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INSIDE

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Work Culture: Breaking Down Silos, Ending the Silence

A healthy culture protects patients, healthcare workers

By Gary Evans, Medical Writer

Experts say workplace culture change — a critical issue in an era of pervasive burnout — must include leadership, but it often begins at the grassroots level with some simple but aggravating problem.

For example, a persistent computer glitch — frequent auto logout requiring password re-entry — finally culminated in a "rage ticket" send to IT by a normally calm and collected clinician.

"One day it happened, and it was just too much for me," said **Lakshmana Swamy**, MD, MPH, a critical care clinician at Boston Medical Center. "I was screaming into the void: 'Why is this interfering with my patient care?'"

> "ONE DAY IT HAPPENED, AND IT WAS JUST TOO MUCH FOR ME. I WAS SCREAMING INTO THE VOID: 'WHY IS THIS INTERFERING WITH MY PATIENT CARE?'"

Swamy described the situation, and the far-reaching changes it led to, in Orlando at the Institute for Healthcare Improvement's 2019 National Forum on Quality Improvement in Health Care. The overall theme of the session was that healthcare workers too often are in their own silos, playing the "strong silent type," showing little emotion and communicating at a minimum. The result can be a culture of distrust, where workers fear showing weakness, and rarely extend compassion to their colleagues.

In the process of rounding, Swamy would access an ICU computer to view data and scans, then talk to the patient and family in a process that took 20

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to 30 minutes. When he returned to the computer to round with the next patient, he had been logged out and had to sign in again.

"It seems like such a small thing, but when you are in a busy ICU — there are sick people and you are being pulled in 10 different directions — typos happen," he said. "Typos lead to getting locked out of the system, and this would happen at least every other week or so."

Being locked out for mistyping information or password meant IT had to be called to rectify the situation. Finally, frustrated, Swamy filed the IT ticket expecting little more than a "sterile reply of 'That's just the way it is because of these reasons,'" he said. Instead, he received a phone call from Brian in IT, who was surprised because automatic logout was supposed to be set at one hour — not 15 minutes. The computer tech realized other hospital computers also were incorrectly set, and told Swamy a systemwide change was needed.

"This guy to me was like a superhero," he said. "In 10 minutes, he finds the switch and flips it. This problem never happened again. Reducing login attempts isn't as flashy as dropping mortality rates, but it makes a difference over time — how many people in the system who were using this software were logging in, getting locked out, and calling IT to use their valuable time to fix it."

Beyond that was the realization the healthcare systems were operating in silos when someone figuratively down the hall was unaware of the problem, which the clinician saw as insurmountable, fixed it in minutes, he said.

"I really wanted to break down silos," Swamy said. "I thought, 'Why am I communicating with everyone through the chart? Why do I not know what other people are doing?'"

This thought spurred further action, made possible when an unrelated quality improvement effort led to medical residents filing more safety reports after patient incidents. These incidents were reported, but did not necessarily lead to immediate action and full communication between staff. Swamy and colleagues started a one-hour, monthly workshop open to all caregivers to discuss one of these patient safety incidents. This format proved critical when a major patient safety incident occurred that led to staff acrimony and blame, he said.

Hospital policy is that vital signs for patients on diuretics, which can lower blood pressure, should be checked more frequently. One patient's vital signs were not checked for 16 hours, and the patient was admitted to the ICU.

"It wasn't pretty," Swamy said. "There was a lot of blaming going on. Everyone kind of felt someone else dropped the ball. The residents thought the nurses weren't getting the vital signs; the nurses were saying 'You didn't highlight that this was important.' We said, 'Let's use this case and bring it in to the workshop.'"

They brought in nursing, physicians, pharmacists, physical therapy — "whoever we could get," he said. Participants were divided into small interdisciplinary groups to discuss the case. "These are people who normally barely communicate through the chart, and have no idea what the other person actually does," he said.

In the ensuing conversations, they discovered a systems problem that contributed to the incident.

The policy regarding checking vital signs was outdated, and did not account for the different nursing shifts.

"Nurses used to work standard eight-hour shifts at this hospital," Swamy said. "That changed over time. Nurses are working all kinds of shifts, but the way we ordered [vital signs] had not [changed]. They can be ordered every eight hours, three times a day, or every shift. That used to all be the same thing, but now it means totally different things."

