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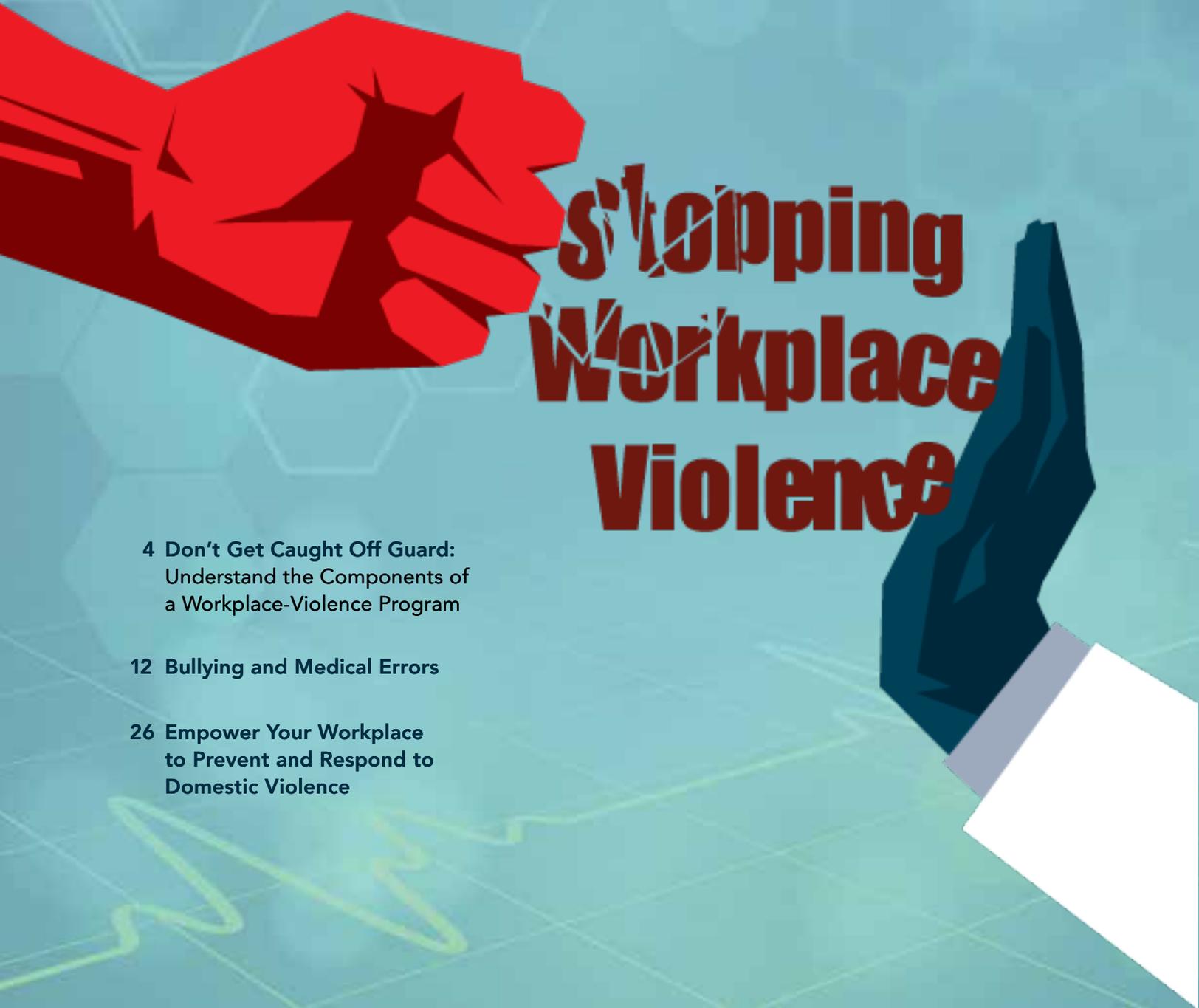
Stopping Workplace Violence

THERE WAS NO TRIGGERING EVENT. WE HAD NO PIVOTAL MOMENT.

It was simply the understanding that we can't wait for a disaster to hit before planning how we'll protect our employees and patients from violence.

The reality of violence in our society today—against health-care workers or otherwise—necessitates that employers seriously address potential risks of violence.

We're not a large, public medical facility with the expected security staff that a hospital has. We're a clinic and an ambulatory-surgery center with five locations, where patients are put under sedation regularly.

We have had a Disaster Committee in place for a while, but increased employee concerns about violence led us to reinvigorate our efforts and host training from outside entities. In fact, our recent training events were a direct response to employee concerns.

We participated in a seminar from Physicians Insurance, and we had a safety expert train employees at each of our locations about managing an active-shooter episode. We practiced real-life scenarios that included countering a shooter. We learned what a safe room is. We determined where the safe room would be at each location, plus how to barricade it against a perpetrator if necessary.

Hosting such hands-on training can be unnerving, but we owe it to our employees. Health-care providers and our front-line staff have enough unpredictability in their day. Building predictability for employees with workplace-violence policies within an overall safety plan gives them better footing to provide patient care and to watch out for each other.

When you face workplace violence head-on by understanding and training for the threats your workforce may encounter, you are telling your employees that you care about their safety. You improve the health-care environment, and can make a difference in the wellbeing of your staff. And when your environment is safe and your employees can thrive, your organization is better able to focus on delivering quality care to patients.

Rachel Todd, MBA, FACHE
CEO, Puget Sound Gastroenterology

FEATURES

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Don't Get Caught Off Guard

Understanding the Components of a Workplace-Violence Program

By Jenny Schmitz,
MA, MEP, Co-CEM, HEM

PICTURE THIS: It's an average day in your organization. The Emergency Department is busy, and an experienced nurse is caring for a patient in an exam room. As she turns her back to make a note in the patient's record, the patient jumps from the bed and kicks her in the back. She cries out, falls to the floor, and hits her head. She starts bleeding from her wound.

ASK YOURSELF:
- If this were your employee, what would you do?
- What type of workplace violence is this?
- What policy covers this event?

Unfortunately, this is not an uncommon scenario in health care. The Bureau of Labor Statistics (BLS) reports that between 2011 and 2013, health-care and social-service settings accounted for 74% of workplace assaults.[1] 74%! And these types of violent events are thought to be significantly underreported. In a 2011 survey, the Emergency Nurses Association found that nurses who experienced a physically violent event only filed a formal report 35% of the time.[2] Reports filed for verbal abuse dropped to 14%.[3]

The financial impact can be staggering. Employees who are hurt on the job will typically be covered by worker's compensation insurance at a cost. For example, one hospital system had 30 nurses in one year who required treatment for violent injuries—at a cost to the hospital of $94,156.[4] Some costs are less obvious. Caregiver fatigue and stress, for example, can be tied to errors and patient infections.[5] Employees often leave an organization for

The Bureau of Labor Statistics (BLS) reports that between 2011 and 2013, health-care and social-service settings accounted for 74% of workplace assaults.

these reasons, and the estimated cost of replacing one registered nurse is $27,000–$103,000.[6]

WHAT IS WORKPLACE VIOLENCE?
To begin, let's define workplace violence. The Occupational Safety and Health Administration (OSHA) defines "workplace violence" as any physical assault, threatening behavior, or verbal abuse occurring in the workplace, which can include physical harm to a person, threats with a weapon, sexual assault, verbal threats, obscene phone calls, and intimidation.[7] "The workplace" is any location where an employee performs work-related duties, including buildings and their surrounding perimeters, field locations, and anywhere on the way to and from work assignments. As you begin to think about workplace violence and a strategy for preventing it, think about all the places where your employees do their work.

Remember: each employee can be at risk for workplace violence, as risk factors abound in health-care facilities. Health-care employees often work in isolation with patients in an exam room or procedure room, which leaves them with minimal ways to protect themselves if a patient becomes violent. The public can access most health-

care facilities freely, which makes for a pleasant patient experience—but facility openness can also lead to a significant compromise in employee safety. Additional risk factors include the availability of pharmaceuticals and money in health-care facilities; the presence of trauma victims and distraught families; patients/clients who have a history of violence or drug use; and poor environmental design and lighting that limits the field of view.

TYPES OF WORKPLACE VIOLENCE
There are four types of workplace violence in health care, as defined by OSHA:

TYPE 1: Violence by Strangers
Violence by strangers is most likely to occur in organizations that have contact with the public and that have (or may be assumed to have) items high in value on-premises. In health care, strangers can target facilities and employees alike, with robbery, vandalism, and car theft topping the list of types of violence in this category. Often, violence by strangers increases in high-crime neighborhoods and within the community around health-care facilities.

TYPE 2: Violence by a Patient, Family Member, or Visitor
This is the largest source of violence in the health-care setting. In 2013, the BLS found that 80% of serious violent incidents reported in health care were caused by interactions with patients.[8] There is also a perception that there is no repercussion for this type of violence and that it is "part of the job," with many health-care employees understanding that some of the injuries caused by patients are unintentional, and being willing to accept them as unavoidable. According to the same 2013 BLS survey, the most common injuries in this category were from hitting, kicking, beating, and shoving.

Although most injuries in this category are inflicted by patients on employees, there are a few other considerations to be taken into account. Family members and visitors can also be the source of violent acts toward employees. Especially in times of stress and angst, emotions can run

Pulling Together

to Manage a Workplace-Violence Program

By Jenny Schmitz

There are so many parts to creating a workplace-violence program. In December 2015, the Occupational Safety and Health Administration (OSHA) published "Preventing Workplace Violence: A Road Map for Health-care Facilities" as a guide.[1] Not only does the road map outline the process for creating a program, but it also offers real-world examples from health-care facilities across the country that have created and implemented different processes to address workplace violence.

THE FIVE CORE ELEMENTS
OSHA has identified five core elements to be included in a workplace-violence program:

1. **Management Commitment and Employee Engagement**
The success of any program begins with management commitment and employee engagement. In a 2011 survey conducted by the Emergency Nurses Association, only 16% of nurses surveyed reported that hospital administration was "completely committed" to eliminating workplace violence against emergency nurses.[2] In the same survey, physicians were reported as "completely committed" by 35% of nurses, Emergency Department management staff by 40%, and

the workplace-violence committee will not be effective without the voice of the employee. It is important to include employees from various departments across the organization, and to encourage open participation. Include employees in policy revisions, and let them be the cheerleaders of the committee with their peers. Successful employee engagement will increase compliance with the program and encourage prompt reporting of violent incidents.

2. Worksite Analysis and Hazard Identification
Identifying hazards and assessing the workplace should be a constant process. Initial assessments should be reevaluated regularly. Use a varying group of people to conduct these assessments, in order to get different perspectives on the assessment. Collect data, look at security reports, conduct hazards assessments of every workspace, and talk to employees to get their input. When violent events happen, review them and learn from them.

3. Hazard Prevention and Control
Once the hazards are identified, they need to be prioritized and addressed. Allocate funding to address the more severe hazards, and look for creative and cost-effective ways to address the others. Implement new processes, and document your decisions.

4. Safety and Health Training
Ensure that all employees have education or training regarding workplace violence, because all of them are at risk of at least one of the four types of workplace violence. Training can include online education, verbal de-escalation training, and what to do if an employee is the victim of a violent event. Consider a tiered training program, involving some lessons for all employees and others for those in "high-risk" areas. Add workplace violence to the mandatory training program, and reach out to other hospitals and contact experts to assist

with the program.

5. Recordkeeping and Program Evaluation
Data on injuries, illnesses, accidents, assaults, training programs, corrective actions, and hazard assessments will help you identify gaps, understand the severity of workplace violence, and identify trends in its occurrence. This will help you identify and target your biggest risk areas.

And just as with other committees and programs, evaluate your workplace-violence program. Identify your success and keep looking for area to improve. Document your findings, and share them with your organization's employees and management.

