Occupational Hazard: Disruptive Behavior in Patients

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Accurate reporting of disruptive behavior enables the development of strategies that provide for the safe delivery of health care to patients.

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While private or other public health care organizations can refuse to care for patients who have displayed disruptive behavior (DB), the VA Response to Disruptive Behavior of Patients law (38 CFR §17.107) prohibits the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) from refusing care to veterans who display DB.[1] The VHA defines DB as any behavior that is intimidating, threatening, or dangerous or that has, or could, jeopardize the health or safety of patients, VHA staff, or others.[2]

VA RESPONSE TO DB LAW

The VA Response to Disruptive Behavior of Patients requires the VHA to provide alternative care options that minimize risk while ensuring services; for example, providing care at a different location and/or time when additional staff are available to assist and monitor the patient. This can provide a unique opportunity to capture data on DB and the results of alternative forms of caring for this population. DB may represent a symptom of a health problem. Further, patients who are refused care because of DB may pose a threat to the community if their medical conditions are not treated or managed properly.

The reason public health care organizations refuse care to persons who display DB is clear: DBs hinder business operations, are financially taxing, and put health care workers at risk.[3-10] "In 2009, the VHA spent close to $5.5 million on workers' compensation and medical expenditures for 425 incidents–or about $130,000 per DB incident (Hodgson M, Drummond D, Van Male L. Unpublished data, 2010)." In another study, 106 of 762 nurses in 1 hospital system reported an assault by a patient, and 30 required medical attention, which resulted in a total cost of $94,156.[8] From 2002 to 2013, incidents of serious workplace violence requiring days off for an injured worker to recover on average were 4 times more common in health care than in other industries.[6-11] Incidents of patient violence and aggression toward staff transcend specialization; however, hospital nurses and staff from the emergency, rehabilitation and gerontology departments, psychiatric unit, and home-based services are more susceptible and vulnerable to DB incidents than are other types of employees.[8,10-19]

Data reported by health care staff suggest that patients rather than staff members or visitors initiate > 70% of serious physical attacks against health care workers.[9,13,20-23] A 2015 study of VHA health care providers (HCPs) found that > 60% had experienced some form of DB, verbal abuse being the most prevalent, followed by sexual abuse and physical abuse.[20] Of 72,000 VHA staff responding to a nationwide survey, 13% experienced, on average, ≥ 1 assault by a veteran (eg, something was thrown at them; they were pushed, kicked, slapped; or were threatened or injured by a gun, knife, or other weapon).[8,21] Although 13% may seem small, the incidents may have lasting financial and emotional distress. Risk factors associated with DB include medication nonadherence, history of substance abuse, disappointment with care, history of violence, and untreated mental health concerns.[19,24,25] Also, unmarried and young patients are more likely to display violence against health care workers.[26]

To meet its legal obligations and deliver empathetic care, the VHA documents and analyzes data on all patients who exhibit DB.

A local DB Committee (DBC) reviews the data, whether it occurs in an inpatient or outpatient setting, such as community-based outpatient clinics. Once a DB incident is reported, the DBC begins an evidence-based risk assessment, including the option of contacting the persons who displayed or experienced the DB. Goals of the risk assessment are to (1) prevent future DB incidents; (2) detect vulnerabilities in the environment; and (3) collaborate with HCPs and patients to provide optimal care while improving the patient/provider interactions.

Effects of Disruptive Behavior

DB has negative consequences for both patients and health care workers and results in poor evaluations of care from both groups.[27-32] Aside from interfering with safe medical care, DB also impacts care for other patients by delaying access to care and increasing appointment wait times due to employee absenteeism and staff shortages.[3,4,20,32,33] For HCPs, patient violence is associated with unwillingness to provide care, briefer treatment periods, and decreases in occupational satisfaction, performance, and commitment.[10,28,31] Coping with DB can compromise the HCP's ability to stay focused and engaged in providing health care, increasing errors.[9,15,31]

