Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Healthcare Program Evaluation – Veterans Health Administration's Management of Violent Patients

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health (10/10B5)

SUBJECT: **Final Report** – Healthcare Program Evaluation – Veterans Health Administration's Management of Violent Patients, Report Number: 02-01747-139

1.   Purpose

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation of the Veterans Health Administration (VHA) management of violent patients. The evaluation was conducted to determine the effectiveness of VHA's program to identify violent patients, and to reduce the risk to employees, patients, and others visiting VA facilities of encountering threatening and violent patient behaviors.

2.   Background

The Bureau of Labor Statistics estimated that 2,637 non-fatal assaults on hospital workers occurred in 1999. This is much higher (8.3 assaults per 10,000 employees) than the same rate for all private-sector industries (2 assaults per 10,000 workers).[1] These statistics represent violent incidents precipitated by varied sources, including patients. However, the statistics suggest that people who work with ill and potentially highly stressed clientele can be at increased risk for experiencing violent acts. The National Institute for Occupational Safety and Health, a Centers for Disease Control and Prevention research agency, defines workplace violence as "… violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty." Examples of violence include:

- Threats: Expressions of intent to cause harm, including verbal threats, threatening body language, and written threats.

- Physical Assaults: Attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives.

- Muggings: Aggravated assaults, usually conducted by surprise, with intent to rob.

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[1] Violence: Occupational Hazards in Hospitals, National Institute for Occupational Safety and Health Publication No. 2002-101, April 2002.

The effects of violence range in intensity from minor to serious physical injuries, temporary or permanent physical disability, psychological trauma, and death. Violence in the workplace adversely affects employee morale, increases job stress and employee turnover, reduces trust in managers and coworkers, and creates a hostile working environment. Managers of healthcare organizations must be committed to maintaining a worker-supportive environment that places as much emphasis on employee safety as it does on providing safe patient services.

In an official letter, the Designated Agency Safety and Health Officer (DASHO) for the VA reported that "...violence perpetrated by nursing home or mentally ill patients/beneficiaries is a pervasive, long standing, and under-reported occupational health problem…accurate data and comprehensive analysis concerning employee assaults (e.g., number of assaults, job titles of victims, activity at time of assault [restraint, seclusion, etc.], cause and severity of injury) is essential to effective injury control."[2] The Occupational Safety and Health Administration (OSHA) published guidelines in 1996 that addressed workplace violence.[3] The OSHA guidelines emphasized that the main components of an effective program to prevent workplace violence were management commitment and employee involvement, worksite analysis, hazard prevention and control, and safety and health training.

The OSHA guidelines prompted VHA to develop the Violent Behavior Prevention Program (VBPP).[4] The VBPP was implemented to reduce employees' exposure to violent behaviors (including violent patient behaviors) by developing response procedures to incidents, and by designing employee-training programs that address warning signs of pending violent behavior, formulate prevention techniques, and design defensive techniques. The VBPP handbook stipulates that employees, who may be exposed to violent behaviors as part of their work assignments, must successfully complete specialized annual violent behavior prevention training.

In fiscal year (FY) 2000, the Deputy Under Secretary for Health (DUSH) created a Task Force on Workplace Violence with the goal of assessing the adequacy of VHA's violence prevention strategies. In August 2001, the task force reported that patients demonstrating violent behavior tended to be older, substance abusers, and seriously mentally ill. The task force concluded that essential components of an effective violence prevention program in VHA were either poorly developed or missing entirely. These components included: identification of responsible persons at the Veterans Integrated Service Networks (VISN) and facilities to oversee activities; establishment of employee education on the subject; assessments of environmental security and design of the facilities and individual patient care units to reduce the risk of violent behaviors; and alignment of current reporting systems to facilitate nationwide tracking and trending of violent behavior incidents.