The problem was solved in a manner amenable to the various disciplines. The workshop meeting has since become highly attended, in part due to the promise of pizza and candy, he said.

"People love it because it is about their actual work," Swamy said. "Some of them told us 'For the first time I felt like I had a voice in the work I do, in making changes and having that autonomy and control over my daily work.'"

A 'Broken System,' Limits of Resilience

Many tangible improvements have resulted from the workshop and other silo-busting efforts, he said. For example, a labyrinth of steps to transfer patients to the cardiac care unit created the impression among residents that cardiology was intentionally putting up barriers to transfer.

"That's the kind of antagonism that broken systems produce," he said. "When you chip away at these silos, you really start to see trust come back."

If left up, silos and barriers in workflow can lead to a toxic culture among healthcare workers, many of whom may not know what challenges their colleagues in other departments are facing.

"When you don't know what another person is doing, and something goes wrong, people assume the worst," Swamy said. "They assume people are lazy, they are not smart, or they don't work hard enough. None of that could be farther from the truth. You realize that when you are in a room talking to [colleagues]."

It is important to underscore that broken systems and silos were responsible for the conditions of anger, blaming, and ultimately profound misunderstandings among these workers. Yet, the answer to this problem too often is that workers must become more personally resilient, said **Jessica Fried**, MD, a resident in the diagnostic radiology program at the Hospital of the University of Pennsylvania. "Interventions to date have focused on activities that can address wellness, balance, and well-being," she said.

While yoga, meditation, and mindfulness are valid approaches, the problem is that it places an enormous burden on the individual to see after his or her own well-being, she said.

"If you are burned out under this model, it is your fault," Fried said. "You didn't take enough time for mindfulness; you were not resilient enough. Victim-blaming is something we never want to do. It's also really obvious that resilient people also get burned out and depressed. We must move beyond mindfulness and yoga. The burnout epidemic facing healthcare professionals requires major culture change."

This often is expressed in the adage "Culture eats strategy for breakfast, lunch, and dinner," she observed. "We also know that culture change is incredibly difficult."

Burnout eventually degrades employee performance, manifesting as irritability and cynicism. In other professions, this behavior may be ignored or tolerated, but the stakes are too high in healthcare.

"Burnout in healthcare professionals matters because it can impact patient care," Fried said. "If we don't do something about the burnout epidemic in healthcare professionals, this could be a public health crisis."

'Culture of Silence'

A "culture of silence" often exists in healthcare settings that feeds and perpetuates burnout, normalizing perfection, and stigmatizing struggle and failure, Fried said.

"We were brought up in healthcare professions under a similar model of the strong, silent type," she said. "Through both implicit and explicit professional modeling, we have learned to hide our struggles, failures, and mistakes. This creates a toxic work environment in which people must struggle and suffer in silence and isolation."

Breaking this silence can begin at the individual level by asking colleagues how they are doing and speaking more openly about you own feelings, she said, urging interacting with co-workers with compassion and honesty.

"Take some time to say to your colleagues 'How are you doing today?' It really can make a difference," Fried said. "If you feel tension in the room so thick you can cut it with a knife, face it and acknowledge it before moving on with your work. If you are having a terrible day, be open

about it. If you are having a fantastic day, where you remember why you love doing your job, share that, too."

These small gestures might seem trivial within the thicket of factors that contribute to burnout in the workplace, but healthcare workers can slowly create a culture in which emotional expression in the workplace is normalized, she added.

In addition to suffering in silence, healthcare workers will sacrifice their own well-being in the name of patient care, forgetting the IHI adage that "you cannot pour from an empty cup."

"We sacrifice ourselves, thinking it will contribute to the greater good," Fried said. "Coping with untenable work schedules and suboptimal work conditions by constantly sacrificing small but key elements of self-care perpetuates the burnout cycle."

Instead of skipping breaks and coming to work sick, take as little as 10 minutes a day to focus on personal well-being, such as eating lunch away from the desk, celebrating small victories, and other things to help recharge.

"Many may feel that addressing burnout in their workplace requires tectonic changes that require buy-in from the C-suite," Fried explained. "There are some issues that can only be addressed from the top down, but you have an incredible power to influence a successful workday for your colleagues."

