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Patient 'sitters' at high risk of violence, physical threats

Landmark study reveals threats to largely unknown workforce

By Gary Evans, Senior Staff Writer

"The young lady was nice to me the whole eight hours, and at the last 30 minutes she just walked up to me and said, 'I don't like you. I'll kick your ass,'" the patient "sitter" recalled. "I looked back. Was she looking at somebody else but me? Because we were cool. She said she wanted popcorn, and I went and got her popcorn out of the vending machine, bought her sodas, and washed her hair, and when I turned around she was standing in my face and she is like, 'I'll knock you out,' and she actually swung, and she hit me."

This and other harrowing accounts of violence and abuse suffered by healthcare sitters — who are assigned to watch patients for a variety of reasons — are detailed in a landmark new study[1] that found that 76% of respondents experienced at least one event of patient threats and violence in the prior year. Among sitter respondents, 61% reported physical assault, 63% cited physical threat, and 73% experienced verbal abuse. The small study, which appears to be the first to document and specifically describe threats of violence against healthcare sitters, was bolstered by extensive interviews and focus groups.

> "WE DID A LOT OF INTENSE FOCUS GROUPS, AND IT WAS REALLY DISTURBING AND OVERWHELMING — IT IS INCREDIBLE WHAT THEY ARE DEALING WITH."

"We did a lot of intense focus groups, and it was really disturbing and overwhelming — it is incredible what they are dealing with," says co-author

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Lisa A. Pompeii, PhD, a former employee health professional who is now a professor and researcher in the school of public health at the University of Texas Health Sciences Center in Houston. "[Hospitals] need someone in this sitter role but they need to get up to speed and really train these workers on what is expected, when do they call for help, how do they leave the patient. This is something that is just beneath the radar and I suspect others will start to study this work group as well." *(For comments from sitters, see story on page 41.)*

Sitters appear to be a shadow work force — generally undefined in both duties and qualifications — that has fallen between the margins of occupational health and patient safety. They may be asked to prevent patients likely to fall from getting out of bed, watch a patient with dementia, stay with someone who is suicidal, or sit with patients who are disoriented but have not been put in restraints.

"There is just a real range of the type of patient they are going to monitor," Pompeii says. "The other thing is that nurse managers are really at kind of a loss in how to train them — what do they need? It's really kind of this loose workplace [role] right now that is really needed by the hospitals, but isn't formally defined like a nurse's aide, a nurse, or a physician. There seems to be a greater need for this role, but a nurse sitter comes in and she weighs 102 pounds and she is sitting next to a guy who is suicidal and she has to stay within five feet of him or arm's reach. Some of it doesn't make sense and it's really dangerous."

Indeed, a manager commented in one of the study interviews: "The sitters are the least-trained individuals in this hospital. And they are the ones who are really, really on the front lines. There are times when I will go in, and I will see a [psychiatric] patient who is really scary, and I'm like, 'If this guy decides to go for [the sitter's] throat, [the sitter's] not going to get out of the room. They're not going to be able to call for help. They're going to be dead."

Protect patients at own risk

Despite ambiguity in the details of sitters' job responsibilities and training, there was "consistency across study participants that sitters' overarching role was to protect the patient — even without adequate tools, training, and resources to do so," the authors found. "Protection of the patient sometimes came at the expense of sitters' own safety and well-being, as well as that of their personal belongings." Although constant observation may be carried out by a variety of provider types (e.g., nurses, security personnel, nurses' aides, other paid employees, volunteers, family members), it is generally the unskilled or untrained hospital worker who fills this role, they note.

A hospital security report recommended that sitters be trained in violence prevention and de-escalation techniques, but agreed with the current general approach of not using security guards for sitting duties. "The presence of a uniformed officer may give the impression that the patient is in custody and may actually escalate fear, especially in a semi-private room," the report noted.[2] *(See related story, page 42.)*

Currently, there are no consensus national guidelines or regulations on the role of sitters or protecting their

health and safety on the job. There is considerable variability in sitters' job descriptions, their purpose (i.e., custodial versus therapeutic) and the definition of patients needing observation, the researchers report. "Particularly striking is the absence of research focused on the occupational safety, health, and well-being of sitters," they found.

The Occupational Safety and Health Administration (OSHA) issued a healthcare violence prevention report last year that in general calls for risk assessments, worker surveys, and a job hazard analysis that prioritizes workers "with high assault rates due to workplace violence."[3] It appears there are no specific new regulatory requirements in the emphasis on violence prevention, but OSHA inspectors have some leeway under their General Duty clause requirement that employers provide a workplace that is "free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."

