

Original Publication

 OPEN ACCESS

Maintaining Personal Safety: Understanding and Addressing Aggression and Violence in the Health Care Setting

Julie Niedermier, MD*, David Kasick, MD

*Corresponding author: julie.niedermier@osumc.edu

Citation: Niedermier J, Kasick D. Maintaining personal safety: understanding and addressing aggression and violence in the health care setting. *MedEdPORTAL*. 2018;14:10722. https://doi.org/10.15766/mep_2374-8265.10722

Copyright: © 2018 Niedermier and Kasick. This is an open-access publication distributed under the terms of the Creative Commons Attribution-NonCommercial-Share Alike license.

Abstract

Introduction: A 2-hour introductory lecture-discussion curriculum was developed to provide medical students and residents with education about personal safety in the health care setting. The course focused on providing learners with proactive and practical advice for understanding, recognizing, and responding to difficult patients or others who may pose risks of violence. It was designed for participants to gain knowledge about initial management of often unfamiliar situations before untoward behaviors escalate to violence. **Methods:** Eight hundred thirty-eight medical students participated in this required element of the third-year psychiatry clerkship experience. Sixty first-year through fourth-year psychiatry residents participated as part of departmental orientation. Instructors provided the same seminar for both learner groups throughout the project's duration. In addition to a PowerPoint presentation, learners participated in discussion about personal safety threats in the health care setting. Evaluations were obtained, and more recent cohorts also completed a postcourse assessment of knowledge. **Results:** Results suggested that learners from both groups viewed the session favorably, indicating the personal safety curriculum was beneficial and practical and helped increase their knowledge about this important topic. The session received a high number of positive comments from learners, reinforcing its valuable take-home message. **Discussion:** Given the growing magnitude and understanding of risk of aggression and violence in health care settings, we incorporated a required personal safety session into our psychiatry residency and medical school curricula. The session's emphasis was on preventative and proactive strategies to employ with patients before and during escalation of potentially violent situations.

Keywords

Residents, Violence, Health Care, Preparedness, Aggression

Appendices

- A. Maintaining Personal Safety Slides.pptx
- B. Maintaining Personal Safety Discussion Guide.docx
- C. Maintaining Personal Safety Evaluation of Course and Instructor.docx
- D. Maintaining Personal Safety Postcourse Assessment .docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this activity, learners will be able to:

1. Describe current evidence and epidemiology of violence in the health care setting.
2. Recognize pertinent factors suggestive of current and future risk of violent behavior by patients.
3. Identify helpful strategies and communication styles to consider implementing during encounters with potentially violent individuals.

Introduction

Workplace violence is defined by the Occupational Safety and Health Administration as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site.¹ Health care workers, relative to other professions, are at high risk for aggression, including verbal or physical assaults perpetrated by patients and visitors.² Employees of residential care settings, emergency departments, and psychiatric units are at highest risk among the health care workforce.³⁻⁵

Like those at other hospitals, workers at The Ohio State University encounter patients and others who pose everyday safety risks to the organization and jeopardize the well-being of caregivers. Employees participate in mandatory orientation sessions to address clinical threats to personal safety; however, no

such training, other than to “be safe,” was in place for students and residents, despite their frontline and frequent involvement with at-risk patients. There are numerous educational resources available via *MedEdPORTAL* about such topics as patient safety, community/school violence, and assessment and interventions for patients who are victims of violence, sexual assault, or child abuse. However, we could identify no previous *MedEdPORTAL* publications describing proactive strategies for learners to use to address workplace violence, making this a unique scholarly work intended to help health care trainees themselves keep safe amid challenging and potentially life-threatening clinical situations.

Residents and medical, nursing, and other students new to the clinical environment and zealous about embracing opportunities for patient interaction may have modest, if any, awareness of the inherent risk of violence that accompanies their newfound role. Students may be naïve regarding the potential for violent threats or actions by patients, at a loss for managing their personal safety during difficult situations, and in need of strategies to recognize and respond to escalating conflicts in the health care setting. In addition, it can be a challenge for both seasoned and inexperienced workers alike to reconcile their implicit caregiving role with the impact of victimization by interactions with violent or potentially violent patients.