For example, Fried suggests telling colleagues at the end of a tough workday: "I see how much you care about what you do. I appreciate that."

Emotional availability in this sense requires a certain level of "psychological safety." IHI defines this as workers feeling comfortable enough to openly communicate without fear of repercussions. Such an environment — a "just culture" — enables learning, reduces risk, and builds camaraderie.

Situational Humility

"Situational humility" can improve a culture of psychology safety, Swamy said, citing an example of a surgeon at a meeting with members of nursing and other disciplines who asked for input on a case, unexpectedly saying that he was not sure he made the right decision.

"That one statement changed everything. Suddenly, you had the interns, the nurses, everyone in the room asking questions," he said. "If [the surgeon] could say that, then the rest of us could ask the questions that otherwise we might not have the psychological safety to ask."

Fried made a similar effect by telling some medical school students that it is all right to be anxious about some of the challenges and that she experienced similar feelings.

"So often in heirarchical medicine, people really feel like they are expected to know all the answers," Swamy said. "When you feel that inside, you show that outside. When you can crack that a little bit and say 'I am not totally sure,' it is not going to erode people's high esteem for you."

The IHI speakers underscored that a healthy work culture must be inclusive, going beyond clinicians to include housekeeping, food service workers, and other employees. Fried said she makes a point of interacting with all staff at the hospital as part of creating a healthy work culture.

"All of us owe it to ourselves to make sure that we are inclusive of our community as a whole," she said. "Everyone makes this engine that we call healthcare run, and we need to all be part of that of together."

By way of example, Swamy mentioned the story of Rana Awdish, MD, a physician who wrote a book about going into severe shock and receiving more comfort from patient transporters than clinicians. *(For more on Awdish's story, see the article in the August 2019 issue of* Hospital Employee Health *at: http://bit.ly/2RZWsR2.)*

"There is a point where the only people who get her — and who get her back — are the patient transport workers," he said. "They work together as this amazing community that she had never known about." ■

Surprised by Joy: A Framework for Finding Meaning in Work

'We're going to fail, and learn what works'

There may seem to be a chasm between healthcare work and the commonly understood meaning of "joy," but the Institute of Healthcare Improvement (IHI) is dedicated to bringing the ambitious goal of "joy in work" into reality.

The idea stems from preventing burnout, which is reaching epidemic proportions in healthcare, said **Jessica Perlo**, director of IHI.

"Burnout is characterized by emotional exhaustion, depersonalization, cynicism, and a low sense of personal accomplishment," she said in December at IHI's 2019 National Forum on Quality Improvement in Health Care in Orlando. "Anywhere from 54% to 60% — depending on the study — of U.S. physicians are experiencing symptoms of burnout. Usually 40% to 50% of nurses. Around 30% of ancillary staff. This is not any one discipline."

The bias in work assessments is to look at gaps and negatives, but healthcare "is one of the few professions that regularly provides the opportunity for its workforce to profoundly improve lives," the IHI stated in a white paper on the issue.[1] "Caring and healing should be naturally joyful activities. The compassion and dedication of healthcare staff are key assets that, if nurtured and not impeded, can lead to joy as well as to effective and empathetic care."

The IHI framework is designed to reduce staff burnout while improving patient care and overall organizational performance. "Making a workplace joyful is the job of leaders," the IHI report noted. "Nevertheless, everyone from senior executive leaders to clinical and administrative staff has a role to play. From creating effective systems to building teams to bolstering one's own resilience and supporting a positive culture, each person contributes."

> "WE ARE GOING TO FAIL, AND LEARN WHAT WORKS IN ONE SETTING BEFORE WE APPLY IT TO ANOTHER. WE ARE GOING TO CELEBRATE WHAT WORKS, AND LEARN TOGETHER."

Although the approach becomes more detailed and complicated in the report, the initial steps are straightforward.

"We found that working with thousands of organizations around the globe that these steps were what people were asking for," Perlo said. "They wanted simple steps they could take to a complicated problem. They are not overly complicated, but they are really challenging to do."

The four steps, with Perlo's comments, are as follows:

• Ask staff what matters to them.

