, de-escalate, move those items out of the way, out of arm's reach.

One trick that I actually saw a provider do, I heard a call for a really agitated patient was normally, we, you know, for the de-escalation side of things, we talk about, getting down to their level can be a really good way to de-escalate. If they're sitting on the bed, if you get down close to them or under their level that can help de-escalate. But it also puts you in a pretty vulnerable position. So if your chair doesn't happen to have arms, you can do it the old school, cool kid in class, where you sit with the back facing and the patient kind of grabs that barrier, it allows you to escape backwards if you need to. Rather than most chairs, you got to go out to the front or try to get off to the side which is lot harder to get out of.

So those are a handful of positioning things and I wanted to touch on the next thing is hand positioning. A lot of people will put their hands in their pockets or they'll lean up against the wall and cross their arms sort of thing. One, those show that you're not interested, that's what it makes the patient feel like, so it doesn't help with your de-escalation. And getting your hands out of your pockets to react to a strike, or patient coming at you takes a lot longer than if you have your hands up and ready. Same with arms crossed. You still have to uncross your arms to get to the position to do anything. So talk with their hands which is really great for safety and stuff like that. Talk with your hands and your chest area, stomach, head. Anywhere in that area, you can do it, and as long, just you know, talk with your hands get them here, keep talking. That sort of thing will help them not feel like you're threatening them, but it helps keep your hands in a position that you can block, or move or swipe something away, help, get yourself out of the way, whatever you need to do. And it also shows that you're interested, you're engaged.

A lot of people have a hard time with this, because growing up in school, they teach you don't talk with your hands when you're presenting. So it's kind of one of those things you kind of got to get over. But talking with your hands is a really good safe way of talking with somebody. It keeps your hands in a good position and they don't feel threatened by it.

A couple of other things, we teach a couple of blocks, getting out of holds, when somebody grabs your ponytail, how do you get out of that. Somebody grabs your wrist, how do you grab

that thumb. Pull, pry their hands off, thumbs are really great too, getting people's hands off your wrists. And then another big thing, especially if the patients are restrained, is wearing your EyePro. A lot of us are doing that anyways because of COVID protocols, whether it's eyeglasses, or the face mask or the shield. For face-to-face, patient contact is one of the protocols we have around here at least. That's a really good thing to keep going even after those COVID protocols go away, especially if the person's restrained. If the person is really agitated, they're restrained, what can they do? They could try to bite or they can try to spit. It's pretty much their only options.

So if you have a face shield or EyePro on, at least you can prevent that exposure from getting spit on. A couple of things to touch on for de-escalation. A lot of people tell you, you know, everybody knows. You got to de-escalate, you got to de-escalate. But a lot of people have never actually been taught, gone through, what do you do to de-escalate? One big thing that we like to talk about is knowing your trigger. Everybody has one. We all have something that triggers us to get upset and it frustrates us. Whether it's being called a certain word or being told we're not good at our job or whatever it is, everybody has something. If you can learn what that trigger is, you can help use that to prevent yourself from overreacting. If you know what your trigger is, you can work out a pre-conscribed response to that trigger and have that pre-planned response. And that will help you stay calm and not agitated, or make things worse.

Next thing is, I was introducing yourself, you don't have to -- it's better for de-escalation purposes to introduce yourself in a personal level. I don't go on there, "Hey, I'm Lieutenant Akervik. I'm here, blah, blah, blah." No I was going, “My name is Austin, I'm here to just help you out. Can you tell me what's going on today?” Something really on the personal level will help with the de-escalation down the road. Explaining your role. Clinicians obviously differ than mere security, but I I'm just here to see if I can help you out. Make sure everybody stays safe. That way, they know why you're there. They're not wondering, prejudice positions a little more easier to understand why you're there than security. The tone of your voice is really important. If they're talking loud and you're talking loud to try to talk over them, because you're working off of each other and building up that, you know, getting that loud tone and trying to talk over each other, that just amps everything up and keeps going on.

