1/31/2018

Dear Representative Claman,

Thank you for your support of HB 312. As a health care profession who has been assaulted multiple times while on duty I feel it is imperative for the police to have a more aggressive law regarding assaults against health care professionals. The current laws to do allow police to take patients who have been assaultive to the appropriate place, which I believe is a jail cell. More often than not a patient who has committed assault against health care worker will be cited and released. Even for the most serious and repetitive offenders. Please continue to support the safety of our Alaskan health care workers.

Sincerely,

Ed Czech RN

Anchorage, AK

Lizzie Kubitz

From: Gena Deck <radeck@alaska.edu>
Sent: Friday, February 02, 2018 9:27 AM
To: Rep. Chuck Kopp; Rep Matt Claman; Lizzie Kubitz
Subject: House Bill 312

Follow Up Flag: Follow up
Flag Status: Flagged

Good morning. Thank you for introducing House Bill 312 that will be up for public hearings on Monday, February 5th.

This bill is meaningful to me in that I am the person working in the Emergency Department in Juneau strangled by a patient. I have strong feelings about the bill, and will hopefully have an opportunity to voice support on Monday during the public hearings.

The impact of violence in the workplace extends far beyond the day of the event. The judicial process is difficult, and often nurses and others in the health care environment do not speak up because it is so torturous, and often will little justice for the perpetrator. In Alaska's small towns, including Juneau, the issue is complicated further by lack of other health care alternatives. Therefore the interactions at the hospital and in the community are not single events.

Thank you again for promoting the bill. I would welcome the opportunity to discuss my experience and those of my peers in person.

Gena Deck, MSN, RN
Assistant Professor, Nursing
University of Alaska Anchorage
907-796-6372

House Judiciary 2/7/18
Written Testimony

February 1, 2018

Dianne Dalen
314 Slater Drive
Fairbanks, AK 99701

Dear Members of the Alaska State Legislature,

I am writing to you to ask your support for House Bill 312, an act relating to arrest without a warrant for assault in the fourth degree at a health care facility; and relating to an aggravating factor a sentencing for a felony offense against a medical professional at a healthcare facility.

I have been a nurse for 41 years with over half that time spent working as an Emergency Room nurse at Fairbanks Memorial Hospital. Over the years I've watched heath care delivery improve while treatment of medical professions deteriorate. While I love serving my community I am sad to say that during my career I've been physically and verbally assaulted on numerous occasions by patients including being spit on, yelled at, receiving verbal threats of harm, scratched and hit. The latest attack occurred in October 2017 when I was physically assaulted by a young male.

This young man was brought to Fairbanks Memorial Hospital Emergency Room by law enforcement after he had been using methamphetamines for approximately four days. The intention of law enforcement was to have this man placed in protective custody in the ER where he can be observed in a safe environment until he was able to metabolize the drug. The man was agitated and provided medication to calm him. When a member of our security staff stepped away to retrieve a warm blanket to provide to him, the man bolted out of his room and punched me in the jaw. The strength behind the punch immediately knocked me to the ground furthering injuring my arm during the fall. Although a police report was filed, the man was not arrested for the assault.

I returned to work on my next scheduled shift with a large fist size purple bruise on my jaw and continued to provide medical treatment to the members of my community that I love dearly. While the bruise eventually healed, the emotional scars of the incident will never leave my mind and the minds of my coworkers. Healthcare providers took an oath to do no harm and in the process risk their lives trying to save the lives of others. Sadly, my story is not unique. It's estimated that between 8% and 38% of healthcare workers suffer physical violence at some point in their careers and by showing your support for HB 312 you are showing your support for the health and safety of our healthcare workers.

Thank you.

Dianne Dalen

Dianne Dalen
458-5556

Lizzie Kubitz

From: House Judiciary
Sent: Tuesday, February 06, 2018 8:50 AM
To: House Judiciary
Subject: FW: You got a message "Testimony for SB 312"

From: WordPress [mailto:wordpress@akhouse.org]
Sent: Monday, February 05, 2018 3:09 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: You got a message "Testimony for SB 312"

From: David Scordino
Subject: Testimony for SB 312

Message Body:
I apologize for the broken connection of my cell phone. I did not write my testimony but I have attempted to summarize it as best as possible.

My name is Dr. David Scordino and I am an Emergency Physician at Alaska Regional Hospital. I write in strong support of SB 312 and use this testimony to provide an additional story of support as well as to answer some of the questions raised by the Representatives during the prior testimonies. A few months ago, I had a patient present to my Emergency Department complaining of acute abdominal pain. Their behavior was unruly and they struck out at myself, the nurses and security officers attempting to help get the patient in the bed, assess and treat them. During the deluge of verbal and physical assault, the patient threatened to kill every person in that room in turn, as well as, kill our children, spouses and pets. This patient was not intoxicated nor experiencing an acute mental health emergency. However, according to EMTALA and liability obligations, I could not discharge this patient despite the patient's behavior nor the acts of violence. If the patient had a surgical emergency in their abdomen then I would be liable for this missed diagnosis and the patient would suffer potential harm. Similarly, for the person who may be intoxicated, their confusion may also be an indication of an intracranial hemorrhage, which is a life threatening condition where blood is surrounding or in the brain. A misdiagnosis in this scenario is dangerous to that patient, since a delay can result in death and it is dangerous to the provider as they have medical liability for this patient. Even if the person punches me in the face, my medical liability does not go away. In smaller hospitals and rural hospitals, there may not be another provider to assume care and thus, even after they are abused by this person; they may need to go back in the room and try to care for them.

I have heard concerns regarding alcohol, drugs and mental health. I agree that these issues exacerbate the problem however, multiple of the individuals that have either assaulted myself or some of my co-workers did not have any of these. I do however, agree that the states mental health and substance abuse capabilities is greatly lacking and that additional funding and resources for these would be a welcome improvement. These do not however, negate the need for this bill to help to deter this form of workplace violence. Do you know any other workplace where almost every employee can describe, often in detail, a time when they were assaulted or they felt their life was in danger? I can think of very few and this is why healthcare workers are being singled out in this bill because we have been singled out as a workplace with increasing violence.

Additionally, unlikely other workplaces, we can not stop someone from coming back to our hospital and can not simply remove them if they have not been medically stabilized under EMTALA and under medical liability as I previously described. This makes the healthcare setting unique.

I thank you for your time and for the introduction of SB 312. I apologize again for my technical difficulties. I am open to questions at anytime.

--

This e-mail was sent from a contact form on Representative MATT CLAMAN's legislative website (http://akhouse.org/reps/claman/contact-me/)

Lizzie Kubitz

From: Roxanne Lefleur <roxannelefleur@gmail.com>
Sent: Thursday, February 08, 2018 9:22 AM
To: House Judiciary
Subject: HB312

Follow Up Flag: Follow up
Flag Status: Completed

Roxanne Lefleur, BSN, RN

14082 N Tongass Hwy

Ketchikan, AK 99901

(954) 673-3687

February 8, 2018

Dear Representatives Claman, Kopp, Millett, Grenn, Kawaski, Tuck and Johnston,

I am writing this letter regarding HB312, Crimes Against Medical Professionals. I am going to share two previous professional experiences below

1. As a hospital administrator in Ketchikan, Alaska in 2015, I received a phone call from a floor nurse. She stated that she had been repeatedly poked in the face by her nurse manager while he was yelling at her. The assaulted nurse was told by administrators that the incident was hear say and no investigation took place. Since the incident, the assaulted nurse and her family packed their belongings, sold their house and left Alaska. We cannot afford to lose qualified nurses who have resided and worked in Alaska for many years.
2. I am originally from Florida. While working in Miami, I witnessed two male nurses in a fist fight in the hospital hallway. The fight was about a personal incident that had happened outside the facility. Both nurses face repercussions. When the offending nurses returned to work, they were very professional and even friendly with each other.

While sitting through the February 7, 2018 Alaska Board of Nursing meeting with my husband, Joe Lefleur in the education seat, I heard testimony only about patient's abusing nurses and psychological reasoning. I want to make clear psychiatric allowances should only be considered by a judge in a court room and should have no affect on the decision to make crimes against medical professionals a felony. A judge and medical professionals determine criminal psychological condition after an arrest for committed crimes. Therefore, psychological conditions should not be a consideration regarding HB312.

Please take my statement into consideration. We must protect our medical professionals in Alaska so that they can continue to protect and serve the Alaskan community members. Please pass HB312 into law.

If you have any questions, please contact me via email or telephone.

Thank you for your time and consideration,

Roxanne Lefleur, BSN, RN

--

Roxanne Lefleur
cell: 954-673-3687

Lizzie Kubitz

From: Roxanne Lefleur <roxannelefleur@gmail.com>
Sent: Thursday, February 08, 2018 9:22 AM
To: House Judiciary
Subject: HB312

Follow Up Flag: Follow up
Flag Status: Completed

Roxanne Lefleur, BSN, RN

14082 N Tongass Hwy

Ketchikan, AK 99901

(954) 673-3687

February 8, 2018

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If you have any questions, please contact me via email or telephone.

