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THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

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INSIDE

Boston Strong: Raising a Voice Against Hospital Violence

Leaders emerge in wake of surgeon shooting, marathon bombing

By Gary Evans, Medical Writer

In the conclusion of our report on healthcare violence from the December 2016 issue of Hospital Employee Health, *we look at some underlying causes and much-needed solutions in a conversation with officials in Boston, which has suffered healthcare violence and a terrorist attack in recent years.*

An incident that shook the Boston medical community occurred in January 2015, when a surgeon at Brigham and Women's Hospital was shot and killed at work by a relative of a deceased patient. That shocking event, on the heels of the 2013 Boston Marathon bombing, has certainly instilled a sense of readiness and vigilance in the city's healthcare facilities.

That said, the open campus of a medical facility cannot be locked down like airport security, so officials strive for a balance between delivering care and protecting patients and healthcare workers.

> "THE QUESTION ALWAYS COMES UP: DO YOU HAVE METAL DETECTORS? DO YOU ARM YOUR STAFF? YOU HAVE TO WEIGH WHAT IS MOST APPROPRIATE FOR PATIENT CARE AND KEEPING EMPLOYEES SAFE."

"The question always comes up: Do you have metal detectors? Do you arm your staff?" says **Constance L. Packard**, CHPA, executive director of support services at Boston University Medical Center. She answers "no" to both questions, though her team

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has handheld wands for weapon detection if needed.

"You have to weigh what is most appropriate for patient care and keeping employees safe," Packard says. "I learned a lot from my colleagues in the Boston Marathon bombing — have those tools and be able to put them in place when you need to use them. That's versus having, for example, a stand-alone metal detector. We see 12,000 to 15,000 people here a day. It's a very busy place with 42 buildings and hundreds of entrances. It's just impossible to do that and do it well."

Having developed active shooter training videos and scenarios, Packard praised The Joint Commission's recent development of a violence prevention resources portal for healthcare. *(To see the portal, visit: http://bit.ly/2d8U2IW.)*

"I know from going through Joint Commission accreditation for numerous years that emergency management and workplace violence are probably two areas that they do focus on when they look at environment of care standards," she says. "They are interested in how you are doing your program, and more importantly, how you are educating your staff should an event occur."

At Boston Medical, that education includes an ongoing reminder to staff that no incident is "too little" to report.

"We want them to give us a heads-up that [for example, a patient] has an outburst," Packard says. "It gives us, from a public health perspective, the ability to look at risk. As police officers, it gives us the opportunity to reduce vulnerabilities. In the last year, we have worked with our IT department to put something in the [patient] chart called administrative precautions — an FYI or flag when we have a problem patient or a problem family member."

The staff are supportive of having that information in the patient chart, which may encourage reporting of incidents that may otherwise go untracked.

"I can tell you the staff has been very vocal about how important it is to see that information," Packard says. "They have to call us and tell us about the event, whether it was the patient or the patient's family, and then we will determine if it is at the level that needs to be [recorded in the medical record]. It may just generate a public safety report or it may develop what we call a comprehensive care plan, but we have nothing to lose by sharing the information."

While such policies may encourage more reporting of violent or threatening incidents, many healthcare workers are reluctant to take it a step further and formally press charges against patients they may regard as suffering from drug-related behavior or mental health problems.

"Others, depending on the injuries, say, 'Yes, I want to go forward,' and we work with them and pursue prosecution in the courts," Packard says.

Though some violent incidents are completely unpredictable, the training advised by Packard and others can still mitigate a situation and save additional injuries or loss of life. In July 2016, a man entered Parrish Medical Center in Titusville, FL, and fatally shot a patient and caregiver for no apparent reason. Security guards managed to disarm the man and hold him for law enforcement, prompting this comment from Titusville Police Chief **John Lau**: "I cannot stress enough [that] the response of the

Parrish Medical Center staff, without a doubt, saved more lives."[1]

The Broken Window

The failure to report and act when an incident may be verbal or seem minor can contribute to the "broken window" effect, which essentially suggests that an ongoing tolerance for a low level of crime may contribute to its subsequent escalation, says **James P. Phillips**, MD, of the Department of Emergency Medicine at Beth Israel Deaconess Medical Center in Boston.

"Both verbal and nonverbal violence from patients against providers are classified as 'Type II' workplace violence," Phillips explains to *Hospital Employee Health*. "The broken windows theory is adapted from street crime, and [suggests] that intolerance of low-level crimes such as broken windows — or in the case of workplace violence, verbal escalation and disrespect — helps to prevent higher-level crimes such as physical battery in the workplace."