JUST WHAT EVERYONE WANTS: ANOTHER COMMITTEE
It's a common sentiment—but a Workplace-Violence Committee is the most common way to coordinate all the moving parts that make up a successful workplace-violence program. You can address all five of the program's core elements within the committee, and the committee can keep the progress on track.

As with any committee, you must have a strong chair. The chair could be someone from management, or an employee—or perhaps a co-chair model would work for your organization. In addition to management and employee representatives, other key participants in the committee commonly include personnel from human resources and risk management, safety specialists, security officers, nurses, physicians, and pharmacists. Your organization can always adjust participation as needed, but be sure to select committee members who will be champions of the committee, broadcasting the committee's work to the whole organization.

As you create your committee, you may find that some of the core elements of your workplace-violence program are already covered by other committees (risk assessment, injury review, safety training,

nurses themselves by 55%.[3] Management commitment can be the motivating force that proves that employee emotional and physical safety is a priority, and that addresses workplace-violence issues. With management commitment and engagement, policies can be reviewed, implemented, and enforced— and it's an organization's management that can allocate funding to support efforts (security systems, staff training, etc.). Just as strong management is needed,

MD vs. RN: The Patient Always Loses

By Kathleen Bartholomew, RN, RC, MN

I worked very, very hard to care for five children while living in a single-wide trailer, attending nursing school full-time, and working thirty-five hours per week. This feat required me to drive nearly a hundred miles each day, since we lived in the country. So when the dean of the school of nursing ceremoniously pinned me at graduation, I could not stop sobbing with relief.

I was really looking forward to being a nurse, but I was shocked when in my first position the physicians treated the nurses so badly. I watched the nurse call in a temperature of 102.6 on her post-op patient. And then I watched her jump because the doctor slammed down the phone without even speaking a single word. I witnessed a physician verbally abusing a nurse and then found her crying in the locker room. At 38, I seriously questioned my choice of profession.

Every nurse I know can recall at least one disturbing physician-nurse scene, and research validates the subjective observations. More than 90 percent of nurses witnessed disruptive behavior in the workplace an average of six to 12 times per year. When asked if they knew of a nurse who left the workplace specifically because of verbal abuse by a doctor, 35 percent responded "yes." Many of these conflicts leave deep scars. They are extremely personal, and have the power to be extremely hurtful to individual integrity and the profession of nursing. Research affirms a direct link between negative relationships and morale (Rosenstein, 2002).

After four years as a staff nurse I moved with my family to Seattle. As the manager of a large surgical unit, I witnessed poor RN-MD relationships from a new perspective, and again found no shortage of examples. When rounding one morning, I discovered from a patient's husband that his wife had been in excruciating

pain for three hours. I immediately sought out the night nurse and asked for an explanation. "I gave her every drug I could. I just didn't want to be yelled at again by the doctor. He is so degrading and irate, and screams at me if I call before 7 a.m." When nurses and physicians don't communicate, it's the patient who loses every time. The bottom line is: negative relationships equal negative patient outcomes.

A review of the literature shows that neither collaboration nor enhancing opportunities for communication improves these relationships. Studies show that poor physician-nurse relationships impact morale, job satisfaction and job retention. A survey of over 120 physicians, nurses, and administrators showed that physicians and nurses do not agree on potential solutions, barriers to progress, or responsibility for the problem. The main reason for this is that physicians do not understand the nurses' role.

Most significant are findings that units with good relations between doctors and nurses have decreased mortality rates (Knaus 1986, Baggs 1992). In a study of thirteen intensive-care units, patient-risk-adjusted mortality increased 1.8-fold as a result of poor nurse-physician communication (Knauss, 1986).

The reason that collaboration and communication attempts to improve physician-nurse relationships have failed is because neither group understands the power differential. The dominant role of physicians and the subordinate role of nurses are rooted in the very history of the nursing profession. Early in the 1900s, physicians argued that "the nurse does not need an education, because the physician already has one." This belief in superiority was further compounded by gender issues and the fact that most nurses were from middle-class backgrounds while physicians were often from the upper class. Based on the military model, nurses

When the doctor

approached the main desk with a loud voice shaking his finger at the nurse shouting, "I don't know how many times I have to tell you…", she calmly said,

"Can I see you for a minute in private?"

"First of all, I am very bright and you only have to tell me something once and I will remember it. I have no idea what you were talking about. And lastly, please don't ever shake your finger in my face again."

What happened next is what might happen every time if more physicians were confronted — he apologized.

learned not to act independently unless given an order, and not to question superiors (Charge Nurse, Post-op orders, and General Surgeon, etc.).

The major problem is that neither group—nurses nor physicians—is aware of the power play that keeps the nurse subordinate and the physician in the dominant position. For example, physicians often ignore nurses, make poor eye contact with them, and quite frequently don't know their names. Likewise, nurses often begin a late-night call to physicians with "I am sorry to bother you," implying that the order they need is an imposition. And most critical of all, nurses generally tolerate and do not report disruptive and verbally abusive physicians.

What can nurses do differently? Always speak your truth. If the physician does not know your name, introduce yourself—and if he or she forgets, then remind him or her. Hold the expectation that as a professional, you require this courtesy. If a physician is intimidating or abusive, pull him or her aside. Describe the behavior that bothered you, the way it made you feel, and the impact it had on your relationship and ability to communicate for the common goal of what is best for the patient. Compliment physicians who create a collegial atmosphere where you can ask questions, raise concerns, or make suggestions.

Physicians may not realize the behaviors they have picked up, and unless we point

Caring for Those on the Front Lines of Medicine

Many medical responders and health-care providers are at the front lines of violence every day while receiving and treating patients.

Hospitals play a critical role in responding to the events of community violence that occur in their geographic areas or, even worse, within the vicinity of the medical centers themselves.

Disaster and emergency-response planning plays a critical role in ensuring staff are equipped with the steps and skills they need when an emergency strikes. However, these caregivers are very often not protected from or treated for the violence and trauma they face each day in their work.

St. Cloud Hospital lies in the city of St. Cloud, a city in the heart of Minnesota with a population of 65,000. Lessons from what that Level 2 trauma center experienced can serve other hospitals that may find themselves in similar situations.

Rachel Mockros, an emergency-preparedness coordinator for the hospital, says they've never been immune to critical events, with

Minneapolis only 60 minutes away and a steady stream of trauma patients from much of rural Minnesota. Because of this, they train a considerable amount for disasters, including violent events.

One such traumatic happening occurred in October of 2015. A patient who had attempted suicide was brought in, unconscious. "He had a warrant for his arrest because he had committed some very violent acts against his wife," Mockros says. "He was placed in the ICU, and because of security concerns, he had a county deputy guarding him."

When the man regained consciousness just around dawn, he attacked the deputy on duty, grabbed his service weapon, and shot him during a struggle. A hospital security guard, at great risk to his own safety, rushed in and shot the man with a Taser, sending him into cardiac arrest. "Our staff was in lockdown, and suddenly we had two medical emergencies," Mockros recalls.

But their training did not fail them. After the shots were heard, emergency buttons were pushed, summoning security. Every employee on duty, without exception, immediately followed the protocols they'd learned for dealing with an active shooter on the premises, and when the all-clear was given, personnel rushed in to provide emergency care to the wounded deputy and his assailant.

Though neither the assailant nor the deputy survived, Mockros says, "We feel very fortunate we had been training for several years for these types of events, which I feel is a key to a proper response. Training frequently, taking it seriously, and taking the time to go through the steps you'd do in real life is invaluable."

After the shooting, Mockros adds, "I was very humbled by the amount of gratitude the staff expressed about their training and preparedness. We'd taken a stand to say that this kind of training is important, that it is a part of our culture, and that we take it seriously. I feel at the end of the day, it has become a mindset for us."

The staffers at St. Cloud Hospital were tested again in May 2016, when a patient in a secure mental-health observation room attacked a staff member. Though everything in the unit was accessible only to those with secure badges, the patient grabbed a badge reader from the wall, pulled wires out of it, and tried to strangle a staffer. The staffer came through the experience okay, but the event was so unpredictable in nature that it caught the team off-guard. "We learned from this, of course, and now all badge readers are safely secured to walls. Environmental safety is so important in mitigating these events," shares Mockros.

Both events highlight the need for hospital staff to communicate from wherever they are. The hospital's communication strategy includes loud personal alarms on every staff badge, as well as silent staff-alert buttons that can be pressed discreetly to call for help, so that a potentially dangerous situation can be de-escalated without alarming or further aggravating the patient, visitor, or intruder.

"For situations like shooters, we practice 'run, hide, fight' twice a year," Mockros says. "We practice as though there's an armed person intending to cause harm to people in the building. We help staff learn how to choose the best option for safety, wherever they are."

The St. Cloud team members were tested yet again, months later, when eight shoppers were stabbed at a local mall. The assailant was shot and killed by an off-duty police officer who happened to be shopping in the mall at the time.

EMS workers performed triage at the scene and brought in the most critical patients first. "We were privileged to have a police officer in the emergency room at the time, and he was able to give us information as the event was occurring," Mockros says. "This gave us a 20-minute warning, and we were able to clear out half of the emergency room in preparation."

Again, they were aided by their advance training—in this case, for responding to mass casualties. "We shared with the patients in the lobby what was happening, and told them we had these critical patients coming in," says Mockros. "Some of the patients stuck around, and several left. We opened treatment rooms very quickly. We managed it with the staff on duty, although we called staff from within other places in the facility." All the victims survived.

Since those three events, the hospital's staff has done a lot of thinking about what worked and didn't work, Mockros shared. What continually arose was the importance not just of regularly training to respond safely and effectively to violent events or mass casualties, but of attending to staff humanely in the aftermath of such events. The deputy's shooting and death in the hospital, for example, shook the sense of safety of many in the workplace, she said.

"The biggest piece to deal with was the healing," Mockros recalls. "No staff member was physically harmed, but emotionally, they were definitely impacted. How to provide them with the tools they need to heal is the challenge."

For some staff, the needs were as simple as having security walk with them to their cars at the end of each shift. Others needed a healing touch, brought to them by massage therapists at work. Others responded to therapy animals. "We offered everything," Mockros says. "Prayer services, counseling—you

> "We'd taken a stand to say that this kind of training is important, that it is a part of our culture, and that we take it seriously."

name it, we offered it. Everybody heals differently, and at a different pace."

Perhaps one of the most audacious things the hospital did was to offer as much paid leave as anyone wanted. "We just gave it to them, and nobody abused it. Everyone used it, we feel, for good reasons," Mockros says, adding, "After all, we heal patients, so why not heal the staff?" PR

Bullying and Medical Errors

By Kathleen Bartholomew, RN, RC, MN

Only six months into my tenure as nurse manager, a sentinel event occurred that directly linked bullying behaviors to medical errors.

On morning rounds, I was informed that a patient, found with an oxygen saturation of 52 percent, had been taken to the ICU. An MRI showed anoxic changes of the brain that were so significant, the physician was concerned his patient would not return to baseline. Even on a full re-breather mask, the patient could not converse normally. I took the Patient Controlled Analgesia (PCA) machine into my office and opened it up to find that the machine had been mistakenly programmed for morphine instead of Dilaudid. The patient's decreased saturation was a direct result of his or her receiving more than 10 times the normal dose of narcotics.

Just then the door opened, and the nurse who was responsible for the patient came into my office. Before bursting into tears, she mumbled something under her breath. After reviewing the narcotic administration policy and debriefing her shift, I finally asked, "What did you say when you first came into

my office? It sounded like 'I shouldn't have let them get to me.'"

Immediately the young nurse looked downward at the floor as she told her story:

I was about seven or eight minutes late for my shift last night. When I came around the corner of the nurses' station, a group of nurses who had been talking suddenly stopped when they saw me. I don't mean to be paranoid, but the conversation never picked up again. I went into the ladies' room—you can hear from there, you know. Ellie said, "She'll never make a good nurse, will she?" Then someone else, whose voice I didn't recognize, said, "She just doesn't have what it takes, does she?" I let those words destroy me. This is all my fault.