Thank you for your time and consideration,

Roxanne Lefleur, BSN, RN

--
Roxanne Lefleur
cell: 954-673-3687

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Commerce, Community, and Economic Development

BOARD OF NURSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8161
Fax: 907.269.8196

February 7, 2018

Representative Matt Claman
Alaska State Capitol
Juneau, AK 99801

Dear Representative Claman,

The Board of Nursing discussed House Bill 312, Crimes Against Medical Professionals, at its public meeting today. The Board of Nursing is supportive of this bill.

The Board heard from health care professionals who have been abused in their professional setting. We think they will benefit from this bill knowing they have protection from abuse and threats. The Board thanks you for addressing this topic.

Sincerely,

Jennifer Stukey, LPN

Alaska State Board of Nursing

Chair

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 12, 2018 8:26 AM
To: Lizzie Kubitz
Subject: FW: HB312

Follow Up Flag: Follow up
Flag Status: Flagged

From: Kamaree [mailto:kukulcan71@msn.com]
Sent: Monday, February 12, 2018 7:26 AM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>; Rep. Chuck Kopp <Rep.Chuck.Kopp@akleg.gov>; rep.gabrielle.ledux@akleg.gov; Rep. Lora Reinbold <Rep.Lora.Reinbold@akleg.gov>; Rep. David Eastman <Rep.David.Eastman@akleg.gov>; Rep. Mike Chenault <Rep.Mike.Chenault@akleg.gov>; Rep. Les Gara <Rep.Les.Gara@akleg.gov>; Rep. Andy Josephson <Rep.Andy.Josephson@akleg.gov>; Rep. Charisse Millett <Rep.Charisse.Millett@akleg.gov>; Rep. Mark Neuman <Rep.Mark.Neuman@akleg.gov>; Rep. Tammie Wilson <Rep.Tammie.Wilson@akleg.gov>; Rep. Chris Tuck <Rep.Chris.Tuck@akleg.gov>; Rep. Lance Pruitt <Rep.Lance.Pruitt@akleg.gov>
Subject: HB312

Hello,

I am writing today to encourage you to support this HB 312. As a mental health care worker for the past 12 years, I have been assaulted and seen my colleagues injured. Many of the assaults are deliberate and not a result of the illness. People know nothing happens to them. If we don't change anything, it support a poor coping strategy to get perceived needs met and Alaska health care workers get hurt. I have seen injuries that range from minor to people requiring years of medical attention and who never return to where they started. Mentally, you can never prepare to have another person be violent towards you and be the same after.

I urge you to pass the bill as is, with no amendments. Workplace violence impacts ability to staff with qualified people, the overall milieu, employee retention, and has interpersonal consequences. If you have any questions about my experience, please feel free to contact me by email or telephone. Thank you for your attention to this issue.

Kamaree Altaffer, LSCW

907-830-9372

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 12, 2018 8:29 AM
To: Lizzie Kubitz
Subject: FW: HB 312

Follow Up Flag: Follow up
Flag Status: Flagged

-----Original Message-----
From: Ben-Shabat, Yonatan M [mailto:Yonatan.Ben-Shabat@providence.org]
Sent: Sunday, February 11, 2018 3:06 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Cc: Rep. Chuck Kopp <Rep.Chuck.Kopp@akleg.gov>
Subject: HB 312

To my Alaskan representatives,

I am a healthcare worker at Providence Alaska Medical Center. I have been assaulted several times at work, often receiving injuries. Almost all of my co-workers have also had similar experiences. I support and appreciate HB 312 and believe that patients in a healthcare setting should not be exempt from following the law. No matter what, if a patient assaults a healthcare worker they should have consequences. This bill must be passed without amendments.

Yonatan Ben Shabat

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 12, 2018 8:37 AM
To: Lizzie Kubitz
Subject: FW: HB 312 letter of support

Follow Up Flag: Follow up
Flag Status: Flagged

From: Sami Ali [mailto:misssamiali@me.com]
Sent: Sunday, February 11, 2018 8:52 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 312 letter of support

Dear Representative Claman:

I am writing in full support of HB 312 which protects healthcare workers from violence in their workplace.

As a health care provider at Providence Alaska Medical Center where we have a psychiatric ER, I have persobnally witnessed this abuse of staff by patients. This is intolerable behavior. Most recently, I was made aware of a teenage healthcare staff member who was physically assaulted by a patient. We should empower the police to deal with these violent patients who threaten the health of the providers who are caring for them. I strongly support measures that protect me and my colleagues.

Please work to pass a clean bill.

Sincerely,

Sami Ali, MD FACEP

Emergency Medicine

Providence Alaska Medical Center
713-391-7369

mrssamiali@me.com

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 12, 2018 8:37 AM
To: Lizzie Kubitz
Subject: FW: HB 312 Thank you for support.

Follow Up Flag: Follow up
Flag Status: Flagged

From: Jack Pomerantz [mailto:jpomerantz@gmail.com]
Sent: Sunday, February 11, 2018 10:07 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: Re: HB 312 Thank you for support.

Dear Representative Claman:

As a your constituent and as a health care professional I am writing to tell you I am very grateful that you have stepped up to the plate to defend our safety.

In the busy emergency department where I work physical assaults on nurses, medical technicians and occasionally physicians are all to frequent.

As the emergency physician on duty it is my job to examine the injured as well as to treat these often violent patients.

Your efforts to protect our safety as we do our jobs are greatly appreciated.

Jack Pomeranz M.D.
Emergency physician
Providence Alaska Medical Center

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Thursday, February 08, 2018 2:36 PM
To: Lizzie Kubitz
Subject: FW: 2012 Evaluation of Workplace Violence FMH ED
Attachments: ED EBP Final draft.docx

Follow Up Flag: Follow up
Flag Status: Flagged

From: Huffaker, Karina [mailto:Karina.Huffaker@foundationhealth.org]
Sent: Thursday, February 08, 2018 2:16 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: 2012 Evaluation of Workplace Violence FMH ED

Representative Claman,

Karina Huffaker RN from Fairbanks, Alaska.
I was not able to share my public testimony yesterday for HB312 addressing workplace violence within health care facilities.
I did hear multiple questions in regards to research around workplace violence and I wanted to share the research we conducted at FMH in 2012.
-97% of our staff have been verbally assaulted by a patient
-62% of our staff have been physically assaulted by a patient
-50% of our staff have experienced sexual misconduct from a patient

Our goal was to increase the use of security in the ED but we were also working with representative Kawasaki to amend first responder laws and increase penalties for crimes against health care workers.

I have been working as an RN in Alaska fro 15 years and have seen mental, physical and sexual acts against coworkers in all areas of nursing.
If you have any questions regarding our research please let me know.

Sincerely,
Karina Huffaker RN CEN
Karina.huffaker@foundationhealth.org

A Nursing Evaluation of Workplace Violence at Fairbanks Memorial Hospital Emergency Department

Karina Huffaker ADN RN CEN
Reviewed by: Leah Hoppes MSN, MPH, RN CEN

Abstract

A systemic review of workplace violence towards nurses at Fairbanks Memorial Hospital's Emergency Department over the course of 2012-2013 in an attempt to bring greater awareness to the volume of violent activity our nurses are facing at the bedside. Review of hospital census data, staff surveyed results, best practice guidelines set by the ENA, ANA, JACHO and OSHA plus current literature identifying solutions to increase nursing safety at the bedside. Focused prevention strategies, staff education, zero tolerance policies and lobbying for harsher penalties for perpetrators are steps we can take to decrease violence at the bedside.

INTRO

Confronting a culture of violence in an Emergency Department can be a daunting task, but over the past several years the ENA, (Emergency Nursing Association), has encouraged providers to bring awareness to the gravity of this professional issue. Emergency nursing is in the front lines of crisis management, with nurses identified as the leading occupation for assaults in the American workforce. (ENA 2010) (Chapin 2010) (Pitch 2012) (Gilmore-Hall 2001). "According to the Bureau of Labor Statistics, among health care practitioners, 46% of all nonfatal; assaults and violent acts requiring days away from work were committed against registered nurses." (ENA 2012). As we step into this multifaceted issue ENA directs three guidelines for restructuring ED's to deal with workplace violence. Prevent, respond, report is the comprehensive approach coined by the ENA Workplace Violence Toolkit to "better understand the strategies necessary to effectively address this problem and facilitate a safer workplace for emergency nurses." (ENA 2012). Nationally, there has been an increase in "the number of patient with mental health and substance abuse issues who are seen in ED's, from 1.6 million in 2005 to over 2 million in 2008." (Stickler 2013) Fairbanks is no exception to this trend in health care. With the lack of psychiatric treatment facilities and substance abuse programs in Fairbanks, FMH ED is the primary location for treatment. Facilitating this particularly violent population has brought the safety and security of our staff into focus as we recognize the importance of a safe working environment.

