

Violence Prevention (VPP) and Risk Assessment.....

How to Get Your House in Order.....

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Objectives: VPP and Risk Assessment Process

- **DUE DILIGENCE**
- The quality of work life and the quality of patient/resident/client care or service will be enhanced
- The VPP program involves the marriage of OH&S and clinical practice and is based on a commitment to the core principles of a “harm reduction” philosophy and the highest regard for human dignity
- The potential for physical and psychological injuries and the inherent financial losses for workers and the employer will be reduced

Objectives cont.

- The VPP and Risk Assessment process will meet or exceed our statutory obligation to WCB
- Risk assessments will be carried out by a multidisciplinary team that includes, OH&S, unions, management, and front line workers /service providers who understand the workplace reality

Objectives Cont.

- The transfer of knowledge from risk assessments/classroom to the clinical setting (actual workplace) will be enabled and prioritized
- Program evaluation will be based on reliable qualitative and quantitative methodologies

Violence Prevention Program Risk Assessment

Is this sometimes your response to the
term Risk Assessment????



OR



Risk Assessment...so what's the big deal????

RISK ASSESSMENT

VPP Policies/Procedures

Educational/training
Strategies/
Team consultations

Commitment/Ownership
All Staff and SLT

Accident reporting,
Investigation &
Follow up:
(Operational &
CISM)

Hazard Prevention and
Control:
(engineering, work
practices and
administrative controls)

Program
Evaluation

Risk Assessments

- Statistical analysis – reported data (*include data from similar places of work*)
- Environmental risk assessment
- Staff surveys (perception)
- Job shadowing/staff focus groups
- Accident reports/checklists/investigations
- Patient/resident/client Aggressive Behavior Risk Assessment tools
- Victim profile

Risk assessments must be viewed from:

- Environment
- Work practices
- Resident/Client profile
- Victim profile

Recommendations should be categorized as:

- ▶ Highly changeable
- ▶ Somewhat changeable
- ▶ Can't control

Statistical Analysis: Criteria to assess incident severity (*potential for serious physical and/or psychological injury*)

- Homicidal threat (to self, family, friends, colleagues) or witness to threat in person, via telephone or mail
- Threat perceived to be intentional and personal
- Use of particularly offensive words
- Threat comes from family member(s)
- Weapons involved
- Stalking
- Blow to head, neck, and/or spit/slap to face
- Strike with closed fist to head, neck, face, back, abdomen, groin or chest
- Bite - any violence related injury involving BBF exposure
- Throwing/attempting to destroy hospital equipment
- Multiple assailants or victims, more than one assault in a shift
- Collateral from victim and witnesses
- Previous personal or professional history of abuse/assault
- Lost time/claim costs

Stats – Violence Related Incidents

#'s, Time Loss. Costs, Potential for Serious Injury

SPH, ER - # violence related incidents (March 31, 2004 – April 1 st , 2005)	Time Loss	Compensation Costs *** 50% accidents potential for serious injury/fatality
14	73	\$8, 474.95
VGH, ER - # violence related incidents (March 31, 2004 – April 1 st , 2005)	Time Loss	Compensation Costs
4	0	0
4 year total – SPH, ER (01 – 05) 59	4 year total - 579	4 year total - \$55, 706. 54

<u>ER Fast Track Pilot Project #'s:</u> (x 1 month)	OH&S reports for same time period
54 (41%patients reported-escorted from ER)	0

Worksite Inspection Checklist (facility)

- Lighting
- Staffing levels
- Other patients/clients/residents
- General appearance and area
- Maintenance of general security systems/security equipment
- Isolation
- Building perimeter
- Visibility
- Reception area(s)
- Treatment rooms/medication rooms
- Offices/work stations/area design
- Waiting areas
- Files/records
- Stairwells and exits
- Equipment and tools

Worksite Checklist (community)

- Personal safety devices
- Personal possessions
- Traveling
 - a) public transit
 - b) car
 - c) parking
- Moving Within an Apartment Building
 - a) elevators or stairwells
 - b) approaching apartment units
 - c) doors/doorways
- Weapons
- Approaches for major mental health disorders/substance use/personality disorders
- Knowledge of nonverbal/paraverbal communication
- **Buddy systems and CHECK IN protocols**

