

TRIGGERS AND CARE PLANNING IN WORKPLACE VIOLENCE PREVENTION

This resource has been developed to enhance and advance knowledge, skills and culture in the area of triggers and care planning, in the service of reducing violence and safety risks in health care settings. Using it will better protect the health and safety of workers and patients and assist in creating a better overall patient care experience. Like many safety-oriented improvement goals, implementation of leading safety practices and adequate training requires not only frontline knowledge of key practices, but also adequate environmental infrastructure, operational incorporation into standard frontline work and sustaining leader and manager-level oversight to realize the safety gains of this resource package and recommended processes.

As colleagues working in other areas of this initiative may highlight, adoption of standardized approaches to risk factor and trigger management varies both amongst and within health care settings. This resource is intended to facilitate reflection amongst a wide variety of health care setting employers and clinicians on the strengths and opportunities in their current procedures and approaches to predict, recognize and prevent violence in health care settings, and advance their workplace violence program and practices to promote those goals.

This package includes introductory information highlighting the broader challenge of violence in health care and the role of trigger management as part of the workplace violence prevention program in reducing the incidence and impact of violence. It also includes broad, user-friendly content re:

- a) Violence Risk Identification and systems, communication and Management Strategies
- b) Trigger Identification and Management Strategies
- c) The Use of Care Plans to Reduce Risks and Triggers
- d) Analyzing Code Whites as a means to prevent incidents of violence
- e) Using safety huddles/shift changes as another means to communicate risk
- f) Sample/Example Care Plans

Frontline health care workers and clinicians have to master a variety of tasks, skills and approaches to provide patient-centred and effective care. Some workers provide patient support in specialized clinical settings, such as post-surgical wards, forensics or tertiary

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dementia-care units. Others work in more broadly focused settings such as primary care offices or community emergency departments. What all these workers and settings share in common is the potential for patient-originating violence or aggression.

A wide variety of factors may contribute to the risk of violence in a health care setting. Patients may be under the stress of evolving illness that exceeds their capacity for mature adaptation. Patients may suffer from illnesses or syndromes that increase their impulsivity or aggression. The physical care environment may provide too little or too much stimulation. Sensory or language or cultural barriers may contribute to patient uncertainty or fear. Previous negative or traumatic health care experiences may contribute to tension or escalation between patients and providers, fear of the unknown or unfamiliar setting away from the supports of family and friends.

Given the complexity of the challenge, it's essential that health care employers and providers improve knowledge, skills and approaches to reducing risk in their particular workplace.

LENS

Health care workers are not only at increased risk for injury as a result of violence, but many also tend to view patient-originating violence aggression as “part of the job”. HCWs may form this belief if they do not see anything changing or do not sense that preventing violence is important to the organization or to coworkers. Risk and trigger management procedures are thus doubly important: they may not only reduce violence incidence but may also help dispel the notion that injury or risk is inevitable or acceptable in the provision of health care.

To reduce risk and build a stronger safety culture, health care workplaces need standardized processes for identifying patients and situations of risk, implementing evidence-informed interventions and managing triggers that lead to or have the potential to lead to violence. This type of approach can produce a safer environment for both staff and patients.

A wide variety of leading safety-enhancing practices may reduce risks in health care workplaces. This concise resource package focuses specifically on improving violence risk identification and violence trigger prevention and management.

SCOPE

This package will include broadly applicable information and recommendations regarding Trigger Management and Care Planning. This package is intended to support a wide

variety of settings, health care workplace employers and providers to help advance their approach to Trigger Management and Care Planning. The information was compiled with an appreciation that many specialized settings serve patient populations with specific behavioural risks, such as a psychiatric ICU, a tertiary dementia-care unit, or a detox setting, to name a few, that require more diagnosis-specific patient assessment, trigger management and care-planning approaches.

Please note, for further reading, there is a list of resources at the end of the document.

RISK FACTORS, TRIGGERS AND CARE PLANNING 101- IMPROVING KNOWLEDGE

DEFINITIONS

Risk factors — are a circumstance or characteristic that may increase the likelihood that violence may occur, particularly if triggers are also present. It predisposes a patient or situation to the risk of violence. Examples might include a history of violence or delirium with paranoia. It is important to note that risk factors do not make violence a certainty — many people with risk factors will not demonstrate violent behaviour.