The Joint Commission suggests taking "extra security precautions in the Emergency Department, especially if the facility is in an area with a high crime rate or gang activity. These precautions can include posting uniformed security officers, and limiting or screening visitors." (Joint 2010). According to a 2010 Fairbanks, Alaska Crime rate report, "the city's violent crime rate for Fairbanks… was higher than the national violent crime rate average by 95.5%." (FBI 2010). In 2013 Fairbanks' violent crime rate was compared to national standards with <50 being very low and > 1000 being very high, Fairbanks ranked 480.8 compared to the U.S. average of 223.2. (Crime 2013). Drug and alcohol abuse continue to be the primary aggravators to this aggressive patient population. "Members of Alaska's law enforcement community and others who are part of Alaska's criminal justice system have long known that the greatest contributing factor to violent crimes, including domestic violence and sexual assault, is drug and alcohol abuse." (Alaska 2011). Currently, FMH has no full time security guard designated to the ED, compared to Northern Colorado Medical Clinic who has two full time officers and a K9 unit and McKee Medical Center, which is staffed with one full time officer designated for the Emergency Rooms at all times. All three facilities operated under the Banner Health Care Corporation. (D. Hockett, personal communication June 2013). FMH and Denali Center are serviced by 1-4 security guards for the entire 252 bed facility, depending on the time of day and shift change. Security is also responsible for off campus facilities: Tanana Valley Clinic, Home Medical Equipment and campus patrols. (D. Flemming, personal communication November 25, 2013). Security does respond to all staff calls when notified.

The risks we take when caring for patients in the form of verbal abuse, physical assaults and sexual misconduct is a consistent problem for the staff at Fairbanks Memorial Hospital ED. In researched reports common traits predicting workplace violence were most associated with "male(s) (51%), frequently seen in the ED (46%), had a history of violence (46%), suffered from mental illness (42%), used illicit drugs (67%), abused alcohol (64%) and was between the ages

of 26 years old and 57 years old" (Chapin 2010). National trends indicate communities with high rates of crime will have higher incidents of violence in the ED. Higher volumes of psychiatric and substance abusing patients is also associated with higher risk of violence toward Emergency Department workers. It's our intent to bring greater awareness to the frequency and risk of work place violence at FMH ED, present best practice solutions and recommendations to improve the safety of our staff and our patients.

DEFINITION

Workplace Violence: an act of aggression directed toward persons at work or on duty, ranging from offensive or threatening language to homicide. National Institute for Occupational Safety and Health NIOSH (Gacki-Smith 2009).
Physical Violence: includes being pushed, hit, scratched or kicked. (Strickler 2013).
Verbal abuse: includes being called names, being threatened or intimidated, or being the recipient of sexual innuendo. (Strickler 2013).
Sexual Misconduct: misconduct of sexual nature. www. Medical-Dictionary.com
Code Violet: The hospital code to assist with communication of a violent situation involving threatening or violent behavior and summoning the security officers on duty. Policy 12415 Restraint Use in Violent Situations
ED Stat: Emergency or life-threatening situation exists (Soba-Gonzalez 2013).
ED Stand By Assist: a call for security's assistance with patient care to stand by, it does require an immediate response. (S. Rice, personal communication, November 25, 2013).
Title 47: AS 47.30. 705 Emergency detention for evaluation. (a) A peace officer, a psychiatrist or physician who is licensed to practice in the state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Association Examiners who has probable cause to believe that a person is gravely disabled (Alaska Statue: AS 47.30. 705).
Type II Violence: includes violence committed by clients or customers (Strickler 2013).

BACKGROUND

Staff and management observed an increase in patient violence towards nursing staff in an area of the department designed for medical exams of our psychiatric and intoxicated patient populations. This area is made up of 5 secured rooms, a legal blood draw area and a toilet with wash basin. After multiple events including fires in rooms, Title 47 elopements, patients' physically and verbally assaulting staff and an increase in nursing time designated to caring for these patients, we made changes to the psychiatric patient's dress code, seclusion room policies, installed panic buttons to triage and our psychiatric hallway, added a badge access lock to the exit in this hallway, and changed the nursing to technician ratio to deal with the volume of patients in this area.

In April of 2012, we conducted a review of the number of online incident reports submitted by staff related to safety and security in the ED. The number of safety and security reports recorded did not reflect the observed activity of violence in our department. With the goal to more accurately document these events we initiated the R.E.S.P.E.C.T project: Respecting Everyone's Safety, Employee Centered Treatment and introduced the ENA's Safety Event Form, (Appendix A) to make documentation easier for staff. The written documentation from the Safety Event's form was then transcribed by a designated staff member to the online incident reporting domain.

In the span of 10 months, we increased our recorded department incident reports from 13 recorded safety and security events for the years of 2010-2012 (C.Found, personal communication) to 41 recorded safety and security events from the end of April of 2012 to Feb of 2013. While this was an improvement in our reporting, many violent events were incidents still unreported. "Up to 80% of violent episodes go unreported. Reasons given for not reporting included time and effort, a view that violence is to be expected, perception of performance failure, increased tolerance for minor incidents, and a concern for the perpetrator." (Hodge 2006).

Addressing the importance of charting these safety and security incident reports to staff we began to uncover barriers associated with underreporting: staff knowledge of the system, the amount of time it takes to complete the online incident form, that the reporting system times out of initiated reports, and that there is no area for reporting patients assaults to staff members. Interestingly enough, nurses nationwide described similar barriers when charting workplace violence. The common problems identified were, " perception that reporting ED violent incidents might have a negative effect on customers service scores… ambiguous ED violence reporting policies; fear retaliation from ED management… incidents (are) a sign of incompetence or weakness; lack of physical injury… the attitude (that) violence comes with the job; and lack of support from administration/ management." (Gacki-Smith 2009). Hurdling this obstacle will be a major stride for our department to overcome. "Acknowledging that occurrence reports hold valuable information for future improvements and lack of reporting can impede an initiative to improving the safety of our departments" (ENA 2012) has been a priority outcome of our research.

Turing to our security department's log we were able to ascertain a more concrete measure of responses to the ED by a security officer for a Code Violet, ED STAT call or a Stand by Assist, where we need help with the aggressive actions of a patient. Between May of 2012 and February of 2013 security recorded 4 ED Code Violets, 12 ED STAT calls, and 1,229 ED Stand by Assists. (Appendix B) (J. Lowinski, personal communication, 2013). Currently, FMH ED does not have a designated security guard for our department and they are called via a hand held radio, vocera staff call system, phone call to operator, panic buttons in triage, the psychiatric hallway, under the desks in the C&D pods, or via overhead paging as a Code Violet in the location of the event. OSHA recommends the "installation and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones and private channel radios where risk is apparent or may be anticipated." (OSHA-environment 2004). Through our research we identified that many staff members have not been trained to the location of the panic buttons or know our department's policies for calling for help. The value of these reports to our research raises awareness to the areas in need of improvement as we focus on ways to prevent, respond and report our findings for a safer working environment.

METHODS

Following a review of the Emergency Department's online safety and security incident reports, we surveyed (Appendix C) staff employed during the summer of 2013, which included travelers, prn (as needed employees), full and part time staff. The survey was an anonymous one page

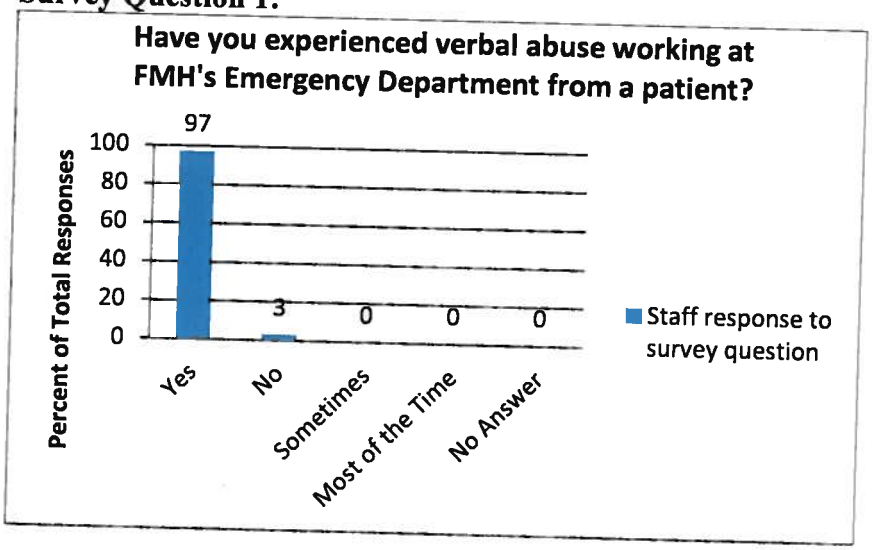
formatted questionnaire based off an ENA survey. All nursing staff responsible for direct patient care were given the opportunity to complete the survey; including both CNA (Certified Nursing Assistants) and RNs (Registered Nurses). In addition to the survey, we compared FMH's psychiatric and drug/alcohol abuse patient populations to Northern Colorado Medical Center (NCMC) and McKee Medical Center, sister facilities to FMH within the Banner Health Care system, to gain a better understanding of how our population compares to other facilities. Twenty six articles were evaluated addressing subjects on Workplace violence; ENA standards of practice, ANA Expert Panel on Violence and JACO regulations. We also referenced OSHA and the ENA's guidelines for preventing workplace violence.

