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Safety & Health Assessment & Research for Prevention (SHARP)

The Washington Work, Stress, and Health Project:

Western State Hospital Workplace Violence Report

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**Washington Work, Stress, and Health, Project:
Western State Hospital Workplace Violence Report
Executive Summary**

In April, 2009, researchers from Washington's Department of Labor and Industries SHARP research Program conducted a study to:

- (1) Obtain background information on manager, union, and staff perceptions of workplace violence hazards, solutions, and recent changes;
- (2) Understand the organization of work, workplace culture, and physical and nonphysical workplace violence exposure of the direct care staff in the current work scheduling conditions;
- (3) Review current workplace violence policies, reporting procedures, practices, and assault prevention training;
- (4) Make recommendations for decreasing risk of assault in current operations;
- (5) Provide a substantive report to the hospital's management team on findings generated from interview sessions and observations.

This report summarizes our findings based on three ward observations, focus group interviews with 25 direct care staff, 10 supervisory nurses, and individual interviews with 4 union representatives, and 14 managers/directors at Western State Hospital's campus.

Key results are briefly summarized below:

- (1) Lack of control over work is a serious stressor that impacts staff and patient safety.
 - a) Control issues include external pressures on the organization, and internal control issues such as inadequate staffing levels, lack of direct care staff schedule control, long hours and overwork, and high levels of staff turnover and churn.
 - b) Excessive overtime for line staff at most risk for violence poses an increased safety hazard to patients and staff.
 - c) Excessive use of less experienced intermittent staff poses an increased safety hazard
- (2) The hospital culture and is a serious stressor that contributes to reduced safety, health, and wellbeing of patients and employees at all levels.
- (3) SAFE Team assault prevention training is a critical program with much support from WSH employees. This program could be strengthened. Currently, due to staffing shortages, not all direct care staff are receiving this training.
- (4) The hospital needs an improved comprehensive system for data collection, management and analysis.

At this time, the workgroup has four primary recommendations from this study. They are listed below. Also, JCAHO addresses safety culture in Standard LD.03.01.01. Additional

recommendations are included in this report so they can be addressed over time as the hospital develops and implements its Continuous Quality Improvement Plan.

PRIMARY RECOMMENDATIONS

- (1) *Control over Work* – Increase employee schedule control. Analyze staffing and scheduling systems to provide adequate coverage that allows staff to recover from work stress. Staff for stable work teams and reduce pulling or floating staff. Reduce use of overtime and intermittent staff.**
- (2) *Organizational Culture* – Apply an appreciative inquiry approach to develop a systems level intervention to address organizational culture concerns.**
- (3) *Organizational Culture* – Train managers to role model respectful behavior and safety behaviors, communicate the value of a culture of non-violence and safety, and stimulate enthusiasm for teamwork, communication, and social support at all levels. Outside expert support is needed to guide culture change efforts toward sustainable results.**
- (4) *Training and Education* – Continue to develop and strengthen the SAFE Team training program. Ensure all staff get adequate training. Create a formal peer mentoring program on each ward for seasoned and new staff. The goal is to facilitate SAFE Team assault prevention training transfer, team integration, and development of safety behavioral skills.**
- (5) *Data-based Decision making* - Assess the current hospital data tracking system and develop a comprehensive system for improved data collection, management, and analysis.**

Based on Western State Hospital's readiness for change, new CEO, and the high number of positive interactions we have had with the executive management team, union representatives and direct care staff, we would like to propose future research collaboration. We see opportunities based on our key recommendations that we would be willing to discuss further with the executive management team and others at Western State who have interest. If there is mutual interest, we will gladly submit a research proposal.

Introduction

Western State Hospital Background

Western State Hospital (WSH) consists of three programs, Center for Forensic Services (CFS), Center for Adult Services (CAS), and Center for Older Adult Services (COAS) on a campus in Lakewood, Washington. Approximately 1,947 staff work at the Hospital. CFS has a capacity of 254 patients and provides care and treatment to adults found to be guilty except for insanity and sentenced to supervision. CFS also provides treatment to restore fitness to proceed in a trial to persons who were determined not competent to aid and assist their attorney. CAS has a capacity of 362 patients, and COAS has a capacity of 190 patients. Two treatment malls are cornerstones of patient therapy (Western State Hospital, 2009).

Purpose and Scope of the Study

The risk of work-related violence in psychiatric healthcare settings has long been well-known. The workers compensation claims rates for Psychiatric Hospitals far exceed those for any other industry. A study by the SHARP program (Bensley, Nelson, Kaufman et al., 1993) 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, claims rates for psychiatric hospitals remain as high as in the mid-1990s. Ongoing research efforts strive to determine more about the risk factors, including various situational and environmental factors, which contribute to *workplace violence* in psychiatric health care settings with worker-client interaction. Workplace violence is defined as violent acts, including physical assaults and threats of assault, directed toward persons in a workplace or on duty. Washington House Bill 2899, passed in 2000 to address violence in health care, requires mental hospitals to give employees violence prevention training at least annually and to have procedures for reporting and responding to physical and verbal assaults. To address this issue, the Mental Health Division Director and the Western State Hospital executive management team invited the Washington State Department of Labor & Industries Safety and Health Assessment and Research for Prevention (SHARP) program to collaborate and provide a study regarding the hazards for workplace violence at Western State Hospital. The research activity for this report was comprised of focus group interviews with direct care staff and charge nurse supervisors,

individual interviews with managers, and union representatives, in addition to on-site physical environment walk-through for workplace violence hazard assessment (Appendix A) and observations of the psychosocial environment. 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 (client to worker) workplace violence in the state psychiatric hospital. As defined by 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 that directly interact with the hospital organization affect employee sense of control, a known potential work stressor. Organizational factors of interest are staffing systems, scheduling practices, and availability of violence prevention training for staff. Finally, workplace factors considered were the culture for nonviolence and safety, organizational, supervisor and coworker-team support, and task attributes such as worker-patient interactions, worker-worker interactions, control over work, and physical and psychological demands experienced by state hospital psychiatric direct care providers such as long work hours and lack of control over work schedule.

In summary, the objectives of the study were to 1) Obtain background information on managers' and staff perceptions of workplace violence hazards, solutions, and recent changes; 2) understand the organization of work, workplace culture, physical and nonphysical workplace violence exposure of the direct care staff in the current work scheduling conditions; 3) Review current workplace violence policies, reporting procedures, procedures, and SAFE Team assault prevention training; 4) Make recommendations for decreasing risk of assault in current operations, and 5) Provide a substantive report to the hospital's management team on themes generated from interview sessions and observations.

In the following sections, we will report on the study research methods, procedures, and data analysis approach. The main body of the report comes after and includes the qualitative research findings organized by theme.

Methods

Sampling Frame and Participants

The sampling frame for the consultation and 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 Mental Health Technicians, Psychiatric Security Attendants, Institutional Counselors, and Security Guards were recruited to attend focus groups interviews. Supervisory nursing staff were also recruited for focus groups to obtain information from those whose role was to lead and direct direct care 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. Finally, managers and directors of programs were interviewed individually to obtain perspectives that included leadership roles in managing the organization for workplace violence prevention and intervention as well as union representatives whose role is to influence the organization with the aim of increasing worker health and safety in relation to workplace violence.

To ensure anonymity, we did not collect participant information such as age or gender. We asked participants to describe their work responsibilities and tenure with the organization. Of the 25 participants in the five direct care staff and SAFE Team/CISM focus groups, all were or had been direct care providers on the hospital units, 6 were PSAs, 3 were ICs, and 1 was a PSN. The range of years of service in the hospital was 3-25+ years. The supervisory nurse focus groups were comprised of 10 registered nurses, 8 RN3s and 2 RN4s. The range of job tenure was 2.5-20+ years. The 14 manager and 4 union representatives participating in the individual interviews ranged from upper level managers and directors of programs to direct care providers and supervisory nurses with 3-30+ 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).

Observation of the Physical and Psychosocial Environment

Physical Environment. A walk-through of 3 wards was conducted with the Workplace Violence Hazard Assessment tool. Researchers were guided by hospital staff members who answered questions during the walk-through.

Psychosocial Environment. Researchers conducted on-site observations on three ward communal areas at Western State Hospital. Observation on the ward took place for at least 6 hours and covered three shifts including shift changes. The purpose of the observations was to better understand the psychosocial context of the workplace. Observations can reveal approaches for increasing workplace violence prevention strategies and facilitating supervisors' and coworkers' communication and supportive behaviors. Activities and social interactions were observed and documented in notes. No individual names or personally identifying information was identified or recorded.

Observations included assessing routine practices, communication between supervisor, employee, and coworkers, transporting patients, practices for administering medications, smoking, other planned activities, response to patient requests, and safety behaviors in practice such as verbal de-escalation.

Direct Care Staff and Supervisory Nurse Focus Groups

Five focus group interviews, with 2-10+ employees per group, were conducted to identify salient barriers to reporting incidences, violence prevention strategies, organization and supervisor response to violent incidents, organizational, supervisor and coworker support, communication, violence prevention training, acuity-based staffing, and schedule flexibility, as well as inquiring about recent changes or current conditions that facilitate effectiveness at work toward violence prevention.

Supervisors and non-management employees 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 Interviews

Semi-structured interviews ($N = 14$) were conducted with managers at Western 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.

Union Representative Interviews

Semi-structured interviews ($N = 4$) were conducted with employee/union representatives of the SEIU and AFSCME unions at Western State Hospital. Topics mirrored those covered in management interviews. 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 analysis was 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.

Safety and Health Management

Managing health and safety has been shown to add value to an organization. Two primary components of managing health and safety are management leadership and employee involvement. When management demonstrates that working safely is an organization priority, employees feel more empowered to behave in a manner that will prevent injuries. Furthermore, incorporating employee input for improving working conditions will help develop solutions to caring for patients in a safe, efficient, and therapeutic manner.

Joint Safety Committee and SAFE Team

The Joint Safety Committee can be a valuable tool for addressing the burden of workplace injuries as a result of workplace violence. The Committee is tasked with the

responsibility of assisting the employer with the health and safety management system. This is to be done by informing management of areas in the health and safety program that need to be improved. Joint Safety Committee members should receive training on hazard identification as well as principles regarding effective accident and incident investigations. Options for this training include Washington OSHA workshops such as “Developing Effective Safety Committees.”

The joint safety committee could help in any changes that may be made as a result of this study. At a minimum, the Committee could help perform self-evaluation of any systems setup to prevent employee injury as a result of violence. Ideally, the joint safety committee would fulfill an active role in identifying safety issues including workplace violence with an innovative solution-generating approach.

In addition, the joint safety committee could collaborate with the SAFE Team to focus on solutions to addressing workplace violence concerns. The SAFE Team members work closely with direct care staff on the wards in regard to working safely with patients to prevent or handle workplace violence. Therefore, these members will have a unique perspective on workplace violence safety issues and will likely have innovative solutions.

Study Findings

Overview of Themes

The qualitative data analysis produced themes that are categorized under control over work, organizational culture, hospital environment, 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 exemplifiers of the themes, and bulleted recommendations. To more fully include the voices of those in the organization, we included a table of quotes organized by theme as well (Appendix B).

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 (p. 13-24) 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, 1999a) 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

External Control

“External control” refers to issues related to pressures from outside parties and from the legal/political context in which Western State operates. State funding and laws, the federal Department of Justice and the Civil Rights of Institutionalized Persons Act (CRIPA), the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the court system, the community mental health system, and patient advocacy groups are examples of outside organizations and parameters with impact on Western State Hospital. Under this theme, participants at WSH discussed lack of complete control over admissions and discharges, lack of community support, the patient right to refuse medication, competing demands from among outside agencies, and budget for staff as external control concerns.

Budget for Staff

Lack of staffing is largely due to legislative budgetary constraints the hospital contends with and has for many years. The hospital has appealed to the legislature for more staffing funds in the past. Many workers and managers brought up the lack of sufficient direct care staff as a factor leading to assaultive behavior.

“If we could have more FTEs so that people could take the time with the patients, I think that’s what really reduces assaults is the same staff being there day after day that gets to know the patients and we know the approaches that work best with them.” Direct Care Staff

Others believed that existing resources are being poorly allocated due to the hiring too many RN2s and RN3s as opposed to direct care staff (MHTs, PSAs). This, they believe, exhausts the hospital’s resources without providing sufficient levels of staff out on the floor interacting with the patients. According to participants, another area to which the hospital should commit more resources is in the work of community nurse specialists. These staff are critical as they can help alleviate the bottleneck the hospital faces when discharging patients into the community:

“Our community nurse specialist goes out and does PR with places. That’s made a huge difference... Western State had a bad reputation in the community and he’s gone out and kind of repaired that, and our willingness to train facilities and adult family homes on how to work with the people. ...And I think that helps. When a patient’s been discharged even a month later, and

something starts to go sideways and they call and we can send out to go help and try to keep that placement. And that's saved, and made people successful on their discharges." Manager

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 job safely. This and other staff-related issues are discussed further in the section on Internal Schedule Control.

Control Over Admissions and Discharges

All groups of participants at WSH (direct care staff, managers, and union representatives) expressed frustration with overcrowding and agreed that the primary reason for overcrowding was the fact that the hospital has little or no control over who is admitted and when, as well as limited control over when patients are discharged. The forensics unit is impacted when the courts send patients to Western State Hospital and the hospital has to find space to place them. Overcrowding makes it much more difficult to create a therapeutic environment, and increases the risks of violent assaults toward patients and staff.

In addition, patients are often transferred to a different ward not because of any clinical decision, but because that was the only ward with a vacant bed. This can create an inappropriate patient mix, and can even lead to a dangerous and assaultive patient being placed in a ward with no provisions for seclusion and restraint.

Overcrowding also increases the workload for staff. For example, a standard caseload for social workers is 15 patients, but there are several in the hospital that have 28 patients. This makes it much more difficult for them to find time to talk to their patients and follow through on patient requests.

"So the workloads have increased exponentially. And that decreases our ability to provide care for our patients, and meet their needs." Manager

"I'll give an example, one ward this morning, started out with 5 patient monitorings, that's 5 people that can't do anything but watch a patient one on one. You can do the math. That's 40 chart notes -- in addition to three band new (patients) and two transfers. So, they are consumed and that's where my RN frustration is -- that they're not getting to do the work they're trained to do. They're doing paperwork. . . Six to seven hours. I think the floor staff feels put upon like

they're at the front line – nobody cares. The RNs feel like they're not getting out to do what they're trained to do. It just adds more to the stress.” Supervisory Nurse Focus Group

Another barrier to controlling the mix of patients admitted to the hospital comes from an inability to conduct competency evaluations at the jail site instead of at the hospital. Staff would like to do more of these offsite, but say that courts often prevent this. Finally, concerns were expressed that courts were requiring the hospital to admit patients with acute medical needs for whom the hospital was not an appropriate setting.

“Sometimes we get patients that are really medically challenging. And I'm wondering, ‘Why are they court-ordered here and not to a medical facility?’ Those types of patients require a lot of staff time.” Supervisor

Lack of Community Support

Respondents reported that when patients are stable and ready to be discharged, they often have nowhere to go. Many of the community housing options where they could go are already full, and if a new one opens, the community or neighborhood often gets it closed down. In some cases, people aren't able to access the mental health care that they need in the community, and without the proper medication and support they may decompensate, according to direct care staff.

The barrier formed by the limited capacity of community mental health resources was an issue raised several times during our interviews:

Speaker 1: “When we get ready to release them, they've got no place to go.

Speaker 2: Well, sometimes they're not released.

Speaker 1: So they become angry and frustrated...The resources in the community are almost non-existent. So, how long can I hold you here before you get so angry you take someone's head off....The spaces we had to put mental health patients in have been taken over by DD patients. They're more stable for the most part, they pay more money than mental health pays, so when our guys get to the street, we have a shuffle and they have no place to live...Pierce County has a moratorium that says I can't put anybody else in a group home.” Direct Care Staff Focus Group

Right to Refuse Medications

Direct care staff reported frustration with laws regarding patient medication. Patients have the right to refuse medication unless a judge decides medication is necessary. While this law was put into effect to protect patients' rights, participants reported that it has the opposite effect - that patients can decompensate for weeks before they can get a court order for needed medication. The staff perception is that medication is often an important component of treatment, and not providing it compromises their ability to provide the best patient care possible. Respondents also noted that lack of medication for some patients may result in more violent outbursts and more injuries to other patients and staff.

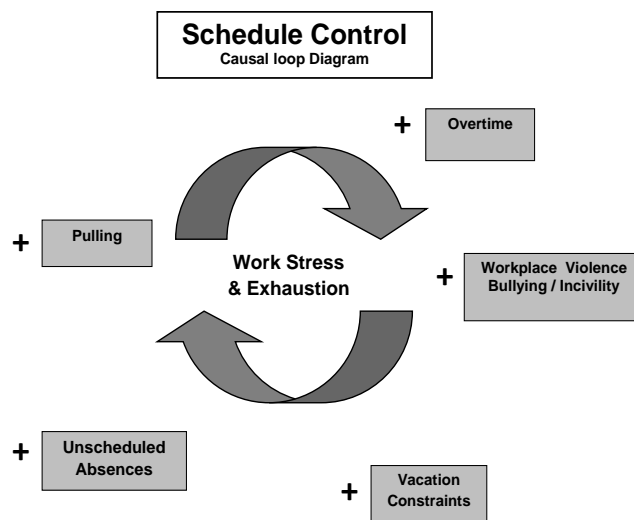
"Today's a good example, all seven came in without a forced med order. So we are dealing with very unhappy dangerous people that come in, and we have no way to control them other than to make safety the highest priority, because they're new to us." CFS Nurse

"A lot of our patients come in un-medicated. The courts do not give us the opportunity to force medications, and so they're very dangerous and extremely—if they do have a mental illness they're extremely decompensated." CFS Supervisor

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 - Schedule Control includes concerns regarding low staffing levels, long hours due to mandated and voluntary overtime, inconsistent teams from floating or pulling staff, unscheduled absences, threat of investigation, control over hospital change, and managing turnover and churn. Many of the control issues are linked in a positive feedback loop. For example, low staffing levels lead to mandated and voluntary overtime. Working long hours through mandated or voluntary overtime results in stress, exhaustion, illness, and work-family conflict which lead to unscheduled absences. In turn, a high rate of unscheduled absences leads to increased mandated and voluntary overtime. Workplace violence and incivility are an additional stressor that contributes to this spiraling cycle of events.