Workplace Survey (perception)

- a) Your security on the job
- b) Violence Prevention Policy
- c) Incident Reporting and Follow Up
- d) Education and Training
- e) Incidents at work
- f) Security
- g) Your recommendations

Client Assessment Tool – risk of violence

<p style="text-align: center;">HIGH</p>	<p style="text-align: center;">MODERATE Score – 2 For each item checked</p>	<p style="text-align: center;">LOW Score – 1 For each item checked</p>
<ul style="list-style-type: none"> <input type="checkbox"/> Known history of violence <input type="checkbox"/> Use of a weapon. <input type="checkbox"/> Verbal/physical threats & or attacks <input type="checkbox"/> Throwing objects <input type="checkbox"/> Hitting out at ER property <input type="checkbox"/> Acute intoxication <input type="checkbox"/> Potential for withdrawal <input type="checkbox"/> Acute psychotic state <input type="checkbox"/> Other: _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Holding on to objects or people and/or invading caregiver’s space <input type="checkbox"/> Refuses requests. <input type="checkbox"/> Pain <input type="checkbox"/> Recent substance use with no withdrawal symptoms <input type="checkbox"/> Paranoia <input type="checkbox"/> Anxiety / Panic attack <input type="checkbox"/> Head injury <input type="checkbox"/> Dementia/delirium <input type="checkbox"/> Suicide intent 	<ul style="list-style-type: none"> <input type="checkbox"/> Hand gestures <input type="checkbox"/> Glaring at caregiver <input type="checkbox"/> In recovery from substance use <input type="checkbox"/> Reaction to medications <input type="checkbox"/> Undetected pain <input type="checkbox"/> Suffering grief/loss <input type="checkbox"/> Sleep deprivation <input type="checkbox"/> Other _____
<p>Score: Note: Any one indicator in High Risk column will be designated “High Risk”</p> <p>Total Score: _____</p> <p style="text-align: center;">7+ = High Risk 3-6 = Moderate Risk 0-2 = Low Risk</p>		

Checklist for Assessing Violent Tendencies

QUESTIONS	Yes	No
1. Is the client abusing alcohol or other substances?		
2. Is the client demonstrating alcohol or other substance craving, intoxication, withdrawal symptoms?		
3. Is the client making threats to harm others?		
4. Has the client ever committed violent acts with subsequent arrests or in conjunction with criminal activity?		
5. Was the client physically abused as a child?		
6. Has the client demonstrated recent acts of violence? (including damage to property)		
7. Has the patient recently brandished weapons, including objects that may be used as weapons (e.g., forks, rocks)?		
8. Does the patient have fears of harming others? a) With intent? b) With current plan? c) With means?		

QUESTIONS	Yes	No
<p>9. Does the patient have command auditory hallucinations?</p> <p>a) With specific instructions?</p> <p>b) With familiar voice?</p>		
<p>10. Is the patient clinically depressed with severe psychomotor agitation, suicidal ideation, panic attacks, or suicidal plan with urge to take family with him/her</p>		
<p>11. Is the person experiencing a paranoid delusion</p> <p>a) With planned violence towards the perceived persecutor?</p> <p>b) With a hallucination related delusion?</p> <p>c) With a history of acting on a delusion?</p> <p>d) With accompanying intense anger or fear?</p>		
<p>12. Is the patient experiencing threat control override symptoms</p> <p>a) Thought insertion/sensation of mind control by external force?</p> <p>b) Delusion of being followed?</p>		
<p>13. Does the client have a personality disorder with rage, violence or lack of impulse control?</p>		
<p>14. Does client have one of these factors: male, age 15 –24, low socioeconomic status, few social supports, brain disease, frontal lobe syndrome?</p>		
<p>15. Does the patient display catatonic or manic excitement?</p>		
<p>16. Does the patient have more than one major Axis 1 diagnosis? (major mental health disorders, substance use disorders, dementia, delirium, depression ADHD, FAS)</p>		

