

Safe and Equitable Staff Experience

Owners: Andrea Turner

Team: Aiyana Johnson, Christine Falvey, Adrian Smith, Jenna Bilinski

Coaches: Will Huen, Chris Ross

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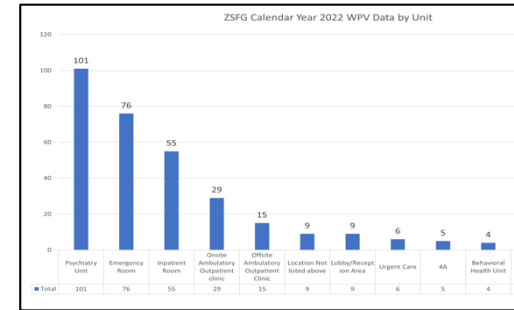
I. Background: What problem are you talking about and why focus on it now?

- 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."

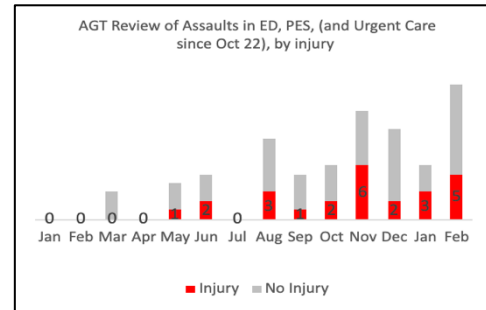
II. Current Conditions: What is happening today and what is not working?

- 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.

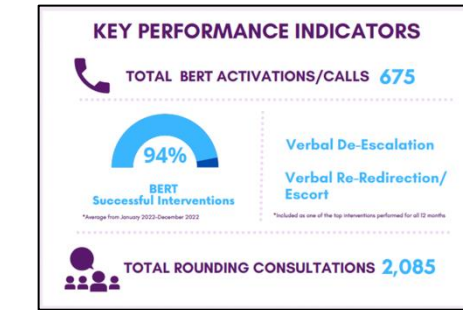
- High-Risk Areas: Top five high risk areas for WPV in the organization remain the **ED, PES, BHC, Inpatient, Urgent Care**. Example Below: WPV UO data, verbal and physical.



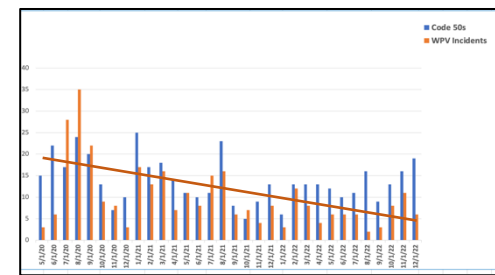
- Focusing on Injury and Prevention: AGT reviews physical assaults in PES, ED, UCC, with injury severity (Red below) and prevention strategies.



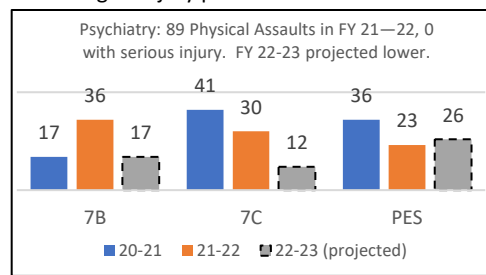
- BERT increased coverage, successfully intervening at 94%. However, BERT continues to improve and remains below full capacity and scope. Below: 2022 data