Employee health professionals should help establish clear policies and guidelines to define and protect the sitter work group, says lead author **Ashley Schoenfisch**, PhD, MSPH, assistant professor at Duke University School of Nursing in Durham, NC.

"Constant observation is an essential and integral part of patient care practice in hospitals across the US," she says. "Employee health professionals should be knowledgeable about the roles and responsibilities of sitters in their institutions when developing, implementing, and evaluating occupational safety and health policies and procedures — including training."

When providing care to sitters who have experienced an adverse work-related event, employee health professionals should be cognizant of both the physical and mental demands placed on sitters, she adds.

"Employee health may serve as an important liaison between sitter managers and managers of patient care units to ensure a safe work environment," Schoenfisch says.

Comments made by sitters and unit managers in the study's focus groups include a lack of clarity about their role and responsibilities.

"I MEAN, IF THE PATIENT'S BECOMING COMBATIVE TO THE POINT THAT THEY'RE HITTING, THEN KICKING, THEN SPITTING, WHAT ACTIONS DO YOU TAKE?"

"They tell you, 'Go sit with this patient,'" one sitter said. "Is it ok to talk to them? Should I be ignoring them? Am I like the security?"

Another sitter told the researchers that they are told to keep the patient safe, "but most of them don't understand why they're there, what actions to take and not take if you are in a situation. I mean, if the patient's becoming combative to the point that they're hitting, then kicking, then spitting, what actions do you take?"

In the study, sometimes other hospital workers were required to sit with a patient in the event a sitter was not available. This so-called "warm body" affect is often seen with patient fall concerns, but may occur with many other situations, Pompeii says.

A nurse manager recounted in a focus group, "I have a new unit secretary who has been pulled to sit. One of the first things she said to me is, 'I have not been trained on how to handle this patient if they decide to get up. If they start falling, what do I do?' So I had to make some phone calls to figure out [the protocol]."

During the course of a larger study focused on type II violent events in the hospital setting (HCWs threatened by patients or visitors), sitters emerged as an occupational group that warranted further examination. *(See related story, page 43.)*

The study took place in two large healthcare systems in North Carolina and Texas, with each comprised of one large medical center and two smaller community hospitals. The hospitals vary by size, location, and types of communities they serve. Combined, they employ approximately 11,000 workers who likely interact with patients or visitors as part of their job. According to the policies at the study hospitals, sitters are responsible for providing a safe environment for a patient (or patients) requiring continuous observation, performing required patient care within their scope, and reporting observations to the appropriate direct patient care provider.

The policies surrounding sitter assignment, skill set, and expectations vary across the health systems, they reported. In one of the study health systems, sitters were primarily certified nurses' aides who come from the hospitals' internal float pools or external contract services. In the other health system, sitters typically do not have training as a certified nurses' aide. Rather, they attend an orientation session on patient safety maintenance. In both health systems, other staff may function as a sitter as

needed, including unit secretaries, dietary workers, housekeeping staff, or light duty staff, the authors note.

"Just as we saw in this study, we anticipate hospitals across the US will vary in their processes of sitter management and assignment, as well [the] required skill set and job expectations," Schoenfisch tells *Hospital Employee Health*. "However, concerns surrounding sitters' occupational safety and health are applicable to hospitals across the U.S., given the need for constant observation practices."

In general, an RN is responsible for assigning a sitter, establishing the responsibilities, and a lunch/restroom break schedule, they reported. Sitters are responsible for completing patient "handoff" forms as a way of communicating with the unit nursing staff various elements of their shift, including the number of times they prevented patients from pulling on tubes or falling, as well any linen change, bathing, oral care, vital signs, etc. Sitters' shifts are typically eight or 12 hours long.

The 'others'

In the aforementioned larger study,[4] researchers identified a small number identifying themselves as sitters in the "other" job description category. The researchers followed up with focus groups and interviews after 41 sitters were identified. They gathered additional data from sitters, nurses, sitter managers, and nurse managers. Although this group was small, they observed a significantly higher proportion — relative to other occupational groups — of patient-to-worker violence in the previous 12 months. Between April 2012 and December 2013, 21 focus groups and seven key informant interviews were conducted with a total of 110 participants.

