Institute *for* Healthcare Improvement

Preventing Verbal and Physical Violence across the Health Care Workforce

Developed by the IHI Leadership Alliance Workforce Safety and Well-Being Workgroup

Toolkit
ihi.org

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Foreword

The Institute for Healthcare Improvement (IHI) Leadership Alliance is a dynamic collaboration of health care executives who share a goal to work with one another as well as in partnership with our patients, workforces, and communities to deliver on the full promise of the IHI Triple Aim. As part of the Alliance programming, members have the opportunity to participate in and lead content-specific workgroups that center around priorities for Alliance member organizations.

IHI Leadership Alliance members prioritized workforce safety and well-being as an urgent priority, leveraging one of their many workgroups to collectively explore this topic, share relevant best practices, and harvest learnings from one another. During the 2021–2022 Alliance year, the Workforce Safety and Well-Being Workgroup homed in on verbal and physical workplace violence in the pursuit of demonstrating alignment of workforce violence prevention and response efforts with advancing system transformation to improve workforce safety and well-being.

An excerpt from an unpublished 2020 IHI Innovation Report, *A Systems Approach to Identifying and Addressing Workplace Violence*, states the following:

> *The Occupational Safety and Health Administration (OSHA) defines workplace violence as "an act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site." Most incidents of workplace violence are verbal but can also include assault, battery, domestic violence, stalking, and sexual harassment. Workplace violence has long been a prevailing problem in health care and affects workers in health care disproportionately. Approximately 75% of the almost 25,000 reported workplace assaults occurred in health care settings and health care workers are four times more likely to experience violence in their workplace, compared to those in private industries, according to the Bureau of Labor Statistics.*
>
> *Workplace violence has obvious costs including, but not limited to, loss of life, injury, and suffering by patients and health care workers. But there are also several hidden costs including counselling for those affected, the time required for administrators to address the issue and conduct investigations and increased medical claims for stress-related conditions. Workplace violence can also result in significant financial implications for the workers' place of employment. Compensation for workers is often thousands of dollars and there are additional costs related to overtime. In the long term, workplace violence can affect staff morale and fear levels, lead to absenteeism, decrease productivity, result in high turnover among employees, and make it difficult to recruit and retain workers.*

To address workplace violence across health systems, it is important that we first define the term. As stated above, OSHA defines workplace violence as "…any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide.It can affect and involve employees, clients, customers, and visitors."

Many organizations build on the OSHA definition of workplace violence and add to it specific forms of workplace violence, such as the following:

- Verbal aggression or verbal assault
- Racist, sexist, homophobic and transphobic slurs
- Sexual innuendos and sexual harassment

Health care delivery systems are reporting an increase in verbal and physical violence against their staff by patients, visitors, and co-workers. Federal data from 2018 shows that US health care workers faced 73 percent of all nonfatal injuries and illnesses due to workplace violence. The number of days away from work due to nonfatal workplace violence injuries and illnesses has steadily increased since 2011.

The COVID-19 pandemic has also magnified workforce safety risks and harms in the health care space and introduced new threats to an already fragile system. To create a physically and psychologically safe environment for health care workers, hospitals and health systems must prioritize innovative, cross-sector strategies aimed at addressing workplace violence.

IHI Leadership Alliance Workforce Safety and Well-Being Workgroup Members

AltaMed

Atlantic Health

Bellin

CareSouth Carolina

Cincinnati Children's Hospital Medical Center

Charleston Area Medical Center

Coastal Medical

Dialysis Clinic, Inc,

Foundation Health Partners

GBMC HealthCare, Inc.

