Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Summary Report

Management of Workplace Violence in Veterans Health Administration Facilities

Report No. 11-00215-194

June 14, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections completed an evaluation of the management of workplace violence (WPV) in Veterans Health Administration (VHA) facilities. The purpose of the evaluation was to determine the extent to which VHA facilities managed violent incidents.

Inspectors evaluated the management of WPV at 29 facilities during Combined Assessment Program reviews conducted from April 1 through September 30, 2011.

We identified six areas where VHA needed to strengthen requirements and facilities needed to improve compliance. We recommended that the Under Secretary for Health ensures that:

- VHA's comprehensive national guidance for managing WPV is formalized in a directive(s) or a handbook that addresses WPV programs for the management of violent behavior and establishes processes for managing disruptive or violent behavior by patients.

- VHA policy development includes formalizing comprehensive national guidance for managing WPV that establishes procedures for managing disruptive or violent behavior by employees and others.

We also recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensures that:

- Facility managers monitor compliance with VHA policy related to WPV programs and management of disruptive behavior by patients, employees, and others.

- Facilities periodically assess all work areas for risk of violence.

- Facilities provide specialized WPV prevention training to employees who work in high-risk areas, assess competence annually, and provide refresher training annually or as necessary.

- Facilities provide WPV prevention training to all supervisors, assess competence annually, and provide refresher training as necessary.

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

TO: Under Secretary for Health (10)

SUBJECT: Combined Assessment Program Summary Report – Management of Workplace Violence in Veterans Health Administration Facilities

Purpose

The VA Office of Inspector General Office of Healthcare Inspections evaluated the management of workplace violence (WPV) in Veterans Health Administration (VHA) facilities. The purpose of the evaluation was to determine the extent to which VHA facilities managed violent incidents.

Background

The National Institute for Occupational Safety and Health defines WPV as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty." The Bureau of Labor Statistics reported that the majority of assaults (59 percent) occurred in the health care and social assistance industries.[1] Nearly 40 percent of employees in California emergency rooms who responded to a survey reported that they had been assaulted on the job in the previous year.[2] Reasons for higher rates of WPV in health care settings include the prevalence of handguns, increasing numbers of mentally ill patients treated as outpatients, and the availability of drugs in health care settings.

The Office of Healthcare Inspections conducted a WPV review in 2003[3] and recommended that:

a. Trained teams be established and appropriately respond to all emergency calls.
b. A consistent method of identifying and reporting violent incidents be developed.
c. Interdisciplinary committees be established to review and track violent incidents.
d. Patient record flag guidelines be implemented and flagged records be systematically reviewed by the Disruptive Behavior Committees.

[1] U.S. Department of Labor Bureau of Labor Statistics, "Survey of Workplace Violence Prevention, 2005," October 27, 2006.
[2] Jessica Garrison and Molly Hennessy-Fiske, "Violence afflicts ER workers," *Los Angeles Times*, July 31, 2011.
[3] *Healthcare Inspection – Healthcare Program Evaluation – Veterans Health Administration's Management of Violent Patients*, (Report No. 02-01747-139, May 3, 2004).

VHA concurred with the findings and recommendations from this review and submitted an acceptable action plan.

The Occupational Safety and Health Administration (OSHA) has recently cited health care facilities in New York and Maine for inadequate WPV prevention safeguards.[4] According to a VHA program official, several VHA facilities have experienced OSHA enforcement actions that reached the national level and are in various stages of appeal.

Scope and Methodology

Inspectors evaluated the management of WPV at 29 facilities during Combined Assessment Program reviews conducted from April 1 through September 30, 2011. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). We reviewed facility policies and training plans related to WPV and the management of 77 actual assaults involving patients, employees, and others (visitors and relatives).

We generated an individual Combined Assessment Program report for each facility. For this report, we analyzed and summarized the data from the individual facility Combined Assessment Program reviews.

Inspectors conducted the reviews in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Facility Policies and Management of Assaults

OSHA's general duty clause requires all workplaces to have a written WPV prevention policy.[5] In 1997, VHA issued an Information Letter that reiterated the OSHA requirement for all facilities to have a written WPV prevention policy and provided a comprehensive sample policy for facilities to individualize.[6] We found that only one facility did not have a WPV policy.

Both OSHA and VHA have provided excellent guidance detailing the expectations for WPV prevention programs.[7] However, this guidance is advisory and considered

[4] http://www.osha.gov/pls/oshaweb/searchresults.relevance?p_text=workplace%20violence&p_osha_filter=NEWS_RELEASES&p_logger=1.
[5] *Occupational Safety and Health Act of 1970*, Sec. 5, Duties, http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=3359&p_table=OSHACT.
[6] Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.
[7] OSHA 3148-01R, *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*, 2004.

voluntary. The only formal requirement VHA provided was in 2003 with a directive that addressed some aspects of patients who exhibit disruptive behavior (re-issued in 2010).[8]

In January 2012, program officials told us that directives addressing violence prevention policies and risk assessments, management of disruptive employees, and training requirements for all staff had been drafted but not released. Although most facilities had WPV policies, we recommended that the VHA strengthen the comprehensive guidance in the form of a directive(s) or handbook and define processes for managing violent behavior by patients.