No amount of counseling could console her. Six weeks later she transferred off the unit to the very first position in the hospital. Was this an isolated event, or a trend? As a manager, I

- **Covert**: unfair assignments, refusing to help or ignoring someone, making faces behind someone's back, refusing to work with certain people or not working with others at all, whining, sabotage, exclusion, and fabrication

The current system is perfectly designed to hide the relationship between bullying and medical errors, because both bullying and horizontal hostility create feelings of shame in all humans, regardless of their level of education. Neither physicians nor nurses report them because, often, their perception is that "there must be something wrong with me." The deep-seated emotion of shame keeps the very behaviors we need to address traveling just under our cultural radar—like an undertow,

> "I understood clearly that my patients would never be safe until the nurses themselves were safe."

invisible and strong, taking our profession way off-course.

2. Absent and Ineffective Leadership

Despite the data, leadership in health care (from the front lines to executive level) has often fallen short of creating the team environment proven to provide a safe environment, and it has not heeded the critical call for leveling power dynamics.

A recent meta-analysis of all articles published on patient safety showed that a patient-safety culture possesses seven distinct subcultures. The first one is leadership. This is where we commonly fail. Leaders do not perceive their own cultural norms because they themselves are immersed in them everyday. Therefore, they also do not dedicate the necessary funds and resources to change the culture, and a few disruptive health-care workers may continue to destroy trust. Leaders may perceive relationship issues as "soft stuff" or unworthy of budget allocation, so education in this area is slim to none.

MISTRUST SQUARED: LACK OF TRANSPARENCY

Making harm more visible increases trust, which is the fundamental characteristic of a team. But damage from medical errors is often driven underground in the current culture because of shame and a litigious society. A longstanding cultural meme says, "A good nurse or doctor does not make mistakes." Yet our solutions for eliminating errors do not even begin to address these powerful longstanding cultural norms. Both nursing- and medical-school curricula have failed to abolish this established myth. For example, I was speaking on creating a just culture to a group of third-year medical students, and asked, "When was the last time you did something wrong?" And a voice from the back of the room called out, "When was the last time I did something right?" We immediately stopped the presentation and discovered that the entire class felt exactly the same way. As long as we continue to beat up residents and nurses and deliver their education in silos—so long as nurses and physicians continue to feel ashamed of imperfection and hide their medical mistakes—nothing will change.

Because of a culture of blame and shame, medical errors are underreported and hidden within the system. There is no universal system for reporting errors or a way for hospitals to be immediately notified of an error to ensure that it does not happen again.

3. Poor Communication Skills and Inability to Confront = Fear-Based Culture

It is also well known that communication is the number-one cause of all sentinel events. A recent study of more than 4,000 health-care workers revealed that nurses were afraid to speak up because of fear of retaliation, fear of making the situation worse, or fear of isolation from the group. Health care breeds a fear-based culture, and strong leadership over an extended period is necessary in order to change a culture. However, due to a focus on financial survival in a time of great change, the attention of health-care leaders is constantly diverted to the bottom line, and the consistency needed

realized that if I didn't change the conditions under which this event happened, there was a strong possibility it could recur. I understood clearly that my patients would never be safe until the nurses themselves were safe. I also knew that my role as a nurse leader must expand to accept the responsibility for creating and monitoring the atmosphere in which my nurses worked. What were those systemic conditions?

1. Culture of Horizontal Hostility

Horizontal hostility is defined as a consistent pattern of behavior designed to control, diminish, or devalue a peer (or group) that creates a risk to health or safety. Some specific examples include:

- **Overt**: name calling, bickering, fault finding, criticism, intimidation, gossip, shouting, blaming, put-downs, and raised eyebrows

Protecting Health-care Workers

A Summary of Laws in Our Members' States

By Justin Steiner, JD

As violence in health care has reached the national consciousness, states across the country have responded by enacting laws and regulations to prevent such violence.

A handful of states have enacted laws requiring health-care employers to implement workplace-violence programs.[1] Other states have responded by increasing the criminal penalty for violence against health-care workers.[2] Below is a summary of the law in four Western states relating to the problem of violence against health-care workers.

ALASKA

Alaska is in the majority of states without any law specifically requiring employers to implement preventative and/or reporting mechanisms for violence against health-care workers. However, Alaska imposes mandatory minimum sentences for individuals convicted of assault in the fourth degree or harassment in the first degree against medical professionals and emergency responders. Specifically, A.S. 12.55.135(d)(1) provides that an individual convicted of assaulting or harassing a medical professional or emergency responder faces a mandatory minimum term of imprisonment of sixty days—or thirty days, if there was no physical injury to the victim.

IDAHO

Idaho has yet to enact any law relating specifically to the prevention and/or reporting of workplace violence in health care. However, in 2014, Idaho adopted Idaho Code 18-915C, which makes battery against (i) any person licensed, certified or registered by the State of Idaho to provide health care; or (ii) any employee of a hospital, medical clinic or medical practice, a felony punishable by up to three years in prison. However, the statute applies only if the victim was in the course of performing his or her duties during the battery, or the battery occurred because of the victim's professional or employment status.

OREGON

In 2007, the Oregon State Legislature passed House Bill 2022, subsequently codified as Oregon Revised Statutes 654.412 to 654.423, requiring health-care employers (meaning hospitals[3] and ambulatory surgical centers[4]) to implement strategies to protect health-care employees from acts of violence in the workplace.[5] More specifically, the law requires health-care employers to: (i) develop and implement an assault prevention and protection program[6]; and (ii) maintain records of assaults against employees.[7]

Assault Prevention and Protection Program. Each health-care employer must develop and implement an assault prevention and protection program, which is based on periodic security and safety assessments.[8] The periodic assessments must, at a minimum,

of the setting; (ii) staffing, including security staffing; (iii) personnel policies; (iv) first aid and emergency procedures; (v) procedures for reporting assaults; and (vi) education and training of employees.[11]

As part of its program, each health-care employer must provide assault prevention and protection training to its employees on a regular and ongoing basis.[12] The training should address the following topics, taking into account the employee's job duties:

- General and personal safety procedures
- Escalation cycles for assaultive behaviors
- Factors that predict assaultive behaviors
- Techniques to obtain medical history from patients
- Techniques to de-escalate/ minimize assaultive behaviors
- Strategies to avoid physical harm and minimize restraint use
- Restraint techniques
- Self-defense
- Procedures for documenting and reporting assaults
- Programs for post-incident counseling and follow-up
- Resources available to employees for coping
- The employer's assault prevention and protection program[13]

The training can consist of classes, videos, brochures, or other verbal or written training, and should occur

measure the frequency of assaults committed against employees in the preceding five years, and identify the causes and consequences of such assaults.[9] While the law fails to define "periodic" guidance from Oregon, OSHA suggests employers have substantial discretion, provided assessments are conducted at regular intervals.[10]

A health-care employer's program must address the following security considerations: (i) physical attributes

within 90 days of the employee's initial hiring.[14]

Required Record of Assaults. Health-care employers must maintain records, for no fewer than five years, of assaults committed against employees on their premises.[15] Oregon Revised Statute 654.416(1)(a)-(i) describes specific information which must be included in the record, but Oregon OSHA has developed a form that satisfies the requirements of the law.[16]

WASHINGTON

In 1999, the Washington Legislature enacted RCW 49.19. This law applies in health-care settings (defined as hospitals, home health, hospice, and home-care agencies, evaluation and treatment facilities, and community mental-health programs[17]) and requires: (i) development and implementation of a workplace-violence plan; and (ii) maintenance of records of violence against employees.[18]

Workplace Violence Prevention Plan. Each health-care setting must develop and implement a plan to reasonably prevent and protect employees from violence.[19] The plan should be based on a security and safety assessment that identifies existing or potential hazards for violence and determines the appropriate preventive action to be taken.[20] More specifically, the plan should address the following security considerations: (i) the setting's physical attributes, (ii) staffing, including security staffing, (iii) personnel policies, (iv) first aid and emergency procedures, (v) reporting of violent acts, and (vi) employee education and training.[21] Washington encourages health-care settings to consider any guidelines on violence in the workplace and/or health care issued by state and federal agencies and health-care accrediting organizations.[22]

Sea Mar Community Health Centers
A Place for the Community to Come Together and Support Its Own

Sea Mar Community Health Centers serve the Western Washington community as one of its largest providers of community-based health and human services, providing everything from dental and medical care to housing assistance and social services to a diverse population.

The name "Sea Mar" stems from the organization's beginnings in 1977, when a group of community activists recognized the need for bilingual and bicultural services for Latinos in Washington. The group applied for a federal grant to open the first Sea Mar clinic in Seattle's South Park neighborhood, with the goal of later opening another clinic in Marysville.

Sea Mar's mission statement says, in part, that it's a "community-based organization committed to providing quality, comprehensive health, human, housing, educational and cultural services to diverse communities." This mission is reflected by its 2,500 employees, each of whom is dedicated to serving Sea Mar's patients and clients in the community.

One such employee, Michael Leong, began serving as a board member at Sea Mar Community Health Centers. Their mission to provide medical and other crucial services to underserved people around the state so resonated with him that he eventually took a role on staff as a practicing attorney for the organization.

"I realized that what I really wanted to do was work in a team environment that was mission-driven," says Leong, who is now—17 years later—Sea Mar's senior vice president for corporate and legal affairs. "The staff is compassionate and dedicated to serving underserved communities."

The health and social services agency is now located in 11 counties throughout Western Washington, and provides services to almost 250,000 patients and clients annually. While serving in diverse communities, Sea Mar specializes in service to Latinos.

The organization's core offerings are medical, dental, mental-health, and substance-abuse services, but it has expanded its services in answer to community demand. These now include:
- Long-term-care and skilled-nursing facilities
- Inpatient substance-abuse treatment
- Health education
- Maternity-support services under the largest privately run WIC program in the state

In addition, Sea Mar's offerings include a bilingual child-development center, two low-income housing developments, seasonal farmworker housing, educational achievement programs, youth services, work-skills training, and two Spanish-language radio

Sea Mar Community Health Centers provide services to 250,000 patients at 90 different locations in the following Washington counties:

Clallam / Clark / Cowlitz / Franklin / Grays Harbor / Island / King / Pierce / Skagit / Snohomish / Thurston / Whatcom

stations that promote community advocacy and health education.

To ensure it meets all the needs, both physical and mental, of those it serves, Sea Mar employs a number of outreach strategies. One of these is a boxing club to help youth keep fit and stay in school. "We work with the Seattle School District to coordinate school objectives with our boxing program," Leong says. "The youth in the boxing club are required to achieve a certain GPA to participate, and the program includes a tutoring component. We try to be as comprehensive as possible in our services."

Sea Mar is committed to integrating care. A care coordinator at each medical clinic works with patients to help them meet their health goals and understand the resources available to them. Staff members even make referrals to resources, both within Sea Mar and in the greater community, to ensure everyone is connected with the services they need.

"There is a current trend of integrating behavioral health and primary care, and we've been doing that for a long time," Leong says. "We recognize that people usually need more than what they initially come in for. I think we're good at understanding the full range of needs of patients, and also excel at being flexible and responsive in meeting those needs." This includes quickly connecting medical patients with dieticians or social workers during a visit, or arranging a meeting with an integration specialist who works with a patient's primary-care provider to make sure any behavioral health needs are addressed.

"We're only able to do what we do effectively because of the caliber of our employees," Leong says. "Our key strength is that we have a very committed staff of professional providers, as well as support staff. The people who work here see personal value in our mission." A lot of Sea Mar's providers and employees have been with the organization for many years and envision Sea Mar as their career—and in that way, their mission creates longevity. This is reflected throughout Sea Mar at all staff levels, including provider staff, support staff, and executive leadership. Rogelio Riojas, for example, who was Sea Mar's first executive director in 1978, remains its chief executive officer, and Sea Mar's chief dental officer, Dr. Alex Narvaez, joined the organization in 1982.