Victim Profile (risk factors)

- Inexperience
- **Worker doesn't know that they don't know**
(eg. unconscious anger)
- Set too many limits or not enough
- **Not listening**
- Refusing to meet reasonable requests
- Worker is perceived to be judgmental/disrespectful/pushy bossy
controlling/arbitrary/uses "psychobabble"/terminal perkiness
- Behaving in an overly kind or motherly manner *(esp. w/ psychotic clients)*
- Worker shows obvious signs of fear with client
- Forcing clients to confront upsetting material
- Worker not mindful of personal space issues
- Worker denies potential for violence/ignores client threats

Competency Continuum



Policies and Procedures

- “Protection of Workers from Violence in the Workplace”
- Patient/resident Flagging
- Team Response – CODE WHITE
- Working Alone
- Partnership for Care – NB Signage
- Lethal Weapons
- Criminal Charges – Restraining orders/No Go
- Respect in the Workplace
- Restraint Protocols
- Blood and Body Fluid Protocols

Aggressive Behavior Flag

- Place a ● on file
- Plan in place

Signage

For the protection and safety of patients, visitors, clients and staff:

We strive to treat you with courtesy and respect, and expect that you will behave in a similar fashion. Please do not use abusive language or aggressive behavior.

Anyone behaving in this manner may be asked to leave or may be escorted from the facility

Thank you for your cooperation.

Education - Primary Resources

Acute Care:

- Nonviolent Crisis Intervention – Crisis Prevention Institute
- Verbal Judo – Vancouver Police Department
- Drawing the Line – WCB of BC
- An Integrated Model for the Management of Co-occurring Psychiatric and Substance Use Disorders – Kenneth Minkoff, MD
- Treatment of Behavioral Emergencies – The Expert Consensus Guideline Series, Annenberg Center for Health Sciences

Residential:

- Alzheimer's Disease – Pieces of the Puzzle, Arizona State Gerontology Center
- The Eden Alternative – Bill and Judy Thomas
- Individualized Dementia Care – Joanne Rader
- Geri – Psychiatric Education Program (GPEP) – Vancouver Richmond Health Board
- The Supportive Approach - Len Fabiano
- Caregiving to Persons with Dementia - Mary Lucero

EDUCATION: Core elements and Risk Specific

Universal Strategies

- Follow basic safety precautions
- Increase your self awareness
- Identify Risk factors and Triggers
- Understand importance of nonverbal/paraverbal communication

BASIC SAFETY PRECAUTIONS

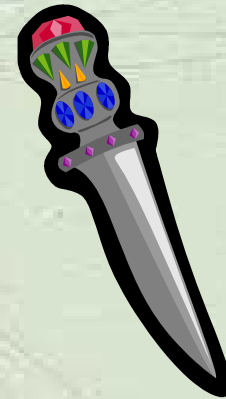
Weapons/hostage taking

NB Stay as calm as possible

- ◆ Listen...speak only when spoken to
- ◆ Fully cooperate...ask permission to move
- ◆ Drop to floor if shots fired
- ◆ Call VPD and clear area if possible
- ◆ Write down demands
- ◆ Indirect eye contact

DO NOT...

- ◆ Attempt to disarm or accept a weapon
- ◆ Delay or argue
- ◆ Focus on weapon
- ◆ Be a hero.....attempt to apprehend, impede, chase

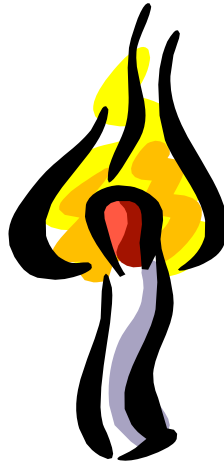


Self Awareness

- Identify personal triggers
- Identify internal cues
- Relate triggers and cueing to childhood and family of origin
- Understand nature of projection in terms of personal triggers
- Identify biased thinking