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[2] DASHO Letter, 00S-97-7
[3] Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA 3148, 1996
[4] VA Handbook 7700.1, Occupational Safety and Health, paragraph 8.b, July 8, 1998

In March 1996, OHI reviewed VHA's policies and practices for managing violent patients.[5] At that time, we found that VHA managers needed to develop uniform methods for monitoring and reporting assaultive behaviors at medical centers and needed to include all employees who work in high-risk areas in violence prevention and management training programs. In early 1996, the Under Secretary for Health (USH) responded to the report by stating that the task force was reviewing the risk management processes and the technical feasibility of incorporating network flagging in an automated reporting system. The USH informed us in 1996, that various types of computer flagging systems had been developed by medical facilities and VHA would review these systems. VHA was to remind facilities in national teleconferences about the approach to flagging dangerous patients. The OIG did not believe initial actions taken by VHA addressed the recommendation and continued to pursue solutions to this initiative through the late 1990s. VHA managers began development of a national violent patient flagging system in June 2002. The VHA Directive on National Patient Record Flags was issued on August 28, 2003. The Patient Flag patch for managing violent patients' records was released to VHA facilities on September 11, 2003. The OIG closed the 1996 recommendation in September 2003, noting that this report would serve to continue follow-up oversight of this issue.

3.   Scope and Methodology

As part of the OIG's Combined Assessment Program (CAP) reviews we inspected the procedures in place to manage violent patient behaviors at 13 VA healthcare facilities from October 2002 through April 2003. Data anyalysis was completed in the summer of 2003.

We evaluated the extent of support and coordination that VISNs provided to VHA facilities for identifying and managing violent patients. We evaluated facility policies, procedures, and training programs pertaining to the identification and management of violent patients. We also evaluated safety and vulnerability assessments and the implementation of recommended interventions to reduce the risk of incurring adverse outcomes resulting from violent events.

We analyzed VHA facilities' procedures used to identify and manage violent patient events, and reviewed incident reports and the medical records of 125 patients who perpetrated acts of violence against other patients or employees.

We interviewed managers and employees to evaluate adherence to the facilities' policies and procedures for reporting, investigating/reviewing, and following-up on incidents of patient violence, and facility and VISN VBPP coordinators to determine whether procedures to alert employees of patients' histories of violence existed through an electronic flagging system.

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[5] Evaluating VHA Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients, Report Number 6HI-A28-038, dated March 28, 1996

We analyzed data on Office of Worker's Compensation Program (OWCP) costs associated with incidents of patient violence for each facility for the period from July 1, 2000 through June 30, 2002.[6]

We assessed employees' perceptions of the VHA facilities' cultures and attitudes toward zero tolerance for patient violence. We used an electronic questionnaire to survey employees at the 13 facilities prior to and during our CAP site visits. Not all employees responded to every question, resulting in different denominators, however 2,295 employees responded to 1 or more of the 14 questions related to patient violence.

We conducted the evaluation in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

4. Evaluation Results

While we found opportunities for improvement in the management of violent patient events at the facilities we visited, we also found that several components for successful violence prevention programs were in place.

We queried 11 VISN managers to determine if VBPP coordinators had been appointed to direct facilities in key aspects of their violence prevention programs, including management of violent patients. Of the 11 VISNs, 9 (82 percent) had designated coordinators. In FY 2002, a VHA Network Director Performance Monitor required VISN Directors to appoint VISN-level VBPP coordinators. The names of the coordinators and status of the VHA-required employee-training programs was a DUSH action item due July 31, 2002, to the VA Occupational Safety and Health Office.

At the facility level, we found that 11 (85 percent) of 13 facilities had VBPP coordinators, and that 12 (92 percent) of the 13 facilities had written policies governing their programs. The policies defined violent behaviors and addressed the management of violent patients. Additionally, policies described response procedures and employee training plans, and identified interdisciplinary committees to review and recommend follow-up actions to manage violent patients.

All 13 facilities visited provided employees with violence prevention training, which included management of violent patients. Six facilities (46 percent) required every employee to have this training, and the remaining facilities required the training for employees who worked in identified high-risk areas. The training programs included recognition of warning signs of escalating behavior, verbal and non-verbal de-escalation techniques, and safe physical interventions that could be used when necessary. The training programs also provided introductory information on management of violent patients during new employee orientation. Our review of employees' training records showed that 149 (99 percent) of 151 employees completed the annual training, and that

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[6] OWCP tracks their data according to "charge back years" which run from July 1st of one year through June 30th of the following year. We collected data for two "charge back years," July 1, 2000 through June 30, 2001 and July 1, 2001 through June 30, 2002.

new employees received introductory training during their orientations.