Phillips wrote a definitive review article[2] on the problem of violence in healthcare last year in the *New England Journal of Medicine*, noting that while the murder of a healthcare worker certainly draws national attention, there is still an underappreciation of the scale of the daily problem.

"[E]pisodes of workplace violence against medical providers happen daily across the country," Phillips wrote in the review article. "Although the majority of these incidents of workplace violence are verbal, many others constitute assault, battery, domestic violence, stalking, or sexual harassment."

In the paper, Phillips places violence into four categories, including the aforementioned Type II. Each of the categories reflect the relationship of the perpetrator to the workplace or employees:

- **Type I:** No association (e.g., person with criminal intent commits armed robbery).
- **Type II:** Perpetrator is a patient or customer of the workplace or employees (e.g., intoxicated patient punches nurse's aide).
- **Type III:** A current or former employee of the workplace (e.g. recently fired employee assaults former supervisor).

> "BOTH VERBAL AND NONVERBAL VIOLENCE FROM PATIENTS AGAINST PROVIDERS ARE CLASSIFIED AS 'TYPE II' WORKPLACE VIOLENCE."

- **Type IV:** Perpetrator has a personal relationship with employees, none with the workplace (Ex-husband assaults ex-wife at her place of work).

As Phillips emphasizes, Type II violence — which can be physical or verbal assaults — is the most common form faced by healthcare workers. Indeed, a 2014 study[3] found that healthcare workers had the highest number of Type II incidents in U.S. workplaces. Type II workplace violence accounted for 75% of aggravated assaults and 93% of all assaults against employees, Phillips reports.

In addition, there appears to be a direct relationship between patient contact time and possible violence, placing nursing aides and nurses at the greatest risk. Not surprisingly, ED nurses report high rates of violent incidents, and in one study[4] approximately 25% of emergency medicine physicians reported being targets of physical assault in the previous year.

Given the level of violence against healthcare workers documented, it is disconcerting to consider Phillips' conclusion that episodes of workplace violence of all categories are "grossly underreported." In particular, he notes that nurses have cited fear of retribution from supervisors and disapproval of administrators as barriers to reporting, possibly in part due to the prevailing "the customer is always right" mentality. This raises the disturbing connotation that somehow a level of violence is ingrained in the healthcare work culture.

"The recent trend over the last two decades toward viewing a patient as a customer has had deleterious effects on the patient-physician and patient-nurse relationships in many ways, in my opinion," Phillips says. "There has been a depersonalization, and a subsequent decrease in respect between patients and physicians in both directions. This obviously is not the case in every field or every situation, but I think most physicians and nurses would agree with my opinion in general. That decrease in respect for the provider has certainly contributed to increased verbal disrespect and probably violence."

By the same token, the patient as a customer expecting quality service may be less tolerable to long waits in the ED, beds temporarily placed in hallways, or lack of nursing and physician attention due to census overload.

"Patients who do not feel they are getting their 'money's worth'

are much more likely to act out, in my opinion," Phillips says. "In regards to underreporting, there are many barriers that prevent victims from documenting and reporting such incidents. There is a general feeling that there is no worthwhile consequence or punishment for the offender that is worth the time and energy of the provider-victim to pause their work, fill out a form, make a phone call, or file a police report."

Healthcare administration must address this problem, encouraging reporting and taking action to overcome this depressing status quo.

"Providers have not been made to feel that violence prevention and redress is a priority in their workplace despite the statistically proven risk in healthcare, and without that, I do not think we will see much increase in reporting." Phillips says. "It is an administrative responsibility to acknowledge that this violence exists in every healthcare setting, and that if individual institutions do not start making real improvements, the government and accrediting bodies will eventually regulate them into doing so."

Budgeting for Violence Prevention?

Phillips and colleagues are undertaking a multiple hospital study to look at whether facilities have sufficiently dedicated budgets and policies to protect healthcare workers from violence.

"Preventing workplace violence is not free — it may not be cheap," he says. "It certainly requires a budget, and employees who are working in the field should not be expected to volunteer their time to fix this problem. I would bet that the large-scale hospital study we are beginning now will demonstrate that most do not have a dedicated budget for prevention of patient-to-provider violence, and I hypothesize that many probably do not have any hospital policy on the subject, either. Equipment and personnel are expenses, and for administrators who are responsible for keeping the lights on — and for some, generating profits — I do not think we will see widespread change until OSHA, The Joint Commission, or government regulations mandate it."