Among the survey respondents who worked as a sitter (41), 24% were less than 30 years old, 88% were female, and 80% were non-white, they reported. One-fifth of sitter participants spent less than a year working in their profession. Overall, 80% of sitters said they had experienced some form of patient violence in their careers. Among the 31 sitters who experienced patient violence in the previous 12 months, the number of events by sub-type was 69 physical assaults, 77 physical threats, and 119 events of verbal abuse. These were not mutually exclusive events.

When asked to describe their most serious event in the previous 12 months, sitters indicated the perpetrator was often a patient (94%), with whom the sitter was alone in two-thirds of the incidents. Threatening patients were often disoriented (66%), had behavioral issues (45%), were sundowning (34%), or drunk and/or on drugs (31%). Nearly three-fourths of sitters' events involved an object used against the sitter, commonly a body part(s) (e.g., fist, nails) or bodily fluids.

Sitters and managers described "the need for support and respect from staff" on the patient care units, the authors note. Sitters' efforts to seek assistance from unit-level staff — for crisis situations as well as for required lunch and restroom breaks — were not always effective. "They described being left alone to deal with challenging situations, disregarded after voicing concerns — related to both personal and patient safety — and disrespected as an occupational group by patients, visitors, and hospital staff," the researchers concluded.

Yet even in this work environment, hospital sitters are an essential part of ensuring safe patient care at the bedside. "Institutionally-supported policies that focus on sitters' safety, well-being, and human rights are crucial," Schoenfisch and Pompeii argue. "Such policies will provide guidance to sitters, as well as to the managers who supervise them and managers of patient care units where sitters work."

At a minimum, they recommend, policies should do the following:

- clearly define the role of the sitter;
- recognize sitters as an integral part of a patient care unit;
- provide education to sitters on identifying, managing, and preventing events of violent behavior, as well as remaining safe during such events.

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Patient sitters' disturbing, firsthand encounters

'In a situation like that, I want to know, what do I do?'

A recently published study[1] that included numerous focus groups and interviews with healthcare "sitters" documented a number of firsthand accounts of disturbing and violent patient encounters, including the following:

• **Sitter:** "When I came in, the sitter that I was taking over for had not even left, [the male patient] touched me on my butt and was smiling. I told him, 'Don't do that.' I had to hold him to try to prevent him from falling out of bed. He tried it again, so I had to call the nurse ... I told her, 'I can't take care of this guy. They need to get a guy for him, because he is touching me inappropriately."

• **Sitter:** This [patient] hated me so much because of how I was trying to prevent him from falling ... So this guy was so mad, he smashed my food and that was about may be nine hours after I had been there. I was so tired. So he smiled and his hand is full of poop because he has been messing around with stuff and you know. Then the nurse came in and that is when they relieved me for break, after nine hours."

• **Sitter (speaking about communicating with another sitter during handoffs):** "We do our best ... besides the basics of what we need to do for the patient, the other information that's more personal ... watch out for this certain family member. There are some times when it is not communicated, and there are some situations I feel like nurses know a little bit more personally what's going on with that patient that as sitters we don't get. And we kind of face that head-on when we're sitting in that room."

• **Unit nurse:** "Sitters, um, sitters are harder. Usually we try to catch them before they go in the room so we can kind of give them a little bit of what's going on because otherwise we kind of have to stand at the doorway and talk about it, in which case we ... can't really talk as much about the social aspects."

A RECENTLY PUBLISHED STUDY THAT INCLUDED NUMEROUS FOCUS GROUPS AND INTERVIEWS WITH HEALTHCARE "SITTERS" DOCUMENTED A NUMBER OF FIRSTHAND ACCOUNTS OF DISTURBING AND VIOLENT PATIENT ENCOUNTERS.

• **Nurse manager:** "We don't give the sitters information that they need to know to sit with the patient ... The nurses don't do a good job consistently of letting the sitter know the real reason why they're there."

• **Sitter assigned to a patient at risk of falls, describing exchange with nurse:** "The nurse came and said ... 'He'll listen to you if you [verbally] redirect him.' I said, 'Well, ma'am, I just tried to re-direct him and he wouldn't listen to me.' [She said] 'Well, what are you [sitters] here for?' [I said] 'I cannot physically hold this guy down in the bed.' She said, 'Well, just let him fall then.' ... This ain't no kind of conversation to be having. We need to kind of figure out what we going to do about this situation here. [The patient] don't want me holding him down, and I don't want to get myself in no trouble. [The nurse] is not cooperating with me, so in a situation like that, I want to know, what do I do?"

