Podcast Transcript

Violence in the Healthcare Workplace

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Guest

Gordon Gillespie, PhD, DNP, RN, CEN, CNE, CPEN, PHCNS-BC, FAEN, FAAN

- Registered nurse for over 25 years working in emergency department, public health, and academic settings.
- His research on workplace violence against healthcare workers has been funded by the CDC-National Institute for Occupational Safety and Health (NIOSH), Robert Wood Johnson Foundation, American Nurses Foundation, and Emergency Nurses Association Foundation.
- Invited by the CDC-NIOSH to develop an educational program on workplace bullying and consult on two national online learning modules.
- Chaired the national workplace violence conference, guest edited an interprofessional journal issue on workplace violence, co-chaired the Registered Nurses' Association of Ontario's second edition of the Best Practice Guideline "Preventing and Managing Bullying and Violence in the Workplace", and served as an international Director of the Emergency Nurses Association.
- Currently he is a Professor and Associate Dean for Research at the University of Cincinnati College of Nursing.

Host

Jannah Amiel, MS, BSN, RN

- Senior Product Manager with Colibri Group
- Visionary nurse leader with extensive clinical experience in high-acuity hospital settings
- Education expertise in pre- and post-licensure nursing education and leading organizational teams in building and developing products and talent.She is the founder and nurse educator of an online bootcamp-style course experience that prepares pre-licensure nursing graduates to pass the NCLEX-RN and enter the workforce.

Transcript

Episode 1 – Identifying the Risk of Violence

(SOUNDBITE OF MUSIC)

GORDON GILLESPIE (GUEST): we definitely have risk factors and we also have a culture of acceptance. And that culture didn't start overnight. It's come over years and years. And when I started in emergency care, it was like my second year in practice and it was so is probably like 1997 or 1998. Like in January I started working in the ED and then I had coworkers who were physically assaulted by an adult male and the violence was so severe that two of them suffered fractures, one had an arm fracture, and the other I don't remember what was broke.

(SOUNDBITE OF MUSIC)

JANNAH AMIEL (HOST): Hi, I'm Jannah Amiel, and thank you for joining us for another episode. In this podcast we will be talking about violence in the healthcare workplace. Risk factors will be described, and we will delve into strategies to manage this violence as well as actions we can take to mitigate the impact of workplace violence. Joining me is Gordon Gillespie. Nurse. Congratulations, I'm also a nurse. RN for over 25 years. And I understand you worked in the public health, academia. You've done a ton of research on the topic that we're going to be speaking about, workplace violence, that's been funded by some big organizations. What else can you tell us about yourself?

GORDON GILLESPIE (GUEST): Say that. So, it's kind of like a claim to fame might be a bit of bragging rights, but I still enjoy saying it that I've had practitioners and researchers across six continents cite my work.

AMIEL: Amazing

GILLESPIE: No one from Antarctica, but of course no one's allowed to live there. So that kind of makes sense.

AMIEL: So you're only a little bit famous?

GILLESPIE: Yeah, it is. A little bit. If I could just find a way to get a permanent resident down to Antarctica to see me, then I'd be all set. But. But I think what really matters for that, I think, is the fact that it's not nursing alone. It's other professions, business, industry, lots of different professions outside of healthcare have looked at my work and used be able to use those findings to transform their work environments to be a safer, healthier workplace.

AMIEL: Yeah. And the work that that you're talking about really is the work that you've done around workplace violence, which we're going to get into. And I kind of have to take a moment to [inaudible] because it feels like one of the conversations, you know, the drum we've been beating forever in nursing, let alone healthcare. And it kind of feels like maybe we're getting attention, maybe we're not like maybe we're solutioning it, maybe we're not.

But it's a big topic. It's a loaded topic. And I think right now in the state of the world. Right. And kind of like what we're all witnessing and experiencing. It's come to the forefront again. It's come to the forefront again. So, let's talk a little bit about workplace violence and defining that. What is that?

GILLESPIE: So I would just kind of first want to add that I definitely see a major shift in people having open conversations. I think a lot of that started with the American Hospital Association. I went to a stakeholder

meeting in Chicago, like probably six or so years ago, maybe seven. And we learned at the time that prior to that year, the (AHA) American Hospital Association told their constituents not to discuss workplace violence.

Don't use the construct anywhere in paper in. So if you're not even allowed to have a conversation about it, it's really challenging to do something to prevent it because you can't prevent something that you can't talk about. And so I think their shift in ideology to saying we now recognize workplace violence. We want our stakeholders, our constituent hospitals say 4000, 5000 hospitals across the country to start discussing it and mentioning it. And that was really a shift. And then they actually had I think they were our host in Chicago, along with the Emergency Nurses Association, the American Nurses Association and the International Association for the US Hospitals or Health Care, Safety and Security. I always kind of get their name wrong, but it's HFCS is the acronym. But with all of us together, we're really going to be able to start talking about what can we do as groups partnering to try to tackle the problem.

And I think that was probably really the probably really the number one thing that I think nationwide really kind of helped. And in terms of the actual definition, NIOSH, which is the United States National Institute for Occupational Safety and Health, they do have a formal definition and they define workplace violence ranges from offensive and threatening language to homicide.

And they also say that as violent acts, including physical assaults and threats of assault directed towards persons at work or on duty. And the thing that people sometimes look at is that there is no such thing as verbal violence. There is verbal abuse. And most nurses I know always talk about verbal violence. And now that I work a lot with criminologist, people in criminal justice field and psychologists, they let me know that violence is a criminal term.

It's a legal term, but verbal violence, you can't go to a court and say, this person verbally assaulted me and they should go to prison or go to jail. And so a better construct, a better word is verbal abuse. And the reason I bring that up is in the definition from NIOSH. They don't talk about verbal, but they do say including physical assaults and threats of assault, which really lets you know that acts of intimidation, sexual abuse, verbal abuse, that is a form on a continuum of verbal violence, or excuse me, a continuum of workplace violence.

And with all that allows people to remember that, well, you might say, I've only been verbally abused. I only had racial slurs. That's actually a significant assault, not in the legal sense that you can go to jail or prison or be prosecuted, but definitely in the sense that needs to be eradicated and we need to have systems in place to allow our patients of business the right to exercise our freedom of speech, but do it in a way that doesn't cause repercussions to them and the ability to receive safe care and safe practice.

AMIEL: Right. And it's my understanding, too, that when we talk about workplace violence, I believe it was the CDC even broke it down into different types. I think I saw criminal intent, client on worker. Can you talk a little bit about this and how we're breaking up the types of violence aside from that verbal abuse that you're speaking of?

GILLESPIE: Yeah, and I think a lot of that started actually with the California Occupational Safety and Health Administration. I have a colleague that was on that initial panel with the University of Iowa, and they came up with this typology. And there are four types and which are different from categories. Categories like verbal abuse, sexual abuse, assault. Right. But the typology is really the relationship of the target.

Who is the worker in terms of who the aggressor is. In type one is criminal intent. It doesn't happen as much in traditional health care because usually we're not dealing with people of criminal origin. However, some places are set, such as if you're an advanced practice nurse working at a clinic, in a grocery store or in a pharmacy, or if

you're the pharmacist themself, you can have people that come in because they're trying to get to opioids or other narcotics. Or when I worked at a children's hospital, we had nurses who had their purses stolen because they were stored in an area where patients got access. And so that is criminal intent. They're not there to receive health care. They're there to get something. But they can also be in the parking lot. You might find a night shift. I used to work nights there for a long time. And our primary role for hospital security was to patrol the parking lot and guard our vehicles because nobody wants their radio stolen, their windows broke out. And so that would be an example because I'm at work, I am on duty myself and my property that becomes workplace violence in terms of type one? Type two is the one that historically has had the most attention over the continuum.

And I think there was a physician name I think is I think his last name was Durbin. It was like back in maybe the seventies, actually first talked about physical assault from patients or visitors. And so type two is more about they call customer oriented, or patient related violence. And that's really where you have a person has a legitimate reason to be there and they're there to receive care such as a patient or the patient's family members or other visitors. Most often that manifests from the patient. Which kind of makes sense given that patients are always in the facility you're at, and visitors may or may not be there. So just by sheer volume and normality, you'd receive it from patients and by patients. And that tends to display more as physical assaults that's reported. But we do believe that based on research evidence that I've done research and articles I've reviewed, that the highest prevalence is really verbal abuse.

And whether it's name calling or it's just lewd comments that might personalize that sexual abuse versus verbal abuse, a little bit of definition in there. But a lot of it's these words also like hitting, biting, kicking, punching. A big misconception is the intent. And what I dealt with a lot, especially when you work with older adults or pediatric care. So both of us have probably seen this. The two-year-old bites you is is that workplace violence. And I would say absolutely. It's absolutely workplace violence because it's an act of assault. Had a 30-year-old you at a grocery store would you have said that's a normal thing in a grocery store. You would be upset you'd be like call the police. This person bit me, but a two year old in a hospital, it can be expected and you can look at and say, no, there's no intent. They didn't want to intimidate or intentionally harm you. They want to do to stop something such as inserting indwelling urinary catheter. And spurting intravenous catheter to start IV fluids. Like it makes sense that they're upset and they bit you. But it's still definitely violent because if I would say this little baby Gordon or two year old bit Jannah last week beat Andrew the week before, would you do anything differently?