We found that managers completed physical security surveys/vulnerability assessments annually, and reported findings to the appropriate facility committees. VA Police Unit 11 Guidebook, Physical Security Assessment and VA Handbook 0730[7] requires managers to conduct, document, and assure appropriate follow-up of annual physical security surveys for VHA facilities. We reviewed completed physical security surveys/vulnerability assessments at each facility and interviewed the Police Service employees who conducted them. Managers identified areas that they considered at increased risk for incidents of patient violence. Examples of identified high-risk areas included mental health outpatient clinics and inpatient units, and ambulatory care clinics. Surveillance cameras were present in high-risk areas at 7 (54 percent) of the 13 reviewed facilities, and emergency alert systems, such as panic buttons, were available in high risk areas at all facilities. Twelve (92 percent) of 13 facilities had implemented recommendations to reduce the risks of patient-perpetrated violence in vulnerable areas.

Responses to our employee questionnaire showed that 872 (38 percent) of the 2,295 employees who responded asserted that patients had verbally or physically threatened them. Of those, 706 (81 percent) reported the incident, and 689 (79 percent) felt supported by their supervisors in their decisions to report. We concluded that employees were generally satisfied with the VBPPs in their facilities and believed that their supervisors promoted zero tolerance for patient violence. Of the 2,055 employees who responded to the question that they received training in the management of violent patients in the past 12 months, 1,585 (77 percent) believed that the training would help them successfully manage a violent incident. Two hundred fifty-five employees responded to the question regarding feeling safe from violent patient incidents in their work environment, and 197 (77 percent) responded that they generally felt safe. We asked employees for recommendations to improve the layout and design of their work areas to enhance security. Their recommendations ranged from installing more panic buttons and surveillance cameras to redesigning work areas to improve privacy and improve access to exits.

Issue 1:   Responding to Violent Patient Incidents

Each facility had a policy that described emergency response procedures to violent patient episodes, but only seven of the policies (54 percent) identified interdisciplinary response teams. The remaining six facility policies (46 percent) identified either police officers or nursing employees as responders. OSHA[8] guidelines suggest that organizations establish trained response teams to react to violent emergencies. Each team should have a designated leader; and one or more members of the team should be skilled in diffusing volatile situations or aggressive behaviors, managing anger, using medications as chemical restraints, and using physical restraints when required. The

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[7] There are two references from VA Handbook 0730: Paragraph 6, Physical Security, and Appendix B.
[8] Guidelines for Preventing Workplace Violence for Health-Care and Social-Service Workers, OSHA 3148, 2003 (Revised)

six latter teams would benefit from interdisciplinary membership and would maximize facilities' effectiveness in protecting employees, patients, and others from violent patient behaviors.

Issue 2: Reporting, Reviewing, and Follow-Up

We found that facilities used two separate systems to report violent incidents resulting in inconsistent or incomplete data collection. The two systems did not interface, and access to the databases was restricted to a small cadre of employees. For example, only police employees had access to Uniform Offense Report (UOR) data, and patient incident reporting data was typically restricted to patient safety, risk management, or quality management employees. VHA revised and reissued a risk management directive on September 25, 1997. The directive requires employees to report patient-on-patient and patient-on-employee assaults using VA Form 10-2633, Report of Special Incident Involving a Beneficiary. Similarly, police officers are required to use the UOR, VA Form 1393 to report major felonies, which include aggravated assaults. If police were not called to respond to threatening or violent patient episodes, the episodes would not be recorded in the UOR data. We found that only 1 (8 percent) facility of the 13 facilities we reviewed cross-referenced the 2 databases in an effort to identify, analyze, trend, and effectively manage all violent patient incidents. The lack of reconciliation of the two reporting databases resulted in incomplete reporting and trending, making it difficult to analyze incidents for the purpose of recommending strategies to reduce or prevent violent incidents.