• **Sitter:** "One time I told the nurse that the patient had hit me and she said, 'Well, tell me if he hits you again.' I'm like ... 'I've got glasses on here. I can't afford new glasses.'"

• **Sitter:** "I have never reported any of my events. Like one time I was bitten, but she did not break my skin. I just had little marks, so I didn't really feel the need ... Even with the guy I worked with last week ... he did not really physically touch me. Though he charged at me and people had to stop him ... there was not really anything to report."

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Report: Train sitters upon hire, and annually

Focus on spotting aggression, summon help

A report[1] by a hospital security association, citing the lack of guidelines for healthcare sitters, recommends the following:

All staff who may take the role of patient sitter must attend training upon hire and annually thereafter. The training must include identification and management of aggressive behavior using one of the nationally recognized programs such as Crisis Prevention Institute (CPI), Management of Aggressive Behavior (MOAB), and Nonviolent Crisis Intervention (NVCI).

The training must take place prior to job assignment and include role-playing and scenario based training that includes the following:

- verbal and physical signs and symptoms of agitation,
- de-escalation techniques and fall prevention strategies,
- suicide risk prevention strategies,
- the proper process for removing dangerous objects and items,
- the proper method to document monitored behavior,
- use of deployed technology,
- proper restraint techniques, and
- how to summon assistance if needed.

Other recommendations include:

- Facilities must also have clear policies and procedures for ordering, reviewing, and discontinuing the patient sitter. Facilities must define the intervals for reviewing the continuation of the patient sitter.
- Patient sitters should provide services to the same patient for their entire shift. This allows the sitter and the patient to form a relationship, minimizes the number of staff that the patient has contact with, provides for continuity of care, and makes it easier for the sitter to identify a change in behavior.
- Facilities must have clear policies and procedures on the type of activities that the sitter can do while providing the service. The use of electronic devices, reading, watching television, or any other distracting activities will divert the sitter's attention from observing the patient. If the sitter is not monitoring the patient, the risk of injury to the patient and the sitter increases.

FACILITIES MUST HAVE CLEAR POLICIES AND PROCEDURES ON THE TYPE OF ACTIVITIES THAT THE SITTER CAN DO WHILE PROVIDING THE SERVICE.

- If warranted and clinically appropriate, the patient sitter may monitor more than one patient, preferably no more than two. The patient sitter does not have to be the same sex of the patient unless there is reason to believe the presence of the same-sex sitter will be beneficial. There are many times when the same gender providing the observation may support clinical outcomes such as during bathroom usage, showering, and intimate clinical interventions. Same-sex sitters will also provide more comfort to the patient's roommate in a semi-private room.
- A patient identified as suicidal must be placed in a facility-provided gown and searched for any contraband or items that could harm the patient or others. The patient should not be allowed access to their personal clothing or belongings. These items should be secured outside of the patient room. The room should be searched and objects such as staff belongings, phone, oxygen tubing, IV poles, plastic trash bags, medical supplies, trapeze, hangers, chemical solutions, foot pumps, BP cuffs, electrical devices, and extra furniture and supplies not in use should be removed.
- Visitors must not be allowed to bring items in the patient room without prior authorization. This includes items such as food and drink, purses, bags, and clothing. To eliminate the introduction of potential weapons, the patient should not be provide with eating utensils and only allowed to eat finger food on paper products.
- The patient sitter should be required to remain inside the room with the patient and not leave the patient's side, especially when in the bathroom. Every second counts when responding to a situation that could lead to patient or staff harm or injury.

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Healthcare violence now a public health issue

Moving beyond limited occupational risk view

It's time to view violence against healthcare workers as a public health problem, not just another in a long list of occupational hazards, says the lead author of new study[1] on the issue.

"Workplace violence sometimes — at least in the research world in healthcare — gets siloed," says **Lisa A. Pompeii**, PhD, a former employee health professional who is now a professor and researcher in the school of public health at the University of Texas Health Sciences Center in Houston. "It's published in an occupational journal and seen as a workplace issue — not as a public health issue. We think of violence happening in our community as public health-type violence, but when it occurs in the workplace it seems to be hidden a little bit."

Broadening the focus would put the threat in bolder print and show that a vital part of the community is under siege.