You'd say, Of course, I'm going to have extra people come in and help hold that, because, you know, it's not normal. You're not going to report it to the police. You better not bite the kid back. That's definitely not good. And I've been involved in having to manage that event before, and that's just not good. But you wouldn't do anything to the person, just like an older adult who has dementia, Alzheimer's. They might slap you when you're trying to do care or an assessment. It's not intentional, but it's still an act of workplace violence that we can implement interventions if we know about it to do better. And so it's again, it's about the action, not the intent.

AMIEL: Yeah, that's a really good point.

GILLESPIE: In type three, is I just can't think of like coworkers essentially, but it's in nursing most like, and that's what's given more attention nowadays, and that's like bullying. It's sometimes they say the word wrong, so I'll try to say it better. It sounds like I say bowling. Bullying. And so you get these negative behaviors and some people define that.

You can't say you've been bullied unless it's happened persistently for six months. But me, like I don't worry about that because in order to change something, how many times do I have to hit you for it to be bad? And if you're getting bullying behaviors, it's more about the behaviors, because also bullying by definition implies intent. And again, workplace violence is not really always about the intent. It's about the act. Did the act occur? And if you're receiving bullying behaviors, those should be stopped. But that's definitely between coworkers. You can still have assaults and have other categories of violence. It's just which one predominately occurs. And historically, when I was early in my career, I've been a nurse for I think it's 26 years now, and historically it was really more from physicians, but it was also the background I work with emergency care. So they're throwing a stapler or at you. They're trying to do head sutures and like is that really more of an assault or is that bullying? But really, they're doing it to be intimidating more than anything else, right. But nowadays, I think what I've learned is that it tends to be more often between nurses. And nurses will say things such as I want to make sure that they really know they have to do this and I'm trying to protect the patient.

So although it was incredibly humiliating with them on the floor, it was to teach them because in true essence, we do know that if you have an emotional injury where something kind of scars you, you will always remember it. And just think about a person who tries to attack you. You're going to remember that. And so if I can create emotional memory, that's going to be much longer lasting than an educational memory.

So just like Gordon, this is how you do the IV, right? But if I said, Gordon, you are so stupid, you have no idea what you're doing. You will always remember that and you probably will definitely do it right the next time. But also that intimidation creates a hostile work environment, which has other untoward consequences. But just but it's definitely type three. Type three is that coworker aggression or coworker violence between workers current or previous. And so it can be someone that used to work there. They don't have to currently be employed and they can still be coming back into the workplace. And that's one if you think about the old days, use the term he went postal, or she went postal like the post office worker would come back in. And nowadays we're seeing active shooters. Yeah, former employees are coming in unfortunately on a regular basis. And so those previous employees coming back is still part of type three workplace violence.

Then the final category type four one that's really infrequently studied. And I think it's just do the nature and that's about relationship, personal relationship violence. And with personal relationship, it's most often intimate partners, current or previous.

It could be a spouse, it can be a boyfriend, girlfriend. Doesn't really matter that definition, but really it's somebody that's in a personal relationship outside of just a normal collegial relationship. And I think the reason that category tends not to be focused on is because some people perceive it as it's not the work's job to manage your personal affairs. However, when that person comes into the workplace where they're calling in every 30 minutes and they're harassing the employee, it's where the employee gets in trouble because they keep taking these personal phone calls that now is broached into the realm of the workplace environment and how it impacts care. And that's an area that I really believe that it probably happens a lot more.

And there's also, I think, that sense of shaming. And do you want to tell your coworkers, my boyfriend or my girlfriend is harassing me, or I'm being abused at home and this person's calling me. Or the person's coming into the workplace and maybe try to physically intimidate you. But when it comes to you as a target, they also may potentially harm other employees.

And that's the reason why we can't ignore type four the person. Relationship violence is because there is a strong risk for others, particularly if it's an active shooter event. They're going in for their partner. Who else are they going to injure on the way in and on the way back out?

AMIEL: Yeah. And you know, speaking of risks and speaking of something, you said it really stuck with me. Right. And I chalked it up to even though it might be expected from that person for whatever reason, whatever they have underlying that we expect this type of response. Right. It should not be accepted. Right. So that's my big takeaway there.

And so I'm curious like what is the reality then around that? Because I certainly and if that you can too, can think back on patients and think back on experiences where there was a lot of underlying current, a lot of things just orbiting around that patient that you expected a potential response in this way. But, you know, really, truly like what are those risk factors? Where are we seeing this happen most often and kind of what's the driving thing here?

GILLESPIE: So I think part of it, so we definitely have risk factors and we also have a culture of acceptance.

AMIEL: Yes.

GILLESPIE: And that culture didn't start overnight. It's come over years and years. And when I started in emergency care, it was like my second year in practice and it was so is probably like 1997 or 1998. Like in January I started working in the ED and then I had coworkers who were physically assaulted by an adult male and the violence was so severe that two of them suffered fractures, one had an arm fracture, and the other I don't remember what was broke.

And so they did prosecute. The prosecutors, work with them. And it's also kind of rare for police to take a report. And if you do, you've got to go to the police station. So there are systemic, systematic barriers to you reporting. But the prosecutor did not drop charges, went forward. And at one point the judge finally just dismissed the charges. He said it's kind of like other duties as assigned is part of the job, which is kind of offensive. Because if you break my arm, it's legal. But if I spit on a police officer, that's a felony offense. And so how do those how do you reconcile that? And so when you hear that, basically, you don't count. You just think, you know what, you own it up.

And when I first met my dissertation chair back in the day, her research was focused on workplace violence and she was talking about it. And I was like, Oh, it happens all the time. And at that point I had literally been assaulted over 100 times by definition. And not verbal abuse, actual physical assaults. And part of that was one of my risk factors is fact that I'm a man and I work in a predominantly women populated or women people profession, which is nursing. Men account for maybe 10 to 12%.

So the majority of your coworkers will be women. And the Department hospital I worked I was only one of three men in the building on a typical given night security officer, probably the physician and then myself. And so if a violent patient were out anywhere in the building, it was like they called the violence response team and during the day shift that included the maintenance man because there was always a man. And so the maintenance men responded to manage violence, which in hindsight I'm like, he's not allowed to bring a wrench with them. So what exactly is he going through? But it was really we just want manpower as opposed to people power. And over the years, I've taught folks how to leverage the strength of a woman that may or may not be as strong as a man to depend on the situation and still manage some really aggressive men and do it in a way that minimizes injury to all.

But in that situation, because I was a man, I was pretty much if there was an event in the building, we need help. Gordon, come. As a man in my in my culture, how I grew up Appalachian. You don't just say, you know what? I'm hundred percent believe in equality, so therefore do it on your own.

AMIEL: Right?

GILLESPIE: Like, even if I believe in equality, I still need to respond because that's kind of machoism or it's a man's job to help protect women for this type of situation. So I responded, but all of that over the years led me to believe that is just accepted. And so as a result, I got put in harm's way.

And when I met this researcher, she's like, she's looked at me like, you make no sense. And this is a faculty member, tenured faculty member. And I'm like, Well, that's just how it is. And she goes, That makes no sense if you're going into a grocery store. Do you think the shopping clerks or do you think telemarketers, anyone else in any other industry, even police, would they just say, yeah, it's okay, just get assaulted?

And I said, Well, no. So then she got me changing my thought pattern. I've done it all my research. I include a component about what do you think about it? And for the most part, most everyone says they have some level of acceptance. And I think it goes not just because of the bigger system, the judicial system, the law enforcement system.

It's not maybe that they may or may not be helpful. I think that really varies based on who the individual is or who the prosecutor philosophy is. But at the institution and if you report a violence, what happens? If you don't report it, then no one can do anything about it and it becomes this hidden problem. And then as you try to get people to report and I did one of my studies, my dissertation. When I was doing that study, some people said, you know, I don't know why we're bothering to do this because nothing's going to change. You're asking us about the problem and we're telling you. And part of it was just trying to get the reporting to increase because if we can get the reporting to increase, we can then design effective interventions that have local context to prevent. Because it might work at that hospital on the left, it won't work in the hospital on the right because the causations are different.

So the more data we get, the better we can do to prevent. But at this hospital, because when they found out my job wasn't there to correct it, it was to provide a report back to the hospital. Then the reporting immediately dropped in it. And it actually, the reporting got worse. We're doing all these efforts to make it better and it actually got worse.

And we found out that was one that people said, if you're not going to actually do something, you're just wasting our time. So why report? It just makes us angrier than it was just by being victims. I'm happy being a victim than I am being a person that's been heard and then dismissed. So I thought that makes sense. So in terms of I'm just going to jump in the risk factors that are right for it.

AMIEL: Go for it. Yeah.