Harmful health effects experienced by HCPs who have been victims of DB include fear, depression, and anxiety, all symptoms of psychological distress and posttraumatic stress disorder (PTSD).[10,22,30,34-36] In a study of the impact on productivity of PTSD triggered by job-related DB, PTSD symptoms were associated with withdrawal from or minimizing encounters with patients, job turnover, and troubles with thinking.[35,36] Nurses with PTSD symptoms who stayed on the job had difficulty staying cognitively focused and managing "higher level work demands that required attention to detail or communication skills."[36] Due to the detrimental impact of DB, it is reasonable to expect a decrease in the quality of care rendered to patients by impacted employees. The quality of care for all patients of HCPs who have experienced a DB is poorer than that of patients of HCPs who have not experienced a DB.[29]

Reporting Disruptive Behavior

The literature suggests that consistent and effective DB reporting is pivotal to improving the outcome and quality of care for those displaying DB.[37-39] To provide high-quality health services to veterans who display DB, the VHA must promote the management and reporting of DB. Without knowledge of the full spectrum of DB events at VHA facilities, efforts to prevent or manage DB and ensure safety may have limited impact.[7,37] Reports can be used for clinical decision making to optimize staff training in delivery of quality care while assuring staff safety. More than 80% of DB incidents occur during
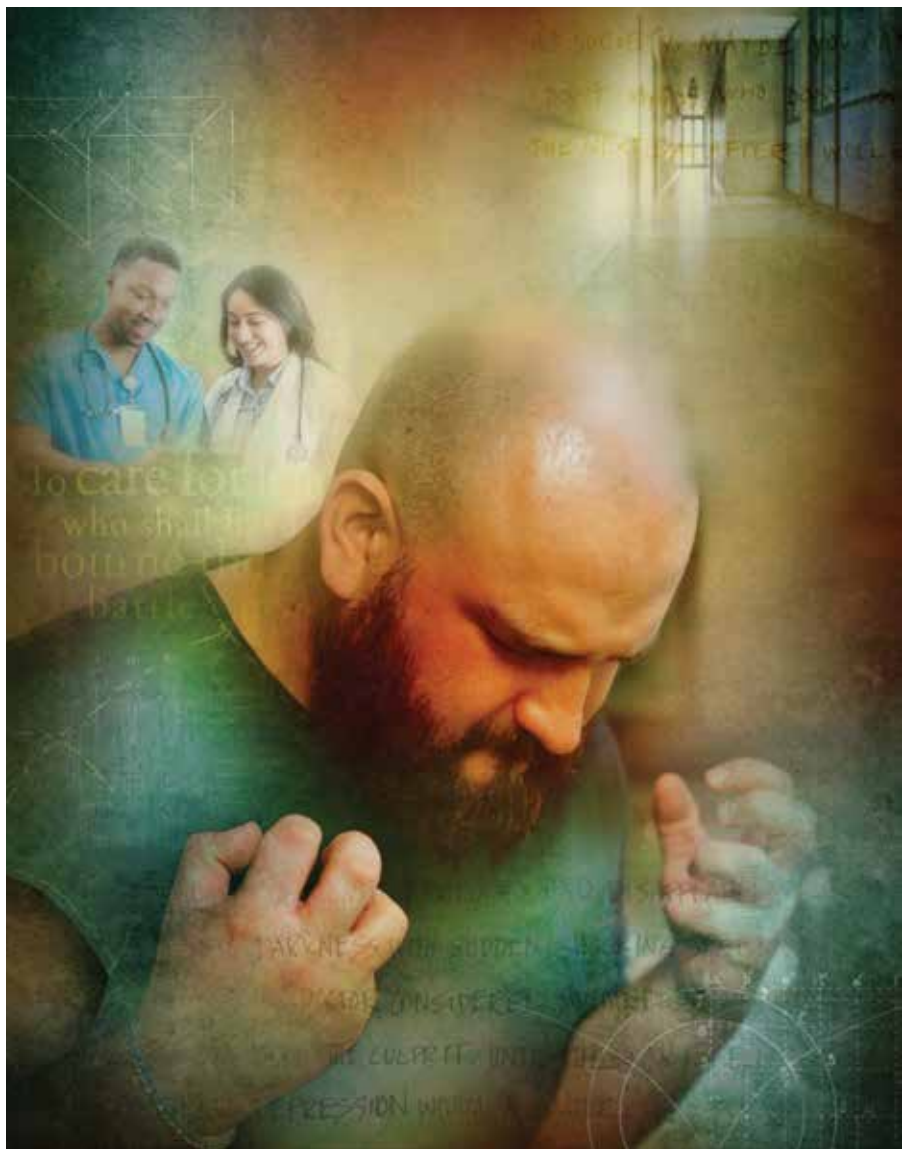
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interactions with patients, thus this is a clinical issue that can affect the outcome of patient care.[8,21]