Hackensack Meridian Health

Henry Ford Health System

Highmark Health / Allegheny Health Network

Inova Health System

Jefferson Health

John Muir Health

M Health Fairview

Memorial Hermann

Memorial Sloan Kettering Cancer Center

MemorialCare

Meritus Health

Northern Light Health

OCHIN

Parkland Health

Parkview Health

Penobscot Community Health Care

Presbyterian Healthcare Services

Roanoke Chowan Community Health Center

Spectrum Health

The NARBHA Institute

University of New Mexico Health Sciences Center

Virginia Mason Franciscan Health

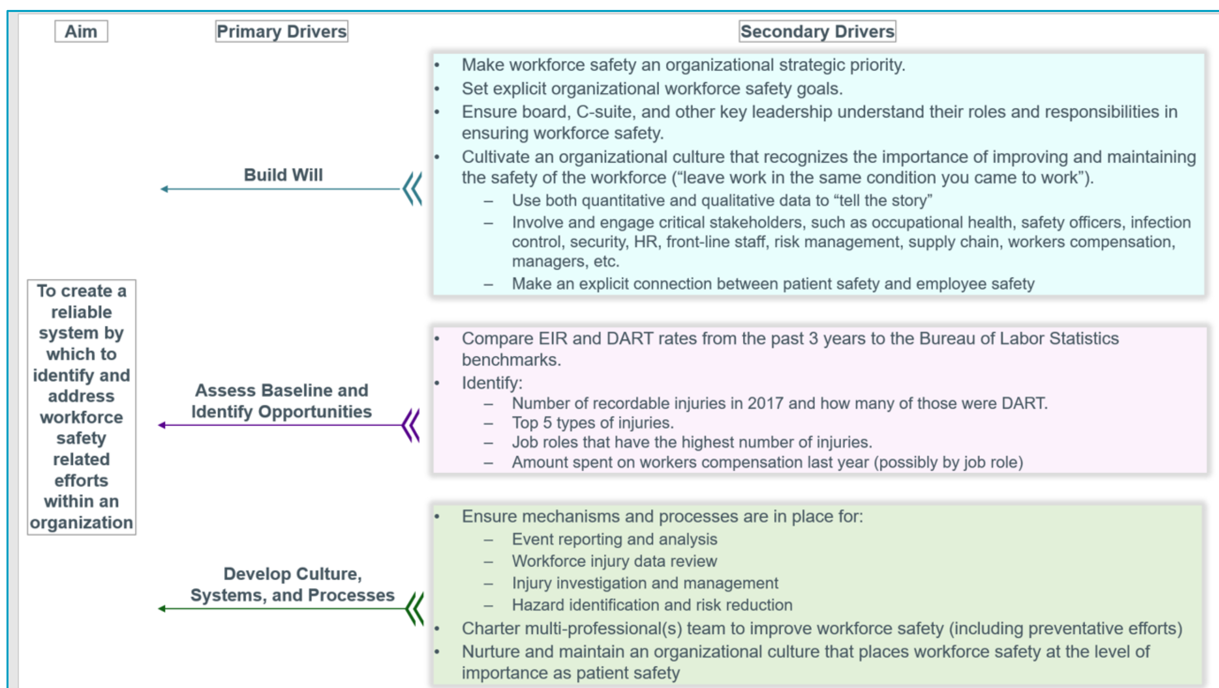
WellSpan Health

Workforce Safety: Five Foundational Pillars

In 2018–2019 the IHI Leadership Alliance Workforce Safety and Well-Being Workgroup developed and began testing a theory of change focused on reliably identifying and addressing workforce safety related issues with a particular focus on ensuring each organization has:

- An explicit strategic goal focused on reducing workforce injuries;
- A process for senior leadership to review workforce safety data as close to real time as possible (at least monthly);
- A robust injury review and reporting process;
- Multi-professional teams chartered to improve workforce safety; and
- A means by which to share with and learn from other organizations.

Under the guidance of Dr. Steve Muething from Cincinnati Children's Hospital Medical Center and Dr. Jeffrey Boord from Parkview Health, IHI Leadership Alliance members have been working to ensure that workforce safety is elevated to the same level of importance as patient safety, using many of the same principles and improvement methods to develop a systems approach to drive down rates of harm. Committing to leading with trust, respect, and dignity has been at the core of workgroup engagement. The emergence of the COVID-19 pandemic and the continuing strain it puts on the health care system has further underscored the vital importance of attending to the physical safety, psychological safety, and well-being of the health care workforce.



Original workgroup driver diagram (2018).

Introduction

IHI Leadership Alliance members have universally signaled that verbal and physical workplace violence is an urgent priority in their efforts to improve workforce safety and well-being. Members urged a shift to peer-to-peer discussion and a learning system for developing additional strategies and change ideas as part of 2021–2022 Alliance programming. There is an opportunity to expand on resources like the American Hospital Association's *Creating Safer Workplaces: A Guide to Mitigating Violence in Health Care Settings*, and to demonstrate the alignment of workforce violence efforts with advancing system transformation to improve workforce safety and well-being. The Spring 2022 series of Alliance programming related to workforce safety was designed to move members toward actions that are meaningful and measurable; in the words of author Jonathan Kozel, "Big enough to matter, small enough to win."

As the 2021–2022 IHI Leadership Alliance year concludes, we are excited to share a member-led toolkit on preventing verbal and physical violence across the health care workforce that represents input from the member organizations and is supplemented with external industry scanning. This toolkit is intended to be a starting place for health care organizations on their journey to address workplace violence and is by no means all-encompassing.

The recommendations and examples from Alliance organizations that are included in the toolkit offer system-level strategies and tactics that hospitals and health systems can implement, organized in the following categories:

- Prevention and Prediction
- Prioritization and Measurement
- System Designs
- Leadership and Policy
- Community Partnerships and Strategic Relationships

Equity, Inclusion, and Belonging Reflections and Considerations

As you read through the toolkit, and reflect on what is currently taking place within your own organization, please consider the following questions:

- Inclusion: Are the people directly impacted by these decisions consulted and engaged in making the decision beforehand?
- Diversity: Who are our partners in this work? Who is perhaps being left out?
- Access: Do all staff, patients, and families have appropriate access to tools and resources?

- Equity: Is injury and harm data segmented using race, ethnicity, language, gender, and/or other segmentation? What about our training data?
- Justice: How do values surface in daily decision-making? Are just culture concepts applied to address accountability for violent or threatening actions?

Prevention and Prediction

OSHA offers several guiding principles for health care and social service organizations specific to building a strategic approach toward workplace violence prevention. Prevention and prediction strategies, processes, and tools must be incorporated into an organization's overall safety and health program. The OSHA building blocks for developing an effective workplace violence prevention program include the following:

- Management commitment and employee participation;
- Worksite analysis;
- Hazard prevention and control;
- Safety and health training; and
- Recordkeeping and program evaluation.

A violence prevention program and its prediction strategies focus on developing processes and procedures appropriate for the workplace in question.

Finally, The Joint Commission created a Workplace Violence Prevention Compendium of Resources, which accredited hospitals and critical access hospitals can use to assist in their efforts to comply with the new and revised requirements effective January 1, 2022.

Example: Spectrum Health

Spectrum Health is an integrated health system based in Grand Rapids, MI, that merged with Beaumont Health in early 2022 to form Michigan's largest health system. During the pandemic, Spectrum rolled out a *Be Kind Campaign* that involved photos and compassionate language with the aim of preventing workplace violence (WPV). The campaign displayed visuals in hallways and patient rooms with photos of staff team members for patients and their visitors to see. The signs suggest behaviors to patients and visitors with humanizing text saying, "Be Kind. Behind the mask is a [grandmother, neighbor, dad, mom, person]."