+



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FUEL

RISK FACTOR

+

MATCH

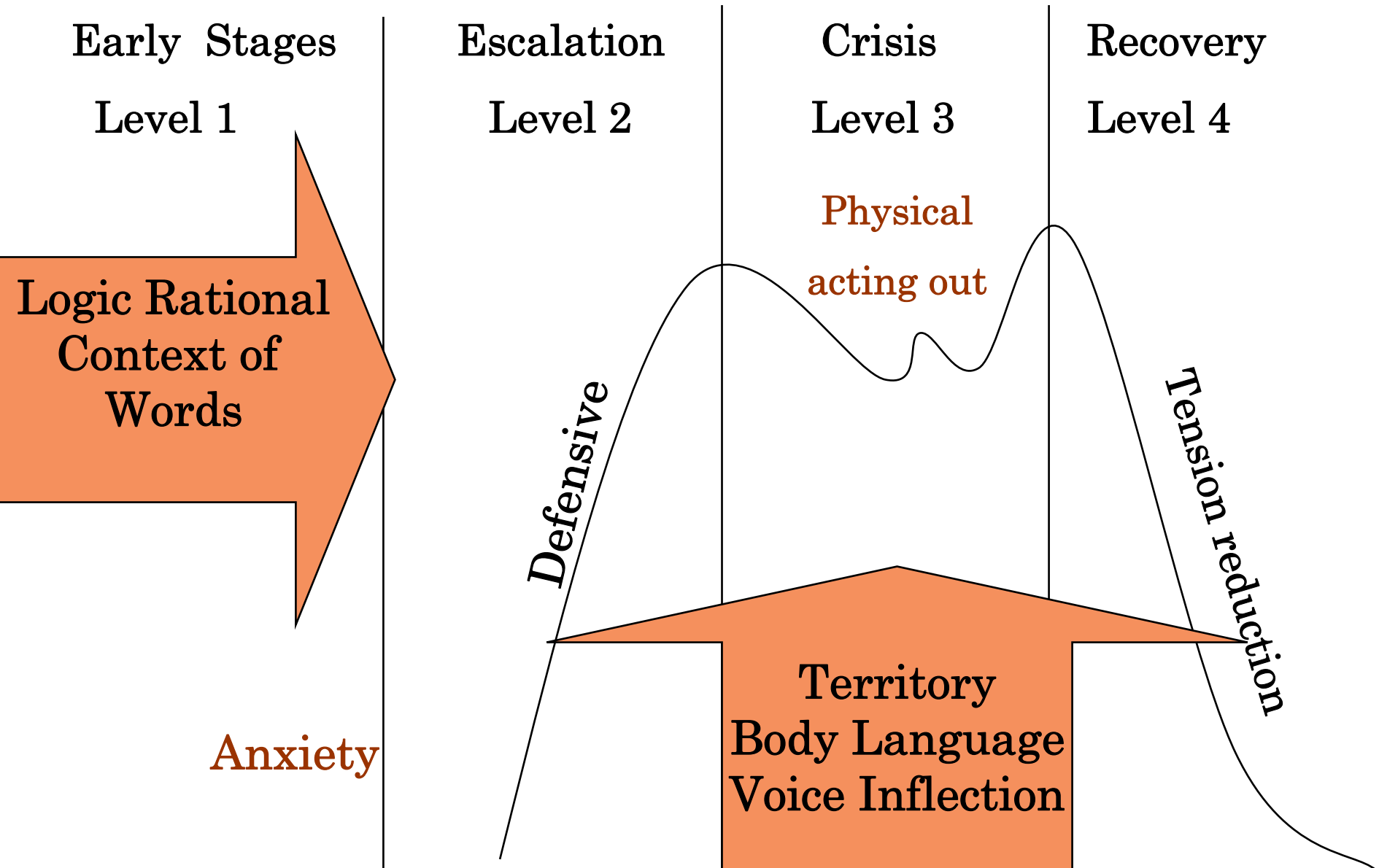
TRIGGER

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FIRE

**AGGRESSIVE
BEHAVIOR**

Crisis Cycle- NVCI



NVCI: Behaviors and Approaches

Behavior Level	Approaches	Goal	Skills
1. Anxiety	Supportive	Prevention	Listening
2. Defensive	a) Directive b) Distract/ Redirect	De-escalation	a) Limit setting b) Enter their World
3. Physical Acting Out	Team response (NVCI)	Control and Protect	Physical Self Defense
4. Tension Reduction	Therapeutic Rapport	Negotiate Support	Debriefing