Sea Mar has taken big steps to ensure that the next generation of health-care providers is ready to serve their clients, by founding residency programs for physicians and advanced registered nurse practitioners. Sea Mar was one of the first health centers in the country to offer a community-health-center-based residency program at its South Park Seattle clinic,

in partnership with Swedish Hospital. They are now in the process of opening their own accredited program in Marysville, in partnership with Providence Hospital. Already, hundreds have applied for the first six medical-resident slots.

"We've learned that a lot of the residents who had worked here had decided, during their training, that community health was what they wanted to pursue, and they either stayed with Sea Mar or went on to another community health center," Leong says. "Our chief medical officer, Dr. Ricardo Jiménez, originally came to Sea Mar as a

ABOUT COMMUNITY HEALTH CENTERS

Community Health Centers (CHCs) in the Pacific Northwest have been a safety net for millions, providing high-quality medical care and a place for the community to come together and support its own. The CHC model of being a member-directed organization has kept the mission focused, providing targeted services where they are needed most.

What makes CHCs unique is that they focus on serving Medicaid patients who have difficulty accessing care in the larger health-care system, and they serve uninsured patients, regardless of ability to pay. In support of the CHC's work, the federal government has provided grants and professional liability coverage through the Federal Tort Claims Act (FTCA). There are 26 CHCs in Washington State, 36 CHCs in Oregon, and 27 CHC organizations in Alaska.

CHCs are best viewed as primary-care and/or multispecialty-care clinics serving low-income and underserved or uninsured people, often including patients from migrant and immigrant populations. Some CHCs, such as Sea Mar, offer non-medical services, including youth outreach, community centers, and skate parks. Dental care is also a hallmark of most CHCs in our region.

WHAT IF?

Events that threaten your organization can come in a wide variety of types, and not all of them are physical violence. Consider what your organization would do in the following real-life examples:

Your facility is located in a neighborhood with a high crime rate and significant gang activity. When you arrive for work, you see a racial slur and a threat aimed at your employees and patients painted on the wall. As employees begin to arrive and see the graffiti, some are afraid, some are anxious, and some are mad. You call Facilities Services, and they quickly paint over the graffiti—but when you arrive for work the next day, there is another slur painted on the wall and even more graffiti painted on other parts of the facility.

A gang shooting has brought in two trauma patients to your facility. One of them survives, and is moved into the ICU. The other patient does not survive. As the deceased patient's family members begin to arrive, emotions run high. When the physician arrives to talk to the deceased's family, they insult her training, say she is incompetent, and threaten her and her family. One family member tries to attack her, but is restrained by other family members.

After the holiday party for your unit, two co-workers begin a personal relationship. They date for a few months, then break up. In retaliation, one posts some private photos they exchanged, along with some very insulting comments, on social media. As most of the unit is connected on social media, the other co-workers see the photos and comments.

An experienced nurse is hired by the organization, and he is assigned to "shadow" another co-worker to learn the clinic and processes. He makes a mistake on the computer system, and his co-worker says, "I can't believe you got hired. You don't know what you're doing." Later, he overhears the same co-worker saying to another nurse, "Why did we hire him? He's an idiot. I don't think he'll last long here; Dr. Smith will eat him alive."

You are the manager of an inpatient unit. A female nurse reports to you that her ex-boyfriend was in the parking lot after her shift yesterday. He parked his car behind her car, so she could not leave. As she got closer, he screamed obscenities and threats at her. She is scared to leave her shift today.

A developmentally disabled patient is admitted to the medical floor. A male patient from a nearby room enters her room during the night and sexually assaults her. She is non-verbal, and is not able to call out for help. When a nurse enters her room later, she finds the patient sobbing.

(Don't Get Caught Off Guard, Continued from page 5)

high for those who care about a patient, which can lead to violent outbursts. While this may not end in physical violence, upset family members and visitors sometimes use verbal threats and intimidation to impact employees. Violence inflicted by one patient on another comprises a third subcategory of this type of workplace violence.

TYPE 3: Violence by a Co-Worker
Violence by a co-worker tends to be a bigger concern in larger organizations, especially organizations (like those of the health-care industry) that routinely have employees working closely together under stressful conditions. Threatening each other, sending inappropriate text messages, or making inappropriate comments on social media are all ways that co-workers can bully each other; other forms of psychological violence can manifest as stalking, insulting, and displaying degrading photos to co-workers. Disrespect, incivility, and discrimination may be added to the list as well. And it's not just current employees whom organizations need to worry about: stories abound of former employees taking revenge in various ways on employers. All of these are all considered instances of violence by a co-worker.

TYPE 4: Violence from a Personal Relationship
Each employee has relationships outside

The best way to address workplace violence is to create a comprehensive program to review policies, monitor events, and support employees.

of the workplace. Although female employees are at the highest risk of violence in this area, a violent personal relationship can impact the ability of any employee to perform his or her work duties. Relationship violence goes beyond physical abuse, and can include financial abuse (controlling financial assets or spending habits), sexual abuse, child abuse, and stalking. Employees who experience a difficult divorce or custody battle can also be considered to be suffering from violence from a personal relationship.

COMPONENTS OF A WORKPLACE-VIOLENCE PROGRAM

The best way to address workplace violence is to create a comprehensive program to review policies, monitor events, and support employees. The program should include strategies to prevent or mitigate the impact of violent events, prepare employees for violent events, respond to violent events when they happen, and help employees recover from each event.

PREVENTION AND MITIGATION

Conduct a hazard assessment of the workplace to understand the existing risk factors that your employees face. More than one assessment may be needed if there are a variety of locations, or in certain other circumstances. Look at environmental design, lighting, lines of sight in vulnerable

areas, security-sensitive areas that may be more prone to violent events, and security systems (alarms, panic buttons, cameras, etc.), and ask for your employees' perceptions of workplace safety. This assessment process will help you identify where your employees are vulnerable to violent events.

Collecting data on violent events from all parts of the organization is crucial. Data is often held in silos, so reach out to other departments to develop a full picture of the organization. Look at security reports, the OSHA 300 log or occupational health injuries, reports of violent patients or patients with a history of violent acts, and crime statistics from the neighborhood in which your facility is located. These data points will help paint a picture of the kinds of workplace violence that are already occurring in your organization.

Implement strong workplace-violence policies that your employees can understand and follow. Develop a human-resource policy that defines "violent acts," provides a clear process for reporting events, describes the investigation process, and outlines disciplinary actions for those employees who don't follow the policy. In addition, have another policy in place to define the process employees should follow in dealing with a violent patient or visitor. Define "violent acts," determine

the reporting process, and outline the consequences for the patient or visitor. In both policies, be strong with your words and enforce the policies. They are in place to protect your employees, and to show them that their organization supports them.

In addition, understand your state legislation. There are many states that have specific legislation in place to define workplace violence and give you a legal ground for your policies. Many states also have legislation in place specifically to protect health-care workers from acts of violence or assaults that happen in the workplace. (See page 14 to understand your state's legislation.)

PREPAREDNESS

Preparedness for workplace violence is largely a matter of employee training. All employees are vulnerable, so all employees need training in their organization's policies, risk factors, methods to prevent or de-escalate violent events, workspace safety devices and their use, and employee-support programs. That said, there may be areas in your workplace that are more susceptible to violent events, and employees who work in these areas may need to be given special training, in addition to base-level training, in order to work safely in their environment. Finally, provide specialized training for managers and supervisors that explains what to do

Hiring, Firing, Retaining, and Everything in Between

Answers to your questions about employment liability

If you have employees or use contractors, you have obligations and responsibilities, regulations and laws, and general good-sense practices that need to be followed. Even the best of employers can find themselves needing advice or help.

WHAT IS AT RISK?

The Federal Government regularly allocates millions of dollars in proactive enforcement of and investigation for existing employment-related laws. Areas previously looked at included hiring, retaining, leaves of absence, termination or resignations, employee discipline, compensation, and taxation issues. Newer legislation adds additional classifications of protection impacting types of leave, discrimination, disabilities, and even genetics. In other words, where there is employment of any kind, there is also risk.

Even with this increase, most claims come in the form of an unexpected demand by an attorney or a civil lawsuit.

CLAIMS ARE COSTLY AND RISING

According to a review of claims by the Equal Employment Opportunity Commission from 2009–2015, claims frequency was on the rise in five of 10 categories tracked, with retaliation and disability discrimination leading the set.

According to TrustedChoice.com, over the last 20 years employee lawsuits have risen about 400 percent, with wrongful-termination suits jumping up more than 260 percent. Nearly 41.5 percent of employee lawsuits are brought against private companies with fewer than 100 employees. The financial damage of employee lawsuits can be dramatic; the cost of settling out of court averages $75,000, and jury awards hit an average of $217,000 if a case loses in court.

A WIDE RANGE OF CLAIMS NEEDS COMPREHENSIVE COVERAGE

Here are just a few examples of real claims and cases involving employment-practices liability:

- A certified medical assistant who was experiencing pregnancy-related medical problems was accommodated by the doctor/employer, who permitted her to work temporarily at the receptionist desk. She had previously been counseled on numerous occasions for poor work performance, absenteeism, and tardiness. Nevertheless, when she received a particularly bad write-up, she threatened that if the doctor terminated her, she would sue and say she was fired because she was pregnant. The claim was finally settled for more than $8,000.

- A delivery man had been delivering packages to an emergency clinic for about six months and had become friendly with the clinic's staff, frequently having conversations with the receptionist. On one occasion, the delivery man shared that he was in a committed same-sex relationship. Afterwards, he noticed that the receptionist would act strangely toward him and avoid eye contact with him. He asked if there was a problem, and she responded by telling him that she was uncomfortable speaking with him because she did not approve of his lifestyle due to her religious beliefs. The delivery man filed a complaint with the

Employee Claims Filed
- 2009
- 2012
- 2015
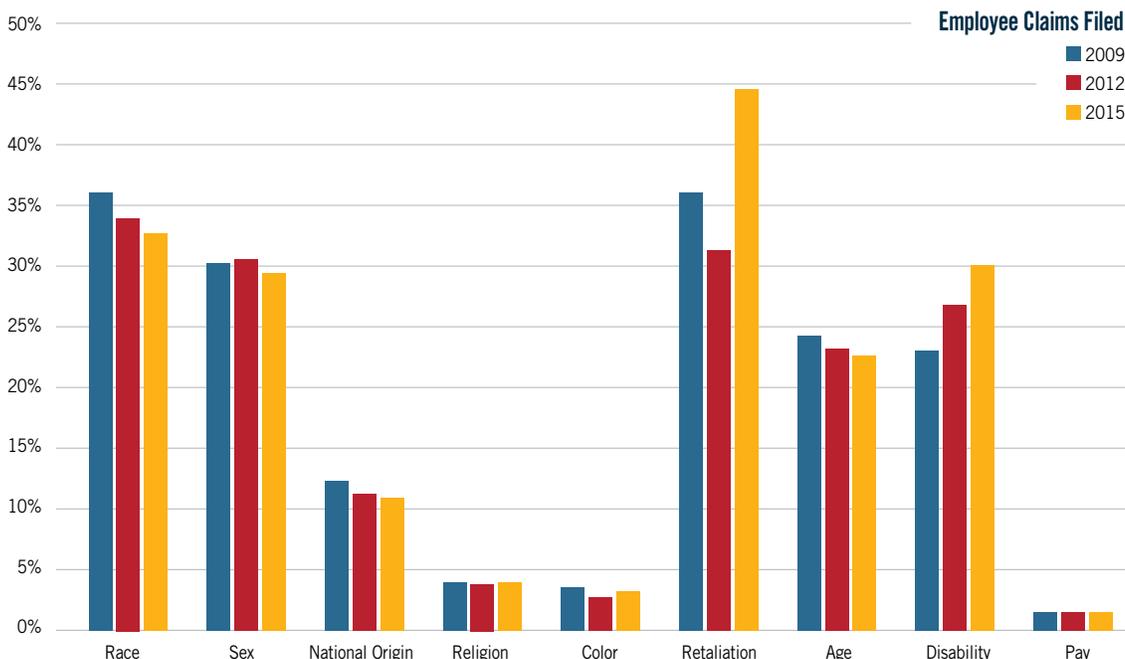
Source: Charges filed FY 1997 through FY 2016, as compiled by the Office of Research, Information and Planning, U.S. Equal Employment Opportunity Commission. https://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm

Human Rights Commission against the clinic, alleging discrimination based on sexual orientation, which triggered coverage under the EPLI endorsement.