VHA has not issued any directives or handbooks that address violent or disruptive behavior from other sources, such as employees, visitors, and volunteers. Each of these groups has different circumstances and protections that require different approaches. For example, when an employee is involved in a violent incident, OSHA and VHA advise post-incident debriefing and counseling for the employee and his or her co-workers. When we asked to see evidence of such counseling, we were told that counseling would only be provided if the employee pursued it through the independent Employee Assistance Program and that the facility would have no knowledge of it. OSHA states that debriefings and counseling educate staff about WPV and positively influence workplace and organizational cultural norms to reduce trauma associated with future incidents. We recommended that VHA define processes for managing disruptive or violent behavior by employees and others in the form of a directive.

We assessed 77 actual assaults involving patients, employees, visitors, and others to determine whether they were managed in compliance with facility policies. We found that 65 (84 percent) of the assaults were managed appropriately according to the facilities' policies. The 12 assaults that were not managed appropriately according to the facilities' policies had the following problems:

- Disruptive patients were not referred to the Disruptive Behavior Committee (or equivalent).
- Patient incidents were not reported properly.
- Patient disruptive behavior flags were posted in the electronic health record but not communicated to patient.
- There was no Accident Review Board evaluation for employees involved in the assaults and/or the Accident Review Boards did not meet regularly.
- VA Police were not engaged in the Disruptive Behavior Committee (or equivalent).

We recommended that each facility's managers monitor their own facility's compliance in managing disruptive behavior.

[8] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

Issue 2: Training Plans

OSHA's and VHA's informal guidance encourage facilities to assess worksites for potential sources of violence and to provide violence prevention training to all staff who work in areas at high risk for violence. These employees should maintain competence and undergo refresher training annually or as needed. In addition, the guidance advises that violence prevention training should be provided to all staff during new employee orientation and to all supervisors. However, the only formal requirement is for emergency department/urgent care clinic staff to receive specific training known as Prevention and Management of Disruptive Behavior training.[9]

We found that only 2 of the 29 facilities did not have training plans that addressed preventing and managing violent behavior in some way. Of the 27 facilities with training plans, 2 facilities' plans did not address employees who work in the emergency departments/urgent care clinics and inpatient mental health units. Of the remaining 25 facilities, 5 did not require that annual refresher training be offered for employees working in these potentially high-risk areas.

We found that all 27 training plans addressed WPV awareness for new employees, but 4 plans did not address WPV prevention training for supervisors. Of the remaining 23 plans, 5 did not require annual refresher training for supervisors.

We recommended that facility managers periodically assess all work areas for risk of violence and provide specialized training, such as Prevention and Management of Disruptive Behavior training, to employees who work in high-risk areas. These employees should have their competency for managing violent behavior assessed annually and should be required to take refresher training annually or as necessary. All supervisors should have training in preventing and managing violent behavior, have their competency assessed annually, and take refresher training as necessary.

Conclusions

Most VHA facilities had policies for management of WPV and training plans that included WPV prevention training for new employees at orientation. However, VHA's guidance for WPV assessment, prevention policies, and management of incidents involving all sources of violence is considered voluntary and would be stronger if issued in a directive(s) or a handbook. Facilities did not consistently comply with their policies in managing actual assaults. In addition, WPV training requirements need to be more comprehensive and monitored.

[9] VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health ensures that VHA's comprehensive national guidance for managing WPV is formalized in a directive(s) or a handbook that addresses WPV programs for the management of violent behavior and establishes processes for managing disruptive or violent behavior by patients.

Recommendation 2. We recommended that the Under Secretary for Health ensures that VHA policy development includes formalizing comprehensive national guidance for managing WPV that establishes procedures for managing disruptive or violent behavior by employees and others.

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facility managers monitor compliance with VHA policy related to WPV programs and management of disruptive behavior by patients, employees, and others.

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities periodically assess all work areas for risk of violence.

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities provide specialized WPV prevention training to employees who work in high-risk areas, assess competence annually, and provide refresher training annually or as necessary.

Recommendation 6. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities provide WPV prevention training to all supervisors, assess competence annually, and provide refresher training as necessary.

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 23, 2012

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Combined Assessment Program Summary Report: Management of Workplace Violence in Veterans Health Administration Facilities**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations.

2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

(original signed by:)
Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Combined Assessment Program Summary Report: Management of Workplace Violence in Veterans Health Administration Facilities *(VA IQ 7215517)*

Date of Draft Report: February 7, 2012

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health ensures that VHA's comprehensive national guidance for managing WPV is formalized in a directive(s) or a handbook that addresses WPV programs for the management of violent behavior and establishes processes for managing disruptive or violent behavior by patients.