Triggers — are a circumstance or element that may provoke or negatively impact patient behaviour by increasing the likelihood of a violent or aggressive response or reaction. It precipitates violence. Examples might include undertreated pain, loud alarms, care to a sensitive part of the body, requests that can't be accommodated or behaviours of patients or visitors in close proximity.

A care plan — is a set of actions and approaches designed to optimize the quality and safety of care and continuity of care among various providers. It may be diagnosis-specific, risk-specific or patient-specific.

For example, a care plan might stress the need for care to be provided by two health care providers, limit loud noise, be conducted at certain times of day, or with the use of an interpreter.

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FURTHER EXAMPLES OF COMMON VIOLENCE RISK FACTORS AND TRIGGERS

	PREDISPOSING FACTORS = RISK FACTORS	PRECIPITATING FACTORS = TRIGGERS
Patient Factors	<ul style="list-style-type: none"> ▪ History of Violence/Aggression ▪ Presence of Neurocognitive Disorder- e.g. Dementia, Delirium, Intellectual Disability, Acquired Brain Injury ▪ Substance Intoxication/Withdrawal ▪ Impulse Control Disorder ▪ High Stress with Limited Supports/Coping Mechanisms ▪ Mental Health Detention ▪ Communication/Language Barrier 	<ul style="list-style-type: none"> ▪ Change of Care Providers/Care Plan ▪ Undertreated Pain ▪ Hunger/Thirst ▪ Physically Intrusive Care ▪ Personal/Peri-Care ▪ Overstimulation ▪ Under stimulation ▪ Elopement Prevention ▪ Having a request denied in absence of alternative ▪ Hearing unwelcome news related to status, condition or discharge
Health care Setting Factors	<ul style="list-style-type: none"> ▪ Crowded Setting ▪ Settings with Long Waits for Care ▪ Understaffing ▪ Sub-optimal Staff mix ▪ Loud Environments ▪ Lack of Stimulation ▪ Sub-optimal violence prevention programs/training/information for staff ▪ Clinician/health care provider factors (training and 	<ul style="list-style-type: none"> ▪ Transition of Care ▪ Loss of Care Plan Continuity ▪ Change of Shift ▪ Lack of care provider continuity

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	PREDISPOSING FACTORS = RISK FACTORS	PRECIPITATING FACTORS = TRIGGERS
	<p>knowledge, nature of approach, previous interactions)</p> <ul style="list-style-type: none"> ▪ Work flow, ▪ Patient acuity, ▪ Patient surge. ▪ Lack of drills to test procedures – for example, a code white drill 	

IMPROVING RISK FACTOR AND TRIGGER IDENTIFICATION AND MANAGEMENT- A REFLECTIVE EXERCISE: 3 SELF-ASSESSMENT CATEGORIES

RISK FACTORS

- Does your organization or unit or health care setting do any standardized screening (e.g for referred/admitted/presenting patients) for COMMON VIOLENCE RISK FACTORS?
- IF YES, How is it done? How is the information communicated to frontline staff? AND What steps are taken to reduce violence risk once VIOLENCE RISK FACTORS are identified to ensure information about a history of violent behaviour is passed on when a patient is readmitted (e.g. visual and electronic flagging, care-planning, structured hand-over, environmental modification, family engagement)?
- If NO, what are the barriers to structured risk factor screening?

TRIGGERS

- Does your setting or unit already take steps to reduce common patient and setting related TRIGGERS (e.g. crowding, pain management, transitions of care discontinuity, noise)?

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- Do you regularly review violence incidents to determine potential TRIGGERS and TRIGGER reduction interventions?
- Do you have an effective strategy to quickly identify triggers for staff?
- Do those strategies include analyzing code whites to identify triggers, behaviours and safety measures for patient and workers?
- Is information about a history of violent behaviour, triggers, safety measures updated in the electronic and paper chart?

CARE PLANS

- Do you have structured care plans for patients at increased risk for violence?
- Do you have structured care plans for patients with a history of violent behaviour in your setting?
- If you have care plans for at-risk patients, how is clinician adherence to care plans assessed? Is there a process for reviewing and optimizing care plans?
- If you do not use care plans, what is the barrier to doing so?
- Do you communicate the risks, triggers, behaviours and safety measures identified in the care plan to all staff at risk (e.g., safety huddles and at each shift change)?