RESULTS

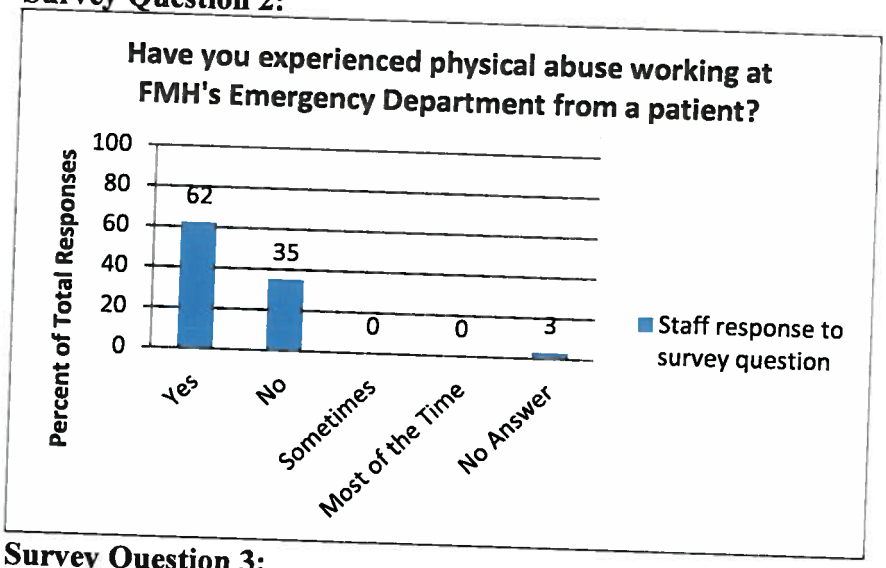
Our survey results were consistent with national standards in the fact that the majority of staff has been verbally assaulted, some have been physically assaulted and nurses are under reporting workplace violence. "The American Nurse Association found that less than 20% of nurses surveyed in 2001 felt safe in their current work environment. Research has consistently found that users are concerned about violence and aggression, inadequate safety measures, and personal vulnerability in the workplace." (Gacki-Smith 2009). Generally, staff does feel safe at work, think our security guards are effective at preventing violence, which is consistent with the number of ED Stat calls to ED Code Violent calls provided by security, but indicated that they feel security does not spend enough time in the ED to prevent violence against staff.

The survey questions and results in percentages are as follows:

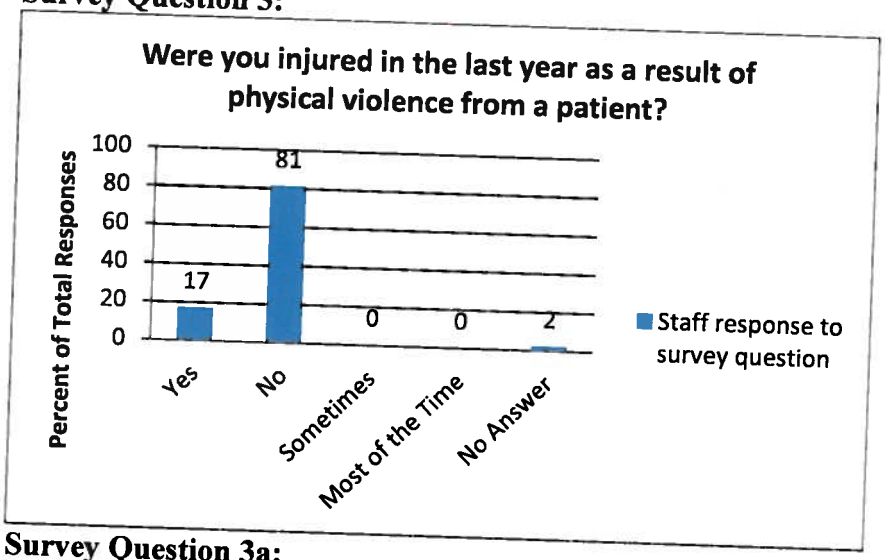
Survey Question 1:



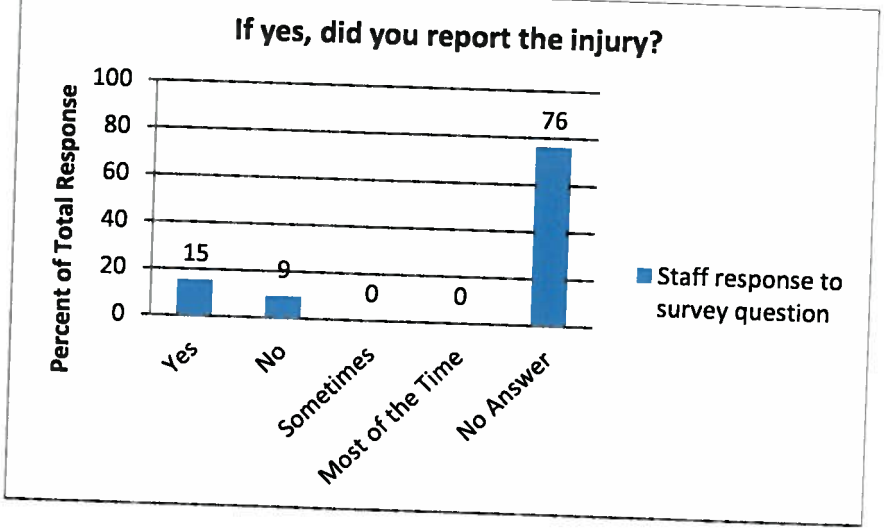
Survey Question 2:



Survey Question 3:



Survey Question 3a:



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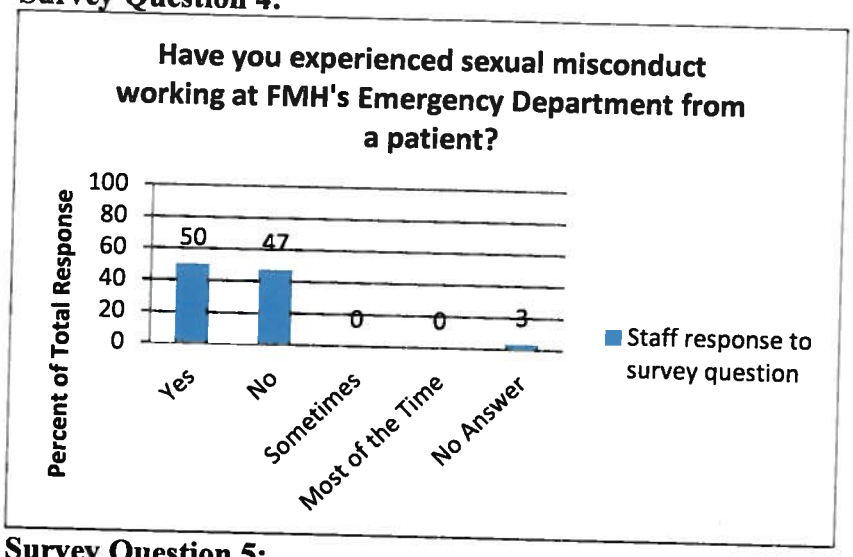

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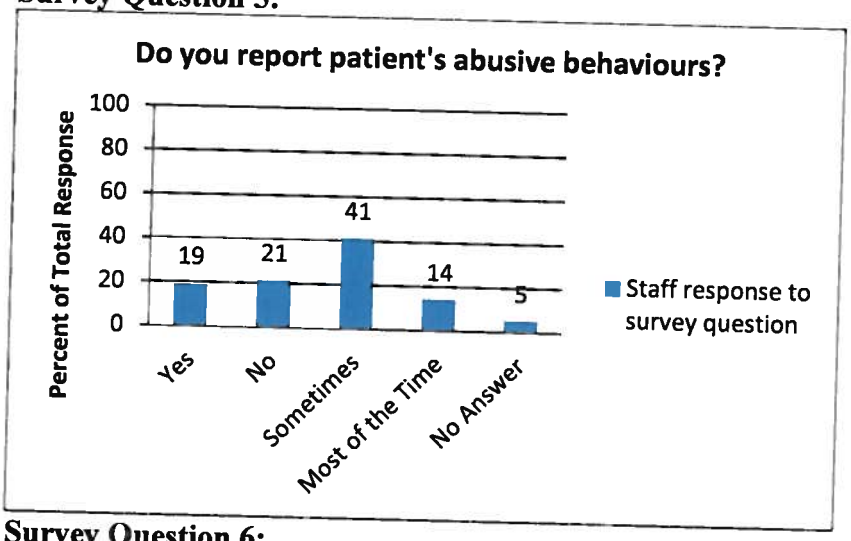