> "EACH HOSPITAL MUST FIRST ADMIT THAT THEY ARE NOT SPECIAL, AND THAT SUCH VIOLENCE OCCURS IN EVERY FACILITY."

In the interim, employee health professionals and their healthcare colleagues can take the first step by acknowledging the problem and raising awareness.

"Each hospital must first admit that they are not special, and that such violence occurs in every facility," Phillips says. "I understand the apprehension that hospitals may have toward publicly acknowledging that there is violence in their facility. Even more so, it will take a brave, dedicated administration to be willing to allow research and release of violence statistics in their hospital because of the perceived risk that such public admission will be deleterious to patient and employee recruitment. I ask for such courage from hospital administrations."

Phillips suggests establishing a multidisciplinary workplace violence committee that includes administrators, supervisors, technicians, nurses, and physicians and other employees. With the input of clinicians and providers, develop a basic reporting system that includes — as cited by Packard — a "red flag" warning to future providers of a patient or family member with a history of violence.

"Most importantly, frontline providers must be made certain that their administrators and supervisors will support them fully and will 'have their backs' in such cases," Phillips says. "This requires real communication and acknowledgment of the issue. Hospitals should eliminate customer service measurements like the Press Ganey scale, which are often tied to physician payment. [These scales hinder] the provider setting limits with patients when disagreements and conflict arise, which ultimately contributes to the continued decline in the quality of the patient-physician relationship." ■

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The Death of a Surgeon

The late **Michael J. Davidson**, MD, a brilliant and popular surgeon at Brigham and Women's Hospital (BWH) in Boston, was gunned down by an obsessed family member of a deceased cardiac patient on Jan. 20, 2015.[1]

A father of three with a fourth child on the way, Davidson's last act was running out of the exam room to warn others of a shooter in the hospital. The gunman then took his own life.

"Dr. Davidson was part of the remarkable team that performed the hospital's first tricuspid 'valve-in-valve' procedure and was involved in establishing BWH's Cardiac Hybrid OR, one of the most advanced operating rooms in the country," the hospital said in a statement.[1] "The loss of this visionary, talented, and caring physician is felt deeply in Cardiac Surgery and Cardiology, throughout the entire Brigham community and broader healthcare community, and by countless patients and families who received remarkable care and experienced his unwavering compassion."

That OR is now named in honor of the surgeon, whom a colleague recalled never left his patients with "a perfunctory visit. He didn't leave the room until he was satisfied that the patient was well-served."

Such was the case on the day of the shooting, as Davidson took a prolonged period of time trying to explain that he did everything he could to save a man's 78-year-old severely ill mother from dying of heart failure.

According to an investigative report[2] by the Boston Globe, here are some key facts in the tragic incident:

• While the patient's death certificate lists "cardiovascular collapse" caused by her preexisting illnesses, her 55-year-old son blamed her death on a postoperative drug Davidson had prescribed.

• Court records and interviews with the shooter's family members reveal he had been troubled for decades and embroiled in family disputes with a deep belief in his own "righteousness."

• Security cameras showed the man entering the hospital at 8:48 a.m. It was later determined he had a holstered gun hidden beneath his sweater. At 9:24 a.m., he began asking to see Dr. Davidson, declining to schedule an appointment for a later time.

• Davidson met the man in an exam room with a physician assistant at 10:25 a.m. The assistant remembered the man as angry, but not raising his voice as he began questioning the surgeon about a "toxic" drug used to regulate heartbeat.

• Davidson explained he was aware of the possible side effects but said the man's mother did not have a reaction to the drug and was being monitored. He explained that many drugs have potentially dangerous side effects that must always be factored into the patient care equation. However, the man kept repeating his mother died because of the drug and did not seem to be listening to the surgeon's explanations.

• After about 10 or 15 minutes Davidson told the assistant to go ahead and assist the next patient while he continued talking to the man. The conversation continued for some 25 minutes, but nobody recalls hearing raised voices. At 11:03 a.m. there was the sound of two gunshots, mortally wounding the surgeon, then a third when the shooter took his own life. ■

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Positive Vibe: Nursing Through a Different Lens

We often dwell on the negative aspects of nursing, trying to raise awareness and create positive change. In doing so, however, we create a blind spot. What about all the abiding positive aspects of nursing that contribute to high retention of this indispensable work force?