The causal loop diagram to the right illustrates the study findings on schedule control in a systems feedback loop where + signs indicate increasing levels. In this diagram, constraints on when vacation time can be scheduled with pulling staff to other wards, mandated overtime, incidents of workplace violence and incivility, and unscheduled sickness absence contribute to conditions in the system that are positively reinforcing, resulting in work stress and exhaustion.



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 job demands and job control are associated with mental health (Karasek, 1979; Van der Doef & Maes, 1999) and with physical health (see Belkic et al., 2000; Belkic, Landsbergis, Schnall, & Baker, 2004; Bosma, Peter, Siegrist, & Marmot, 1998; Karasek & Theorell, 1990; Schnall, Belkic, Landsbergis, & Baker, 2000).

The qualitative data indicate that schedule control is a key concern for WSH managers, supervisory nurses and direct care staff and much of the interview discussion revolved around mandated and voluntary overtime, floating staff, and unscheduled absences, all schedule control issues.

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.

“You’ve got patients that have needs that aren’t getting met, because there’s nobody there to meet them, because everybody is spread out to the four winds trying to accomplish everything.”
Manager

“But, in terms of the culture of safety, I would say not lack of concern from administration. My experience in talking with them is they’re just as frustrated. They’re -- they are not lost on the fact that any way you cut the dollar, we’re still short-staffed. That is not lost. They have been very conscientious about creative ways that they can do things for staff. But it’s hard. I mean, their hands are tied - you can’t squeeze something out of nothing.” *Direct Care Staff*

Overtime

Voluntary overtime is a commonly used scheduling strategy at Western State Hospital. Direct care staff frequently work long hours, cover various shifts, and work with inconsistent schedules and little schedule control. Research has documented the effects of these scheduling practices which include higher work stress, exhaustion, burnout, cognitive failure, psychological distress, depression, disrupted sleep, and work-family conflict among others. Under the current conditions, patient care and patient and staff safety are compromised.

Intermittent Staff

One strategy employed by hospital management in an effort to control costs while keeping staffing levels high is to supplement staffing with intermittent or non-permanent employees. This program appears to be causing morale issues for permanent direct care staff. The quote below reflects a point of tension around fairness when hospital employees are working with intermittent staff.

“When I come in Wednesdays and Thursdays, I know I have one or two regular floor staff besides me. Everyone else is going to be pulled. Most likely it’s going to be an intermittent who floats all around the hospital. And then, out of those intermittents, I might get four or five females. And that is very stressful. When I came to work today, my (stress) level was high. Even when people ask, ‘Are you okay?’ I’m like, ‘I’m fine.’ But I’m really trying to motivate myself because I know what I’m up against.” *Direct Care Staff Focus Group*

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

*“When you have to move staff around a lot, it just creates dangerous situations.”
Supervisory Nursing Staff*

“The place is safe when you can maintain your own staff. In the NGRI wards the patients have a great deal of familiarity and trust and they bond with these staff. So, when the staff gets pulled, that can be very tough, because they don’t feel they have anybody to talk to. . . . As far as I’ve seen, it’s the floor staff that gets the brunt of it (assaults).” Supervisory Nursing Staff

“I try to teach people that when you float, you have to have skills so you don’t get stressed. You have to have the ability to be moved to a new environment with new patients and be able to identify those leaders that are on the ward. You can tell who the experienced ones are and get close to them so you can have a safe day and get through the shift. However, a lot of people don’t have the ability to do that, and they get floated, and that causes stress right off the bat to start the shift off. It also puts the ward and themselves at more risk for injury. Okay?”

SAFE Team Focus Group

Unscheduled Absences

Long hours, psychologically demanding work, inflexible schedules, and low schedule control contribute to employee excessive use of unscheduled absences to recover from stressful work conditions and illness, and to manage their work and nonwork lives.

“This is a 24/7 service. So that requires probably the majority of the nursing staff to work antisocial hours. They’re working either evening shift or night shift. And they don’t have regularly scheduled weekends off. So the question is, does that contribute to excessive unscheduled absences?” Supervisory Nurse

The above quote describes one way that some staff might respond to gain a kind of 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. Another issue for staff is that schedule inflexibility for taking vacation leave leads to a strategy of calling in sick to get needed vacation time, family time, or recovery time from stressful work.

“We schedule early in the year for vacations for the entire year. The first round of vacation scheduling (by seniority) the prime vacation times are full. We’re not allowed to give enough people off even to be able to use the time they have earned. If you really have to have time off, you call in sick. If you request a day off, and they say ‘no’ then you’re on – really under pressure not to call in sick. So you don’t even try to request a day off.” SAFE Team Focus Group

In a functional staffing and scheduling system, direct care staff would have greater schedule control -- flexible avenues and options for scheduling vacation time, handling needs for recovery from stressful work, and for managing work and non-work commitments.

Threat of Investigation

The key purpose of investigations of violent incidents is to ensure patient safety and high quality patient care. The hospital has a current culture of fear and mistrust which is the psychosocial context of direct care staff experience of threat of investigation. Direct care staff reported uncertainty, *lack of control*, and fear regarding decision making around patient care when patients become agitated. The threat of investigations initiated by patients, patient’s families or other staff is ever present and highly stressful for direct care staff.

The elements of control mentioned by direct care staff in regard to this fear of investigation are the number of investigators involved (patient advocator, internal and external investigators), and incivility from coworkers on their team. Sense of control is diminished for staff when uncivil coworkers file false reports, or instigate patients to file false reports against a coworker (see *Incivility* section p. 42).

“There’s a lot of people looking over your shoulder, and maybe some of it’s necessary, but it truly does feel like a fishbowl.” Supervisory Nurse Focus Group

“It’s a very detrimental thing when somebody is questioning your honesty and you haven’t done anything, even if there are no findings. They may go through an awful lot of people questioning them, so they are damaged at the end of the process.” Manager

The content analysis revealed that workplace violence and control are complex issues for patients and staff. Tensions exist for line staff around concerns for patient rights for safety and nursing staff job security that can be threatened by an investigation initiated by patients or others. The threat of investigation, loss of licensure, and limited control in the face of that threat is a significant workplace stressor that nursing staff contend with every day on the job. In addition, fear of investigations may lead to underreporting of violent incidents or over reporting when incivility is involved.

Recommendations for Control - External and Internal and Schedule Control

- a. Continue to develop relationships with external organizations such as the legislature and court system to communicate hospital perspectives with the goal of influencing decisions that directly impact the hospital.
- b. 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 and increase safety.
- c. Provide a means for staff inclusion in planning and decision making in key areas of concern for direct care staff.
- d. Increase organizational, supervisor, and team support for direct care providers working under the threat of investigation.
- e. Limit use of mandated and voluntary overtime.
- f. Create a float pool of permanent workers who have the ability and desire to function in this capacity.
- g. Identify options to increase schedule flexibility for direct care nursing staff.
- h. Create a culture of schedule control.

Control - Turnover and Churn

Turnover and Churn

One of the greatest challenges faced by any organization is the competition to recruit and retain productive staff. Unplanned losses of trained staff to other organizations and a high rate of transfers within an organization (churn) are disruptive to the hospital's mission of providing a continuum of patient care. Since the work of the hospital cannot be adjusted to the availability of

staff, such events lead to excessive overtime use and to the placement of less experienced staff into high-acuity wards. Turnover and churn also divert hospital resources that could be better allocated to improving the training and development of staff.

Factors in Turnover

Participants indicated that turnover is generally high among line staff, although some wards have higher turnover than others. Clinical staff, such as psychologists and social workers, tend to have low turnover rates. Incivility was cited as one of the key factors that leads to staff separating from the organization. Participants explained that because of low staffing levels, the hospital has had to hire some under-qualified staff who are not necessarily capable of performing the job and are more likely to quit due to lack of a psychiatric nursing background. Other factors included stress associated with the practice of pulling staff to other wards resulting in lack of control, safety concerns, higher pay elsewhere, and poor treatment by coworkers.

“We were so short on RNs, if you had an RN after your name and there wasn’t a ding on your license and you were breathing, we hired you. So it’s been very difficult, and some of them that we hired are not going to survive.” Manager

“I see it wearing on people. And I know that I have some good friends who have left the hospital because of it, strictly because of how they were treated by colleagues.” Manager

Problems Caused by Turnover

High turnover creates a variety of problems, many with safety implications. Without stable staffing on each ward, it is more difficult to respond quickly and appropriately to situations because many staff may be unfamiliar with patients and their needs, which places both patients and staff at higher risk for assault and injury. This can create frustration among direct care staff and managers. In addition, repeated turnover in the upper levels of management (such as the CEO position) can destabilize the entire organization as the focus of the hospital is constantly changing with each change in administration.

“We’ve had 15 CEOs in 30 years. How can you have continuity of care and management if the CEO’s position itself [is] a political football? How can you organize?” Safe Team Focus Group

A specific example of the negative impact of turnover can be found in the Human Resources department. According to one manager, the entire Human Resources department

(HR) was recently cut, and a new group of people was hired to replace them. During the data collection phase, everyone in that department was still fairly new to the job and participants reported that it was difficult to get appropriate and timely help from HR due to the department's lack of knowledge and experience.

“There’s a whole new team in [Human Resources] who doesn’t know Western State... You just feel bad even when you have to call for a basic question, because they’re all so stressed out and overworked. And I think they’re the key for us -- for disciplinary action, for dealing with employees who are toxic or whatever. And so that just isn’t there.” Manager

Excessive Churn

Participants reported that there has been a recent push to reduce middle management in government positions in the state of Washington. Western State Hospital has eliminated some of these jobs, but the people working in them were simply moved to other positions in the hospital. Former program managers now have titles such as RN3, insurance investigator, and behavioral analyst. Participants expressed frustration that the hospital has no money for new direct care staff, but it is still paying the salaries of people in management positions who were supposed to be let go. According to respondents, this is particularly frustrating because using the money for new direct care staff would greatly increase safety for patients and staff.

“Governor Gregoire came up with this idea of reducing middle management in government... And so, a bunch of these people were relieved of their jobs. They went off to other jobs. And then, they got re-hired back into seemingly the same jobs as if they had pulled the wool over Governor Gregoire and her team.” Direct Care Staff Focus Group

Other forms of churn in the organization are due to moving staff because of incivility, investigations, and stress and burnout. Floating and pulling and excessive use of unscheduled absences may also be considered forms of churn at Western State. The level of turnover and churn at Western State Hospital is likely to impact quality of patient care as well as patient and staff safety.

Recommendations for Control - Turnover and Churn

1. Hire direct care staff and require them to obtain psychiatric certification for their position to improve skills for patient interaction and care. This will reduce stress, risk of assault, and staff turnover.
2. Improve opportunities for development for CFS direct care staff as they rise in seniority.
3. Formalize mentorship of new staff from seasoned staff in order to increase team support, build skills and confidence in new staff, and reduce turnover.
4. Staff satisfaction surveys should be undertaken to identify main causes of turnover and churn. Conduct exit interviews with staff that leave and compile results for leadership to address.

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). Leaders have an opportunity to shape cultural norms through what they focus attention on, how they respond to crises, the behaviors they role model, and individuals they attract to their organizations. The leadership of an organization teaches the characteristics and qualities of its culture and these are eventually adopted by its members. *"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."* (Schein, p. 375).

Culture change that is sustained over the long term 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 mission statements, policies, 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 style. A non-violent safety culture is recognized to be a superordinate 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*, *culture of fear and mistrust*, *culture of non-violence*, and *staff entitlement*.

Workplace Violence Policy

Written documents such as workplace violence and communication policies are *formal* expressions of an organization's culture, and expectations for culture. Washington House Bill 2899 requires that state psychiatric hospitals provide an assault prevention and protection plan and a training program for employees. This plan should include workplace violence policies for personnel. 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 staff from violence. In addition to developing sound policies on violence, supervisors have a powerful role in communicating the value of zero tolerance and quickly addressing issues related to workplace violence and incivility with hospital staff and members of the public with access to the hospital campus.

When asked about the hospital's workplace violence policy, responses from direct care staff and managers indicated that they were aware of a policy or policies that were in existence. We have also learned that the hospital workplace violence policy was revised on 5/14/2009. A review of the current policy indicates that its scope includes all WSH staff, students, interns, PALS employees and persons with access to the WSH campus. The policy addresses workplace violence committed by members of the public while on the campus, includes threat assessment procedures, options for victims and perpetrators, and training strategies. In addition, the policy states that the chief executive officer is responsible for implementing and monitoring the policy.

Culture of Fear and Mistrust

Direct care staff, union representatives and managers most often referred to fear and mistrust when asked about the culture of the organization. This was the strongest subtheme identified in the data analysis of the organizational culture theme and has implications for patient and direct-care staff safety as well as incivility among hospital staff. Participants discussed fear and mistrust as occurring at many levels in the hospital and gave examples of fear at the management level, staff fearing investigation for misconduct, staff mistrusting management and coworkers, and staff fearing patients. We included several quotes below to illustrate the depth of this dimension of culture across levels of the organization.

“I think that the culture is fear and status quo versus solution-based management.”

Direct Care Staff

“So, if the leadership of the organization were - had integrity, had transparency, had competence, they could begin to build trust. I talked to a person that was hearing this grievance, and . . .she said, ‘I see what you mean when I walk around here. I can’t believe the level of stress I see.’ And she’s not talking about the working staff. She’s talking about the executive committee. The stress is just huge. When they took that CEO out of here, it was like a terrorist attack on all the upper supervisors who felt safe. So, we don’t have leadership here. What we have is management and I think the hospital has been held captive by risk managers.” *SAFE Team Focus Group*

“I think there’s a sense of being afraid of management. They’re afraid of the response of management - that ‘if we put somebody in restraints, if we make a decision, we’re going to be questioned, and we’re afraid of that’ - maybe because they don’t know how to defend themselves.” *Manager*

SPEAKER 6: ‘And you will do it this way.’

SPEAKER 10: And there’s -- and there’s no transparency in that. Everything’s a secret --

SPEAKER 6: Behind the doors.

SPEAKER 10: -- until it’s dumped on you. All of a sudden, ‘this is what we’re going to do, we made this decision,’ I don’t know who this ‘we’ is, but ‘we’ made this decision.

SPEAKER 3: They won’t admit who made the decision.

SPEAKER 6: They never put their name to it.” *SAFE Team Focus Group*

“How do you build trust? That’s what keeps me awake at night is, ‘am I being fair?’ ”

Supervisory Nurse

“I really get a sense that there’s a culture of fear and that what we get is reactionary responses from being afraid. And afraid not only of being hurt, but afraid of mental illness and not understanding what it means to be psychotic and how that changes the person. . . I don't think we do a good job of teaching people that those folks get well. They move from that and we end up with folks ready for discharge, and staff has alienated them, because they’re so afraid of being hurt.” *Manager*

The quotes above describe a range of responses to issues of organizational culture. These statements reflect an organization’s negative aspects of culture. While there were many direct care staff, managers, and supervisors who expressed a desire for a positive culture and were clearly working toward that goal, the organization is in need of intervention to address culture change.

The mission of the hospital is to “promote recovery and safety” and the organizational culture is the psychosocial environment for carrying out the hospital’s mission. A hospital culture of respect, trust, transparent communication, and staff involvement in policy development and continuous quality improvement planning would contribute much toward promoting recovery and safety for residing patients. Moreover, a positive culture would also improve direct care staff and manager safety, physical and mental health, job satisfaction, and retention.

Culture of Non-Violence

Much of the discussion among direct-care staff and managers focused on reduction of seclusion and restraint as a practice and goal of a non-violent culture initiative begun at the hospital in 2004. The data analysis revealed tensions in staff understanding of the meaning and purpose of seclusion and restraint. On the one hand, direct care staff expressed the value of creating a culture of non-violence with reduction in seclusion and restraint practices. However, there was also a perception among some staff that there was a strong value in using seclusion and restraint to maintain safety for patients and staff. Direct care staff reported that there was an increase in the use of seclusion and restraint methods. Managers, supervisory nurses, and direct-

care staff also acknowledged a profound level of fear and need for control in informal discussions during our observations and in the formal interviews we conducted.

