

WASHINGTON STATE DEPARTMENT OF LABOR & INDUSTRIES  
Safety & Health Assessment & Research for Prevention (SHARP)

**The Washington Work, Stress, and Health Project:**

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**Eastern State Hospital Workplace Violence Report**

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2/22/2011





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**Recommended citation:**

Yragui, N. L., Silverstein, B. A., & Jellison, J. L. (2011). Washington Work, Stress, and Health Project: *Eastern State Hospital Workplace Violence Report*. Technical Report #: 87-6-2016.

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## ***Eastern State Hospital Workplace Violence Report: Executive Summary***

In May 2009, researchers and consultants from Washington's Department of Labor and Industries' Safety and Health and Research for Prevention (SHARP) research program undertook a study toward the following aims:

**Aim #1.** Obtain background information on manager, union, and direct care staff perceptions of workplace violence hazards, interventions, and recent changes;

**Aim #2.** Understand the organization of work, workplace culture, and physical and nonphysical workplace violence exposure of direct care providers in the current work scheduling and staffing conditions;

**Aim #3.** Review current workplace violence policies, reporting procedures, incident debriefing, and assault prevention training.

This report presents our findings based on 2 ward observations, 3 focus group interviews with 10 direct care staff, and individual interviews with 1 union representative, 3 supervisory nurses, and 2 managers at Eastern State Hospital's Medicine Lake campus. In sum, we found the following key results for each aim:

**Aim #1.** Executive Summary Table 1 below presents the interventions suggested by Eastern State Hospital managers, union representatives and direct care providers. These suggestions for improvement were made by respondents in the individual and focus group research interviews.

***ES Table 1. Respondent proposed interventions.***

<b>Category</b>	<b>Examples</b>
<b>Promote value of direct care staff</b>	Increase awareness of staff contributions; Recognize team supportive actions
<b>Revise staff assault report forms</b>	Shorten forms to expedite staff reporting
<b>Increase staff participation and leadership engagement</b>	Increase the voice of care providers; Participative decision making
<b>Improve communication systems and skills</b>	Across shifts, units, and organizational levels; Share successful methods in patient care
<b>Provide training and development</b>	Annual violence prevention training; Interpersonal & communication skills; Professional development programs
<b>Improve staffing management</b>	Alternative shifts (1-9pm); Increase unit schedule control; Permanent float pool
<b>Remove performance constraints</b>	Improve quality of treatment programs; Computer staffing system
<b>Develop/enforce policies and rules</b>	Implement policies between shifts consistently; Cross-train staff across units
<b>Reward good practices</b>	Provide positive feedback; Ask each employee how they want to be recognized

**Aim #2.**

- Lack of control over work is a serious stressor that impacts patient and staff safety.
  - a) Control issues include external pressures on the organization, inadequate staffing levels, lack of direct care staff schedule control, long hours, and high levels of staff churn.
  - b) Excessive unscheduled absences for direct care staff pose an increased risk for violence and injury for patients and staff.

**Aim #3.**

- The current hospital culture reflects acceptance of violence as part of the job, reluctance to report incidents, low social support from senior management, and failure to conduct incident debriefing for direct care staff. The hospital would benefit from a comprehensive system for data collection and analysis to make data-based decisions for safety.
- State law, RCW 72.23, requires direct care providers to get annual violence prevention training. However, employees reported not receiving adequate training.
- Patient and staff safety may be compromised by failure to follow hospital policies and procedures consistently. Eastern State Hospital should undertake a thorough safety assessment to determine if and why practice variance occurs. Nursing practice variance is the difference between existing policies and procedures and actual practice. Higher nursing variance can negatively impact behavioral and medical safety outcomes.

The top three recommendations from this study are as follows:

- (1) *Control over Work* - Analyze staffing and scheduling systems to reduce unscheduled absences, floating, and overtime use. Increase employee schedule control. We recommend a hospital computerized scheduling system such as Kronos.
- (2) *Organizational Culture* - Train managers, physicians, supervisory nurses to implement all hospital policy and procedures consistently. Train managers and supervisory nurses to role model respectful and safe behavior, communicate the value of a culture of non-violence and safety to nursing staff, and foster communication and social support at all levels including debriefing violent incidents.
- (3) *Training and Education* – Ensure all staff get adequate training on an annual basis as per RCW 72.23. Create a formal peer mentoring program for new staff to facilitate training transfer, team integration, and development of safety behavior skills.

In closing, we would like to say that we found the study participants to be very concerned for their patients and their organization, thoughtful in contributing many suggestions for interventions, and dedicated to their work and the hospital mission of providing quality patient care. We hope this report encourages decision makers to renew their efforts to improve working conditions in nursing care at Eastern State Hospital.

We plan to pursue further intervention development research with Washington's state psychiatric hospitals, have written a grant toward that end, and have submitted it to the National Institute for Occupational Safety and Health (NIOSH). We are waiting for the results of the scientific peer review grant application process. We are hopeful for this funding and look forward with excitement to continuing to contribute our expertise and engage in collaborative efforts with hospital employees toward improving patient and staff safety at Washington's psychiatric hospitals.

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## THE EASTERN STATE HOSPITAL WORKPLACE VIOLENCE REPORT

### Overview

The risk of work-related violence in psychiatric healthcare settings has long been well-known. Workplace violence is defined as violent acts, including physical assaults and threats of assault, directed toward persons in a workplace or on duty. The workers' compensation claims rates for psychiatric hospitals far exceed those for any other industry. The Bureau of Justice Statistics report based on the National Crime Victimization Survey data for 1993 to 1999, lists the average annual rate for non-fatal violent crime for all occupations as 12.6 per 1,000 workers (Duhart, 2001). The average annual rate for physicians is 16.2; for nurses, 21.9; for mental health professionals, 68.2; and for mental health custodial workers, 69.

A study in Washington state psychiatric hospitals (Bensley, Nelson, Kaufman, Silverstein, & Kalat, 1993; Bensley et al., 1997) called attention to violence and the need for better prevention efforts. This research established that the incidence of assaults on staff was seriously underestimated by either the number of claims filed or by the injuries reported on incident logs. Further, while the rate of workers' compensation claims has declined steadily at most other healthcare and social service industries, rates for psychiatric hospitals remained high.

In 2000, RCW 72.23 was enacted by the Washington Legislature and signed by the governor. This law states that patients and employees should be assured a reasonably safe and secure environment in state hospitals. The law requires that state psychiatric hospitals create a workplace safety plan with an annual evaluation, conduct training for violence prevention, keep records of violent acts, and submit an annual report to the legislature.

In 2008, violence rates continued to be high in Washington's state psychiatric hospitals. SHARP proposed to examine broader systemic issues that may contribute to workplace violence. To address systemic issues, the Washington State Mental Health Division Director, Richard Kellogg, invited the Washington State Department of Labor & Industries, Safety and Health Assessment and Research for Prevention (SHARP), program to conduct a study regarding the environmental and organizational factors that contribute to workplace violence at Washington's state psychiatric hospitals.

In addition, on January 1, 2009, the Joint Commission (TJC), a national accrediting agency, required health care organizations to have a formal process for managing behavior seen as unacceptable, such as a code of conduct and policies that support zero tolerance for workplace violence and bullying.

Currently, not enough is known about risk factors, including various situational and environmental factors, which contribute to workplace violence in psychiatric health care settings. The research activity for this report was comprised of focus group interviews with direct care staff and individual interviews with union representatives, nurse supervisors, and managers, as well as an on-site physical environment walk-through for workplace violence hazard assessment and observations of the psychosocial environment on the hospital wards. Content analysis of the qualitative data identified themes relevant to workplace violence hazards, solutions, barriers, and recent changes made by the hospital management team.

An important focus of the study was to examine the organization of work as it pertains to Type II (violence directed at employees by customers, clients, patients, or any others for whom an organization provides services) workplace violence in the state psychiatric hospital. As defined by the National Institute of Occupational Safety and Health (NIOSH, 2002), *organization of work* refers to the work process and organizational practices that affect job design. External, organizational, and workplace factors contribute to the organization of work. External factors of interest are how other systems directly interact with the hospital organization such as the criminal justice system and the community mental health system. Organizational factors of interest are staffing systems and scheduling practices, such as long work hours and lack of control over work schedule. Incident reporting practices and availability of violence prevention training for staff are important to understand. Finally, workplace factors to consider are the culture for nonviolence and safety, organizational, supervisor and coworker-team support, and task attributes such as worker-patient interactions, control over work, and physical and psychological demands experienced by state hospital psychiatric patient care providers.

### ***An Occupational Health Psychology Perspective on Workplace Stress and Safety***

According to Sauter and Hurrell (1999), Occupational Health Psychology (OHP) emerged in response to three developments: "(a) the growth of and recognition of stress-related disorders as a costly occupational health problem; (b) the growing acceptance that psychosocial factors play a role in the etiology of emergent...problems such as upper extremity musculoskeletal disorders; and (c) recent and dramatic changes in the organization of work that foster both job stress and health and safety problems at work" (p. 177). Quick (1999) suggests that OHP has the general goals of developing, maintaining, and promoting healthy workplaces in the context of industrial and organizational (I/O) psychology. Thus, OHP researchers blend an understanding of the psychological processes that guide individual behavior with a recognition of the occupational and organizational factors that influence how people respond to situations at work.

In alignment with this OHP perspective, our research examined manager, union and staff perceptions of workplace violence hazards, the organization of work, workplace culture, and the workplace violence exposure of direct care providers.

#### ***Eastern State Hospital Background***

Eastern State Hospital is the 312-bed state psychiatric hospital for 21 eastern Washington counties and is accredited by the Joint Commission on Accreditation of Health Care Organizations (TJC) and certified by the federal Centers for Medicare and Medicaid Services (CMS). The hospital consists of three programs, the Adult Psychiatric Unit (APU), the Geropsychiatric Unit (GPU), and the Forensic Services Unit (FSU) on a campus in Medical Lake, Washington. The hospital provides evaluation and inpatient treatment for individuals with serious or long-term mental illness that have been referred to the hospital through the Regional Support Network (RSN) system or through the criminal justice system. Approximately 700 individuals are employed at Eastern State Hospital. Treatment components provided by clinical staff include psychosocial rehabilitation (recovery model), psychotropic medications, group/individual therapy, and drug & alcohol education.

