ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

SAFE AND EQUITABLE STAFF EXPERIENCE...*A Focus on Workplace Violence Prevention*

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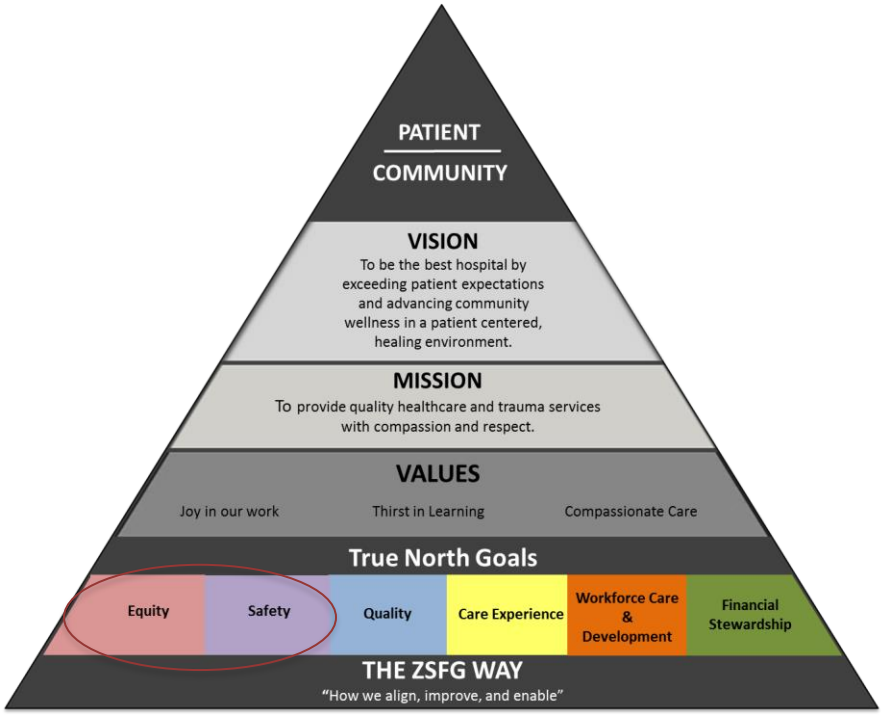
San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Department of Public Health

ZSFG TRUE NORTH



ZUCKERBERG SAN FRANCISCO GENERAL
Hospital and Trauma Center

Safe and Equitable Staff Experience

Owners: Andrea Turner
Team: Aiyana Johnson, Christine Falvey, Adrian Smith, Jenna Bilinski **Coaches: Will Huen, Chris Ross**

V10	3/23/2023		

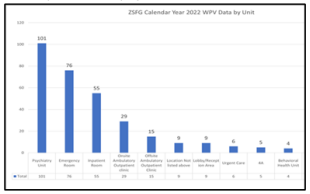
I. Background: What problem are you talking about and why focus on it now?

- Nationally, health care workers are nearly four (4) times likely than workers in most other industries to experience workplace violence*.
- Hospitals must take steps to prevent workplace violence to keep our staff safe and meet regulatory standards, which include implementation of written workplace violence prevention plan (procedures, assessments, controls, corrections, and other requirements), a violent incident log, training, incident reporting, and recordkeeping.
- In the past 2 years ZSFG has worked with law enforcement to decrease use of force and battery incidents involving patients.
- However, workplace violence directed at staff continues, which has created an unsafe environment to provide healing care with compassion and respect. Unfortunately, our staff experience patients' kicks, punches, slaps, spit, and objects hurled at them. Some of these incidents result in moderate or severe injury.
- In 2020, ZSFG began a campaign to reduce workplace violence. In 2021, ZSFG established a multi-disciplinary governing body known as the Assault Governance Task Force (AGT) to review physical assaults with a mission to evaluate, learn, and provide effective support to mitigate incidents of violence with proactive PDSA strategies to prevent re-occurrences. Multiple efforts ensued to curtail a destructive pattern that was becoming synonymous with working at "The General."

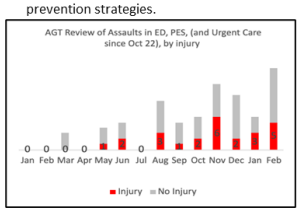
II. Current Conditions: What is happening today and what is not working?

- The Workplace Violence Prevention Committee (WPV) was created to use data to effectuate a plan to prevent violence and promote safety through cultural change, training, and communication. Expanded membership includes frontline staff in high-risk areas, house staff, sheriff, and executives.

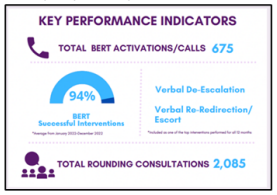
- High-Risk Areas: Top five high risk areas for WPV in the organization remain the **ED, PES, BHC, Inpatient, Urgent Care.** Example Below: WPV UO data, verbal and physical.