“And if you’ve got staff who have been working with those patients for 15 and 20 years, and they’ve been hit 20, 30, 40 times, they’re not going to let go of that fear very well. They’re going to suffer from PTSD for quite some time. I mean, how many times can you see a coworker get smashed in the face or have their leg broken or their arm broken before it becomes a lingering effect? It doesn’t go away. You wake up in the morning with it, and you go to bed with it at night. And so, for a staff member to say, ‘Well, I can’t restrain or seclude these patients anymore,’ created a huge amount of fear among the workers.” Direct Care Staff

“There’s that tension between what’s the appropriate therapeutic intervention - medication, quiet space, versus custodial - let’s take control.” Manager

“And, one of the problems is the admit wards are where a lot of our patients come in un-medicated. The courts do not give us the opportunity to force medications, and so they’re very dangerous -- if they do have a mental illness they’re extremely decompensated. We kind of said, ‘Okay, administration, we understand what you want, but we’re still going to do it our way.’ We did try to make some headway into de-escalating patients verbally and -- and try to meet their needs before it went to -- to restraints, but I think that, um, some of our culture now is slipping back into just put them in restraints and we’ll sort it out later and talk to them after they’re in restraints and we have some control over them.” Supervisory Nurse

“There is a predominant culture of an “us versus them” with line staff and patients. It’s going to be restraints, seclude. It’s going to be slam you to the floor so you know that ‘you don’t mess with me - or, you don’t mess with us.’ And, you know, people say what they will, I know what I see. And again, that’s not every single floor staff because we’ve got floor staff, and ICs, and RNs that are phenomenal.” CFS Direct Care Staff

Participants reported a perception of practices reverting back to the previous culture in place before the nonviolence culture focus of the past several years. The tensions between using a custodial versus therapeutic approach were reflected in the data and bring up control issues and struggles to understand the meaning of the relationship of the staff with patients within the hospital culture. CFS staff and supervisor responses indicated that some struggle with the question of whether they are providing therapeutic treatment for recovery for severely mentally ill patients who have committed crimes *or* acting as custodians of criminals who have mental illness and are serving a sentence for their crime. The concept of control gained through use of seclusion and restraint and equated with safety is expressed in the following quotes.

“Because it’s very frightening to try to confront a patient who’s out of control, who has -- who has free access to you. In other words, they can slug you, they can bite you, they can spit on you, they can throw stuff at you. It’s very difficult to approach that kind of person and try to de-escalate them verbally. But, if you have them in restraints, you have some control. You have a little bit more control and a little more safety for your staff.” Supervisory Nurse

“Our goal was supposed to be to totally eliminate (seclusion and restraint) and, I don't think that was a realistic goal for the forensic unit to begin with. I think . . .the staff felt we lost the ability to control patients, that we were supposed to not put them in restraints. There’s a feeling now that we’re gaining some back, but we’re only doing it by using more and more restraint time.” Supervisory Nurse

“Because, basically, you don't want to wait until somebody’s hurt. Which is kind of what was happening, because all -- they wanted to get all of the restraint and seclusion hours down, and so people were backing off on it. Well, people were getting hurt. And she said, ‘No. That’s not a good thing.’ ” Direct Care Staff focus group

Research has demonstrated that reducing seclusion and restraint can be accomplished without increasing direct care staff injury (Fisher, 2003; Forster, Cavness & Phelps, 1999; LaFond, 2007). Below are two contrasting perceptions from hospital staff concerning whether or not injury is increased with a reduction in use of restraints.

“People were freaking out (after non-violence initiative was introduced). They didn't know whether we could or we couldn't, even if it was obviously the type of situation where you could put a person in restraints. And people got hurt. People don't feel like the management really cares about them. There's less (injury) than there was, because we've slowly gotten kind of back to doing it (restraints) more frequently than we were two years ago or a year and a half ago.” Supervisory Nurse

“I've been involved in the safety battles at this place for the last ___ years. I've been heavily involved in accident investigation, all these things going on and why they happened. I kind of disagree on the issue of the restraint, though. I've seen the results of -- of the wards that have tried to go restraint free. And in reality, the injuries dropped.” Direct Care Staff Focus group

Direct care staff need strong support from supervisors and management to cope with fear of violent behavior and manage the need for control over patients. The hospital can share data that documents relationships between use of seclusion and restraint and reports of violent incidents and patient and staff injury. Seclusion and restraint practices are needed at times but as a safety measure of last resort and should not be used as a substitute for low staff-to-client ratios. Recommendations specific to seclusion and restraint are listed in documents such as the National

Association of State Mental Health Program Directors report (NASMHPD, 2007) and need regular review by hospital supervisors and staff because the practices are systemically related to a hospital non-violence and safety culture.

Staff Entitlement

Interview participants reported on a culture of direct care staff entitlement where staff members feel privileged to behave in various ways including taking excessively long breaks on or off campus, sleeping on the job, and threatening or bullying others singly or by banding together. If these employees receive promotions, they may become managers who use bullying strategies to attain their goals. The following quotes illustrate some of the ways that a culture of entitlement is manifested in the organization.

“There is a sense of entitlement - people who spend hours out in the parking lot doing whatever they do, in full view of the center director’s office. No shame. I mean, at least go around to the other side of the building.” Manager

“ They say, ‘I have a disability and that’s why I have the exceptions and the privileges that I do to come in and go as I want, and I fought battles before and I’ve won battles before. I’ve litigated against the state and won.’ -- Being willing to use their power in a certain way and letting you know, ‘I know people in _____. Watch what happens to you this coming year.’ ” Direct Care Staff

“The difficult staff who have been here a long time, who feel privileged, who feel ‘Nothing can happen to me.’ They take up so much time. Its way harder working with difficult staff than it is working with a patient. I mean, even the toughest of toughest patients that I’ve worked with over the years -- staff are more challenging.” Manager

“Right now, there is a _____ problem among staff. There’s a few times I’ve attempted to clamp down on it and then quickly, it was like a band, everybody banded together, like, you’d better back off. And I did, you know. I stood down.” Union Representative

“I can’t really say a lot of managers, but some of the managers use bullying out here as a way to get their people motivated. I’m not sure why. I don’t approve of that type of behavior, but, a lot of it comes from employees that have been disciplined before, and won lawsuits against the state or whatever, and then placed back into the same environment. They tend to be extreme bullies out here. They throw their weight around -- they say, ‘I’m untouchable,’ you know.” Manager

Recommendations for Organizational Culture

- a. Create a Workplace Violence Policy and introduce it to employees in the new employee and annual refresher assault prevention training.
- b. Train managers on the policy and how to implement it.
- c. Train managers to encourage innovation and problem solving toward increasing safety behaviors while reducing S&R, creating a safe environment and a culture of non-violence.
- d. Train managers to speak to non-violence safety culture issues in daily communications and through role modeling effective safety behaviors.
- e. Train managers to build trust and relationship with direct care staff, and to stimulate enthusiasm for teamwork, communication, and support.

Organizational Culture - Communication

Communication is an important aspect of an organization's culture. The values and attitudes of members of the organization are reflected in formal and informal communications. Networks of communication occur between management and direct-care staff, coworker to coworker, within a team or a discipline. Communication structures, systems and processes can be analyzed to determine how effective communication is. For the purposes of this study, we can provide a general sense of communication concerns, however, a more extensive investigation is needed to more fully understand the complexities of culture/communication in the WSH system.

Poor communication can affect patient and direct care staff safety in several ways:

1. increased staff turnover
2. increased staff absenteeism
3. higher error rates in patient care
4. Increased use of seclusion and restraint
5. poor policy enactment
6. lack of focus on safe patient care
7. frustrated or agitated patients
8. decreased innovation for safety problem solving
9. limited knowledge of patients' current status and triggers

Important questions for the hospital management team to consider are how well communication functions currently and how will communication methods need to change over time. Employees will put in that extra "discretionary effort" when they are kept informed openly and honestly on aspects of their job and the hospital, when they feel that they are being listened to with empathy, and when decisions that directly impact their work are made based on their input. This section focuses on communication challenges between or within the organizational levels of units, teams, and individuals based on the data collected in direct-care staff focus groups and individual interviews with union representatives and managers.

The interview data revealed that communication issues fell into subthemes including *hospital organizational structure, cross-level communication, reporting workplace violence incidents, and shift reports*. The picture that emerged from the limited number of focus groups and individual interviews we conducted was that some communication efforts by managers and supervisory nursing staff were successful, such as regularly scheduled meetings on daily, weekly, or a monthly basis, emails sent to staff, and newsletters such as the CAS newsletter.

Hospital Organizational Structure

The hospital has undergone a recent change in organizational structure in the CAS, CFS, and COAS units. The previous structure was flatter with interdisciplinary teams reporting to a ward program manager. The 30 or so ward program managers reported to the CEO. The system changed in May of 2009 to a deeper, columnar structure where each discipline; nursing, psychology, and social work were separated. For example, nursing reports within its discipline in a chain of command from line staff to charge nurses (RN3s) to supervisory nurses (RN4s) to Unit Managers, to the Nurse Executive Manager, to the CEO. The respondents that addressed organizational culture and communication in reference to structure were primarily managers who, in their supervisory role, may be more aware of these changes and their effects. Responses varied as to preference for one structure or the other. Some respondents were concerned about team work and collaborative interdisciplinary communication centered on patient care. Others welcomed the separation of disciplines as more conducive to information flow up or down the chain of command. The two quotes below illustrate these contrasting perspectives:

“In my opinion the hospital is structured in such a way that it makes it really difficult (to communicate). They have what I would call disciplinary silos. Social work is in this silo where all social workers report up the line to social workers. Psychologists just go up to psychologists. Nursing only reports to nursing. So you have these separations between disciplines. . . In most progressive institutions, they are all interdisciplinary and you have a team, and it’s a team made up of all different disciplines and you’re all working together and you all report to the same person. When everybody reports to a different person, you have structurally fragmented the team.” Manager

“We have a scenario where center directors’ chains of command interfere with and block. . . so when there is something to communicate to the administration, there’s a filter blocking it at this level of center director because of the disciplinary mismatch. . . The only thing that filters up is what the center director knows and what the center director can understand. We have to make sure that all components of Western State Hospital have an unobstructed chain of command to their clinical leader.” Supervisory Nurse

Because patient care and recovery is the primary mission of the hospital, management needs to consider how to encourage interdisciplinary teams to work together at ward, unit and across levels to accomplish goals related to creating and sustaining a non-violent safety culture toward fulfilling its mission. One respondent commented specifically on the need for disciplines to understand and work across their varying perspectives in the quote below:

“The lack of understanding in relating to the patients and the lack of understanding between the different disciplines and divisions here at the hospital (causes me the most stress). If you can’t understand and relate to this patient, you can’t work with this patient. If the RN3 can’t understand how to relate to her MHTs, if the doctor can’t relate to the nursing staff, if the psychologist can’t relate with the social worker – that’s where the frustration lies, because everybody wants everybody to change to the ways that they see things . . . and you can’t get to what really needs to happen.” Manager

Cross-level Communication

The topic of communication was discussed in direct care staff focus groups and in individual interviews with union representatives and managers. The term “feedback loop” was mentioned frequently among interviewees and concern was expressed that effective cross-level communication from staff to upper management was not occurring due to a broken feedback loop in the system.

“I sat there listening to all this and the problem here is that here’s all these frustrated people that have all these issues and there’s really no way to get some kind of feedback loop going for

most of them. Like, would some manager come back and sit down and say, 'Well, we heard what you said and here is the answer?' ” *Direct Care Staff*

“My stressors are when the administration does not listen, when that feedback loop doesn't go all the way to the top, like now.” *Manager*

“No one wants to claim to be management. But an entity that becomes management is there and someone is making the decision. Someone is. I don't know who.” *Direct Care Staff*

“I do believe that from time to time the administration expresses an interest in hearing the opinion of the line staff and the union, and I think the evolution of the Central Safety Committee has been helpful working towards that end. I don't believe the impact has been felt as widely as it needs to be, and part of that is because staff may not be available because of short staffing to participate in the ancillary safety committees.” *Union Representative*

While direct care staff expressed more frustration with communicating with managers, nearly every manager reported that they have an open door policy and encourage communication with staff by checking in and letting staff know they are available. They discussed strategies they employ for communicating such as regular meetings, newsletters, walking through the wards, as well as their own frustrations with communication:

“It's only been a couple of years, but we worked really hard at listening to the staff, trying to increase the morale, having work groups set up so staff feel like they have a voice, but it's very frustrating from a manager's point, because all of this stuff we continue to implement - meeting daily, monthly . . . it's still lingering. Staff are still frustrated over things that happened years ago that are now out of our control. I think across the board staff would say, 'It's going to change because it always has changed.' And so they always go with that, taking a step back and going, 'I can't feel comfortable, because it's going to change.' ” *Manager*

In a number of interviews long-term staff and supervisors referred to a sense of continuous change at Western State Hospital that was perceived as overwhelming. One respondent commented that he thought there may have been 15 CEOs in the past 30 years. The source of frustration among managers and direct care staff that is focused on communication may be due in part to repeated organizational change at the top management level over many years of the organization's recent history. Another respondent indicated that things are always changing and she sometimes resists change and waits for things to “go back to the way they were, the way I liked it.”

Reporting Workplace Violence Incidents

Direct care staff and managers reported that staff are encouraged to fill out Administrative Reports of Incidents (AROI) for all assaultive incidents except verbal assault. In the quotes below, a staff member and manager comment on the formal reporting system.

“My experience has been on both wards that reporting everything is what we’re asked to do in terms of AROI if there’s a staff injury. But if a patient just curses at staff or just pushes staff, generally, we would just get something in charting. My experience just sitting on those boards (is stressful), absolutely. And it’s equally as stressful when they’re making direct threats to you. They’re cursing you. They’re being just abusive towards you. . . For some people, it’s a cumbersome process (AROI forms). The general attitude about assaults, unless they’re really significant, the general attitude I’ve seen is, ‘toughen up.’ ” Direct Care Staff

“I always say, ‘If there is a question, just fill it out and send it up here. They can print the form right off and just hand write in the form. . . We’ve never had anybody complain that the form was too cumbersome, but at least not to me.” Manager

“I can’t speak for other wards, but I know that I’ve been a bear about, ‘You’ve got to report this, got to report it, got to report it.’ ” Manager

Direct care staff in focus groups and managers agreed that reporting is encouraged for all violent incidents, verbal abuse is not reported in an AROI but may be charted, is stressful and may result in PTSD, and is either tolerated or verbally discouraged in patients by staff. In terms of reporting physical assaults, direct-care staff and managers had different perspectives on the AROI forms as too cumbersome to fill out and the degree of underreporting with line staff noting that 80% - 90% of incidents do not get reported. One manager discussed a means of double checking on AROI reports through cross checking with debriefing reports and verbal reports in a daily triage meeting for the unit every morning. This manager reported routinely seeking out any report that may be missing because the data is needed to track certain variables of interest for patient care. Finally, another manager commented that there may be over reporting and that many staff-to-staff confrontations get written up as well as patient-to-staff incidents. In sum, the data indicate that there may be a variety of reporting practices across units at the hospital and that when underreporting occurs, it may be due to attitudes held by staff that it takes too much time to fill out forms, and that they should endure and minimize assaults that do not result in injury or result in very minor injury. In some units or wards, over reporting may be a concern.

Other issues that emerged from the data include that temporary workers may not report incidents out of fear of losing their jobs if they miss a day due to injury, or staff cannot afford to wait during a lag time of 4 weeks or longer before they get their worker's compensation paycheck. However, line staff, union representatives and managers also acknowledged that incident reporting benefits the patient, staff member and hospital because it is protective for all, allows the hospital to track trends and make changes to improve safety for patients and staff, and has improved over time. Direct-care staff recalled the past use of a Violent Episode Incident Form that was the first page in every chart and summarized the patient's history of violence. Staff members noted this was phased out but they found it effective in communicating about the patients' history of violence and current status which may have prevented assaultive incidents.

Shift Reports

Shift reports occur at the beginning of each shift and are a critical communication practice to inform the incoming staff of recent developments in patient health status. Safety increases for patients and staff when staff are well-informed about recent events on the ward, changes in patient health status and behavior, as well as decisions regarding patient care.

“Our report system is inadequate the way it is right now. If things worked out well, we would be able to read ahead of time who we were to pull to another ward. At the beginning of the shift we give a report on every patient. Well, if you're pulled from another ward, you don't know any of the patients.” Manager

SPEAKER: “There's only 15 minutes for report, but one person is potentially counting meds to take over the med room. One person is taking a census, so that is potentially two people that are not hearing the report.

SPEAKER: Usually you have the next shift standing there, but a lot of times they have to go out and deal with what the patients want right away, so not everybody is usually there.

SPEAKER: If you are a pulled staff you will probably not get it (the shift report).”

Direct-Care Staff Focus Group

The most effective system of shift reporting will include all direct care staff members. Reasons given for various staff not being present were; staff taking census, attending to meds, attending to patient needs, and incivility between staff members. Improvements to this system are warranted considering the greater risk of assault to staff and patients when staff members do not know patients at all, may not know of their recent health status and violence history, and may not be familiar with ward procedures and practices if pulled to the ward. One solution

mentioned by direct care staff as effective was the practice of one nursing staff person working across the next shift for a period of time to help in the transition, keeping new staff informed and allowing more staff to participate in the shift report.

In terms of overall communication, direct care staff expressed a desire for improved communication with management to have their voice heard and acknowledged. This can be accomplished through formal and informal channels such as a group email system and upper level managers, unit directors, and RN4s walking through the wards, being a strong positive presence for staff and patients. In terms of communication method toward fostering a stronger organizational culture, face to face communication is a powerful tool for leadership.