"We need healthy healthcare workers — that's the whole point of looking at this from a public health perspective," she tells *Hospital Employee Health*. "We need these workers. They're really important to the overall health of the public and we really need to take care of them. We need to see the workplace as part of the larger public health environment."

Dangerous job

Do healthcare workers have the most dangerous job in the U.S. labor force? If not, they are on the short list.

"It's a very dangerous job because there are so many occupational hazards," Pompeii says. "They are dealing with violence, physical strain, musculoskeletal injuries, blood and body fluid exposures, respiratory hazards. It is a really demanding and a really valuable job."

It's hard to quantify and rank these myriad risks, though one could hazard a guess that physical injuries associated with unsafe handling and lifting of patients is certainly one of the leading occupational threats to heathcare workers. Another is the aforementioned violence from patients and visitors, both physical assaults and the implied threat that comes with verbal abuse. Fears raised by possible violent situations can certainly contribute to ongoing stress, job dissatisfaction, and anxiety. For example, about two-thirds of "sitters" assigned to watch over at-risk patients reported during threatening encounters they felt frightened or worried about their personal safety.[2] *(See related story, cover.)* In the broader study[1] of healthcare workers in general, 38% reported fear for their safety during threatening encounters with patients or visitors.

In this latter study, Pompeii and colleagues sought to estimate the prevalence, nature and consequences of type II violence (patient or visitor threat to healthcare workers). They solicited input directly from hospital workers whose jobs likely involved interacting with patients and/or visitors across six hospitals in two large health systems, in geographically distinct regions of the U.S. Eleven thousand workers were invited to participate in the survey and about half responded. The overall prevalence of respondents reporting at least one type II violent event in the prior 12 months was 39%.

Breaking down the 39%, Pompeii and colleagues reported that 2,098 of 5,385 workers surveyed reported 1,180 physical assaults, 2,260 physical threats, and 5,576 incidents of verbal abuse. Direct care providers were at significant risk. Participants in jobs typically involving direct patient care were more likely to indicate physical assault, including 30.5% (75/246) of the events experienced among nurses' aides; 24.5% (62/253) among physical therapists/techs; and 21.5% (229/1,093) among nurses. For comparison, OSHA reports that registered nurses have more than a threefold higher risk of violent injury resulting in days lost (14 per 10,000 nurses) than U.S. private industry as a whole, which suffers 4.2 lost-day violent injuries per 10,000 full-time employees. Workers classified as "nursing assistants" have injury levels off the charts, more than tripling the rate in RNs with 55 injuries per 10,000 full-time employees, OSHA reports.[3]

Verbal abuse

In the Pompeii study, workers in jobs that require more verbal interaction than direct care with patients and visitors were more likely to report verbal abuse. These included 61% (66/108) of events experienced by nurse managers; 78.1% (32/41) experienced by social workers/ case managers; 86.7% (13/15) by pharmacists; 80.8% (21/26) by food service workers and 80.7% (152/177) by administrative staff.

Overall, 4.6% of workers were

injured and 2% missed workdays. In a particularly concerning finding, the researchers noted that only 19% of the total events were reported into official reporting systems.

"People don't report because they fear retribution, they accept it as part of the job, they don't think management will do anything about it, or they don't think that it is severe or serious enough," Pompeii says. "What we found is it depends on how you define reporting. While 75% of respondents indicated they reported the incident — the majority of them didn't report to a formal reporting system. They reported it to their manager or a coworker, but it didn't go into formal reporting system."

As may be the case in many other hospitals, the facilities under study had no formal requirement that a manager had to then report the injury into an official surveillance system.

"Some hospitals do have that policy, and it would probably be a good policy to have nurse managers make those reports once their employees report to them and make sure these [incidents] go into the system," she says.

Perpetrator circumstances attributed to violent events included altered mental status, behavioral issues, pain/medication withdrawal, and dissatisfaction with care. Moreover, events of verbal abuse resulted in 30% of respondent victims feeling frightened for their personal safety — indicating that it should not be assumed that these events are not as serious as physical assaults or threats. Physical assaults more commonly involved a body part as a weapon followed by body fluids, while traditional weapons were used in less than 1% of events.

The perpetrator was a patient in 1,596 incidents and another 502 involved visitors, who were most often angry about some aspect of patient care. Visitors were involved in 18 physical assaults. "Visitor perpetrated events, which were mostly verbal in nature, centered largely on concern for the patient," the authors reported. "Wait times and crowded waiting rooms were not as prominent as we expected based on other reports."