To further support their WPV strategy, Spectrum uses an Aggressive Behavior Risk Assessment Tool (ABRAT) in their emergency department (ED). The screening tool is used to identify potentially violent patients and is integrated into their EPIC electronic health records (EHR) software. This tool allows the system, and staff working within the system, to be proactive rather than reactive to violent events. When a patient is flagged to have a high likelihood of escalating, staff meet for a huddle or case conference, leverage the knowledge from their Quality Behavioral Solutions training and de-escalation training, and create a mitigation plan to protect emergency staff and patients.

Violence Risk Assessment Tools for Potential Use in EDs

- Aggressive Behavior Risk Assessment Tool (ABRAT): The tool has high sensitivity (the ability to correctly identify violent patients prospectively of all those who become violent) and specificity (the ability to correctly identify nonviolent patients prospectively of all nonviolent patients)
- Brøset Violence Checklist (BVC)
- Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling and Pacing Framework (STAMP)
- Violence Risk Assessment Tools suggested by the Centers for Disease Control and Prevention and The National Institute for Occupational Safety and Health

Example: MemorialCare

MemorialCare is a nonprofit health system in Orange County and Los Angeles County, California, that includes four hospitals, two medical groups, imaging centers, surgical centers, and other sites. Starting in October 2022, MemorialCare will have four WPV Prevention and Response Ambassadors at each facility who will be thoroughly trained in de-escalation and well versed in the Avade WPV Prevention training that all MemorialCare staff are required to complete annually. These ambassadors will build trust with staff through onboarding and annual compliance trainings as well as through conversations with point-of-care staff. Ambassadors will work in partnership with the Human Resources, Risk Management, and Quality Improvement Departments to determine who is assigned to trainings at what time of year and if the trainings and follow up are working effectively or need to be modified.

During a WPV safety event at MemorialCare, security personnel are typically the first to respond. Starting in the fall of 2022, ambassadors will follow up with staff after a WPV safety event to investigate what occurred, how staff and security responded, and if there is a need for a refresher training based on the outcome. This learning will be brought back to the WPV Prevention and Response team to incorporate in future discussions with staff. To ensure staff are prepared in the case of a WPV safety event, ambassadors will also make rounds with staff to ask questions such as: Where are fire extinguishers located? Where is the nearest safe room located? How would you respond if there was an active shooter on your floor?

Workplace Violence Prevention Trainings Used by Alliance Members

- AVADE
- Management of Aggressive Behavior (MOAB)
- Essentials of Aggression Management (EoAM)

Finally, patients can be subject to profiling and discrimination by hospital staff, driven by internalized racism and unconscious bias. Learning from a set of interviews led by IHI's Innovation team surfaces that health systems' workplace violence teams and leaders should be aware of this possibility and look for any instances of this trend. When reviewing workplace violence incidents and responses, teams can also look at race, ethnicity, and language data to look for any trends of bias. This is the approach taken by Brigham Health (as identified in IHI's interview series), Brigham also asks the following questions when reviewing the data, which can be adopted by other health systems:

- Are there any issues of bias?
- Were we reacting to a particular group of people?
- Am I precipitating part of the problem with the bias I hold?

The use of predictive violence risk assessment tools, such as the Brøset Violence Checklist, may open doors to discrimination and consequences of bias from employees. To look for instances of bias, it may be helpful for health systems to audit results of predictive tools to ensure unconscious bias plays no role in the risk assessment. For example, reviews can look to see if staff are more likely to flag Black, Indigenous, and people of color (BIPOC) compared to white patients. Taking these steps to address bias is key to ensuring a fair and equitable workplace violence approach for the workforce and patients and visitors.

Prioritization and Measurement

How does an organization prioritize where to focus workplace violence interventions? Two specific tactics surfaced during Alliance member discussions, including system self-assessment — baseline, benchmarking, and gap analysis — as well as regularly asking employees at all levels of the organization, "What matters to you?"

A 2020 IHI Innovation Report on workplace violence[1] offers that, after establishing a definition of workplace violence, it is important for health systems to design an effective reporting system that: 1) acts as a single source of truth, 2) is easily accessible to all employees, and 3) categorizes instances of workplace violence to create a more complete view of the issues based on this data. It is widely acknowledged that instances of workplace violence are vastly underreported in health care. Proper reporting gives health systems both the ability to address individual incidents and to take a systematic approach to addressing workplace violence.

Segmenting Data

Alliance workgroup members crowdsourced ways to segment WPV data from incivility data — incidents where staff are not physically harmed or verbally threatened but may experience rude or inconsiderate behavior that can cause harm. Many member organizations collect and encourage the reporting of incivility events in addition to, and separate from, events that involve physical violence and threats. For example, Parkland Health's Risk Management Information System (RMIS) has the capability for staff to record "verbal assault" incidents to capture what they experienced, selecting from options such as verbal aggression, racial slurs, sexual innuendos, and gender-related comments. Additionally, Parkland differentiates between intentional versus unintentional WPV events; for example, if a patient has dementia and slaps a staff member, this is considered unintentional because of the patient's cognitive condition. Whichever method(s) your organization is planning to use to segment data, it is crucial that staff across the system have a common understanding of the definitions for terms being used in the reporting system.

Example: Memorial Sloan Kettering Cancer Center

Memorial Sloan Kettering Cancer Center (MSKCC) is the world's oldest and largest private cancer center with 514 inpatient beds and 31 locations in Manhattan, New York State, and New Jersey. In 2017, MSKCC conducted an internal violence prevention audit to analyze systemwide

gaps in preventing patient-to-staff violence. At that time, the organization's data illustrated three primary challenges with violence prevention:

- Absence of a centralized incident reporting and case management system: MSKCC acknowledged that comprehensive incivility data is needed to drive organizational improvement.
- Inconsistent responses to "bad behavior" and using silence as a mitigation strategy: Harmful behaviors therefore continued to persist and individuals who were harming staff continued to receive care.
- Lack of a standardized incivility process and a behavioral discharge process: There was no process to document harmful behaviors or to discharge patients who surpassed the organization's defined tolerance levels for such behaviors.