While 12 facilities had policies establishing committees to review violent incidents, make decisions regarding dispositions of the patient perpetrators, and regularly follow-up on the committee's decisions, we found only 5 (42 percent) of 12 facilities had committees that actually fulfilled these functions. Two (17 percent) of 12 facilities left decisions about actions and follow-up to single persons, even though the policies indicated that this was to be a committee function. One facility did not provide for any follow-up of violent incidents. Committees that are charged with the responsibility of reviewing and developing strategies to reduce violence need to be accountable for performing these functions.

Issue 3: Computerized Warning Flags

VHA managers have not implemented an effective violent patient warning system. We were told that a system-wide plan to support computerized advisories was presented to the Information Technology Advisory Committee (ITAC) in August 2001. To determine whether facilities developed local policies and procedures (in the absence of a finalized VHA initiative) to place warning flags into the Computerized Patient Record System (CPRS) and Veterans Health Information Systems and Technology Architecture (VISTA) that alerted employees about patients with histories of violence, we reviewed medical record documentation and interviewed managers. We found that:

- Three (23 percent) of 13 facilities established procedures to use warning flags in both CPRS and VISTA.

- Eight (62 percent) of 13 facilities established procedures to use warning flags in one or the other system, but had no mechanisms to carry over the information from CPRS to VISTA or vice versa.

- Two (15 percent) of 13 facilities did not have any computerized warning flag notification systems.

- Of the 11 facilities that had flagging capabilities, only 4 (36 percent) had actually activated warning flags in either CPRS or VISTA.

In addition to the medical record, we reviewed the UORs and the VA Forms 10-2633 pertaining to 125 patients who perpetrated incidents of violence against other patients or employees. We found that 88 (70 percent) of the 125 patients committed incidents that were recorded as physical attacks. Fifty-six (45 percent) of the 125 patients were repeat offenders. In the 12 months prior to our CAP reviews, these patients each perpetrated an average of four acts of violence. The number of multiple violent incidents per patient ranged from 2 to 18. Only 10 (18 percent) of the 56 repeat offenders had electronic warning flags activated.

At 1 facility, we encountered a patient with dementia who had perpetrated 18 violent acts during a 12-month period. Employees had not flagged the patient's medical record because it was the facility's practice not to take follow-up action when a patient had a psychiatric diagnosis. At another facility, we found a similar practice to refrain from follow-up action for violent patients, if a review of the incident showed that the patient had a psychiatric diagnosis and/or was non-compliant with medications. Both facilities were in the same VISN. The practice of not taking actions against violent patients who had psychiatric diagnoses (for example, issuing a warning letter, providing police escort, or flagging the medical record) was contrary to both facilities' policies.

It is important for warning flags to appear in both systems (CPRS and VISTA), because clinicians (physicians, nurses, and social workers) primarily use CPRS; and clerical and support employees primarily use VISTA to schedule appointments, verify eligibility, and update records. All employees who work directly with patients need to have access to information about patients' histories of violent behavior.

We were told that VHA was testing a system-wide computerized warning program to alert employees about high-risk patients who travel between facilities. This testing was taking place in a VISN that was included in our review. For the period of the test, employees within this VISN will have the ability to view patients' warning flags for those patients who present from other facilities within their VISN. The release date for the VHA Directive 2003-048, known as National Patient Record Flags (PRF), was August 28, and software to create the flags was released on September 11.

Issue 4: <u>OWCP Costs</u>

We reviewed OWCP data for each facility to determine the number of claims that were related to employee injuries associated with violent patient incidents. We also reviewed the related costs associated with those injuries. We compared each facility's total OWCP costs with OWCP costs specifically related to incidents of patient violence. The following table summarizes our overall findings:

OWCP Costs For 13 Facilities			
Categories of Expenses	Total Incidents for Facilities	Incidents Related to Patient Violence	Average % Related to Incidents of Patient Violence
OWCP claims	3,189	175	5
Lost workdays	16,691	1,458	9
Salary costs for lost workdays	$7,166,179	$515,451	7
Medical expenses	$3,003,289	$235,528	8

While overall percentages of violent patient-related OWCP costs were relatively low, five facilities were outliers in one or more categories of OWCP costs when we compared them to the other facilities. Two facilities had disproportionately high numbers of claims (52 percent and 21 percent) related to employee injuries, that occurred during violent patient episodes. The remaining 11 facilities reported 7 percent or fewer such claims. The facility with the highest number of claims had a flagging system, but managers had not activated flags for the five patients we reviewed; and four of those patients were repeat offenders.