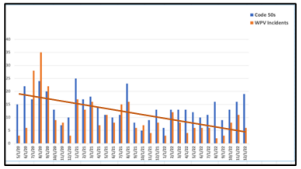
- Focusing on Injury and Prevention: AGT reviews physical assaults in PES, ED, UCC, with injury severity (Red below) and prevention strategies.



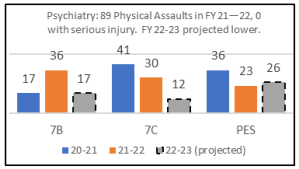
- BERT increased coverage, successfully intervening at 94%. However, BERT continues to improve and remains below full capacity and scope. Below: 2022 data



- ED Unit-Based Leadership Team implemented multi-disciplinary approach to threat management (CODE 50 = blue), reducing WPV incidents (orange). Assaults & injuries remain.



- Psychiatry Dept – Detailed review, CPI training, DMS Huddles with CPI tips, have reduced assaults with serious injuries, but assaults leading to injury persist.



Additional Gaps/Learnings:
- Despite these significant efforts, staff are enduring physical assault with injury.
- CPI: 43% of staff in high-risk areas have completed Crisis Prevention Intervention trainings. Many staff are uninformed of countermeasures
- Without unifying ownership or safety frameworks, there is a lack of transparency with disparate and siloed actions
- New SAFE system is not yet optimized to allow workplace violence analysis by AGTF, Exec Security

Problem Statement: *Because our staff is getting hurt at work, they do not feel safe; therefore, until our staff stop getting hurt at work and begin to feel safe at ZSFG, staff's perception will continue to be that ZSFG is an unsafe place to work and will not want to work here.*

III. Goals: A safe environment in which staff can provide care to all patients with compassion and respect.

Selected Metrics	Baseline	Target by April 2024
Reduce the # of physical assaults that lead to injury	3.1 per month ED/UCC/BHC/Psych/PES (6 month avg) (Med-Surg and Inpatient Psych Baseline to be established)	**By April 2024** = Less than 2.0 physical assaults per month Reduce avg # of physical assaults per month by 35% across ED/UCC/Psych/PES/Med-Surg/ **Long-term goal** = 0 physical assaults per month that lead to injury

IV. Analysis – Why is this problem happening?

A. People	B. Method
1. **Staff and leaders have variable knowledge, attitudes and skills in prevention of WPV** 2. **No department to oversee or own the work comprehensively** 3. **BERT team is highly successful, but still has limitations in scope and rate of successful interventions** 4. Shift from SFSD, though no evidence this is leading to escalation	1. **Threat management is perceived, implemented and documented inconsistently**, preventing effectiveness of CPI 2. Lack of clear delineation of roles and responsibilities of Care Teams and SFSD in WPV events. SFSD moving towards using time and distance as a way to engage agitated patient leading to more confusion about roles and responsibilities in WPV events.
1. **Firefighting culture with lack of shared ownership, direction and transparency leads to more resources being directed towards responding to rather than preventing violence.** 2. Increased homelessness, substance use (meth), behavioral health	1. **Variable review and quantification of assaults, injury by departments, UO and SAFE system** 2. **We do not have a standardized process to collect and share lessons learned to prevent WPV from reoccurring**
C. Environment	**D. Data, Feedback, Monitoring**

V. Possible Countermeasures

Barrier/Constraint	*Countermeasure*	*Description ("If-Then")*	*Impact*	*Effort*
C1. Shared direction & ownership B2. Roles and Responsibilities A3. Oversight/Ownership	**Governance, Policy and Direction Setting** through WPV Strategic Team	If we create unifying strategic team, then we will create shared ownership and vision, and a common safety framework and transparency across siloed departments.	H	H
D1. Variable quantification of workplace violence and injuries	**Data/Feedback:** Data for Defining Problem and Feedback	If we build on AGT standardized method and optimize SAFE system, then we will establish baseline data, analyze trends, and support learning and feedback for departments.	M	H
A1. Staff and leaders have variable knowledge, attitudes, and skills in WPV prevention	**Training:** Deploy new CPI training plan based on risk level and unit-based trainers	If we deploy a new staff centered CPI training plan based on risk level with built in process to collect staff input, then we will increase staff capacity and assess effectiveness of CPI.	H	H
A3. Limitations on BERT System Response	**Increase BERT** (Behavioral Emergency Response Team) capacity and effectiveness	If BERT team studies and tests ways to expand scope or effectiveness, then we may increase % successful interventions and reduce assaults.	H	H
B 1-2. D2. Variability and limitations of Unit Interventions	**Supporting Unit Based problem solving**	If we support units to test tools and practices to prevent WPV, then they will reduce assaults with injury within units (e.g. Code 50 in ED, PES DMS Huddles)	H	H