"I think that in nursing research, as in many other applied science disciplines, there is a natural tendency to focus on addressing problems," says **Robert Sinclair**, PhD, a professor of industrial-organizational psychology at Clemson (SC) University. "[That] leads to a focus on reducing negative and stressful aspects of work, rather than recognizing and increasing positive aspects."

Though noting that nursing research should certainly address such negative factors and attempt to improve them, Sinclair became intrigued with the idea of the other

side of the coin. What positive aspects of nursing could be identified and leveraged to keep the field viable in the face of shifting demographics? The result was an ongoing research collaboration called the Oregon Nurse Retention Project (ONRP), which was founded in 2007 to look at the critical stressors and positive work experiences that influence nurses' retention. We reached out to Sinclair via email and he provided the following responses to *Hospital Employee Health*.

HEH: Despite the well-documented challenges and stress, you note that surprisingly little research has been done on the positive work experiences of nursing. This side of the story seems more important than ever with the shifting demographics of nursing and the need to retain and recruit nurses. Can you speak a little to why you think this positive aspect has not been more emphasized and why you decided to document this aspect in your work?

Sinclair: This tendency is certainly not bad, as applied research should focus significant effort on addressing important problems at work. My research really just explores the added value of focusing on positive events at work. [My colleagues and I] at the ONRP read the literature at the time and realized that research was mostly focused on why nurses leave their jobs and there was comparatively less research focused on why nurses stay. We were also in close discussion with the Oregon Nurses Association at the time; they expressed a similar strong interest in better understanding nurse retention and helped us realize the need to focus on the positive aspects of nursing, not just the negative. For example, they pointed out that some events we might have thought of as negative were often described by nurses as positive, one example being a nurse who helped a patient die with dignity. We thought that looking at nurses' daily work lives in terms of the specific positive experiences they have at work might help us understand why nurses stay on the job, despite having many highly demanding experiences and difficult interactions with patients and coworkers.

HEH: You mention there may be an evolutionary aspect to the tendency to focus on negative experiences.

Sinclair: At a deeper level, interest in negative events is probably a function of human nature. A research review[1] showed that negative experiences are thought to be more influential on peoples' perceptions of other people, of situations, etc. And some research suggests that it takes several positive experiences to overcome one negative experience in a particular situation.

Some psychologists propose that this is grounded in evolutionary principles — that it is more important to focus on negative stimuli because they contain more "survival value" than positive stimuli. Simply put, attending to threats, demands, etc., helps us survive. I think this natural interest in identifying and solving problems probably has played a role in researchers' and managers' interest in addressing negative concerns.

HEH: Can you provide a few examples of positive work experiences based on the scientific literature as well as your own experiences and research?

Sinclair: The ONRP research team conducted both qualitative and quantitative research on this topic. In the qualitative research, we identified these six broad categories of positive events based on nurses' descriptions of the best event that happened to them at work each week over a series of 12 weeks:

- **Making a difference:** Instances where nurses had a positive effect on patient outcomes.
- **Programs and processes:** Essentially, hospital systems working well.
- **Professional development:** Learning new skills or increasing knowledge.
- **Coworker support:** Receiving needed help from others.
- **Helping others:** Being able to support coworkers with their problems.
- **Feeling appreciated:** Being thanked and recognized by others for their work.

Some examples of nurses' descriptions of specific events include:

- "A complicated discharge went very smoothly. All care needs and equipment needs were in place at the time of discharge and all questions were answered to family's satisfaction."
- "I helped a new nurse whom I have been orienting to the floor successfully start a difficult IV on an elderly male patient. Due to my coaching — but not touching anything — she got it on the first try. The best part of it is the confidence she has built."
- "A trauma patient I had taken care of the previous week came back to our unit with a thank-you card and chocolates, and thanked each one of us personally for the care she had received at our hospital."

HEH: Can positive work experiences be used to offset the negative effects of nursing (stress, etc.) in some kind of systematic way?

Sinclair: Yes. There are a few ways a positive event might offset some of the negative effects of nursing. First, our research shows that positive work experiences contribute directly to various positive outcomes that

might be weakened by negative experiences. So far, we have found that experiencing more positive events lead to higher levels of work engagement, occupational, and organizational commitment, as well as lower turnover intentions.[2,3]

Second, experiencing positive events may protect people from experiencing the harmful consequences of negative events. Although we have not focused as much on this question, our initial evidence shows that experiencing more events in which one receives support from coworkers helps protect workers from the negative effects of workplace stressors. This finding is consistent with a very large literature on the health benefits of social support. Third, positive events could reduce the chances that nurses experience negative health outcomes such as burnout and depression.

