Minnesota’s approach to preventing workplace violence in health care

Michael Mock
Wednesday, March 4
10:15 – 11:15 a.m.
Michael Mock

Michael Mock joined St. Luke’s in 1997 as a security officer. Mike received a degree in correctional sciences in 2001 while at St. Luke’s. Mike became a security coordinator in 2006 and security manager, the role he holds today, in 2010. Mike has seen firsthand the changes and new challenges to health care safety and security over the last 23 years. Mike’s free time is spent with his wife and 4 children. The family likes to hike and bird in state and national parks. Mike is an avid collector of … everything and the family spends many weekends a year playing modern board games.
Workplace Violence Causes and Mitigation Measures

Michael Mock
St. Luke’s Hospital
Security Manager

Unique Challenges for Minnesota

- **Opiates and Street Drugs:**
  - Methamphetamine seized by MN Violent Crime Enforcement
  - 2009 – 72 pounds
  - 2017 – 625 pounds
  - *MN Dept. of Public Safety 2018*

- **Synthetic Drugs:** chemically-created drugs grown in lab (often home lab) to mimic or otherwise replicate organic drugs.
  - Strength of drugs often unknown / wide variation
  - Generally much cheaper
  - Harder to identify
  - Easier to obtain
  - Often sold legally and mixed with other legal items to form dangerous cocktails
Overdose (EMS /ED / Hospital Impact)

- MN Opioid OD Deaths – 2000 – 52
- MN Opioid OD Deaths – 2017 – 422 (7.8 per 100,000)
- WI Opioid OD Deaths – 2017 – 926 (16.9 per 100,000)
- TX Opioid OD Deaths – 2017 – 1,458 (5.1 per 100,000 - Least)
- WV Opioid OD Deaths – 2017 – 833 (49.6 per 100,000 - Most)

*National Institute on Drug Abuse

Concentration can vary wildly
- Carfentanil – a synthetic opioid that closely resembles heroin or cocaine
  - 10,000 times more potent than Morphine
  - 100 times more potent than Fentanyl
- These and other synthetics pose significant risk to LE, EMS, and Emergency Department staff
- Touching by accident can be fatal (direct or airborne)
Mental Health / Suicide

MN Suicide – 1999 – 437
MN Suicide – 2017 – 783 (13.9 per 100,000) (35th lowest nationally)
WI Suicide – 2016 – 866 (14.7 per 100,000)
NJ Suicide – 2016 – 687 (7.2 per 100,000) (lowest nationally)
MT Suicide – 2016 – 267 (25.9 per 100,000) (highest nationally)

*NAMI (National Alliance on Mental Illness)

Opioid OD's lower 1/3 nationally
Suicides lower 1/3 nationally, but...
  Rate of opiate increase in MN
    711% increase since 2000
  Rate of suicide increase in MN
    78% increase since 2000

Effective 2014: MN Statute 253B.10
  The “48 hour rule”
  Prioritizes patients being admitted from JAIL or CORRECTIONAL INSTITUTION
  These patients MUST be admitted to service operated by the commissional within 48 hours
Mental Health Beds

* 2016 – 37,679 state hospital beds nationally (11.7 per 100K)
  * 5.5 of 11.7 occupied by forensic patients
* 2010 – 43,318 beds (14.1 per 100K)
* 2005 – 50,509 beds (16.8 per 100K)
* 1955 – 558,922 beds (337.0 per 100K)

* Treatment Advocacy Center: 2016 Going, Going, Gone report

Minnesota Beds

* MN 2016 – 194 beds (3.5 per 100K) (2nd Lowest in US)
  * Iowa (2.0 per 100K – lowest)
  * Wyoming (34.3 per 100K – highest)
* 2015 ER Physician Survey – 70% boarded psychiatric patient more than 24 hours
  * 10% boarded a psychiatric patient more than a week

*Treatment Advocacy Center: 2016 Going, Going, Gone report
Case Study (Mental Health)

* Patient on MHU committed to Anoka
* Unable to admit due to lack of beds
* On MHU 9 months
  * No exposure to sunlight
  * No athletics
  * No close family around
* **Wanted** to go state facility

Case Study (cont.)

* Approached LPN (good rapport)
* Loose comment to patient (due to good rapport)
* Significant Assault
* After restrained and in seclusion asked staff, “Now do I go?”

**Things we need to look at:**
* Environment / Length of Stay / Patient Population (mix) / Staff Education / Activities and Engagement on MHU
Old challenges, New Challenges...

- Provide sense of safety to staff
- Improve response time (from responders)
- Mitigate risk of slowed response from victim (freeze, loss of fine motor skill, hard to dial/talk)
- Radio, duress, panic, callbox, elevator, camera, trip sensor, magnet, lockdown; lock elevators, badge control

Alarms / Notification
Alarms (Cost & Maintenance)

- Most alarms are relatively inexpensive
- Many can be tied into existing systems (nurse call, access control)
- Can be monitored by Operators, Nursing, Security, Plant Servicers, 3rd Party Monitoring Company, etc
- Most are maintenance free after install
- Routine testing ensures ready and working when needed

Alarms (Types)

- **Handheld Radios**
- **Duress - Portable** (wireless)
  - Send signal to stationary sensor (gives location)
- **Duress – Hardwired**
  - Send signal direct to operator or other monitoring station
- **Callbox** (add-ons include: camera, intercom, light, audible alarm)
- **Trip sensor** (on hard-to-see or seldom used doors, etc)
- **Through Access Control** (improper use alerts)
- **Elevator Lockout**
- **Wandergard / HUGS** (dementia, sundowner’s, infant, minor)
Fuselier’s Behavioral Change Stairway