GILLESPIE: So one of the risk factors that most everyone knows enough when I do lectures or I'm just chatting with folks, they always bring up mental health, disease and disorder. So it's quite often schizophrenia or the bipolar disorder, something that's really going to affect a normal response for what I would deem as like a normal reaction. And they process differently with their brain.

And if they're not, their therapy, whether it's medication or other, if it's not well maintained or well managed, they're going to their perception of the world is going to change. And then they can start to act out more aggressively. And some folks may say that's their fault, it's intentional. Some folks may say, oh, it's part of their brain chemistry, it's not their fault.

But again, that goes to intent. It doesn't go to the fact that it still happens. Other things are things like substance abuse disorders. And people don't always think about it. But smokers, if you have a tobacco addiction and you come in the facility, whether it's emergency department, you're only going to go out a few hours, maybe, maybe 8 hours but in the inpatient setting you might be told you going to go without four days. It's an addiction. And as you start to go through withdrawal, you don't act as normal as you normally would. You don't manage stress as well, because if your stress mechanism is to smoke and you've been you've now lost your one mechanism to manage stress, you're no longer having a, you don't have a way to do that.

And what I would say is most people, when I ask about things like prevention strategies, so what do you do with a person like how close do you stand? I'm like, Oh, I always maintain a safe distance. And when people always kind of ask how far that is, I always tell them it's spitting distance from personal experience.

AMIEL: That's subjective, I guess. And how fast you can spit it is.

GILLESPIE: But but at least likely to be like can you conceptualize four feet, six feet? They have to think about it for a while. But if you think how far can you spit, that's also probably how far you can swing your arm, or how far a person can kick. So if you're at least that distance, you really probably want 4 to 6 feet.

And I think most people could probably only spit a couple. But if you're at least that far away, you're less likely to be punched or kicked without having a chance to at least move away. But most people always know there are certain things you always do for mental health patients, but they don't think about other risk factors, such as a person who is experiencing pain.

I've got it. And we found some of our research that about half the patients that or about half the employees who were physically assaulted were from things that you would always expect, such as they've got a mental health, disease or disorder, they have a previous history of violence, or they're potentially there with a partner who is abusive. And so you kind of get stuck in this situation where the aggressor and the victim and you're like in the middle, and all of a sudden you become assaulted because of that relationship and you got in the middle of something.

People always kind of think that really makes sense. Or if they came in with a weapon. If a person comes in packing a firearm, there's a good chance that they're more willing to use a firearm than a other person. So that definitely increases risk. But they don't think about people that come in with dental pain or abdominal pain.

And we actually found a large portion of our sample of nurses and physicians and patient care attendants who have been assaulted were by these other complaints. And I always kind of believe part of that is I know the mental health person is at high risk to assault me, so I'm going to do things to protect myself. The abdominal pain, the toothache.

They'll never hit me. That makes no sense. And so I get in their personal space, and if they're experiencing crisis, they don't know how to manage the pain response. And I believe pain is a normal human response as part of our body, whether it's good or bad, I think it's normal. There's extremes that you can't live with that becomes horrible.

But when people don't know how to manage that stress of pain or other crises, we get in their space and we're not thinking about protecting ourselves. And so then that becomes this risk factor where it starts to become more and more. Everyone should be presumed to have a risk to become violent. And I think about it like a construct. You say universal violence precautions. We have universal bloodborne pathogen precautions. You assume everyone has HIV, you assume everyone has hepatitis. Nowadays, you assume everyone has COVID

when they come in the door until proven otherwise. I mean, it's a new world, but you don't assume everyone can become violent. And we really should. Because if you assume that Gordon come in and he can just assault you at any second, would you interact with me differently?

You probably would. You might not say what you were about to say. You might think, you know, that's probably not the nicest thing. I could probably rephrase that. Or when this person is asking for something instead of saying no, or I consider saying heck no, as some people might even say, it could just rephrased and say, you know, we would like to however, there is these limitations or we can't prescribe 200 tabs of this, or it's not indicated to do a full body CAT scan because of the radiation, we're not probably going to find anything. And that puts you at more risk. And I think if we could explain things to people that can really help. And so as a result, we don't think. Then there's other things that are risk factors. A big one is situational crisis. Then I look at it that is much as I would love to eradicate violence hundred percent. It will never completely go away.

And I had some people that I worked with that I did a research trip to Cuba. Back, I think it was like 2011 or so. We went to Cuba with the group of emergency nurses, and my angle while I was there was to look at workplace violence. And it was the hard thing for the Cuban community, the nurses, because they said they don't understand what that means.

The way at what point myself and the president of the Emergency Nurse Association, we were there pretending like to box and they were like, no, that would never happen. Why would a why would a patient ever hit a nurse? I'm like, well, it happens a lot in the United States, in other countries. And they were just shocked. But I think a lot of it is the cultural differences.

But they also they think about things and they know about situational crisis and they assume everyone's going to act out. And so what they do is knowing that a person is going to act a certain way. Like if you become been diagnosed with the physical disability or you've had a major car crash or car trauma and you expand cord injury, not going to able to walk, you're probably going to assume that person is going to be upset.

You can't walk. You can't drive. You probably can't keep your same employment anymore. What's going to happen to your world? You're not going to see. Know what? I'll be okay. I'm sure somebody will help you. Just go home and have a good day. That's probably not going to happen. They're going to become upset. They're going to scream. They might be cussing. It's not just going to take it out on you because you're there, but it's not because of you. It's because of the crisis, the situation. And so there in Cuba, they were like we talked to families early on. And to patient’s say, we know you're going to act this way. We know it's normal, but we're going to ask you not to do those things because that makes us fearful to take care of you.

That could cause harm to us. And if it does, then there's no one here to take care of you. But this is how you can do when you're feeling this way. This is what you should do. And we know it's going to happen and it's okay. But when it does, this is what we want you to do so that we can help you to be safe and for us to be safe.

And it's a very proactive way. And if you really think about it, it really is that idea of everyone can act out very smart. And then there's things such as age and gender. And I look back at when I was younger, I had a whole lot more energy. I just hit my 50th birthday last month and it's like I am nowhere near as just as robust you could say as I was when I was in my twenties and when a patients would come in, I was like bouncing off my chair. Person came in like maybe leg came in first. The other leg came in and then a little bit later the front of the body came in. and we were resuscitating, actually survive this person.

And it was like I thought it was just all exciting to have the person come in and pieces like this really not normal. But I was adrenaline junky at the emergency trauma center. What do you do? But with all that, I was really hyper and those kind of things don't always work well when you have a family under stress, right?

It's like, I really need somebody to listen to me and be empathetic. I don't need you acting like the man cheerleader in the crowd during this horrible time in my life. And so what I kind of look at is that nurses, with the more years of experience, they look at a situation and think, I want to live today. I think I'll act differently with that person.

AMIEL: Turn it down a notch maybe.

GILLESPIE: Yeah. And I'm thinking, yeah, I'm invincible. I want to go have fun. This is going to be cool. The other nurse is like, Yeah, I really just want to live, you know, live to fight another day. And so nurses with more years of experience look at the situation differently and they know how to mitigate risk and they still provide the care, but they're not going to do it the same personality type. Or they might just be able to look at subtle cues and say, you know, I've been hit enough in my life that looking at that guy right there, it just don't look right. And maybe we need to take someone else in with me because something about this, I don't know what it is, but something's not right. And I need, I need a backup person. Yeah. Whereas a gung-ho younger person. Yeah. I haven't really seen anything. This person looks like every other person, but they don't see those subtle signs. And used to kind of think that it was years of experience. But I think it's also just maturity and the more you age, you look, you have more experiences.

So I think it's coupled between both years of experience and just general maturity with age. And then one that I find fascinating and of course there's no strong evidence. It's more about my impression, but those who are married tend to have lower rates of assault. And I don't know that it's significant, but it's like that's the trend. And I think a lot of it is if you can navigate a marriage and stay married, you can navigate a violent person because you know.

AMIEL: I write that down and I'm going to tell my husband.

GILLESPIE: And I can say I've now been married for 30 years, so I got married in my teens to a lovely lady. And we've been married for a long time. And it's one of those you learn when to fight and when to walk away like I think it's a Kenny Rogers song or something about playing cards.

AMIEL: When to hold and when to fold. That's right.

GILLESPIE: Yeah, exactly. And so if you can stay married happily. So that's the challenge. If you're happily married and you can do that, you've done things and you've learned, is it really worth arguing a point that doesn't matter. And some nurses or the health care workers they'll argue the point because I need them to understand. And when I've done some research, I've had people say I needed them to understand why we did this. I needed them to understand why they were wrong.

And I want to say was you needed to have a rationale to be hit. I mean, it's not that it's really your fault for what you did, but you also increased the risk. And I think that's why if we can really navigate really healthy relationship up. You're practicing every single evening when you get home from work. You're practicing every single morning when you're fighting for the hot water, for the place to brush your teeth, or who's going to let the dog out before you leave, whatever it is. You've learned, the art of negotiation and tolerance and patience and listening, which is really important pieces. And that's why that's my reason why I believe that people that are really well partnered have lower rates of violence enacted against them.