However, we also have found that negative events (i.e., stressors) tend to have a much stronger influence on the negative outcomes. So, experiencing positive events may be important for enhancing nurses' engagement and commitment, but to avoid negative health outcomes it is also critically important to reduce stressors.

HEH: Is this something that could be directly incorporated into an employee wellness program?

Sinclair: I have had various conversations about these findings with nurses over the years who have talked about the need for programs and processes that encourage nurses to see the positive sides of their jobs and some hospitals are engaged in efforts to do just that, such as through asking nurses to write about and publicly share their positive experiences. Our findings indirectly show that encouraging nurses to write about their experiences can have work-related mental health benefits, and some participants even thanked us for the opportunity to write about their experiences.

Some hospitals are experimenting with other ways to publicly share positive events at work. There are challenges in these efforts, such as protecting patient confidentiality and ensuring that nurses trust management enough to share their experiences without concerns about possible repercussions. I do not think the organizational science is definitive on what works just yet, but I expect we will continue to see more research documenting effective policies and practices in the near future. ■

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For Addicted Nurses, a Way Back to the Bedside

Washington state allows return to work with oversight, conditions

Healthcare workers who divert drugs are understandably reviled for potentially harming patients by depriving them of pain relief and putting them at risk of infections from tampered medications. But somewhere beneath the distortions of addiction and denial, shame and stigma, is a person who once sought to care for others.

People like **John Furman**, PhD, MSN, CIC, COHN-S, director of Washington Health Professional Services (WHPS) in Olympia, are now trying to care for them, and if possible, restore them as healthcare workers empowered again to help others.

"I don't want to make a direct analogy, but it can be said that to some degree, Washington state looks at substance abuse disorder as chronic relapsing disorder much the same as asthma and diabetes," Furman says. "Now, it's not exactly the same — I'm not trying to pull the wool over anybody's eyes — but the point is that all healthcare professionals should have the right to have their legitimate medical condition [treated]. And if it can be managed successfully, they should have the right to re-enter the workforce and continue their profession just as anyone else would."

That said, there are public safety issues to be strongly considered, and if a nurse referred to the WHPS cannot make the necessary changes, or further acts to endanger patients, the state nursing commission may revoke his or her license.

"In many cases they can return to practice, that can be accomplished, but in some cases it can't and they do end up losing their license," Furman says.

WHPS is the state alternative to a discipline substance abuse monitoring program for nurses with substance use disorders, again seen as medical conditions driven by biological traits that can change over time. Though opioids may certainly be the drug abused, the situation with nurses is not simply an extension of the national opioid epidemic that has become a public health crisis. Despite the recent focus on the opioid epidemic, the number of substance-abusing healthcare workers remains in the same general range as it has for years.

"I don't see a big difference with regard to the numbers and rates of HCWs with substance use disorders or the circumstances surrounding their initiation and continued use all the way up to diversion," says Furman, a 35-year veteran in the field. "I think the numbers and research has stayed fairly steady over the years. Depending on the research you look at, about 10% to 15% of the general population with some level of substance abuse disorder and that's mirrored in the healthcare profession — with healthcare workers having a higher rate of prescription drug abuse than the general population. With the opioid epidemic, that gap may be narrowing a little bit."

Chronic Pain

As employee health professionals are well aware, nurses can suffer injuries from moving patients and endure chronic pain thereafter.

"We have many nurses in our program, and it is my experience with other states' programs that are fairly similar, with chronic pain issues that have a great deal to do with their substance use disorders," he says. "[These include] nurses who have hurt themselves on the job and have been mismanaged by their healthcare provider with regard to their pain issues, or possibly by their employer with regard to bringing them back on duty prematurely and not providing appropriate oversight and support. That really contributes to their [drug] behavior if a nurse who doesn't have sufficient leave time because of that comes back prematurely from an injury."

> "WE HAVE MANY NURSES IN OUR PROGRAM, AND IT IS MY EXPERIENCE WITH OTHER STATES' PROGRAMS THAT ARE FAIRLY SIMILAR, WITH CHRONIC PAIN ISSUES THAT HAVE A GREAT DEAL TO DO WITH THEIR SUBSTANCE USE DISORDERS."