The APU is comprised of 91 hospital-level beds on 3 units to serve adult patients who have been

civily committed to the hospital due to serious and persistent mental illness. The FSU provides care and treatment to adults found to be guilty except for insanity and has 95 beds. FSU also provides treatment to restore fitness to proceed in a trial to persons who were determined not competent to aid an assist their attorney. Geriatric patients are served in the GPU which contains 101 beds. A treatment mall was recently initiated in 2009 to provide patient therapy (Washington State Department of Social and Health Services, Eastern State Hospital, 2010).

#### ***Purpose and Scope of the Study***

The objectives of the study were to 1) Obtain background information on manager, union and staff perceptions of workplace violence hazards, interventions, and recent changes; 2) Understand the organization of work, workplace culture, workplace violence exposure of the direct care staff, and current work scheduling and staffing conditions; 3) and review current workplace violence policies, reporting procedures, incident debriefing, and assault prevention training.

In the following sections, we will report on research methods, procedures, and the data analysis approach followed by the main body of the report that focuses on the qualitative research findings organized by theme.

### **Methods**

#### ***Sampling Frame and Participants***

The sampling frame for the research included participants at different levels in the organization to obtain multiple perspectives on the topic of workplace violence. Participants with the highest risk for workplace violence, direct care providers such as nursing staff, were recruited to attend focus groups. Supervisory nursing staff members were recruited for individual interviews to obtain information from those whose role was to lead and direct nursing staff, who were making decisions related to restraint and seclusion, and who were witnesses to patient assaults on staff as well as being at risk for assault. Managers were interviewed individually to obtain perspectives that included leadership roles in managing the organization for workplace violence prevention and intervention. Finally, union representatives whose role is to influence the organization with the aim of increasing worker health and safety in relation to workplace violence were included in individual interviews as well.

To provide confidentiality, we did not collect participant information such as name, age, gender, or job title. We asked participants to describe their work responsibilities and tenure with the organization. Of the 10 participants in the two direct care staff focus groups, all were direct care providers on the units with 3-28+ years of service in the hospital. The manager and union representatives participating in the 6 individual interviews ranged from upper level managers, to supervisory nurses, nurse managers, and union representatives with 8-30+ years of service in the organization.

#### *Procedures*

Research documents and procedures were approved by the Washington State Institutional Review Board (WSIRB). The WSIRB is responsible for reviewing and approving human subjects research in the jurisdiction of three Washington State Agencies: the Department of Social and Health Services, the Department of Health, and the Department of Labor and Industries (L&I).

#### *Direct Care Provider Focus Groups*

Focus group interviews ( $N = 3$ , with 3-5 employees per group) were conducted to identify violence prevention strategies, organization and supervisor response to violent incidents, organizational, supervisor and coworker support, communication, violence prevention training, salient barriers to reporting incidences, staffing, and schedule flexibility, as well as inquiring about recent changes or current conditions that facilitate effectiveness at work toward violence prevention.

Nursing staff volunteered to participate and did so during their work time. No incentives were offered to participate in the focus groups. Focus group interviews took approximately 90 - 120 minutes.

#### *Manager and Union Representative Interviews*

Semi-structured interviews ( $N = 6$ ) were conducted with supervisory nurses, managers and employee/union representatives of the AFSCME Union at Eastern State Hospital. Topics included workplace violence hazards, awareness of current policies, practices and incidents/injuries related to workplace violence, the organizational culture, organizational barriers to reducing violent incidents, and recent hospital change efforts, supervisor to coworker and coworker to coworker support, communication, acuity-based staffing, and schedule

flexibility. Each interview took approximately 60 minutes.

#### *Qualitative Analysis*

The recorded narrative data from the focus group and individual interviews were transcribed into text documents by a Washington Department of Labor and Industries transcriptionist. The text documents were coded by the SHARP research team using an open coding approach. A coding structure of themes was developed and refined throughout the coding process. Reports were generated by theme and researchers summarized each theme from these reports. Quotes were selected for the purpose of exemplifying primary and secondary themes. The steps in the analysis were conducted using a committee approach. SHARP researchers held discussions concerning emerging coding issues, developing themes, and presenting these themes and corresponding recommendations for the final report.

#### **Study Findings**

##### *Overview of Themes*

The qualitative data analysis produced themes that are categorized under control over work, organizational culture, and training and education. The findings are presented by theme and subtheme and include a definition of any relevant concepts, some content or background information, quotes from the interview data as exemplars of the themes, and bulleted recommendations.

##### **Control and Organization of Work: External Control**

As defined by the National Institute of Occupational Safety and Health (NIOSH, 2002), *organization of work* refers to the work process and organizational practices that affect job design. External, organizational, and workplace factors contribute to the organization of work. This section of the report is categorized into two parts; External Control, and Internal - Schedule Control. External Control refers to the outside influences that the organization may have limited control over. Internal - Schedule Control refers to areas within the organization where steps can be taken to increase sense of control for employees especially around staffing and scheduling systems. *Lack of control is a known and important work stressor* (Theorell, 2003). The first sections of findings focus on various control issues for the hospital.

External Control factors of interest are how other systems that directly interact with the hospital organization affect employee sense of control. Internal and Schedule Control includes organizational factors such as staffing systems, scheduling practices such as mandated overtime resulting in long work hours, and unscheduled absences that also impact employee sense of control. In terms of the issue of long hours, for example, data suggest that the average work year for prime-age working couples has increased by nearly 700 hours in the last two decades (Bluestone and Rose, 1998; DOL, 1999) and that high levels of emotional exhaustion at the end of the workday are the norm for 25% to 30% of the workforce (Bond et al., 1997). In one work stress study, the main stressors for psychiatric nursing ward staff were around staff shortages, health service changes, poor morale, and not being notified of changes before they occurred (Fagin et al., 1996). The sections that follow will present findings for the control over work themes; External Control, and Internal and Schedule Control.

#### ***Findings for External Control***

External control refers to issues related to pressures from outside organizations. State funding and laws, Department of Justice (DOJ), The Joint Commission, an accreditation body for healthcare organizations (TJC), Department of Corrections (DOC), the community mental health system, and patient advocacy groups are examples of outside organizations whose activities impact Eastern State Hospital. Under this theme, participants discussed lack of complete control over admissions and discharges, lack of community mental health systems support, and budget for staff as external control concerns.

#### ***Low Staffing***

Lack of staffing is largely due to legislative budgetary constraints the hospital contends with. Because of low staffing levels, hospital employees are expected to work overtime on a regular basis, which can lead to exhaustion and make it very difficult for direct care staff to do their jobs safely. This and other staff-related issues are discussed further in the following section on Internal - Schedule Control.

Table 2. Examples of staffing demands

<b>Core staffing demands</b>	<b>Working definition</b>
<b>Work load intensity</b>	Amount of direct and/or indirect care necessary to offer patients.
<b>Patient acuity</b>	Severity of patients' conditions.
<b>Staffing mix</b>	Education and experience of other nurses and/or other assistive personnel on the current shift.
<b>Personnel demands</b>	Unexpected absence/presence of other personnel, such as unscheduled absences or reassignments.
<b>Charge nurse responsibilities</b>	The extent to which the nurse has regular, relief, or intermittent charge nurse responsibilities.
<b>Patient census</b>	Number and mix of patients on each particular shift.
<b>Performance constraints</b>	Availability of other necessary personnel (e.g., nursing staff) or resources (e.g., supplies).
<b>Patient characteristics</b>	Characteristics of a patient's condition that create special/additional demands (e.g., violence history, physiological and/or psychological instability).
<b>Shift characteristics</b>	Length of current shift; time of day of shift, pulling, alternative shifts, characteristics of other recent shifts (e.g., amount of overtime, shift rotation).
<b>Supervisory nurse characteristics</b>	Characteristics of supervisory nurses' leadership style, engagement on the ward, and support of nursing staff

### Control - Internal and Schedule Control

Internal and Schedule Control is a term that encompasses job control issues experienced by direct care providers and managers within the hospital. The theme of Internal and Schedule Control includes concerns regarding low staffing levels, restricted vacation leave availability, long hours for some direct care staff due to mandated and voluntary overtime, inconsistent teams from floating or pulling staff, unscheduled absences, and managing churn. Churn refers to change and complexity among staff such as direct care providers leaving the organization or leaving their ward when floated to another ward. Table 1 on page 8 lists various staffing demands in a hospital system, some of which emerged as important issues in the current study.

Schedule control, defined here as the ability to determine when one works, where one works, and how many hours one works, is a complementary dimension of job control (see Barnett & Brennan, 1995). Psychological and physical strain are more likely when workers face high psychological work demands and when workers have little control over when or how work is done (Karasek, 1979; Karasek & Theorell, 1990). There is fairly strong evidence that high job demands and low job control are associated with poorer mental health (Karasek, 1979; Van der Doef & Maes, 1999) and with poorer physical health outcomes (see Belkic et al., 2000; Belkic, Landsbergis, Schnall, & Baker, 2004; Bosma, Peter, Siegrist, & Marmot, 1998; Karasek & Theorell, 1990; Schnall, Belkic, Landsbergis, & Baker, 2000).

Research confirms that flexible work arrangements that increase worker control and choice (such as self-scheduling) reduce stress and healthcare costs; improve productivity and job satisfaction; increase retention; decrease absenteeism; and improve loyalty and commitment. Employees working flexibly are more satisfied with their jobs, more satisfied with their lives, and experience better work/family balance. In a review of ten studies of flexible work conditions, Joyce and colleagues (2010), found that flexible work interventions that increase worker control and choice (such as self-scheduling or gradual/partial retirement) are likely to have a positive effect on employee health outcomes. These include primary health outcomes (including systolic blood pressure and heart rate; tiredness; mental health, sleep duration, sleep quality and alertness; self-rated

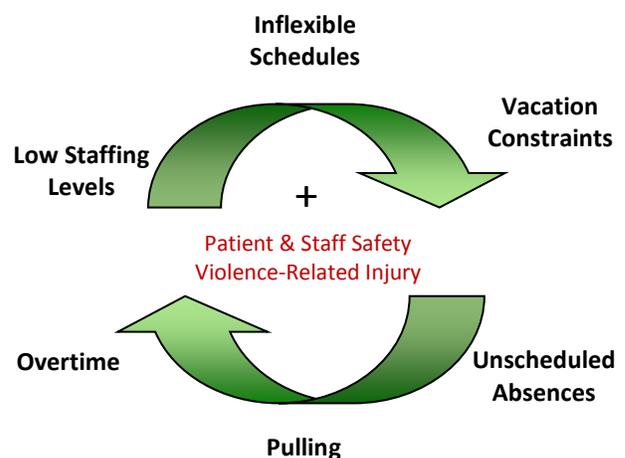
health status) or secondary health outcomes (co-workers social support and sense of community). In the ten studies no ill health effects were reported for flexible work schedules.