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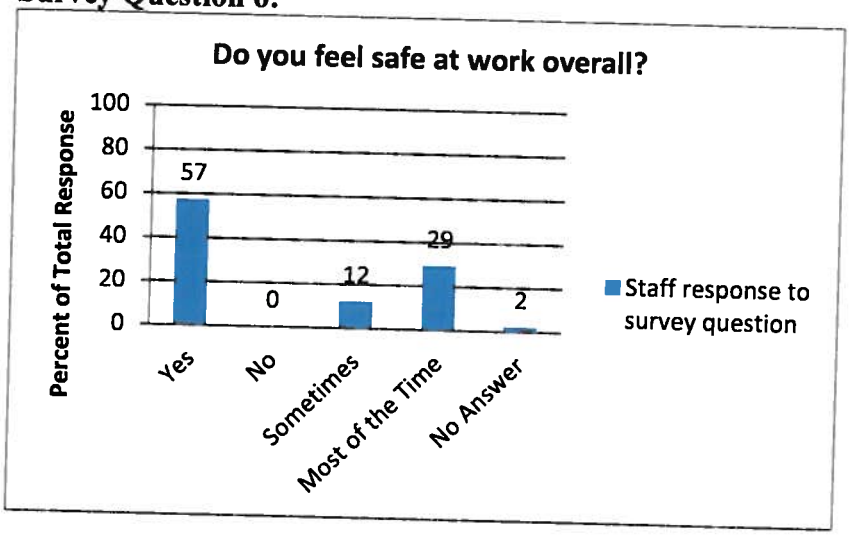
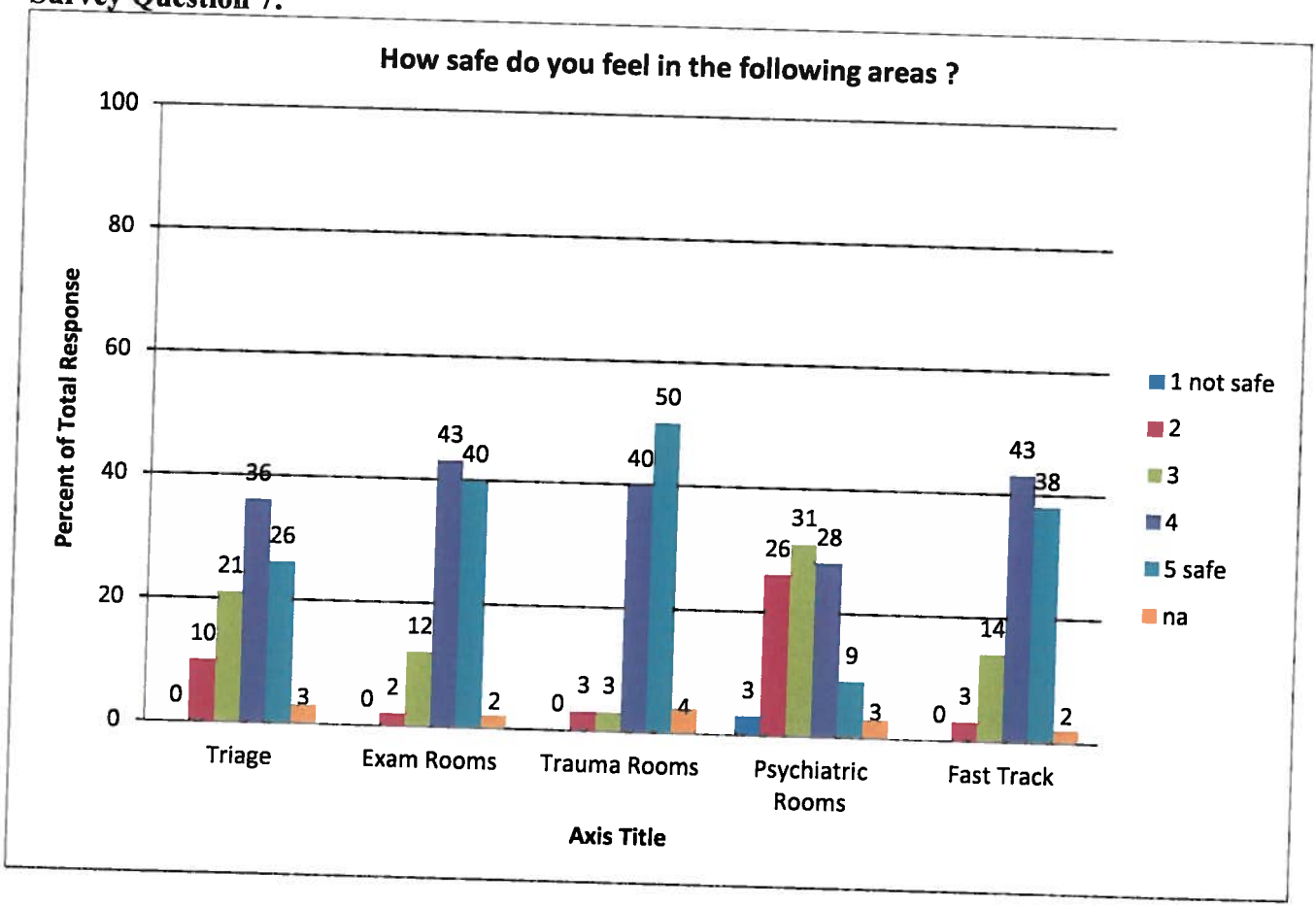


Additionally, staff had an opportunity to rate their feelings of safety in specific areas of the department that was linked to direct patient care. On a scale of 1 being unsafe and 5 being safe, 31% of staff rated triage a level 1 or 2, followed by our psychiatric rooms rated by 29% of staff as a level 1 or 2. Our trauma rooms were rated the safest by staff with 54% of participants rating this area a level 4 or 5. Identification of the potential for harm in certain areas of our department is crucial as we look for improvements in our approach to workplace violence.

Survey Question 7:



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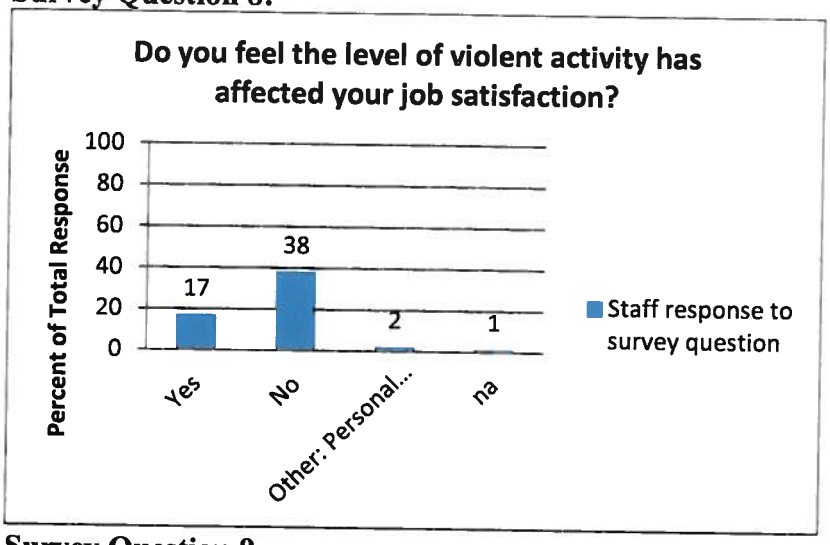

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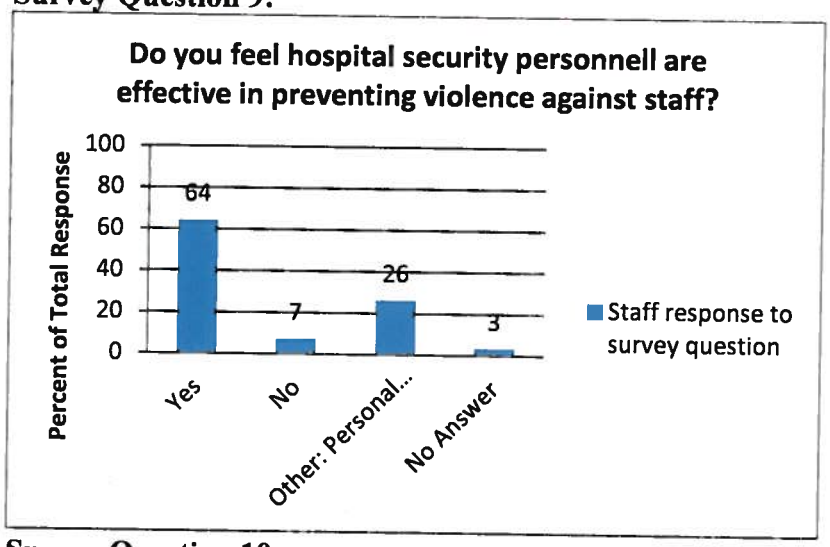
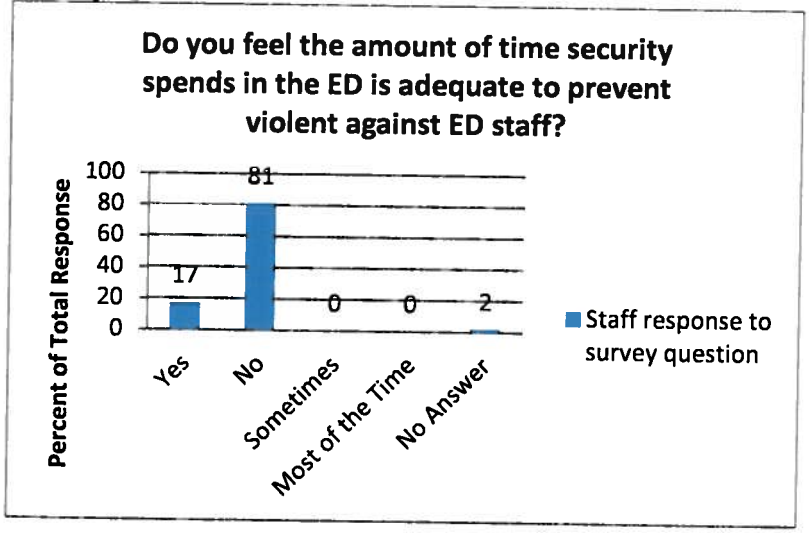
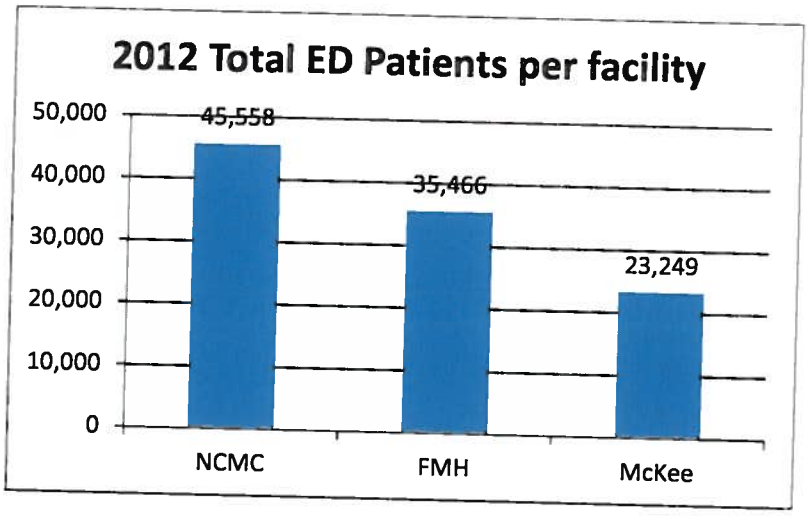