Thus, the occupational hazards of healthcare work can lead to substance use for pain, which may cross over into abuse if addiction sets in through a process called neuroplasticity.

"The brain is malleable and changes in response to different stimuli, whether they are internal or external," he says. "It is also important to realize that at one point medical science thought our brain was set in concrete by late adolescence or early adulthood. Now we know that our brain changes all the time throughout our lifespan. When an individual is exposed to something — drugs, alcohol, opioids, — the brain changes in response to that exposure and becomes an addicted or chemically dependent brain. By removing that exposure and also having psychotherapy as part of treatment, then the brain is able to change and reset back to its original state."

Common drugs used or diverted by healthcare workers include hydrocodone, morphine, oxycodone, fentanyl, Ambien, Xanax, Valium, and Ritalin, Furman says. Common diversion methods include medication substitution, removal of medication without orders, frequent medication overrides, giving less than high-end ordered and diverting the waste, signature/order falsification, and salvaging from waste, he notes.

"In Washington state right now, the average age of nurses is about 48 years," he says. "So they are getting older and they are more prone to musculoskeletal injuries and other injuries that may result in chronic pain issues. It is a significant issue."

The majority of nurses come into the WHPS program after a complaint has been filed against their license for substance misuse. It may be personal misuse or it may involve drug diversion at their workplace, but the vast majority are referred by the state nurse commission, he says.

"However, we do have an alternative discipline track that most nurses take to enroll in the program," Furman says. "So even though a

complaint's been filed — and the rule of thumb is that no patient harm has occurred as a result of the behavior — they are allowed the option to come into the program in lieu of discipline. That means there is no formal action taken against their license and the fact that they are in the program is non-public in nature. This is never reflected as part of a public document."

In Washington and many other states, you can look up a nurse's name and see if he or she has had any discipline taken against his or her license. If so, it will be noted in the public record and include some details of the incident. The alternative track at WHPS can spare a nurse this public disclosure and the attendant stigma.

"Our mandate from the legislature is twofold. One, they have directed the state Department of Health, which licenses healthcare providers, to provide an alternative to the traditional disciplinary process for health professionals with substance abuse disorders. The second part of that mandate is that we are to make every effort to safely allow nurses to continue or return to practice. The legislature looks at healthcare workers in total as a state resource. If there is something that can be done to retain that resource — something that can be reasonably and safely done — they want that to be explored."

Conditions vary from state to state, and in some cases relapse means automatic license revocation. In the WHPS program, nurses who do overcome their addictions and return to the workforce are subject to random drug tests, ordered to attend counseling or a support group, and have a series of work conditions that can include the following:

- worksite restrictions, e.g., no home health work,
- will not have multiple employers,
- limits on overtime and shift rotation,
- will not float from unit to unit, and
- no access to controlled substances for at least 12 months.

"In Washington, our graduation rate — the number of nurses who graduate from our program — is about 65% to 70%," he says. "We feel pretty good about that, and also the nurses are in the program for a minimum of five years. The standard throughout the nation is at least three to five years."

Nurses in the program must call in or check in via computer every work day.

"If they are selected to take a drug test that day, they must submit a sample that calendar day," Furman says. "Test results may result in sanctions on their license."

Though admitting it sounds counterintuitive given medicine is their profession, Furman says the lack of education about drugs and addiction is still a major contributor to the problem.

"There is very little direct education in nursing schools with regard to substance abuse, especially addressing the risk to health professionals," he says. "Some states have enacted legislation that requires a certain number of hours, or at least to some degree [education], as part of the nursing curriculum. But that is in very few states and it needs to be much broader. Then in the healthcare facility itself, they should have clear policies and procedures on substance abuse. Those should not sit on a shelf. They need to be part of new orientation and revisited as part of mandatory ongoing training on a routine scheduled basis." ■

Worried About Staff Burnout? Here are Prevention Strategies

Cross-training, holistic nursing, and getting off the clock

Most healthcare organizations have to deal with staff burnout and stress, but there are healthy strategies and policies that can help staff deal with these common workplace woes.

For instance, it's important to cross-train staff and vary schedules with both full-time and part-time nurses, says **Kristine Kilgore**, RN, BSN, administrative director at Surgical Care Center of Michigan, an ophthalmology center in Grand Rapids. Kilgore recently spoke about staff burnout at the Becker's ASC 23rd annual meeting, held Oct. 27-29, in Chicago.