"How often have you stopped and asked someone whom you may have worked alongside for years what makes for a good day for them? Why did they get into this?" she said. "Or, reflect yourself on your values and communicate them to peers."

• Identify unique impediments to joy in work in the local context.

"What are the pebbles in your shoes? What is getting in the way of more good days?" Perlo said. "Often, what we find with this step is that these things fall into innate human needs that aren't being met, things like meaning, choice, camaraderie, and equity."

• Commit to making joy in work a shared responsibility at all levels.

"We need to think differently about leadership with this [step] because that's what it takes," she said. "We need to think differently about power, and about inviting different voices to co-create solutions. The people with the problem can become authors of the solutions."

• Use improvement science to test approaches to improving joy in your organization.

"We are not revamping the system all at once," Perlo said. "We are using improvement science. We use some tests of change together. We are going to fail, and learn what works in one setting before we apply it to another. We are going to celebrate what works, and learn together." ■

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Healthcare Worker Attitudes and Perceptions About Respiratory Protection

Inaccessible masks, diagnostic confusion, distrust

In an unusual qualitative study, healthcare workers revealed a variety of attitudes about respiratory protection equipment, including motivations and suspicions that could improve or undermine compliance.[1]

"My background is in anthropology, so I think about the [work] culture of these different parts of the hospital. You want to have a safety culture that highly aligns with the protocols," says **Gemmae Fix**, PhD, lead author and a researcher at the Center for Healthcare Organization and Implementation Research in Bedford, MA.

Fix and colleagues conducted 12 focus groups with nurses and nursing assistants at four medical centers. They analyzed the themes and content of the "stories" told by focus group nurses. The researchers sought to characterize perceptions of respiratory protection equipment (RPE), and assess how work factors may encourage or undermine use. They focused on registered nurses and nursing assistants, using a qualitative approach that solicited comments from these frontline workers.

The main themes that emerged included:

- policies are known and seen during work routines;
- during protocol lapses, use is reinforced through social norms;
- clinical experiences sometimes supersede protocol adherence;
- when risk perception was high, there was concern about accessing supplies;
- ED workers were seen as ignoring protocol because risk was ever-present.

Generally, healthcare workers were aware of the importance of respiratory equipment and following protocols, researchers found. However, compliance could be undermined by inaccessible equipment, diagnostic confusion and distrust, and observing ED staff not wearing masks routinely.

COMPLIANCE COULD BE UNDERMINED BY INACCESSIBLE EQUIPMENT, DIAGNOSTIC CONFUSION AND DISTRUST, AND OBSERVING ED STAFF NOT WEARING MASKS ROUTINELY.

"Some of the stories we heard were specifically about the emergency department," Fix says. "It was felt that the reason that people in the ED didn't wear their masks as they should is that they just didn't know [patient status]. They had all of these patients coming in without a diagnosis. By the time they were given a diagnosis, the perception was it was too late; they had already been exposed. People from the ED work all the time without masks, and when they go to other floors to bring patients, they still are not wearing masks."

The primary focus of the group discussions was N95 respirators, which generally are recommended for airborne isolation precautions for pathogens like tuberculosis and measles. N95s also are commonly recommended for novel respiratory viruses like SARS and pandemic flu, as well as emerging infections like Ebola and MERS.

"Participants' stories included a variety of cues prompting RPE use, including door signs on patient rooms, personal protective equipment carts in front of patient rooms, documentation in the electronic medical record, and patients being in a negative air pressure room," the authors reported.

Wearing RPE was consistently recognized as "one of the things that you have to do," although some complained the masks were "suffocating" and "claustrophobic," Fix and colleagues reported.

Despite the discomfort, a common perception was that RPE was protective against occupational airborne infections. "I wouldn't want to wear [RPE] all the time," a nurse in a focus group said. "But they're manageable, and I'd rather have them on than have them off."

Stories underscored that it was socially acceptable among workers to identify RPE compliance lapses. For example, when a disoriented patient with TB unexpectedly walked out of his isolation room, coughing up blood and sputum, some nurses rushed to help. "Others told them to put on a mask," Fix says.

In another focus group story, a food service worker entered a clearly designated airborne precautions negative pressure room without donning a respirator. "After informing

this individual, the nursing staff reported the event to supervisors, who helped organize a respiratory precaution training for food service staff," the authors reported.