### Findings for Internal Schedule Control

The qualitative data analysis indicates that schedule control is a key concern for ESH managers, supervisory nurses and direct care staff and much of the interview and focus group discussion revolved around restricted vacation time, floating staff, and unscheduled absences, all schedule control issues.

Many of the schedule control issues are linked in a self-reinforcing or positive feedback loop as modeled in Figure 1 below. For example, low staffing levels, inflexible schedules, and vacation constraints contribute to high levels of unscheduled absences, increased floating of staff and mandated and voluntary overtime. Low staffing levels, working long hours through mandated or voluntary overtime and the unpredictability of floating staff to unfamiliar wards results in stress, exhaustion, illness, and increased work-family conflict. Risk of violence and injury is increased and patient quality of care may be seriously compromised. Patient and staff safety is at stake under these conditions.

**Figure 1. Schedule Control Factors on Patient and Staff Safety & Violence-Related Injury**



### Low Staffing Levels

In nearly every manager, supervisory nurse, and direct care staff focus group interview, low staffing levels were reported as significantly related to problems in safely providing quality patient care. In

the individual and group interviews, low staffing levels for direct care nursing staff were attributed to chronic lack of funding. The current economic climate and recent budget cuts have added further burden and stress to existing hospital staff. The importance of addressing control issues related to staffing levels, overtime use, and unscheduled absences is critical.

*"We need to have continuity—*

*And you go somewhere where you don't know the patients or the-- the staff, I don't know anybody from FSU. So when I go there I don't even know the staff let alone the patients. I don't feel comfortable. I am not productive on these wards because I don't know them."*

*Direct Care Provider Focus Group*

*"And what happens is because we are spread out all over and we're doing different things -- So they end up standing around waiting to have their needs met. And if they're truly mentally ill, they hate it and they can't deal with that."*

*Direct Care Provider Focus Group*

*"In my role, my job is to balance to-- to be fiscally responsible and manage our resources as best as I can - versus the needs of our patients and our programming, the organization -- and find that proper balance, and it's a constant challenge daily. It's difficult especially when those resources are eroding and the money is not there. Then the people aren't there. The staff see that and they get concerned because they start thinking, 'There is no one else around. If something happens it's going to be me.' And then, do you think they're going to be the most therapeutic when something occurs? No." Nurse Manager*

#### *Inconsistent Teams – Floating or Pulling Staff*

Floating or pulling staff from some wards to other understaffed wards at the start of a shift is a regular practice at the hospital to address adequate staffing coverage. The challenges of this form of low schedule control for direct care staff are many including disrupted teams, poor quality and lack of continuity in patient care, staff stress, frustration

and disengagement, increased burden on regular staff, and increased risk for patient frustration and escalation that sometimes leads to violent incidents.

*"It's not unheard of for every person on that ward staff to not be from that ward. It happens pretty frequently." Supervisory Nurse*

*"Well, if you end up with just one regular staff person it can be-- and again I'm thinking of APU, it can make it for a really dangerous situation if you have all pulled staff and nobody knows the patients and you have pulled nurses too, um, you can have the whole ward blow up."*

*Direct Care Provider Focus Group*

*"And the staffing we do get is often float staff, especially on certain days of the week. And float staff have not been trained in security issues. Some of them are female and elderly. And these people (care providers) cannot handle them in the way they need to be handled. And that's a safety hazard."*

*Direct Care Provider Focus Group*

#### *Unscheduled Absences*

Psychologically demanding and stressful work, constrained ability to take vacation time, and low schedule flexibility contribute to employee excessive use of unscheduled absences to recover from stressful work conditions and illness, and to manage their work and nonwork lives. Unscheduled absences were reported by nurse managers as a significant problem impacting scheduling practices such as floating. Direct care providers also acknowledged the frequent use of unscheduled absences and the negative effects of increasing floating, unpredictability, and risk of violence.

*"And that impacts your level of annual leave sick leave, the number of hours you can kind of predict. You know, I might have to float today because we have this many staff. Because each ward has a minimum amount of staff that they're going to have and if you're going to be over that, chances are somebody is going to float. So it's not hard to figure out. That creates even more unpredictability."*

*Direct Care Provider Focus Group*

*"It's probably the most stressful job I've ever had in my life and I've done some pretty difficult things. But that unpredictability (from unscheduled absences) is a huge piece."*

*Direct Care Provider Focus Group*

*"We had-- we had 20 call-ins I believe, yesterday. The mall was cancelled. The day before that we had 18 call-ins. We have enough call-ins every month that I don't know what its equivalent to. I would guess that it's equivalent to at least 20 to 30 full time FTE's." Supervisory Nurse*

*"Unscheduled leave is a problem. It is an issue for safety."*

*Supervisory Nurse*

*"When you take that time on a repeated timeframe, you're actually imposing on my ability and my staff's ability to work in a safe manner."*

*Supervisory Nurse*

*"You know, we have to plan our vacations a year in advance and, uh, you know, that makes it really difficult. There is just no flexibility. If you want a day off you don't ask for it off because it's going to be denied, so you take it off using your leave."*

*Direct Care Provider Focus Group*

The above quotes describe ways that some staff might respond to gain some control over their schedules when they are stressed due to working under the conditions of schedule inflexibility and overtime. Staff also can be listed for unscheduled absence due to lateness, calling in sick, or caring for a sick family member. An important issue for staff is that schedule inflexibility for taking vacation leave leads to a strategy of calling in sick to get vacation time, family time, or recovery time from stressful work.

In a functional staffing and scheduling system, direct care staff would have greater schedule control -- flexible avenues and options for responding to a family emergency, handling needs for recovery from

stressful work, and for managing work and non-work commitments.

The content analysis of the data revealed that workplace violence and schedule control are related issues for patients and staff. The complex cycle described here has a significant impact on patient quality of care and on patient and staff safety.

### **Recommendations for Control: External and Internal and Schedule Control**

- Bring union and management groups together to revise vacation guidelines to increase schedule flexibility.
- Hire additional direct care staff and identify mechanisms to ensure that consistent teams provide patient care on each ward. Adequate numbers of stable staff should reduce use of practices such as overtime, floating staff, and unscheduled absences.
- Provide a means for staff inclusion in planning and decision making in key areas of concern for direct care staff.
- Limit use of mandated and voluntary overtime.
- Create a float pool of permanent workers who have the ability and desire to function in this capacity.
- Identify options to increase schedule flexibility for direct care nursing staff.
- Create a culture of schedule control.

### **Organizational Culture**

#### *Organizational Culture Overview*

From a systems perspective, each aspect of organizational culture can be seen as an important environmental condition affecting the system and its subsystems. The examination of organizational culture is also a valuable analytical tool in its own right. The culture of a group is defined as a pattern of shared basic assumptions within an organization developed through solving problems concerning external adaptation and internal integration. These shared assumptions and beliefs are taught to new members as the correct way to perceive, think, and feel in relation to those problems (Schein, 2001). *"The bottom line for leaders is that if they do not become conscious of the cultures in which they are embedded, those cultures will manage them."* (p. 375).

Culture change requires a major investment of time and resources due to the fact that culture is so deeply rooted in an organization's history and collective experience. Organizations often draw on help from an external change agent because it is difficult for insiders to perceive their "reality" as co-constructed within the organization, and to see meaning in things they normally are not aware of.

Culture is comprised of formal and informal elements. Formal elements include written documents such as policies, mission statements, a formal workplace violence safety plan, and concrete violence prevention and safety goals. Informal elements include common organizational language and communication norms, social support, and leadership. A non-violent safety culture is recognized to be a super ordinate goal of the organization and the result of goal-directed interactions between the individual members of an organization, the work they do, and the organization as a whole. In the following sections, we present findings on the organizational culture subthemes of workplace violence policy, violence as normative, and culture change.

### **Workplace Violence Policy**

Written documents such as workplace violence and communication policies are *formal* expressions of an organization's culture, and expectations for culture. Nachreiner and colleagues (2005) found that policies that specify types of prohibited behaviors emerged as being protective for staff in psychiatric settings. However, because many employees are unaware of existing policies, these alone cannot protect hospital patients and staff from violence. In addition to developing sound policies on violence and educating employees about their content, supervisors have a powerful role in communicating policy to employees and ensuring that policies are reasonably followed. Supervisors can communicate frequently to staff about the value of zero tolerance and can quickly address issues related to workplace violence and incivility with patients, hospital staff, and members of the public that visit the hospital.

Washington State law, RCW 72.23 directs state hospitals to develop and review annually a workplace violence prevention plan. This plan should include workplace violence policies and procedures for personnel. In addition, The Joint Commission (TJC) requires nursing leaders to have defined policies and procedures, which detail common nursing practices, available on every

hospital unit. These policies and procedures are typically developed by a committee of nurses and other caregivers. The Chief Nurse Officer (CNO) signs off on all nursing policies and procedures. Job descriptions and new employee training should include reference to the need for clinicians, nurses, and direct care providers to follow hospital policies and procedures. Just as important, however, is the need for senior leaders to create an organization-wide culture of nonviolence and safety and to educate staff on the need to follow policies and procedures consistently.

At the same time, nurses, physicians, and other clinicians need to be empowered to make decisions that are in the best interest of individual patients—even if those decisions deviate from hospital-wide policies and procedures or from a physician's order. *In those cases, the clinicians must be required, by policy, to document their reason for choosing a different action.* It is important to decrease variance in nursing practice as well as medical practice because it is related to accidents and medical errors. Decreasing nursing variance enhances patient care quality and safety for patients and staff.

### **Findings for Workplace Violence Policy**

Overall, when asked about a workplace violence policy, direct care staff respondents recalled a policy introduced in February, 2009 - ESH 2.2, *Disruptive and Intimidating Behavior by Staff*. This is a policy for all staff, students, and volunteers and concerns staff behavior. This policy does not address patient assaults on staff. Managers and staff did not recall or discuss any workplace violence policies specific to patient assaults on staff during our interviews.