"I have a good mix of full-time and part-time," Kilgore says. "On lighter days, I say to the full-time staff, 'Would you like to go home early today?'"

Part-time nurses are very happy because they won't lose hours, and the full-time nurses often are thrilled to be able to leave early, she says. "One person told me, 'You wouldn't believe

what I got done — I got the house cleaned and I made a full dinner for the family.'"

Kilgore doesn't worry about whether the full-time employees' hours dip below full-time hours, and she doesn't make them use vacation time. Instead, she sees this as a positive for her, as well as for them.

"I look at it that they are helping me out by going home early," she explains.

Another strategy is to focus on wellness and holistic solutions to stress, notes **Adrienne Schultz**, RN, HN-BC, assistant vice president of patient care services at Cancer Treatment Centers of America in Zion, IL. The organization, which sees 5,000 patients annually, has a 73-bed inpatient facility as well as outpatient services, ambulatory surgery and clinics. Schultz also spoke about stress at the Becker's ASC 23rd annual meeting.

"One of the most exciting things we've done is an initiative to support holistic nursing," Schultz says. "I'm a board certified holistic nurse, so we've sponsored cohorts of nurses — about 20 at a time — to undergo training in holistic nursing."

The benefits of this additional training are huge, she says. "It benefits both patients and stakeholders."

The Cancer Treatment Centers of America will have four cohorts of nurses going through holistic nursing training by the end of this month. The organization has dedicated resources to the training because it fits in well with its vision. Holistic nursing can benefit both the nurses, who learn more about self-care, and patients, Schultz says.

Physician burnout also can be an issue for ambulatory surgery centers, although not every site has this worry, Kilgore notes.

"For our organization, physician burnout is not as much of an issue because the physicians are owners of the company," she explains. "So they set the agenda and the pace. They determine how many cases they can do in a half-day."

Kilgore is more concerned about the staff: "Last week we had a physician in the morning do 16 cases, and then a physician came in the afternoon to do 22 cases. They might think 22 cases is not that big of a deal, but for the staff it's 16 plus 22."

Bright Ideas to Beat Burnout

Full schedules and a fast pace can contribute to stress and burnout, but there are ways to buffer staff from the effects. Kilgore and Schultz offer the following ideas for reducing staff stress:

• Make sure new employees can handle the workload. Everyone hired at the Surgical Care Center of Michigan is trained based on what they need, given their own experience and education, Kilgore says.

"I tailor it to what the person needs," she says. "I start with pre-op because it's the most consistent, depending on the doctor, and the last part is circulating because it's the hardest thing to learn and you need to learn each doctor's preferences."

One critical step in hiring new staff is to have them spend a day job-shadowing, Kilgore says.

"This is to make sure they're even interested in the work," she explains. "They come in for a half-day and shadow a nurse to see pre-op, circulating, and recovery."

The goal is to make sure the job is a right fit for that particular nurse. "This is a fast-paced environment, and it's not for everyone."

• Offer access to wellness activities. Larger organizations can provide employee assistance programs, along with wellness activities, including gym membership discounts and staff exercise sessions, Schultz says.

"We have exercise sessions that people can sign up for and that are available at all different times to accommodate all of our stakeholders," Schultz says. "We also have an onsite yoga room that people can go to during their lunch time, and there are open, instructor-led sessions."

• Cross-train nurses. Registered nurses at the Surgical Care Center of Michigan are trained to work in each area of the surgery center.

"They can work in the pre-op area, take care of patients to get them ready, and they also can circulate and recover patients," Kilgore says. "I make sure they go to each area throughout the month."

A nurse might work in the pre-op area for one week and then work in the recovery area.

"They are learning ophthalmology, one specialty," Kilgore notes. "They are not having to learn 20 different specialties."

• Stagger shifts and include nurses for the breaks. "The pre-op nurses are staggered, starting at 6:30 a.m., 6:45, 7, 7:15 — every 15 minutes, depending on how many nurses I need," she says. "It's usually three to five people."

At 7, the circulators start to arrive and the nurses in recovery arrive at 8 or 8:30 a.m. The surgeons start at 8 a.m., except on the busiest of mornings when they'll begin at 7 or 7:30, Kilgore says.

"The surgeons have a four-hour block and go until noon, and the afternoon surgeon starts at 12:30 p.m.," she says. "Then I bring in a nurse that does all the breaks for the nursing staff, and I have an extra

scrub tech to turn rooms over."