- 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
<i>Reduce the # of physical assaults that lead to injury</i>	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
<ol style="list-style-type: none"> Staff and leaders have variable knowledge, attitudes and skills in prevention of WPV No department to oversee or own the work comprehensively BERT team is highly successful, but still has limitations in scope and rate of successful interventions Shift from SFSD, though no evidence this is leading to escalation 	<ol style="list-style-type: none"> Threat management is perceived, implemented and documented inconsistently, preventing effectiveness of CPI 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.
<ol style="list-style-type: none"> Firefighting culture with lack of shared ownership, direction and transparency leads to more resources being directed towards responding to rather than preventing violence. Increased homelessness, substance use (meth), behavioral health 	<ol style="list-style-type: none"> Variable review and quantification of assaults, injury by departments, UO and SAFE system 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	<ol style="list-style-type: none"> Expand WPV committee to include high-risk areas (PES, ED, M/S, UCC, BHS) Engage high-risk areas in setting up internal review of assaults Develop policy addressing physical violence against staff with zero tolerance. Conduct a racial equity impact analysis of patients and staff involved 	WPV Committee	10/2023
Data/Feedback	<ol style="list-style-type: none"> Optimize SAFE system to meet standardized WPV reporting and classifications Centralize ownership of data analysis and reporting in QM 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	<ol style="list-style-type: none"> Engage DET, managers/directors in high-risk areas to develop CPI training plan to >90 % staff Develop and implement a process for CPI training new staff through onboarding Communication strategy to all staff around CPI highlights in huddles, rounding 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	<ol style="list-style-type: none"> Collect data on BERT interventions to evaluate effectiveness. Piloting a concept to embed BERT in areas that are high risk for patient escalation Develop business case for sustainability and expanded scope of BERT 	Joan T/Justin D.	12/2023
Supporting Unit-Based Response and Problem Solving	<ol style="list-style-type: none"> Review existing literature and best practices from our peers Create a framework to support the work necessary to mitigate physical assaults 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	
<ol style="list-style-type: none"> Weekly report out of workplace violence incidents in the SAFE System at Security Meeting and AGTF Monthly review of progress of countermeasures at WPV Committee meetings. Routine reporting to Executive Team, Expanded Exec, JCC 	

Strategic
(Establishes Direction,
Removes Barriers)

Workplace Violence
Prevention Committee

WPV A3

WPV PASTA

WPV Project Plan

Report to WPV
with
A3-SR



↓ Assault with Injury

Operational
(Problem solving systems)

DET
Justin Dauterman

↑ CPI Training

BERT
Joan Torres

↑ Successful Interventions

AGTF
Andrea Turner,
Adrian Smith

↓ Assault with Injury

Security
Basil Price

↓ Assault

WPV SAFE
Scorecard
Alex Shoemaker
Jason Victoriano

↑ Timely, actionable data



Report to
AGTF with
A3-SR

Unit-Based
(Driving change with
frontline staff)