(SOUNDBITE OF MUSIC)

AMIEL: In this first episode we have covered a lot of ground. We have come a long way in acknowledging that violence does exist in healthcare and research is being done on the topic. And we defined what violence is, and identified some risk factors. Join me for the next episode as we continue the conversation. This is Jannah Amiel for Elite Learning.

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Episode 2 – Strategies to Manage Violence

INTRODUCTION

GILLESPIE: ...As an employer, if you become aware of a trend or problems and you do nothing about it, you are going to end up being liable for the bad outcomes down the road because you chose to do nothing.

(SOUNDBITE OF MUSIC)

AMIEL: Welcome back to the second episode where we are talking about violence in the healthcare work environment. In this episode we continue our conversation with Gordon Gillespie, an expert in the topic. Let's begin with an interesting fact. Here is Gordon.

GILLESPIE: The odd one is if you've received violence training, you're significantly more likely to be assaulted.

AMIEL: Why?

GILLESPIE: And so I think that's the one you hear that it makes no sense. You've been trained and now you're going to be hit. But if you call for a violence response team, who's going to come? The trained or the untrained?

AMIEL: That's right.

GILLESPIE: And when I went to my research, when I got looking at one of the persons that we worked with, you had training. He had over 100 and was weird because like I had over 100 when I was younger before I realized that you actually can just move away and not get hit. But I didn't realize those things. But this other person had 100, a lot of other people had 20 to 30 over this period of time of a year.

And I looked at his occupational role. It was security. So he worked in a facility where he was the only the only security officer on night shift. So every event on his shift the entire year he responded and also he's helping to manage so he's more likely to get, and they weren't all like being punched and injured there's also pinches and slaps, hair pulls. Those things are violent. They might not cause a permanent injury or significant injury, but they're still considered an act of violence. And so a lot of it is our role and the fact that we're trained, we're now requested. Because you've been trained, you now need to enter into a potentially hostile environment.

AMIEL: So you're just more present. You have more opportunities to be in that scenario.

GILLESPIE: An opportunity is a great way to phrase it. You have the opportunity? Yeah. Lucky you. But you also had the opportunity to be assaulted, but also the opportunity to resolve the situation without injury to either party.

AMIEL: Yeah, absolutely. You know, I have to ask you, because as we're talking about these risk factors, right, and naturally we're thinking about the risk factors as they relate to the patient or somebody else inflicting harm on the clinician, the nurse, whoever that health care worker is. But when I think about things like mental health diseases and disorders, history of violence, all of these different components is factors that can increase the risk for violence. I'm also thinking about nurses themselves who have mental health disorders and disease and have a history of violence, and are also people who come with these real things. And I wonder if we forget that. We forget that we think about the direction of the violence being inflicted this way. But it can also be a combination of both ways, right, coming from both ways. And how does that play into this?

GILLESPIE: So a nice thing that the CDC, NIOSH, National Institute for Occupational Safety and Health, they now have a new construct called Total Worker Health, and I believe they like copyright, register it. But it's this really great construct where it really kind of helps to consider this very issue where if you're at home and you're having stressors, whether it's financial troubles, marital problems, which make you definitely horribly stressed, we all know that. And if you have a significant other parent or partner that dies, those are major life stressors that just throw your whole world out of balance. And even if you have a mental disorder or not, this is going to make you potentially more toxic or volatile, or if you've had illness, COVID, I mean, a lot of people are having COVID over and over.

So how do you manage that? Or if you have just diabetes or other health issues that can impact your ability to function in a way that you feel is healthy, you bring that to work and now you've got to be able to perform. But you have all this stuff at home and vice versa. If you've been assaulted at work, if you're having stress at work, you're exhausted from just the COVID world or the COVID nonstop rates and pandemic just ongoing.

All of that is exhaustion and burnout. Then you take home and you interact differently with people at home. And I've had nurses I know of that won't let their kids ride bicycles because they'll get killed by a car because they've taken care of so many kids have been injured at a pediatric trauma center. It doesn't happen that much in reality for the number of kids on bikes, but that's all they see. So their whole worldview changes and it impacts their home life. And so it's that idea of total worker health and it's an area that's growing greater prominence. And I think that provides some hope where employers can help work with our employees and the workforce to really look at are there risk factors within the individual that we can help manage.

And I think some of those is watching for the subtle signs. And you hear this phrase about if you see something, say something. That's really probably more in terms of terrorism and those things that really needs for everything. If you see something that don't feel right, if they don't look right, say something. And it might be that you say like, say, Gordon, you know, you're just not acting like your normal happy self. Like, do you want to talk about it? Like what's going on? And maybe I usually while medicated I'm under physical stress or I've had an infection and that's going to throw off all my doses in my body, my metabolism. So what was normally well managed is not being managed now and I'm starting to act differently. And it's when those people usually see it, but people have this concern that I don't want to upset them or offend them.

So I'm just going to say nothing. And then it becomes really volatile, really hostile to the point where now we're talking about corrective action termination, where if we see something that, again, if it just doesn't feel right, doesn't look right, just call people out. There's ways to do it respectfully and privately, like definitely not at the break room table.

So Gordon, like you seem kind of - whatever today. Like, that's not the thing to say. It's better to say, you know, get me partner or give me closer. Can we just talk for a few minutes? No, I'm just concerned for you. You just don't seem you're happy. Normal self. You don't seem hyperactive. Like normal like. Do you want to kind of talk about what's going on?

And, and then if I might say, yeah, something's happening and I can offer for myself, I would say I'm not a mental health specialist, so I can't offer service. But I can listen. I can be a good friend and I might say, you know, that's what EAP is for. It's confidential employee assistance program. Their services are free, they're confidential.

Maybe you can give them a call. And because of our pride as individuals, as professionals, or because of our stigma with mental health, a person's probably not going to take the number. They're probably not going to they have to tell you no, it seems, especially when you want to come off as the strong nurse, regardless of your gender or biological origin. You just want to be like, I can handle everything. And so what I've had employees in the past when they've asked that way. So you know what I'm going to do? I'm going to email you this phone number for EAP and because I'm emailing it to you don't have to receive it. I won't know if you received it.

You can delete it, you can keep it, you can print it. But if I handed them a phone number, they will never, ever take it because they can't. There is something with them they just can't accept it. Yeah, but I can email them a phone number or put in their mailbox envelope so that nobody knows and just remind that they're there to help you.

But what I found is that in addition to kind of identifying these individuals, that people that they tend to trust can help them. It's sometimes it's the chaplain. And what's really interesting is that people might say, you know, I will never go to EAP, but if Paul made rounds, I would definitely have him help. And he's like a real guy that I knew back in the day. And people just thought he was wonderful. Like he was the hospital chaplain. He came when all the kids had deaths and he would just be there and he would just sort of sit with people and you didn't have to say anything and eventually you just start talking. And he would be like you would go and he would say nothing and you would just like spill your guts. And you

AMIEL: All you needed.

GILLESPIE: Feel refreshed. And it was almost like maybe he was deaf. I don't know. But he is just. But that kind of person I think because they see how he interacts with family members and patients and other clients, that he becomes this trusting person and that becomes a person that they don't work with on the team. Because sometimes it's hard to have your team member provide any kind of counseling because they're not counselors, probably.

But then it's also I don't want you to know that I have weaknesses because that could that has been used. We have a weakness. If you're in a situation that's a toxic work environment and you have bullying being exposed, you now become a target of the work culture because you're not strong enough to work here. So we need to help you to leave so that we can have a strong group here.

And so there's a lot of reasons why people can't share. One thing I would say is that in terms of workplace violence, it's really about the aggressor. And it's kind of a narrow path in terms of do we look at it as victim blaming? A lot of people would say if we start diving into too much about the target, that we didn't go into victim blaming, which then creates more of a culture of acceptance and a culture of non-reporting which are both harmful.

But I do know there are some people whose personalities are just more toxic and they just haven't gotten the emotional intelligence or the maturity yet to learn how to navigate stressful situations. And so sometimes that's where there needs to be coaching from an organizational level, either one on one coaching, mock sessions where they can practice how to communicate effectively and how to get their needs met without escalating the situation.

And then sometimes it really comes down to is this work environment is not good for you. That you're just not going to be able because it's, it's a high stress like psych mental health this high stress emergency department sometimes labor or delivery especially if you're having a bad delivery or there's interpersonal violence involved, those can be really rough areas.

And your personality, we love you. You're an excellent nurse. It just seems that you're not meshing well and you're not able to navigate these relationships in a way to help protect you from harm. So we might need to make a decision to move you into a different area of the facility in order to have you stay safe, as well as the culture to remain safe.