The biggest challenge is finding a good scrub tech, Kilgore says. "It takes a long time to train a good scrub tech."

The last staff will arrive at 8:30 or 9 a.m. and be one of the recovery people, relieving the last late person and following up on the last patients, she adds.

• **Attend to employees' emotional health.** At the Cancer Treatment Centers of America, employees can attend a panel session to discuss an issue that concerns them, Schultz says.

"About once a month, our folks come to speak on a panel about a particular instance or issue they need to share with others," she explains. "This is multidisciplinary with nurses, physicians, pharmacists, and others who want to debrief or talk about something very personal for them or to share how they handled it."

For instance, one session involved a long-term patient who died. Some employees were very close to the patient and wanted to share their feelings about the loss, Schultz says.

"We have one topic per event, and usually different people can share at the event," she adds.

The sessions are held in a large meeting room, which sometimes has standing room only. Attendees can bring their lunch with them, as the meeting takes place at lunch time.

"People want to share," Schultz says. "They want that ability to garner input and support from their co-workers."

• **Create nice surprises.** "The day the physician had 22 patients, starting at 12:30, he said, 'I'd like to get a treat for the nurses in the afternoon — I know it's going to be a long day,'" Kilgore says. "Those little things are huge, and it comes from me or the surgeons."

Other nice surprises will be a catered lunch for staff after a particularly busy week or month, she says.

"I try to acknowledge everyone," she says. "I'll do a nurses' week and bring in lunch or breakfast."

• **Recognize employees.** "Our company does an employee recognition day, usually on a Friday in June," Kilgore says. "We feel it's important to recognize every employee, so we close the surgery center early."

After closing at noon on a Friday, all surgery center employees head across the street to a botanical garden called the Frederik Meijer Gardens for a holiday luncheon. Employees from the surgery center are joined by staff from the company's various clinics, as well.

"We have over 300 employees, and it's fun because everyone gets to see everyone," Kilgore says. "Also, we have fun activities planned that change each year."

For example, one activity was a game show led by the management team.

• **Keep staff aware of how they're doing.** Merit reviews typically occur at the end of the year, but these reviews should not have any surprises for employees, Kilgore says.

"Hopefully, if there are issues, you are not waiting until the year end to go over them," she explains. "If something is identified by a staff member or an anesthesia provider or a physician, I try to raise it when it occurs so at the review time it's not a surprise."

Giving employees real-time assessment makes it easier to discuss issues with them at the annual review. "You know their strengths and weaknesses," Kilgore says.

"I always ask employees what their goals are for the next year," she adds. "I ask, 'What do you want to accomplish in a year?' and sometimes you find out interesting things from them.'"

• **Take employees' suggestions seriously.** Kilgore learned when talking with nurses during one evaluation that they wanted to be trained to use one new surgical device: a laser that required a certified trainer to come in and show staff how to use it. A couple of nurses said that next time there was a class, they'd like to have the trainer train four nurses at a time, she recalls.

"I had no idea they were even interested," she says. "What I've learned over time is to listen to my staff. People might think they're just complaining, and there is some complaining, but sometimes you pick up little pearls that could work."

Listening to staff also can prevent misunderstandings. For example, Kilgore brought in an ancillary employee to help the RNs. The idea was to ease some of their burden, but some nurses were worried they were going to be replaced by LPNs.

"I said, 'No, I've listened to what you say and you need help, so I'm bringing in someone to help you,'" she says. "It's a balancing act." ■

COMING IN FUTURE MONTHS

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- Proven training techniques for proper respirator use
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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. In terms of violence prevention, the "broken window effect" refers to:

A. lack of building infrastructure staff.
B. failure to report minor incidents.
C. metal detectors for only main entrances.
D. prohibiting armed staff.

2. According to James P. Phillips, MD, the "Type II" violence most often faced by healthcare workers means the perpetrator:

A. has no association with the victim.
B. is a current or former employee of the workplace.
C. is a patient or customer of the workplace.
D. has a record of violent behavior.

3. According to Robert Sinclair, PhD, which of the following themes emerged in research as having a positive effect on nurses?

A. Professional development
B. Co-worker support
C. Feeling appreciated
D. All of the above

4. The alternative discipline track that many nurses take to enroll in the Washington state substance abuse program means no formal action is taken against their licenses, but treatment will become public record.

A. True
B. False

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.