Med-Surg
Tanvi Bhakta
Gabriel Ortiz

↓ Assault with Injury

BHC
Charisse Li

↓ Assault with Injury

Psych/PES
Andrea Chon
Mark Leary

↓ Assault with Injury

ED
Matt Talmadge
Malini Singh

↓ Assault with Injury

UCC
Merjo Roca
Ronald Labuguen

↓ Assault with Injury

Example: Unit-Based Countermeasure Summary

True North Metric: **Safety**

True North Goal: **Reduce Psychiatry Physical Assaults with Injury**

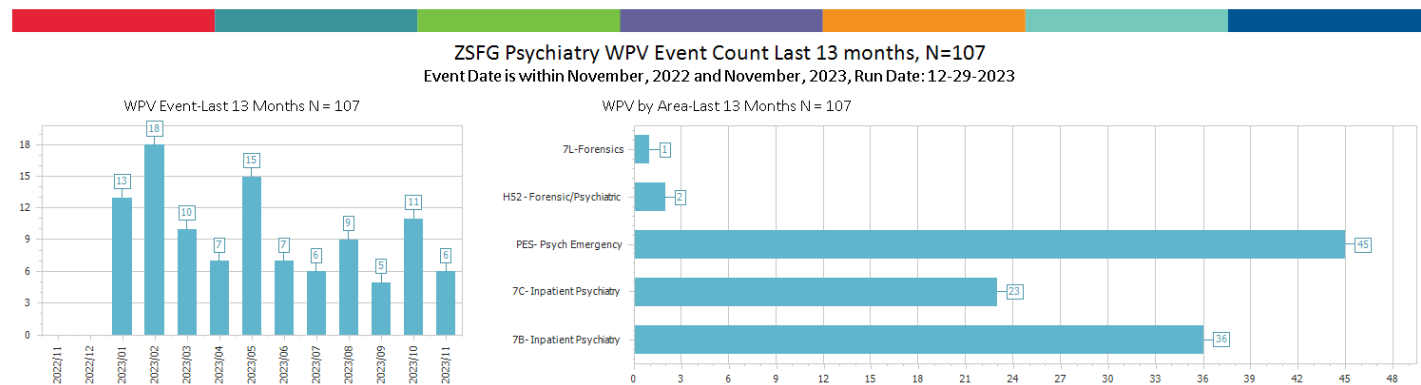
Month/Year: **November 2023**

Owners: **Andrea Chon & Joan Toi**



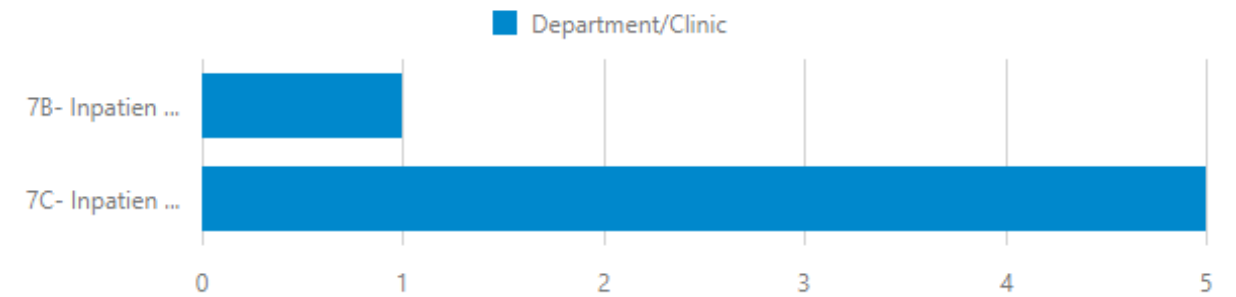
Target: **0 Physical Assaults with Injury**

Historical Data



- **6** WPV Safe Report Events Reported
- **6** WPV Physical Events
- **0** WPV Verbal Events Reported

Stratification of Data



- WPV events occurred most in **7C**
- WPV events occurred second most in **7B**
- **1** SAFE Report with severity E-I
- **0** staff CPI trained as of today

Top Contributors

SAFE REPORT # [5059](#)

Summary about staff assaulted in 7C

Brief Summary:

What happened?

While staff were assisting a patient with showering, the patient suddenly made shaving gestures; however, shaving supplies were not readily available in the shower room. He got upset and immediately started swinging at staff. He exited the shower naked and threw the shower chair at additional staff. He threw himself to the floor and used a towel in his hand to strike and attack staff.

Update on person assaulted- Staff did not take time off work; no injury reported

Update on assaulter Assailant declined an interview; staff were eventually able to de-escalate the patient. Patient is on a safety plan.

What's going well in the department? Safety Tips are reviewed with all staff regularly; ARB Action Plan Meetings