AMIEL: Yeah. And there's a ton of work, I think we all know this that still needs to be done. It's a whole ball of wax in and of itself, on workplace culture and things like that, how we communicate, how we remember to be humans to each other. So that's a big component. I really want to do to bring up this point, because we've we've said the word, the C word. That's COVID. We said it a bunch of times. And here's the reality. COVID happened, and I strongly feel that for a lot of people, not just in health care, because, boy, were were we hit the nurses and the physicians and everybody else. Right. But COVID was the pulling back of the curtains and revealing a lot of things that maybe we hadn't seen or processed or digested before in healthcare.

Talk about culture, talk about the environment and in the world, quite honestly, and in the world. And that has had to have an impact on this conversation, on talking about workplace violence. And I imagine that we're talking about it a lot more because we were seeing it a lot more and we were experiencing it a lot more. So what's true about that? What's true about COVID's impact?

GILLESPIE: So if you would have asked me this question just under just about two years ago, like during the 2020, after we've been in COVID for a few months. I would have said the world's on lockdown. No one's leaving except for those that really have to go to work. The essential workers, which is a variety of industries, including healthcare and then patients that needed to go.

Surgery centers were closed. Everything optional was being shut down. You got to wait. So there a lot less volume cycling through the hospitals. So I would have assumed based on that the rates have to be going down, but in reality the rates have gone up and they just don't seem to be stabilizing back yet. And I think a lot of it is at least in so also is worrying is it just United States that it really is a global and I have had a conference calls with folks in other countries, particularly through the Emergency Nurses Association. So it's been predominantly emergency nurses as opposed to other professions. But they said, yeah, COVID has made a great impact. And I think a lot of it is somewhat political because COVID is either not a real disease in some countries is it's not a real disease. In some countries, like even in Mexico, nurses were assaulted because they caused the pandemic.

Nurses were spreading the disease and they were the result. And it's just like, wow, like I don't know where that would have come, where the health care workers blame for causing the disease. No one wants the disease to go to where all this cruddy equipment on is. Just it's hot and sweaty and expensive. It you have it.

AMIEL: Yeah.

GILLESPIE: In some areas had no PPE for a while. And when I was on the Emergency Nurses Association Board of directors, some the areas like Detroit, the states that I oversaw, they had they had such limited supplies where some cities were abundant. And so no one wants to have this COVID, but part of it's become political. So where if you bring a family and you want to test them, it's how dare test me.

It's my right not to be tested and I don't want to wear a mask. And now you've got to fight with them to wear a mask to help spread it, to stop the spread, or they don't you wearing a mask because you're implying that they have COVID and they don't want you wearing a mask. Where in the prior to COVID, no one would have cared if the health care worker wore a mask and back in the day of H1N1, which was way back in the day, ever since then, when I started working clinically, I wore a mask almost all the time because it's like, you know, you just don't know what's going to happen.

And not because it was a pandemic. It was just the risk was there. At that time, H1N1 was impacting 35- to 45-year-old men had the greatest fatality rate. And I was like, that's like my age group. It's like now I've actually got a disease that I actually got to be fearful for. I'm like, just because you're healthy meant nothing.

So I just got the habit of wearing a mask. And now to be told, if you wear a mask, I'm going to get violent. Or if you give the family the diagnosis and said, yeah, they were they've been diagnosed with COVID or the worst of case, they're now dead and their primary diagnosis is COVID. People become violent and angry and it's like, there's no way I can have COVID.

It's fake. Or they just go on and on. And if you offer immunizations, then it's one of those you used to be able to offer them. People are like, thank you for giving me immunization. And now if this one, you can't offer it in the pandemic doesn't show signs of really waning because we can't get the world immunized.

And so, yeah, the C word, COVID, it's just it's made the work environment very hostile because we have to do things to protect the workforce and protect other patients in the building and doing that it has become this political divide. And it's not just in the U.S., it's in other countries. It's become a taboo to discuss COVID within the healthcare setting as a potential diagnosis or even for prevention strategies.

AMIEL: Yeah, it's become a fear, right? Like you see it and like something bad might happen, you know, as a result of just even discussing it.

(SOUNDBITE OF MUSIC)

AMIEL: In this episode we identified some of the risk factors that clinicians should be aware of that can lead to violence. We also identified some strategies that can be used to manage the risk. COVID has had an impact on the healthcare environment in many ways – for the healthcare worker as well as patients and their families. The stressors that come with the pandemic can be exaggerated in the healthcare environment. Please joint me once more for the final episode of this podcast as we dig deeper into how we can mitigate the impact of workplace violence. This is Jannah Amiel for Elite Learning.

(SOUNDBITE OF MUSIC)

Episode 3 – Actions to Mitigate the Impact of Violence

AMIEL: Welcome back to the final episode in this series. In the previous episodes we identified some of the contributing factors related to violence in the healthcare environment. Stay tuned as we continue the conversation with Gordon Gillespie, an expert in the subject.

I want to talk a little bit about how we're managing this. I actually read an article recently, it was this week and I think it was Chicago. Chicago, UI believe it was that system hired or made a role. Let's say they have a role and they've hired for that role. And it really is like a single designee, a person that's really in charge of strategizing

workplace violence as far as how we manage that, how we mitigate that, you know, being that that point of contact, I imagine not every single hospital will do the same exact thing, you know, for different reasons.

But what are the ways that we are now and, you know, from your knowledge that we can in the future manage this?

GILLESPIE: So I kind of like the idea of them having a single contact person, but I'm also a bit concerned about them having a single contact person. And it's a part of it is, I don't know enough about it. So the context of it is if you have one person and it becomes, Oh, here comes Gordon talking about his one issue again and how integrated are you and that's your one thing.

And if you also become the great expert, what happens if another institution that says, Oh, wow, I just got this great person, I'm here at University of Cincinnati, let's like recruit that person away. The only way they do who is left and what's the infrastructure. And so you just took all that brain trust and it got all got it's kind of sucked out.

So I like the idea of having like, say, the czar, so to speak. Who is that over person who knows it's all there. The hub. And so if they leave, hopefully they've got a backup hub. But I prefer to be kind of integrated into a culture of safety where it's about, did someone give a wrong med? They have root cause analysis, they have a team of people that SWAT it all out and see what can we do to make it better.

They look at the medication dispensing system. When you go in and get a medicine out, you don't have the normal saline vial with the heparin sodium vial. You put them in different drawers, you've labeled them differently. You have ATP in caps so that you do things to make it safer.

That group looks at it. That group should also have on their standing agenda medication errors, pharmacy errors, and incidents of workplace violence. So it becomes something that they always talk about. And it's not like, Oh, what's this? John's not here today. He's not coming to our meeting. We don't need to talk about this item. It's like, No, this is a standing item regardless who comes in, we can have someone from his committee come to us or we can go to them. But it becomes ingrained at the department or unit level so that we have a safety group at every level. And it's not, again, just about patient safety, it's about worker safety. And a subset of worker safety is workplace violence.

And one of the projects I did, we ingrained it so that nurses, the charge nurses would do rounds every 4 hours. And there's already things that they do to check in and be like, how is the team working? How are you doing? Are there any kind of issues that need to be concerned about? And we put on their checklist and have there been any events of workplace violence or anything of that nature?

And then it was like, oh yeah, actually there was like, but you didn't tell me. Well, you know, we have other things to do calling you like we're busy or wasn't that bad, so we're okay. And it's like, okay, well we need to know these things. And so by purposefully asking then when that charge nurses into the shift, they would then report off on to a safety line.

For that it was more it wasn't necessarily like a safety line, but it was a line that they reported off to a central administration at the end of every eight-hour shift. It was like, Yeah, this is the emergency department, this is Gordon I'm reporting on... And they had a checklist that this is things that happen. This is how people have been in restraints as some people will be intubated.

This is our time for a mission to discharge for the Emergency Departments you provided provide additional details. And these are the events of violence or safety issues. So then it was like, okay, then that kind of gets forwarded to another layer that they can then be like, you know, this is like three nights in a row that we've had significant events like what's going on. And that can then initiate a procedure that could be from this hour or another person to say, you know, I'm seeing now a trend.

But I think having it ingrained to where it's multiple people's responsibility, not a single person but again IU might be doing that and I just don't know but having it ingrained through multiple layers ensures that it becomes so it's always talked about because it's always talked about you have to do something about it. And that's the advantage of the general duty clause.

I'm not sure. Are you familiar with that?

AMIEL: No.

GILLESPIE: So the general duty clause is part of the Occupational Safety and Health Act that was passed, I think it was in the seventies. I don't know the exact date, but then that's where you have your blood borne pathogen law is in the federal code. And then there's that part of the OSHA Act is that basically what it says is if we didn't talk about it in a specific act or there's a specific standard and you learn about it as an employer, you have an obligation to still do something about it.

If you think about latex allergies, latex didn't used to be a problem until it was, and nurses were experiencing latex sensitivities, latex sensitivities and like they take off their gloves, they're starting to get rashes and eventually it becomes worse and worse. And they said, you know, we need latex free gloves. Nope, can't afford it. Ain't going to do it. It's not a requirement of the federal government. There's no standard. But what happened was nurses started filing suits, saying under the general duty clause, we have now put you on notice that a problem exists. You've not done anything about it, and you're now liable. And when those started happening in several states, then all of a sudden hospitals realized they have an obligation now to move to latex free environment and eventually did become a standard.