The Ten Commandments of De-Escalation

1. You shall respect personal space
2. You shall not be provocative
3. You shall establish verbal contact
4. You shall keep it simple and be prepared to repeat yourself
5. You shall identify wants and feelings
6. You shall listen
7. You shall agree, **validate** their reality, agree to disagree
8. You shall set respectful, reasonable limits
9. You shall offer choices
10. You shall debrief

ACCIDENT REPORTING....INVESTIGATION....FOLLOW UP

Checklist – Challenging Aggressive Behaviors

1. Where did the incident take place?
2. Is this the first incident of challenging behavior or is there a history?
3. Where is the potential for challenging behavior documented
(eg. ADL, Care Plan, file, computer flag, kardex?)
4. Is the patient/resident cognitively impaired?
5. What are the underlying causes for the behavior?
(eg. excess stimulation, boredom, wait for service, change in medication, substance use, psychiatric disorder, delirium, dementia, head injury, PAIN, infection, UNMET needs?)
6. What was the resident/patient doing before the incident?
(behavioral cues?)
7. Do you see any patterns to the behavior? *(time/events/ people)*
8. Do you have any recommendations for prevention in the future?
9. **Did you receive adequate support following the incident?**

Psychiatric	Psychosocial	Physical	Environmental	Spiritual	
Dementia Delirium Depression Bipolar Affective Disorder Personality Disorders	Psychosis Life experiences Relationships Coping strategies Losses	interests pleasures strengths abilities	Acute illness Chronic illness Pain medication constipation	Physical Communication Approaches Other patients	Cultural norms and values Religious beliefs and practices rituals

Multidisciplinary
Plan for:

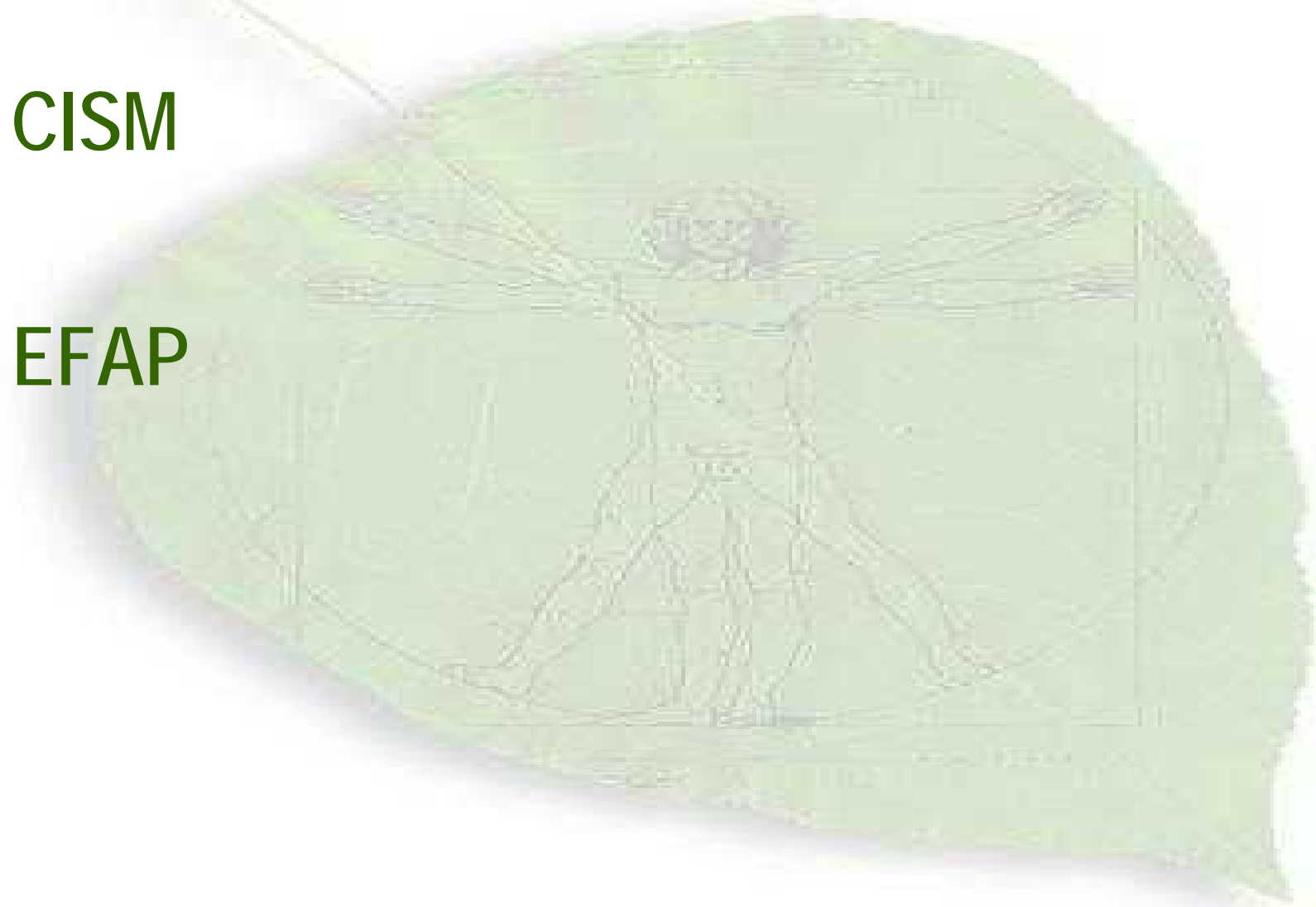
Date:

