The Continuum of Violence in Healthcare: A New Era

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OBJECTIVES

- To examine the foundational facets of vulnerability risk
- To identify the overarching profiles of violence
- To utilize the tenets of conducting a vulnerability risk assessment in daily healthcare practice.

Some Overarching Thoughts

- The motivational intent of interpersonal violence has increasing interest for contemporary healthcare settings (including clinical and other professional settings).
- Most at risk areas in healthcare?

Some Overarching Thoughts

- There is an ongoing need to expand the identification and understanding of forensic and nursing-based theoretical tenets, with translational application to practice, to enhance assessment and intervention relative to bio-psycho-social risk-factors.

A New Era?

Patient to Nurse/employee…

- Family member to nurse/employee
- Patient to family member/visitor
- Family member to family member
- Employee to employee

A “Positive Spin” on Violence?

- Over the years, workplace violence has become a growing concern, particularly in the health care sector where nurses and other health care providers experience high rates of verbal and emotional abuse, physical violence and sexual harassment while on the job.
Foundations of Positive Spin

- NIOSH – increasing rates? Counterintuitive?
- CDC
- OSHA
- ANA
- APNA

Primary prevention tied to:
- Early identification
- Proactive approaches (de-escalation techniques)
- Ultimate safety responses (sometimes exit is the correct strategy)
- Post-event analysis

Some Overarching Thoughts
- There is an increasing interest toward understanding the underlying factors related to those persons who commit acts of interpersonal violence or property damage, including indicators for probability and prediction, including examination of general profiles of behaviors and from analysis of:
  - high-risk situations
  - post-violent events
  - Injury/death scene indicators

The Risk Continuum: Some ongoing challenges...
- Intrapsychic facets
  - Not assessed
  - Not understood
  - Not recognized
  - Recognized and avoided
    - Fear of violence
    - Not our business
  - Fear of being perceived as invasive or inappropriate

Phenomenon of Blurring....
ANGER and VIOLENCE
The "self-fulfilling prophesy" phenomenon

The Risk Continuum: Some ongoing challenges...
- Interpersonal facets
  - Internalization/Externalization
    - Many of the clues toward increasing risk lie within these two broad categories
    - Verbalizations (frequency, content, tenor, ellipses marks…)
    - Unit behaviors
    - Non-verbal language

The Risk Continuum: Some ongoing challenges...
- The contemporary challenge of the "telling" factor
  - Verbalizations
    - Story telling
    - "hypothetical situations"
    - "One of these days…"
    - "I wonder what would happen if…"
  - Written communications
  - Drawings/sketches

TWO PREVAILING PROFILES OF VIOLENT BEHAVIOR

HIGH EMOTION, LOW THINKING
- "Disorganized"
- Scene reflects a high level of chaos
- High level of emotion is evident in the crime
  - Typically rage or revenge is clearly evident
  - "Overkill" is often present

LOW EMOTION, HIGH THINKING

Targets and Victims
- Target(s) – Focus of the violence
- Victim(s) – Others who circumstantially happen to be in the area during the violence
Related Factors

- Typically agitated or affectively charged person who has:
  - become hopeless
  - feels coerced
  - believes they have been "wronged" in some way
  - feels the need to retaliate/exact revenge
- Weapons of opportunity are typically used
- Psycho-motoric indicators are typically evident
- Usually "obvious" from the onset that something is "wrong"

LOW EMOTION – HIGH THINKING

- "Organized" behaviors
- Events reflect a low level of respect for the target
- Expresses minimal to no guilt for what he/she is planning to do
- Reflects a calculated approach to the violence

LOW EMOTION – HIGH THINKING

- Clearly identifies his target(s) and has extrapolated many of the potential scenarios and outcomes.
  - May have a distorted perception of the target(s)
    - "You never liked me. Why?"
    - "Why are you treating me this way?"
    - "You know this is going to ruin my entire life…"
  - Knows he/she may have significant consequences for their action but accept this.

LOW EMOTION – HIGH THINKING

- SCENE REFLECTS ORGANIZED PLANNING AND PROGRESSION
  - Has monitored daily routines
  - Plans progression around targets
    - Targets – those who are intended to be acted out upon
    - Victims – others who happen to be in the surrounding area who might get injured
  - Demand for acknowledging "wrong"-ness
  - Demand for an apology

The Issue of Human Design/Intuition

Overt Threats vs. Cold Threats

- My lawyer will be contacting you very shortly
  - Who should he call?
  - What is her number?
- Cold Threats
  - Ellipses marks…
  - An example?
WHO IS AT RISK?

Unfortunately, all of us may be at risk. There is a higher risk to those who must directly set limits with a patient, such as caregivers or unit managers. It's also important to note that depending on the personality structure and behavioral profile (i.e., low emotion and high thinking), there can be multiple targets which can result in multiple victims.

There is a global high risk for everyone when someone hears a threat (overt or veiled) and tells no one, disbelieves it, takes a "watch and wait" stance, etc. Under-reporting contributes to inaccurate perception of violence in a facility and can significantly impact facility/administrative understanding.

WHAT CAN BE DONE?

- Examine limit setting actions
  - How are these managed during the active process?
  - How can the goal be attained with minimal perceived threat to the individual’s ego integrity?
  - Enhanced/targeted post-action assessment
    - Once the decision is made, and if it is unfavorable to the patient, how is safety of others ensured?

- TARGET HARDENING:
  - As awareness of potential risk factors increases, risk for violence and serious injury decreases.

- SAFETY ASSESSMENT OF:
  - Lounges
    - Seating
    - Power outlets
    - Weapons of opportunity
  - Units
    - Interview rooms
    - Unit stations
  - Emergency response
    - Access
    - Egress
    - Emergency call mechanisms
WHAT CAN BE DONE?

- Education of employees/managers regarding methods of responding to de-escalating individuals who are agitated or potentially violent or who become violent.
  - Trends in Human Resources
  - Zero Tolerance for Violence Policies
    - Legal implications

WHAT CAN BE DONE?

- A post-event functional analysis should be conducted after every violent episode
  - (of any category)

WHAT CAN BE DONE?

- Although de-escalation and limit setting are typically best, psychotherapeutically, in a quiet place:
  - This differs from an isolated place
  - Someone else aware and available
  - With the person between you and the door
  - With a clear plan of what will and will not be tolerated
  - Or, for example, on admission if the person seems impaired (AOB)

WHAT CAN BE DONE?

- Best practices:
  - Use a room, preferably with two doors
    - However, most psychiatric units were not constructed this way!
  - Sit closest to the door
  - Let at least another staff member know about the meeting and that they can be available in the surrounding area.
  - Don’t place items nearby that can be used as weapons of opportunity.
  - Be mindful to maintain intact “integrity of self” for the client

A “Positive Spin” on Violence?

- Positive spin? A new era?

Drexel University

RE-FRAMING THE MESSAGE DELIVERY—HELPING THEM TO A SUCCESSFUL DE-ESCALATION
WHAT CAN BE DONE?

• QUESTION:

If your agency orientation and annual education requirements includes fire safety, CPR and OSHA training/policy review, does it also include:

• Various options for getting help in an emergency?
• WHO to report WHAT, HOW and WHEN a patient has made any comments, direct or indirect?
• How to maintain a safe workplace environment (both physical and interpersonal) — including environmental assessment.
• A vulnerability assessment of the physical workplace environment
  • Weapons of opportunity
  • Emergency escape routes
• A “Zero Tolerance” policy for any level of violence, inferred or direct?
  • Defining what Zero Tolerance means
  • What to do when violence is observed