While our questions were specific to workplace violence policies, direct care provider respondents in focus groups had much to say about policies and procedures in general. Staff expressed strong concerns regarding policies that are not followed consistently and noted that supervisory nurses have a great deal of leeway to make decisions that go against written policies and procedures, sometimes compromising safety for patients and staff. For example, mixing FSU and APU clients is against policy but occurs at the treatment mall and cafeteria; staff escorted FSU patients against procedure and without knowing the patients; and staff felt their relationships with patients were undermined when they worked to uphold policy with patients and supervisors made decisions against policy.

The series of quotes below provide a sense of the seriousness of the concerns of Eastern State Hospital nursing staff. Addressing this issue of nursing variance is critical for patient and staff safety

*“And this is one of the biggest problems we have on the ward that I work on, which is the admission ward for APU. There are policies and procedures. But they’re not followed.*

*“Our leadership pretty much dictates at this point whatever it is they want to do - which really creates a lot of problems for the floor staff. The MHTs are what I’m talking about because I can have a client come up to me and not have the appropriate levels to go outside. And they’ll ask me if they can go outside. I’ll tell them ‘No, you don’t have the levels at this point.’ And explain why. They’ll go immediately to -- usually to the supervisor. They’ll come back and – ‘Well I’m going out anyway.’ And they (RN3) won’t back up the policies or the procedures.”*

*“Which really targets the MHTs. And I - - you know, a lot of time I’m known as the bad guy. I enforce the rules. I follow the policies. I have no support whatsoever. The rules at this point seem to be made up on a daily basis on however they feel they want to do it.”*

*Direct Care Provider Focus Group*

*Respondent 6: “Since the inception of our treatment mall, every policy is --*

*Respondent 4: Pretty much ignored.*

*Respondent 6: Uh huh. Are you able to go to your charge nurse and ask about policies? And do you have a sense that they are knowledgeable?*

*Respondent 1: Usually I have to show my supervisor the policies.”*

*Direct Care Provider Focus Group*

*Respondent 3: We escort one to ones outside to the yard, which is totally against policy, ward holds. Totally against policy.*

*Half the stuff we do on our ward is against policy and regulations. And nobody seems to care. And I’m talking right down to the escorts. We’re not allowed to be escorting more than six at a time. Well, seven, eight, nine, ten (are escorted).*

*Interviewer: And this is escorting through the tunnel -- the underground tunnel to the treatment mall?*

*Respondent 1: Or out to the yard.*

*Respondent 3: Or outside.*

*Respondent 1: Which has access to the outside. And that’s why you’re limited -*

*Respondent 2: Including forensic patients.*

*Respondent 1: -- to the numbers because you can’t keep track. And we’ve lost people -- we lost, what, three in a week?*

*Respondent 3: STA was catching them. That’s the bus service into Spokane.*

*Direct Care Provider Focus Group*

*“I have groups over in the mall where I will have sometimes all FSU patients and no FSU staff but me. And I’m not FSU. I’m APU. And that happens a lot. Or one day I escorted five of FSU’s patients. I don’t know anything about these people. Absolutely nothing. And I escort them to the other end of the hospital by myself.”*

*Direct Care Provider Focus Group*

*“I was told by a supervisor that policies are just guidelines. Well, in my -- I’ve been a nurse for 29 years. And policies are what protect my license.”*

*Direct Care Provider Focus Group*

Supervisors were more positive than direct care staff in their perceptions of workplace violence policy at Eastern State Hospital. A new policy effective February, 2009, ESH 2.2, *Disruptive and Intimidating Behavior by Staff*, had recently been introduced and presented to hospital employees. Supervisors reported that hospital employees were asked to read the policy and sign a HRDS form. One manager did not appear to know the details of the policy and reported that there was no training for supervisors on how to implement the policy.

Another supervisor acknowledged not being familiar with all policies especially when they are needed only on occasion. This supervisor relied on a policy book to look up policy as needed. Finally, a manager commented on the usefulness of the policy and how a strong policy is an effective tool to support decisions in response to handling occasional staff interpersonal conflict.

*"I thought the content was much more specific and I think they were much stronger guidelines. I remember commenting and saying, 'Boy, I wish I had this at that time because it really would have strengthened my position' - and my position was fine. It would have placed that emphasis with the employees on how serious of an issue I considered it."*  
 Manager

SHARP researchers reviewed the new policy and found it to be a strong policy, linked to other DSHS policies such as Standards of Ethical Conduct for Employees and Discrimination and Harassment Prevention. There were clear procedures for action outlined in the policy with detailed actions for supervisor response, monitoring and intervention. We also assessed Eastern State Hospital's Code of Ethical Conduct which was reviewed February, 2009, and found it to be a clearly explicated, detailed policy in alignment with DSHS and TJC recommendations.

As stated previously, strong policies are not sufficient to prevent workplace violence. Supervisors have a critical role in communicating and enacting policies consistently to foster a therapeutic and safe environment for patients and staff. All hospital policies and procedures should be followed consistently to reduce nursing practice variance and prevent accidents, violence, and injury. If a policy or procedure is not followed, there should be documentation including what was done and a rationale for the change.

#### **Recommendations for Organizational Culture: Workplace Violence Policy**

- Create a Workplace Violence Policy and introduce it to employees in the new employee and annual refresher assault prevention training. Train managers on the policy and how to implement it.
- Encourage accountability to follow policy and procedure in job descriptions,

performance reviews, and new employee orientations

- Empower staff to voice concerns over inconsistencies in policy and procedure enactment
- Provide continuing training to nursing staff on policies/procedures
- Train supervisors on why and how to consistently implement policy and procedures and the importance of reducing nursing variance.
- Train managers to encourage innovation and problem solving toward increasing safety behaviors, a safe environment, and creating a culture of non-violence.
- Train managers to speak to non-violence safety culture issues in daily communications and through role modeling effective safety behaviors.
- Train managers to build teamwork, communication, and support.

#### **Organizational Culture: Reporting Violent Incidents**

It has been estimated that as few as one in five violent events are reported in psychiatric settings (Mayhew, 2000). Typically, violent acts that result in injury to patients or staff are reported, whereas acts of physical violence that do not result in injury are not reported. Verbal or nonphysical types of violence and sexual harassment also tend to not get reported. Findorff, McGovern, and Sinclair (2005) found that 43% of physical violence incidents and 61% of nonphysical violence incidents went unreported in any form. In another study, (Findorff, McGovern, Wall & Gerberich, 2005), reporting among health care workers was low and most reports were oral and to the supervisor. Women tend to report more often than men and also experience more health symptoms related to exposure to violence.

Several factors may explain the low incidence of reporting. Thirty-two percent of assaulted employees and 8% of those experiencing nonphysical violence reported that they considered violence to be part of the job, whereas others felt they were informing on a coworker or were concerned that reporting the incident would negatively impact their working relationships.

Verbal violence is another form of workplace aggression and has been linked to negative consequences, including anxiety, depression, and stress (Spector, Coulter, Stockwell, & Matz, 2007). In psychiatric settings, verbal aggression from patients directed at staff can occur frequently, is generally not considered reportable, and the negative effects are often unrecognized as a stressor for patients and direct care providers. *RCW 72.23.400 states that state hospitals will address “development of criteria for determining and reporting verbal threats.”*

There have been a number of reasons cited for the underreporting in psychiatric settings:

- unclear definition of violence and what is reportable (Lanza, 1988)
- perception that violence is part of the job (Findorff, McGovern, and Sinclair, 2005; Poster & Ryan, 1994)
- peer pressure not to report (Lanza, 1988)
- organizational culture (Mayhew, 2000), including onus on the victim to be proactive and make the complaint (Jackson, Clare, & Mannix, 2002) and the employer’s belief that it would be too costly to institute protective measures for the staff
- fear of blame of provoking the assault or being negligent (Lanza, 1992)
- victim’s self-blame (McCoy & Smith, 2001)
- stigma of victimization, embarrassment (Mayhew, 2000) isolation, and fear of judgment
- fear of job loss (Poster, 1996)
- excusing the behavior of “ill” patients (Mayhew, 2000)
- time-consuming, ineffective, or gender-biased reporting mechanisms (Mahoney, 1991)
- no benefit, personal or organizational, of reporting (Poster & Ryan, 1989)
- negative experience with prior reporting

*RCW 72.23.410 requires state hospitals to address the “use of the multidisciplinary treatment process or other methods for clinicians to communicate with staff regarding patient treatment plans and how they can collaborate to prevent violence.”* Accurate reporting is necessary to include patient verbal and physical assaultive behavior

incidences in the patient’s treatment plan with the goal of preventing further disruptive behavior.

Without accurate reporting, employers are unaware of the level of violence in their workplace and may not take corrective action to prevent its recurrence. Under high stress conditions of patient verbal and physical aggression on some wards, the quality of the ward milieu is compromised with negative impacts on patients and on direct care providers’ health and well-being.

### **Findings for Reporting Violent Incidences**

The interview data from direct care providers, supervisory nurses, and managers showed some variability in response to the issue of reporting, but also an acceptance of violence on the job as normative with serious physical injury most likely to be reported. Nursing staff generally agreed that reporting was difficult and time consuming and a factor in underreporting patients to staff assaultive incidents. Patient to patient assaults were noted as a less cumbersome reporting process and were always reported.

*“It’s extensive and it’s confusing and you have to go to 10 different people to fill things out. People don’t do it because of that.”*

*Direct Care Staff Focus Group*

*“And quite honestly, I’ve only filled out L&I things in the 13 years four times and it was all for broken bones. Other than that, when you get punched in the back of your head or whatever it’s like, why, because then you’re going to have the L&I side that’s going to fight you and question it and L&I is very hard to deal with.”*

*Direct Care Staff Focus Group*

*“I will say that, you know, what I was referencing patient to staff assault. If it’s a patient to patient assault it’s all reported. It’s not quite so cumbersome. It’s a little easier to-- to do.”*

*Direct Care Staff Focus Group*

*“I got bit by a patient. I had my glove on, it was clear to me that it didn’t break the glove. I could feel it--it cut the skin but my glove was intact. I mentioned it to my supervisor but I didn’t go through the*

*official channels to report that. It was not worth my time. We're encouraged to do all of that. But as an employee, I have to decide for myself is this really what I need to do."*

*Direct Care Staff Focus Group*

One manager's approach was particularly supportive of staff following an assault and took immediate action on behalf of the staff to begin filling out forms for reporting the incident.