- A fertility clinic discovered that not everyone was in agreement with expansion plans when one doctor claimed breach of contract and wrongful termination. It seemed the new location would ultimately draw more affluent patients away from the existing center, and the disgruntled doctor felt his revenues and profit-sharing would be slashed. The claim was ultimately settled for $210,000.

- A patient, originally from Japan, who frequently visited a clinic and formed relationships with most of the physicians and medical team, experienced unfriendly and hostile care from a nurse who was new to the group. The patient believed this stemmed from her thick accent, and she filed a complaint with the Human Rights Commission alleging discrimination based on national origin.

This triggered a Third Party Discrimination claim under the EPLI endorsement.

COMPREHENSIVE COVERAGE
Employment-related lawsuits represent one of the fastest-growing types of civil litigation in the United States. To meet this threat, Physicians Insurance offers Employment Practices Liability (EPL) coverage to meet our members' human-resources needs.

Our basic Employment Practices Liability (EPLI) endorsement includes the following at no additional charge:
- $100k/$100k for the defense and costs of employment-related claims
- Third-party coverage for wrongful actions of employees toward nonemployee(s)
- A $2,500 deductible per insured event

Our upgraded EPLI endorsement provides the basic coverages, plus the following additional benefits:
- Higher limits options of $300k/$300k, $500k/$500k, $1M/$1M, or $2M/$4M
- The option to purchase defense outside the limits and wage-and-hour coverage
- No deductible
- Expanded definition for wrongful

employment acts includes coverage for (but is not limited to):
- Violations of the Family Medical Leave Act and Uniformed Services Employment and Reemployment Rights Act
- Breaches of civil rights, including violations of the Civil Rights Act of 1866
- Allegations of emotional or mental anguish, wrongful demotion, and failure to hire

ESSENTIAL RESOURCES AND SERVICES
To ensure members are equipped with up-to-date information and regulations, we offer access to a host of authoritative and practical online tools and resources, including:

- Updates and comparisons on federal and state laws, state-specific compliance guides, forms, posters, job descriptions, online training programs, and more
- Legal consultation, by phone, for employment practices issues
- Webinars and ongoing education on contemporary topics (PR)

For more information about employment practice liabilities, visit www.phyins.com/epl or call (800) 962-1399.

In a study of 13 intensive-care units, patient risk adjusted mortality increased 1.8-fold as a result of poor nurse-physician communication (Knauss, 1986).

them out, the behavior will continue. Only a new response to an old behavior will create the collaborative dynamic we need in order to provide a healing environment.

What can doctors do differently? Publicly thank those nurses who do a great job, and you will raise the morale of the entire unit. Never tolerate poor nursing care, or complain to the manager, but rather take on the role of coach and mentor, and speak with outliers in private. Ask for feedback from the charge nurse quarterly (What do I do well? And what would you like to see more of?), and meet monthly with the unit manager. Your position at the top of the hierarchy makes you the most powerful force in creating and sustaining a truly patient-centric culture.

Research shows that good nurse-physician relationships are ego-boosting for both nurses and physicians. And the safest environment for the patient is one where staff openly communicate—where no one is afraid to speak, and where relationships are solid. Great working relationships add meaning, depth, and purpose to our everyday life. In the end, both nurses and physicians want the same things: to be valued, and

respected, to belong, and to provide excellent critical care. (PR)

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Kathleen Bartholomew is the author of Speak Your Truth: Proven Strategies for Effective Nurse-Physician Communication, Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other, *and* The Dauntless Nurse: Communication Confidence Builder. *She can be reached at Kathleenbart@msn.com.*

📞 MANAGING PHONE CONTACT

Nurses state that telephone calls are often a source of conflict. Nurses should make it a point to always have the chart and the most recent labs and vital signs ready—plus, they should learn the SBAR tool for physician-nurse telephone conversation. Each letter represents a single sentence. While nurses are taught to paint the whole picture and speak narratively, physicians receive information better if it is brief and to the point.

- **S – Situation** – In one sentence, state the patient's name, age, doctor, and diagnosis.

- **B – Background** – State any significant history, and the current reason for the patient's hospitalization.

- **A – Assessment** – Relay the clinical signs and symptoms that concern you.

- **R – Recommendation** – Tell the doctor what you want—for example, "I want you to come and look at this patient," or "I need a chest tube now."

The "R" is the hardest part of this tool for nurses. Yet many physicians in root-cause analysis have said, "If only I knew she wanted me to come in…" Therefore, the SBAR tool should be introduced to both physicians and nurses, and supported with education.

RISK MANAGEMENT

NEW CME!

Mitigate Workplace Violence with Our New CME

74%
of all workplace assaults between 2011 and 2013 happened in health-care settings

80%
of emergency medical workers will experience violence during their careers

100%
of emergency-department nurses reported verbal assault, and 82.1% reported physical assault, during the last year

61%
of home health-care workers report violence annually

Source: Occupational Safety and Health Administration, Preventing Workplace Violence: A Road Map for Healthcare Facilities, U.S. Dept. of Labor, December 1, 2015, accessed May 25, 2016, www.osha.gov/Publications/OSHA3827.pdf.

Building a Workplace-Violence Program: An Introduction

A one-hour webinar for clinic administrators and managers. Physicians and clinical staff can also participate.

Workplace violence comes with a high cost. First and foremost, it harms workers—often both physically and emotionally—and makes it more difficult for them to do their jobs. Employers also bear several costs. A single serious injury can lead to workers' compensation losses of thousands of dollars, along with thousands of dollars in additional costs for overtime, temporary staffing, or recruiting and training a replacement. Even if an employee does not have to miss work, violence can still lead to hidden costs, such as higher turnover and deterioration of productivity and morale.

Health-care providers and staff in hospitals, nursing homes, and other health-care settings face significant risks of

workplace violence, which can refer to any physical or verbal assault toward a person in a work environment. Violence in health-care facilities takes many forms and has different origins, such as verbal threats or physical attacks by patients, gang violence in an emergency department (ED), a distraught family member who may be abusive or even become an active shooter, a domestic dispute that spills over into the workplace, coworker bullying, and much more.

This webinar will help define workplace violence, the risk factors specific to health care, and strategies you can develop to deal with them.

View CME accreditation details at www.phyins.com/WVprogram

All CME is offered at no charge to our members

Leveraging the Right Resources to

Minimize the Threat and Liability of Violence

We spend more time at work than anywhere else. It is not surprising, then, that incidents of violence happen there, whether as the result of work-related issues or of some other facet of life that makes its way into the workplace.

In 2015, there were 405 workplace homicides in the United States. 70 percent of workplace homicides are perpetrated by unknown assailants who have no connection to the premises. But the other 30 percent of workplace-violence incidents involve employees, family members of employees, customers or patients, or their family members. And most of these events involving individuals known to the workplace do not occur without warning. For example, in 81% of cases involving an active shooter on the premises, at least one other person knew of the planned attack. In 59% of these cases, two or more people knew of the perpetrator's plans.

To minimize the impact of violence for your organization, you can learn more about developing and practicing a workplace-violence program in this issue (page 4). Keep human resources proactively involved, take steps to enhance workplace security, and think about how your organization can provide supportive resources to employees before, during, and after an incident. It is also important to involve the law or FBI when necessary; it may sound extreme, but they are specially trained to recognize and assess threats. But what else can you do to detect and prevent violence before it occurs?
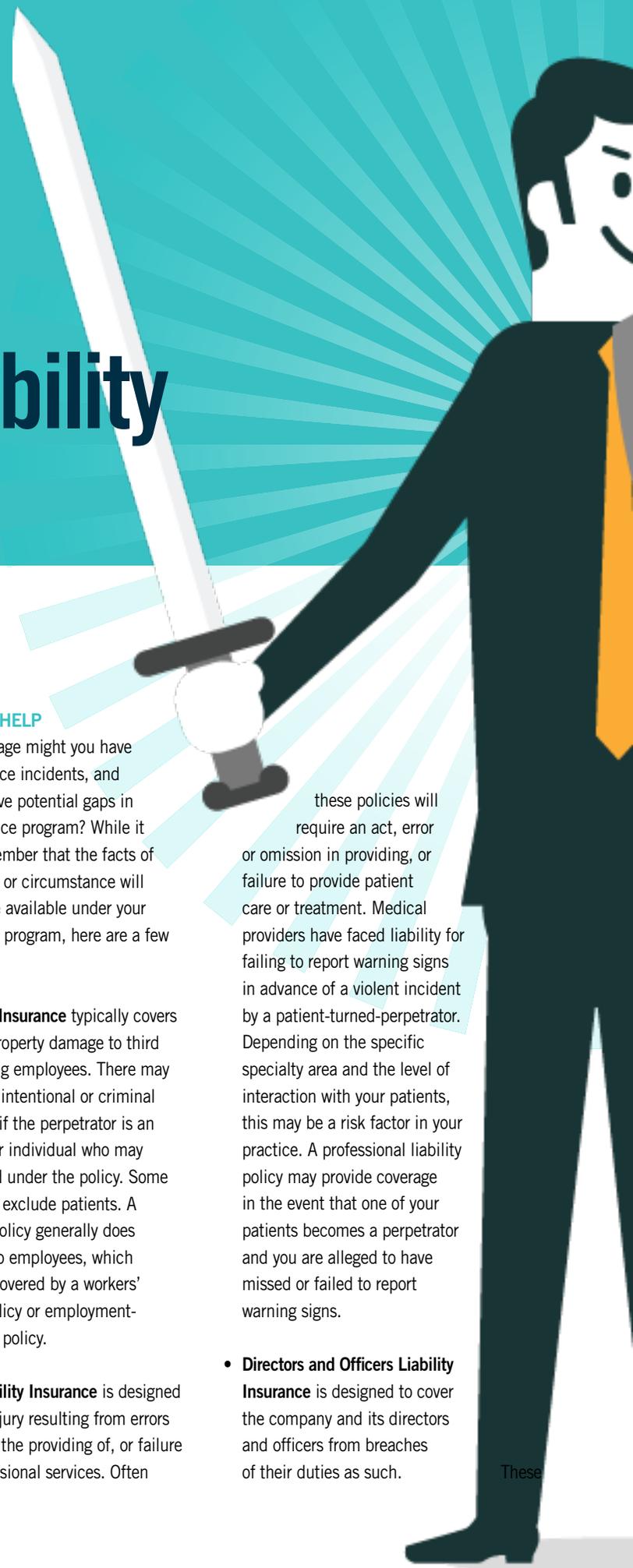
INSURANCE CAN HELP