Survey Question 10:

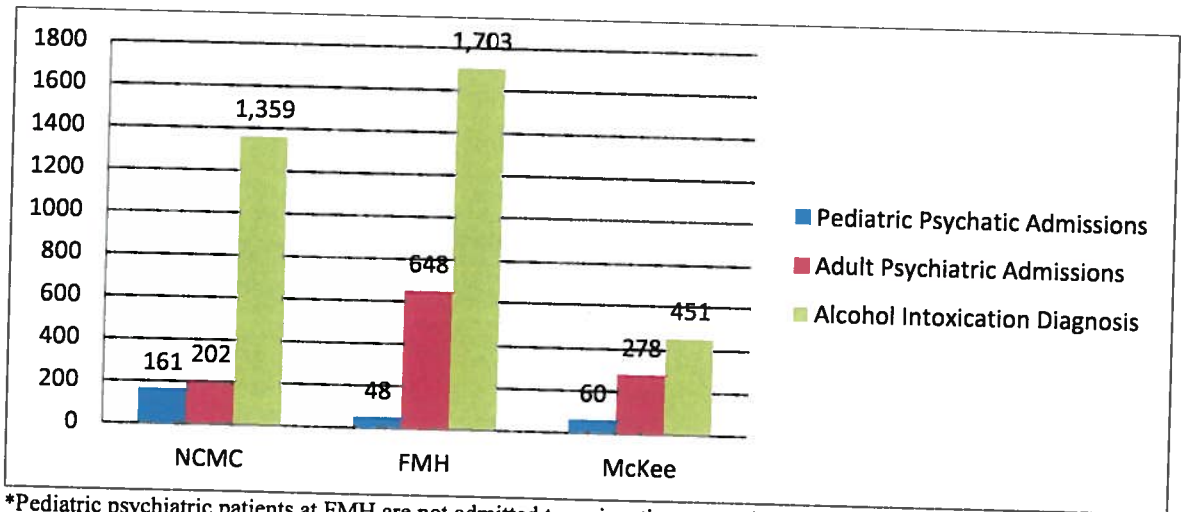


Our final question in the survey asked for staff feedback to what they thought would help alleviate some of our problems with violent patients in the Emergency Room. The majority of answers addressed problems with communication, the presence of security in the department, ways to alert security immediately from within the department and more applicable education for the violence we face on a daily basis.

In 2012 NCMC reported 45,558 ED visits FMH reposted 35,466 visits and McKee reported 23,249 ED visits. (L. Miller, personal communication, August 2, 2013).



Of these visits, NCMC reported 161 pediatric psychiatric admissions, 202 adult psychiatric and, 1,359 alcohol intoxication patient diagnoses from the ED. FMH reported 44* pediatric psychiatric transfers, 648 adult psychiatric admissions, and 1,703 alcohol intoxicated patient diagnoses from the ED. McKee reported 60 pediatric psychiatric admission, 278 adult psychiatric admissions, and 451 alcohol intoxication patient diagnoses from the ED. (L. Miller, personal communication, July 25, 2013)



*Pediatric psychiatric patients at FMH are not admitted to an inpatient room due to the fact that there are no accepting providers for these patients at FMH. Pediatric psychiatric patients are medically evaluated in the FMH ED, held in a secured room and transferred to an accepting facility when a bed becomes available. The pediatric FMH pediatric value is based on transfers not admissions.

CONCLUSION

Preparing staff to handle the volume of aggression at the bedside will take a multifocal approach and commitment by staff and management for improvements. Currently, FMH ED participates in a mandated NVCI, nonviolence crisis intervention, class that certifies departmental staff on a yearly basis to national standards of restraint use and basic de-escalation of aggressive patients. "A strong, comprehensive violence prevention program requires an interdisciplinary team approach with clear goals and objectives suitable for the size and complexity of the workplace." ((Gacki-Smith 2009). Management of Aggressive Behavior (MOAB) Training International, Inc was a suggested training program that "presents principles, techniques and skills for recognizing, reducing and managing violent and aggressive behavior. The program also provides humane and compassionate methods of dealing with aggressive people both in and out of the workplace." (http://www.moabtraining.com) 3 Exploring alternative workplace violence training to the NVCI coarse for security, the ED and psychiatric units could lead to safer outcomes for staff faced with high levels of violence at the bedside. FMH ED wants to be proactive not reactive when keeping our staff and patients safe and are aware of the vital role education plays on our department's safety awareness.

Prevention is a key component in avoiding violent events against nursing staff in the Emergency Department and early identification of patient's with a history of violence was a priority intervention. We began to reexamine the use of the Threat Alert flag and how to apply its use in the ED setting. House wide, the History of Violence alerts were currently tagged to any patient that activated a Code Violet, but the charting form used in-house was different in the ED and not linking a flag to staff when the chart was opened. Secondly, for the majority of our violent patients, FMH's ED staff is intervening before a code is called with our ED Stat and Stand by Assist calls to security. These patients have a tendency for violence and need to be identified to staff on future visits.

The R.E.S.P.E.C.T. team created a Threat Alert form, (Appendix D), which was merged with the simultaneous work at Banner Corporate. We joined the review of policy #14061, Identification and Flagging Potentially Violent Patients Policy 6/2013 (Soba-Gonzalez 2013). We held the initiation of this form based on concerns from the House wide Practice Council with the establishment of an In-House Response Team, questions related to the process of review and removal of a Threat Alert and how our facility was going to implement the Threat Alert form. Our team was specifically concerned with the removal of a Threat Alert from a patient's chart when they are seen in our department without an incident. The social learning theory, biological theory of violence and frustration-aggression theory (Hodge 2006) all confirm that violent and aggressive patient responses are learned, neurologic, genetic or hormonal reactions to frustrating, unwanted, threatening stimulus in their environment. "A previous episode of aggression and a longer length of stay in an in-patient clinic are the most consistent 'predictors' of violence in psychiatric facilities. The systemic review further suggested that keeping careful records increases awareness of risk and improves risk assessments to prevent further violence." (Slade 2012). Despite the ED being an outpatient department, we felt this research to be valid as we continue to explore the need to identify patients with a history of violence, without compromising staff safety and respecting a patient's rights.

Positive outcome for staff, facility and patient care start with early interventions.

> "By addressing violence as a systems problem that can be addressed with systems fixes, facilities can attempt to eliminate hazards through preventive measures. This approach shifts the focus away from either blaming the victim or profiling patients as potential perpetrators…knowing your patient's physical and psychological factors may lead patients to behave aggressively. Assess patients completely for their potential for violence and take appropriate precautions." (Gilmore-Hall 2001)

Education, early de-escalation and prevention, again, are key components to detecting patients with a potential of violence or circumstances where violent acts are precipitated. Policies that focus on a team approach between admissions, security and nursing can help with identification of aggressive behaviors. The sooner we are able to recognize the early warning signs of stress, anger, hostility, pain and prolonged waits, the more focused our communication can be when empathizing with someone not coping in our environment.

