

The (long) road toward safety and wellbeing for all: are we there yet?
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Working on violence management in university hospitals from a PLN's perspective. The pros and cons of staff training. Should we do more?

Background

The University Hospitals of Geneva (HUG) are composed of five hospitals. With over 11,000 employees, it's the largest employer in the region of Geneva. Since June 2000 I've been working there as a psychiatric liaison nurse (PLN) and clinical nurse specialist. My practices regroup three spheres of expertise: direct care with patients and relatives, education and support of interdisciplinary staff, and clinical leadership. It's a transversal function depending directly on the Nursing Directorate (ND), with no hierarchical link to the medical departments. I work essentially in surgical, medical and neurological wards. I offer specialized mental health nursing care to patients with somatic and psychological needs and help ward nurses in the care of this specific group.

In 2002, in order to better identify difficulties and needs, I conducted a survey amongst 1686 nurses and orderlies with a response rate of 39% (n=657). Aggression, agitation and non-compliance clearly emerged as the three main sources of difficulties frequently encountered (sometimes 50%, often 40% or very often: 7%). Nearly 70% of respondents felt that some training was needed to offer proper care to these "difficult" patients.

Patient and visitor violence (PVV) is not a new phenomenon and has grown significantly in recent decades (Kingma, 2001; Kuehn, 2012). *In 2011 (USA), the incidence of injuries and illnesses resulting in days away from work from a nonfatal assault was 14.6 per 10,000 workers in health care and social assistance compared with 3.8 per 10,000 workers in all private sector workplaces* (Lipscomb, 2013).

The HUG don't have reliable statistics on workplace violence, but local surveys of nurses and physicians (in 2002, 2013 and 2014) suggest that violence is a serious and widespread problem in our hospitals. The data seems to be comparable to the national statistics (Hanh, Needham, 2008) available and to those of other international studies. Let's face it, here, as elsewhere, we must recognize that violence in health care facilities is not an epiphenomenon: it has now integrated them (Guerrieri, 2011).

HUG have numerous resources available to help staff prevent and manage violence at work, such as an internal security service, an employee health service, a team of personality protection, a medical unit for prevention of violence (UIMPV), a legal service, in-house training, PLN's and a consultation-liaison psychiatric service.

Despite this the survey (in 2002) showed that our staff felt unprepared and vulnerable. Where was I supposed to start to address those feelings? Those difficulties?

Methods

At first I organized small 2 hours workshops in the medical wards, as they were interested in developing violence management skills.

These workshops were well received by the participants, but were too short to meet their needs. However they were an excellent start to work on a concept, to revisit the international initiatives and even to refine the training strategies.

Over time these workshops evolved and spread to other wards. A network of people interested in this matter developed with clinical nurse's specialists, care managers, physicians and quality officers. This network created several educational interventions:

- half-day module called "managing conflict and violence" as part of the basic training course of the health care and community assistants

- one-day module called "managing violence and incivility" as part of a nurse post-graduate training course: care for patients with psychic suffering

- half-day module called "managing violence and incivility" as part of a nurse post-graduate training course: care of patients affected by musculoskeletal system pathologies

More recently, at the request of the emergency and psychiatric departments, this network developed a full four day course. This course is now offered to all in the in-house training program and four sessions are held each year. Each session can accommodate 14 participants. Several topics are covered: personal relationship to violence, violence in care, physical and relational positioning, intervention strategies, institutional resources and legal aspects.

In 2012, an awareness module about violence prevention and management was introduced into the new employee's training program. In April 2014, our institution organized a one day conference on the topic of violence in health care settings. Being close to the employees' concerns, this day was a great success. It has enabled professionals and guests to share thoughts and experiences, as well as to highlight several projects already initiated in various medical departments.

Finally, for almost two years, in collaboration with the nursing department and medical managers of the Department of Rehabilitation and Palliative Medicine (DRPM), we created a one day workshop (RSVP: Coping together) entirely devoted to the prevention and management of PVV. It is mandatory and intended for all employees in direct contact with patients and their families. At the end of 2014, nearly 500 employees will have benefited from this course. This training distinguishes itself by a unique approach: it's based on interdisciplinarity. It allowed the development of a conceptual model and a common language (team approach). It clarifies the responsibilities of each staff member and provides emergency guidelines in case of a violent event. This program has been evaluated through a questionnaire addressed to all participants before the training and six months after.

Results

We found (evaluation of trainers and feedback from participants) that participation in such (all) training sessions allows employees to:

- feel less alone and less isolated
- take the necessary distance to promote reflective practice
- acquire a conceptual model (prevention, assessment and interventions)
- improve knowledge of available resources

We are convinced that staff training can increase safety and reduce the risks for both health care providers and patients, but what evidence do we have? There is little research on the subject.