From 2018 to 2020, MSKCC assessed their current strengths in preventing patient-to-staff violence, underwent a risk assessment, and developed recommendations to close gaps identified by this analysis. The organization began to implement these recommendations in 2021; by June 2022, MSKCC implemented 75 of the 80 required elements identified via the gap analysis. Since implementing the Office of Threat Management, one of the recommendations surfaced by the gap analysis, MSKCC has seen a reduction in loss of work time due to a toxic work environment, violence, and injury.

Additionally, there has been an increase in incivility reporting across the organization, a decrease in repeat incivility offenders, a decrease in urgent care and critical care department incivility (especially on weekend and evening hours), a reduction in the frequency of disruptive behaviors and related employee trauma, and overall improved employee engagement.

System Designs

Meaningful, sustainable strategies aimed at addressing violence and incivility require building structures and systems and embedding processes that are reliable and adaptable across complex care delivery settings. Effective designs also include a robust continuous learning system, which includes the proactive and real-time identification and prevention of system gaps, errors, and harm. Leaders foster a culture of continuous learning by encouraging problem identification, experimentation with improvements to address these problems, and codification of solutions that work best.

Finally, in 2021 The Joint Commission proposed new and revised standards for workplace violence prevention in hospitals and critical access hospital accreditation programs. These standards provide helpful guidance for organizations.

Example: University of New Mexico Hospital

University of New Mexico Hospital (UNMH) is a public teaching hospital located in Albuquerque, New Mexico, and is the only Level 1 trauma center in the state. In October 2021, UNMH launched *Operation Healthcare Workforce Safety.* Under this approach, onboarding for all staff

involves understanding what workplace violence is and how to report it. Additionally, since data indicated that the majority of assault and battery against health care staff was happening at the bedside, UNMH rolled out updated staff trainings designed to keep the workforce safe at the bedside.

The UNMH electronic health record system has the capability to issue SAFE (Situational Awareness for Everyone) flag alerts for patients that have previously threatened, battered, or posed violence against staff. For example, if a patient calls the hospital and threatens staff, security will issue a SAFE alert; this alert will pop up in the EHR if the patient subsequently presents to the ED. These system alerts brief staff on the patient history and aid staff in developing safety plans. The UNMH Patient Behavioral Review Board is tasked with reviewing patient SAFE alerts and evaluating if they were warranted. In some cases, the review board may send a letter to patients who have been flagged, letting them know that the behavior they engaged in is not acceptable or tolerated. The alert may be removed from the patient EHR after a period of time without safety issues. Alternatively, the board can decide to discharge a patient from all non-emergent care in cases where the threat or past behavior was serious enough.

Example: Virginia Mason Medical Center

Virginia Mason Medical Center (VMMC), part of Virginia Mason Franciscan Health and CommonSpirit Health, is an integrated hospital, training, and research facility located in Seattle, Washington. In 2019, after multiple VMMC staff were subjected to aggressive behavior by patients and their loved ones, VMMC developed a Stay Safe Huddle Tool to empower staff to take action and provide a standardized process to follow during times of escalation. A Stay Safe Huddle can be activated by any team member if they recognize a patient that is likely to threaten safety and involves clearly outlined roles and responsibilities for those participating in the huddle.

After using the huddle to discuss the event, staff display a colored visual on the patient’s door that acts as a patient safety alert and is visible to the entire care team. This signifies a Stay Safe Huddle was completed and the type of safety event that happened: yellow indicates the patient refused care, purple indicates the patient engaged in yelling or shouting, and grey indicates the patient was physically combative. This subtle signage allows staff to use appropriate mitigation strategies, such as at least two staff are in the room with the patient at all times.

VMMC celebrates and recognizes teams for empowering staff to speak up about these incidents. The learning from these events is shared across the hospital at daily safety huddles. Elements that have been fundamental in the efficacy of the Stay Safe Huddle Tool include:

- The Stay Safe Huddle Tool is available in a centralized location.
- Scripts are readily available for staff, to support them through the huddle process.
- Trainings involve role-play scenarios for each incident color (yellow, purple, grey).
- Leadership is involved and champions this work.

STAY SAFE HUDDLE TOOL

The STAY SAFE huddle tool addresses the following signs witnessed by team members that threaten safety

SIGNS	• *Refusing Care* • *Agitation* • *Altered mental Status* • *Bartering* • *Suspicious /Guarded* • *Staff Splitting* • *Resistance to Safety Intervention Bed/Chair Alarm, Virtual Companion, Gait belt, Hoyer Lift, Turns, other*	• *Verbal Aggression = raised tone or abusive language* • *Physical Aggression = pacing or aggressive body posture* • *Under the influence of substances*	• *Verbal Threat(s)* • *Combative /Aggression* • *Damaging property*
	If unsafe AMA suspected or attempted please follow AMA policy		
TEAM	• Clinical Care Team • MD/Provider • Patient Relations* • Unit Leadership*	• Clinical Care Team • Security • Nursing Supervisor • Unit Leadership • MD/Provider • Patient Relations* • MSW/Case Manager	• Clinical Care Team • Security • Nursing Supervisor • Unit Leadership • MD/Provider • Patient Relations • MSW/Case Manager
ACTION	• De-Escalation • Stay Safe Plan of Care • Documentation • Door Visual • Submit a PSA	• Security Assist • Door Visual • Stay Safe Huddle • Door Visual • Submit a PSA	• Code Gray Response • De-Brief • Code Gray • Door Visual • Submit a PSA
	*as needed		

Refusal of care: The patient and the staff have fundamental rights to physical and psychological safety. Patients with capacity for decision making (capacity is determined by a provider) have the right to refuse medical treatment, including life-sustaining treatments and continued admission. Safety equipment and monitoring are not a medical treatments, they are tools to maintain a safe environment for patients and staff.