Clinical Experience in Favor of Protocols

Beyond protocols, participants evaluated patient behaviors and symptoms to determine whether to wear RPE. This meant they might decide to use RPE even if protocol specified only droplet precautions or no precautions.

"Several healthcare workers we spoke with talked about wearing N95s when the protocol specified a surgical mask," the researchers found. "This was because they suspected, based on their clinical experience, that the patient might later be diagnosed with a respiratory infection."

One nurse stated, "I'm not going to make that mistake again." In addition, some nurses wore RPE based on patient symptoms like coughing, regardless of diagnosis and isolation level.

"It's not just Ebola anymore," one nurse said in focus group. "There are a lot more viruses coming down the pike. We could end up wearing masks all the time at work."

When nurses did not trust the working diagnosis, they relied on their own clinical judgment, which often led them to use a higher level of RPE, the study revealed. Inappropriate overuse can raise confusion and alarm in others, while depleting supplies of N95s for nonclinical reasons.

"The important thing here from a patient safety perspective is that they are not following the hospital protocol," Fix says. "You can imagine if you work in a hospital — you know what the protocol is, and you see your colleague doing something different. Other colleagues in the emergency department may be doing what they want. This breaks the social norms, and disrupts the safety culture."

The researchers found a relationship between risk perceptions, perceived access to equipment, and local context. For example, nurses working in rural sites reported easily available equipment, a perceived lower risk of exposures, and fewer patients in airborne isolation. In contrast, nurses in urban settings perceived a greater risk of exposure, more patients in airborne isolation, and respiratory equipment that was not easily available.

"They keep them [in another area] because they know how expensive they are," a nurse told the researchers. "[Because] some people go to grab the yellow masks for droplet precautions, and they might put on the N95 respirator for a droplet [by mistake]."

These perceptions and suspicions that costs trump worker protection can contribute to a toxic work culture. "People talked about the hospital trying to save money," Fix says. "They thought they were at risk, and wanted to get a mask, but the [PPE] was all the way down at the end of the hall. Or, they were locked away, or they didn't have masks in the appropriate size. That undermines the worker's trust in that healthcare system."

Given these many variables that may influence respiratory use, Fix and colleagues recommended "team huddles" to review RPE issues when a patient is placed in airborne isolation. A review of the basics could open the huddles for other concerns about the use and availability of respiratory equipment.

"You have to be able to have conversations and address these concerns out front for your patient safety culture," Fix says. "Not if, but when, the next [infectious agent] comes around, the system has that strong safety culture, and is ready for these events. People want to do their jobs, and they want to be safe. It's not so much an education problem. I would say it's a communication and perception problem." ■

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Applying Ethics to Burnout

Recognizing moral distress in healthcare workers

Between one-third and one-half of U.S. clinicians are experiencing burnout, according to a report from the National Academies of Sciences, Engineering, and Medicine.[1]

"As an occupational hazard, burnout occurs when work demands exceed resources. It is not a personal failing or a mental health diagnosis," says committee member **Cynda H. Rushton**, PhD, RN, FAAN, professor of clinical ethics at Johns Hopkins University.

The report confirmed that burnout among U.S. clinicians is occurring at alarming rates, says Rushton, and made recommendations for system reforms and human factors redesign. "Clinical ethicists are ideally situated to recognize patterns that undermine the integrity and well-being of clinicians and negatively impact patient care," Rushton says.

Systemic problems include ineffective communication about goals of care at the end of life, lack of clinician teamwork, throughput pressures that undermine relationships and threaten safe discharge, and inadequate staffing levels. "The ethics piece really comes down to moral distress," says **Christine Cassel**, MD, co-chair of the committee that wrote the report.

Sometimes, moral distress involves conflict about the treatment plan, such as nurses believing a family's request that "everything" be done is harming a patient. But ethicists also are seeing moral distress coming up because physicians know what the patient needs, but cannot do it because of time constraints, she says. For example, physicians are seeing complicated patients with just 10 minutes allotted for the visit. "You are not able to really do what you know the patient really needs, and it eats at you," she laments.

Some may need to express their discomfort about being unable to meet the needs of a particular patient because of time constraints. "People in the hospital ethics consultancy world have the trust and the knowledge base to contribute to that set of problems," says Cassel, senior advisor on strategy and policy, and professor of medicine at the University of California, San Francisco.