Benefits of walk-through from leadership –

1. Provide positive attention, recognition, and engage staff in conversations about their work and family - role model appropriate professional boundaries
2. Convey and reinforce key organizational culture messages
3. Be a presence and a role model for comfort being on the floor, nonviolent communication, team problem solving, and safety behaviors for patients and staff.
4. Problem solve innovatively for improving therapeutic environment, safety, staffing
5. Ask about needs and concerns, listen to patients and staff and take notes
6. Provide follow-up information in person to address prior walk-through communications

Recommendations for Organizational Culture - Communication

- a. When making a major decision, management could open up a 2-day window for comments from line staff, so that they could
 1. Gain insight on how the decision is likely to affect patients
 2. Avoid resentment and resistance to change
- b. Well-designed organizational culture surveys and employee communication surveys can determine how well the communication systems and practices are contributing to or hindering hospital performance.
- c. Consult direct care staff on major decisions regarding environment, organization, staffing and equipment, as they are likely to have insight on how patients and patient care will be affected.
- d. Meetings for direct care staff will ensure consistent communication and promote teambuilding. Combine a task focus and a relationship-group process focus in each meeting.
- e. Include direct care staff in treatment plan meetings - ask for and value their contribution for improved patient care and safety.

- f. Provide regular bulletins to all staff on changes in policies, procedures, safety practice tips from coworkers, and new hospital changes.
- g. Provide written shift reports to all staff at shift change.
- h. Enforce communication policies such as giving a report to the person who is relieving staff on a one-to-one precaution.
- i. Top leadership can cultivate two-way communication directly with line staff and throughout the organization as an alternative to communicating down the line through the levels of management. When communicating with direct care staff:
 - 1. Communicate the change often.
 - 2. Address why the change needs to occur.
 - 3. Identify what the changes mean to the employee and to the patients.
 - 4. Use a mix of mediums and methods to address all employee communication styles – email with input or questions encouraged, face-to-face meetings with dialogue, newsletters with graphic displays and detailed bulleted information with next steps.
- j. Work with direct care staff, union reps 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. Social support in organizations is defined as employee perceptions that their organization, supervisor, and coworkers value their contribution and care about their well-being. Debriefing is a specific form of support designed specifically to follow-up an assault, and incivility is a form of negative support. In this section, *organizational*, *supervisor*, and *coworker-team support* subtheme findings will be presented, followed by *debriefing* and *incivility* subtheme findings.

Organizational Support

Upper level management and hospital employees in managerial roles convey that the organizational supports its supervisory nurses and direct care staff by keeping lines of communication open and giving positive feedback on staff and program accomplishments, delivering violence prevention and safety messages, encouraging participatory decision-making on issues important to direct care staff, visiting wards on occasion and listening to staff concerns, providing needed safety equipment and training, and role modeling respectful boundaries and communication. Participant reports included some examples of organizations support but more often expressed a need for greater support from upper level management and supervisors.

“I feel support immediately from some of the folks above me, but in the whole general sense of this hospital, I don’t feel supported. I don’t feel safe. I feel like if I had to take on an issue with an employee that is leading to violence because of their reaction to a patient or something, that I’m going to end up in more trouble than the employee. . .because I’m not going to get supported.” Manager

“The staff that we have here are a very valuable resource. And I’d like to see the administration give us credit for that. Don’t think that’s ever going to happen, but hey, I feel better now that I’ve said it to somebody.” Union Representative

“It would be nice if the larger hospital recognized our program was able to accomplish sometimes, because I don’t think we get that very much.” Manager

Supervisor Support

Supervisor support and leadership are extremely relevant for patient and staff safety. In the psychiatric hospital setting, unit supervisors 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 selected for skills and abilities in working with others and if trained well, an engaged direct care staff supervisor will increase safety on the ward and as a strong presence on the ward will:

1. Focus on hospital goals and values and implement policy consistently;
2. Role model safety behaviors, ethical behavior, and high patient care standards;
3. Give line staff individual attention, focus on line staff skills, build team bonds and strengths;
4. Build confidence and team trust among line staff, promote team teaching and coaching;
5. Communicate concern through delivery of safety messages to staff and patients;
6. Provide support for incident report submission;
7. 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, as well as acknowledging that some supervisors’ hands off approach limits direct care staff learning and effectiveness with patients.

“I talk to people about, ‘Hey, you did a good job with that patient. Thank you for talking to him that way.’ That changes people’s minds. You have to make that one-to-one connection with somebody.” Supervisory Nurse

“If you let someone know that you are concerned for their safety. . . if you let them know – and the supervisors here do let them know – that they’re concerned that they got hurt and they’re sorry. It’s that little interconnection that makes all the difference.” Union Representative

“A lot of supervisors don’t know they can do anything. They would be hands off. ‘Okay, you gave me this information, but when I’m sitting down with Susie, how do I say that to her in the moment?’ That she can accept it and not challenge me –to really do something differently, and that’s where I think sitting down with a more experienced supervisor and watching how they do it helps someone learn. Or, doing it yourself and getting feedback on how you could have done it goes a long way in making that transfer of education into actual action. If we just say, ‘Go do it,’ and nobody’s there onsite to kind of help them then they’re going to struggle and may not make that change. I see that happening a lot.” Manager

Team / Coworker Support

Direct care nursing staff must be equipped with the competencies and skills needed to effectively and efficiently organize and operationalize patient care delivery practices. One skill of great importance to workplace violence prevention while delivering quality care is working together as a team. Teamwork was a theme of importance to direct care staff workers in particular, because their safety depended on coworker and team support to safely manage agitated patients on the ward. At all levels of interviews teamwork was valued and reported on as, in some cases, successful and in others, tenuous or less successful.

“There’s more of a sense that there’s an interdisciplinary team that is really working. It’s exciting to be part of that, to see how that’s grown under a RN3 who has taken the lead on that. And she’s shifted the culture, so we see the strong partnership. We have the doctors that are actively involved.” Direct Care Staff

“I think better personal support (is needed). I think that they need to be mindful of how they talk to each other. In two wards, where there’s a teamwork mentality, again, it’s the people who have worked together for a long time. They know each other’s shortcomings; they know each other’s strengths.” Union Representative

“I don’t see how a supervisor here as an RN3 can function without being on the ward. . . That sort of camaraderie and teamwork really depends on a supervisor’s attitude that is in touch and aware of their own limitations, because then their appreciation of the strengths of their staff

grows enormously, and it won't grow if they're not on the ward working with that person, their team.” SAFE Team Focus Group

“Okay, so we have a treatment plan. And I have heard people say, ‘Oh, well, that’s not my responsibility,’ and I have told them, ‘It’s the treatment plan -- the final project is all of your responsibilities. It’s the responsibility as a team to make sure it’s done, it works for the patient, it’s correct, the patient’s been included in the process, it’s all of your jobs,’ - trying to get them to see that they’re a team . . . but, it hasn’t worked always when other people have been there, because the system is set up to not be a team.” Manager

“When an RN2 or 3 engages their people in decisions in which they have a stake, they feel included and they feel safer. Every time you put somebody in restraints or take them out, you have an opportunity to build team, or you have an opportunity to really strongly undermine the sense of, ‘We’re in this together.’ ” SAFE Team Focus Group

Debriefing Workplace Violence Incidents

Violent and traumatic incidents may evoke stress reactions. 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.

The debriefing process at Western State Hospital and some of its challenges was described by a manager as follows:

“There’s a debriefing process that was actually designed to put everybody in the same room at the same time to do an immediate debriefing, and then the treatment team does the second debriefing. And then there is an individual debriefing with the patient. Sometimes the debriefing with the patient is done very soon after the incident, when the patient is really not even in a place to talk. Debriefing proximate to the incident often can’t put people in the same room at the same time which is really the crux of a debriefing process, because that meant that we just pulled everybody from where they were to the incident, and now everybody has gone back to where they belong because we don’t have anybody sitting on whatever they were supposed to be doing.

It’s not the quality of debriefing one would like to have if one had the opportunity. So this morning’s incident, I had the three RNs in the nursing station, and I spoke to one of the PSAs who was then supervising the patient, and there were two or three other people that were part of the escort and I never tracked them down. They were off where they were supposed to be. So the questions for the patient are: What happened? What could staff have done differently? And what could you do differently? Sometimes they write what the patient actually says. And then, the third part, which is done with the treatment team, which would be the doctor, the social workers, the day shift, RN, and whomever else. It’s sort of a macroanalysis. What are the programs or system modifications that might be brought to bear? And then, any treatment modifications that they’re going to recommend back around the clock. The problem with the system is analyzed.” Manager

“After an incident occurs, they walk around and they talk to each and every staff. ‘Are you okay? Did you see anything we could have done differently?’ You know, in not really a punitive way – a sort of information seeking way.” Union Representative

In addition to the above described debriefing process, direct care staff and managers reported that informal debriefing during morning report and between individuals was commonly employed and was useful to assaulted staff and coworkers. Managers also reported calling employees while on leave due to assaults to check in with them and offer support. Supervisory nurses and direct care staff also agreed that it can be difficult to hold a formal debriefing because staff have left and returned to their wards.

There was agreement among managers, union representatives, and some direct care staff that the formal CISM voluntary debriefing process was functioning and useful, although, with room for improvement, and that it was utilized only for the most serious assaults. Direct care staff in one focus group reported that for an incident where a staff member broke a leg, staff debriefing didn’t occur until one month after the incident – this is quite late when debriefing is

optimal within 24 hours of the incident. Some staff may feel vulnerable admitting they had problems and may not want to perceive themselves as victims when they must return to work and face the assaultive patient and, therefore, may not make use of the CISM process. One suggestion from direct care staff was for the CISM debriefing team to come to the ward and meet with staff after an incident. Another suggestion from a manager was to have patients take de-escalation and debriefing classes so they can participate more fully in understanding “*what it was that made them upset and how we can do it differently next time.*”

Incivility

Mutual respect for the dignity of others at all levels within the workplace is one of the key characteristics of successful organizations. That is why incivility and violence are unacceptable. A form of negative support, incivility is low-intensity counterproductive behavior with ambiguous intent to harm the target and is in violation of workplace norms for mutual respect (Andersson & Pearson, 1999). Examples of incivility include hostility, inappropriate or loud tone of voice, nonverbal gestures such as glaring, failing to pass on information, exclusionary behavior, intimidation, derogatory comments, and gossiping (Martin & Hine, 2005). Bullying is a more intense form of negative support and is defined as when a target is exposed to negative acts, from unconscious incivilities to blatant emotional abuse and physical assaults; negative acts are repeated and there is a prolonged nature of the experience over time, 6 months or longer (Einarsen, Hoel, Zapf & Cooper, 2003).

Incivility and bullying at work cause considerable stress to the victims, and can negatively impact their colleagues, families and friends. In some cases, individuals are unable to function normally at work and in everyday life. Incivility and bullying can lead to post-traumatic stress disorder, loss of self-esteem, anxiety, depression, apathy, irritability, memory disorders, sleep disorders and problems with digestion, and even suicide. Symptoms may persist for years after experiencing this form of harassment at work. At the organizational level, incivility can result in increased absenteeism and staff turnover, and reduced effectiveness and productivity. In a hospital environment, patients may witness staff-to-staff bullying and may become enlisted in the bullying interaction. The therapeutic environment of the psychiatric hospital is severely disrupted by incivility and bullying among staff members and patients.

It is important to take early action to prevent incivility and bullying once it has been identified as a problem in an organization. First, a risk assessment should be carried out, to help identify appropriate action. This can include formulating a civility or respect in the workplace policy, providing conflict management and leadership training, redesigning the work environment, and providing support for victims if incivility or bullying occurs (e.g. counseling, supervisor and organizational support).

Success factors in tackling incivility include:

1. Strong CEO leadership and executive management team role modeling respectful behavior;
2. Commitment from the employer and employees to foster a violence-free work environment;
3. Outlining the kinds of action that are unacceptable;
4. Outlining the consequences of incivility and the sanctions it will lead to;
5. Indicating where and how victims can get help;
6. Commitment to 'reprisal-free' complaint filing;
7. Explaining the procedure for making a complaint;
8. Providing details of counseling and support provision;
9. Maintaining confidentiality;
10. Following fair and quick procedures to gain resolution, and
11. Communicating results to all parties involved.

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).

Incivility and bullying are a serious and pervasive problem at Western State Hospital. At the time of data collection all hospital employees were participating or had recently participated in mandatory incivility training. Nearly every participant discussed the issue at length and many were clearly disturbed by witnessing bullying incidents or in relating their personal experience as targets of bullying. Participants reported incivility, bullying, or physical assaults that were

coworker-to-coworker, supervisor-to-supervisee, and supervisee-to-supervisor, as well as by upper-level management and union representatives. It was reported that incidents sometimes occurred in front of patients and that patients had been enlisted by staff to participate in attacking a target staff member.

Participants reported that the organization has been ineffective in responding to bullying and incivility because investigations were slow, employees did not learn of the outcome of investigations, employees were not held accountable, and were simply moved to another location or even promoted. Targets often do not report because of fear of retaliation and this leads to supervisors not learning of conflicts until they have escalated. Some participants noted that reports of incivility and bullying were “swept under the rug” by supervisors and that supervisors often became involved in the gossiping, exclusionary, and uncivil behaviors.

*“I think that there are people who are the known bullies in the hospital - a number of which are associated with unions and are part of the union stewards, and they bully both managers and staff.”
Manager*

*“We move people. Well, that, you know, they’re mad at their manager because they’re holding them accountable and we move them. ‘They’re too much for me to work with,’ so we just move them to a different spot on the hospital rather than dealing with the problem.”
Manager*

*People put up with it instead of documenting, documenting, documenting. Then, generally, people get promoted. That’s what happened with the individual who was cussing me out, Next thing you know – he’s promoted.”
Manager*

Direct care staff and managers held upper level management as ultimately responsible for addressing the issue, but also saw management as part of the problem.

*“Any organization that is inadequately managed, where the experience of staff working there has that toxic level, then you are going to see more horizontal peer-to-peer kinds of conflicts. I like to describe it as a parallel to domestic violence. It’s institutional violence. It’s like a dysfunctional family.”
SAFE Team Focus Group*

*“I’ve seen other upper management who are completely inappropriate and act uncivil in meetings and such. And I’m thinking, ‘They’re managers here?’ I think it definitely needs – it can always be improved upon.”
Supervisor*

In addition to discussing incidents of incivility and bullying, participants described the effects of bullying as extremely stressful. Participants noted bullying was experienced as staff frustration, confusion, feeling demoralized, helpless to affect change, a drain on energy, and resulted in poor sleep quality, retaliation, and stress that is taken home to families. Other reported organizational effects of bullying were that it takes the focus off of patient care, creates a non-therapeutic environment, increases unscheduled absences, churn, and loss of talented employees or turnover. In one supervisor's words the lack of response or slow response by management has lead to a culture of "rampant incivility and bullying." Staff-to-staff conflict was reported by many as their greatest stressor at work and was tied to reduced safety.

"When you have staff who is bullying other staff, the whole team breaks down. And when the team doesn't work together, the patients pick up on it, and then you really have a problem. It's very unsafe." Supervisory Nurse focus Group

"In terms of their stress, I think they take it out on each other. There's a lot of negativity that goes around this place – just gossip and negative and mean things said." Supervisory Nurse Focus Group

"What keeps me up night mostly is I'd be thinking about interactions with certain staff, or between certain staff – and how hard it is to affect any change." Direct Care Staff Focus Group

If the RN3s try to clamp down on the problems, the people they're clamping down on gang up on them." Supervisory Nurse

"It's awfully distracting if you work against somebody who's bothering you all the time...Maybe you'll get in a bad mood. It sucks all your energy out and you constantly try to keep an equilibrium while dealing with patients." Direct Care Staff Focus Group

"It's just so volatile – the anger and the bitterness towards each other sometimes. There are so many unexcused absences, because it's not just me. All my coworkers are the same way. A lot of us, we'll wake up and say, 'Not tonight.' " Direct Care Staff Focus Group

"I see it wearing on people. And I -- I know that I have some good friends who have left the hospital because of it, strictly because of how they were treated by colleagues." Supervisor

Recommendations for Organizational Culture – Social Support

- a. Train upper level management, unit directors, and SAFE Team members on organizational, supervisor and coworker-team support behaviors and how to foster these in the organization to create a culture of nonviolence and support for safety.
- b. Retain and strengthen the CISM team and obtain ongoing feedback from direct care staff on the functioning and effectiveness of the CISM team to shape it to meet their needs.
- c. Develop and implement a “Respect in the Workplace” hospital incivility policy that defines and addresses incivility including the organizational response to uncivil/bullying behavior. Refer to TJC Standard LD.03.01.01 for guidance.

The Physical and Psychosocial Environment

To assess the physical and psychosocial environment, researchers conducted a walk-through on 3 wards with a workplace violence hazard checklist (see Appendix D). The tables below present the results of the physical environment assessment.