Example: Wearable Duress Alarm Systems

As part of their workforce safety efforts, multiple Leadership Alliance member organizations implemented wearable duress alarm systems ("wearables") to enable staff to summon assistance when confronted with a violent or aggressive patient, visitor, or other staff member. The most basic wearable duress solution incorporates a "panic button" on ID badges (which are worn every day) that health care staff can press discreetly when they need help. The panic alarm is routed to security and provides the staff member's specific location within the facility.

Workforce members universally reported feeling safer once wearables were in place at these Alliance organizations, and security officers reported much faster response times based on more specific locating data. Staff at Northern Light Health, for example, noted that wearables provide a mechanism to obtain help that does not exacerbate the situation or heighten the undesirable behavior.

Alliance organizations identified some common challenges with wearables that need to be considered:

- Security staffing: Some locations in the health system lack sufficient security staffing, while other locations have robust security to respond to a duress alarm. This can lead to relying on non-security staff (e.g., the charge nurse) when there is not enough security capacity to respond to alarms.
- Internet-dependent devices: Wearables rely on Internet capability to signal where staff are located in the facility when they press the "panic button." Staff may need the ability

to activate help in an area of the hospital where Internet connectivity may not be available (e.g., parking garage).

- Funding: Some organizations have insufficient funds to pay for wearable duress alarm systems.
- Location precision: Some duress alarm systems only provide the wearers general location rather than a precise location in a patient room, clinical department, or other space within the facility.

Leadership and Policy

All health care leaders have a responsibility to advance workforce safety, and therefore should commit themselves and their organizations to safety and the elimination of harm. Leadership and governance structures may not look identical across health care organizations; however, health care systems can leverage the influence of leadership and governance "to commit to safety as a core value of the organization and drive the creation of a strong organizational culture (Safer Together: A National Action Plan to Advance Patient Safety)." This journey should be centered on equity and involve patients, families, care partners, and the health care workforce. Additionally, it is vital that leaders assess their organization's capabilities around safety and commit the necessary resources to advance this priority.

To ensure your leadership team and organizational policies are working in parallel to advance workforce violence prevention, you should also consider the following:

- Foster collective action to uphold safety as a core value;
- Get your organization's C-suite and governing board engaged in quality and safety;
- Develop or adapt a strategic plan that explicitly calls out workforce safety; and
- Create a culture of psychological safety, accountability, and support.

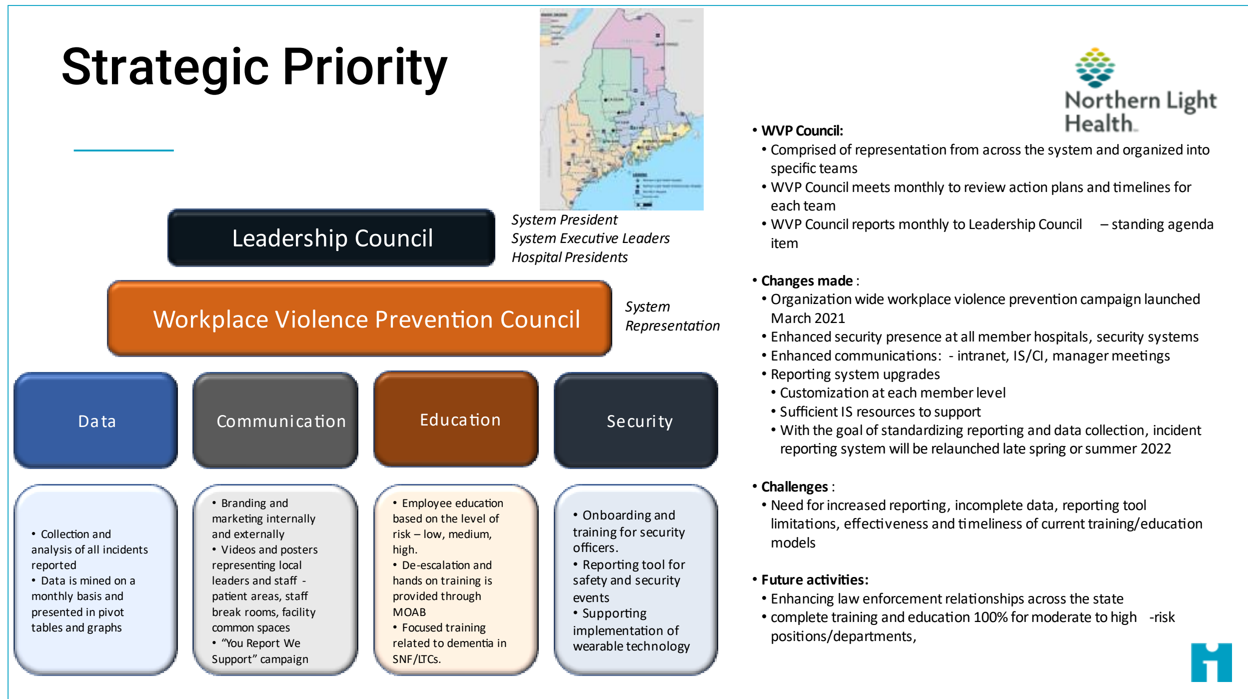
Safer Together: A National Action Plan to Advance Patient Safety, developed by IHI and the National Steering Committee for Patient Safety, provides further direction on how to effectively utilize governance structures and organizational policies to make significant advances toward safer care and reduced harm across the continuum of care.

Example: Northern Light Health

Northern Light Health is an integrated health delivery system in Maine, comprising ten member hospitals, a physician-led medical group, two nursing homes, five emergency transport members, and 41 primary care locations across the state. Northern Light Health has made WPV prevention a strategic priority systemwide, with the support of both their Leadership Council of senior-most leaders systemwide and WPV Prevention Council with representatives from each member hospital.