*"But the minute that a staff member of mine has hands laid onto them by another patient -- and it doesn't matter if it's a push, if it's a slap or anything else on that point on up. Then I start getting the assault packets out . . . because I do believe that there's a state law in place for a reason. And that's to protect us. And that we have to exercise our right in using that."*  
*Supervisory Nurse*

Other supervisors and direct care providers acknowledged leaving it to the staff person to initiate reporting and not encouraging them to report. The quote below appears to reflect a level of apathy or inurement towards violence in the hospital psychosocial environment. From the number of interviews we conducted we could not determine the extent or source of this attitude towards violence.

*"If any of us are assaulted I have a-- I have a great supervisor and that's never been an issue. Never felt that I couldn't report it. Sometimes people just don't want to fill out the paperwork and then they'll come to work and they'll be hurt."* *Direct Care Staff Focus Group*

Direct care staff and managers indicated that verbal aggression and other low-level physical assaults were often charted in the patient's record rather than reported through the Unusual Occurrence Report Form. It was not completely clear if this was a reporting procedure or used only in some severe cases of verbal assaultiveness.

#### **Recommendations for Organizational Culture: Reporting Violent Incidents**

- Hospital policies and procedures for reporting need to be reviewed and amended to ensure clear criteria for

determining and reporting efficiently and consistently all physical and nonphysical or verbal assault incidents.

- Supervisory nurses should encourage direct care providers to report all incidences of physical and verbal violence in writing to document accurate levels of exposure.
- Compile data in a report to the Safety Committee for discussion about innovations in policy and procedures for prevention of future incidents.
- Streamline reporting forms for direct care staff.
- Employ a research data analyst to design a data tracking system and analyze data for trends.
- Work with direct care staff, union representatives and middle management to streamline incident reporting.

#### **Organizational Culture: Social Support**

Social support from the organization, immediate supervisor, and coworker-teams is a component of organizational culture. Debriefing is a specific form of support designed specifically to follow-up an assault, and incivility is a form of negative personal interactions that employees find distressing and unsupportive. In this section, following an overview on social support, we present organizational, supervisor and coworker-team support findings, followed by debriefing and incivility findings.

#### **The Organizational Context**

Prior research has shown a direct relationship between health care management style and several issues including group cohesion, turnover intentions, job stress, organizational commitment, and actual turnover (Force, 2005; Laschinger & Finegan, 2005; Laschinger & Havens, 1997; Leveck & Jones, 1996; Shabbrook & Fenton, 2002; Taunton, Boyle, Woods, Hansen, & Bott, 1997; Volk & Lucas, 1991). Health care researchers also have acknowledged the importance of hospital climate factors such as organizational support, trust, and decision involvement (Aiken et al., 2002; Laschinger & Finegan, 2005; Laschinger & Havens, 1997; Scott, Sochalski, & Aiken, 1999). These findings highlight the idea that stress research needs to study how the work context influences direct care providers' experiences. Three relevant features of the context

include: perceived organizational support, perceived supervisor support and coworker support.

**Perceived Organizational Support.** Perceived organizational support (POS) reflects employees' sense that their organization values them, recognizes their contributions, and is concerned with their welfare (cf. Eisenberger, Huntington, Hutchinson, & Sowa, 1986). POS theory predicts that employees who feel stronger support from their employer will respond with more favorable job attitudes and behavior and should have more favorable injury and retention outcomes. A meta-analysis of over 70 studies on POS strongly supported this idea, showing that employees with higher POS report less work stress, more favorable job attitudes, stronger organizational commitment, increased job performance, and lower turnover (Rhoades & Eisenberger, 2002).

Patient care depends on the smooth operation of several different systems and units. Direct care staff feel appreciated and supported when these systems run smoothly and when management introduces new programs that help these systems function more effectively. When workers believe management is committed to improvement, workers are more likely to adopt behaviors that lead to successful improvement, such as compliance with new safety procedures (Zohar, 2002). When senior management solves problems as they arise and are communicated from nursing staff (instrumental support) with strong and substantial actions, they build a climate for improvement and support (Choo, 2007; Tucker & Singer, 2009). Examples of organization supports include:

- Ensuring adequate staffing levels through hiring to fill potential gaps in patient care.
- Seeing other groups or committees take action to remedy a concern raised by the staff - having the problem actually be addressed.
- Seeing improvements in morale because of important changes to scheduling or staffing policies.
- Creating a culture of safety and reporting that includes follow through using data tracking and analysis for decision making that impacts patient and staff safety.

**Perceived Supervisor and Co-worker Support.** A great deal of organizational literature has established that employees' work experiences are

strongly affected by perceptions of the quality of their relationship with their supervisors and coworkers. We use the term perceived social support to refer to employees' perceptions of the extent to which their supervisors and coworkers provide emotional support (i.e., chances to express negative emotions) informational support (i.e., knowledge that makes one's work live easier), and instrumental support (i.e., tangible actions to help the employee).

For direct care providers, three important groups of coworkers include their nursing staff colleagues, supervisory nurses, and managers. Prior literature on social support strongly suggests that the more support nursing staff receive from their coworkers, the more favorable their occupational health outcomes (e.g., Rhoades & Eisenberger, 2002) and often shows that perceived support can buffer employees from the adverse effects of job stressors (DeLange, Taris, Kompier, Houtman, & Bongers, 2003).

*Supervisor support* referred to positive social interactions in which direct care providers received critically needed help from supervisory nurses and managers. Examples include supervisors who:

- Assist in making schedule changes to help staff balance work and family responsibilities.
- Provide recognition and appreciation of staff successes.
- Ensure providers receive Therapeutic Options training annually.
- Role model safety behaviors such as de-escalation and responding quickly and respectfully to patient requests.

*Coworker support* referred to positive social interactions in which nursing staff received critically needed help from coworkers. Examples include colleagues who:

- Go out of their way to be helpful during orientation.
- Cover shifts for a sick colleague.
- Support the colleague during difficult circumstances.

### **Findings for Organizational Support**

Interview data revealed a pervasive belief among direct care staff and the middle managers who supervise them that upper level management are disconnected from the realities of what occurs

on the wards. Specifically, direct care staff reported feeling expendable to upper management. Middle managers reported a lack of connection and presence of upper level management. the importance of relationships between management, nursing staff, and patients.

*"We're secondary because I guess we don't bring them in any grant money or any funding at all. So quite honestly, they're willing to sacrifice us in order to bring in funding." Direct Care Staff*

*"From what I'm hearing over the years, a lot of staff don't feel that they're supported by management or the administration or Olympia, and I think that I've heard reoccurring are complaints that they feel that we're being paid to get hurt. There are a lot of staff hurt a lot. They don't feel that administration cares." Supervisory Nurse*

*"I think for a lot of the upper echelon, I don't think they do know because they have not been there. But I think it's important that staff see the supervisors and the CEO once in a while. It'd be nice if the administration could become a little bit more engaged in who is working for them." Manager*

*"I've never seen anybody from nursing management above my supervisor on the unit whatsoever on my shift. I really do believe that the further away you get from the events, the less you really understand of what's happening down here." Manager*

### **Findings for Supervisor Support**

Supervisor support and leadership are extremely relevant for patient and staff safety. In the psychiatric hospital setting, upper level managers, and RN4s, are influential on the wards through their occasional presence. The charge nurse is also influential in the role of immediate supervisor to floor staff. If trained well, active and engaged managers will increase safety on the ward and will:

- focus on hospital goals and values and implement policy consistently
- role model safety behaviors, ethical behavior, and high patient care standards

- give direct care staff individual attention, focus on staff skills, build team bonds and strengths
- build confidence and team trust among nursing staff, promote team teaching and mentoring
- communicate concern through delivery of safety messages to staff and patients
- provide support for incident report submission
- suggest and seek new ways of working effectively and safely

The qualitative data reflect a variety of perspectives on supervisor support including recognizing its importance and providing examples how supervisors give support. Manager interviews convey that building relationships with staff, providing clear communication, being available to staff and setting clear boundaries are important mechanisms of support and direct care staff interviews show agreement.

*"I think people respect those supervisors who are front and center. It's their ward, it's their patient, the staff are supporting them... My supervisor is right there. I support him and I also feel support from him. If I have a problem I just have to say hey-- I need you here right now and he's that fast, he's there." Direct care staff*

*"...really good communication patterns for everyone. That builds trust between you and the staff. And it also makes them feel like, um -- it makes the staff feel supported so that they don't feel like, you know, you're turning your back on them." Manager*

*"And I make certain that I -- if there's a raucous or something going, I'm there as quickly as I can be. And yet at the same time, not being the boss. Not being in the front. If someone else is handling it and they're doing a good job, stay in the background, observe." Manager*

While direct care staff reported that they can rely on their supervisors for support with patients, they also reported that they are more likely to hear negative feedback about tasks that are not done than given credit for a job well done. Even informally, acknowledgement of good work practices, are dependent on the supervisor.

Management interviews indicate an effort by supervisors to recognize their staff and an acknowledgement that they could do more for recognition.

*"But I will say the RN4 on GPU and I don't know if you guys have had the same, uh, experience with it has absolutely complimented the care that the patients on B ward receive and says they look great, they look comfortable, they're clean, their hair looks nice and I'm really happy with the care that's being given on this ward. And he's said that to me and he's the RN4."*

*Direct Care Staff Focus Group*

*"Counsel them later on about, 'Did a great job. You were on time. You know, you said the right things at the right time. You don't get pissed off. You don't take anything personal.' And for some people, it's hard when they get spit in the face." Manager*

*"The most valuable tools I have here at Eastern State Hospital to work with are my staff members. Because like I said, safety and respect with everybody else like that is a priority with me out there like that." Manager*

*"And so I do encourage them to do that. Um, if I have a staff member that's actually physically injured in the process, then I take it upon myself and start filling out the packet. I've had a guy that got his ankle broke on the ward one time because of an action. And we took care of the patient. Then I started writing up the assault packet and assured him that I did everything I could with the packet and stuff so he would be able to get his benefits from the assault process." Supervisory Nurse*

*"If somebody's doing something, I've learned it doesn't hurt one bit to come up to somebody and say 'Thank you for what you've done.' Right then and there. Or, 'Hey, could you please do it this way?'" Supervisory Nurse*

*"I get so involved with some of the stuff, I definitely need to do a better job in giving them some positive feedback for what*

*they're doing right. I think-- I don't have a problem telling them what they're doing wrong." Manager*

Across all levels of the organization, evidence in the data indicated that time is the main barrier when it comes to recognizing staff either formally or informally; affecting communication between staff and their supervisors.