Workplace Hazard Checklist Results

Overall Security			
	C8	E6	F2
Parking lot is attended or otherwise secure	Yes	No	No
Security personnel are provided outside building	No	No	No
There is a duress communication system	Yes	Yes	Yes
Exit doors can only be opened from the inside	Yes	No	No
Floor plans are posted showing building entrances, exits, and location of security personnel	Yes	No	Yes
Floor plans are visible only to staff and not to outsiders.	Yes	N/A	Yes
Emergency information is posted (such as telephone numbers)	Yes	No	No
Circulation			
	C8	E6	F2
Ward has unrestricted movement of the public	Yes	No	No
Ward has no alcoves or hallways	No	No	No
Employees can observe patients in waiting areas	Yes	N/A	Yes
Employees can observe patients in leisure areas	Yes	Yes	Yes
Employees can observe patients in bedroom areas	No	Yes	Yes
Employees control lighting adjustment	Yes	Yes	Yes
Ward has night lighting	Yes	Yes	Yes
No poorly lit areas in ward/department	Yes	Yes	Yes
No poorly lit areas around building	No	No	No
Ward has a waiting room	No	No	No

On-Ward Offices			
	C8	E6	F2
Offices have locking provisions	Yes	Yes	Yes
Offices have a duress communication system	Yes	Yes	Yes
There is adequate visibility for entering/leaving offices	Yes	No	Yes

Nursing Stations			
	C8	E6	F2
Workstation maximizes view and supervision	Yes	No	Yes
Work areas designed to prevent unauthorized entry	Yes	Yes	No
Employee-only work areas and communal areas are separate	Yes	Yes	Yes
Employee-only work areas and patient areas are separate	Yes	Yes	Yes
There are physical barriers	Yes	Yes	Yes
Safety equipment is available for restraint or takedowns	Yes	No	Yes
Safety equipment is secure	Yes	N/A	Yes
Ward has a secure place for employees to store belongings	Yes	Yes	Yes
A violence incidence log is available and filled out	No	No	No answer
Communal Areas			
	C8	E6	F2
Free of picture frames	No	No	No
Free of loose HVAC louver blades	Yes	Yes	Yes
Ceiling tiles are secure	Yes	Yes	No
Free of objects that could be used as weapons	Yes	No	Yes
Free of furniture with sharp edges, loose hardware, spring coils, or cords	Yes	Yes	No answer
Furniture heavy enough to prevent throwing	Yes	No	No
Furniture arranged to prevent employees from being trapped	Yes	Yes	No answer
Communication			
	C8	E6	F2
Noise generators are isolated (TV, stereo, active programs)	No	Yes	Yes
Noise level is low enough that two individuals can talk without raising voices	Yes	Yes	Yes
No yelling or loud calling out from staff to patients	Only once	Yes	Infrequent
Staff is mingling with patients in the communal areas	Yes	Yes	Yes
Patients do not have to go to nurse station for assistance	No	Yes	Sometimes
Staff tone is respectful when redirecting patients or denying a request	Yes	Yes	Yes

Observations on the Wards

Three wards were observed: C8, E6, and F2. Researchers were present on the floor and in the nursing station to observe the psychosocial context of the workplace. Activities and social interactions were observed and documented in notes. Observations included assessing routine

practices, communication between supervisor, employee and coworkers, transporting patients, practices for administering medications, smoking, other planned activities, response to patient requests, and safety behaviors in practice such as de-escalation.

When interacting with patients, staff demeanor was noted as being gentle and friendly. Occasionally a patient would become agitated and raise their voice, but in most cases staff defused the situation fairly quickly. In all wards, noise level was low enough that two individuals could talk without raising their voices and staff had a respectful tone when redirecting patients or denying a request.

C8

Staff consistently responded to patient needs promptly. Line staff took the time to interact with patients in a positive way, joking around with them or looking at their artwork. The graveyard shift was staffed by three women, who were afraid because they felt that a male coworker needed to be on their shift, and the two males who had previously been on it had been pulled. Night to day shift transition was very busy with many patient requests and nursing staff responsibilities to attend to.

E6

Staff were concerned with keeping patients from annoying each other, as this is often what instigates patient-to-patient assaults. One of the ways they did this was by gently leading “cruisers” away from other patients. At one point a patient picked a chair up over his head, indicating that the chair could easily be thrown. In this instance, he was simply trying to be helpful and put the chair down when staff asked him to. The nursing station and day room were both left unattended for several minutes at a time.

F2

During the observation, a code green was called because of a patient-to-patient assault. Within a couple of minutes, approximately 20 staff and security arrived and the patients were escorted to their rooms. During shift change, staff disagreed on whether or not the patients should be able to be out of their beds. The night staff wanted patients to stay in their rooms and rest, while the swing shift said that it was the patients’ right to be out whenever they want to.

This could create an inconsistent environment, which may be associated with higher patient agitation.

Physical and Psychosocial Environment – Interview Data

The physical and psychosocial environments are contributing factors in situations that lead to assaults. The psychosocial environment also includes patient and staff characteristics. The content analysis of interview data indicated that there was high concordance between management and line staff on what factors contribute to potentially assaultive situations.

Good Practice

Participants indicated that staff have changed their approach to patients somewhat in recent years. One manager gave the example of a patient wanting more milk, something that could turn into an assault three years ago because staff were unwilling to give the patient more milk, but now staff are more likely to give the patient extra milk unless there is a medical reason for them not to. Because of this, there is less “fighting over things that aren’t significant.” Also, patients in the treatment mall used to become frustrated because they couldn’t choose which groups they were enrolled in, but now they have more choice in the matter.

Physical Environment

Various locations in the hospital have had air quality issues such as histoplasmosis, which has resulted in some patients developing pneumonia. When a patient has a disease such as pneumonia, they require more direct care, which leaves fewer staff members available to attend to other patients. Bats living in the HVAC system have also been a problem, and the medication room on one of the wards reportedly has mold growing on the walls. Overcrowding, noise level, lighting, and temperature can all have an effect on the level of patient agitation.

Participants indicated that they felt safer because of the panic buttons that they wear. They know that “when I hit that button, within seconds I’ve got people descending on me.” There appear to be some places in the hospital where the panic buttons do not work, however, such as the art center and certain stairwells.

Psychosocial Environment

Transitional situations such as shift change were seen as times for patient stress, as busy staff were less available to meet their immediate needs during this time. Also, agitations are often carried over from the previous shift, and staff on the new shift may not understand what the problem is or how to deal with it. Graveyard shift was noted as being the most dangerous shift because it has the lowest number of staff. Some patients are aware of this and may actually wait until the graveyard shift to act out. An important aspect of the psychosocial environment is the fact that all patients are involuntarily committed to Western State Hospital and some patients are ready for discharge but are waiting for long periods to obtain placement in the community, which is sometimes difficult to achieve because of limited options.

On the wards, standing in lines for medication, food, and showers was seen as problematic, because patients wanted quicker service and may be paranoid about others invading their space. During mealtimes, patients may be more likely to intimidate each other and fight over food. Another food-related issue is that if a patient sleeps through a meal, staff are supposed to throw their food away, which can cause patient agitation.

Many participants discussed the potential for perceived disrespect to lead to assaults. Patients may interpret a denied request as intentional disrespect, and staff may not even be aware of the miscommunication. This can be particularly dangerous if other people are around and the patient feels the need to prove themselves.

“Even if they’re yelling at you, because they’re already looking maybe low in front of the others, so they’re posturing in front of the other patients, so it’s real important that you give them a graceful way to back down and not humiliate them, because you can’t win that way and then they feel like they have to do something to prove their manhood or whatever.” Supervisory Nurse

Recommendations for the Physical and Psychosocial Environment

1. Use the Workplace Violence Hazard Checklist (Appendix D) to conduct evaluations of all other wards at Western State Hospital.
2. Request an industrial hygienist inspect the air quality at the hospital.
3. Adjust staffing levels based on staff characteristics, patient mix and transitional situations such as shift change.

Training and Education

Training and education refers to formal staff assault prevention training and further learning opportunities for nursing staff and others providing patient care. These include additional courses and informal violence prevention training on the ward in the form of mentoring. Participant responses on the theme of training and education tended to fall into the categories of formal training, informal training, suggested extra training, training for specific types of employees, and staffing issues related to training.

Good Practice

The general consensus was that training in the hospital has improved in recent years. This is attributed partly to the implementation of the Safe Team, which has reportedly had a “huge impact” on safety in the hospital. The setup of the recovery center allows an opportunity for extra staff training; one manager discussed “Fun Tuesdays”, when patients can shop at the incentive store, watch movies, and engage in other activities that are not considered active treatment. During this time, the recovery center can be run with only half the staff, allowing the other half to go to trainings.

Formal Training

Nearly all participants indicated that all employees are required to be trained in assault prevention before going on the ward, and that this training does occur. However, most line staff and most managers indicated that staff sometimes don't receive annual refresher courses, even though they are supposed to be mandatory. Nurses are required to be retrained annually in infection control and other “*stuff that doesn't affect your daily life in the same way that this would.*”

Line staff and managers had similar views on the quality of training in the hospital. Several participants from both groups indicated that the training program has improved in recent years, but there are still some problems with it, particularly the training transfer of techniques for dealing with a violent patient. *Training transfer* is the appropriate and continued application of skills learned during a training course to the working environment. Several factors make it difficult to apply techniques for dealing with a violent patient to situations in the working

environment: violent patients are often too unpredictable to allow staff to get into the appropriate position, adrenaline and fear make it difficult to think clearly, and attacks can happen so quickly that staff do not have time to think about the techniques.

“The safety training we get -- it’s impractical. We’re not going to have patients that are going to allow us to come up beside them and use our hip and do this stuff...It doesn’t apply.” Line Staff

Informal Training

Informal training includes mentoring and on-the-job training, which can be found at Washington State Hospital in the form of the Safe Team. Many participants had positive comments about the Safe Team, and it was cited as one of the reasons that the hospital is safer now than it used to be. Participants indicated that the Safe Team was not utilized often enough, although several acknowledged that they could ask for extra training from Team members at any time.

Currently, some seasoned staff are mentoring new hires on a very informal basis. Some managers expressed concern that the new staff may be learning incorrect procedures when this happens, because some seasoned staff may not have learned the newest procedures or may prefer older procedures. A more formalized system of mentoring could improve this, as managers could then select the particularly good role models to be trainers.

Mentoring can be a valuable tool for facilitating the speed with which new staff develop skills for handling agitated patients. An additional advantage to mentoring is that newly hired employees will be incorporated into the team more quickly and easily. If new hires have a mentor to facilitate learning, they will be less likely to turnover. Reduced turnover will increase patient and staff safety due to team stability.

“DSHS and the mental health division both announced that they want to see us do more in mentoring. But the only mentoring they’re doing is for psychologists, social workers, and psychiatrists. Floor staff -- We have some terrific floor staff here who could go onto the wards and assist the other staff in learning how to manage the patients better. We don’t get a chance.” Line Staff

“I think they take from their peers, and so if you have good peers, and you get new employees, and they’re showing you the ropes -- if you get toxic -- what I call kind of toxic employees and

you get new people in there, then they're going to imprint on those folks. That's why I think a mentoring kind of thing is really, really important." Manager

Suggested Extra Training

Managers and direct care staff agreed that the hospital would benefit in many ways from more training. Several suggestions were made about what kinds of trainings would be the most helpful. Training staff as a team came up repeatedly as something that should be done more often. When two wards were trained as teams for the Medication Alliance Training, it resulted in a large reduction in the number of seclusions and restraints on those wards.

"I think the fix is putting more -- giving more attention to resources for Western so that we can have better-trained staff who stay longer and don't quit in frustration, um, because this is a very hard job." Manager

"If we were able to better train them, if we had the resources to provide coverage so that we could give them more in-house training, teach them better to deal with some of these difficult patients, I think life would be better all around, but we don't. We just don't." Manager

Several participants indicated that they would like to see training that would improve their ability to interact positively with patients. This includes de-escalation techniques, therapy and counseling skills, and clinical trainings such as dialectal behavior training and cognitive behavior training.

Other suggestions included debriefing, conflict resolution for supervisors, specific areas of the hospital (e.g., training that is specific to the forensics ward), and information about mental illnesses that can be particularly difficult to deal with, such as antisocial personality disorder, schizophrenia, and mood disorders. After one patient committed suicide, a member of the line staff did some research on their own about signs to look for in a mental hospital that may indicate that a patient is suicidal, and "most every single one of our male patients here had at least six out of the ten" signs, so more information about suicide could be useful as well.

Training for Specific Types of Employees

Participants expressed frustration with some of the differences in the training received by different types of employees. Most of these frustrations revolved around line staff having much

less access to training than psychologists, doctors, upper management, and others. Direct care staff have the most contact with patients, so lack of training is particularly dangerous for them.

“And those are the people, especially the MHTs, we give the least amount of training to. The least. They don’t have continuing ed. requirements, like the registered nurses do. And yet, we expect them to respond to these patients in ways that don’t escalate patient negative behavior.”
Manager

It was also mentioned that psychologists and psychiatrists are not required to complete the Safe Team training, and that this creates problems because when psychologists or psychiatrists are on the ward, they may not be aware of interventions that have taken place or that are currently taking place.

“Having the psychologists and the psychiatrists not be mandated to do the training is to me a real glitch in the system when the psychiatrists are the ones who are writing the orders for seclusion and restraints.” *Union Representative*

Staffing Issues

Lack of staffing appears to be one of the biggest barriers to adequate training. Currently, continued education is available at the hospital, but it is very difficult for staff to get someone to cover their shift so that they can go to classes. Managers and line staff both indicated that the hospital would be safer if more people were able to go to trainings. However, it appears that some managers with a strong interest in education have still creatively managed to get their employees to trainings.

“We hear all the time that everybody has to go to this training, it’s mandatory, and yet we’re not given the resources to get those people to the training. So if I’m running with my ward bare minimum staffing, I’m not going to cough one up to go to a four-hour training or a two-hour training when it’s going to put everybody else at risk.” *Safe Team Focus group*

Solutions from Staff

Several managers brought up the Medication Alliance Training, a program that is no longer used in the hospital. It was used on two wards initially, and those wards reportedly had a large drop in the number of seclusions and restraints after the training. The main purpose of it was to improve patient adherence to medications, but it also incorporated teamwork, staff-patient

interactions, and teaching therapeutic skills to line staff. Participants indicated that these skills could be very useful to line staff but are not part of their normal training.

Some participants made suggestions for working around the staffing issues. One manager discussed the idea of going onto the wards and doing half hour trainings to “*just start to get this information going.*” Another stated that an effort is currently being made to offer the same refresher course two years in a row, so that staff who miss it one year can have a chance to go to it the next year.

One manager indicated that some patients could benefit from certain trainings, such as those on de-escalation, debriefing, and respect. Training patients could reduce the number of patient-to-patient assaults, and it may be possible to train patients and staff together in some cases, which could ease the burden caused by low staffing as it would not leave the patients unattended. This could also foster a sense of community and better relationships between patients and staff.

“A lot of that is what happens is patients assault other patients. And we need to have some kind of training for the patients, too, that that’s just not okay. We don’t do that. It’s not acceptable in the community. If you want to leave this hospital, we don’t do those kinds of things.” Manager

Recommendations for Training and Education

- a. Ensure that annual refreshers are actually taking place for all staff.
- b. Match new staff to more experienced staff to create a formalized peer mentoring program that will improve training transfer to the wards.
- c. Schedule staffing to account for a ratio of experienced to new staff that facilitates training transfer, skill development, and teambuilding.
- d. Train staff as a team to improve their ability to work together in a crisis and to ease tensions in day-to-day interactions.
- e. Give more training to direct care staff, particularly in therapeutic skills such as those taught in the Medication Alliance training.
- f. Mandate Safe Team training for employees such as psychologists to improve consistency and increase their awareness of what is happening on the floor.

- g. Managers should make training a priority and look for creative ways to work around the challenges presented by current problems with low staffing levels.
- h. Conduct short trainings on the wards. Use “safety huddles” and “teachable moments” as part of debriefing or shift report to communicate safety strategies and problem solving.
- i. Look into the possibility of training patients in respect, de-escalation, and debriefing to decrease patient-to-patient assaults, allow staff to be trained without leaving patients alone, and create better relationships between patients and staff.

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. Sampling for multiple perspectives in the organization was helpful in giving a broad sense of issues concerning workplace violence and safety. We focused on interviews with nursing staff that have the highest level of contact with patients and also with supervisory nurses working on the units, union representatives, and managers, some with nursing backgrounds and others with administrative backgrounds. Given more time and resources, we would have interviewed more deeply across disciplines including more 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 also 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. This would have improved our ability to do a more complex and comprehensive qualitative data analysis and provide findings with increased depth.

Summary of Recommendations by Theme

There are many detailed recommendations here as we thought this may be of benefit to Western State Hospital. We recognize that the hospital has an extensive Continuous Quality Improvement Plan (CQIP) and has initiated many changes that we may be unaware of because we have not examined this 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 the CQIP for long-term organizational change.

Recommendations for Control - External and Internal and Schedule Control

- a. Continue to develop relationships with external organizations such as the legislature and court system to communicate hospital perspectives with the goal of influencing decisions that directly impact the hospital.
- b. 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 and increase safety.
- c. Provide a means for staff inclusion in planning and decision making in key areas of concern for direct care staff.
- d. Increase organizational, supervisor, and team support for direct care providers working under the threat of investigation.
- e. Limit use of mandated and voluntary overtime.
- f. Create a float pool of permanent workers who have the ability and desire to function in this capacity.
- g. Identify options to increase schedule flexibility for direct care nursing staff.
- h. Create a culture of schedule control.

Recommendations for Control - Turnover and Churn

- a. Hire direct care staff and require them to obtain psychiatric certification for their position to improve skills for patient interaction and care. This will reduce stress, risk of assault, and staff turnover.
- b. Improve opportunities for development for CFS direct care staff as they rise in seniority.
- c. Formalize mentorship of new staff from seasoned staff in order to increase team support, build skills and confidence in new staff, and reduce turnover.
- d. Staff satisfaction surveys should be undertaken to identify main causes of turnover and churn. Conduct exit interviews with staff that leave and compile results for leadership to address.

Recommendations for Organizational Culture

- a. Create a Workplace Violence Policy and introduce it to employees in the new employee and annual refresher assault prevention training.
- b. Train managers on the policy and how to implement it.
- c. Train managers to encourage innovation and problem solving toward increasing safety behaviors, a safe environment, and creating a culture of non-violence.
- d. Train managers to speak to non-violence safety culture issues in daily communications and through role modeling effective safety behaviors.
- e. Train managers to build trust and relationship with direct care staff, and to stimulate enthusiasm for teamwork, communication, and support.