Changing the culture of nursing to stop the violence at the bedside will take more than icons on a tracking shell and written reports indicating a problem. Change starts with good documentation by nurses to help identify a problem, it starts with management advocating for the best training for our staff and it starts with administration providing safety and security for our facility and lobbying for greater penalties against patients who choose to harm a health care worker. "A significant amount of workplace violence is preventable…programs should include leadership's commitment… employee involvement, worksite analysis… measures for violence prevention and control, safety and training for staff, to …ensure the safety of all health care workers, their patients, and visitors." (ENA 2010b) Change starts with commitment to be our best.

Based on the literature review, recommendations from other Banner facilities, and national standards for reducing workplace violence, we would like to recommend the following:

- A comprehensive security risk assessment of the FMH Emergency Department; with a focus on the throughput of pediatric and adult psychiatric patient include parking lots, entryways, triage, reception areas and staff hallways; identify escape routes and ways to summon help from local law enforcement for all staff; formulate a written plan describing how our institution provides for the security of patient, staff and visitors. (Chapin 2010)
- A full time security guard assigned to the Emergency Department. "Ensure that adequate and qualified staff is available at all times." (OSHA admin 2004)
- Implement a standard of care when addressing patients with a known history of violence, with Threat Alert notifications clearly identified on our patient's tracking shell. "Policy goals should focus on the science of preventing, predicting, managing, and measuring violent events in health care settings from all sources, particularly patients." (Love 2003).
- Educate Resource nurses, admission and security to a lockdown protocol where the Emergency Department is able to close the unit for a time period to visitors when patients propose a risk to staff or others.
- Creation of a threat alert form and review team based on Banner Health Policy #14061 (OSHA admin 2004)

- Signage on the front doors leading into ED for all concealed weapons to be returned to your vehicle or checked into security and education to our public regarding our zero tolerance policy for violent actions. Notification to the public that they will be removed immediately from the premises for any aggressive behaviors. "Hospitals should 'make it clear that no threatening or violent behavior is acceptable and no violent incident will be ignored." (Chapin 2010) (OSHA admin 2004)
- Implementation of an easier documentation system for online incident reports or changing the way these reports time out once they are initiated to encourage more accurate documentation of violent incidents. (ENA 2010a)
- Increase staff awareness of patients with a history of violence and triggers for violent activities, including education on how to address wait times with crowds with more comprehensive educational training. The Moab Training International, Inc has been recommended as the leader in training for professionals who need to know "how to protect themselves from injury, and at the same time, control individuals without causing them harm… (providing) its customers with the most innovative, comprehensive and effective non-lethal training programs and…(creating) a win-win situation in difficult confrontations and the ability to resolve conflicts decisively and diplomatically regardless of their age, size or strength." www.moabtraining.com (mission statement) I think it would be worthy to evaluate the possibility to send designated staff to a 3-day Instructor class offered by MOAB to be trained to instruct staff at our facility. (http://moabtraining.com)
- Send 2-4 staff members to the MOAB Training facility as trainers to return to the facility and teach staff members in high risk departments: Security, Emergency Department and Psychiatric units
- Education of staff to department standards for contacting a security officer, location of panic and call buttons, ways to call a Code Violet, ED Stat and ED Stand By, and include these protocols in the training of all new staff .
- Evaluate the process for blood draws at the bedside in the psychiatric rooms. Currently, our phlebotomists have to kneel at the bedside for blood collection in our seclusion rooms placing them at risk for injury either in the form of a needle stick or physical assault.(ENA 2010b)
- Evaluate the use of the current legal blood draw room with the potential to restructure space to meet department and facility security needs. Security has recommend the installation of a one way mirror or security glass window that would allow the officer in this posted position visual observation of the front door of the ED and parking lot, as well as direct access to our psychiatric hallway. By relocating an officer to this position we could accomplish department needs to have a 24/7 security guard available and direct visualization of the activity coming into the department. Security has requested video surveillance of our seclusion rooms to be added to this post. (S. Rice, personal communication, 2012). The legal blood draw area could be relocated to another area in the department to support the recommendations from security. The current officer at the front desk in the ED waiting room does have direct access to this hallway, but they are not stationed here on a 24/7 basis and are responsible for the security for the entire hospital and Denali Center.
- Security glass around our security officers, admissions staff, doctors pod and triage windows

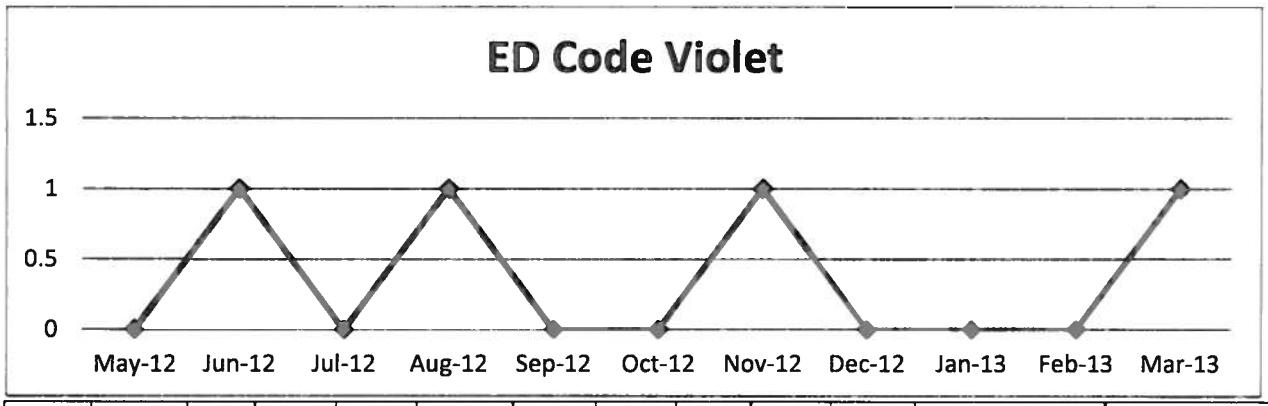
- Continued support by administration to lobby for greater punishments of perpetrators committing crimes against nursing and medical professionals. As a facility we must set a standard of care and have our medical providers protected by holding assailants accountable for their actions in the great state of Alaska. (ENA 2010a)

Appendix A

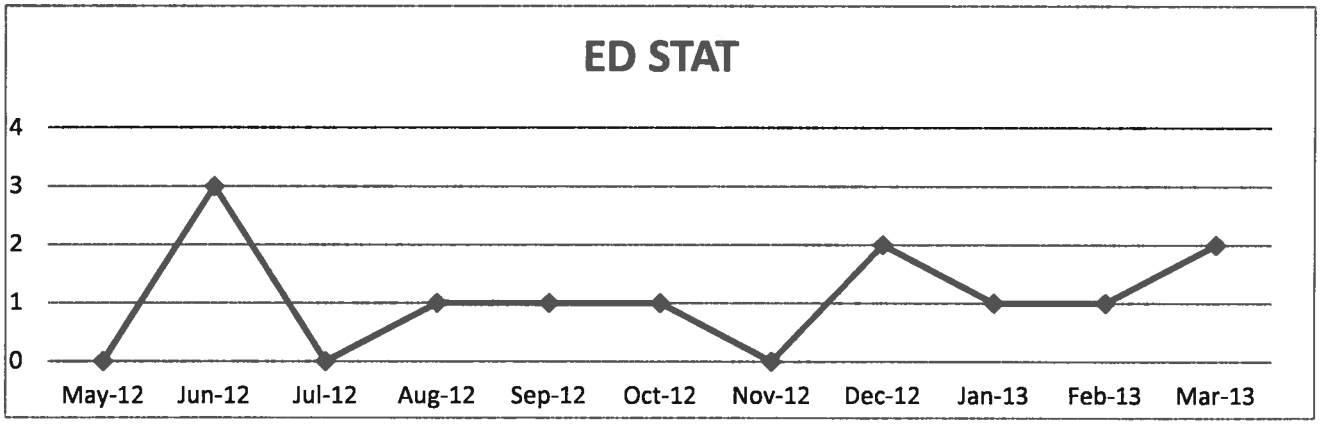
Safety Events Form

Incident Date (DD/MM/YYYY)	**Incident Time**
Location of the Incident □ Admitting/triage areas □ Corridor/hallway/stairwell/elevator □ Entrance/exit □ Patient room	□ Nurses' station □ Waiting area □ Seclusion/time out room □ Other (specify):
☐ **Verbal**	
Who or what was threatened?	**What was said?**
☐ **Physical**	
□ Bitten □ Choked/strangled □ Grabbed/pulled □ Hair pulled □ Hit by person (punched, slapped) □ Hit by thrown object(s) □ Kicked □ Pinched □ Punched	□ Pushed/shoved/thrown □ Scratched □ Sexually assaulted □ Shot/shot at □ Slapped □ Spit on □ Stabbed □ Voided/Vomited on purposefully □ Other (specify):
Were weapons were used? ☐ Yes ☐ No	Type of weapon used:
☐ **Physical Injury**	
□ Head/face/neck □ Arms/hands □ Abdomen/chest □ Back/shoulder □ Hip/buttocks/genitals □ Legs/feet	□ Abrasion/scratch □ Bruise/contusion/blunt trauma □ Exposure to bodily fluids □ Internal injuries □ Laceration/cut/puncture □ Sprain/strain/spasm □ Fracture
Describe physical injuries.	
Any property damage ☐ Yes ☐ No	**How was the perpetrator handled?** ☐ Incident was defused
Police Notified ☐ Yes ☐ No	☐ Perpetrator voluntarily left ED ☐ Perpetrator was escorted out of ED ☐ Perpetrator was arrested
Would you like any other treatment/assistance? ☐ Employee Assistance Program ☐ Medical evaluation ☐ Debriefing – individual ☐ Debriefing – team ☐ Other (specify):	Patient Label
Any other information you would like to include?	**Soft Med Report** ☐ Done