The first results of the RSVP project are encouraging. Participants stated that they acquired new knowledge (96%) and 89% used it in their practice. Participants feel more comfortable with the manifestations of aggression they encounter in their work (70%) and 95% would recommend this training to their colleagues. Finally, we can note a decrease in the anticipated anxiety level's at the evocation of a confrontation with a violent event, and an increase in the use of de-escalation techniques (comparative survey before and after).

This training, as well as the others, also highlighted the staff difficulties:

- Difficulty to be heard or to get adequate support
- Lack of assessment tools and/or clear guidelines
- Lack of knowledge of the available resources

Discussion

After several years of working on those different training courses, we can now appreciate their benefits, but also their limits. Staff training is an essential element, but alone it cannot solve the problem. It could be a dangerous pitfall to think that once you've trained your staff, the violence problem is solved.

Violence is not just a relational problem, it's an **institutional** problem. Therefore it must be treated as such. The HUG are aware of this. This is why they also provide institutional responses in addition to the current in-house training and of all the others resources available. They published an information brochure for all employees: where to find help in case of violence at work (2007)? This brochure was also accompanied by two official guidelines: procedures in case of criminal offense against an employee or against a patient or visitor. The general management has recently taken new measures to further secure the workplace: restricted access requiring electronic badge and the presence of a security guard from 21:00 to 06:00 in the emergency wards, doubling the night staff in psychiatry and ending working alone in isolated care structures. The ND has made the prevention and management of violence a working priority: training, information, better diffusion of existing procedures, and is even considering an awareness campaign for the users.

Taken individually, each and every one of those "answers" has a relatively limited impact. It is by multiplying them that we can obtain a "safety net" that benefits to both employees and users alike.

Perspectives

Staff training is an essential element, but as we have seen, it's one element among many others. So what else can be done? New perspectives can be found both in literature and in elements brought by the training participants. Here are some other alternatives to consider:

- Precise institutional expectations

The creation of easily accessible emergency measures could help the employees to position themselves, to know what's within their competence's range, what's expected of them, and when it's time to "pull the alarm", so that other institutional actors can also fulfill their respective roles. This would also increase the employee's knowledge of the available resources.

- Integration of assessment scales in the computerized medical record (CMR)

In addition to being a medico-legal requirement, clinical documentation is a powerful tool for ensuring care continuity and safety. Scales for rating violent behavior should be incorporated into the CMR. This would facilitate documentation and would also help “keeping alive” the conceptual models outside the training courses.

- Improving the management of incidents

The value of systematic hospital incidents reporting (falls, bedsores, etc.) is well established. These incidents are used to analyze the context, identify risks, contributing factors and to bring improvements. The same logic applies to the management of violent incidents. Yet it does not seem to be the case. The International Council of Nurses believes that only one case of violence in five is officially reported. Why? Because reporting is often seen as an additional and unnecessary workload, it could give a poor self-image or harm the department's image, or because those who declare do not receive a response or satisfactory support. They sometimes have the feeling of not being taken seriously (ICN, 2007).

Since it's not easy to improve what's not measured, it would be the next logical step for the HUG to adopt (for the whole institution) a classification scale (types and dangerousness levels) of encountered violent incidents. It would also be useful to create a rapid response system in case of a violent incident report. This kind of rapid response should be available to all workers, regardless of the medical department where the incident has occurred.

Finally, the creation of a violent incident analysis grid for the incident management group members would help them to identify the relevant factors (human, organizational and environmental) to be considered in order to provide effective support and enable the formulation of recommendations to improve safety and security.

Since violence incidents are underreported, we should welcome an increase in the numbers of reporting. Initially our goal should not be to reduce it.

Conclusion

Start by addressing issues you can have an impact on, and keep working on them. But there are only so many things that you can do alone: building a network in and outside of your institution is essential.

PVV has important human and financial impacts (Kingma, 2001). It's a complex problem that requires complex answers. This is why the HUG deployed, in addition to training, many measures and resources to improve the safety and security at work.

So far the results of our in-house trainings are promising: they increase knowledge, skills and staff confidence for dealing with PVV. Although training is a necessary element of a comprehensive approach to address workplace violence, it's not by itself sufficient to prevent staff and patient workplace violence entirely. You can't rely only on workers training as your sole strategy for violence prevention and management (Lipscomb, 2013).

We still have work to do. Currently we are exploring additional means for optimizing the prevention and management of PVV: specifying institutional expectations, improving clinical documentation, developing the process of incident management and seeking better ways to support our teams.

Violence management isn't an end in itself but an ongoing and never-ending process. And we all have a part to play. We've come a long way toward safety and wellbeing for all. Are we there yet? No, but we are getting closer.

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