If you can keep that calm tone of voice, that will a lot of times, bring them back down to your level even if it's a, "Hey man, I'm right here. We're talking. I can hear you just fine. Let's just talk." Keeping that calm voice, a lot of times people will mirror your calm. So if you're amped up, they're going to be amped up. If your calm, they stay calm. Being honest is also a big part of de-escalation. We harp on our officers with this and we teach them de-escalation, because if you get caught in a lie, all de-escalation goes out the window. They're never going to trust you again or if they do, it's going to take a lot, a lot of work to get there. So, even if it's a hard truth, the hard truth is better than telling a lie that you get caught up in.

Then, we go through a behavioral change stairwell. This was developed by the FBI Crisis Negotiation team. This is a big part of our de-escalation. Start off with active listening. Active listening, and show them you're listening by repeating back. "Okay, so if I understand you correctly, this is what you're saying." Make sure you're maintaining that eye contact. You're not sitting with your arm crossed like we talked about earlier. You're actively listening. And then,

after active listening, you show some empathy towards them like, "Hey man, I understand your frustration." For us it's, a lot of times, it's visitor issues. They're not allowed to visit their loved one, because of COVID rules or COVID visitation policies. “I understand you're trying to visit your loved one. I'm really sorry about that. I can't imagine what you're going through.” Those types of things, showing the, building that empathy and showing that you care.

After that, you build rapport, whatever you can do to build that rapport. Once that trust is built, then you can try to influence them and hopefully get that behavioral change. Sounds like a lot. It can be done in a very short amount of time, depending on how co-operative that person is, have empathy and building that rapport. A lot of people, especially in hospital settings, a lot of time are rushed with security or since you guys are, got a lot of things to do, too. So, back in these situations, a lot of people try to rush the stairwell and they don't build that rapport to gain the trust before they try to throw that influence out there, influence it out there prematurely, then, you know, you’re not going to get that prescribed behavioral change that you want. The other thing is, a lot of people will be the person in crisis, the person that's talking, a lot of times will talk in circles, and then eventually, if you can take the time to let them vent fully before you talk that will help build part of that active listening and that empathy. If you start interrupting them, that frustrates a lot of people. People don’t like to be interrupted. That really hurts the de-escalation side of things.

And then the other one that people tend to do that we dislike are using words like, calm down, or relax. Those don't work, they tend to escalate more than they help. I think, that's about all I got for you guys. So give it back to you, Dr. Hick.

John: Great. Thanks so much Austin. I really appreciate it. So, a couple of questions for you. One, just to reinforce, some of the things that you guys have taught me is, you know, just remaining calm. Let them kind of get some of it out, and then just say, “Listen, I wasn't necessarily a part of what caused this to flare up. Can you tell me again, how can we help you?" And let them restate the problem in their words, restate it back to them and then let them know what you can do to help them, and what you can't do. And like you said, be truthful about what is in bounds and out of bounds. But I can't tell you the number of times that that has really de-escalated a person, is just knowing that they've been heard, and having a chance to just kind of reflect on what their exact needs are and why we can or can't meet them.

So, a question came in from the audience, which I think is a great one. So, for our example, our clinics that don't have on-site security, what are your recommendations for what do you need for training and how would you escalate up to community law enforcement or others to engage in a situation?

Austin Akervik: That is a great question. I would definitely recommend bringing extra staff in with you, if your person's got that history or they're agitated, because that having two or three staff in there might deter them from doing something. It makes it a lot harder if you don't have on-site security or if you don't have private security or anything or really security at all, because your only option is law enforcement at that point. And law enforcement, unlike security, is probably not just going to come stand-by when you talk to an agitated person. So then, definitely I would keep -- if threats are being made, or anything like that, then I would definitely, in my

opinion, I would recommend calling law enforcement, reporting the workplace violence with those threats against you. That will help keep you guys safe if they do try to fall through on those threats.

But otherwise, keep that safe positioning, make sure that doorway is always behind you, so you have that exit route if you need it. Have that other person in with you that can help you if you need be keep those hands up. If you can create a barrier with you, something in the room or something like that to prevent them from getting to you, giving you that escape route out. Definitely make sure you have those going into it.

John: And another quick question that I'll just follow that up with, is for actually, I'll just make a comment quickly that this is a whole different training session, but knowing the run, hide, fight reaction to violence actually occurring in your immediate area with or without a weapon, you know, knowing where your escape routes are, having locked doors, either labeled or well known to staff that they can shelter behind, really, really important. What are the criteria for a BERT response, Behavioral Emergency Response Team response at Hennepin and who comes to those?