What can employee health professionals do to develop a more proactive approach to the problem?

IN A PARTICULARLY CONCERNING FINDING, THE RESEARCHERS NOTED THAT ONLY 19% OF THE TOTAL EVENTS WERE REPORTED INTO OFFICIAL REPORTING SYSTEMS.

Make sure the incidents are formally reported and the workers' feel their concerns are being documented and addressed, Pompeii says.

"A lot of hospitals don't have a workplace violence prevention policy and some don't [require] reporting," she says. "Reporting should be an integral part of the policy and workers should be trained on the importance of reporting and be told what employers will do with that information and why they need it. There needs to be some process to validate the workers concerns [and acknowledge] what they reported. Then they will be more likely to report in the future, so I really think that should be anchored in policy. The policy should be real specific to what systems they should report and make it very clear."

While the threat of occupational violence could certainly undermine patient safety, the problem has not been traditionally recognized as such, but rather seen as a separate and often a lower priority issue.

"Healthcare professionals have a tendency to kind of 'own' some of this," Pompeii says. "I don't think they should be owning it, but in some of our focus groups what really came out was that the workers are conflicted. It's their job to take care of that patient, and then they turn around and report them — it's almost like tattling. There is some conflict there for the worker. There is more that could be done by hospitals to show concern, but there is lack of hardcore evidence right now of how it affects patient safety and the quality of care. There is anecdotal stuff, small bits of information, where nurses indicate that [violence] affects my ability to provide care, but there hasn't been larger study done on that. That is probably the next step."

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Bullying entrenched, but more speaking out

A conversation with national expert Renee Thompson

A healthcare nursing culture with all manner of occupational hazards has one of the toxic variety that comes in two distinct personas: the overt bully and the covert bully. Pick your poison.

As outlined by nursing leader and work culture expert, **Renee Thompson**, DNP, RN, CMSRN, CEO and president of RTConnections, LLC (www.rtconnections.com), bullying is a major reason 60% of new nurses quit their first job within six months.[1]

The overt bully commonly displays the following unsavory behavior:

- verbal criticism or name-calling;
- intimidation;
- blaming;
- ethnic jokes or slurs;
- finding fault;
- threatening;
- physical violence.

As one might expect, covert bullying is a little more insidious, as a seemingly nice and helpful worker attacks the victim through gossip and innuendo. The covert bully has their own distinct cruel practices, including the following:

- sabotage;
- withholds information;
- excludes others;
- unfair assignments;
- undermines;
- downplays accomplishments.

A frequent speaker on such workplace challenges, Thompson gave *Hospital Employee Health* some common sense advice on how to defuse these difficult situations.

HEH: Do you detect any trends — for better or worse — on this issue of nurse bullying? It's been a recurrent issue of discussion. Are there any favorable signs of healthcare settings that are successfully addressing this problem? On the other hand, healthcare is under a lot of fiscal pressure so it may be hard to break out of such a culture in a stressful environment.

Thompson: When I speak on this topic, a lot of nurses ask me if there is a higher prevalence of bullying on the East Coast, in the North, West or South, and I always say it is the same everywhere. Though there is no difference in trending from any part of the country, I do see an increase in people reaching out and asking for help in dealing with a bullying situation at work. Almost every day of my life a nurse reaches out to me for help — somebody messages me on Facebook, sends me an email, or contacts my website asking for help. I think we are seeing a trend where it is getting worse: We are seeing increased stress in the hospital setting, especially the acute care setting. They are being asked to do more and more with less and less. We work in stressful environments and the unpredictability of healthcare causes stress. As human beings, none of us are always well-behaved when we are in stressful situations; we tend to lash out at each other. But there is a difference between [bullying and] 'my patient is coding and I'm freaking out.' I may say something unprofessional, but that is different from repeated patterns of bullying behavior over time. I do think we are seeing an increased prevalence of bullying, especially in the acute care settings.

HEH: Can you elaborate a little on "naming the behavior" as a way to disempower bullying? Does openly stating what you are being subjected to change the dynamic, make it "real" and concrete?

Thompson: It makes it clear what the behavior is that might be considered destructive in terms of the [work] environment and even to the point of bullying. Here's what typically happens: I used to be a unit manager of a very large medical-surgical unit, and some of my employees would come say, 'She is bullying me or this one is a bully.' I can't help you [unless] you help me understand what this person is doing. What is the behavior that makes you think she is bullying you? So for example, naming the behavior makes it very clear. It takes all of the opinion and the emotion out of it.