Behavioral Change Stairway Model

Education and Training

- Mandatory Violence Prevention Education for ALL staff (annual)
- De-escalation training for ALL Nursing on hire (MOAB)
  - Annual refreshers for Mental Health
  - Available to all departments on request
- Scenario specific training for Homecare (CIT model), PT, Registration and others
Case Study: Communicating between Departments

- Very large male (6’3” – 375lb) presented for care
- Agitated, verbally threatening, loud, aggressive posturing
- Registration called for Security called to de-escalate
- In checking of Security reports; not first incident of this behavior
- Notified: Quality, Registration, Clinic Manager, and Patient’s Provider
- All agree due to repeated behavior the patient will be terminated as a patient (customer)

Case Study: Communication Round 2

- Same patient registers for a procedure at a DIFFERENT CLINIC, but still within our organization
- Patient account presents with message

- PAR notifies manager; Manager requests history from Security
Case Study: Cont.

* Same group alerted to patient registering at different clinic
* (new) Provider would like to see patient, but understands / appreciates the history
* Security will be on-site for visit
* Behaviors, if any, will be shared with group and documented in incident reporting system
* Future behaviors will result in termination across organization (with exception of emergency treatment)

Workplace Violence Mitigation Measures

* **Hospital Policy** that outlines a list of violence prevention measures including:
  * Safety Screen of behavioral patients arriving to Hospital
  * Actively engage all on campus who appear through their actions to not have legitimate business
  * Camera monitoring
  * Inventory of belongings on admission to hospital (contraband removed)
  * Use of Disruptive Person Code and / or various alarm notifications

“We only have a few rules around here, but we really enforce them.”
Workplace Violence Mitigation Measures (cont.)

- Documentation of events in incident reporting system
- Alert placed on patient EMR
- Visitor Search and / or Visitor restriction of any visitors who have made threats, acted out violently, or attempted to bring contraband into facility
- De-escalation training for all nursing staff (working toward all staff)
- Discussion of events at daily Safety Huddle
- Close collaboration with Local Law Enforcement
- Violence Prevention Team review of documented events
  - Improvement recommendations based on reported events

Signage

- Posted in Urgent Care Lobby, Emergency Room Entrance, and Emergency Garage
- Posted at every public entrance point on campus.

Soft Attractive Signage in areas where a softer touch may be needed.
Signage

Very specific signage to inform patients, visitors, and staff how we respond to very specific and known issues.

This sign is present in every Urgent Care and Emergency Room on Campus.

Success Measures

- Total NA / Security 1:1 activations on rise
- Length of 1:1 activations of rise
- Total Violence Events on decline:
  - 2017: 351 Events
  - 2018: 339 Events
  - 2019: 281 Events
St. Luke’s Emergency alerted to very specific threat from local crisis center

[name withheld] is coming to your facility to exact revenge. States: *Is ready and has means to kill a shit-ton of people. His power has returned.*

Emergency staff contacted Security with threat received

**Case Study #2 (cont.)**

- **Immediate Response**
  - Dispatch staff (Security) to most common entrance points (Access control / lockdown measure)
  - Notify 911 of threat
  - Call crisis center back for more information
  - Mass notify Violence Prevention Team
  - Research EMR for Hx with this person
  - Update responding staff, law enforcement, and VPT with additional information
  - Description
  - Timeline
  - Known History
Case Study #2 (cont.)

- Threat is deemed credible
- Staff at front desk recognize man matching description walking in
- Cordon set up around area to keep civilians out of suspects path
- 911 notified of suspect location
- Suspect approached / apprehended
  - Found to have firearm, bear spray, knives, and other weapons on his person

Planning for the Future (Case Study)

- New Emergency Department – Q3 2020
- Current – 19 beds (3 in 1 room) / 5 in hallway
- Current – 1 psyche bed
- Current – 4 public entries into ED – all locked 1-layer deep
- Security planning begins early 2017
- 37 beds / all individual rooms
- New – 4 psyche beds in separated suite (lockable suite and individual rooms)
- New – 1 public entry into ED – locked 3 layers deep
Planning (cont.)

- Garage opens on arrival to all
- Reception staff first to receive public
- Many blind spots for staff and security cameras

- Garage locked to public – EMS and LE only. Public enters via covered parking lot and vetted at 3-layers of locked doors by Security
- Security first to receive public
- Number of cameras 400% higher than in previous ED space

Summary

- Successful Violence Prevention requires an interdisciplinary approach
- EVERY Department has a role
- Examples:
  - Registration is often first set of eyes / ears when on lookout for something
  - Biomed / IT identify and fix security infrastructure
  - Nursing to report events
  - Quality to initiate follow-up or provide past Hx from EMR
  - Admin to identify Violence Prevention as an organizational priority
  - Education / Training / Drills
Summary (cont.)

- Communication is key
  - Who to notify
  - When to notify
  - How to notify
- Communication METHODS are key
  - Pager
  - Radio
  - Email
  - Office Phone
  - Cell
  - Overhead PA
  - Mass Alert

Summary (cont.)

- Pre-Event Communication
  - If you see something, say something
  - If a known patient / visitor with Hx of violence is coming back, have a plan of action in place
- In-Event Communication
  - Get leaders involved
  - Notify response teams
  - Notify frontline staff
  - Notify local Law Enforcement
- Post-Event Communication
  - Document the event
  - Follow up with Law / Courts (where appropriate)
  - Follow up with staff (EAP, possible PTSD)
  - Debrief with Violence Team
Questions / Comments

Michael Mock Jr
St. Luke’s Hospital
Duluth, MN – 55805

218.249.5151

Michael.Mock@slhduluth.com