*"There is employee recognition monthly, employee of the month thing, annually even. Then in the evaluation process, there is supposed to be quarterly reviews, and mostly those should be positive. They don't always happen. You know, mostly it's because of time."*

*Direct Care Staff Focus Group*

*"So if I can get ten hours a week sitting on the floor, doing floor stuff, interacting with the patients and stuff like that, I consider that a good week." Supervisory Nurse*

### **Debriefing Following Violent Incidents**

Violent and traumatic incidents may evoke stress reactions. Schat and Kelloway (2003) found that support (e.g., showing concern, listening to the victim's story) from coworkers and managers had a positive effect on study participants who were primarily nurses, patient care assistants, counselors, and social workers. The support reduced worker's negative physical and psychological symptoms and negative attitudes toward their work. Although social support was identified as an effective strategy for protecting against the negative consequences of violent events, Schat and Kelloway reported that the support had no effect on a worker's fear of future workplace violence. They suggested that this fear must be addressed through interventions such as formal debriefings or professional counseling sessions to increase the social support of a worker.

Individuals experiencing or witnessing workplace violence may use incident debriefing as a means of coping with the trauma. Debriefing offers frontline nursing staff immediate emotional support from peers and enables them to recognize, understand, resolve, and normalize their reactions. Sharing common experiences synthesizes this process and contributes to understanding the events and learning from them for future prevention of violent incidents. Immediate social support is a key element of debriefing. Debriefing may also include

education about normal stress reactions and referrals to appropriate resources.

The Critical Incident Stress Management (CISM) debriefing process involves members approaching a scene and quickly assessing the event. It also involves getting a sense of where each person was when the incident occurred and finding a safe and private place to see as many people involved as possible. Direct care staff experiencing trauma are more likely to recognize the normalcy of their reactions by sharing their feelings, thoughts, and perceptions with each other through debriefing. Participating in CISM debriefing is typically voluntary. If debriefing includes problem solving for future events, it is critical that staff not feel that fingers are being pointed at them in blame for their actions in a rapid sequence of events. This is a particularly sensitive issue in a psychiatric hospital setting because direct care staff work under the threat of investigation for patient abuse.

#### **Findings for Debriefing Violent Incidents**

Interviews reveal that the debriefing process at ESH takes place on a largely informal basis and is not a standardized process. When debriefing does occur it is done by the supervisors and their staff who experience the traumatic event. Interviews do not reveal a consensus on the presence of a formal debriefing process. It was reported that Eastern had a CISM team; however, there is some disagreement between interviews whether it is currently in use. Barriers to receptiveness of staff involved in critical incidents to debriefings were captured by interviews with management. The culture within the psychiatric medical field typically supports the belief that violence and assaults are to be expected as part of the job. This may impact the willingness of staff to take part in a debriefing process. One manager reported on a traumatic incident involving his staff for which no formal debriefing was conducted. Managers and supervisors of affected staff would also benefit from a debriefing process.

*"We used to have a critical incident stress management team. And it just kind of fell apart." Direct Care Provider Focus Group*

*"I've seen too many times where people have been injured and there's no support there to get them through it." Supervisory Nurse*

*"We have some clinical nurse specialists.*

*We have a debriefing team. And that tends to help a little bit. But sometimes, um, the staff are reluctant to open up because the debriefing team and maybe even the psychologist weren't there. You know, 'You weren't dealing with what I was dealing with.'"* Supervisory Nurse

*"It's strictly informal." Manager*

*"I think what we fail to do as management-- we don't really have a formalized process and most, um, many staff won't admit that they would need that anyway, um, because--there is-- I think there is a lot of men here that have that ego, you know, I don't need that - I'm okay and it's expected that I deal with this one.*

*But it-- it's a cultural thing. You can see that they're really-- they were really traumatized by this. It really affected them. And I wish we had something in place and part of that is, is it almost reinforces that management doesn't care. But if we had it in place they might also-- they might not take advantage of it anyway." Manager*

*"What I think I could do better of and that the hospital could do better of is-- is to have some debriefings after these. Well, you never see any debriefings." Manager*

It is vitally important for Eastern State Hospital to address the need for safe debriefing following a violent incident. Victims of workplace violence have an increased risk of long-term emotional problems and post-traumatic stress disorder (PTSD). If direct care providers are not comfortable discussing incidents with coworkers and hospital clinical staff, they may make use of the hospital Employee Assistance Program (EAP). An EAP can provide post-trauma services to employees and often employs counselors who specialize in helping employees who have lived through a traumatic incident or else can refer the victim(s) to a local crime victim counselor or other mental health specialist. EAP staff may understand the culture of the work environment and thus be better able to assist employees after an incident. Before seeking assistance from an EAP, employees should be assured that their discussions with the counselors will remain confidential.

## **Incivility - Disruptive Behavior**

Interpersonal conflict is increasingly recognized as an important issue in the health care workplace. Interpersonal conflict can range from workplace violence to incivility. Incivility typically consists of low intensity but stressful events involving mistreatment by a patient or coworker, such as being treated rudely by a patient, being spoken to in a demeaning manner by a manager or doctor, or getting into an argument with a coworker (Andersson & Pearson, 1999).

Rosenstein & O'Daniel (2005) found that nurses were nearly as disruptive as physicians. Other professional and care providers in the hospital environment have also been reported as engaging in disruptive behavior on the job (Walrath, Dang & Nyberg, 2005). Other researchers have estimated that as many as 90% of hospital staff experience some form of verbal abuse at work (Winstanley & Whittington, 2002).

Some research links incivility to retention. Cortina et al. (2001) found that greater exposure to incivility was associated with lower job satisfaction, increased psychological distress, and stronger intentions to leave the organization. Similarly, Guidroz, Wang, and Perez (2006) found that interpersonal conflicts with doctors, patients, and supervisors influenced nurses' retention outcomes by increasing their emotional exhaustion. Walrath, Dang, & Nyberg, (2005) found that 48% of nurses reported knowing a nurse that had transferred to another unit or department due to disruptive behavior. Nurses (34%) also reported that they knew of nurses leaving the organization because of disruptive behavior.

Workplace violence has been recognized as a significant performance and health concern for nurses (e.g., Lanza, 2006). However, while physical violence consists of intense but often isolated events, disruptive behavior or incivility appears to be wide spread and, more importantly, is implicated in patient safety.

The Joint Commission published a Sentinel Event Alert on intimidating and disruptive behaviors in health care organizations that undermine a culture of safety - this document includes requirements for a new leadership standard (LD.03.01.01) effective January 1, 2009 and suggested actions for organizations (The Joint Commission, 2008). According to TJC, disruptive

behavior is verbal or physical personal conduct that negatively affects or potentially may affect patient care - among the behaviors mentioned is conduct that interferes with other members of the healthcare team (2008).

The impact of disruptive behavior is costly for organizations - it causes distress among other staff, undermines productivity, leads to low morale and high staff turnover, and results in ineffective, substandard patient care, poor adherence to practice guidelines, medical errors and adverse outcomes, loss of patients, and malpractice suits (Rosenstein & O'Daniel, 2005; TJC, 2007).

Providing high quality patient care requires collaboration – defined as “Physicians and nurses and other care givers working together. Sharing responsibility for solving problems. And making decisions to formulate and carry out plans for patient care” (Baggs et al., 1999, p. 1991). Collaboration requires open communication and mutual respect in addition to collective decision making. Incivility and disruptive behavior interrupt good collaborative communication and reduce staff safety and patient safety and quality of care (Rosenstein & O'Daniel, 2008).

### ***Findings for Incivility – Disruptive Behavior***

Incivility and bullying were not viewed by participants as a serious or pervasive problem at Eastern State Hospital. Direct care staff reported either no problem with bullying or if present a very subtle presence but it was not viewed as problematic. Managers reported that gossiping and exclusion among direct care staff are the most common forms of incivility at Eastern State Hospital. However, managers also indicated that they tend to respond in a proactive manner to immediately address the issue.

For example, managers reported setting expectations for behavior, in regards to bullying and incivility, and holding staff accountable for participation in such behavior. Some managers also reported including these expectations in staff's performance reviews. These types of behavior are not tolerated by nurse managers because they are viewed as a threat to the integrity of the team environment which compromises the staff safety.

*“I have never run into it.”*

*Direct Care Focus Group*

*"I haven't ever felt like I was bullied."*

*Direct Care Focus Group*

*"It's subtle if it occurs. There have been a couple incidents where I think it's been somewhat blatant with just a few individuals but not necessarily supervisors."*

*Direct Care Focus Group*

*"I don't see it. Not to say it doesn't happen, but I'm saying I don't see it." Manager*

*"And I'm going to put this in your evaluation. This is going to come up on our quarterly review. And it's going to be along the lines of being able to be a team member and to be able to work with your fellow employees. And this affects everybody because the patients see it, too. They see it when you turn your back on someone. They see it when you're rude to someone. And for the staff, each of us as staff members get enough crap from the patients without you giving it to that person, too." Manager*

*"I think spreading gossip should be reported. I think raising your voice at somebody should be reported. I think that those things need to be addressed early before it gets to the point of pushing. I mean, I've been a recipient of-- of rumors and gossip before that it was just blatant. It was very frustrating for me, but the malicious nature of it is what really bothered me - that somebody was going to some kind of lengths. I don't think people should have to be subjected to that sort of thing." Manager*

### **Recommendations for Organizational Culture - Social Support, Debriefing, and Incivility**

- Train upper level management and unit supervisors on organizational, supervisor and coworker-team support behaviors and how to foster those in the organization to create a culture of nonviolence and support for safety.
- Train managers to encourage innovation and problem solving toward increasing safety behaviors, a safe environment, and creating a culture of non-violence.
- Train managers to speak to non-violence safety culture issues in daily communications and through role modeling effective safety behaviors.
- Train managers to build teamwork, communication, and support.
- Reinvigorate the CISM debriefing team and obtain ongoing feedback from direct care staff on the functioning and effectiveness of the team to shape it to meet their needs. Ask staff how they want to be debriefed and tailor the process to meet their needs.