Often, no one takes the time to talk though moral distress arising from all the systems issues blocking patient care. "People feel they can't be heard, and that nobody really cares about these tough issues," she notes. "That's where ethicists play such a vitally important role."

Some clinicians may share that system issues are standing in the way of patient care in a pervasive way. "If you add lots of these episodes to an already busy and overworked clinician, that's a contributing factor to burnout," Cassel adds.

Help does not always need to arrive in the form of a formal ethics consult. Not many clinicians will reach out in that way. Instead, while rounding in clinical areas, ethicists can ask this direct question: Do you feel frustrated about not being able to do what is right for patients? "It doesn't have to take hours," Cassel says. "It just takes a skilled ethicist to let people talk and be heard."

Most existing data on burnout focus on nurses and doctors. "But the same thing is happening with many other healthcare professionals as well," Cassel observes.

The report emphasized the need for everyone in healthcare to be involved. "Everybody's got a role in thinking about how the decisions we make, and the way we organize the work, contribute to burnout," Cassel says.

Pressures of documentation requirements, payment requirements, treating too many patients with not enough members of a team, and inadequate support from pharmacy or other departments all are contributing factors. "That can lead to ethicists being drawn in to discussions on system redesign. I would certainly hope that would be the case," Cassel says.

The report authors did not give specific recommendations for ethicists. "But [the report] does look at how healthcare organizations can create and maintain safe, healthy, and supportive work environments that foster ethical practice," says **Neil A. Busis**, MD. Clinicians and healthcare leaders may be unaware of conditions that are gradually eroding the organization's ethical climate. "How clinicians experience the organization may not match the realities of the work environment," Busis adds.

Here are two examples:

- Hospitals may espouse a patient-centered mission, but then limit the number of Medicare or Medicaid patients who can be scheduled for nonurgent outpatient visits;
- Hiring or promotion practices do not necessarily reflect the organization's claim that they value diversity. "Aligning structures and processes with organizational and workforce values requires a sustained intentional focus on collective values," Busis says.

A previous review of the literature concerned whether burnout affected the quality of care.[2] "This would be important to know if we are to build a case for the healthcare system to take measures to prevent burnout," says **Carolyn S. Dewa**, MPH, PhD, the study's lead author and professor in the department of psychiatry and behavioral sciences at University of California, Davis.

Dewa and colleagues found evidence of a link between burnout and quality of care, but the studies were not consistent in how quality of care was measured. Therefore, says Dewa, "it was difficult to come to conclusions about the magnitude of the effects and the dimensions of quality affected."

Better understanding is needed on exactly how burnout negatively affects quality of care, whether it causes medical errors, poor communication, lower satisfaction, or other problems. "Healthcare systems are constantly changing and seeking ways to decrease costs while introducing innovation," Dewa notes.

This raises the question of whether anyone is considering how the changes are affecting providers. "Neglecting to do so seems like a missed opportunity for good stewardship of their most important resource: their clinicians," Dewa offers.

Frequently, professional burnout is associated with poor quality of care in the published literature. "However, reporting biases are common in many fields of literature. These biases typically result in exaggerated effects being published," explains **Daniel Tawfik**, MD, MS, an instructor of pediatric critical care medicine at Stanford (CA) University School of Medicine.

The authors of a recent study examined whether published studies provide exaggerated estimates of the link between burnout and quality of care.[3]

"Research on burnout and quality of care appears especially vulnerable, because many studies are not prespecified or have several potential methods of analysis," Tawfik notes. If studies with more impressive results are more likely to be published, this would give a skewed picture. "We wanted to summarize what is currently reported regarding this relationship between burnout and quality of care, and to look for evidence that these reported relationships might be larger than the true relationship," he explains.

The researchers expected to find a variety of burnout measures and quality of care outcomes reported in the literature. "However, the sheer number of different combinations of burnout and quality of care assessments was a little surprising," Tawfik reports. The authors found a moderately strong relationship between burnout and quality of care, despite the finding of some excess significant findings. "Burnout is associated with several adverse outcomes, not just related to quality of care but also related to other aspects of physician well-being and patient satisfaction," he says.