What types of coverage might you have for workplace-violence incidents, and where might you have potential gaps in your current insurance program? While it is important to remember that the facts of any particular claim or circumstance will dictate the coverage available under your particular insurance program, here are a few considerations:
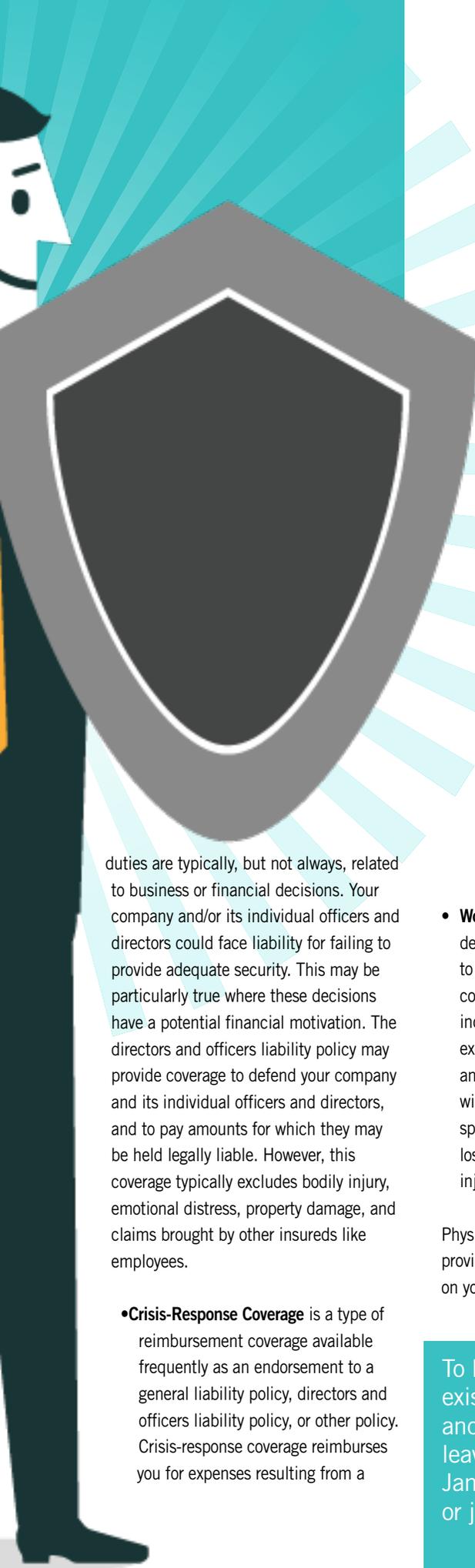
- **General Liability Insurance** typically covers bodily injury or property damage to third persons, excluding employees. There may be exclusions for intentional or criminal acts of insureds, if the perpetrator is an employee or other individual who may qualify as insured under the policy. Some policies may also exclude patients. A general liability policy generally does not cover injury to employees, which will typically be covered by a workers' compensation policy or employment-practices liability policy.

- **Professional Liability Insurance** is designed to cover bodily injury resulting from errors and omissions in the providing of, or failure to provide, professional services. Often these policies will require an act, error or omission in providing, or failure to provide patient care or treatment. Medical providers have faced liability for failing to report warning signs in advance of a violent incident by a patient-turned-perpetrator. Depending on the specific specialty area and the level of interaction with your patients, this may be a risk factor in your practice. A professional liability policy may provide coverage in the event that one of your patients becomes a perpetrator and you are alleged to have missed or failed to report warning signs.

- **Directors and Officers Liability Insurance** is designed to cover the company and its directors and officers from breaches of their duties as such. These

duties are typically, but not always, related to business or financial decisions. Your company and/or its individual officers and directors could face liability for failing to provide adequate security. This may be particularly true where these decisions have a potential financial motivation. The directors and officers liability policy may provide coverage to defend your company and its individual officers and directors, and to pay amounts for which they may be held legally liable. However, this coverage typically excludes bodily injury, emotional distress, property damage, and claims brought by other insureds like employees.

• **Crisis-Response Coverage** is a type of reimbursement coverage available frequently as an endorsement to a general liability policy, directors and officers liability policy, or other policy. Crisis-response coverage reimburses you for expenses resulting from a

crisis event, and may cover the cost of media or public-relations officials, temporary or enhanced security measures, and other costs designed to minimize the harm to your reputation and financial condition after a crisis event, and to assist in restoring public confidence.

• **Employment Practices Liability Insurance** is designed to cover the company and its employees from harassment and other employment-related wrongful acts. It may also be extended to include coverage for similar wrongs against a third party, though this coverage typically excludes patients. An employment-practices policy may provide coverage for targeted incidents, such as one in which an employee or former employee targets the company or another employee in a workplace-violence incident. This policy typically excludes bodily injury and criminal acts, but may provide coverage for the emotional distress that arises from workplace-violence incidents.

• **Workers' Compensation Insurance** is designed to cover workplace injuries to employees, regardless of fault. This coverage may provide medical and indemnity coverage to employees, but will exclude coverage for patients, their guests, and independent contractors. The policy will not cover claims brought by employees' spouses, children, or other beneficiaries, for loss of services and companionship due to injury or death of the employee.

Physicians Insurance Agency can assist with providing all the coverages listed above, based on your unique needs. (PR)

To learn more about your existing insurance coverage, and the gaps that could be leaving you exposed, contact Janet Jay at (800) 962-1399 or janet@phyins.com.

(Pulling Together, Continued from page 7)

and data collection, for example). In this case, don't reinvent the wheel—have members of the other committees share their information with the workplace-violence committee. Use your committee meetings to set goals, report data and trends, review policies, monitor staff training, and prioritize expenditures.

IT TAKES WORK
Creating a committee and managing a workplace-violence program takes work. It also takes commitment from the highest levels in each organization to dedicate employee time and support the actions of the workplace-violence committee. If your organization is ready, take the leap: understand the components of a successful program, and endeavor to improve the safety of all of your employees. (PR)

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[2] "Emergency Department Violence Surveillance Study." Emergency Nurses Association, November 2011. Accessed April 14, 2016. P. 31. https://www.ena.org/practice-research/research/Documents/ENAEDVSReportNovember2011.pdf

[3] Ibid.

Empower Your Workplace to Prevent and Respond to

Domestic Violence

When an employee faces the threat of violence, even in his or her personal life, it can easily and quickly become a workplace-violence issue.

Whether it is a high-performing employee who suddenly displays a change in behavior due to a violent spouse at home, or an employee who has a stalker waiting for them at their vehicle when they leave the workplace, the signs should not be ignored, and human resources should get involved.

Because personal topics are often uncomfortable to broach in the workplace,

HR professionals often overlook signs of domestic abuse out of consideration for staff privacy, and from a fear of making false assumptions. However, worse than the risk of inquiring after the wellbeing of a staff member who turns out to be doing fine, is not confronting a staff member who is experiencing the threat of violence in his or her life.

In addition, relationships in the workplace, particularly in large health organizations, are prevalent and often hidden. These relationships can sometimes turn volatile and affect both individuals' behavior at work. And even if a violent act doesn't occur in the vicinity of the workplace, the individual affected by it will undoubtedly be suffering through his or her daily activities, and his or her performance—or worse, patient-care delivery—will suffer as a result.

According to Lisa Kim, Senior Program Specialist at Futures Without Violence, "Domestic violence can follow victims to work, spilling over into the workplace when a victim is harassed, receives threatening phone calls, is absent because of injuries, or is less productive due to extreme stress. Domestic violence is a serious, recognizable, and preventable problem, similar to other workplace health and safety issues that affect businesses and their bottom lines."

The Center for Disease Control and Prevention estimates that the annual cost of lost productivity due to domestic violence is $727.8 million (in 1995 dollars), with more than 7.9 million paid workdays lost to it each year. The measurable financial impacts of violence include lost wages, sick leave, absenteeism, and the costs to the medical, legal, and social service systems. The domestic-violence cost calculator (www2.texashealth.org/dv)

can help you determine the potential cost of not addressing the issue for your workplace.[1]

Resources like this and more can be found on Workplaces Respond (www.workplacesrespond.org). The site offers a helpful outline to understanding domestic and sexual violence—as well as stalking—for HR professionals, and includes the following facts:

• On average, four to five women are murdered by their husbands or boyfriends each day in the United States,[1] and women suffer two million injuries from intimate partner violence each year.[2]

• The FBI defines a workplace threat as "[a]ny verbal or physical conduct that threatens property or personal safety or that reasonably could be interpreted as an intent to cause harm,"[3] including the following subcategories:

- **Domestic violence** becomes a workplace threat when an employee, or anyone with a familial or intimate relationship with an employee, engages in violent or threatening behavior designed to control or harm the target. Domestic violence usually involves people with a preexisting personal relationship, whether as family members, spouses, or persons with a child in common. Understanding this relationship may help a workplace evaluate and respond to the nature and frequency of the threat posed by the perpetrator.

- **Sexual violence** becomes a workplace threat when anyone who comes in contact with the workplace engages in sexually harassing or criminal acts. Sexual violence can be committed by someone known or unknown to the victim: a family member or former dating partner, co-worker, supervisor, security guard, customer/client, member of the public on company property, or stranger. Crimes of sexual violence are defined differently in every state, but generally include rape, incest, sexual touching, threats, sexual harassment, assaults and battery.

- **Stalking** is often a precursor to or co-occurs with sexual or domestic violence. A stalker can be known or unknown to the victim: a co-worker or client, a family member or intimate partner, an acquaintance or a stranger. The threat posed to the victim and the workplace will depend upon the perpetrator and their actions.

• **Addressing the workplace impact** of domestic violence (and stalking) requires both prevention and response. Prevention includes creating an environment that is supportive of victim-employees, and where potential perpetrators are deterred from such acts because they know there will be consequences. Responses include:

- **Addressing any threats or actual violence**. Employers may be held liable for ignoring or failing to address potential or actual threats, but when they do address them,

they should do so in consultation with the victim and in a manner that is mindful of the victim's privacy and safety.

WORKPLACES RESPOND:

HOSPITAL PILOT PROGRAM AT UNIVERSITY OF MARYLAND ST. JOSEPH MEDICAL CENTER

The University of Maryland St. Joseph Medical Center became a pilot site for the innovative Workplaces Respond program to address domestic and sexual violence among their hospital employees, both in and outside of the workplace.

As part of its program, the hospital conducted staff training sessions for employees and managers using a first-of-its kind curriculum, and developed a policy that addresses domestic and sexual violence. This curriculum and its successful implementation now show the potential to set a new standard for other major hospitals. The training sessions have covered topics such as the signs of violence and its impact on worker productivity and performance, and provide staff with a roadmap for responding to reports of violence.

To read more about how St. Joseph Medical Center is tackling the issue, visit: http://bsun.md/1SPOYIk

Human-Resource Tips
for Supporting a Workplace-Violence Program

Human-resource professionals often play a critical role in developing workplace policies, not to mention communicating, enforcing, and providing training or practice drills for these policies. They must also be prepared to guide their managerial staff in supporting employees with these policies in a number of ways.

The following information is meant to help human-resource professionals address questions frequently asked by their supervisors:

- **How can we protect our teams from violence?** Once policies are in place, it is critical that they be enforced consistently at all levels of the organization. Also, an Employee Assistance Program (EAP) provider contract will give employees an outlet to deal with personal and relationship issues so that they do not escalate. Training for supervisors about these tools will ensure that they will have the information they need, relevant to policies and support resources, when a problem arises.

- **What are some behavioral warning signs to watch out for?** Whenever co-workers or supervisors notice rude, intimidating, or aggressive behavior, action should be taken. Often, however, the signs are not as outward—isolation, withdrawal, fatigue, stress, or signs of drugs or alcohol use are cues as well. Right before a violent outbreak, a person may also display changes in voice, eye contact, body tension, or skin tone.

- **How can supervisors intervene early?** A constructive conversation is essential to document the behaviors present and to refer the employee to an EAP professional. These behaviors will affect performance, so documentation is critical. HR is an important partner in these processes, and typically coordinates EAP activities. Again, supervisor training on conducting these conversations is critical.