### **Training and Education**

The long-held belief that violence is part of the nursing job, and that it is an inherent nursing occupational hazard, is thought to limit the extent of violence prevention training and education in the nursing workforce (Pieri, 2004). However, training and education should be a primary focus in psychiatric hospitals where direct care providers are at higher risk for workplace violence. Washington RCW 72.23.400 requires that state psychiatric hospitals provide an assault prevention and protection plan and a training program for employees.

The severity of workplace violence in psychiatric facilities and consequences of assaults and injuries are well documented. For example, Love and Hunter (1996) documented staff injury rates in six state psychiatric hospitals that ranged from 11.7 to 16.9 injuries per 100 employees. In addition, the lack of research-based violence prevention standards has left thousands of nurses working in hazardous conditions. Aggression and violence are costly to the institution (Hunter & Carmel, 1992) and result in considerable psychological impact for the staff (Duxbury, 1999; Lanza, 1992; Love & Hunter, 1996; Ryan & Poster, 1989). Direct care providers assaulted by their patients may experience loss of time from work, financial costs and protracted psychological repercussions, including posttraumatic stress responses. In one study, the cost to one hospital for a single assault in terms of lost time and legal fees was approximately \$250,000 (Hunter & Carmel, 1992).

There are few reliable resources for direct care providers to prevent and effectively manage violence toward themselves, their coworkers or patients in health care settings. One available

resource is formal training. Eastern State Hospital uses Therapeutic Options, a violence prevention training (Partie, 2001) that includes: verbal de-escalation strategies, principles of body mechanics and movement, personal protection skills for staying safe during a behavioral emergency, and aggression management skills (restraints) for containing violent behavior. The training is based on a recovery model with a focus on developing a therapeutic relationship with patients and prevention.

Morrison & Love (2003) evaluated four programs for managing aggression in psychiatric settings and gave the highest score to Therapeutic Options. They did critique the program for the assumption in the training that the patient is cooperating, “when in reality most are resisting or actively fighting” (p. 154). The second critique addressed the point that team techniques are not adequately covered in the training.

### **Findings for Training and Education**

The data analysis theme of *Training and Education* refers to formal staff assault prevention training such as Therapeutic Options and further informal learning opportunities for nursing staff and others providing patient care through violence prevention education on the ward in the form of mentoring. Participant responses on the theme of training and education tended to fall into the categories of barriers to formal training, training transfer, informal training, and training for team roles and safety.

### **Barriers to Formal Training**

Lack of staffing appears to be one of the biggest barriers to adequate formal training. While Therapeutic Options training is available at the hospital, it is very difficult for staff to get someone to cover their shift so that they can go to classes. Managers and direct care staff indicated that the hospital would be safer if more people were able to go to trainings and go more often. Managers noted that it was difficult to send employees for training due to staff shortages.

The general consensus from respondents was that employees are required to go through an eight hour Therapeutic Options training when they are hired, and typically go through a refresher course every two years. Nursing staff and managers agreed that staff did not receive enough training and the recommended schedule for training refresher courses was not always followed.

*“Yeah, that’s an eight hour class that really should be given annually. I don’t think it’s-- I don’t think everybody gets it annually. I think I had it twice in the past eight years.”*  
Direct Care Provider Focus Group

*“I understand from the administrative point. It’s where do I come up with the money to take staff off the wards to give them this kind of training?”* Manager

Direct Care staff also expressed frustration with the delays in getting additional training on personal protective equipment that nursing staff perceive as highly valued and needed.

*Respondent 3: “We’re currently working on this. We tried to put that together in the late eighties. We had to go through the legislators finally to get that done three years ago. And they still haven’t completed or even, I believe, started the training.”*

*Respondent 4: “But they haven’t even written a policy.”*

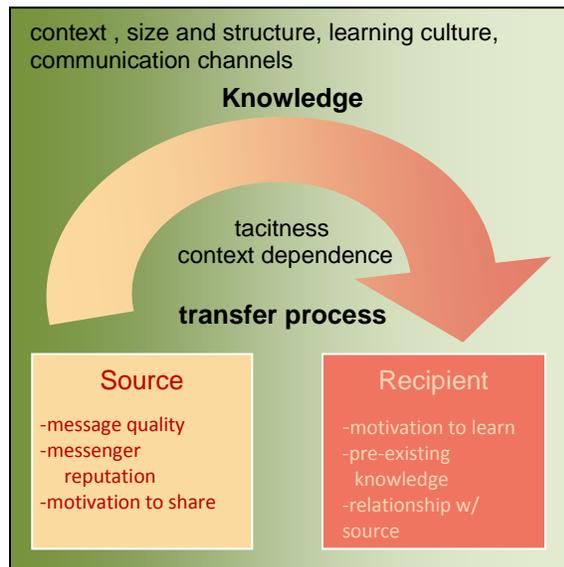
*Respondent 3: “The training, the policy. That’s something we’ve been trying to do for twenty years.”*

Direct Care Provider Focus Group

### **Training Transfer**

*Training transfer* is the appropriate and continued application of skills learned during a training course to the working environment or the unit. Training transfer includes mechanisms for sharing and reinforcing learning such as site visits, refresher lectures, one-on-one communication with a mentor, and face-to-face meetings with colleagues such as in shift report. Mechanisms for integrating new knowledge and skills include written policies and procedures, informal group meetings for problem solving dialogue, and role modeling from experienced coworkers and supervisors. The model and mechanisms for training transfer are presented below in Figure 2.

**Figure 2. Training transfer: A summary**



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<p>☐ mechanisms for sharing</p> <ul style="list-style-type: none"> <li>-site visits</li> <li>-lectures</li> <li>-one-on-one communication with mentor</li> <li>-face-to-face dialogue</li> </ul>	<p>☐ mechanisms for integrating</p> <ul style="list-style-type: none"> <li>-policies and procedures</li> <li>-group meetings/problem solving</li> <li>-debriefing</li> <li>-practice</li> </ul>
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Direct care staff reported that that training transfer from the Therapeutic Options training was very poor. Participants reported that the Therapeutic Options training may be sufficient for situations where patients are compliant and calm, but the training doesn't prepare staff for situations when a patient is agitated and potentially assaultive. Supervisory nurses were consistent in calling for more frequent hands-on training, including training on the units.

*"I think they can get more training. And I think what it would be is -- in all honesty . . . I think there should be a timeframe set aside to where somebody comes around and reviews those processes with you on the unit."*

*Supervisory Nurse*

*"When's the last time that any group of my guys in a session got any kind of hands-on training on the unit on some aspect -- not*

*the whole program -- just some aspect of Therapeutic Options?"* Supervisory Nurse

*"Practice. I don't think we do enough practice. We do CPR over and over and over and over again."* Supervisory Nurse

Certain complex skills such as manual restraint do require repetition so that the proper techniques can be applied safely, preventing injury to the patient or care provider. Team practice also develops confidence in staff that they can rely on one another to perform well when needed.

The quote below provides a clear indication that current training is not adequate or effective. When direct care providers are trained well with opportunity for practice and timely refresher courses, there is no reversion to prior ineffective behaviors. That this occurs is a serious concern because patient and staff safety are at stake.

*"It's amazing how when things do go bad, people revert back to the stuff that they've learned as kids in fights and wrestling and stuff like that, instead of the tried and true -- or the tried and true -- the recommended process. Because one night of training does not last beyond that period of timeframe."* Supervisory Nurse

#### *Informal Training through Peer Mentoring*

Direct care providers indicated that most of their violence prevention skills come from obtaining on-the-ward experience. Supervisory nurses can focus on informal learning through peer mentoring as a way to enhance training transfer. Novice staff will quickly develop new skills for handling agitated patients when seasoned staff with well developed skills mentor them. An additional advantage to peer mentoring is that newly hired employees will be incorporated into the team more readily. If new hires have a mentor to help them learn, they will be less likely to leave the organization. Reduced turnover will increase patient and staff safety due to team stability.

Nurse supervisors and managers have a strong role in informal education on the ward and one manager reported that communicating clear expectations for staff were part of this process.

*“Informal training occurs at any given time. I-- and I also do direct my RN3's to be very clear with their expectations and they direct it with staff.” Nurse Manager*

On overhearing a direct care provider's interaction with a patient, a manager provided an example of intervening to educate the direct care provider:

*“And it was not a tone that would elicit the responses we would want from the patient. So one of the other RN's had picked up on it and kind of intervened and the patient de-escalated and everything was fine. And at that moment it wasn't the time or the place and because it was not what I considered an abusive situation. About a week later when I had contact with that employee. . . he came to me to discuss something, I said and by the way, last week when I was up on the ward I had observed your interaction with this patient.*

*I said I only caught a small piece of that process but what I did observe concerned me because on this particular ward we've got patients that are admitted from the jail, uh, for competency evaluation., I can't make the determination whether someone is sociopathic or whether they're competent or not. My point being that, we need to treat people with respect rather than having, any type of opinions about an individual.*

*And I said I just want you to file that in the back of your mind . . . You're entitled to your opinion but just know these are my standards, these are my expectations. And I want you to be aware of that.”*

*Nurse Manager*

Direct care providers expressed a strong interest in increasing informal learning and sharing successes they experienced when working with patients, especially effective verbal responses.

*“You know when you hear a staff person get into a situation with a patient and they say something that just absolutely works. If there is any way we can write that down and pass it on, it would just help so much.”*

*Direct Care Provider Focus Group*

### *Training on Team Roles for Safety*

We define “team” as every person on the ward during a shift. When an assault occurs, everyone has learned a role and can take action that is appropriate to their position and ability. In this way, everyone feels supported and safety may increase for patients and staff. Depending on how roles are assigned, some staff can be the eyes and ears before and during escalation, others can calm patients, help patients move to safe places, send an alarm, and, if necessary, help with hands on intervention.