What opportunities exist? Education opportunities- patient was on a safety plan

How are you engaging your teams in all shifts? DMS Huddle Boards

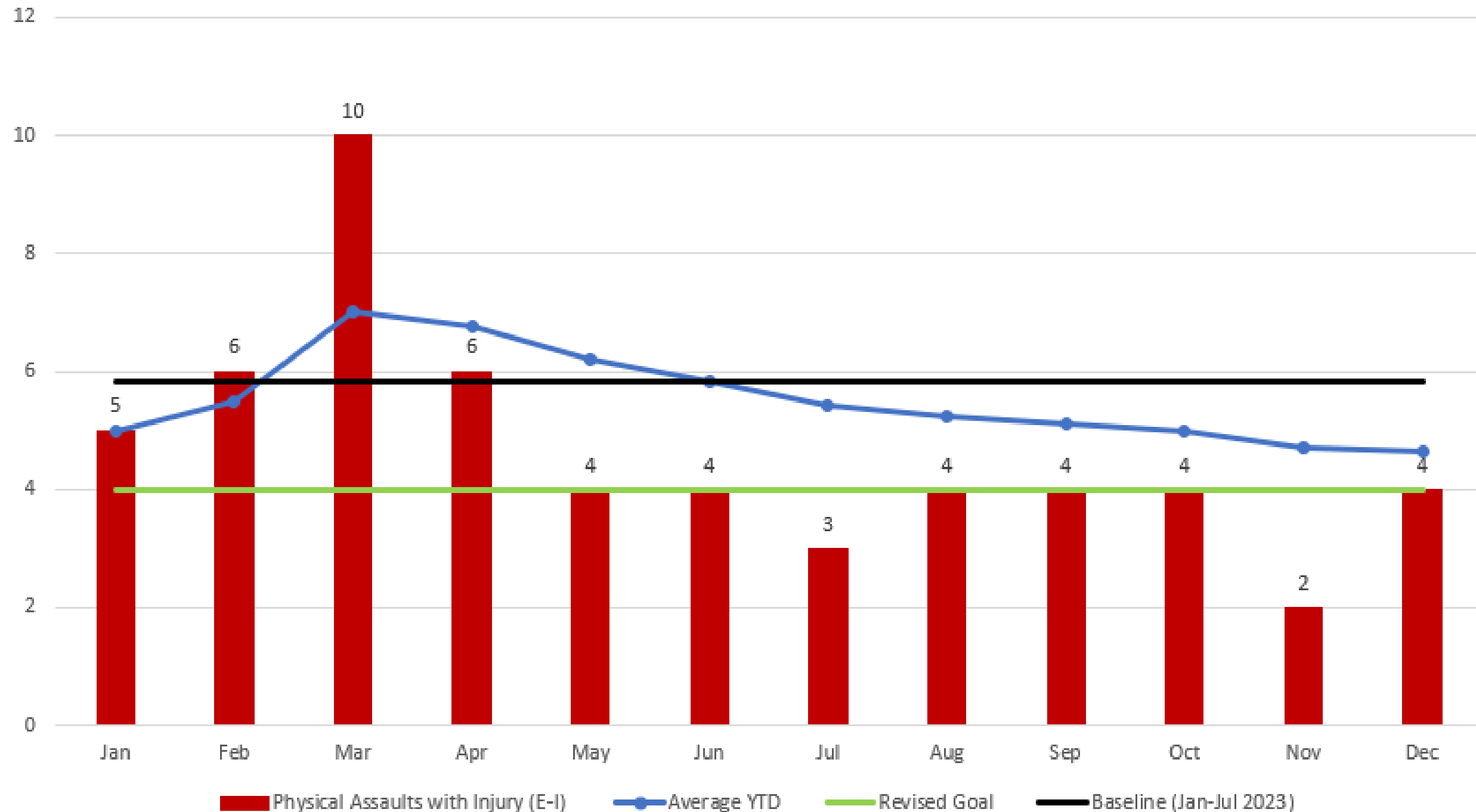
Feedback from staff as improvement opportunities Crisis checklists: step-by step guide for staff

- Psychiatry met **twice** in November (100%)
- Psychiatry had **5 huddles per week** on 7B, 7C, and PES for the entire duration in November (100%)
- Summary of Victim Data from Microsoft Tool:

No.	Root Cause	Countermeasure	Date
1	Patient has major neurocognitive disorder and receptive/expressive aphasia making it difficult to express and verbalize his needs. The patient has a poor frustration tolerance when staff cannot immediately understand him.	Patient's individualized safety plan was updated with option with multiple modes of communication- including visual communication boards .	12/1/23
2.	Communication barrier and response to a patient frustrated.	CPI Tip: integrated experience was distributed to all staff and presented during daily huddle boards. The Integrated experience CPI tip reminds staff to remain in control of their own behavior and teaches that the way we say things is just as important than what we say.	12/11/23
3.	Distance from agitated patient	Intervention and reminders were reviewed during daily huddles to maintain safe distances from patients during a crisis.	11/30/23