Monthly Leadership Council meetings begin with an employee story of a WPV event, a near-miss event, or an instance where there is potential for WPV. The WPV Prevention Council meets monthly to review action plans and timelines for workgroups organized into four topic-based

teams: data, communication, education, and security. The WPV Prevention Council reports to members and the Leadership Council, sharing tools and insights to further progress on WPV prevention strategies and implementation.

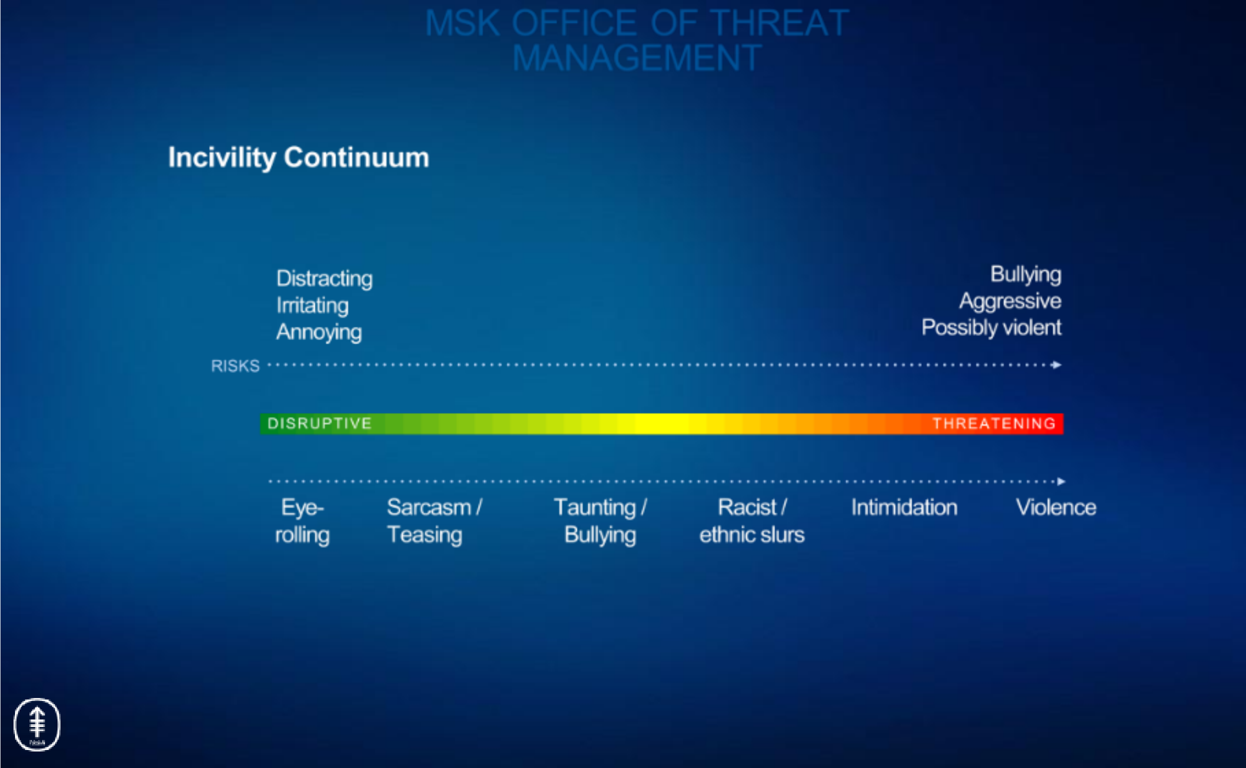


Northern Light analyzed WPV incident volume versus incident rates by hospital using the Occupational and Safety Health (OSHA) model. This showed that some of the smaller hospitals had higher incidence rates than larger sites. Comparing these rates and using real-time data supported Northern Light leadership in making more effective, data-driven decisions. Currently, the WPV Prevention Council and Leadership Council are exploring the following questions:

- How can we improve the accuracy of data and the story the data tells?
- How should we segment our data?
- What are other ways we can support our teams?

Example: Memorial Sloan Kettering Cancer Center

Memorial Sloan Kettering Cancer Center (MSKCC) is the world's oldest and largest private cancer center with 514 inpatient beds and 31 locations in Manhattan, New York State, and New Jersey. MSKCC developed an incivility continuum (see figure below) to illustrate actions that range from being disruptive to being threatening.



This visual explicates the message to staff that "no one has the right to verbally abuse, intimidate, or physically harm you." MSKCC leadership and the Office of Threat Management work closely with staff to ensure that they believe this messaging for themselves; it is vital that MSKCC staff know that workforce safety is equally important and fundamental to the organization as patient safety. The incivility continuum also functions as a tool to categorize each event that occurs. The Executive Response Team, consisting of a multidisciplinary group of MSKCC staff, assesses all escalated incidents of incivility and acts as the patient discharge decision point when necessary.

MSKCC's Office of Threat Management created a Management of Patient and Third-Party Incivility policy to address all behaviors and social interactions that are inappropriate and incompatible with a healthy and safe workplace. This policy helps manage instances of cultural insensitivity, intolerance of differing opinions, and interpersonal violence, and applies to interactions that are either in person or over a virtual platform like telehealth, social media, patient portal, or text.