- **When must the details of an employee's relationship problem be disclosed?** Whenever a personal relationship becomes a threatening situation that poses danger to the employee or other staff, the information must be shared with the proper authorities. Details of circumstances and performance issues should be shared with those who "need to know" in order to prevent injury and properly handle the situation.

- **What should employees do if they have obtained any type of restraining order?** The site security department should be provided with a copy of the order and identification photos, so that security can take measures to prevent the noted individual's access to the workplace.

- **How can we support our teams after an incident?** A Critical Incident Stress Debriefing (CISD) should take place within 48–72 hours. These debriefings follow a standard model for intervention that allows employees to review what happened and how it affected them. Encouraging the sharing of emotions and providing stress-management tools is critical. Again, an EAP provider can assist with such professional support and resources.

CRITICAL INCIDENT STRESS FOUNDATION, INC.

Post-incident, it is critical to perform a CISD within 48–72 hours, in order to assist with affected employees' wellbeing. These debriefings are often provided through an EAP provider and include a structured session for dealing with the emotions and stresses related to the incident. Guidelines for CISDs can be found through the International Critical Incident Stress Foundation, Inc.

www.icisf.org

ONLINE CME

Intimate Partner Violence/Domestic Violence

An online course for providers and staff involved in direct patient care.

The first professional contact for people who experience domestic violence (also referred to as intimate partner violence) is likely to be a physician or other health-care provider. Studies of women who are abused found that they seek medical attention more frequently than non-abused women, even if they tend to hide the fact that they are victims of intimate partner violence (IPV). Often, the uncovering of victimized patients' stories may happen in stages. Many patients hold back from speaking about IPV at first, but continued relationship-building with their physicians may empower them to speak over time. A physician who comes to know that a patient is experiencing IPV is better able to understand the patient's symptoms, better able to diagnose the patient's problems, and better able to help improve the patient's health outcomes. Also, using a process of validation, safety assessment, and referral, a physician may be able to help a victim improve his/her situation.

Upon completion, participants should be able to apply guidelines for screening patients for intimate partner violence/domestic violence, and follow best practices for validation, safety assessment, and referral of the patient when she/he discloses IPV.

View accreditation details at www.phyins.com/IPV

ADDITIONAL NEW, ACCREDITED COURSES

EFM Case Study #1: OP Malpresentation
For obstetricians, family practice, midwives, and obstetric nurse practitioners

Stroke Treatment in the ED: 2013 tPA Guidelines
For ED and other physicians or clinical staff caring for stroke patients in the ED setting

Coping with the Realities of Dental Injuries
For anesthesiologists and other clinicians providing anesthesia services to patients

Prostate Cancer: Screening, Biopsy, and Management
For urologists

Learn more at www.phyins.com/cme

- **Promptly and respectfully respond to victims**. Violence and threats to a victim can cause trauma that stays with the victim wherever she or he goes, including the workplace. Listen without judgement; you do not have to counsel them on what to do, but instead offer support and resources. Employers should conduct an investigation, provide such employees with access to appropriate services, and (in some cases) provide accommodations to employees who suffer injuries due to violence, whether or not those injuries were suffered on the job.

- **Holding perpetrators accountable**. Following an investigation, a workplace can discipline or terminate any perpetrator-employees or cancel contracts with vendors whose employees perpetrate such acts.

The onus to effectively respond to domestic or sexual violence is not entirely upon the shoulders of those in human resources. Organizations can form a multidisciplinary response team, including security, union representatives, legal staff, senior management, EAP resources, etc.

While women are more often affected by it than men, domestic and sexual violence can happen to anyone within all ecosystems of the organization, and from upper management on down. Ensuring the wellbeing and safety of all employees protects not only your bottom line, but also your company's most valuable assets: its people. (PR)

Resources

[1] *Costs of Intimate Partner Violence Against Women in the United States*. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 2003.

[2] U.S. Department of Justice, Federal Bureau of Investigation. *Workplace Violence: Issues in Response*. Quantico, VA: Critical Incident Response Group, National Center for the Analysis of Violent Crime, FBI Academy. 2004. Available at: http://www.fbi.gov/stats-services/publications/workplace-violence

[3] Ibid.

Workplaces Respond to Domestic and Sexual Violence is a national initiative funded by the U.S. Department of Justice's Office on Violence Against Women, spearheaded by Futures Without Violence, which provides information on effective prevention and responses to domestic violence, sexual assault, harassment, and other incidents of violence as they relate to the workplace. www.workplacesrespond.org

Maintaining Practice Independence with

Physician Care Alliance

Physician led. Evidence based. Quality focused. Patient centered.

Economies of scale have never been more important in the delivery of medicine. Demands upon infrastructure, administrative time, staff training, and the cost of care are high—and increased demands are looming. Recent years have seen smaller groups struggle to achieve the economies necessary to continue. That is why Physicians Insurance recently announced the creation of a clinically integrated network called Physician Care Alliance.

Physician Care Alliance (PCA) is a unique collaborative effort on the part of Physicians Insurance, Premera Blue Cross, and The Polyclinic. The leadership and experience of these key groups have developed the governance of the PCA network. They contributed to the formation of the legal entity and its bylaws, articles of incorporation, investor funding, board and committee administration, participating provider group negotiations, contracting, and more.

PCA leverages expertise developed by The Polyclinic's established and successful Physicians Care Network, a separate corporate entity, which has been in existence for nearly 20 years, managing risk through Medicare Advantage products. While clinically integrated networks have gained popularity in recent years, The Polyclinic's early and enduring success with its initial network is pivotal for PCA. It goes without saying that

physician leadership is at the core of PCA.

"With PCA, we have the benefit of The Polyclinic's 20-year experience with integration," says Dr. Mary Anderson, Chief Clinical Integration and Quality Officer of PCA. Many CINs in recent years experienced growing pains as the concept caught on and more entities were formed, Dr. Anderson noted, but "while the PCA entity is relatively new, its infrastructure is not."

In addition to experienced physician leadership and two decades of infrastructure, the PCA provides independent practices across Washington with:

- **A low-cost option for population heath management tools, data, and analytics**. When used correctly, a population health-management system can pay for itself by helping clinics manage quality improvement and care-cost reduction. This system is adaptable, and will help practices demonstrate quality and value while supporting current reporting needs. Its use can help clinics stratify risk, identify care gaps, track population health around complex and chronic conditions, trend quality measures, aggregate disparate data for analysis, and assist staff with outreach.

- **Health-plan reporting and analytics**, including training and administrative

services to streamline data compilation, extraction, and submission.

- **Access to shared savings contracts**. PCA launched with a shared savings contract with Premera and has signed similar contracts with Aetna and Cigna. Discussions are underway with several other health plans. The focus is on sustainable shared-savings agreements, reducing the total cost of care delivered to plan beneficiaries and aligning health-plan quality incentives with PCA's Quality Program.

- **Operational support**, including network management, contracting, patient advocacy, care management, pharmacy analytics, and risk-adjusted coding.

- **Evidence-based medicine and practice-transformation and care-coordination services**, such as committee protocols, quality programs, cost-saving initiatives, and clinical metrics.

As another important offering to participants, PCA offers support such as staff training for increased efficiencies and care improvements. Staff training is an area where smaller clinics

CLINICALLY INTEGRATED NETWORKS (CINS)

are networks of smaller- to medium-sized provider or practice organizations that, when joined together, are able to leverage shared resources that would otherwise be cost-prohibitive.

EFFICIENCIES

Is your practice looking to gain greater efficiencies from a group approach, but maintain its independence too? Learn how your clinic can benefit by joining the Physician Care Alliance. Discounted fee for Physicians Insurance members.

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PCA Project Consultant
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part of our Seattle residency program. It's a great recruitment tool, in terms of what community medicine is about, and it helps people develop a passion for this type of work. Certainly, with a large shortage of primary-care providers everywhere, this program is very helpful."

Looking to the future, Sea Mar is keeping a close eye on the status of the Affordable Care Act, which has benefitted hundreds of thousands of Washingtonians, including many Sea Mar patients. "Right now, challenges surround the repeal of the ACA and what the replacement might be," Leong says. "We're speculating, but it's a tumultuous time, and we're doing a lot of planning and advocacy. There's a lot going on with health-care reform overall, and we'll

> "Our key strength is that we have a very committed staff of professional providers, as well as support staff. The people who work here see personal value in our mission."

MICHAEL LEONG, SENIOR VICE PRESIDENT OF CORPORATE AND LEGAL AFFAIRS

likely see Washington continue with health-care reform efforts. The governor has given priority to mental-health funding, which is a good thing for our community and the patients we serve."

Meanwhile, Sea Mar will continue doing what it does best—caring for vulnerable populations, breaking down barriers to access for services, and advocating for its patients and communities. (PR)

often ask for help. PCA members will have access to staff training and ongoing support for:

• Patient-centered care, including assessment, resource coordination, pre-visit planning, shared decision making, and patient outreach/engagement activities

• Care-management programs, supporting clinics in providing wellness coaching, transitional care, home-visit programs, extended care, and preventative and chronic care

• Embedded workflow training and tools, including prevention, acute, and chronic care

With six provider organizations having joined since its inception in 2016, PCA has grown to encompass over 280 primary-care physicians across five counties. The ideal provider organizations for joining are those willing to participate in population-health activities and cost-efficiency work. In addition, the groups need to be using a Certified Electronic Health Record Technology (CEHRT) EMR.

Physician Care Alliance was initiated by Physicians Insurance as part of our continual commitment to providing services and support to our insureds. If your independent clinic is feeling the market pressure, learn more about how joining this CIN might help you refocus on providing quality care, rather than on survival. (PR)

Each event will provide you with an opportunity to learn, make your procedures stronger, and make your employees safer

when employees come to them for help, what support is available to employees, and conflict-resolution techniques.

RESPONSE

Despite assessments and mitigation strategies, violent events will still happen. Create standard checklists for employees to use after such an event that delineate whom they should call, how to report the event, what to do for an injury, and what support and other resources are available. A best practice is to have separate checklists for the victim, the supervisor, and the manager, as each will play a different role in the response.

Another best practice is to form a Response Team, to provide a quick response to an employee who experiences any kind of violence. The Response Team can also conduct an investigation (with police, if needed), taking a statement from the victim, interviewing witnesses, and ensuring policies are followed. Typically, members of this team include personnel from security, human resources, risk management, and administration.

RECOVERY

Ensure support for employees after a violent event. The victim, witnesses, and co-workers may each be impacted in different ways, so offer the employee-assistance program to all of them. Consider leaves of absence, time off, modified schedules, or changes in work location.

Because each violent event is different, it's important that you conduct a review or debrief of each event, in which you review policies and suggest revisions, and recommend and enforce consequences for perpetrators. Each event will provide you with an opportunity to learn, make your procedures stronger, and make your employees safer.

IT'S ABOUT EMPLOYEE SAFETY

Health care is an evolving and changing industry. As the push for patient satisfaction turns up new ways to make facilities more open and inviting, the safety risks for employees are increasing, due to more violence in communities, less access to specialized mental-health services, and understaffing at facilities themselves. A proactive organization will not lose focus on employee safety; after all, studies have correlated higher patient-satisfaction scores and health-care facilities where there are fewer dissatisfied and burned-out employees.[9]

Work for a safe environment. Collect and analyze the data that will help you create and enforce policies to support your employees. Teach them the skills they need to recognize and de-escalate a potentially violent situation, and give them the tools they need to respond. Support employees after a violent event, and develop a workplace-violence program to better protect them, prevent large workplace-injury claims, lower the risk of medication errors, and increase patient-satisfaction scores. (PR)

Jenny Schmitz is the Director of Healthcare Preparedness at All Clear Emergency Management Group, where she is working diligently to advance the preparedness level in all facets of the health-care industry. She is a FEMA Master Exercise Practitioner (MEP), Colorado Certified Emergency Manager (CO-CEM) through the Colorado Emergency Management Association, and a Healthcare Environmental Manager (HEM). She is also the Safety Officer on the Colorado-3 Disaster Medical Assistance Team (DMAT).