APPROACHES TO SUPPORT RISK FACTOR AND TRIGGER IDENTIFICATION AND MANAGEMENT

RISK FACTORS: IDENTIFICATION AND MANAGEMENT

- Screening questions at triage, admission, ambulatory referral and/or institutional transitions and after a code white
- Use of Visual Management Systems to Communicate Risk
- Diagnosis and/or- Behavioural Specific Care Plans
- Involvement of Specialized Clinicians to Support Care of High Risk/High Needs Populations
- Flagging system that covers every health care worker – from registration to chart to patient.
- The current “visual management system” could be signage at doors - wrist bands, white boards etc.

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TRIGGERS: IDENTIFICATION AND MANAGEMENT

- Best Practice Management of Common Triggers/Unmet Needs:
- Hunger, Pain, Toileting, Thirst, Freedom
- Real-Time Incident Review to identify triggers and trigger-reducing interventions (sustained by care-plan utilization)

CARE PLANS: OPTIMAL CARE PLANS ARE

- **Feasible**-doable by staff
- **Collaborative**- developed by care team with involvement of patient and/or family and security where applicable
- **Dynamic**-regularly reviewed/revise to enhance effectiveness
- **Trigger Specific**- addresses identified precipitants
- **Risk Factor Specific**-addresses identified predisposing factors/diagnoses
- **Patient-Centred**-incorporates patient history & needs
- **Communicated**-shared with involved clinicians & at transitions, also shared at safety huddles and shift change
- **Preventative and consider risk to workers and safety measures needed to protect workers and patients**

Example of Care Plan: Inpatient Example

PATIENT NAME: *John Smith*

DATE: Developed: *July 27, 2016*

LIKES TO BE CALLED: *Johnny*

ENJOYS: *Reading the Toronto Star, Jeopardy TV Show, Chocolate Ensure, Black Coffee*

PEOPLE WHO KNOW HIM BEST: *Retirement Home Nurse Jessica*

RISK FACTORS FOR AGGRESSION/VIOLENCE:

- | | |
|----------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Dementia with Resistance to Care | <input checked="" type="checkbox"/> History of Violence/CODE WHITE in Prior Admission |
| <input type="checkbox"/> Hyperactive Delirium | <input type="checkbox"/> Elopement Risk with Defensive Aggression |
| <input type="checkbox"/> Substance Withdrawal/Intoxication | <input type="checkbox"/> Other |

NARRATIVE

Johnny is an 89 year old man with a history of dementia. He lives in a retirement home. He is a very solitary man who tended to isolate himself all his life but is now living in a retirement home because his dementia progressed to a point where he was getting lost in his community. He is fiercely independent by nature and always wants to be left alone or do his own toileting even though he cannot quite coordinate this himself anymore. He is particularly uncomfortable with men assisting him. He is also a WW II veteran and sometimes has flashbacks of being under enemy fire. He is very proud of his service.

TRIGGERS FOR AGGRESSION/VIOLENCE

- 1. Personal /Peri Care by a Male Nurse/Attendant*
- 2. Loud Alarm Noises*
- 3. Firm stance/telling him what he 'must do'*

BEHAVIOURS CRUCIAL TO OBSERVE IN PATIENT

- 1. Quick glancing and quick movements*
- 2. Loud or profane speech*

RECOMMENDED CARE STRATEGIES

- 1. Give Johnny choices rather than firm directions e.g. ask "Would you like me to give you your heparin injection first or do your blood pressure first?" INSTEAD of saying "Okay Mr. Smith, time for your heparin shot"*
- 2. Try to have female nurse/attendant for Peri-Care*
- 3. Do not use 'bed alarms' for this patient. Risks exceed benefits as he is very triggered and distressed by loud noises. Similarly, do not put him near the nurses' station for falls risk reduction either; the sound of the phones ringing irritate him and make him more aggressive when care is provided.*
- 4. Ask him about his service in the war. It makes him feel valued and less dependent.*
- 5. For any sustained care (ie any wound care) , provide care in pairs for enhanced safety.*
- 6. Defer any non-urgent care if patient is verbally escalated or gruff on initial entry into his room.*

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7. *Reduce vitals frequency to lowest medically appropriate frequency in keeping with goals of care and reduction of intrusive procedures.*
8. *Distraction activities*

STAFF SAFETY MEASURES

Personal panic alarms, working in pairs, reviewing flag for triggers/behaviours, proactive and reactive security support, regular assignments to areas to maintain continuity of care.