Community Partnerships and Strategic Relationships

Example: Parkland Health

Parkland Health is a high-volume safety net hospital system located in Dallas, Texas, that includes a standalone hospital, 20 community-based clinics, 5 school-based clinics and numerous outreach and education programs. Since 2018, Parkland Health has partnered with the Dallas Fire-Rescue Department and the Dallas Police Department to form the Rapid Integrated Group Healthcare Team (RIGHT Care Team) with the goal of reducing the level of law enforcement and justice system involvement in mental health emergencies. RIGHT Care Teams respond to people experiencing behavioral health emergencies by operating in four-person groups composed of two behavioral health clinicians (dispatch and field clinicians), a fire-rescue paramedic, and a police officer. This program was modelled after the Colorado Springs emergency co-response approach.

The RIGHT Care Team determines each patient's disposition and can provide on-scene crisis de-escalation and stabilization, redirect to outpatient resources, and/or transport directly to a medical hospital or behavioral health facility. During the program piloted in South Central Dallas from 2018 to 2020, data showed a 20 percent decrease in psychiatric admissions, a decrease in arrests and ED arrivals, and an increase in mental health patients getting the appropriate services they need. For more information, see these resources: RIGHT Care Team Introduction Video and *RIGHT Care Team responds to mental health crisis* article.

RIGHT Care Protocols

Once deployed, law enforcement will ensure both public and community safety on the scene, the paramedic will assess and determine if emergency medical services are indicated, and the RIGHT Care Team SW will initiate a comprehensive behavioral health assessment.

If at any time during the call, public safety or physical health needs become the primary concern, the RIGHT Care Team clinician will defer decision-making as to the appropriate action to law enforcement and/or the paramedic, depending on the person's specific needs.

After completion of the SW assessment, the RIGHT Care Team will determine the appropriate le of care for the individual necessary for stabilization in the community, or if appropriate, will transport to the nearest emergency department or psychiatric facility for further intervention.

Example: Northwell Health

Northwell Health is New York State's largest health care provider, serving New York City, Long Island, and Westchester. Northwell has multiple efforts underway to improve safety not only for its workforce, but also for its communities.

Center for Gun Violence Prevention: Formed in 2020, Northwell's Center for Gun Violence Prevention is charting a public health approach to end the epidemic of gun violence — for patients, their families, and communities. The center is providing clinical care and support services to those impacted by gun violence, developing best practices for hospitals to prevent firearm injury and death, and mobilizing a national coalition of health care leaders to depolarize gun safety and tackle this public health crisis. The goal is to dramatically reduce gun violence so that it's no longer a driver of hospital admissions for injuries or deaths. The center has launched several initiatives with the goal of developing and implementing best practices and protocols for hospitals to prevent and treat firearm injuries and deaths.

Learning Collaborative for Health Systems and Hospitals: The Learning Collaborative is a multi-year, interactive forum that gives health care professionals the space to have open dialogue about the impact of gun violence, share best practices, and collectively take action. The Learning Collaborative explores experiences regarding existing hospital-based and community-based firearm safety and violence prevention strategies, yielding opportunities for members to use the lessons learned by others to support the implementation of strategies within their own organizations.

Facilitating the Integration of Firearm Injury Prevention into Health Care Workshop: Northwell's Center Gun Violence Prevention and the PEACE Initiative co-sponsored a five-hour workshop on April 25, 2022, hosted by the National Academies of Sciences, Engineering, and Medicine. The event included insights from leading national experts, including trauma surgeons, mental health specialists, policy analysts, the Centers for Disease Control and Prevention, and frontline community leaders, who have established gun violence prevention programs.

Photo: Northwell Health community event to spread awareness on gun violence prevention.

Additional Complex Considerations

Policing

The majority of hospitals employ their own security personnel to handle patient and staff safety issues, in large part to assume control over the training provided to these staff when hospital liability is involved. However, some hospitals have a police presence in addition to or instead of hospital security: 35 percent of public hospitals have a police presence and 76 percent have security with the ability to arrest, compared to 18 percent and 51 percent respectively at private hospitals. Hospital security, in whichever form, are armed with handguns in 52 percent of hospitals.

The role of police and armed security presence in health systems surfaced in several workplace violence and gun violence-specific Leadership Alliance discussions. The issues are complex, and health systems remain eager to learn from the experience of colleagues across the industry. One specific example from Rush University Medical Center is included below. The IHI Leadership Alliance team is eager to include additional perspectives, examples, and learning for the benefit of health care leaders that may access this toolkit. Please consider sharing your organization's strategies and learning as an additional example (IHIAllianceTeam@ihi.org).

Example: Rush University Medical Center

Prior to serving as IHI's current Chief Operating Officer, Cynthia Barginere, RN, was serving as Senior Vice President and Chief Operating Officer for Rush University Hospital, in Chicago, Illinois. This example is an account from her time at Rush (May 2011 to July 2020) and does *not* capture potential changes made after this time.

Rush University Medical Center is an academic medical center, located on the west side of Chicago, with a strong commitment to addressing the social and health care needs of residents in neighboring communities. Throughout 2016 and 2017, staff at Rush completed an engagement survey. Safety emerged as a common theme, specifically physical safety and escalating violence toward staff by patients and their visitors. Even as violence was escalating against staff, Rush chose not to have a police force at that time. Instead, the Rush security team focused attention on adopting a community policing approach as opposed to a show of force approach. Rush security officers maintained a presence on the hospital's floors to build close relationships with charge nurses and engage with patients and family members. This process allowed security personnel to better understand what those on the floor were concerned about and what their needs were to provide proactive support. Rush had dedicated security personnel on intensive care unit (ICU) floors and in EDs due to high levels of anxiety among family members in those departments. In parallel, Rush had dedicated social workers for the ED to meet with psychiatric patients and medical patients with mental health disorders.