Resources

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9 McHugh, M.D., Kutney-Lee, A., Cimiotti, J.P., Sloane, D.M., and Aiken, L.H. "Nurses' Widespread Job Dissatisfaction, Burnout, and Frustration with Health Benefits Signal Problems for Patient Care." *Health Affairs*, 2011. 30(2): 202–210.

Trial Results

The following summaries are Physicians Insurance cases that have gone to trial and are public record. In reporting these legal results, it is our goal to inform members about issues that impact health-care professionals. While we share information we think may be informative, we choose not to disclose the names of plaintiffs or defendants when reporting these results.

ALLEGED NEGLIGENT LABOR AND DELIVERY

SPECIALTY: Obstetrics

ALLEGATION: The parents and the estate of an infant alleged delay in cesarean section indicated by prolonged labor, tachysystole (contraction frequency), and presence of a vaginal septum. They asserted an earlier delivery by cesarean section would have prevented the intrapartum death of a term infant. The defense contended that the labor management was appropriate at all times, with electronic fetal monitoring always reassuring. After consent was obtained for a cesarean section, indicated by failure to progress, the fetus had a sudden bradycardia. The defense contended that the fetal death was caused by a sudden and near complete cord compression resulting in the bradycardia. The parents alleged general damages, and the estate claimed economic damages.

PLAINTIFF ATTORNEY: Grant Gehrmann, Gerhrmann Law Office, Vancouver, WA

PLAINTIFF EXPERTS: Richard Kubiniec, MD, Obstetrics, Vancouver, WA; Elizabeth Sanford, MD, Obstetrics, Tacoma, WA; Clifford Nelson, MD, Forensic Pathology, Portland, OR

DEFENSE ATTORNEYS: Jeff Street and Brad Piscaldo, Hodgkinson, Street and Mepham, Portland, OR

DEFENSE EXPERTS: Gary Hankins, MD, Maternal Fetal Medicine, Galveston, TX; Robert deCastro, MD, Obstetrics, Portland, OR; Carey Winkler, MD, Maternal Fetal Medicine, Portland, OR; Jonathan Fanaroff, MD, Neonatology, Cleveland, OH

RESULT: Defense Verdict. Clark County Superior Court, Judge Stahnke

ALLEGED IMPROPER MEDICATION MANAGEMENT

SPECIALTY: Cardiology and Corporate Negligence

ALLEGATION: An 80-year-old female with chronic atrial fibrillation on anticoagulation therapy with a history of bleeds alleged lack of informed consent and negligence in advising the patient to discontinue her anticoagulation for five days, which she had done before for surgical procedures, while she underwent an extraction of an infected, impacted tooth. The patient experienced a significant stroke and claimed future medical expenses, care costs, and pain and suffering. The defense contended that clinical judgement by the provider and protocols used by an anticoagulation clinic nurse were appropriate.

PLAINTIFF ATTORNEYS: Tom Vertetis, Pfau, Cochran, Vertetis, Amala, Tacoma, WA; and Rodney Ray, Margullis & Ray, Tacoma, WA

PLAINTIFF EXPERTS: Howard Miller, MD, Family Practice, Renton, WA; Michael Wahl, DDS, Wilmington, DE; Kyra Becker, MD, Neurology, Seattle, WA

DEFENSE ATTORNEYS: Rebecca Ringer and Levi Larson, Floyd, Pflueger & Ringer, Seattle, WA

DEFENSE EXPERTS: Rubin Maidan, MD, Cardiology, Bellevue, WA; Dan Doornink, MD, Internal Medicine, Yakima, WA; Ann Wittkowsky, PharmD, Seattle, WA

RESULT: Defense Verdict. King County Superior Court, Judge Middaugh (PR)

> A health-care worker must know beyond a doubt that he or she will be respected and appreciated for speaking up and owning patient safety.

to change the current culture has commonly been sidetracked.

SOLUTION: SYSTEMIC CULTURAL CHANGE

Dr. Avedis Donabedian, famous for his work on the Seven Pillars and Eleven Buttresses of Quality, points out that structure dictates process that produces outcomes. If we work backwards from the negative outcomes (medical errors), we can identify the underlying processes (a culture of hostility and bullying, maintained by ineffective leadership and poor communication skills) and address the structural elements that create medication errors (business hierarchy).

Hostility thrives in a typical hospital hierarchy. It's all about power. So how do you prevent medical errors? By disseminating power and forming a team with the core values of safe patient-centric care. Leaders must accept the challenge and personal responsibility for shifting power from a hierarchy to a tribe. What difference does the best surgeon in the world make if, post-op, you place the patient into a MRSA-infected room? What difference does the best nurse make if she doesn't question a medication order for fear of bothering the physician? All members of the team must know and experience their roles and the value that their specific position brings to the patient.

Health care still functions as a hierarchy with a focus on command and control rather, than on the relationships between its different parts. This power gradient will always produce oppression, which is the major factor behind horizontal hostility and vertical aggression. In human groups of unequal power, the dominant group exerts so much pressure downward that

the oppressed group cannot direct its power upward—so they unconsciously attack each other. Nurses are responsible for the outcomes (quality and safety), yet have no access to the resources needed to accomplish that goal (staffing ratios).

CONCLUSION

Medical errors are severely underreported in a fear-based culture. The problem is further entrenched in the general societal culture, where the huge number of harmful incidents and deaths due to preventable error never makes the evening news. If it did, we would have more support from the general public— and therefore, more government funding.

In the broader societal context, patients continue to place unwarranted and unearned trust in their caregivers and hospitals, due to a longstanding belief that when we proclaimed, "Do no harm" a century ago, we actually meant it. How can a system succeed at addressing its inadequacies if it doesn't have a realistic picture or tally of its own impact and harm? Or if that harm is so deeply embedded in the culture that it doesn't even register with its own leaders, let alone with consumers? Leaders must seek to understand the culture that they are leading, and use this knowledge to frame decision making.

The current fear-based culture is characterized by bullying behaviors and self-silencing. A health-care worker must know beyond a doubt that he or she will be respected and appreciated for speaking up and owning patient safety. Only education and leadership can debunk the current myths that keep suppressing the information we desperately need to decrease medical errors. To reduce medical errors from a social-science systems perspective, leaders must

focus on language and behavior, and accept their pivotal role as stewards of a new, safe, team-based culture that:

- Chases "zero," i.e., holds the vision that it is possible for there to be zero medical errors if the system is designed to catch them
- Holds all staff accountable to the same rules, maintaining "institutional integrity" that breeds trust
- Creates collegial interactive teams, in which caregivers feel free and safe to ask questions and objectively comment, knowing that omnipotence and infallibility are myths

Until we create a safe culture, we will never realistically be able to assess the number of medical errors caused by bullying and hostile behaviors. It cannot happen without visionary leaders who poignantly understand that human factors are essential to promoting effective, patient-centered work.

Kathleen Bartholomew is an author and national lecturer specializing in the nursing profession. She quickly realized as a nurse manager that creating a culture of belonging was critical to retention and patient safety. Her newest book, The Dauntless Nurse: Communication Confidence Builder*, is available on Amazon.com.*

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3 Paulo Freire, *Pedagogy of the Oppressed,* (New York, NY: Continuum International Books, 1970).

4 Kathleen Bartholomew and John J. Nance, "The Silent Treatment" *OR Connection*, vol. 4, no. 2 (October 18, 2011): 22–29.

(Protecting Health-care Workers, Continued from page 15)

As part of the plan, health-care settings must provide violence-prevention training to employees within 90 days of initial hiring.[23] Taking into account the particular setting, job duties, and hazards identified in the assessment, the training should address the following topics as appropriate:

- General safety procedures
- Personal safety procedures
- Violence-escalation cycles
- Violence-predicting factors
- Obtaining patient histories from violent patients
- Techniques to de-escalate and minimize violent behavior
- Strategies to avoid physical harm
- Restraining techniques
- Appropriate use of chemical restraints
- Documenting and reporting incidents
- A process for employees/victims to debrief
- Resources available to employees for coping
- The setting's workplace-violence prevention plan

Violent-Acts Recordkeeping. Each health-care setting must keep a record for five years of any violent act against an employee, patient, or visitor, and include at least the following information.

- Name and address of the setting
- Date, time, and specific location where the violent act occurred
- Identification of both the victim and assaulter as patient/visitor/employee/other
- If the victim was an employee, his or her name, title, and department
- A description of the violent act[24]
- Identification of any body part injured
- A description of any weapon used
- The number of employees present when the violent act occurred
- The actions taken in response by the setting

Records must be made available for inspection upon request of the Washington Department of Labor and Industries.

WYOMING

Wyoming has no laws specifically addressing the prevention and/or reporting of workplace violence in health care, or imposing specific penalties for violence against health-care workers. On January 14, 2013, a bill was introduced in the Wyoming legislature to increase the maximum prison term by two years for aggravated assault against health-care workers. The bill was defeated in the Wyoming House of Representatives on February 15, 2013. (PR)

References

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2 Ibid.

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4 Ibid.

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7 ORS 654.416.

8 ORS 654.414(3).

9 ORS 654.414(2).

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11 ORS 654.414(3)(a)-(f).

12 ORS 654.414(1)(c).

13 ORS 654.414(4)(a).

14 ORS 654.414(4)(b)-(c).

15 ORS 654.416(1)-(2).

16 Per ORS 654.416(3); Oregon Administrative Rules, Appendix A, "Instructions for Recording Health Care Assaults," Oregon Occupational Safety and Health Division, accessed April 13, 2017, http://osha.oregon.gov/OSHARules/div1/div1.pdf#437-001-0706-App-A.

17 RCW 49.19.010(1).

18 Ibid.

19 Ibid.

20 RCW 49.19.020(2).

21 RCW 49.19.020(1).

22 RCW 49.19.020(3).

23 Training for temporary employees should take into account the unique circumstances of temporary employees.

24 As described in RCW 49.19.040(6)(a)-(f).

Resources

US Department of Labor: Occupational Safety and Health Administration. osha.gov/dsg/hospitals/workplace_violence.html

Oregon Department of Consumer and Business Affairs: Occupational Safety and Health Administration osha.oregon.gov/Pages/re/healthcare-assault-log.aspx

Washington State Department of Labor and Industries lni.wa.gov/Safety/Topics/AtoZ/WPV/wpvhealthcare.asp

National Institute for Occupational Safety and Health cdc.gov/niosh/docs/2002-101/

American Federation of State, County and Municipal Employees afscme.org/news/publications/for-leaders/preventing-workplace-violence-a-union-representatives-guidebook

ADDITIONAL RESOURCES TO MITIGATE WORKPLACE VIOLENCE

The Federal Bureau of Investigation (FBI)
The FBI issues a publication for workplace-violence prevention and after-care, with a special focus on violence in health-care settings.
www.fbi.gov/file-repository/workplace_violence.pdf/view

The U.S. Department of Labor
Occupational Safety and Health Administration (OSHA)
OSHA provides tools for assessing risk factors and developing prevention programs, provides training, and enforces standards for reducing workplace-violence hazards.
www.osha.gov/SLTC/workplaceviolence

ASHRM: Health-Care Facility Workplace-Violence
Risk Assessment Toolkit
The ASHRM tool kit for risk managers is designed to assist them in the prevention of the four type of workplace violence, as well as in knowing what to do when faced with an immediate situation.
www.ashrm.org/resources/workplace_violence

Workplaces Respond to Domestic and Sexual Violence
The Workplaces Respond to Domestic and Sexual Violence project offers resources, tool kits, sample policies, and more, for those who must provide effective workplace responses to victims of domestic violence, sexual violence, dating violence, and stalking. It is a national project funded by the U.S. Department of Justice's Office on Violence Against Women.
www.workplacesrespond.org

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