Something that typically happens is, say you are a new nurse in the middle of the nurses' station working with an older experienced nurse. You say something or do something that is wrong. The older nurse might say to you in front of other people, "That's so stupid I can't believe you made that mistake." Or, "You are an idiot." That new nurse — or it can be an experienced nurse, it can be anyone — says, "You just called me an idiot in front of people. You are screaming at me in the middle of the nurses' station." It is a reflection back to that person that the behavior is inappropriate. The problem is that these types of behaviors go unchecked. People think, "Uh-oh, she is at it again," and no one says anything. When we use silence as a strategy, the behaviors escalate. The behaviors continue. Naming it is a simple way of addressing it. For example, "I just saw you role your eyes at me," or, "When I

left here last night you said everything was fine. When I came back, I found out you were talking behind my back." It's very objective. It's very clear.

HEH: Should this be done in front of witnesses or is it more effective in a one-to-one?

Thompson: It can be one to one, but even if other people are there the person can say and should say something. However, some people may not have the courarge to say something to [the bully] in front of other people. This is where the bystander effect comes into play. The best and strongest intervention is for the witness to speak out. For example, if one nurse is screaming at another nurse, whomever is witnessing this behavior should stand up and say, "Excuse me, you just called her an idiot in front of everybody and you need to stop right now." The witness speaks up. So the individual can absolutely speak up, but if they don't have the courage to do that yet, whoever else hears it has an ethical responsibility to speak up.

HEH: If a worker begins to feel their manager is bullying them, that certainly is a more difficult situation. In addition to documenting incidents you mention seeking out someone to talk to and get feedback on the issue. Would the nurse be likely to lose the battle — and possibly her job — if she reported her boss' behavior to their supervisor?

Thompson: This is a common problem. I have probably received more comments, emails, and responses from nurses related to this topic than any other related to bullying. I've had so many nurses say, "This is my situation right now." I don't really like to label people bullies because that doesn't solve the problem; we need to focus on the behavior and not labels. However, it's easier to say you are dealing with a bully, but let's just say you have identified somebody as very abrasive. These people tend to be very competent at what they do. That's a whole other conversation, but they are very competent and therefore get promoted easier than other people. Again, if those behaviors go unchecked, they now have a perceived and somewhat real power over people.

In this situation, I always recommend that nurses first observe the boss' behavior. Is she or he singling you out or does this person treat everybody the same way? Gather your facts. You say your boss never gives you the dates you want off — always changes your schedule but everybody else gets the days they want off. I don't know that I would call this bullying, but if this is the situation and you think you are being targeted, observe until you have facts and then start documenting everything. Document conversations and be extremely objective — dates, times, witnesses to what happened. Anytime you can use a verbatim comment, it makes it easier to identify a clear pattern to this type of behavior. Sometimes I recommend, depending on the situation, that you schedule a meeting with your boss. Go to your boss and say, "I'm really struggling with this. The relationship I have with you is really important to me and I want to talk about some things that I have noticed that I'm not really sure you are aware of." There are so many people who do not realize they are behaving in an abrasive and aggressive manner. This could be an opportunity to sit down and have a conversation.

HEH: While some may fortunately recognize their behavior as negative, what are some other possible reactions?

Thompson: When you actually bring up to that person the behavior you have observed, you are going to get one of three results. The first result is, "Oh my gosh, I had no idea I was coming across this way. I'm so sorry." I love that person — you can work with that person. The second response is that this person has deep-seated issues, maybe mental health issues, some things going on at home that are affecting their ability to function professionally in the work place. I'm not sure you can help this person; they may need an employee assistance program or some kind of counseling, but you can't do it by yourself.

The third category are people who are unwilling to accept any responsibility; they have no sense of self awareness. What you do with these people is you don't work with them — you fire them. They usually represent only about 3% of people in an organization, but they are toxic and are sometimes referred to as sociopaths. You cannot change their behavior. Especially in healthcare, where we are responsible for human lives, you have to fire these people — you can't work with them. [If this is your boss] you can file a complaint, you can go and meet their supervisor, but unfortunately there are situations where I just tell the nurse to leave. Seriously. If they are friends with the executive director and [top administration] the chances of you getting the behavior to change are not very good. There is nothing more important than your physical, emotional, and psychological health. I tell nurses, "You have done your due diligence, you tried to address the problem. It's not worth it. Find another place [to work]."