Vignettes: Examples that Worked

- one dementia care patient who came from LTC and was hitting and scratching – after numerous incidents family consulted and said give rolled up towel and it distracts her – no more incidents since implemented
- one long-term patient in a forensic facility loved the Christmas season and felt calmed by decorations, so ward staff made sure that the seasonal atmosphere was evident all year long.
- A patient in a hospital had assaulted numerous workers during his stay. When staff asked the patient if there was something that triggers his violent behaviours – they learned he was severely claustrophobic and became violent whenever he was bathed in a small space. Staff bathed him in a larger space after this and there were no further incidents.

ENSURING EFFECTIVE CARE PLANS

PATIENT AND FAMILIES NEED TO BE REMINDED:

- Staff are here to help
- That they themselves can help by being respectful of the team and raising any fears, questions, or concerns early in the conversation or interaction.
- Decisions are always informed by current clinical best practice guidelines as well as principles outlined by regulations professional colleges
- Patients are responsible for the decisions and actions they take during their care when in a health care setting
- We need their input in identifying triggers and measures to reduce triggers

STAFF NEED TO KEEP IN MIND:

- It is best to use the language of partnership for decisions: Be welcoming, encouraging, and facilitate joint decision-making
- Say things like, “I need to talk to you about this in order for this visit or interaction to be safe for you and others”
- Ask questions and use the workplace tools and practices to assess the risks of violence from a patient (sometimes triggered by illness, or by individuals if there is a flag on their file for violence from previous visits, or if there is a known history of violent behaviour or by intervention CT scan on a patient who is claustrophobic or by signs of anger or frustration)

ASKING QUESTIONS AND COMMUNICATING THE INFORMATION

- Ask questions, particularly at intake
- Questions can include: “How are you doing? Do you recall the last time you were here? Do you recall any issues from your last visit(s) that may have caused you to become agitated”
- If there were issues, ask further questions about what happened, what did work or not work for that patient?
- If there is a flag for history of violent behaviour, provide this in chart details, such as root causes identified, triggers and behaviours noted or controls put in place for previous events

COMMUNICATION OF THE CARE PLAN, AND THE RISK CONTROLS (IF APPLICABLE):

- If at all possible go over the care plan in advance with family and caregivers and care providers and address any concerns in the moment.
- Ensure any wait time is explained. That is, “You will be waiting for (estimate of how long).” Tell them if anyone will be checking up on them, and if not, how they can seek out attention while they wait.
- Inclusive partnership language will be important: do not label patients or family as being difficult – it infers the message that if they could control themselves or change they would be viewed more favorably. Instead say “This may be challenging for all of us.”
- Use phrases such as “behavioural” care plans, versus “violent” patient plans

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- Make consequences clear for any violent act once it has been investigated.
- Patients/families may think “What you see as difficult, is because you don’t understand.” Use active listening techniques such as paraphrasing to affirm you do understand what they are saying/experiencing.
- Distinguish between validation and agreement. Listen first, acknowledge what you hear — even if you do not agree — before sharing your point of view. Acknowledging a person’s feelings are valid for them, even if we are not feeling the same way, allows them to feel heard and are more likely to listen to the care provider, in return.
- If an event occurs, include the patient’s family (based upon their capacity) in determining what went wrong and what can be done to prevent future incidents.
- Share solutions and safety measures system wide with other care providers/managers – don’t keep an intervention that worked buried in only the patient’s record

CONTROL RISK BY ENSURING:

- There are clearly documented mutual expectations regarding patients’ behavioral care plans
- Consequences for violating behavioral expectations are known to all parties. Actions have consequences, and while everyone does everything possible not to trigger, it may occur
- Managers should ensure that staff members have all the resources and supplies they need in the area
- Managers should ensure that the area is sufficiently staffed
- Staff have the skills or have a mentor to help them develop their positive patient relations/conversations as part of their day-to-day interaction with patients
- Proactive reviews for potential bad news the patient may receive from friends, relatives or staff — plan to give the message and intervene promptly to reduce the impact and involve security as part of planned care to deliver bad news
- Conversations with the patient are determining what works to help de-stress/de-escalate. (Examples include toys MP3 players etc., as well as other distractions/sensory modulations that help them react less or de-escalate when they are triggered.)
- Family and friends are engaged in the care plan where possible, because they know the patient. (For example, some dementia patients do better when a family member sits with them to help them acclimatize to the new setting.)

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- Hold team meetings to discuss the importance of having consistent adherence to enforcing the unit rules and to the specifics outlined in patient care plans.