Recommendations for Organizational Culture - Communication

- a. When making a major decision, management could open up a 2-day window for comments from line staff, so that they could
 - Gain insight on how the decision is likely to affect patients
 - Avoid resentment and resistance to change
- b. Well-designed organizational culture surveys and employee communication surveys can determine how well the communication systems and practices are contributing to or hindering hospital performance.
- c. Consult direct care staff on major decisions regarding environment, organization, staffing and equipment, as they are likely to have insight on how patients and patient care will be affected.
- d. Meetings for direct care staff will ensure consistent communication and promote teambuilding. Combine a task focus and a relationship-group process focus in each meeting.
- e. Include direct care staff in treatment plan meetings - ask for and value their contribution for improved patient care and safety.
- f. Provide regular bulletins to all staff on changes in policies, procedures, safety practice tips from coworkers, and new hospital changes.
- g. Provide written shift reports to all staff at shift change.
- h. Enforce communication policies such as giving a report to the person who is relieving staff on a one-to-one precaution.
- i. Top leadership can cultivate two-way communication directly with line staff and throughout the organization as an alternative to communicating down the line through the levels of management. When communicating with direct care staff:
 - Communicate the change often.
 - Address why the change needs to occur.
 - Identify what the changes mean to the employee and to the patients.
 - Use a mix of mediums and methods to address all employee communication styles – email with input or questions encouraged, face-to-face meetings with dialogue, newsletters with graphic displays and detailed bulleted information with next steps.
- j. Work with direct care staff, union reps and middle management to streamline incident reporting.

Recommendations for Organizational Culture - Social Support

- a. 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.
- b. Continue to form and implement a CISM team and obtain ongoing feedback from line staff on the functioning and effectiveness of the team to shape it to meet their needs.
- c. Develop and implement a “Respect in the Workplace” hospital policy that defines and addresses incivility including the organizational response to uncivil behavior. Refer to JCAHO Standard LD.03.01.01 for guidance.

Recommendations for the Physical and Psychosocial Environment

- a. Use the Workplace Violence Hazard Checklist (Appendix D) to conduct evaluations of other wards at the Salem and Portland locations.
- b. Update the personal alarm system so that it is safe and effective for staff.
- c. Secure items that have been or that can be picked up and used as a weapon on wards that have high risk for this behavior.
- d. Adjust staffing levels based on staff characteristics, patient mix and transitional situations such as shift change.

Recommendations for Training and Education

- a. Ensure that annual refreshers are actually taking place for all staff.
- b. Match new staff to more experienced staff to create a formalized peer mentoring program that will improve training transfer to the wards.
- c. Schedule staffing to account for a ratio of experienced to new staff that facilitates training transfer, skill development, and teambuilding.
- d. Train staff as a team to improve their ability to work together in a crisis and to ease tensions in day-to-day interactions.
- e. Give more training to direct care staff, particularly in therapeutic skills such as those taught in the Medication Alliance training.
- f. Mandate Safe Team training for employees such as psychologists to improve consistency and increase their awareness of what is happening on the floor.
- g. Managers should make training a priority and look for creative ways to work around the challenges presented by current problems with low staffing levels.
- h. Conduct short trainings on the wards. Use “safety huddles” and “teachable moments” as part of debriefing or shift report to communicate safety strategies and problem solving.
- i. Look into the possibility of training patients in respect, de-escalation, and debriefing to decrease patient-to-patient assaults, allow staff to be trained without leaving patients alone, and create better relationships between patients and staff.

References

- Andersson, L. M., & Pearson, C. (1999). "Tit for tat?" The spiraling effect of incivility in the workplace. *Academy of Management Review*, 24, 454-471.
- Barnett, R. C., & Brennan, R. T. (1995). The relationship between job experiences and psychological distress: A structural equation approach. *Journal of Organizational Behavior*, 16(3), 259-276.
- Belkic, K., & Landsbergis, P. A., Schnall, P. L., & Baker, D. (2004). Is job strain a major source of cardiovascular disease risk? *Scandinavian Journal of Work Environment Health*, 30(2), 85.
- Belkic, K., Landsbergis, P. A., Schnall, P., Baker, D., Theorell, T., & Siegrist, J. et al. (2000). Psychosocial factors: Review of the empirical data among men. In P. Schnall, K. Belkic, P. A. Landsbergis & D. E. Baker (Eds.), *The workplace and cardiovascular disease. occupational medicine: State of the art reviews*. (pp. 24-46). Philadelphia, Pennsylvania: Hanley and Belfus.
- Bensley, L., Nelson, N., Kaufman, J., et al. (1997). Injuries due to assaults on psychiatric hospital employees in Washington state. *American Journal of Industrial Medicine*, 31, 92-99.
- Bluestone, B., & Rose, S. (1998). Public policy brief: the unmeasured labor force: the growth in work hours. Blithewood, Annandale-on-Hudson, NY: The Jerome Levy Economics Institute of Bard College, Bard Publications Office, No. 39.
- Bond, J. T., Galinsky, E., & Swanberg, J. E. (1997). The 1997 national study of the changing workforce. New York: Families and Work Institute.
- Bosma, H., Peter, R., Siegrist, J., & Marmot, M. (1998). Two alternative job stress models and the risk of coronary heart disease. *American Journal of Public Health*, 88, 68-74.
- Gerberich, S. G., Church, T. R., McGovern, P. M., et al. (2004). An epidemiological study of the magnitude and consequences of work-related violence: The Minnesota Nurses' Study. *Occupational Environmental Medicine*, 61, 495-503.
- DOL (1999a). Report on the American workforce. Washington, DC: U.S. Department of Labor.
- Duxbury, J. & Whittington, R. (2005). Causes and management of patient aggression and violence: Staff and patient perspectives. *Journal of Advanced Nursing*, 50(5), 469-478.
- Einarsen, S., Hoel, H., Zapf, D., & Cooper, C. L. (2003). (Eds.). *Bullying and emotional abuse in the workplace: International perspectives in research and practice*. London: Taylor & Francis.

- Eisenberger, R., Stinglhamber, F., Vandenberghe, C., Sucharski, I. L., & Rhoades, L. (2002). Perceived supervisor support: Contributions to perceived organizational support and employee retention. *Journal Applied Psychology, 87*(3), 565-573.
- Findorff, M. J., McGovern, P. M., & Sinclair, S. (2005). Work-related violence policy: A process evaluation. *AAOHN Journal, 53*(8), 360-369.
- Fisher, W. A. (2003). Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. *Journal of Psychiatric Practice, 9*(1), 7-15.
- Forster, P.L., Cavness, C. & Phelps, M. A. (1999). Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. *Archives of Psychiatric Nursing, 13*(5), 269-271.
- Gaskin, C. J., Elsom, S. J., Happell, B. (2007). Interventions for reducing the use of seclusion in psychiatric facilities: Review of the literature. *British Journal of Psychiatry, 191*(2), 298-303.
- Hammer, L.B., Kossek, E. E., Yragui, N. L., Bodner, T. E., & Hanson, G. C. (2009). Development and validation of a multidimensional measure of family supportive supervisor behaviors (FSSB), *Journal of Management, 35*(4), 837-856.
- Hellerstein, D. J., Staub, A. B., Lequesne, E. (2007). Decreasing the use of restraint and seclusion among psychiatric inpatients. *Journal of Psychiatric Practice, 13*(5), 308-317.
- Hodgson, M. J., Reed, R., Craig, T., Murphy, F., Lehmann, L., Belton, L., & Warren, N. (2004). Violence in healthcare facilities: Lessons from the Veterans Health Administration. *Journal of Occupational Environmental Medicine, 46*, 1158-1165.
- Islam, S. S., Surender R. E., Mujuru, P., Priscah, M., Doyle, E. J., & Ducatman, A. M. (2003). Risk factors for physical assault: State-managed workers' compensation experience. *American Journal of Preventive Medicine, 25*, 31-37.
- Karasek, R. A., & Theorell, T. (1990). *Healthy work: Stress, productivity, and the reconstruction of working life*. New York: Basic Books. Karasek, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly, 24*(2), 285.
- LaFond, R. (2007). Reducing seclusion and restraint for improved patient and staff safety. *Journal of Safe Management of Disruptive and Assaultive Behavior*, p. 8-12.
- Lee, S., Gerberich, S. G., Waller, L., Anderson, A., & McGovern, P. (1999). Work-related assault injuries among nurses. *Epidemiology, 10*, 685-691.
- Lehmann, L., McCormick, R., & Kizer, K. (1999). A Survey of Assaultive Behavior in Veterans Health Administration Facilities. *Psychiatric Services, 50*, 384-389.

- Martin, R. J., & Hine, D. W. (2005). Development and validation of the uncivil workplace behavior questionnaire. *Journal of Occupational Health Psychology* 10(4), 477-490.
- Myers, D. J., Kriebel, D., Karasek, R., Punnett, L., & Wegman, D. (2005). Injuries and assaults in a long-term psychiatric care facility. *American Association of Occupational Health Nursing Journal*, 53, 489-498.
- Nachreiner, N. M., Gerberich, S. G., McGovern, P. M., Church, T. R., Hansen, H. E., Geisser, M. S., & Ryan, A. D. (2005). Relation between policies and work-related assault: Minnesota Nurses' Study. *Occupational Environmental Medicine*, 62, 675-681.
- National Association of State Mental Health Program Directors. (2001). Reducing the Use of Seclusion and Restraint: Part II Findings, Strategies, and Recommendations for Special Needs Populations. Medical Directors Council. Alexandria, VA. Retrieved on August 7, 2009, from <http://www.nasmhpd.org/publicationsmeddir.cfm>
- National Association of State Mental Health Program Directors. (1999). Reducing the Use of Seclusion and Restraint: Part I Findings, Strategies, and Recommendations. Medical Directors Council. Alexandria, VA. Retrieved on August 7, 2009, from <http://www.nasmhpd.org/publicationsmeddir.cfm>
- National Institute for Occupational Safety and Health (NIOSH). (2002). The changing organization of work and the safety and health of working people: knowledge gaps and research directions. DHHS (NIOSH) Publication No. 2002-116. Washington, DC: US Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention.
- National Institute for Occupational Safety and Health (NIOSH). (2006). Current Intelligence Bulletin 57, Violence in the workplace: risk factors and prevention strategies. DHHS (NIOSH) Publication No. 96-100. Washington, DC: US Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention.
- Occupational Safety and Health Administration (OSHA). (2004; revised). Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. U.S. Department of Labor, Occupational Safety and Health Administration. Washington, DC. Retrieved on August 7, 2009, from <http://www.osha.gov/Publications/osha3148.pdf>.
- Peek-Asa, C., Howard, J. (1999). Workplace violence investigations by the California Division of Occupational Safety and Health, 1993-1996. *Journal of Occupational Environmental Medicine*, 41, 647-653.
- Pieri, L. (2004). Are nurses receiving enough education on workplace violence? *Association of Women's Health, Obstetric and Neonatal Nurses Lifelines*, 8(3), 187-189.

- Schein, E. (2001). *Organizational Culture and Leadership*. In J. Shafritz & J. S. Ott (Eds.), *Classics of organization theory*. Fort Worth, TX: Harcourt College Publishers.
- Schnall, P. L., Belkic, K., Landsbergis, P., & Baker, D. (2000). *The workplace and cardiovascular disease*. Philadelphia, PA: Hanley and Belfus.
- Smith, G. M., Davis, R. H., Bixler, E. O., Lin, H. M., Altenor, A., Altenor, R. J., Hardentstine, B. D., & Kopchick, G. A. (2005). Special section on seclusion and restraint: Pennsylvania State Hospital system's seclusion and restraint reduction program. *Psychiatric Services, 56*, 1115-1122.
- The Joint Commission. (2009). Sentinel event alert: Leadership committed to safety. Issue 43, August 27, 2009. Oakbrook Terrace, IL. Retrieved on October 7, 2009, from http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_43.htm
- The Joint Commission. (2008). Sentinel event alert: Behaviors that undermine a culture of safety. Issue 40, July 9, 2008. Oakbrook Terrace, IL. Retrieved on October 7, 2009, from http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm
- Theorell, T. (2003). To be able to exert control over one's own situation: A necessary condition for coping with stressors. In J. C. Quick & L. E. Tetrick (Eds.), *Handbook of occupational health psychology*. (pp. 201-219). Washington, DC, US: American Psychological Association.
- Thomas, L. & Ganster, D. (1995). Impact of family-supportive work variables on work-family conflict and strain: A control perspective. *Journal of Applied Psychology, 80*(1), 6-15.
- Van Der Doef, M., & Maes, S. (1999). The job demand-control (-support) model and psychological well-being: A review of 20 years of empirical research. *Work & Stress, 13* (2), 87.
- Washington State RCW 49.19, Retrieved on September 14, 2009, from Washington State Department of Labor and Industries, <http://www.lni.wa.gov/Safety/Topics/AtoZ/WPV/RCW49-19.asp>.
- Western State Hospital, (2009). Western State Hospital Fact Sheet. Retrieved on November 2, 2009, from Washington State Department of Social & Health Services, <http://www.dshs.wa.gov/MentalHealth/wshfacts.shtml>.
- Winstanley, S., & Whittington, R. (2002). Anxiety, burnout and coping styles in general hospital staff exposed to workplace aggression: a cyclical model of burnout and vulnerability to aggression. *Work Stress, 16*, 302-315.
- World Health Organization. (2004). *Work organization and stress. Protecting Workers' Health Series No 3*.

Appendices

- A. Workplace Violence Hazard Checklist
- B. Table of Quotes by Theme from focus group interviews
- C. RCW 49.19 The Washington Workplace Violence Prevention Law – Healthcare Settings

Appendix A – Workplace Violence Hazard Checklist

a) Overall security

1. Is the parking lot attended or otherwise secure?
 - Yes No

2. Are security personnel provided outside the building?
 - Yes No

3. What type of security system does the ward/department have:
 - Surveillance system
 - Security guards
 - Metal detectors
 - Panic buttons/ silent alarms in the rooms
 - Door locks
 - Security mirrors
 - Secured entry (buzzers)
 - Other _____

4. Is there a duress communication system?
 - personal alarm
 - wireless cell phone

Describe _____

5. Can exit doors be opened only from the inside to prevent unauthorized entry?
 - Yes No

6. Are floor plans posted showing building entrances, exits and location of security personnel?
 - Yes No

7. Are these floor plans visible only to staff and not to outsiders?
 - Yes No

8. Is other emergency information posted, such as telephone numbers?
 - Yes No

b) Entry area

9. Locking procedures and locking mechanism

a. Describe procedures

b. Describe locking mechanism

10. Are there physical barriers?

 Yes No Plexiglas partitions Elevated counters Bulletproof customer windows Other _____**c) Circulation**