VHA Response

Concur

Veterans Health Administration (VHA) agrees that formalization of national guidance is important and has begun that process. The guidance will be in accordance with VHA Handbook 7701.1, Occupational Safety and Health (OSH) Program Procedures; VHA Directive 2010-008, Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities; VHA Directive 2010-053, Patient Record Flags; Joint Commission (JC) standards; and Occupational Safety and Health Administration (OSHA) guidance.

To accomplish this, VHA will issue a single directive that requires facilities to establish a comprehensive program promoting a culture of workplace safety that addresses disruptive and violent behaviors by patients. This directive will address the following elements:

1. Employee-generated disruptive or violent behavior (see response to Recommendation 2 below)
2. Patient-generated disruptive or violent behavior, including guidance on the implementation of Title 38 Code of Federal Regulations (CFR) 17.107

3. Employee education: The Prevention and Management of Disruptive Behavior (PMDB) Program
4. Disruptive or violent behavior reporting and tracking
5. Environmental design

A communication plan will be developed and used to communicate new requirements and processes. Guidance to assist facilities in implementing the provisions of the directive will be disseminated via multiple methods and media, including conference calls, the intranet, presentations, and print documents.

In process	Directive to be issued no later than (NLT) November 1, 2012

Recommendation 2. We recommended that the Under Secretary for Health ensures that VHA policy development includes formalizing comprehensive national guidance for managing WPV that establishes procedures for managing disruptive or violent behavior by employees and others.

VHA Response

Concur

VHA will issue a single directive that requires facilities to establish a comprehensive program promoting a culture of workplace safety that addresses disruptive and violent behaviors by employees (see response to Recommendation 1 above for more detail).

In process	Directive to be issued NLT November 1, 2012

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities' managers monitor compliance with VHA policy related to WPV programs and management of disruptive behavior by patients, employees, and others.

VHA Response

Concur

The Offices of the Deputy Under Secretary for Health for Policy and Services and Deputy Under Secretary for Health for Operations and

Management will jointly develop an annual program compliance review. This review is expected to include facility level surveys and/or an all employee survey.

In process	Compliance program to be implemented NLT May 1, 2013

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities periodically assess all work areas for risk of violence.

VHA Response

Concur

VHA will develop workplace violence risk assessment tool(s) for use in all facility work areas. Appropriate guidance will be issued to the field about the use of these tools. Compliance will be monitored in the annual program compliance review addressed in the response to Recommendation 3.

In process	Assessment tool(s) to be developed NLT May 1, 2013 and included in compliance program

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities provide specialized WPV prevention training to employees who work in high-risk areas, assess competence annually, and provide refresher training annually or as necessary.

VHA Response

Concur

VHA will publish a directive that requires facilities to establish a comprehensive program promoting a culture of workplace safety that addresses disruptive and violent behaviors by patients and by employees. The responses to Recommendations 1 and 2 provide details.

The program will require facilities to conduct a workplace violence risk assessment to determine minimal, low, medium and high risk areas.

In each facility, a multidisciplinary team of professionals including a senior clinician familiar with the violence incidence patterns in the facility, a Department of Veterans Affairs (VA) police officer, and the facility safety officer (or designee) will conduct workplace violence risk assessments. This multi-disciplinary team may be a subgroup of the Disruptive Behavior Committee.

VHA will require that all employees identified as working in high-risk areas complete Level II, III, and IV of the PMDB training program, which includes Observational and Verbal De-escalation Skills (Level II), Personal Safety Skills (Level III), and Therapeutic Containment Skills (Level IV), for a total of 12 hours of face-to-face training.

The Level I on-line PMDB course is currently available in the Talent Management System (TMS). Tracking of Levels II through IV of PMDB face-to-face training also occurs through TMS. Compliance with training and competence assessments will be included in the annual program review referenced in the response to Recommendation 3.

In process	Program to be implemented NLT May 1, 2013

Recommendation 6. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities provide WPV prevention training to all supervisors, assess competence annually, and provide refresher training as necessary.

VHA Response

Concur

VHA will require all supervisors to complete the level of training appropriate to the area they supervise as determined by the workplace violence risk assessment (see response to Recommendation 5).

The Level I on-line PMDB course is currently available in TMS. Tracking of Levels II through IV of PMDB face-to-face training also occurs through TMS. Compliance with training and competence assessments will be included in the annual program review referenced in the response to Recommendation 3.

In process	Program implemented NLT May 1, 2013

May 2012

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Julie Watrous, RN, Project Coordinator Lisa Barnes, MSW Vickie Coates, LICSW, MBA Audrey Collins-Mack, RN, FACHE Myra Conway, RN Douglas Henao, MS, RD Stephanie Hensel, RN, JD Frank Keslof, EMT, MHA Cathleen King, MHA, CRRN Karen McGoff-Yost, LCSW, MSW Frank Miller, PhD Kathleen Shimoda, RN Virginia Solana, RN, MA Roberta Thompson, LCSW Laura Tovar, LCSW Ann Ver Linden, RN, MBA

Appendix C

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