For organizations, says Tawfik, "our findings highlight the growing ethical and moral imperative to focus on provider well-being as a crucial aspect of their mission." ■

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Patient Watch: Alternatives to Using Nurses and Security Officers

Hospitals often struggle with the need to provide close watch over a potentially dangerous patient without relying on skilled nurses or security officers who are needed elsewhere. Some hospitals find that a patient watch program is the right solution.

A patient watch is not the same as a sitter program in which a healthcare attendant is assigned to watch over a patient who is elderly, disabled, or otherwise impaired. The sitter is effective for patients who may be at risk of falling or other nonviolent risks, but they are not appropriate for patients who are potentially dangerous, explains **Ken Bukowski**, vice president of vertical markets for Allied Universal, a security and facility services company based in Conshohocken, PA.

Rather than a healthcare attendant, a patient watch involves a security officer posted with a patient for the purpose of protecting that patient and others, Bukowski explains. For a patient watch to be appropriate, the patients must be identified according to state laws as a threat to themselves or others and placed in an involuntary patient status by the appropriate authority. Otherwise, directing a security officer to watch a patient could be construed as coercion or even false imprisonment, Bukowski cautions.

Some Require One-on-One Watch

Under some conditions, such as when a patient is suicidal, there must be a one-on-one patient watch with a qualified staff member monitoring the patient at all times, Bukowski explains.

In other situations, it is permissible to direct a staff member to watch more than one noncommitted patient as long as additional staff are available to respond in an emergency, Bukowski says. Those requirements can be difficult for some hospitals to meet. Most facilities do not have enough security officers to watch patients around the clock. Pulling existing officers from their duties to do so would mean leaving other needs unfulfilled throughout the facility.

"We see a lot of hospitals pulling in certified nursing assistants and other clinical staff to do this just because they don't have any other choice. The emergency department is already a busy environment, and no one wants to be taken away from their other duties to sit there and watch a patient," Bukowski notes. "But these patients also can be disruptive, and these clinical staff are not qualified to handle a violent or dangerous patient. Even when you have clinical staff on this duty, you still end up having to call in a trained security professional."

Using staff specially trained for patient watches is sort of a midpoint between the other options of instructing a clinical staff member or a hospital security officer to monitor the patient. Both those other staff members have skills that are needed elsewhere, and they both are more expensive to employ, Bukowski says.

"You're taking nurses away from what they're trained to do and what you're really paying them for — taking care of patients in a medical situation. Or, you're taking security officers away from their other duties and leaving other areas of the hospital unprotected while they watch this patient," he explains. "A lot of hospitals call in their security officers for this, but when you pull that officer from duty in the hospital lobby, now your lobby is exposed and unprotected. Shuffling staff around doesn't work because you had that security officer posted in the lobby for a reason. Now, you don't have that coverage."

Hospitals may have multiple patients requiring a watch at any one time, but the need fluctuates, Bukowski notes. A patient watch program can draw on either a security service or it can develop its own internal program of staff members specially trained for this task, he says. In either case, the hospital can schedule trained patient watch staff for high probability times like weekends. Other staff could be on call for times when such patients are less likely to appear.

"It's important to look at the data and try to project when you will have these patients. It usually follows a pattern of weekends when you have people drinking too much, and some evenings when people are more likely to come in with these kinds of problems," Bukowski advises. "You can have staff there on those shifts, ready to step in so that your more skilled staff don't have to be pulled away. When a doctor orders a patient watch, it starts right then. If you don't have the appropriate person to step in, you have to pull in someone who should be doing something else."

Video Monitoring Possible

Another option is a watch program that uses video monitors. One staff member can watch monitors for several patients, but only if they are noncommitted, Bukowski says. If the patient is committed because he or she is at risk of suicide or other danger, a video monitor may be used if the staff member is constantly monitoring only that single patient, he explains.

"The person watching the camera has to do nothing but watch that monitor for that one patient. There must be a resource who can respond to the patient immediately. That can be either the person watching the monitor or another clinical or security professional who can respond if something happens," Bukowski says. "That's a new directive from CMS."

Bukowski notes that many hospitals are developing seclusion rooms that are grouped together, making it more feasible for a single patient watch staff member to monitor several noncommitted patients at the same time.