Three facilities reported violent patient-related lost workdays that represented 65 percent, 23 percent, and 18 percent of their totals, respectively. The remaining 10 facilities reported less than 10 percent of their lost workdays as being associated with violent patient-related injuries. Our review of 30 patients' medical records at these 3 facilities showed that 16 (53 percent) of the 30 patients were repeat offenders. None of the 30 medical records had been flagged to alert employees of the patients' potential for violence, even though 2 of the 3 facilities had computerized flagging systems.

5. Conclusions

The VHA facilities we reviewed had several important components necessary for successful violence prevention programs. These components included program coordinators at the VISN and facility levels, employee violence prevention training, and annual safety/vulnerability assessments. Additionally, employee surveys indicated that employees generally felt supported by their managers to report violent incidents, and the majority reported that they felt safe in their work environments. Nevertheless, employees made suggestions that they believed would enhance security in their work areas, some of which managers should consider.

VHA could improve its patient violence prevention procedures by establishing interdisciplinary response teams in all facilities. The teams need to be appropriately trained and skilled in violence management and defensive techniques.

VHA could improve reporting of violent incidents by establishing a single database to chronicle such incidents, or by establishing a methodology that facilitates cross-referencing of the existing databases. Additionally, appropriate employees must have access to the data in order to identify all violent incidents, and to facilitate analysis and trending procedures.

Establishing interdisciplinary committees at the VISN or facility levels could strengthen reviewing procedures. The committees should review violent incidents for the purpose of developing violence management and prevention strategies. The committees should also track the implementation and efficacy of recommendations designed to prevent and control workplace violence. This would affirm senior managers' commitment to employee and patient safety.

VHA has not established procedures that alert employees about patients who have histories of violence. This could be accomplished by the development and use of a uniform computerized flagging system. Even in facilities in which flagging systems were available, 64 percent did not utilize the systems. We recognize that VHA has established a national system to implement automated flags. However, individual facilities should explore ways of developing and implementing their own systems until the national system is operational.

Five percent of the OWCP claims and 9 percent of lost workdays in our sampled facilities were attributed to violent patient-related injuries. However, one facility reported that 52 percent of its OWCP claims were violent patient related. Another facility attributed 63 percent of its lost workdays to violent patient incidents. VHA could potentially reduce OWCP costs by improving prevention and management of violent patient incidents.

6. Recommendations

We recommend that the Under Secretary for Health ensure that:

a. Interdisciplinary response teams are established in each facility and are specifically trained in violence management; and that the teams appropriately respond to all emergency calls.

b. A consistent method of identifying and reporting violent incidents is developed, and complete information is available to employees who are responsible for analyzing and trending this data, and recommending corrective strategies.

c. Interdisciplinary committees are established and charged with the responsibility of reviewing and tracking violent incidents for the purpose of developing violence management and prevention strategies.

d. Guidelines are implemented for the appropriate use of automated warning flags, and that they are applied consistently throughout the system, and all employees have access to computer systems that will flag patients' records when there are histories of violence. Patient records that are flagged should be systematically reviewed by interdisciplinary committees to establish the need for continued use of the flags for each patient. Additionally, until the VHA-wide flagging system is fully operational, individual facilities should explore methods to develop local employee alert systems.

7.   Under Secretary for Health Comments

The Under Secretary for Health concurred with the recommendations and provided implementation plans with target completion dates. The full text of the comments and implementation plans is shown in Appendices A and B.

8.   Inspector General Comments

The Under Secretary's comments and implementation plans are responsive to the recommendations. We will continue to follow up until all issues are resolved.