Documented DB reports are used to analyze the degree, frequency, and nature of incidents, which might reveal risk factors and develop preventive efforts and training for specific hazards.[8,39] Some have argued that implementing a standardized DB reporting system is a crucial first step toward minimizing hazards and improving health care.[38,40,41]

When DB incidents were recorded through a hospital electronic reporting system and discussed in meetings, staff reported: (1) increased awareness of DB; (2) improved ability to manage DB incidents; and (3) amplified reporting of incidents.[38,41,42] These findings support similar results from studies of an intervention implemented at VA Community Living Centers (CLCs) from 2013 to 2017: Staff Training in Assisted Living Residences (STAR-VA).[4,12,19] The aim of STAR-VA was to minimize challenging dementia-related DB in CLCs. The intervention initially was established to train direct-care, assisted-living staff to provide better care to older patients displaying DB. Data revealed that documentation of DBs was, the first step to ensuring staff and patient safety.[18,40]

VHA REPORTING SYSTEM
In 2013, the VA Office of Inspector General (OIG) found no standardized documentation of DB events across the VA health care system.[42] Instead, DB events were documented in multiple records in various locations, including administrative and progress notes in the electronic health record (EHR), police reports, e-mails, or letters submitted to DBC chairs.[42] This situation reduced administrators' ability to consider all relevant information and render appropriate decisions in DB cases.[42] In 2015, based on OIG recommendations, the VHA implemented the Disruptive Behavior Reporting System (DBRS) nationwide, which allowed all VHA staff to report DB events. The DBRS was designed to address factors likely to impede reporting and management of DB, namely, complexity of and lack of access to a central reporting system.[43,44] The DBRS is currently the primary VHA tool to document DB events.

The DBRS consists of 32 questions in 5 sections relating to the (1) location and time of DB event; (2) reporter; (3) disrupter; (4) DB event details; and (5) the person who experienced (experiencer) the event. The system also provides a list of the types of DB, such as inappropriate communication, bullying and/or intimidation, verbal or written threat of physical harm, physical violence, sexual harassment, sexual assault, and property damage. The DBRS has the potential to provide useful data on DB and DB reporting, such as the typical staff entering data and the number and/or types of DB occurring.

The DBRS complements the preexisting VHA policies and committees for care of veterans who display DB.[1-3,14,21,24,25] The VHA Workplace Violence Prevention Program (WVPP) required facilities to submit data on DB events through a Workplace Behavioral Risk Assessment report. Data for the report were obtained from police reports, patient safety reports, DBC records, and notes in the EHR. Following implementations of DBRS, the number of DB events per year became a part of facility performance standards.

VHA is creating novel approaches to handling DB that allow health care workers to render care in a safe and effective manner guided by documented information. For example, DBCs can recommend the use of Category I Patient Record Flags (PRFs) following documented DB, which informs staff of the potential risk of DB and provides guidance on protective methods to use when meeting with the patient.[2,21,24] A survey of 140 VA hospital chiefs of staff indicated that DBC procedures were related to a decrease in the rates of assaults.[1] Additionally, VA provides training for staff in techniques to promote personal safety, such as identifying signs that precede DB, using verbal deescalation, and practicing therapeutic containment.