"The key to making a watch program work is to have people who are trained for this role. It's not a matter of taking anyone who is willing to sit there and watch the

patient," Bukowski says. "They must be trained in recognizing signs of escalating behavior and respond to escalating behavior. Otherwise, you're really not solving anything because you still have to pull in the medical staff if this person doesn't know what to do, and keep the incident from turning into a bad situation." ■

Paradigm Shift Needed on Healthcare Violence

Workplace violence in healthcare occurs at rates more than four times higher than in other industries, says **Scott Cormier**, vice president of emergency management, environment of care, and safety with Medxcel, a healthcare facilities management company based in Indianapolis.

Patients and family are under stress, and often take it out on the physicians, nurses, and other employees.

"We are seeing that what we've been doing for decades in healthcare — taking de-escalation cases and writing policies — doesn't work. Organizations will have an incident in which someone is injured, they'll throw some money at it to do some training and write another policy, then they move on until the next incident," Cormier says. "We need a paradigm shift. We need a sustainable process that actually helps protect our workers rather than just going through the motions after an event."

Eighty percent of workplace violence in healthcare comes from patients, but the rest involves co-workers and outsiders such as vendors, Cormier notes. Any solution must begin with collecting data on how violent incidents occur, he says. That should include near-misses.

Cormier recalls working in an ED where it was an accepted part of the job that patients and family members would occasionally become violent. People swung fists at him regularly, but unless the blow landed and caused injury it wasn't reported. If he ducked and the punch missed, that was a good day, and there was no report.

"We need to collect those data, and we have to make it easy to collect those data," he says. "If your employee has to spend 10 or 15 minutes on a website reporting that incident, they're not going to do it."

Once data are collected for a baseline, the paradigm shift can begin, Cormier says. The first step is training, but not just a handful of high-risk employees, he says. "We should be training the whole hospital. Everyone needs to be trained in how to recognize the potentially violent person, and how to respond in a constructive way," Cormier says. "Think of all the people a patient encounters on a visit to the hospital — the volunteers, registration people, triage nurses. All of those people typically are not trained in workplace violence, but they should know what to do when they see someone in the waiting room who is escalating, and how to respond quickly before it gets worse."

The training must not be burdensome, Cormier says. An intense, full-day seminar not only takes the employee away from job duties, but it also overloads them with information that they will file and try to remember months later when needed, he explains.

"A better approach is to use shorter classes of maybe two hours, with monthly updates," Cormier says. "A team huddle also is a good opportunity once a month to talk about what we learned about workplace violence and how to prevent it. That way, it's kept at the front of your mind, and you don't have to dig back so deep when something occurs to try to remember the right response."

Cormier recommends a team approach that includes risk management, human resources, behavioral health, critical care, and surgery leaders, as well as representatives of the workers who have day-to-day interaction with patients but typically are not considered frontline caregivers. Those include housekeepers and administrative clerks.

The plan should involve developing a threat assessment team that can respond at any time, around the clock and on weekends, to situations in which staff are concerned that someone may become violent.

"You also should get your local law enforcement involved with this team because if an incident escalates to violence and they respond, you want them to be familiar with your process," Cormier says. ■

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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **Lakshmana Swamy, MD, MPH, and colleagues hold a one-hour, monthly workshop open to all caregivers to:**

   a. listen to a didactic lecture.
   b. review healthcare worker injuries.
   c. talk about their families in a bonding exercise.
   d. discuss patient safety incident reports.

2. **Jessica Fried, MD, said a "culture of silence" in healthcare:**

   a. prevents violent outbursts by patients.
   b. stigmatizes health workers' struggles and failures.
   c. is needed to allow for personal reflection.
   d. creates self-reliance and resilience.

3. **As explained by Jessica Perlo, MPH, which is *not* one of the key initial steps to finding joy in work?**

   a. Ask colleagues what matters to them.
   b. Identify unique impediments.
   c. Take a sabbatical.
   d. Commit to making joy in work a shared responsibility.

4. **What unusual educational background gives Gemmae Fix, PhD, a unique perspective on healthcare work culture and behavior?**

   a. Anthropology
   b. Systems engineering
   c. Conflict resolution
   d. Positive deviance

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 healthcare 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.