(original signed by:)
 JOHN D. DAIGH JR., M.D.
Assistant Inspector General for
  Healthcare Inspections

Department of Veterans Affairs

Memorandum

Date: March 31, 2004

From: Under Secretary for Health (10/10B5)

Subj: OIG Daft Report: **Healthcare Program Evaluation: Veterans Health Administration's Management of Violent Patients** (Project No. 2002-01747-HI-0222/EDMS 260112)

To: Assistant Inspector General for Healthcare Inspections (54)

1. VHA program officials appreciate the opportunity to comment on the referenced draft report and generally concur in the findings and recommendations. We believe that additional program enhancements made to the national violence prevention program since the period of your CAP reviews have already successfully addressed issues raised in the report. Details of these initiatives are included in the attached plan of corrective action.

2. We believe VHA's comprehensive program of prevention and management of disruptive behaviors ranks among the most progressive in the nation. A National Taskforce on Violence Prevention was formed in 1999 to review violence within VHA, identify policy weaknesses and potential solutions, make recommendations and coordinate program elements and implementation. One of the recommendations was to conduct an extensive national survey to identify actual prevalence, perpetrators, causes of incidents and facility-level characteristics to define baseline rates of violence and characterize victims and perpetrators. That report, based on the survey results, has been submitted to the Journal of Occupational and Environmental Medicine for publication. In addition, since and as the OIG data were collected, VHA developed additional network director performance monitors for FY 2004 that require violence prevention training at the facility level, establishment of local interdisciplinary committees to manage disruptive behavior, and full implementation of the patient record flags.
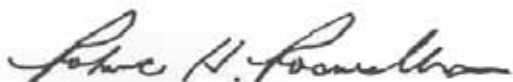
3. In regard to the report's observations about the computerized warning flags, we believe it is important to clarify several issues that might be misconstrued. You accurately state that the VistA software application for the computerized warning flag was released to the field on September 11, 2003. The report concludes that the flags are not being consistently applied, and that "it is important for warning flags to appear in both systems (CPRS and VistA)" since clinical and support staff from many facilities are accessing only one system or the other and thereby limiting warning accessibility. In fact, the flag is stored in one database, VistA, and displayed to all VistA users, including CPRS users, whenever a flagged patient is identified. Some users mistakenly assume that the two systems are separate when they are not; CPRS is front end for viewing VistA information. Through extensive training and implementation efforts by the Office of Information and the Employee Education System via directives, information letters, national conference call announcements, training and reference guides, videotapes, and web-based training and information sharing, facility staff have been made aware of how to use the patient flags and sites are making significant progress in fully utilizing the warning flag software for all relevant users. Once fully utilized in all facilities, the electronic advisory will allow receptionists, emergency staff, pharmacists and other providers to be aware of any patient who has a previous history of serious violence in any VA facility. As part of numerous patient record flag (PRF) implementation initiatives, the PRF Training Development Team established an ongoing monthly national conference call in 2003 to share information and answer any specific questions that might arise about technical implementation details.

4. Although you recommend that interdisciplinary response teams be established in each facility, as the Occupational Safety and Health Administration (OSHA) also suggests, we do not believe that team intervention is necessarily the most effective approach, and think three specific program elements effectively get at that content. First, VHA recognizes the need for specialized skills in violence management, but we focus more on availability of de-escalation skills in the hands of front-line workers to diffuse potential violent episodes before they erupt. This was one of the lessons learned from reviews of our Vet Centers, which experience very low rates of injury or assault despite the high-risk population they serve. In fact, we are currently re-evaluating OSHA guidelines for practical application at the field level. Second, as the need for physical intervention and containment becomes more apparent, some pre-defined approach is necessary. The two available options include the therapeutic model, which relies on passive weight constraints, and the police containment model, which relies on the application of restraining force. Both require specific training and local plans and policies. Facilities, of course, are encouraged to choose techniques that best relate to their unique situations. Third, as part of the 2004 network director performance monitors, each facility is required to create an interdisciplinary disruptive behavior committee to manage the patient flagging process and to conduct threat assessments locally. This committee is established under senior clinical leadership and addresses safety, security, clinical medicine, patient ombudsman and ethical aspects of violence management, including management of chemical and physical restraints. The interdisciplinary nature addresses broadly the prevention of violence and the management of patients and behavior in a strategic way apart from application of physical force. A threat assessment curriculum has been developed and is underway.