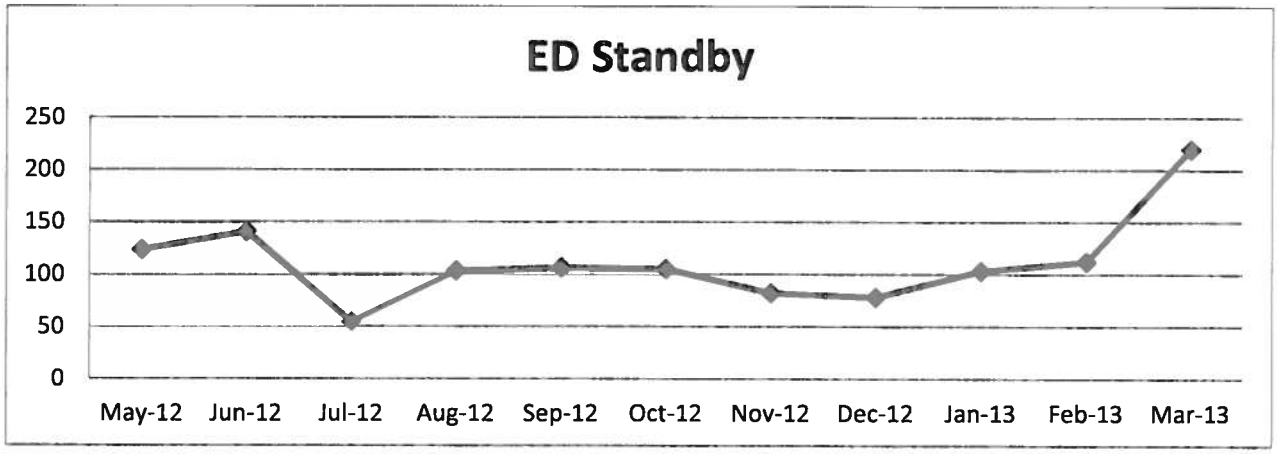
Appendix B (created by J .Lowinski FMH Security Gaurd)



May -12	Jun-12	Jul - 12	Aug -12	Sep -12	Oct-12	Nov -12	Dec -12	Jan -13	Feb -13	Mar -13		Year to Date
0	1	0	1	0	0	1	0	0	0	1		
1			1			1			1			4



May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov -12	Dec-12	Jan-13	Feb-13	Mar -13		Year to Date
0	3	0	1	1	1	0	2	1	1	2		
3			3			3			3			12



May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		Year to Date
124	141	55	103	106	105	82	78	103	112	220		
320			314			263			332			1229

Appendix C

A survey of FMH's Emergency Room

evaluating a patient's history of violence*, towards *nursing staff.

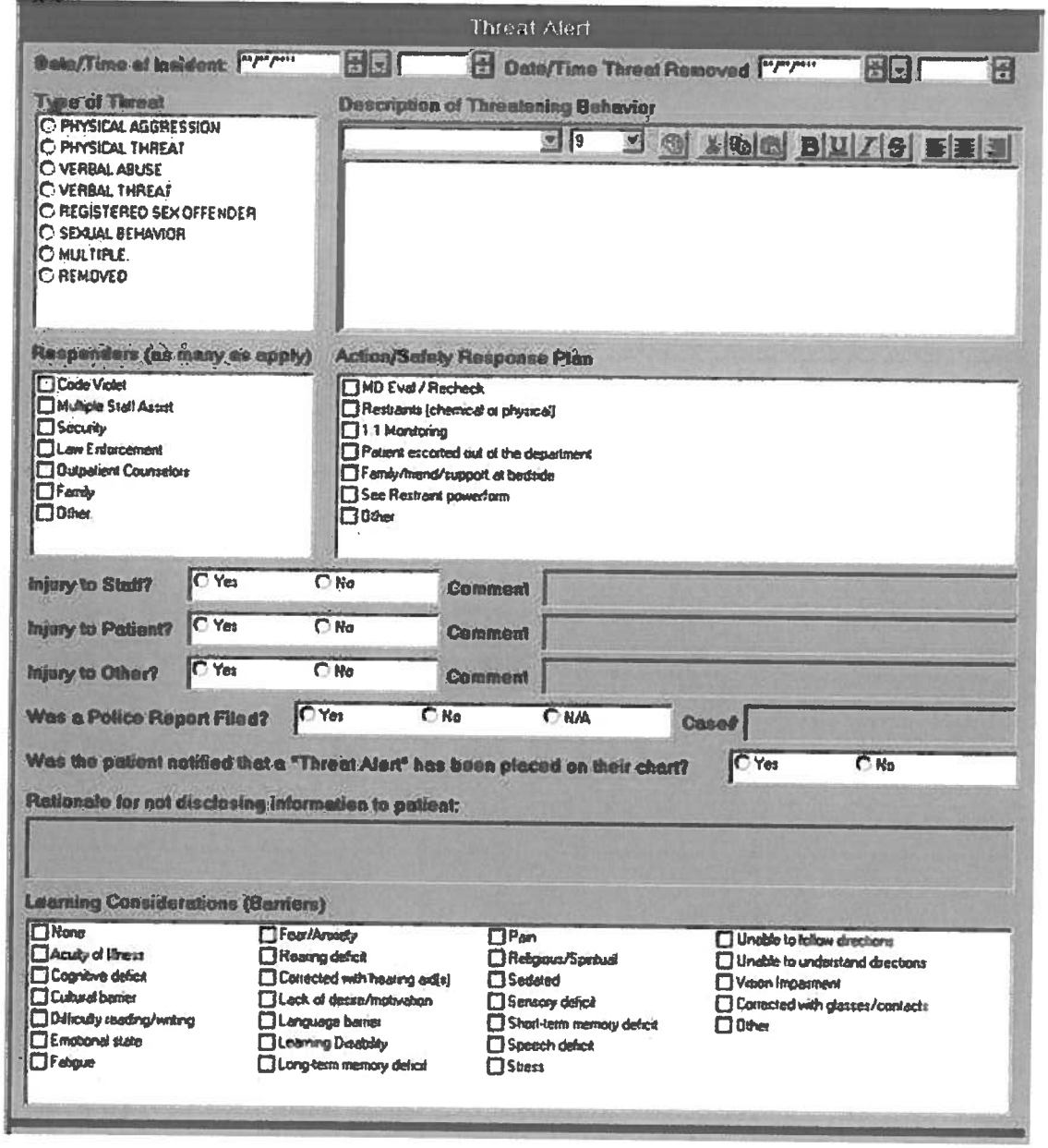
1. **Have you experienced verbal abuse working at FMH's Emergency Department from a patient?**
   Yes No (Circle One)
2. **Have you experienced physical abuse working at FMH's Emergency Department from a patient?**
   Yes No (Circle One)
3. **Were you injured in the last year as a result of physical violence from a patient?**
   Yes No (Circle One)
   If yes, did you report the injury?
   Yes No Sometimes Most of the time (Circle One)
4. **Have you experienced sexual misconduct working at FMH's Emergency's Emergency Department from a patient?**
   Yes No (Circle One)
5. **Do you report patient's abusive behaviors?**
   Yes No Sometimes Most of the time (Circle One)
   Why did you not report patient's violent behavior?
   - It was a minor abrasion, redness or bruise?
   - Forgot
   - Too busy
   - Documentation program is difficult to use
   - Violent abuse is part of my job
   - I was concerned about repercussions from management
   - Other (explain)_____
6. **Do you feel safe at work overall?**
   Yes No Sometimes Most of the time (Circle Once)
7. **Rate how safe you feel in each of the following areas:**

Area in ED (circle one for each area)	Not safe				Safe
Triage	1	2	3	4	5
Exam rooms (non critical/non pshych)	1	2	3	4	5
Trauma Rooms	1	2	3	4	5
Psych holding area	1	2	3	4	5
Fast track	1	2	3	4	5

8. **Do you feel the level of violent activity has affected your job satisfaction?**
   Yes No Other
   (explain)_____
9. **Do you feel hospital security personnel are effective in preventing violence against staff?**
   Yes No Other
   (explain)_____
10. **Do you feel the amount of time security spending in the ED is adequate to prevent violence against ED staff?**
    Yes No Other (explain)_____
11. **What do you think would help alleviate some of our problems with violent patients in the Emergency Room?**

    _____
    _____**Thank You!**

Appendix D



*After review from our House wide Practice Counsel and Risk Management we made revisions to this form, removing any information that could link a victim's identity in a medical chart.

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