Austin Akervik: Yeah, mostly it's, that's our responses for inpatient patients that are typically on the hold, not always. But they're having some sort of outbreak or mental break down, where they're acting out. When they call BERT at Hennepin, we have a security response and we have a team of psychologists from our inpatient psych units that respond and we use our collective skills between psych and security to try to de-escalate the situation. We have those, probably at least twice a day. So we get a lot of practice. We work really well with our psych staff to be able to de-escalate and work together to calm situations down.

John: And that's, I think a good -- ties into another question that we got about how do you create a deliberate de-escalation practice? Kind of, how do you think about a framework for body position, and your approach, getting on level? Are there any templates for doing that or any quick suggestions you can give?

Austin Akervik: I guess my suggestion for that would be, play the what if game. Every scenario you walk into, it's something that we teach our security, we do it in all on our causes. When you walk into the room, try to think of, quickly in your head while trying to focus, but try to think of, “What if this patient gets up, what am I going to do? What order--?” Take a quick panel or look around the room. “What threats are there? What escape routes do I have?” And if you have, if you work in like an inpatient setting and most of your rooms are the same, if you have an empty room, go in there with your staff and try to work it out beforehand. But if you can't take a quick snapshot of the room, “What are my threats? What are my escape routes and how can I keep myself safe if this patient decides to do something?”

Something I do, no matter where I go, personal life, work life, when I walk into a situation, I said, “Okay, if something happens with this or that, where can I go? Where can I hide? What can I use to protect myself? What are the threats in the room?”

John: Yeah, so when you feel the temperature going up a little bit, being deliberate about assessing where you are in the room, what weapons are available and then what your goals are of

the de-escalation. I think that's an important thing that you and I and others engage on pretty frequently, is we'll have a quick conference to bring you guys up to speed or women up to speed on what's happening and then what the legal status of the patient is as well as what our goals are for that encounter. And very different if it's for the patient that's in there for chest pain that we're really worried about versus a visitor that if they wind up leaving or being escorted out, it's not as big an issue if we can't solve that problem.

And another question for you, Austin. How do we go about tracking these type of encounters, these kind of events, like BERT type events?

Austin Akervik: Security, every time we're called to a BERT call or an assault or whatever it is, we use a reporting system that it's pretty standard in law enforcement. Officers will respond, get all the information, and fill it out. If there's any type of workplace violence, we also tell the staff member that was the victim to fill out an event report. And that goes to patient safety and employee occupational health and wellness, and those get combined with our security stats to get accurate stats on what kind of workplace violence and assaults we're getting.

John: Yeah, it's helpful information to have. It helps us target our training and things, too. So, thanks so much Austin. Maybe be back to you with another question here, but I've got a couple of questions for Jim. Jim, can you talk a little bit about if physical restraint is required during an encounter that escalates, is that subject to kind of the usual standards for management to restraint or does it depend on whether the person is a patient, visitor, et cetera?

Jim Kendig: Yes, CMS has specific regulations. A matter of fact, I just wrote an article for EC News, so you have to be careful about that. So if it is a patient, CMS has specific prohibitions and requirements for restraint as you well know, being a physician, you right, as an ER physician. So absolutely. So it all depends whether it's a patient, and of course, typically CMS has a lot to say about that. And I can provide that paragraph to you. But again, if it's a visitor or someone else that does not have a reason to be there, or is causing a problem, again, that goes to the public side, or the public law enforcement, or security can deal with that. But dealing with patients, there are very specific clinical aspects you have to deal with as well.

John: And Jim, can you talk a little bit about -- and Audrey, could we go back to slide, I believe it's 29, which is the SAFER Matrix. Jim, could you just explain that matrix, just a little bit more?

Jim Kendig: The SAFER Matrix was developed a couple of years ago to illustrate to organizations that likelihood to harm a patient. Again, we are using the limited pattern of widespread. For example, in the physical environment field, if we have five penetrations, smoke or fire barrier, that would be widespread, for example, or six items resting upon the approved automatic sprinkler system, that would be probably low and widespread, right because the likelihood of harm to occur is not really there. However, let's say, in the immediate threat to health or safety, we have a process and sterile processing that we realize that we're using out of date test strips, the system wasn't functioning properly. Now, we availed some unsterilized materials into active cases in the OR, so that you can see the differences in the realms of those examples. So again, an immediate threat to health and safety would be jeopardy of a patient or jeopardy or harm that already occurred for example, or something along those lines.