Editor's note: For more information on Dr. Thompson, please visit: http://nursesdonoharm.com. She recently published an ebook on bullying that is available at: http://bit.ly/21DQuF1.

REFERENCE

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Worker psych hospital death prompts action

Acute hospital psych units also at risk

A California state psychiatric hospital has improved the personal security systems for its staff members and revamped how it assesses potentially violent patients, with the changes coming five years after a technician was killed on the hospital grounds by a patient.

Napa State Hospital is a psychiatric facility managed by California's Department of State Hospitals, and the destination for many of the state's mentally ill patients referred by the criminal justice system. More than 80% of the hospital's patients were ordered to the hospital by a court after being found incompetent to stand trial or not guilty by reason of insanity. Napa State reports that its patients committed more than 1,800 physical assaults at the 1,197-bed hospital in the past year.

The hospital has had elevated security for many years, with an extensive system of locked gates and doors as well as metal detectors and personal alarm systems for the staff. But it wasn't enough on Oct. 23, 2010, when a patient dragged psychiatric technician Donna Gross to a secluded spot outside and strangled her to death. Like all staff members then, Gross had a personal alarm she could activate for help. The alarm, however, did not function fully outside the hospital building.

The employee's death was devastating to the hospital staff and prompted a thorough assessment of how security could be improved, says **Ken August**, assistant director of the Office of Communications at the Department of State Hospitals (DSH) in Sacramento. The first major improvement was to introduce a new personal alarm system with GPS capabilities that works on the entire hospital campus and can direct hospital police to the precise location of the emergency.

New staff teams also were organized to create a consistent physical presence around the grounds and at special events, August says. This move was intended to address the scenario in which Gross was killed: supervising a patient outdoors and in transition from one place to another.

Another improvement at Napa State is an increase in communications with staff regarding incidents. When staff members are off work due to injuries as a result of patient aggression, hospital-wide notification is made and posted at the two main entrances to treatment sites. This process is intended to alert staff members to the current risk level of treatment units before reporting to duty, he explains.

Physical violence is also a frequent occurrence in acute community hospital psychiatry units worldwide, researchers reported.[1] "Violent acts by patients cause many direct injuries and significantly degrade quality of care," the authors warned. "The most accurate tools for predicting near-term violence on acute units rely on current clinical features rather than demographic risk factors."

The efficacy of risk assessment strategies to lower incidence of violence on acute units is unknown, but a range of behavioral and psychopharmacologic treatments have been shown to reduce violence among psychiatric inpatients, they concluded.

REFERENCE

1. Szabo KA, White CL, Cummings SE, et al. Inpatient aggression in community hospitals. CNS Spectr 2015 20(3):223-30. ■

Help us serve you better in 2016! Take the three-question *Hospital Employee Health* Reader Survey and tell us what you like, what you don't like, what you'd like to see more of, and what's most helpful to you in *HEH*.
https://www.surveymonkey.com/r/HEHreadersurvey

COMING IN FUTURE MONTHS

- There ought to be a law – on safe patient lifting equipment
- CAL-OSHA may set the standard on preventing violence in healthcare
- Zika and the pregnant healthcare worker
- Regulators: What are CMS, OSHA and TJC looking for in employee health?

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CE QUESTIONS

1. What percentage of patient "sitters" experienced at least one event of patient threats and violence in the prior year?

A. 23%
B. 29%
C. 57%
D. 76%

2. A hospital security report recommended that sitters be trained in violence prevention and de-escalation techniques, and agreed with the current general approach of:

A. using RNs only.
B. not using security guards.
C. reimbursing a family member for sitting.
D. using two sitters alternating every four hours.

3. Which of the following was recommended by the authors of a patient sitter study?

A. Clearly define the role of the sitter.
B. Recognize sitters as an integral part of a patient care unit.
C. Provide education to sitters on identifying, managing, and preventing events of violent behavior.
D. All of the above.

4. According to Renee Thompson, DNP, RN, if a healthcare worker observes a coworker being bullied, they should do which of the following?

A. Speak up and name the behavior to the bully.
B. Remain silent but report the incident to a supervisor.
C. Walk away with obvious disgust.
D. Try to change the topic of conversation to something more positive.

CE OBJECTIVES

After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. Describe how the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the healthcare industry at large;
3. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.