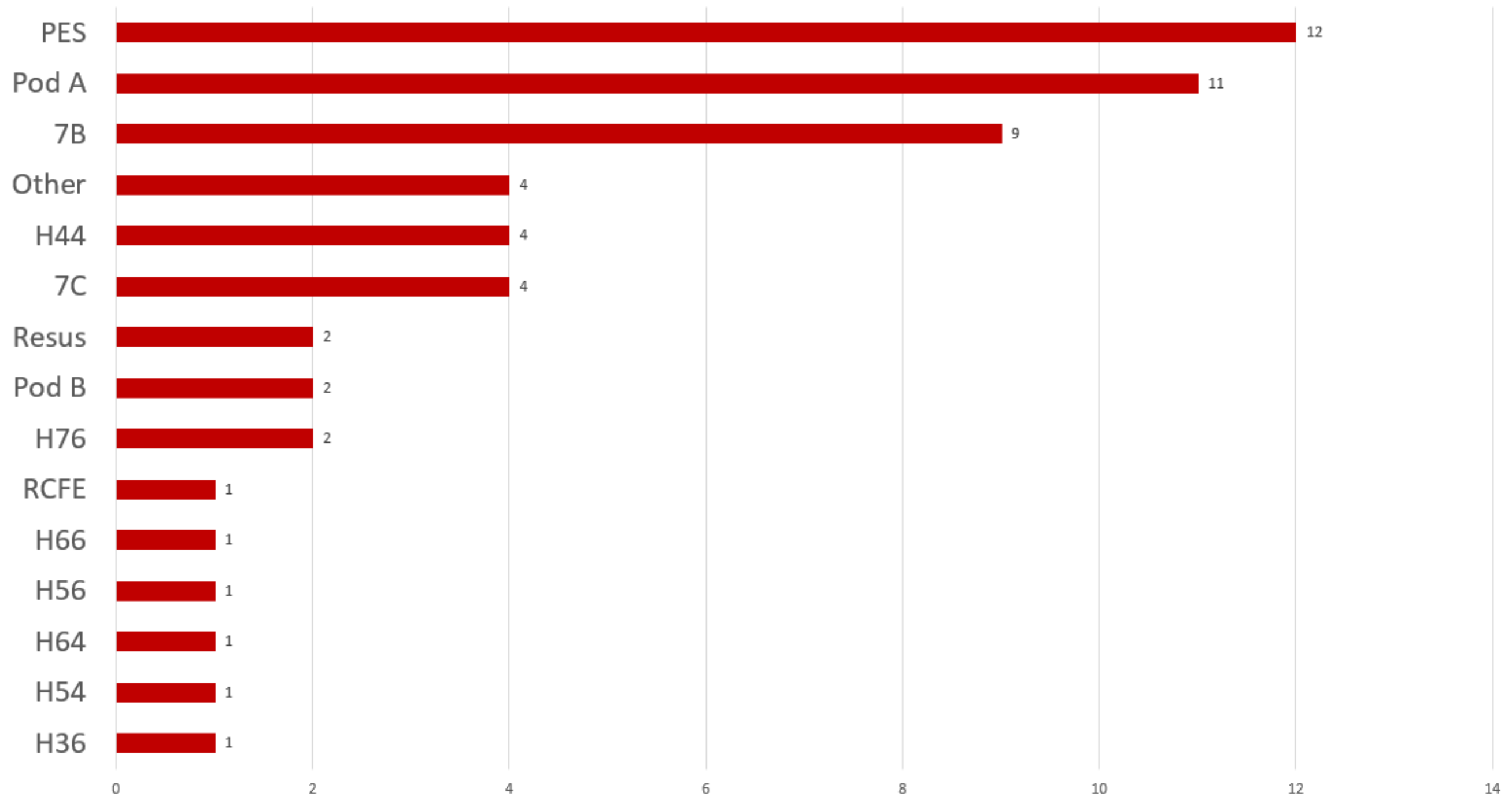
Results & Impact

ZSFG Physical Assaults with Injury (E-I) CY 2023



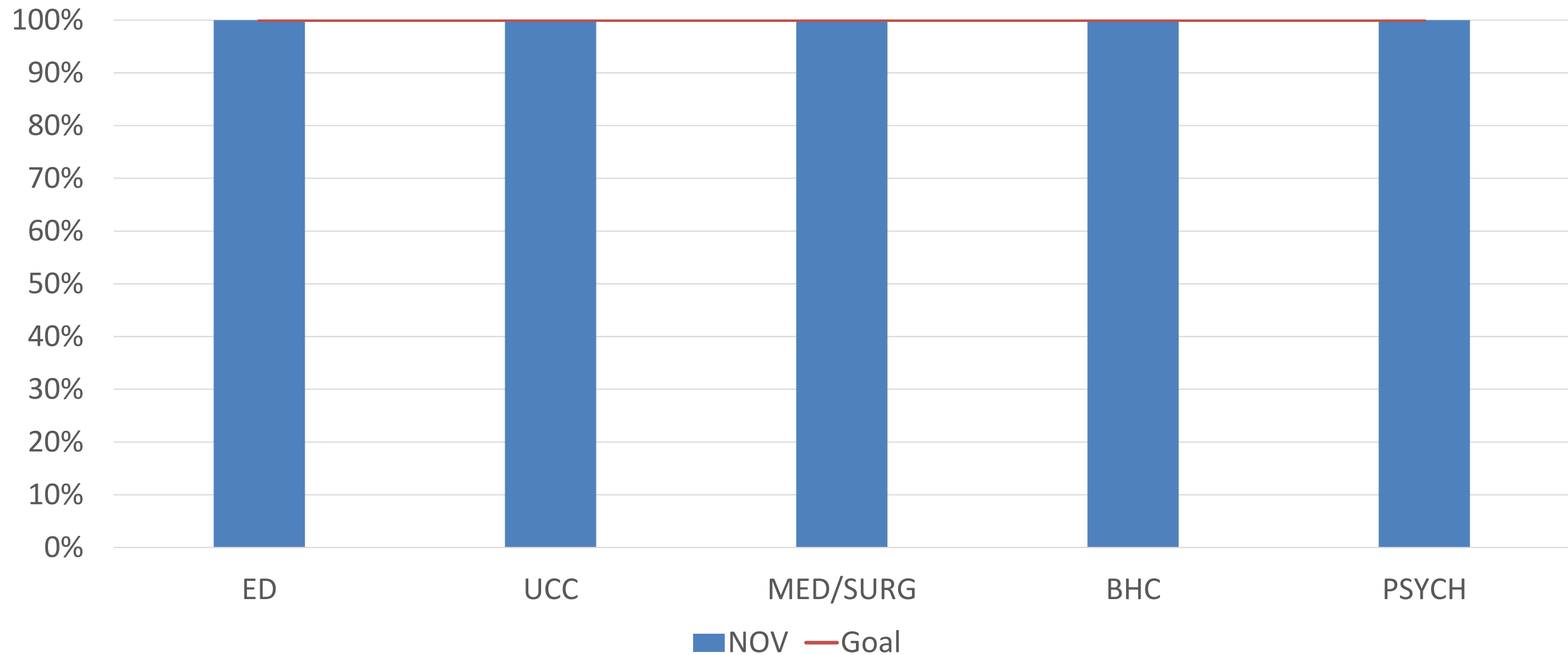
Stratified by Location

ZSFG Physical Assaults with Injury (E-I) by Unit (CY 2023)



Further Analysis – Initial CPI Trainings

CPI Trained % by High-Risk Area
(as of November 2023)



Next Steps

1. Continue engaging high-risk departments through Assault Governance
2. Investigate verbal assaults across high-risk departments
3. Establish CPI subject matter experts in high-risk departments to support use of principles
4. Standardize review committee process across all high-risk departments