Resistance to Reporting
Many health care employees and employers are reticent to report DBs.[22,31,43,45-48] Studies suggest health care organizations can cultivate a culture that is resistant to reporting DB.[49,50] This complicates the ability of the health care system to design and maintain safety protocols and safer treatment plans.[3,41,51] Worldwide, < 30% of DBs

are reported.[47] One barrier may be that supervisors may not wish to acknowledge DBs on their units or may not provide sufficient staff time for training or reporting.[31,46,47] HCPs may worry that a DB report will stigmatize patients, especially those who are elderly or have cognitive impairment, brain injury, psychological illness, or developmental disability. Patients with cognitive conditions are reportedly 20% more likely to be violent toward caregivers and providers.[31] A dementia diagnosis, for example, is associated with a high likelihood for DB.[30,52] More than 80% of DB events displayed by patients with dementia may go unreported.[26,31,50,52]

Some clinicians may attribute DB to physiologic conditions that need to be treated, not reported. However, employers can face various legal liabilities if steps are not taken to protect employees.[47,51] Federal and state statutes require that organizations provide a healthy and safe employment environment for workers. This requires that employers institute reasonable protective measures, such as procedures to intervene, policies on addressing DB incidents, and/or training to minimize or deescalate DB.[51,53] Also, employees may sue employers if security measures are inadequate or deficient in properly investigating current and past evidence of DB or identifying vulnerabilities in the workplace. Unwillingness to investigate DB and safety-related workplace concerns have contributed to increased workplace violence and legal liability.[52,53] The mission of caring and trust is consistent with assuring a safe environment.

Training and Empathetic Care

To combat cultural resistance to reporting DBs, more and perhaps different contextual approaches to education and training may be needed that address ethical dilemmas and concerns of providers. The success of training relies on administrators supporting staff in reporting DB. Training must address providers' conflicting beliefs and assist with identifying strategies to provide the best possible care for patients who display DB.[1,38] HCPs are less likely to document a DB if they feel that administrators are creating documentation that will have negative consequences for a patient. Thus, leadership is responsible for ensuring that misconceptions are dispelled through training and other efforts and information on how reported DB data will be used is communicated through strategic channels.

Education and training must consider empathic care that attempts to understand why patients behave as they do through the information gathered.[55] Empathy in health care is multifaceted: It involves comprehending a patient's viewpoint, circumstances, and feelings and the capacity to analyze whether one is comprehending these accurately in order to demonstrate supportive care.[54,55]

Improving patient and staff interaction once a problematic behavior is identified is the aim of empathic care. Increasing empathic care can improve compassionate, patient-centered interactions that begin once the patient seeks care. This approach has proven to decrease DB by patients with dementia and improve their care, lessen staff problems during interactions, and increase staff morale.[20] Experts call for the adoption of an interpersonal approach to patient encounters, and there is evidence that creating organizational change by moving toward compassionate care can lead to a positive impact for patients.[54,55]

FUTURE STUDIES

There are growth opportunities in utilization of the DBRS. Analysis of the DBRS database by the VA Central Office (VACO) showed that the system is underutilized by facilities across the VA system.[56] In response to this current underutilization, VACO is taking steps to close these gaps through increasing training to staff and promotion of the use of the DBRS. A 2015 pilot study of VHA providers showed that > 70% of providers had experienced a DB as defined by VHA, but only 34% of them reported their most recently experienced DB within the past 12 months.[20] Thus, DBRS use must be studied within the context that patient-perpetrated DB is underreported in health care organizations.[5,9,29,41,43,57,58] Studies addressing national DBRS utilization patterns and the cost associated with implementing the DBRS also are needed. One study suggests that there is an association between measures of facility complexity and staff perceptions of safety, which should be considered in analyzing DBRS usage.[57] Studies addressing the role of the DBRS and misconceptions that the tool may

represent a punitive tool also are needed. VHA should consider how the attribution "disruptive behavior" assigns a negative connotation and leads HCPs to avoid using the DBRS. Additionally, DB reporting may increase when HCPs understand that DB reporting is part of the comprehensive, consultative strategy to provide the best care to patients.

CONCLUSION

Accurate reporting of DB events enables the development of strategies for multidisciplinary teams to work together to minimize hazards and to provide interventions that provide for the safe delivery of health care to all patients. Improving reporting ensures there is an accurate representation of how disruptive events impact care provided within a facility—and what types of variables may be associated with increased risk for these types of events.

Additionally, ensuring that reporting is maximized also provides the VHA with opportunities for DBCs to offer evidence-based risk assessment of violence and consultation to staff members who may benefit from improved competencies in working with patients who display DB. These potential improvements are consistent with the VHA I CARE values and will provide data that can inform recommendations for health care in other agencies/health care organizations.

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