5. We agree with OIG that a more consistent method of identifying and reporting violent incidents throughout the system is needed, and technical staff are currently revising existing reporting systems to help achieve that goal. The referenced "police package" is being re-hosted and will contain a set of coding criteria compatible with the injury reporting system, ASISTS (Automated Safety Surveillance and Tracking System). When revisions are in place, VHA will be able to construct a registry that pulls a uniform set of reports from both systems. At the same time, however, we believe that this might not be a fully effective approach in the long run, since under-reporting of violent events continues at a very high rate. For example, peer-reviewed literature indicates that that only about 5 percent of events are reported in both systems, and no one system is likely to capture all reported events. VHA has therefore decided to also pursue two additional data management strategies. As referenced earlier, we conducted a national survey that provided baseline rates of assaults. Data will also be generated by the patient record flagging system and the Disruption Prevention Committee minutes. We also expect that appropriate facility utilization of such data in violence prevention activities will become an element of the network director performance monitors. The same questions on violence will also be incorporated in a future version of the national survey.

6. Your report also addresses the potential impact of violent patient incidents on Worker's Compensation Program (OWCP) costs. We recognize that injury frequencies and costs vary dramatically among facilities systemwide and appear to be rising in some sites. At this point we are unclear whether current data reflect actual increases or whether sustained attempts at culture change have made it easier for employees to report injuries and file workers compensation claims. In general, we believe that the latter is more likely, given patterns of injury reporting. In addition, it has become clear that some of these injuries relate to training, and an instrumented mannequin is under development to assist in simulating actual physical encounters. Some information was generated through a process evaluation of six VA facilities that VHA conducted in collaboration with the National Institute for Occupational Safety and Health. We plan a more in-depth analysis at these facilities to better identify specific causal factors, and may request your assistance in providing the names of similar facilities included in your reviews. We are concerned that these issues might also reflect aspects of OWCP management that should be addressed.

7. Again, we appreciate your perceptions of our violence prevention program and continue to apply your recommendations in our overall improvement activities.   If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 273-8360.

Robert H. Roswell, M.D.

Attachments

OIG Draft Report, Healthcare Inspection
Healthcare Program Evaluation: VHA's Management of Violent Patients
(Project Number 2002-01747-HI-0222)

VHA Action Plan

RECOMMENDATIONS

Recommendation 1: We recommend that the Under Secretary for Health ensure that:

a. Interdisciplinary response teams are established in each facility and are specifically trained in violence management; and that the teams appropriately respond to all emergency calls. (Concur in Principle)

GOAL: To assure that all facilities have designated staff with specialized training in violence management available at all times to respond in a timely manner to emergency calls.

STRATEGY: Although establishment of interdisciplinary response teams may be the approach of choice at some facilities, VHA is concerned that the strategy outlined by OSHA (Occupational Safety and Health Administration) is not always the most universally effective. VHA considers the OSHA recommendation to be better addressed by three separate elements. First, front line workers must have appropriate de-escalation skills to ward off a potentially violent incident before it occurs. This approach has worked very successfully in our Vet Centers, where staff encounter a high proportion of "high-risk" patients. Second, facilities must choose how to respond to violent incidents. This may occur through therapeutic or police/force containment. Third, all facilities are required to establish interdisciplinary disruptive behavior committees to assess assaultive patients, manage the patient record flags, and ensure that assaultive patients are managed appropriately.

MEASURE: Development by all facilities of a violence management training plan for high risk units and occupations, including actual hands-on training in de-escalation for high risk individuals, was included in the network director performance plan for FY 2003. Establishment of a local interdisciplinary committee, under senior clinical leadership, is also included as part of the FY 2004 network director performance monitors. Performance data are used in quarterly reporting of related activity updates.

TARGET: 100 percent of medical facilities will have developed comprehensive training plans that include pre-determined criteria for acceptability by May 2004. In addition, interdisciplinary disruptive behavior committees will be established in 100 percent of facilities by March 31, 2004.

STATUS: Each facility has provided training for at least two trainers, who, in turn, are conducting training to appropriate staff in high risk areas and in high risk occupations for hands-on skills in de-escalation and personal safety. In addition, 127 of 142 facilities have developed comprehensive violence prevention training plans that detail populations, locations and timelines.