VI. Plan	*Description and Expected Result*	*Owner*	*Date*
Governance and Direction Setting WPV Strategic Team	1. Expand WPV committee to include high-risk areas (PES, ED, M/S, UCC, BHS) 2. Engage high-risk areas in setting up internal review of assaults 3. Develop policy addressing physical violence against staff with zero tolerance. 4. Conduct a racial equity impact analysis of patients and staff involved	WPV Committee	10/2023
Data/Feedback	1. Optimize SAFE system to meet standardized WPV reporting and classifications 2. Centralize ownership of data analysis and reporting in QM 3. Implement post-event review ZSFG-wide at department level	Jason V Alex S	12/2023
Training/Education Deploy CPI training plan based on risk level and utilizing trainers based on units	1. Engage DET, managers/directors in high-risk areas to develop CPI training plan to >90 % staff 2. Develop and implement a process for CPI training new staff through onboarding 3. Communication strategy to all staff around CPI highlights in huddles, rounding 4. Engage BERT in sharing best practices/highlights/successes while rounding	Justin D + Andrea T High-risk Dept leaders	7/2023
Increase BERT Response and Effectiveness ZSFG Wide	1. Collect data on BERT interventions to evaluate effectiveness. 2. Piloting a concept to embed BERT in areas that are high risk for patient escalation 3. Develop business case for sustainability and expanded scope of BERT	Joan T/Justin D.	
Supporting Unit-Based Response and Problem Solving	1. Review existing literature and best practices from our peers 2. Create a framework to support the work necessary to mitigate physical assaults 3. Create and communicate to staff about workplace violence plan checklist (e.g. DMS huddles, onboarding, CPI training, BERT, screening tools, standard work)	Unit Leads (PES, ED, M/S, UCC, BHS)	10/2023

VII. Follow-Up	
	1. Weekly report out of workplace violence incidents in the SAFE System at Security Meeting and AGTF 2. Monthly review of progress of countermeasures at WPV Committee meetings. 3. Routine reporting to Executive Team, Expanded Exec, JCC

Why Physical Assaults?

- Prevalence of workplace violence (WPV) in all sectors of workplace
- Since 2020, WPV has increased by 80%
- Healthcare workers are 4X likely to experience WPV.
- Focus placed on high-risk areas (ED, PES/PSYCH, BHC, UCC, MED-SURG)

Data

- Safe report severity rating scale
- Stratify incidents data by race/ethnicity, age, language, & gender
- BERT intervention stratified by dept, race/ethnicity, age, language, & gender

Physical Assaults Severity Rating

A-I		Specific Details	NDNQI - FALLS	WPV
A	Unsafe Condition	Unsafe Condition		NA
B	Near Miss - No Harm, Didn't reach person	Near Miss - No Harm, Didn't reach person		Low 1
C	No Harm - Reached Person No Monitoring Required	No Harm - Reached Person No Monitoring Required	None	Low 1
D	No Harm - Reached Person; Monitoring only- No Intervention	No Harm Reached Person; Monitoring Only/No Intervention	None	Low 1
E	Harm- Temporary; Intervention Needed	Harm- Temporary; Intervention (mild/mod) needed		
E1 WPV/Falls	Harm - Mild/Temp; Reached Person Monitoring/Mild Intervention Required	Harm- Mild/Temporary; Reached Person; Monitoring/Mild Intervention (ice, band aid, wound clean, topical/oral meds)	Minor	Mod 2
E2 WPV/Falls	Harm Moderate/Temp; Moderate Intervention Required	Harm Moderate/Temporary; Reached Person; Moderate Intervention (sutures, splint, IV/IM meds)	Moderate	Mod 2
F	Harm - Temporary, Hospitalization or Higher Level of Care Required	Harm - Temporary, Hospitalization or Higher Level of Care Needed (left shift)	Major	High 3
G	Harm - Permanent	Harm - Permanent	Major	High 3
H	Harm - Permanent, Intervention Required to Sustain Life	Harm - Permanent, Intervention Required to Sustain Life	Major	High 3
I	Death	Death	Major/Death	High 3/D
NA	Not Applicable	Not Applicable		NA

Problem Statement & Goal

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Goals

- Provide a safe environment in which staff can provide care to all patients with compassion and respect.