11. Is there unrestricted movement of the public in the ward/department?

 Yes No

12. Are there alcoves or hallways?

 Yes No

13. Can employees observe patients or clients in the waiting areas?

 Yes No

14. Can employees observe patients or clients in the leisure areas?

 Yes No

15. Can employees observe patients or clients in the bedroom areas?

 Yes No

16. Do employees control lighting adjustment?

 Yes No

17. Are there poorly lit areas in the ward/department?

 Yes No

18. Is there night lighting?

 Yes No

19. Are there poorly lit areas around the building?

- Yes No

20. Is there a waiting room in the ward/department?

- Yes No

If yes, is it over-crowded? Yes No

When is it most crowded? _____

d) On-ward Offices

21. Are there locking provisions?

- Yes No

22. Is there a duress communication system for offices?

- Yes No

23. Is there adequate visibility for entering or leaving offices?

- Yes No

e) Nursing stations

24. Does workstation maximize view and supervision?

- Yes No

25. Are reception and work areas designed to prevent unauthorized entry?

- Yes No

26. Are the employee-only work areas separate from communal areas?

- Yes No

27. Are the employee-only work areas separate from patient areas?

- Yes No

28. Are there physical barriers?

- Yes No

Plexiglas partitions

Elevated counters

Bulletproof customer windows

Other _____

29. Discuss type and level of security/protection.

30. Is there safety equipment available for restraint or takedowns?

Yes No

31. Is safety equipment secure?

Yes No

32. Is a secure place available for employees to store their personal belongings?

Yes No

33. Is there a duress communication system?

Yes No

34. Is a violent event incidence log available and filled out?

Yes No

f) Communal areas

35. Are there picture frames? Yes No

36. Are there loose HVAC louver blades?

Yes No

37. Are ceiling tiles secure?

Yes No

38. Are waiting, leisure, bedroom, and work areas free of objects that could be used as weapons?

Yes No

39. Is furniture free of sharp edges, loose hardware, spring coils, or cords?

Yes No

40. Is furniture heavy enough to prevent throwing?

Yes No

41. Is furniture in the waiting, leisure, bedroom, and work areas arranged to prevent employees from becoming trapped?

Yes No

42. Is door barricading an issue? (anchor furniture)

Yes No

g) Communication

43. Are noise generators isolated (TV, stereo, active programs)?

- Yes No

44. Is the noise level low enough that two individuals can talk without raising their voices?

- Yes No

45. Is there yelling or loud calling out from staff to patients?

- Yes No

46. Is staff mingling with patients in the communal areas?

- Yes No

47. Do patients have to go to the nurse station to request assistance?

- Yes No

48. What is the average wait time for assistance? _____

49. Is the tone of staff respectful when redirecting patients or denying a request?

- Yes No

Appendix B – Table of Quotes by Theme

<p>Control - External Control – Theme</p> <p>Includes issues related to pressures from outside organizations: State funding and laws, Department of Justice, Joint Commission for Accreditation in Healthcare Organizations (JACHO), the court system, the community mental health system, and patient advocacy groups.</p>
<p>Budget for Staff - Subtheme</p> <p><i>“If we could have more FTEs so that people could take the time with the patients, I think that’s what really reduces assaults is the same staff being there day after day that gets to know the patients and we know the approaches that work best with them.” Direct Care Staff</i></p> <p><i>“Our community nurse specialist goes out and does PR with places. That’s made a huge difference...Western State had a bad reputation in the community and he’s gone out and kind of repaired that, and our willingness to train facilities and adult family homes on how to work with the people. ...And I think that helps. When a patient’s been discharged even a month later, and something starts to go sideways and they call and we can send out to go help and try to keep that placement. And that’s saved, and made people successful on their discharges.” Manager</i></p>
<p>Control over Admissions and Discharges – Subtheme</p> <p><i>“So the workloads have increased exponentially. And that decreases our ability to provide care for our patients, and meet their needs.” Manager</i></p> <p><i>“I’ll give an example, one ward this morning, started out with 5 patient monitorings, that’s 5 people that can’t do anything but watch a patient one on one. You can do the math. That’s 40 chart notes -- in addition to three band new (patients) and two transfers. So, they are consumed and that’s where my RN frustration is – that they’re not getting to do the work they’re trained to do. They’re doing paperwork. . . Six to seven hours. I think the floor staff feels put upon like they’re at the front line – nobody cares. The RNs feel like they’re not getting out to do what they’re trained to do. It just adds more to the stress.” Supervisory Nurse Focus Group</i></p> <p><i>“Sometimes we we get patients that are really medically challenging. And I’m wondering, ‘Why are they court-ordered here and not to a medical facility?’ Those types of patients require a lot of staff time.” Supervisor</i></p>
<p>Lack of Community Support – Subtheme</p> <p>Speaker 1: <i>“When we get ready to release them, they’ve got no place to go.</i></p> <p>Speaker 2: <i>Well, sometimes they’re not released.</i></p> <p>Speaker 1: <i>So they become angry and frustrated...The resources in the community are almost non-existent. So, how long can I hold you here before you get so angry you take someone’s head off...The spaces we had to put mental health patients in have been taken over by DD patients. They’re more stable for the most part, they pay more money than mental health pays, so when our guys get to the street, we have a shuffle and they have no place to live...Pierce County has a moratorium that says I can’t put anybody else in a group home.” Direct Care Staff Focus Group</i></p>
<p>Right to Refuse Medications – Subtheme</p> <p><i>“Today’s a good example, all seven came in without a forced med order. So we are dealing with very unhappy dangerous people that come in, and we have no way to control them other than to make safety the highest priority, because they’re new to us.” CFS Nurse</i></p> <p><i>“A lot of our patients come in un-medicated. The courts do not give us the opportunity to force medications, and so they’re very dangerous and extremely—if they do have a mental illness they’re extremely decompensated.” CFS Supervisor</i></p>

Control - Internal and Schedule Control – Theme

Includes concerns regarding low staffing levels, long hours due to mandated and voluntary overtime, inconsistent teams from floating or pulling staff, unscheduled absences, threat of investigation, and turnover and churn.

Low Staffing Levels – Subtheme

“You’ve got patients that have needs that aren’t getting met, because there’s nobody there to meet them, because everybody is spread out to the four winds trying to accomplish everything.” Manager

“But, in terms of the culture of safety, I would say not lack of concern from administration. My experience in talking with them is they’re just as frustrated. They’re -- they are not lost on the fact that any way you cut the dollar, we’re still short-staffed. That is not lost. They have been very conscientious about creative ways that they can do things for staff. But it’s hard. I mean, their hands are tied - you can’t squeeze something out of nothing.” Direct Care Staff

Overtime – Subtheme

“You’ve got people that are way-- doing way too many overtimes. People who are being floated around, don’t know your patient population, don’t know the treatment care plan, don’t know what triggers them off.” Supervisory Nursing Staff

Intermittent Staff - Subtheme

“When I come in Wednesdays and Thursdays, I know I have one or two regular floor staff besides me. Everyone else is going to be pulled. Most likely it’s going to be an intermittent who floats all around the hospital. And then, out of those intermittents, I might get four or five females. And that is very stressful. When I came to work today, my (stress) level was high. Even when people ask, ‘Are you okay?’ I’m like, ‘I’m fine.’ But I’m really trying to motivate myself because I know what I’m up against.”
Direct Care Staff Focus Group

Inconsistent Teams - Floating or Pulling Staff - Subtheme

“When you have to move staff around a lot, it just creates dangerous situations.”
Supervisory Nursing Staff

“The place is safe when you can maintain your own staff. In the NGR1 wards the patients have a great deal of familiarity and trust and they bond with these staff. So, when the staff gets pulled, that can be very tough, because they don’t feel they have anybody to talk to. . . . As far as I’ve seen, it’s the floor staff that gets the brunt of it (assaults).” Supervisory Nursing Staff

“I try to teach people that when you float, you have to have the skills so you don’t get stressed. You have to have the ability to be moved to a new environment with new patients and be able to identify those leaders that are on the ward. You can tell who the experienced ones are and get close to them so you can have a safe day and get through the shift. However, a lot of people don’t have the ability to do that, and they get floated, and that causes stress right off the bat to start the shift off. It also puts the ward and themselves at more risk for injury. Okay?” SAFE Team Focus Group

Unscheduled Absences – Subtheme

“This is a 24/7 service. So that requires probably the majority of the nursing staff to work antisocial hours. They’re working either evening shift or night shift. And they don’t have regularly scheduled weekends off. So the question is, does that contribute to excessive unscheduled absences?”
Supervisory Nurse

“We schedule early in the year for vacations for the entire year. The first round of vacation scheduling (by seniority) the prime vacation times are full. We’re not allowed to give enough people off even to be able to use the time they have earned. If you really have to have time off, you call in sick. If you request a day off, and they say ‘no’ then you’re on – really under pressure not to call in sick. So you don’t even try to

<i>request a day off.” SAFE Team Focus Group</i>
Threat of Investigation - Subtheme
<i>“There’s a lot of people looking over your shoulder, and maybe some of it’s necessary, but it truly does feel like a fishbowl.” Supervisory Nurse Focus Group</i>
<i>“It’s a very detrimental thing when somebody is questioning your honesty and you haven’t done anything, even if there are no findings. They may go through an awful lot of people questioning them, so they are damaged at the end of the process.” Manager</i>

Control - Turnover and Churn – Theme
Includes mention of people quitting or wanting to quit, as well as transfer to other units.
Factors in Turnover – Subtheme
<i>“We were so short on RNs, if you had an RN after your name and there wasn’t a ding on your license and you were breathing, we hired you. So it’s been very difficult, and some of them that we hired are not going to survive.” Manager</i>
<i>“I see it wearing on people. And I know that I have some good friends who have left the hospital because of it, strictly because of how they were treated by colleagues.” Manager</i>
Problems Caused by Turnover - Subtheme
<i>“We’ve had 15 CEOs in 30 years. How can you have continuity of care and management if the CEO’s position itself [is] a political football? How can you organize?” Safe Team Focus Group</i>
<i>“There’s a whole new team in [Human Resources] who doesn’t know Western State...You just feel bad even when you have to call for a basic question, because they’re all so stressed out and overworked. And I think they’re the key for us -- for disciplinary action, for dealing with employees who are toxic or whatever. And so that just isn’t there.” Manager</i>
Excessive Churn - Subtheme
<i>“Governor Gregoire came up with this idea of reducing middle management in government... And so, a bunch of these people were relieved of their jobs. They went off to other jobs. And then, they got re-hired back into seemingly the same jobs as if they had pulled the wool over Governor Gregoire and her team.” Direct Care Staff Focus Group</i>

Organizational Culture –Theme
Includes the attitudes, beliefs and normative behaviors shared by members of the organization.
Workplace Violence Policy – Subtheme
Culture of Fear and Mistrust – Subtheme
<i>“I think that the culture is fear and status quo versus solution-based management.” Direct Carte Staff</i>
<i>“So, if the leadership of the organization were - had integrity, had transparency, had competence, they could begin to build trust. I talked to a person that was hearing this grievance, and . . .she said, ‘I see what you mean when I walk around here. I can’t believe the level of stress I see.’ And she’s not talking about the working staff. She’s talking about the executive committee. The stress is just huge. When they took that CEO out of here, it was like a terrorist attack on all the upper supervisors who felt safe. So, we don’t have leadership here. What we have is management and I think the hospital has been held captive by risk managers.” SAFE Team Focus Group</i>
<i>“I think there’s a sense of being afraid of management. They’re afraid of the response of management - that ‘if we put somebody in restraints, if we make a decision, we’re going to be questioned, and we’re afraid of that’ - maybe because they don’t know how to defend themselves.” Manager</i>

<p>SPEAKER 6: <i>'And you will do it this way.'</i></p> <p>SPEAKER 10: <i>And there's -- and there's no transparency in that. Everything's a secret --</i></p> <p>SPEAKER 6: <i>Behind the doors.</i></p> <p>SPEAKER 10: <i>-- until it's dumped on you. All of a sudden, 'this is what we're going to do, we made this decision,' I don't know who this 'we' is, but 'we' made this decision.</i></p> <p>SPEAKER 3: <i>They won't admit who made the decision.</i></p> <p>SPEAKER 6: <i>They never put their name to it.</i> <i>SAFE Team Focus Group</i></p>
<p><i>"How do you build trust? That's what keeps me awake at night is, 'Am I being fair?' "</i></p> <p><i>Supervisory Nurse</i></p>
<p><i>"I really get a sense that there's a culture of fear and that what we get is reactionary responses from being afraid. And afraid not only of being hurt, but afraid of mental illness and not understanding what it means to be psychotic and how that changes the person. . . I don't think we do a good job of teaching people that those folks get well. They move from that and we end up with folks ready for discharge, and staff has alienated them, because they're so afraid of being hurt."</i> <i>Manager</i></p>
<p>Culture of Non-violence – Subtheme</p>
<p><i>"And if you've got staff who have been working with those patients for 15 and 20 years, and they've been hit 20, 30, 40 times, they're not going to let go of that fear very well. They're going to suffer from PTSD for quite some time. I mean, how many times can you see a coworker get smashed in the face or have their leg broken or their arm broken before it becomes a lingering effect? It doesn't go away. You wake up in the morning with it, and you go to bed with it at night. And so, for a staff member to say, 'Well, I can't restrain or seclude these patients anymore,' created a huge amount of fear among the workers."</i> <i>Direct Care Staff</i></p>
<p><i>"There's that tension between what's the appropriate therapeutic intervention - medication, quiet space, versus custodial - let's take control."</i> <i>Manager</i></p>
<p><i>"And, one of the problems is the admit wards are where a lot of our patients come in un-medicated. The courts do not give us the opportunity to force medications, and so they're very dangerous -- if they do have a mental illness, they're extremely decompensated. We kind of said, 'Okay, administration, we understand what you want, but we're still going to do it our way.' We did try to make some headway into de-escalating patients verbally and -- and try to meet their needs before it went to -- to restraints, but I think that, um, some of our culture now is slipping back into just put them in restraints and we'll sort it out later and talk to them after they're in restraints and we have some control over them."</i></p> <p><i>Supervisory Nurse</i></p>
<p><i>"There is a predominant culture of an "us versus them" with line staff and patients. It's going to be restraints, seclude. It's going to be slam you to the floor so you know that 'you don't mess with me - or, you don't mess with us.' And, you know, people say what they will, I know what I see. And again, that's not every single floor staff because we've got floor staff, and ICs, and RNs that are phenomenal."</i></p> <p><i>Direct Care Staff</i></p>
<p><i>"Because it's very frightening to try to confront a patient who's out of control, who has free access to you. In other words, they can slug you, they can bite you, they can spit on you, they can throw stuff at you. It's very difficult to approach that kind of person and try to de-escalate them verbally. But, if you have them in restraints, you have some control. You have a little bit more control and a little more safety for your staff."</i> <i>Supervisory Nurse</i></p>
<p><i>"Our goal was supposed to be to totally eliminate (seclusion and restraint) and, I don't think that was a realistic goal for the forensic unit to begin with. I think . . .the staff felt we lost the ability to control patients, that we were supposed to not put them in restraints. There's a feeling now that we're gaining some back, but we're only doing it by using more and more restraint time."</i> <i>Supervisory Nurse</i></p>

"She (supervisory nurse) is very supportive of that. She's never said, 'Don't put them in seclusion and restraints.' She's always said, 'Safety first.' You know, 'Discussions later, but maintain safety.'"

Supervisory Nurse Focus Group

"Because, basically, you don't want to wait until somebody's hurt. Which is kind of what was happening, because all -- they wanted to get all of the restraint and seclusion hours down, and so people were backing off on it. Well, people were getting hurt. And she said, 'No. That's not a good thing.'"

Direct Care Staff Focus Group

"People were freaking out (after non-violence initiative was introduced). They didn't know whether we could or we couldn't, even if it was obviously the type of situation where you could put a person in restraints. And people got hurt. People don't feel like the management really cares about them. There's less (injury) than there was, because we've slowly gotten kind of back to doing it (restraints) more frequently than we were two years ago or a year and a half ago." Supervisory Nurse

"I've been involved in the safety battles at this place for the last ten years. I've been heavily involved in accident investigation, all these things going on and why they happened. I kind of disagree on the issue of the restraint, though. I've seen the results of -- of the wards that have tried to go restraint free. And in reality, the injuries dropped." Direct Care Staff Focus Group

Staff Entitlement - Subtheme

"There is a sense of entitlement - people who spend hours out in the parking lot doing whatever they do, in full view of the center director's office. No shame. I mean, at least go around to the other side of the building." Manager

"They say, 'I have a disability and that's why I have the exceptions and the privileges that I do to come in and go as I want, and I fought battles before and I've won battles before. I've litigated against the state and won.' -- Being willing to use their power in a certain way and letting you know, 'I know people in _____. Watch what happens to you this coming year.'" Direct Care Staff

"The difficult staff who have been here a long time, who feel privileged, who feel 'Nothing can happen to me.' They take up so much time. Its way harder working with difficult staff than it is working with a patient. I mean, even the toughest of toughest patients that I've worked with over the years -- staff are more challenging." Manager

"Right now, there is a _____ problem among staff. There's a few times I've attempted to clamp down on it and then quickly, it was like a band, everybody banded together, like, you'd better back off. And I did, you know. I stood down." Union Representative

"I can't really say a lot of managers, but some of the managers use bullying out here as a way to get their people motivated. I'm not sure why. I don't approve of that type of behavior, but, a lot of it comes from employees that have been disciplined before, and won lawsuits against the state or whatever, and then placed back into the same environment. They tend to be extreme bullies out here. They throw their weight around -- they say, 'I'm untouchable,' you know." Manager

Organizational Culture - Communication – Theme

Includes challenges in communicating across levels or between teams and individuals. This can be between management and line staff, coworker to coworker, or within a team.

Hospital Organizational Structure – Subtheme

"In my opinion the hospital is structured in such a way that it makes it really difficult (to communicate). They have what I would call disciplinary silos. Social work is in this silo where all social workers report up the line to social workers. Psychologists just go up to psychologists. Nursing only reports to nursing. So you have these separations between disciplines. . . In most progressive institutions, they are all interdisciplinary and you have a team, and it's a team made up of all different disciplines and you're all

<i>working together and you all report to the same person. When everybody reports to a different person, you have structurally fragmented the team.” Manager</i>
<i>“We have a scenario where center directors’ chains of command interfere with and block. . . so when there is something to communicate to the administration, there’s a filter blocking it at this level of center director because of the disciplinary mismatch. . . The only thing that filters up is what the center director knows and what the center director can understand. We have to make sure that all components of Western State Hospital have an unobstructed chain of command to their clinical leader.” Supervisory Nurse</i>
<i>“The lack of understanding in relating to the patients and the lack of understanding between the different disciplines and divisions here at the hospital (causes me the most stress). If you can’t understand and relate to this patient, you can’t work with this patient. If the RN3 can’t understand how to relate to her MHTs, if the doctor can’t relate to the nursing staff, if the psychologist can’t relate with the social worker – that’s where the frustration lies, because everybody wants everybody to change to the ways that they see things . . . and you can’t get to what really needs to happen.” Manager</i>
Cross-Level Communication - Subtheme
<i>“I sat there listening to all this and the problem here is that here’s all these frustrated people that have all these issues and there’s really no way to get some kind of feedback loop going for most of them. Like, would some manager come back and sit down and say, ‘Well, we heard what you said and here is the answer?’ ” Direct Care Staff</i>
<i>“My stressors are when the administration does not listen, when that feedback loop doesn’t go all the way to the top, like now.” Manager</i>
<i>“No one wants to claim to be management. But an entity that becomes management is there and someone is making the decision. Someone is. I don’t know who.” Direct Care Staff</i>
<i>“I do believe that from time to time the administration expresses an interest in hearing the opinion of the line staff and the union, and I think the evolution of the Central Safety Committee has been helpful working towards that end. I don’t believe the impact has been felt as widely as it needs to be, and part of that is because staff may not be available because of short staffing to participate in the ancillary safety committees.” Union Representative</i>
<i>“It’s only been a couple of years, but we worked really hard at listening to the staff, trying to increase the morale, having work groups set up so staff feel like they have a voice, but it’s very frustrating from a manager’s point, because all of this stuff we continue to implement - meeting daily, monthly . . . it’s still lingering. Staff are still frustrated over things that happened years ago that are now out of our control. I think across the board staff would say, ‘It’s going to change because it always has changed.’ And so they always go with that, taking a step back and going, ‘I can’t feel comfortable, because it’s going to change.’ ” Manager</i>
Reporting Workplace Violence Incidents – Subtheme
<i>“My experience has been on both wards that reporting everything is what we’re asked to do in terms of AROI if there’s a staff injury. But if a patient just curses at staff or just pushes staff, generally, we would just get something in charting. My experience just sitting on those boards (is stressful), absolutely. And it’s equally as stressful when they’re making direct threats to you. They’re cursing you. They’re being just abusive towards you. . . For some people, it’s a cumbersome process (AROI forms). The general attitude about assaults, unless they’re really significant, the general attitude I’ve seen is, ‘toughen up.’ ” Direct Care Staff</i>
<i>“I always say, ‘If there is a question, just fill it out and send it up here. They can print the form right off and just hand write in the form. . . We’ve never had anybody complain that the form was too cumbersome, but at least not to me.” Manager</i>
<i>“I can’t speak for other wards, but I know that I’ve been a bear about, ‘You’ve got to report this, got to</i>