And now workplace violence is one of those. It's, I think now through Joint Commission. They've got a center, Joint Commission. It's not yet a federal code or a federal requirement, but Joint Commission is helping to move in that direction. But as an employer, if you become aware of a trend or problems and you do nothing about it, you are going to end up being liable for the bad outcomes down the road because you chose to do nothing.

And the perfect example is we were doing a workplace violence implementation study back in the day and one of the hospitals, we were told that after we started the study, they said we just got a notice from our corporate office. They're going to start closure procedures for us in two years. And it was like, okay, so first, the first thought is selfish. What does this do for our research? Because we've got a federally funded research study on a timeline and it was like, well, it won't impact your research, but we're like the rest of the health systems are getting new computer systems, new electronic health records. We're going to get none of that. And it's like, okay, well that is your workflow, but we can still work around that.

And as that facility started posting all of their reports for workplace violence, they went and these members, I don't know the exact but say it was three events over a three month period. Then it became 40 events over a three-month period. That's a huge and I see how your eyes on camera like it's like were shocking. Yes. And so the good part was their risk manager saw that and had the same response.

Whoa, something is happening. What is it? And so being a good steward for the organization, they actually called in people that were not our team, but a different set of external consultants who came in and said, you have a high-risk area. I'm surprised your rates weren't higher. And they were like, Well, it's because they actually weren't reporting.

The problem was there, but no one knew it. And so afterwards they end up getting locked doors for the emergency, the ambulance, at the ambulance entrance. There was a little half wall right next to the main entrance, but patients parked and walk by the ambulance entrance to get into the main. So people could come in the side door and be in and be infiltrating and causing harm like say type one workplace violence.

Or if you're looking for retribution from last night's, you didn't get what you needed, you could have come in. So they end up locking down the doors. They had a person in the lobby that sat on nightshift by herself or himself in the lobby, the registration personnel. So I finally put a camera so that the person the back could watch that person, so that that person had something happening, they could send a team out.

And then probably the greatest thing they did was give a direct walkie talkie to security, because back in the day, they would say, we need here, STAT. Well, can you tell me why? Because he's unlocking the door. He's got to get to a cafeteria for a turkey sandwich. He's got to get in a pharmacy or he's on the parking lot.

Well, we've got an assault going on. I said, well, is it that bad or can it be a few minutes? And so you're having a conversation in the middle of a workplace violent event where you should be helping. So now they got a walkie talkie and went straight to security and it was like, Joe, we need you here STAT for violence.

He goes, I'm on my way. And like, that's what they needed to hear. But those things they couldn't do that. I think they spent about 30 or so plus thousand dollars changing the structure, the environment to allow for the safety. But that was a direct relationship of reporting because the general duty clause, had they not done that, it could have been enacted.

And so really that general duty clause, thank goodness for that great risk manager who saw the data and said we have to do something even though we're closing down this institution. Let's hardwire in some changes to protect our workforce.

AMIEL: Yeah, no kidding. So talk to me more about some of these other strategies.

GILLESPIE: So something that I really love. And it was something I learned from Dr. Cori Peek-Asa. She's from the University of Iowa. And she's now, I think, like either a VP for research or something, but she's taught me a lot about walk through assessments. And it's really the kind of model that I looked at when we did one of ours to get in a professional team.

You want security, you want an administrator, you want somebody from the workforce like, say, the nurse or somebody from the department. And you kind of walk through it. And I always think about it when I did my walk through is for the ED. So let's start from the patient's point of view. Let's get to the parking lot, get to the garage. Let's look around and let's see where they're at. Like, wait a second, I see workers parking next to patients. That's not good. You need a separate parking structure, separate parking entrances. Otherwise, if Jannah and you and I get into a fight in the ED in your discharge, and now 5 minutes later, I'm walking to my car next to you, there might be a problem there whether you're just going to key my car or you get into a fight with me, whatever.

That's not really is safe. So you need to have separate parking areas and then you kind of look at lighting. You want it to be bright as daylight at night. One of the facilities we went through when you kind of looked at it, it was like, I can't imagine being a person that felt vulnerable and saying, I'm going to walk into that parking lot, looking that dark.

It's like, those are things you see on TV and you find out later the person was assaulted, murdered, kidnaped. You're like, wow, why did they even go in there? Because they had to go home. They got to get to their car. So that was kind of an issue. And we talked about lighting. And then when you get into the building, you kind of walk through like what would be the patient's experience?

Are they received? Are they ignored? Are there things laying around? One of the departments we went through, they sponsor a lot of sports teams with. That was really fabulous. These it was a local community hospital. There's actually no hospital attached. It was a freestanding emergency department. They had an outpatient overnight stay. So they had it was like it was more like you're going to be here overnight if you had a stay and we were actually transported to a permanent hospital.

Texas has lots of freestanding EDs, so it's a common thing and in Ohio they're becoming more and more common as well. But in a part of that community outreach and having a develop with communities, you can sponsor events to sponsor sports teams, which is really nice because then you're more connected to your community, so that can help reduce the rates.

That's really great. But what they had was all these plaques for the sports teams were hung on the wall. And so I grabbed one and it comes off the wall. Well, what don't you love to have a 5-poun weight to throw at someone and now you've got them on the wall? They're easily accessible. And it's one of those it's great to have them bolt them in, screw them in, don't just have them hanging on a hook. And that was one thing. And this particular ED, all the main doors were all locked, which is really great. So it helped prevent access so that if you need to control traffic flow or you need to keep certain people out for safety like a partner or a domestic violence incident.

But what they had was their registration desk had a door that they left open because they needed, they said, for airflow. And behind that person was a door into the main ED. Well, now you've got every point is locked down except for that one. And then when that person was not the desk, it's basically leave your doors unlocked.

So that became a challenge in terms of how do you really manage and have the ability locked down. For inpatient settings. It's really hard because at night shift you can lock the front doors and I'm nonsmoker but I would go out with the smoker sometimes on nightshift we go there from the hospital. We realize if you took an ink pen with you, you could take it to the top of the door. The automatic doors, and push it through the little top where the rubber meets and it'll trigger the door release.

AMIEL: Oh, no.

GILLESPIE: So the building is locked down, but you can get in and there's no monitoring the door. Are you really safe? And so if people think, you know, I can throw you out and I can say what I want to because I'm going to make you leave, they actually can get back in. And all it takes is an ink pen, which is very, very minimal effort.

And it took all about like 2 seconds. You reach up, push it in and the doors open because they're not because you have to have them. The ability for emergency evacuation to get out, getting in, it takes a little effort or a little you have to kind of know. But those are things that as you look at, do you have departments, your fire doors, can your fire doors be locked, truly locked down in the event of an active shooter or it was a violent

event like you normally want thing where you can open them, but is there a way to have some type of lockdown? What would that look like for an active shooter type of event?

AMIEL: Yeah.

GILLESPIE: And then it's so part of the walk through. As you look at those things, you look at where things are hanging up and you also actually talk to people. So I go around, be like, Hey, Jannah, so how's it going? Oh, great, great, great. Well, we're I know we're doing a walk through focused on safety and mainly on workplace violence.

Like, what are your thoughts about that? And it's kind of a really open ended. It's like doing qualitative research, but it's very fast paced and impactful. And one thing we said with people is if you could change anything, just ignore the cost. Because no, we got no money, we never do. But then again we do and we really need it, right?

So regardless of that, what would you do differently? And then a lot of us are like, you know, that kill box out there, like when you got to walk in and one of the [inaudible] and that's what we kind of called it. You were who you walked in and you had to meet a but you could actually climb over the counter and the person couldn't go anywhere else.

But you were in this like almost locked room and getting into the building because they were always on this high level security and they call it a kill box. It's because like and it was like, that's interesting. So we need a way for me to escape when I have to go out there, work at that desk and a way for that person not to be able to get to me.

And so it was like, but we want to be customer oriented. We don't want look like we're keeping people out. Good part that is that that was pre-COVID post COVID everybody's got barriers up now and so some of the barriers are there for droplet precautions, respiratory precautions. But there actually can be fold as long as it's made of either bulletproof glass or some kind of more plastic.

So you don't have to worry about shatter glass coming on you. It's actually a perfect way to focus on violence, but you can call it COVID, which can be more acceptable. So from a customer orientation point of view, COVID actually had a positive impact for physical structures may not have been good for anything else, but at least for that one piece that it did.

And as you talk with people, you learn about, are there riskier areas? And we learn about rooms that they always put down in this hallway down on the very end, because we don't have to hear people yelling and screaming. But then again, the person that's the center is all the way down at the end of the hall where you can't hear anybody yelling and screaming for help.

So it's one of those, oh, let's bring that loud, violent person right across to the nursing station, which is a distraction, but it also helps with the safety. And if you need a call for help, it's just help. As opposed to screaming the top of your lungs, hoping that the patient in the next room will say, There's somebody down here screaming at somebody because I can't sleep.