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Analysis

What

Both ED & PES were experiencing the highest severity of physical assaults = Assault Governance Task Force (AGTF)

- Interrogate their systems
- Review training
- Communication
- Culture

Discovery

- Information was not shared with other shifts
- Staff & leaders alike had variable knowledge of de-escalation practices
- Infrequent huddles
- Infrequent use of visual cues in EHR
- Disparate CPI training
- No systematic framework
- No central department owned safety
- BERT limitation
- Constant firefighting
- Variable reporting into the UO (now SAFE) System

Countermeasure

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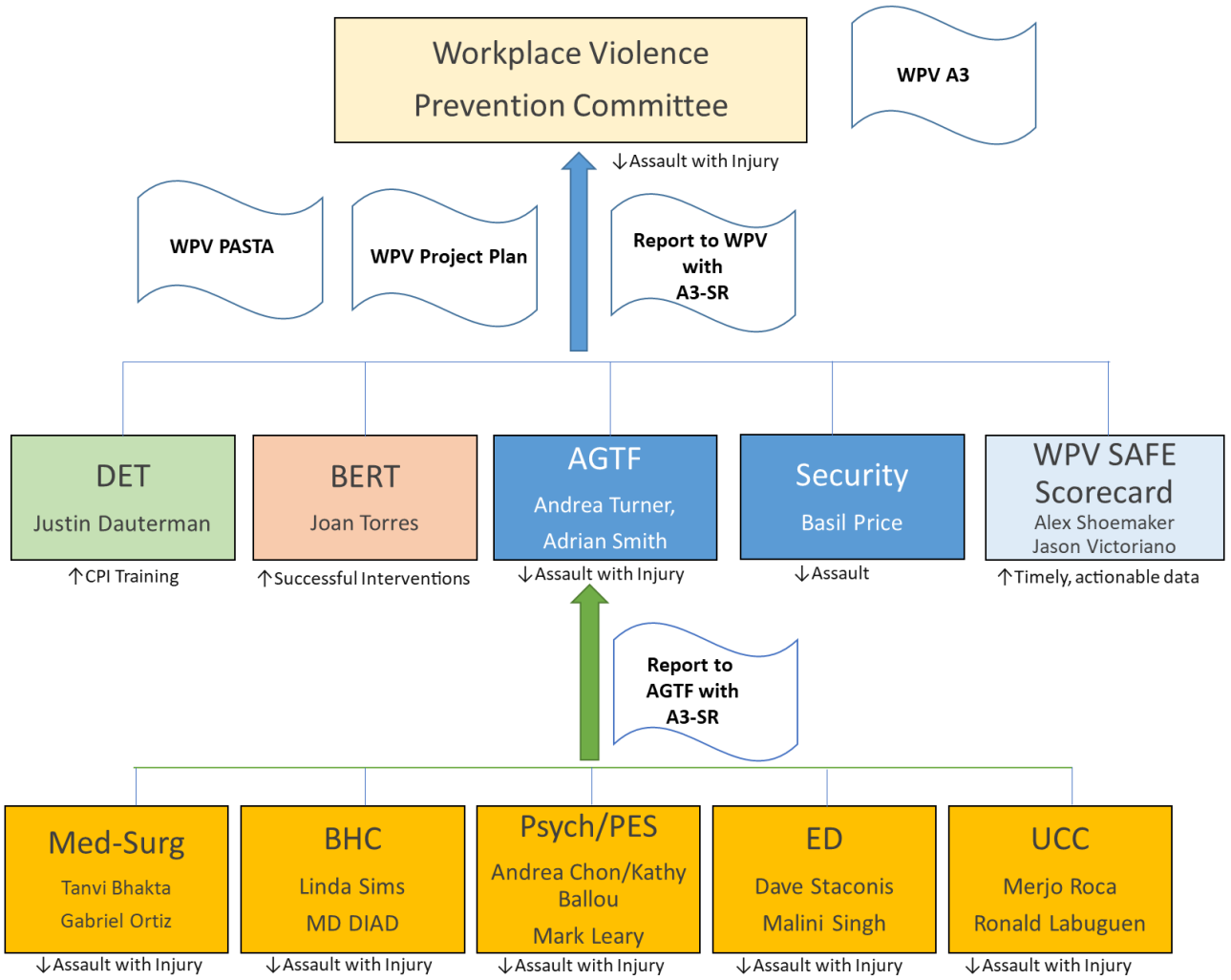
Deployment Strategy

Strategic
(Establishes Direction, Removes Barriers)

Operational
(Problem solving systems)

Unit-Based
(Driving change with frontline staff)



Strategic Team

- RM – Susan Brajkovic & Alex Shoemaker
- KPO – Dr. Will Huen, Chris Ross, Jason Victoriano
- BERT – Joan Torres
- Security – Dir. Basil Price
- DET – Justin Dauterman
- PES – Kathy Ballou & Andrea Chon
- Med Surg – Tanvi Bhakta
- BHC – Linda Sims
- Executive Contribution: Jenna Bilinski, Aiyana Johnson, & Adrian Smith