One example of needing to train specific response teams was brought up by a respondent who mentioned new equipment recently available for handling assaultive patients under certain circumstances. The training would start once a policy was in place regarding when and how the equipment should be used. The respondent commented on his own limitations as follows:

*“It's taken us almost two years to get it, but that equipment is for dealing with assaultive clients. It is our kneepads, our elbow pads, our breastplate, our helmets. . . Not every employee will be trained. I'm too old to do that stuff. Let's be real honest. I'll do it in an emergency, but I'm not going to do it for a living anymore.” Union Representative*

Eastern State Hospital has an aging workforce as many organizations do. This fact makes frequent, effective training and education in prevention such as de-escalation skills critical for staff. An aging workforce will benefit from a strong, supportive team approach where roles are defined for a variety of safety behaviors that emphasize prevention and, when needed, safe interventions.

### **Recommendations for Training and Education**

- Make training a priority and look for creative ways to work with the challenges presented by current problems of low staffing levels.
- Schedule staffing to account for a ratio of experienced to new staff that facilitates training transfer, skill development, and teambuilding.

- Match new staff to more experienced staff to create a formalized peer mentoring program that will improve training transfer to the wards.
- Increase patient and staff safety by increasing formal and informal modes of training.
- Ensure that physically capable staff get adequate practice on physical techniques needed for safe evasion from holds and restraint practices.
- Train team members unable to assist in physical restraint practices for specific role safety behaviors preceding, during, and after assaults.

#### **Qualitative Study Limitations**

Sample size adequacy and sample composition are concerns with the current study. Due to time and financial constraints we conducted a limited number of interviews and observations. We focused on interviews with nursing staff that have the highest level of contact with patients and also with managers, some with nursing backgrounds and others with administrative backgrounds. Given more time and resources we would have interviewed across disciplines including psychiatrists, psychologists, sociologists, and others who participate on treatment teams or are employed on the units. Because sample size was small, we may have missed those employees and managers who are burned out and disengaged from the organization. Related to this concern, we acknowledge that it is possible that those who did participate may have been the most engaged and dedicated employees as well as the most disgruntled employees. Increasing the number of interviews and observations would have allowed us to reach saturation or completeness in our data collection and would have improved our ability to do a more complex and comprehensive qualitative data analysis.

#### **Summary of Recommendations by Theme**

There are many detailed recommendations here as we thought this may be of benefit to Eastern State Hospital. We recognize that the hospital may have a quality management plan and may have initiated changes that we may be unaware of because we have not examined a plan. In light of this, we hope that some of these recommendations will be validating, if the hospital has already

undertaken them, and that there will also be some recommendations that will provide new ideas for the hospital to consider and possibly incorporate into a quality management plan for long-term organizational change.

#### **Recommendations for Control: External and Internal and Schedule Control**

- Bring union and management groups together to revise vacation guidelines to increase schedule flexibility.
- Hire additional direct care staff and identify mechanisms to ensure that consistent teams provide patient care on each ward. Adequate numbers of stable staff should reduce use of practices such as overtime, floating staff, and unscheduled absences.
- Provide a means for staff inclusion in planning and decision making in key areas of concern for direct care staff.
- Limit use of mandated and voluntary overtime.
- Create a float pool of permanent workers who have the ability and desire to function in this capacity.
- Identify options to increase schedule flexibility for direct care nursing staff.
- Create a culture of schedule control.

#### **Recommendations for Organizational Culture: Workplace Violence Policy**

- Create a Workplace Violence Policy and introduce it to employees in the new employee and annual refresher assault prevention training. Train managers on the policy and how to implement it.
- Encourage accountability to follow policy and procedure in job descriptions, performance reviews, and new employee orientations
- Empower staff to voice concerns over inconsistencies in policy and procedure enactment
- Provide continuing training to nursing staff on policies/procedures
- Train supervisors on why and how to consistently implement policy and procedures and the importance of reducing nursing variance.

#### **Recommendations for Organizational Culture: Reporting Incidents**

- Hospital policies and procedures for reporting need to be reviewed and amended to ensure clear criteria for determining and reporting efficiently and consistently all physical and nonphysical or verbal assault incidents.
- Supervisory nurses should encourage direct care providers to report all incidences of physical and verbal violence in writing to document accurate levels of exposure.
- Compile data in a report to the Safety Committee for discussion about innovations in policy and procedures for prevention of future incidents.
- Streamline reporting forms for direct care staff.
- Employ a research data analyst to design a data tracking system and analyze data for trends.
- Make training a priority and look for creative ways to work with the challenges presented by current problems of low staffing levels.
- Schedule staffing to account for a ratio of experienced to new staff that facilitates training transfer, skill development, and teambuilding.
- Match new staff to more experienced staff to create a formalized peer mentoring program that will improve training transfer to the wards.
- Increase patient and staff safety by increasing formal and informal modes of training.
- Ensure that physically capable staff get adequate practice on physical techniques needed for safe evasion from holds and restraint practices.
- Train team members unable to assist in physical restraint practices for specific role safety behaviors preceding, during, and after assaults.

***Recommendations for Organizational Culture: Social Support, Debriefing, and Incivility***

- Train upper level management and unit supervisors on organizational, supervisor and coworker-team support behaviors and how to foster those in the organization to create a culture of nonviolence and support for safety.
- Train managers to encourage innovation and problem solving toward increasing safety behaviors, a safe environment, and creating a culture of non-violence.
- Train managers to speak to non-violence safety culture issues in daily communications and through role modeling effective safety behaviors.
- Train managers to build teamwork, communication, and support.
- Reinvigorate the CISM debriefing team and obtain ongoing feedback from direct care staff on the functioning and effectiveness of the team to shape it to meet their needs. Ask staff how they want to be debriefed and tailor the process to meet their needs.

***Recommendations for Training and Education***

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**Appendix - RCW 72.23.400 - RCW 72.23.451****RCW 72.23.400 Workplace Safety plan**

(1) By November 1, 2000, each state hospital shall develop a plan, for implementation by January 1, 2001, to reasonably prevent and protect employees from violence at the state hospital. The plan shall be developed with input from the state hospital's safety committee, which includes representation from management, unions, nursing, psychiatry, and key function staff as appropriate. The plan shall address security considerations related to the following items, as appropriate to the particular state hospital, based upon the hazards identified in the assessment required under subsection (2) of this section:

(a) The physical attributes of the state hospital including access control, egress control, door locks, lighting, and alarm systems;

(b) Staffing, including security staffing;

(c) Personnel policies;

(d) First aid and emergency procedures;

(e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts;

(f) Development of criteria for determining and reporting verbal threats;

(g) Employee education and training; and

(h) Clinical and patient policies and procedures including those related to smoking; activity, leisure, and therapeutic programs; communication between shifts; and restraint and seclusion.

(2) Before the development of the plan required under subsection (1) of this section, each state hospital shall conduct a security and safety assessment to identify existing or potential hazards for violence and determine the appropriate preventive action to be taken. The assessment shall include, but is not limited to analysis of data on violence and worker's compensation claims during at least the preceding year, input from staff and patients such as surveys, and information relevant to subsection (1)(a) through (h) of this section.

(3) In developing the plan required by subsection (1) of this section, the state hospital may consider any guidelines on violence in the workplace or in the state hospital issued by the department of health, the department of social and health services, the department of labor and industries, the federal occupational safety and health administration, Medicare, and state hospital accrediting organizations.

(4) The plan must be evaluated, reviewed, and amended as necessary, at least annually.

[2000 c 22 § 3.]

**RCW 72.23.410 - Violence Prevention Training**

By July 1, 2001, and at least annually thereafter, as set forth in the plan developed under RCW [72.23.400](#), each state hospital shall provide violence prevention training to all its affected employees as determined by the plan. Initial training shall occur prior to assignment to a patient unit, and in addition to his or her ongoing training as determined by the plan. The training may vary by the plan and may include, but is not limited to, classes, videotapes, brochures, verbal training, or other verbal or written training that is determined to be appropriate under the plan. The training shall address the following topics, as appropriate to the particular setting and to the duties and responsibilities of the particular employee being trained, based upon the hazards identified in the assessment required under RCW [72.23.400](#):

- (1) General safety procedures;
- (2) Personal safety procedures and equipment;
- (3) The violence escalation cycle;
- (4) Violence-predicting factors;
- (5) Obtaining patient history for patients with violent behavior or a history of violent acts;
- (6) Verbal and physical techniques to de-escalate and minimize violent behavior;
- (7) Strategies to avoid physical harm;
- (8) Restraining techniques;
- (9) Documenting and reporting incidents;
- (10) The process whereby employees affected by a violent act may debrief;
- (11) Any resources available to employees for coping with violence;
- (12) The state hospital's workplace violence prevention plan;
- (13) Use of the intershift reporting process to communicate between shifts regarding patients who are agitated; and
- (14) Use of the multidisciplinary treatment process or other methods for clinicians to communicate with staff regarding patient treatment plans and how they can collaborate to prevent violence.

[2000 c 22 § 4.]

**RCW 72.23.420 - Record of Violent Acts**

Beginning no later than July 1, 2000, each state hospital shall keep a record of any violent act against an employee or a patient occurring at the state hospital. Each record shall be kept for at least five years following the act reported during which time it shall be available for inspection by the department of labor and industries upon request. At a minimum, the record shall include:

(1) Necessary information for the state hospital to comply with the requirements of chapter [49.17](#) RCW related to employees that may include:

- (a) A full description of the violent act;
- (b) When the violent act occurred;
- (c) Where the violent act occurred;
- (d) To whom the violent act occurred;
- (e) Who perpetrated the violent act;
- (f) The nature of the injury;
- (g) Weapons used;
- (h) Number of witnesses; and
- (i) Action taken by the state hospital in response to the violence; and

(2) Necessary information for the state hospital to comply with current and future expectations of the joint commission on hospital accreditation related to violence perpetrated upon patients which may include:

- (a) The nature of the violent act;
- (b) When the violent act occurred;
- (c) To whom it occurred; and
- (d) The nature and severity of any injury. [2000 c 22 § 5.]

**RCW 72.23.440 - Technical Assistance and Training**

A state hospital needing assistance to comply with RCW [72.23.400](#) through [72.23.420](#) may contact the department of labor and industries for assistance. The state departments of labor and industries, social and health services, and health shall collaborate with representatives of state hospitals to develop technical assistance and training seminars on plan development and implementation, and shall coordinate their assistance to state hospitals. [2000 c 22 § 7.]