During the time period described in this example, Rush leadership decided against metal detectors in the ED and tasers for security personnel. This decision was grounded in an

understanding that when patients act out, it is often because of fear. Instead, Rush focused on their visitor management system and increasing participation in their de-escalation training. During 2019, the Rush visitor management system involved taking the name and ID of each person that came into the organization. This was done for the purposes of modulating the number of visitors in the space as well as for general security and safety if an emergency was to happen. One concern with this approach was patients without identification and undocumented immigrants. In instances where patients did not have ID or did not want to provide ID, greeters would simply take the person's name before letting them in to visit their loved one. No information collected during this process was shared outside of the facility to protect undocumented immigrants.

Equity, Inclusion, and Belonging Reflections and Considerations

- How do we care for people who come to our health care organizations as opposed to criminalizing them?
- How often are staff members calling security checks for Black patients and other patients of color compared to white patients?
- Have you considered how your safety and security program would affect non-English speaking patients and families?
- Look at the decisions you are making today. When you look back in 10 years, will you and your team be able to say, "We did everything we could to be patient- and equity-centered"? If not, how can you change your process to make "future-backed" decisions?

Staff Resiliency and Burnout

The most joyful, productive, engaged staff feel both physically and psychologically safe, appreciate the meaning and purpose of their work, have some choice and control over their time, experience camaraderie with others at work, and perceive their work life to be fair, safe, and equitable. Strategies and priorities targeting clinician and workforce burnout, fatigue, and even moral injury must systematically, and through lasting system redesign, address workforce well-being, support behavioral health, and prevent workplace violence. The Leadership Alliance ten "new rules" included "Joy in Work" as a core system redesign principle. When the IHI team asked members to reflect on these "rules," an overwhelming number of colleagues crossed out this language and suggested it should instead read "Keep Me Safe."

Example: Southcentral Foundation

Southcentral Foundation (SCF) is an Alaska Native-owned, nonprofit health care organization that serves approximately 65,000 Alaska Native and American Indian people located in southcentral Alaska. Southcentral Foundation's Nuka System of Care (Nuka) is a relationship-based, customer-owned approach to achieving the IHI Triple Aim. Relationships and strong ties cultivate resiliency in the workforce and are foundational to SCF's culture. SCF new hire orientations place a strong emphasis on building connections where staff participate in exercises on listening and responding, approaching one another, and storytelling. SCF believes

that nurturing these skills serves as protective factors for staff to reduce anxiety, increase psychological safety, and improve health and wellness.

Customer-owners, SCF's term for patients, similarly have opportunities to engage in conversations with one another in learning circles focused on wellness and emotional support. Learning circles often center around a topic or theme, for example, yoga, toddler time, or teatime with elders, and these have continued throughout the COVID-19 pandemic with virtual options.

Staff trainings at SCF also focus on burnout and improving one's ability to be resilient. For example, SCF shares resources with staff on how to take an effective micro break, which can take a variety of forms: taking a few minutes out of your day to reflect on how you are showing up and having an impact, following breathing techniques, giving yourself a hug, practicing mindfulness, stretching, and more. Beyond trainings, staff can continue conversations on burnout and resiliency by watching easily accessible videos, joining leadership chats, and engaging in photo exchanges. Each staff member can dedicate one hour of their 40-hour work week to wellness activities.

Additional Resources

Toolkits

- Creating Safer Workplaces: A guide to mitigating violence in health care settings by the American Hospital Association (AHA) and the International Association for Healthcare Security and Safety (IAHSS)
- Fundamentals of Total Worker Health® Approaches: Essential Elements for Advancing Worker Safety, Health, and Well-Being by the CDC and the National Institute for Occupational Safety and Health
- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers by OSHA
- Preventing HealthCare Workplace Violence Toolkit by the Alaska State Hospital & Nursing Home Association and the Washington State Hospital Association (WSHA)
- Workplace Violence in Hospitals: A Toolkit for Prevention and Management by Oregon Association of Hospitals Research and Education Foundation in collaboration with WSHA
- Evidence-Based Strategies for the Prevention of Workplace Violence Against Health Care Workers: Creating an Educational Toolkit by Chibuzor Anyanwu
- Developing Healthcare Safety & Violence Prevention Programs within Hospitals by Massachusetts Health and Hospital Association
- Racial Equity Impact Assessment Tool for Gun Violence Prevention by the Johns Hopkins Center for Gun Violence Solutions

Frameworks

- AHA's Hospitals Against Violence Framework
- Guiding Principles for Mitigating Violence in the Workplace by the American Organization for Nursing Leadership and the Emergency Nurses Association
- 5 Actions for Joint Commission's New Workplace Violence Prevention Standards by AORN
- Moral Injury of Healthcare white paper: How reframing distress can support your workforce and heal your organization

Articles

- Designing a Workplace Violence Prevention and Recovery Program by Patricia McCabe
- It's Time to Reevaluate Police Presence in Emergency Rooms by Mary Bridget Lee
- Police Officer Now on Duty in Emergency Department to Increase Patient Safety by Intermountain Healthcare
- Policing the Emergency Room by Ji Seon Song
- Taking Steps to Prevent Violence in Health Care Workplace by Amy Farouk

Courses and Modules

- CDC's Workplace Violence Prevention for Nurses course

Other Resources

- IHI Leadership Alliance Help Health Care Heal Coalition
- AHA's Recommended Workplace Violence Prevention Resources
- The Joint Commission's Workplace Violence Prevention Resources
- IHI Patient Safety Essentials Toolkit (includes FMEA tool, etc.)
- IHI Quality Improvement Essentials Toolkit (includes project planning, PDSA, etc.)

IHI Innovation Reports (unpublished)

- Imbeah K, Loehrer S. *A Systems Approach to Identifying and Addressing Workplace Violence*. IHI Innovation Report (unpublished). Institute for Healthcare Improvement; 2020.
- Rakover J, Imbeah K. *Building a Workforce Safety Movement with Vocera's Declaration of Principles*. IHI Innovation Report (unpublished). Institute for Healthcare Improvement; 2021.