AMIEL: And that somebody can run fast enough to get to you.

GILLESPIE: Yeah. And that's to me that people aren't are not busy. And so there's the nice things about walkthroughs. And something you kind of mentioned earlier in terms of the worker that they do happen to

have disease and disorder. People have addictions themselves and they're trying to curb those and they can't always manage in or they've got life stressors that are beyond their control.

AMIEL: In this episode we heard that doing a walkthrough your facility with fresh eyes is a way to identify potential areas of concern that can be addressed before something happens. As a positive person, I like seeing the silver lining in challenging situations. And I like that using Plexiglas barriers for infection control purposes can also make the environment safer from a violent situation as well. Please join me for the final episode of this series as we continue to address the issue of violence in the healthcare workplace and actions we can take to mitigate that impact. This is Jannah Amiel for Elite Learning.

GILLESPIE: And so something as proactively doing stress management training, really getting down. And again, assuming that every employee, if you have that perspective, has work life events or home life events that stress them. Let's educate you and prepare you for when something really bad happens. How do you handle it? For me, probably because I'm a guy working the ED setting for so long I've been called so many things that after a while you're just kind of like, Huh, that's kind of funny. And you laugh and I'm like, You actually think you're going to upset me with that? That's almost cute, but. But in reality, it really is offensive. But there are two things that if you say to me all of a sudden, okay, I'm done, we're going to done. I'm going to get back at you now.

And I realized that I had to learn what my trigger response was. And it's really just those two things. And it's only happened a few times, but it was when I went through some stress management training, I was like, wow, when they talk about your trigger word, like those really are my trigger words. So I started to reflect and I'm like, For what?

And it doesn't make like probably if they said that to you, you'd be like, huh, or whatever. It's no big deal. Yeah, but for me, for whatever reason, that's my trigger. Yeah. And so once I learned that, and when I hear it, I'm like, I'll be right back. I know I need to do this. I just need to leave.

I can't stay and I need to immediately leave the room and say, I need somebody else really quick in room seven, I, I just need a minute. Because sometimes, like, it's the middle, somebody is doing something you can't really leave, but you got to. So somebody's got to go back in for safety unless I can just walk out and say, I'll be back in a few minutes and then I just take breather. I'm now prepared for this person. I can go back in, or if I know this person has a history of violence, then I can go in knowing that prepare for battle who get in my zone, get my mindfulness moment, and I can go in. And then when they do it, it's annoying. It bothers me, but at least I can manage it and so everybody going through some type of stress management training helps.

And then like it's not like hostage negotiation but truly getting negotiation skills. And again, it's one of those what is your goal? My goal is to get a lunch break at least half the time, to go to the bathroom at some point in my shift, to get off on time, not be thrown up on, and then of course to live.

And it's like just those natural things that most people would think to just get. But sometimes the things you have to actually be purposeful. And in order to have that, you're thinking about like, what's it worth? And when you negotiate with folks, to me they have to have wants and they have needs and healthcare people want lots and lots of things, but they need none of it, but they don't know why.

And so you have to start to negotiate and see. I hear what you're really wanting and instead of saying No, could we negotiate? A person might say, I really would like to have something to drink. I need this. But if they're on an inpatient unit and they're not allowed to have anything to drink, they're having surgery. What you do? And you might say, What if I could get you a piece of gum?

Because sometimes you just need something in your mouth. And the gum can help stimulate some saliva, but you've got to promise not to swallow it because you can't have even ice chips. So that might be a way to negotiate. How can we get then the need met based on what you want and sometimes it’s just not possible. That might be.

This is really rough. I understand this is a horrible situation. What can we do with you? What can you can you manage like these 3 hours? And then after that, as soon as you can get up, we'll be able to give you this. Can you can we do that as opposed to you can't everything too. After surgery, like there's no end, but you can provide some endpoint, you could do some kind of negotiation.

And thing I've always learned is don't use the words know part of this by watching movies and like hostage negotiation. Never say no, don't say. However, try to use the word and all the time and it's hard.

And I had a stressful situation this morning at my workplace that I had to manage and I had last week we had a crisis at the university how to manage had parents calling me and they're upset and it's one of those people hate to say I'm sorry because it makes it seem like you're a bad person, but in reality, it's one of the best things you can ever do is just say, I'm really sorry about the situation.

I will do everything I can to help fix it. And if I'm not the person to do that, I will find the person or keep try and just provide some information. I think those negotiation skills help train you and prepare you. You're not always going to do it perfect and allowing yourself to fail at times is okay.

But trying to strive to be better, but really doing those. And then now there's a lot of people talk about mindfulness all the time now and I've got this app on my phone for, for it's our health app for the university trying to get our workforce to be healthier so that we use less insurance and all that stuff. And it, it asking me every day like, have you had at least a five-minute mindfulness moment?

And for me personally, when people lead me through mindfulness exercises, it makes me incredibly hostile. And part of it's because, like, I do have ADHD, I'm very hyper, I'm a lot slower than. I was when I was in my twenties, but I'm still by a lot of people. I'm still really hyper and my mind's always racing and trying to talk me through it. It's like, that's stressful. But I have learned that being mindful doesn't have to be this purposeful pause at an organized plan approach.

It can be when you're going to go, when the mornings I take my dog out for a walk. I know now I need a walk in a by the river where there's it's actually by a sewage plant, the woods by the river. But they have a lot of greenery, trees by it. So it's actually pretty nice and if you're upwind or down when that day.

But for me it's actually really, really relaxing and so that's part of my mindfulness is like really connecting with relaxing and kind of brushing off some stress so that I can start my workday. And I think there is a lot of merit to learning about mindfulness and what it means for you as an individual, whether or not you want to do it structured.

But knowing that, and one of the things I think is really, really critical for people to get past an injury, whether it's mental health injury or a physical health injury when it comes to violence, is what you do when you find out. Back when I was earlier in my practice, the first people will say is, what did you do? Because obviously it's your fault you got hit, it's your fault.

You got spat on. It's actually not. But that's the implication is when they say, what did you do? And so a better question is, how are you? What can I do for you? You might have seen the whole thing and you're like, Yeah, you actually pushed that person and they were trying to leave and you kept following out.

You actually did escalate it and that person was trying to stop us. The employee actually created it, worsened it, and led up to the event. That eventually resulted in you being hit. Yes, they did the act, but you did everything you could up to that. The first thing to say is, are you okay?

AMIEL: Yeah.

GILLESPIE: Look at their mental and physical health first. What can we do for you? And then later, let's talk about how we got to this point. What could you have done differently? Would you have like to be done differently? And then you can say part of our what we looked at is that a lot of it seemed like it might have come from you and maybe and like, can we talk about why maybe you acted with these behaviors?

Because it's not about you as a person. It's all about the behaviors. And how can we change these behaviors? But starting with, are you okay? Is one most important thing because then they're being heard, then they're being cared for, and valued. And that helps them to become if it's a modifiable behavior, you can if you come off attacking, you're never really going to get the whole picture in order to do anything better on the back side.

AMIEL: Now, one of the things before we wrap, you know, I was thinking about all these different strategies to protect the employee strategies that that institutions can be using as well. And I know we talked about, you know, flagging that, talked about that safe distance. Now I'm going to practice to see how far exactly does my spit land and if I'm being safe or not with patients, you know, in that way, telling colleagues, you know, where you are.

Your point you talked about, hey, if I shouldn't be with this patient, if this is not the the right scenario, you take myself out of that. But there is an assessment I've not heard about, and I wonder if you can talk about that. And I might be saying it totally wrong. Is it STAMPEDAR?

GILLESPIE: That's how I pronounce it. Yeah. And they're.

AMIEL: One together.

GILLESPIE: And the nice thing is it does not require RN licensure. It is not a formal assessment. It's not like a screening tool. It's not meant to be predictive of workplace violence. It's more about do you want to make it through the day? And if you see these behaviors, what would you do? And this is part of that.

See something, say something. So the STAMPEDAR and I think that the original was a Doctor I believe out of Australia they actually came up with STAMP and then they did a follow up study and added the idea and it stands for steering tone and volume of voice. I believe it's aggression, mumbling, pacing, emotions, disease might have been like anxiety, I believe, and then resources.

And most of those are all about you can look at a person. And the part I love about this is when we did some of this training at one of the hospital systems in a different state, the registration clerk, we actually created a team. And when that person said, you know, I could have told you every single person that would be violent, I'm always right. And she in this and there was actually this person was a guy and it was really impressive because he was very young. And of course, my first thought is, well, you're kind of just a kid, you're a registration person.

What are you really know? But in reality he was gifted, and it was much he's gifted, but he just how to use his eyes and look. An he would go.

When you see the person in the lobby pacing back and forth like a caged lion, that's basically that's, you know, it's anxiety symptoms that's pacing. Those two signs in later when they go the back, of course, they they just escalate because their their needs and wants are not being met. And so as you look at a person and they're staring at you, people like when to say, go shut that door.