INTRODUCTION TO SAFEWARDS

Some hospitals are starting to use the “Safewards Model.” Safewards focuses on building and maintaining positive relationships and care frameworks between health care providers and their patients. Safewards is an evidence-based, best practice model of care that originated in England and is supported by 20 year of research. . It is important to note that implementing Safewards in Canada may have differing results than in England if the contexts are different.

Conflict includes aggression, self-harm, suicide, absconding (walking away from the ward or the hospital), substance abuse and medication refusal. Conflict also covers the breaking of basic rules such as refusing to see care workers or smoking in areas that may lead to arguments with staff or other patients. Containment is defined as use of ‘as required’ prescribed medications, seclusion, withholding privileges, special observation.

Any training in Ontario hospitals must be developed, established and provided in consultation with the JHSC or in workplaces with 6-19 employees in consultation with the Health and Safety Representative.

Safewards Principles

(For more information, go to <http://www.safewards.net/>)

Safewards consists of ten principles that govern a desired hospital environment and how care should be provided.

1. CLEAR MUTUAL EXPECTATIONS

Clear mutual expectations work both ways, and just as the staff have expectations of patients, patients have expectations of the staff. Clarifying these relationships allows staff members to be consistent, and allows the patients to understand their obligations and those of staff.

2. KINDLY SETTING LIMITS

Kindly setting limits with soft words and resources are a way for nurses to build relationships with patients.

3. DE-ESCALATION TECHNIQUES

De-escalation techniques are used when a patient becomes agitated, angry and upset. When a crisis arises and it seems likely the patient might become more violent or harm themselves, it is often possible to talk them to help them calm down. That process is usually called de-escalation, but is also sometimes referred to as “diffusion.” Should the patient become physically violent with others or harms themselves, it may be necessary to undertake a safe physical take-down.

4. POSITIVE ROUNDS

Providing positive words when giving handover can be useful. Staff should say something positive about what each patient has been doing during the shift, or draw attention to some positive quality they have. If this is not possible, something positive about the way in which staff supported the patient (positive appreciation). In addition, if any difficult or disruptive behaviour is reported, a possible psychological understanding of the patient’s behaviour must be offered.

5. BAD NEWS MITIGATION

Bad news mitigation helps us notice these moments rapidly, and act fast to mobilize psychological and social support for the patient, before the distress turns into a conflict incident.

6. ONE PAGE PROFILES

Getting to know each other on a ward is often difficult. When we do have time to chat to patients, it helps a bit to know about their background and interests – these give us conversation topics we can raise that we know they may enjoy talking about. In fact, when we find out about patient interests, this information is often passed around the team so that all can use it to engage the patient. Please note that this is completely voluntary and staff are not required to provide profiles.

However, the same thing can work in reverse. If the patients are given a little more information about caregivers, they can find areas of common interest and conversational topics. If staff members and patients feel comfortable enough to share some information about themselves, a one-page profile for both a patient and staff on the ward can help form relationships, which can help staff orientate patients, enhance their coping skills, ameliorate their more difficult behaviour and make them feel more comfortable and reassured during their admission.

7. COMMUNITY MEETINGS

Community meetings on the ward, at a set time, can help reduce levels of conflict. The success of these meetings relies on patients reacting positively, appreciating each other's point of view, containing their own emotional reactions to the behavior of others, and upholding behavioural expectations.

8. COMFORT KITS

"Comfort Kits" are an intervention used to calm patients before considering PRN medication when it is noticed that a patient is showing behaviours. This is a kit that contains equipment for the patient to help them lower behaviours and agitation.

9. FOLLOW-UP

Following an occurrence of a potentially anxiety-provoking incident on the ward, every patient or patient family should be engaged to determine their understanding of what has happened, what effect it has had on them and to give them an explanation as to what has happened. The goal of staff presence, explanation and support is to leave everyone feeling safe and secure.

10. PARTING THOUGHTS

On the day of a patient's discharge, each patient and family member is to be asked if they would like to complete a survey. Explain to them that it is for the purpose of improving patient, family and hospital staff relationships in the partnership agreement.

A part of the discharge should also be parting thoughts that can be shared on the ward with other patients, family and staff. Encouraging positive thoughts of their stay is essential for others on the ward where they received their care. On the day of their discharge, each patient is to be asked if they would write a card for display on a special public notice board on the ward.