Typically, the immediate threat to health and safety is in the infection control realm. The high, same thing, and also management of patients in the high as well. So again, the probability is along the high, moderate or low. And again, the number is limited pattern of widespread. I hope I did that justice, I could provide additional information from our perspectives article that goes into detail. But essentially, what we do is we show this on the morning briefings during survey to give the organization some idea where they're at. So it looks a little bit differently in this particular model. This was an aggregate model that I was able to pull from our Power BI to aggregate those standards that are currently in the EC as it relates to security.

So we use the SAFER Matrix to discuss in the morning briefing where the standards may rest and potential harm to patients in the organization.

John: Great, thank you. Jim, do you have any ideas on kind of best data practices when you collect incidents of workplace violence? Are you looking at that from a sort of incidents per day, or the degree of severity of the incident, or the FTEs either affected by or incidents per FTE? Is there any standardization around that?

Jim Kendig: Or per patient days, things like that. We leave it up to the organization. And like I said, many organizations already have robust programs in place. As lieutenant mentioned, they have their own security system software where they're able to report case reports, things like that. So we don't expect you to change your current processes, maybe refine them a little bit and take a look at it, and this is a great opportunity to kind of modernize or re-check to make sure the data you're collecting is true and accurate. We know it's underreported significantly, so we don't want to mandate a particular methodology. But some way that you can measure the impact of the program, the training, injuries to staff. I heard the lieutenant talk about employee health and wellness, as well.

So again, some of that parlays into OSHA 300 logs as well. So we're not mandating a particular program or process. We're going to use what you provide, and already have in hand.

John: Very good. Austin, question for you. We not infrequently have domestic situations between an employee and their partner where there's either restraining order or concerns about that individual attacking them in the workplace. Can you talk a little bit about how we handle that and some ideas about how others might?

Austin Akervik: Typically, when we get that information, we'll try to get a picture of the person if we can. Then we post that picture up at our security desk, a place nobody else gets to see it. But the security officer at the front desk that's vetting everybody that comes in the hospital at least can have a visual of this person and know that this person should not be here. We also have deputies onsite, 24 hours a day here now. So we always make sure that they're aware of the situation, because they have more access than we do. They can look up the orders for protections and see what restrictions are there, and they can -- a lot of times, they're the ones that can get us that access to that picture to. And that way, we're aware they're aware. They're usually stationed at the front desk as well. So, that way, we can make sure that they don't enter the hospital.

John: And I would assume for a facility without the kind of access controls and resources that we have, you would work on a similar protection plan and response plan if the individual showed up, but it would just be a little bit more reliant on escape and those sorts of things. Is that correct?

Austin Akervik: Yes.

John: Very good. We did have one other question about the BERT team training, which is our Behavioral Emergency Response Team. So as you mentioned, that's a multi-disciplinary response between security and our behavioral health or mental health staff. That can be called by any provider, any individual, a staff member that feels that they have an escalating situation that they need backup for. Do you have any closing thoughts here as we're out of time, about the training for those team members?

Austin Akervik: All our security and all our mental health workers go through extra de-escalation training, including a lot of scenarios and that really helps us. Our security and mental health workers also deal with it on a daily basis with our seven inpatient psych units. We're dealing with people in crisis all the time and we get a lot of practice from those training, in those scenarios in real life to really help us dial in that what works and what doesn't work.

John: And the team members have a lot of practice working together just like if you're doing sort of a pit crew on a race car, every day, you get comfortable with it. But I think the simulation training for our employees that are more entry level and some of these techniques has been really, really valuable. So, much appreciation Austin, for all the work you've done and working sort of hands-on with the employees to do that. We are unfortunately at time, and just appreciate you being here and for your great questions. I'll just turn it back at this point to Audrey Mazurek for closing comments.

Audrey: That all the time we have. Again, the webinar will be archived and posted on our website at asprtracie.hhs.gov, shortly after the webinar and we will be sending out the recording to this webinar to all attendees and will also be posted on our website. On behalf of the ASPR TRACIE team, thank you for joining us today and have a wonderful day.