<i>report it, got to report it.’” Manager</i>
Shift Reports - Subtheme
<i>“Our report system is inadequate the way it is right now. If things worked out well, we would be able to read ahead of time who we were to pull to another ward. At the beginning of the shift we give a report on every patient. Well, if you’re pulled from another ward, you don’t know any of the patients.” Manager</i>
<i>SPEAKER: “There’s only 15 minutes for report, but one person is potentially counting meds to take over the med room. One person is taking a census, so that is potentially two people that are not hearing the report. SPEAKER: Usually you have the next shift standing there, but a lot of times they have to go out and deal with what the patients want right away, so not everybody is usually there. SPEAKER: If you are a pulled staff you will probably not get it (the shift report).” Direct-Care Staff Focus Group</i>

Organizational Culture - Social Support – Theme
Includes social support from a supervisor, coworker, union, team or the organization
Organizational Support – Subtheme
<i>“I feel support immediately from some of the folks above me, but in the whole general sense of this hospital, I don’t feel supported. I don’t feel safe. I feel like if I had to take on an issue with an employee that is leading to violence because of their reaction to a patient or something, that I’m going to end up in more trouble than the employee. . .because I’m not going to get supported.” Manager</i>
<i>“The staff that we have here are a very valuable resource. And I’d like to see the administration give us credit for that. Don’t think that’s ever going to happen, but hey, I feel better now that I’ve said it to somebody.” Union Representative</i>
<i>“It would be nice if the larger hospital recognized our program was able to accomplish sometimes, because I don’t think we get that very much.” Manager</i>
Supervisor Support – Subtheme
<i>“I talk to people about, ‘Hey, you did a good job with that patient. Thank you for talking to him that way.’ That changes people’s minds. You have to make that one-to-one connection with somebody.” Supervisory Nurse</i>
<i>“If you let someone know that you are concerned for their safety. . . if you let them know – and the supervisors here do let them know – that they’re concerned that they got hurt and they’re sorry. It’s that little interconnection that makes all the difference.” Union Representative</i>
<i>“A lot of supervisors don’t know they can do anything. They would be hands off. ‘Okay, you gave me this information, but when I’m sitting down with Susie, how do I say that to her in the moment?’ That she can accept it and not challenge me – to really do something differently, and that’s where I think sitting down with a more experienced supervisor and watching how they do it helps someone learn. Or doing it yourself and getting feedback on how you could have done it goes a long way in making that transfer of education into actual action. If we just say, ‘Go do it,’ and nobody’s there onsite to kind of help them then they’re going to struggle and may not make that change. I see that happening a lot.” Manager</i>
Coworker-Team Support – Subtheme
<i>“There’s more of a sense that there’s an interdisciplinary team that is really working. It’s exciting to be part of that, to see how that’s grown under a RN3 who has taken the lead on that. And she’s shifted the culture, so we see the strong partnership. We have the doctors that are actively involved.” Direct Care Staff</i>

<p><i>"I think better personal support (is needed). I think that they need to be mindful of how they talk to each other. In two wards, where there's a teamwork mentality, again, it's the people who have worked together for a long time. They know each other's shortcomings; they know each other's strengths."</i></p> <p><i>Union Representative</i></p>
<p><i>"I don't see how a supervisor here as an RN3 can function without being on the ward. . . That sort of camaraderie and teamwork really depends on a supervisor's attitude that is in touch and aware of their own limitations, because then their appreciation of the strengths of their staff grows enormously, and it won't grow if they're not on the ward working with that person, their team."</i></p> <p><i>SAFE Team Focus Group</i></p>
<p><i>"Okay, so we have a treatment plan. And I have heard people say, 'Oh, well, that's not my responsibility,' and I have told them, 'It's the treatment plan -- the final project is all of your responsibilities. It's the responsibility as a team to make sure it's done, it works for the patient, it's correct, the patient's been included in the process, it's all of your jobs,' - trying to get them to see that they're a team . . . but, it hasn't worked always when other people have been there, because the system is set up to not be a team."</i></p> <p><i>Manager</i></p>
<p><i>"When an RN2 or 3 engages their people in decisions in which they have a stake, they feel included and they feel safer. Every time you put somebody in restraints or take them out, you have an opportunity to build team, or you have an opportunity to really strongly undermine the sense of, 'We're in this together.'"</i></p> <p><i>SAFE Team Focus Group</i></p>
<p>Workplace Violence Incident Debriefing - Subtheme</p>
<p><i>It's not the quality of debriefing one would like to have if one had the opportunity. So this morning's incident, I had the three RNs in the nursing station, and I spoke to one of the PSAs who was then supervising the patient, and there were two or three other people that were part of the escort and I never tracked them down. They were off where they were supposed to be. So the questions for the patient is: What happened? What could staff have done differently? And what could you do differently? Sometimes they write what the patient actually says. And then, the third part, which is done with the treatment team, which would be the doctor, the social workers, the day shift, RN, and whomever else. It's sort of a macroanalysis. What are the programs or system modifications that might be brought to bear? And then, any treatment modifications that they're going to recommend back around the clock. The problem with the system is analyzed."</i></p> <p><i>Manager</i></p>
<p><i>"After an incident occurs, they walk around and they talk to each and every staff. 'Are you okay? Did you see anything we could have done differently?' You know, in not really a punitive way – a sort of information seeking way."</i></p> <p><i>Union Representative</i></p>
<p>Incivility – Subtheme</p>
<p><i>"I think that there are people who are the known bullies in the hospital - a number of which are associated with unions and are part of the union stewards, and they bully both managers and staff."</i></p> <p><i>Manager</i></p>
<p><i>"We move people. Well, that, you know, they're mad at their manager because they're holding them accountable and we move them. 'They're too much for me to work with,' so we just move them to a different spot on the hospital rather than dealing with the problem."</i></p> <p><i>Manager</i></p>
<p><i>People put up with it instead of documenting, documenting, documenting. Then, generally, people get promoted. That's what happened with the individual who was cussing me out. Next thing you know – he's promoted."</i></p> <p><i>Manager</i></p>
<p><i>"Any organization that is inadequately managed, where the experience of staff working there has that toxic level, then you are going to see more horizontal peer-to-peer kinds of conflicts. I like to describe it as a parallel to domestic violence. It's institutional violence. It's like a dysfunctional family."</i></p> <p><i>SAFE Team Focus Group</i></p>
<p><i>"I've seen other upper management who are completely inappropriate and act uncivil in meetings and</i></p>

<i>such. And I'm thinking, 'They're managers here?' I think it definitely needs – it can always be improved upon." Supervisor</i>
<i>"When you have staff who is bullying other staff, the whole team breaks down. And when the team doesn't work together, the patients pick up on it, and then you really have a problem. It's very unsafe." Supervisory Nurse focus Group</i>
<i>"In terms of their stress, I think they take it out on each other. There's a lot of negativity that goes around this place. – just gossip and negative and mean things said." Supervisory Nurse Focus Group</i>
<i>"What keeps me up night mostly is I'd be thinking about interactions with certain staff, or between certain staff – and how hard it is to affect any change." Direct Care Staff Focus Group</i>
<i>"It's awfully distracting if you work against somebody who's bothering you all the time...Maybe you'll get in a bad mood. It sucks all your energy out and you constantly try to keep an equilibrium while dealing with patients." Direct Care Staff Focus Group</i>
<i>"If the RN 3s try to clamp down on the problems, the people they're clamping down on gang up on them." Supervisory Nurse</i>
<i>"It's just so volatile – the anger and the bitterness towards each other sometimes. There are so many excused absences, because it's not just me. All my coworkers are the same way. A lot of us, we'll wake up and say, 'Not tonight.'" Direct Care Staff Focus Group</i>
<i>"I see it wearing on people. And I – I know That I have some good friends who have left the hospital because of it, strictly because of how they were treated by colleagues." Supervisor</i>

The Physical and Psychosocial Environment – Theme

Descriptions of situations that may lead to assaults. Includes the physical and psychosocial environment as contributing factors involved in situations as well as patient and staff characteristics.

Psychosocial Environment – Subtheme

"Even if they're yelling at you, because they're already looking maybe low in front of the others, so they're posturing in front of the other patients, so it's real important that you give them a graceful way to back down and not humiliate them, because you can't win that way and then they feel like they have to do something to prove their manhood or whatever." Supervisory Nurse

Training and Education – Theme

Includes staff assault prevention training formally with ProAct and informally through mentoring.

Formal and Informal Training – Subtheme

"DSHS and the mental health division both announced that they want to see us do more in mentoring. But the only mentoring they're doing is for psychologists, social workers, and psychiatrists. Floor staff -- We have some terrific floor staff here who could go onto the wards and assist the other staff in learning how to manage the patients better. We don't get a chance." Direct Care Staff

"I think they take from their peers, and so if you have good peers, and you get new employees, and they're showing you the ropes -- if you get toxic -- what I call kind of toxic employees and you get new people in there, then they're going to imprint on those folks. That's why I think a mentoring kind of thing is really, really important." Manager

Suggested Extra Training – Subtheme

"I think the fix is putting more -- giving more attention to resources for Western so that we can have better-trained staff who stay longer and don't quit in frustration, um, because this is a very hard job." Manager

"If we were able to better train them, if we had the resources to provide coverage so that we could give them more in-house training, teach them better to deal with some of these difficult patients, I think life would be better all around, but we don't. We just don't." Manager

Training for Specific Types of Employees - Subtheme

"And those are the people, especially the MHTs, we give the least amount of training to. The least. They don't have continuing ed. requirements, like the registered nurses do. And yet, we expect them to respond to these patients in ways that don't escalate patient negative behavior." Manager

"Having the psychologists and the psychiatrists not be mandated to do the training is to me a real glitch in the system when the psychiatrists are the ones who are writing the orders for seclusion and restraints." Union Rep

Staffing Issues – Subtheme

"We hear all the time that everybody has to go to this training, it's mandatory, and yet we're not given the resources to get those people to the training. So if I'm running with my ward bare minimum staffing, I'm not going to cough one up to go to a four-hour training or a two-hour training when it's going to put everybody else at risk." Safe Team

Solutions from Staff - Subtheme

"A lot of that is what happens is patients assault other patients. And we need to have some kind of training for the patients, too, that that's just not okay. We don't do that. It's not acceptable in the community. If you want to leave this hospital, we don't do those kinds of things." Manager

Appendix C. Selection from RCW 49.19 - Washington State

CHAPTER 49.19 RCW

SAFETY--HEALTH CARE SETTINGS

Sections

49.19.005 Findings--1999 c 377.

49.19.010 Definitions.

49.19.020 Workplace violence plan--Security and safety assessment.

49.19.030 Violence prevention training.

49.19.040 Violent acts--Records.

49.19.050 Noncompliance--Penalties.

49.19.060 Health care setting--Assistance.

49.19.070 Intent--Finding--Enforcement.

RCW 49.19.005 Findings--1999 c 377. The legislature finds that:

- (1) Violence is an escalating problem in many health care settings in this state and across the nation;
- (2) Based on an analysis of workers' compensation claims, the department of labor and industries reports that health care employees face the highest rate of workplace violence in Washington state;
- (3) The actual incidence of workplace violence in health care settings is likely to be greater than documented because of failure to report or failure to maintain records of incidents that are reported;
- (4) Patients, visitors, and health care employees should be assured a reasonably safe and secure environment in health care settings; and
- (5) Many health care settings have undertaken efforts to assure that patients, visitors, and employees are safe from violence, but additional personnel training and appropriate safeguards may be needed to prevent workplace violence and minimize the risk and dangers affecting people in health care settings. [1999 c 377 § 1.]

RCW 49.19.010 Definitions. For purposes of this chapter:

- (1) "Health care setting" means:
 - (a) Hospitals as defined in RCW 70.41.020;
 - (b) Home health, hospice, and home care agencies under chapter 70.127 RCW, subject to RCW 49.19.070;
 - (c) Evaluation and treatment facilities as defined in RCW 71.05.020(8); and
 - (d) Community mental health programs as defined in *RCW 71.24.025(8).
- (2) "Department" means the department of labor and industries.
- (3) "Employee" means an employee as defined in RCW 49.17.020.
- (4) "Violence" or "violent act" means any physical assault or verbal threat of physical assault against an employee of a health care setting. [1999 c 377 § 2.]

NOTES:

*Reviser's note: RCW 71.24.025 was amended by 1999 c 10 § 2, changing subsection (5) to subsection (8).

RCW 49.19.020 Workplace violence plan--Security and safety assessment. (1) By July 1, 2000, each health care setting shall develop and implement a plan to reasonably prevent and protect employees from violence at the setting. The plan shall address security considerations related to the following items, as appropriate to the particular setting, based upon the hazards identified in the assessment required under subsection (2) of this section:

- (a) The physical attributes of the health care setting;
- (b) Staffing, including security staffing;
- (c) Personnel policies;
- (d) First aid and emergency procedures;
- (e) The reporting of violent acts; and
- (f) Employee education and training.

(2) Before the development of the plan required under subsection (1) of this section, each health care setting 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, a measure of the frequency of, and an identification of the causes for and consequences of, violent acts at the setting during at least the preceding five years or for the years records are available for assessments involving home health, hospice, and home care agencies.

(3) In developing the plan required by subsection (1) of this section, the health care setting may consider any guidelines on violence in the workplace or in health care settings 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 health care setting accrediting organizations. [1999 c 377 § 3.]

RCW 49.19.030 Violence prevention training. By July 1, 2001, and on a regular basis thereafter, as set forth in the plan developed under RCW 49.19.020, each health care setting shall provide violence prevention training to all its affected employees as determined by the plan. The training shall occur within ninety days of the employee's initial hiring date unless he or she is a temporary employee. For temporary employees, training would take into account unique circumstances. 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 49.19.020:

- (1) General safety procedures;
- (2) Personal safety procedures;
- (3) The violence escalation cycle;
- (4) Violence-predicting factors;
- (5) Obtaining patient history from a patient with violent behavior;

- (6) Verbal and physical techniques to de-escalate and minimize violent behavior;
- (7) Strategies to avoid physical harm;
- (8) Restraining techniques;
- (9) Appropriate use of medications as chemical restraints;
- (10) Documenting and reporting incidents;
- (11) The process whereby employees affected by a violent act may debrief;
- (12) Any resources available to employees for coping with violence; and
- (13) The health care setting's workplace violence prevention plan. [1999 c 377 § 4.]

RCW 49.19.040 Violent acts--Records. Beginning no later than July 1, 2000, each health care setting shall keep a record of any violent act against an employee, a patient, or a visitor occurring at the setting. At a minimum, the record shall include:

- (1) The health care setting's name and address;
- (2) The date, time, and specific location at the health care setting where the act occurred;
- (3) The name, job title, department or ward assignment, and staff identification or social security number of the victim if an employee;
- (4) A description of the person against whom the act was committed as:
 - (a) A patient;
 - (b) A visitor;
 - (c) An employee; or
 - (d) Other;
- (5) A description of the person committing the act as:
 - (a) A patient;
 - (b) A visitor;
 - (c) An employee; or
 - (d) Other;
- (6) A description of the type of violent act as a:
 - (a) Threat of assault with no physical contact;
 - (b) Physical assault with contact but no physical injury;
 - (c) Physical assault with mild soreness, surface abrasions, scratches, or small bruises;
 - (d) Physical assault with major soreness, cuts, or large bruises;
 - (e) Physical assault with severe lacerations, a bone fracture, or a head injury; or
 - (f) Physical assault with loss of limb or death;
- (7) An identification of any body part injured;
- (8) A description of any weapon used;
- (9) The number of employees in the vicinity of the act when it occurred; and
- (10) A description of actions taken by employees and the health care setting in response to the act. 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 upon request. [1999 c 377 § 5.]

RCW 49.19.050 Noncompliance--Penalties. Failure of a health care setting to comply with this chapter shall subject the setting to citation under chapter 49.17 RCW. [1999 c 377 § 6.]

RCW 49.19.060 Health care setting--Assistance. A health care setting needing assistance to comply with this chapter may contact the federal department of labor or the state 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 health care settings to develop technical assistance and training seminars on plan development and implementation, and shall coordinate their assistance to health care settings. [1999 c 377 § 7.]

RCW 49.19.070 Intent--Finding--Enforcement. It is the intent of the legislature that any violence protection and prevention plan developed under this chapter be appropriate to the setting in which it is to be implemented. To that end, the legislature recognizes that not all professional health care is provided in a facility or other formal setting, such as a hospital. Many services are provided by home health, hospice, and home care agencies. The legislature finds that it is inappropriate and impractical for these agencies to address workplace violence in the same manner as other, facility-based, health care settings. When enforcing this chapter as to home health, hospice, and home care agencies, the department shall allow agencies sufficient flexibility in recognition of the unique circumstances in which these agencies deliver services. [1999 c 377 § 8.]