Patient/ client Resident Profile	Identified Challenges	Underlying causes (risk factors/ triggers/ unmet needs	Behavioral Cues & Patterns of aggression	Interventions	Limits -Validate reality -Describe behavior - Why - +ve then - ve consequence -Enforce

Staff Supports

1. CISM

1. EFAP



Signals that I should consider getting more help after a critical incident

- ◆ **Intrusive memories/nightmares /flashbacks**
- ◆ **Distress with events that resemble the event**
- ◆ **Numbing**
- ◆ **Hypervigilance**
- ◆ **Confusion**
- ◆ **Irritability/anger/rage**
- ◆ **Obsession with incident/mistakes/self doubt**
- ◆ **Isolation/withdrawal**
- ◆ **Depression/grief/loss/suicidal ideation**
- ◆ **Decline in work performance**

Hazard Prevention and Control

a) Engineering controls

- emergency personal alarm system
- panic buttons/hand held alarms
- video cameras
- curved mirrors
- plexi glass
- Paging/public address
- maintenance schedule
- design of reception
- furniture fixed to floor
- first aid kit
- BBF protocols (biohazard containers/bleach kits)

b) Work Practice and Administrative Controls

- waiting rooms and access to clinic areas controlled by security
- security guards trained in principles of human behavior and prevention and management of aggression
- staff are given the greatest possible assistance in obtaining info to evaluate history of, potential for violent behavior in clients
- working alone and flagging protocols strictly adhered to
- establish liaison with police and “call alert”
- referral systems to psychiatric facilities to ensure ensure prompt and safe hospitalization of clients

Program Evaluation – Goal Action Form

Review of Goals: 2005 – 2006	Accomplishments: 2005 - 2006
Not yet accomplished: 2005 – 2006	Goals: 2006 - 2007
Action Plan: 2006 - 2007	Target completion dates:
Projected results/success indicators: a) Short term b) Long term	Barriers/obstacles:
Relevant Statistical Data: 2005 - 2006	Projected Budget:: 2006 - 2007

BARRIERS

- No research re efficacy of intervention tools
- Time of rapid change/contracting out/fiscal constraints
- Nursing shortage, high turnover rates, increase in casual staff
- Spurious stats due to under reporting (acculturation/shaming and blaming)
- Reactive vs. Proactive
- Relationship with WCB vs. Employer
- Lack of understanding re statutory obligation to WCB and due diligence