By March 31, 2004, it is anticipated that all facilities will have established interdisciplinary disruptive management committees to monitor plan implementation. Network director performance data are anticipated for release in May 2004.

ACTUAL: The remaining 15 facilities whose plans were found to be incomplete are revising and expanding plans in response to a request from the Deputy Under Secretary/Operations and Management.

BENCHMARK: N/A
PRIOR FY: N/A

b. **A consistent method of identifying and reporting violent incidents is developed, and complete information is available to employees who are responsible for analyzing and trending these data, and recommending corrective strategies.** (Concur)

GOAL: Devise a more consistent and accessible system that can be applied nationwide to identify and report violent incidents.

STRATEGY: Existing reporting systems are being revised to achieve better compatibility. The "police package" is being re-hosted to contain coding that is compatible with the injury reporting system (ASISTS). When revisions are completed, it will be possible to construct a registry with uniform reporting capability from both systems. VHA is also pursuing other data management strategies utilizing information generated by the patient record flagging system and the Disruption Prevention Committees.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: At present, VHA is collecting data through ASISTS and the Disruptive Behavior Committee minutes with the plan to examine these data for generalizable lessons. System revisions to the police package are expected to be completed by September 30, 2004.

BENCHMARK: N/A

PRIOR FY: N/A

c. **Interdisciplinary committees are established and charged with the responsibility of reviewing and tracking violent incidents for the purpose of developing violence management and prevention strategies.** (Concur)

GOAL: All facilities will establish interdisciplinary violence management committees to review and track violent incidents, develop prevention strategies and monitor facility compliance with established policies and procedures.

STRATEGY: All facilities are already required to establish such committees as a component of the FY 2004 network director performance monitors. The committees are interdisciplinary, and include members with skills in safety and security management, clinical medicine, patient ombudsman experience and ethics.

MEASURE: Quarterly monitoring data provided as part of the Network Directors performance measures will verify establishment of such committees; follow-up actions will be taken as indicated.

TARGET: 100 percent of facilities will establish interdisciplinary committees by March 31, 2004.

STATUS: Quarterly network director monitoring data to be aggregated and distributed by May 2004.

ACTUAL: VHA is awaiting the quarterly network director performance monitor data call in April 2004, with data aggregation completed in May 2004

BENCHMARK: N/A

PRIOR FY: N/A

d. Guidelines are implemented for the appropriate use of automated warning flags, and that they are applied consistently throughout the system, and all employees have access to computer systems that will flag patients' records when there are histories of violence. Patient records that are flagged should be systematically reviewed by interdisciplinary committees to establish the need for continued use of the flags for each patient. Additionally, until the VHA-wide flagging system is fully operational, individual facilities should explore methods to develop local employee alert systems. (Concur)

GOAL: Establish a fully operational national violent patient flagging system with easy accessibility to all employees utilizing relevant computer systems and assure that appropriate guidelines are provided for successful implementation of the system

STRATEGY: The Violent Patient Flag, along with a brief textual description, is stored in the VistA database and was released to the field on September 11, 2003. Information is displayed to all VistA users (including CPRS users) whenever a flagged patient is selected. The Office of Information (National Training and Education Office) coordinated the development and distribution of training materials for Patient Record Flags (PRF) in support of VHA Directive 2003-048, signed by the Under Secretary for Health on August 28, 2003.

MEASURE: Full implementation of the patient record flag will be monitored as a component of the FY 2004 network director performance monitors.

TARGET: 100 percent of facilities will implement the flag by September 30, 2005.

STATUS: Quarterly network director monitoring data to be aggregated by May 2004.

ACTUAL: The PRF Training Committee has completed a broad range of training and communication initiatives. Field facilities were also provided with training materials prior to the release of the flag software in September 2003. In addition, the Employee Education System (EES) provided supplemental training materials. Target audiences for the training included medical center management and those staff identified to assign and maintain the flagging system, as well direct patient care staff assigned to high risk areas. VHA is awaiting the quarterly network director performance monitor data call in April 2004, with data aggregation completed in May 2004.

BENCHMARK: N/A

PRIOR FY: N/A

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