They keep staring at me. What what you're really doing is throwing a Band-Aid at a big gashing wound that's draining all the blood in their body. And it's not going to work. And then the people that the tone of my voice, they're very loud and obnoxious or they're very kind of people say, see, they're really quiet. You can't really hear them.

That person, like the louder one, you kind of expect the mousy, quiet one. You don't. That's the person that's going to truly explode because they're bottling it all in. And at some point it's just going to be eruptive and mumbling is really also kind of hard, like if they mentally can't really understand them because what they're kind of doing, like my wife is they always say like, are you murmuring again?

She was, I'm sorry because she'll come home from end of the day and she had a job that was really an unhealthy employment for her and she was coming home and just reverberating her day and just recapturing and just I blew. We were just rehashing her conversations. Those persons are having a lot of negative talk and that can also become bad.

And like part of that emotion is like, you know, if you're crying and upset, that's kind of a situational crisis. Could be mental health, disease or disorder. It could be any number of things, could be pain response. But that person, they're experiencing probably a situational crisis. And what they would normally do, they're not going to act as normal as always.

And in terms of disease, it's all things we always think about. And then the resources is one that's really not the patient or the aggressor centric, it's really the environment. And so, this brings up COVID again,

AMIEL: A C word.

GILLESPIE: It was it was a problem before COVID and it's just made COVID has made those things worse. And that's we still have a nursing shortage. We've had it for I don't know how like a decade or something now it seems. And the faculty shortage makes that nursing shortage even harder. But with that shortage, you might be working on a unit that you need to provide care.

You don't want to say it's not safe for me to come in and then there's no one. So you go in being a dutiful nurse, but you're working under-resourced and you don't have enough human resources to manage. And when you don't have those human resources, people's needs are not going to be met as timely as you would like had you had the resources.

So if you've got this angry, volatile person, you might then take one of the employees and make them a center. When have other people that may not be there for violence, but they're there for pain and they can't get an I.V. started because you need to hold her. So they're waiting longer and now they're becoming angry because their needs can't be met because don't have the adequate number of resources.

And so that's one of those that it really takes looking at when you have an event for a root cause analysis, not just why, but you can ask the people there, why do you think it happened? Well, they were in pain or I was in pain. And you can ask patients, but it's all about that one on one.

But you don't find out later on as well how. Many nurses were on the unit what was the nurse to patient ratio? Were like how were the timers for the whole unit being responded to? Then you realize that it really wasn't just, It really wasn't just you and me. It's really that there was an environment that created this situation for this to happen. In COVID, as people become like early on, if you were exposed, you had to be out of the workforce. If you had a community exposure or if you were ill, you had to be out. Guidelines are continually evolving with data, which is good. But if you're now but there's just a higher incidence now of people becoming sick and then they now have to be exiting the workplace for a few days until they're able to recover.

But there's no one left to replace them. So now we're just continually, habitually working lots of places without adequate resources.

AMIEL: Yeah. Gordon, this has been very information and a little bit cathartic, to be quite honest, because coming into it, there's a, there's a lot of like we're going to have the conversation about workplace violence again, and there might not be any solutions again. But I got to be honest, the strategies, even the research that you pointed out that you've done some of the risk factors I didn't even think about in these ways.

And you're right, what comes with wisdom of age and experience and recognizing when you're in a situation or when you might be behaving in a way that's perpetuating something else, it's been super, super informational. Is there anything that you want to leave the audience with that we haven't spoken about, any parting words?

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GILLESPIE: It's just kind of just two and I'll try to be more brief with these two, but one of those is asking if they have weapons on them. It's one of those that usually we always ask people, what medical problems do you have? Do you have any allergies? And those become commonplace. And if we can become common in one of the institutions locally also says, do you have any diseases such as hepatitis or HIV?

And then they say, the reason we ask this of everyone is because we want to keep you safe. There are things that we'll do differently for you and for us if we know we can implement interventions faster for our workforce and that will just speed up time for them to prevent that from becoming infected. We ask that for everyone and we should also be doing that for workplace violence.

Like Do you have any weapons about you and people that you would never expect like the 70 to 75 year old older adult woman who came into one of the EDs and she pulled out a firearm and laid it on the table. Oh, and she goes, I just need this for safety. I carry it everywhere. I go, and in Ohio, we had the right to conceal a carry a right to carry a concealed weapon.

Now, we don't have to have any special permission, any more license, we can just carry. A lot of states have that. So it's one of those people might have weapons and it's better to secure those on the front end. And if you do implement that policy, be aware of whose job it is to handle that weapon. So for the facilities we train, the role is that you call security who is trained to handle a firearm credential lockbox in if your local policy is if I had to go to the police station to get it, if they have a license to have it, then they'll get it back.

Or if it's a knife or other kind of weapon, people are pulled out. So people pulled out things like canes. And we go, No, sir can keep that. We don't consider that a true weapon that we're looking for. And then that will give

you, like anything but a firearm back when you leave. Once you're outside the building security, we'll give it back.

And you'd never want to say I'm great with firearms, because what if you inadvertently shot your registration person, right? They probably would not forgive you. For starters. So that's an important piece. And then the other part is when people come in and you're doing your intake process, whether it's in the ED or surgery or you're an inpatient setting, is have a frank conversation about safety.

We are committed to keeping everyone safe, whether it's our patients, our visitors, our employees. So if you hear or see something that doesn't seem safe, such as if there is a negative or violent encounter or people are starting to yell and scream, or if you feel like your care is not, you're not being safe in the bed let someone know.

And that does two things. The first is that it puts them on alert that someone else may be watching you. So if you act out, there will be witnesses and people will become out, come to help. So you won't be able to get away with it easily. So that makes them think twice about negative behaviors. And the second is, if it does happen, there is someone else there to call for help for you.

And it kind of creates this environment. And then again, doing it for everyone. It's not about you look like you might be violent. It's more about everyone. Yes, you're only five and six. You're the parents or you're 75 and you seem normal, but it's about everyone. And then the other part is that when people do have violence, we kind of talked about how to communicate initially.

There is a thing called diffusing intervention, which it is a formal process that happens at the end of the shift. And it's it's possible to get into the shift. But the most important part about that is to make sure the person has the right to say no and that it's like it's similar to critical incident stress debriefing, which tends to happen three days later.

And that's really built on the model of people who work 24 on 48 hours off, like firefighters and EMS. They might work a 20-hour shift. They come back three days later. And that's where the idea of the CISD would be 72 hours later because it comes back when they are all back on shift. Health care is very different we don't work the same days together like we're not rotation A, rotation B, rotation C, you might work with the person three weeks later like, Oh, I haven't seen you in forever. How are you doing? Like, you know, like may not it just happens. But the important part about this, especially to that same shift, is to say, Jannah, it's okay if you say no, because to force someone into a mental health kind of counseling, if they're not ready for it, that can actually cause more harm than good.

And so and then that probably my last big take home is report. Report, report, report. If somebody is just saying something to you and it's like no big deal in terms like they call me some stupid words and I'm like, you know, it's a dime a dozen. But if it ever feels threatening, if it feels like, you know, the way they said it, like, hey, I will see you later.

They didn't actually threaten me, but it felt threatening. It didn't feel good. Report those and report all assaults, even if it's a bite or slap from a confused person. Because as those get noted, we can provide more FTEs to the department, we can provide more other family techniques to prevent those from occurring, but only really good data. And the more data we have, the better we can prevent injury and any kind of permanent dysfunction within the workforce.

AMIEL: Absolutely. Report, report, report. We want to reinforce that just culture that we're all talking about. Right. In the workplace, and practice. Right? I think we talked a little bit about that. But those drills. Absolutely. Yeah, that would my last kind of parting here. I found that super helpful when I was working bedside in the clinical space in hospitals, the different types of drills to prepare.

It made me feel like at least I've got confidence that we have a plan here in case something happens.

GILLESPIE: Yeah, something with those drills is do a drill with the visitor who's the violent person. And I did do drills at one of our hospitals and the patient when they did a pretty good, everyone knew what to do. But when it became the visitor, it was we call security. And I said, Well, security is not coming yet.

And when we did it, we actually did it as a live drill in security, didn't respond.

AMIEL: Oh.

GILLESPIE: So we identified a failure in the system that particular day. But until they're here, where are you going to do right? We're going to call security. And we actually had paid professional actors, a person that was representing an 18/19-year-old in the emergency department and then adult parent. And the team did not know how to handle the parent.

They didn't know what they were to do. And so doing the drill is really crucial because you can find threats to the system. Faults in the system, what we call this root are not root, failure modes effect analysis. And so you look for failure modes and it's just it's like a term, like in manufacturing, but we use in healthcare.

So you find out what the system's supposed to do and then find those failures. You can then fix them later, but do it not just with patients, but have some drills with visitors as well.

AMIEL: That's smart. That's really smart. Gordon, thank you so much for joining me. Thank you for all of this dialog and conversation and thanks everybody who tuned in and is listening. We hope you find this very helpful and that you join us again for another episode. This is Jannah Amiel for Elite Learning.

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