This introductory course serves to bridge the gap of learners’ understanding of occupational violence risk in the health care setting and provide tangible and practical knowledge to promote personal, patient, and environmental safety under these circumstances.⁶ While increasing emphasis has been placed on the emotional well-being of learners in the health and allied health professions,⁷⁻⁹ we believe this resource is among pioneering work addressing awareness of inherent personal physical safety risks ubiquitous to health care settings. As directors for the education division in psychiatry, we have firsthand experience with the toll this knowledge-to-practice gap creates. Having ready access available to two groups of learners, we targeted third-year medical students and psychiatry residents for this session, albeit for different reasons. We selected medical students due to their relative newness to the clinical setting and psychiatry residents given their relatively high risk of potential exposure to violent or aggressive patient encounters.

Methods

Materials for the course were derived from existing literature regarding workplace safety, communication skills, and verbal de-escalation techniques.

Participants

This class was conducted for all medical students during their required third-year clerkship experience at The Ohio State University Department of Psychiatry. The same instructors provided the same seminar for both residents and medical students throughout the duration of the project. In addition to having a PowerPoint presentation, learners participated in a discussion about personal safety threats in the health care setting that they had experienced. Learners provided evaluations of this session and the course instructor after each administration. In addition, 334 student participants from academic years 2016 and 2017 also completed a postcourse assessment of knowledge.

Logistics

Medical students and residents participated in different sessions, with the residents’ sessions conducted in July of each academic year as part of their orientation. Approximately one-sixth of the medical student class participated in this seminar every other month (generally, six sessions per academic year). The seminar was a required element of the third-year psychiatry clerkship experience.

Facilitators were trained health care professionals, such as physicians having experience in emergency, psychiatric, or other settings and/or having personal experiences with difficult patient situations and comfort discussing them with learners. All educational sessions were conducted in standard classrooms equipped with electronic media capabilities. During the discussion phase, it was conducive to participation

for the facilitator to leave the podium and instead engage learners more intimately by approaching them via sitting or standing in close proximity.

Speakers reviewed the PowerPoint presentation in advance to develop familiarity with the content, as there might have been course instructors uncomfortable or unfamiliar with the material. In the outline format of the PowerPoint presentation, additional notes were available to aid the speakers' understanding. Speakers were encouraged to augment the presentation by use of their own clinical examples. This approach encouraged discussion but could also make particular speakers more or less comfortable.

The class for medical students was composed of a 1-hour lecture and 1-hour discussion session that included a PowerPoint presentation (Appendix A) entitled "Managing Personal Safety: Understanding and Addressing Aggression and Violence in the Health Care Setting." During the discussion phase for medical students, approximately 40 minutes were allotted for discussion of difficult clinical experiences among the group, and the facilitator and learners used the photocopied discussion guide (Appendix B). Approximately 10 minutes each were allotted for the evaluation and the postcourse assessment. The postcourse assessment was uploaded by student learners, who completed it on their electronic devices.

The session for residents also consisted of a 1-hour lecture and 1-hour discussion session that included the same PowerPoint presentation (Appendix A). In advance of the session, residents received the reflection exercise (contained in Appendix B) via email, and paper submissions were collected prior to the start of the discussion.

The postcourse assessment tool was created from the references cited. Additionally, images in Appendix A were created by us.

Assessment

Resident participants completed a reflection assignment on this topic that consisted of responding to the prompt, "Identify a clinical situation in which you became concerned about your personal safety" (Appendix B).

Students completed an evaluation of the class and the class instructor (Appendix C), taking approximately 10 minutes to do so.

Participants from academic years 2016 and 2017 completed a postcourse assessment of knowledge (taking approximately 10 minutes) based on content from the lecture (Appendix D).

Results

To date, over 800 medical students have completed the class. In addition, a total of 60 psychiatry residents have participated in this session over the past 5 years. First-year through fourth-year psychiatry residents (approximately 24-33 annually) participated as a component of their orientation to the department.

Initially, the primary outcome measure was for participants to provide basic evaluative feedback about the course. In more recent years, a postcourse assessment of knowledge has been added. From 2016-2018, 334 student participants returned a postcourse assessment of knowledge that took approximately 10 minutes to complete. The overall average score by medical students on the five-item postcourse assessment was 91.7.

The response rates on the evaluation of the activity by medical students and residents were 93.3% and 97.2%, respectively. Participants completed an evaluation of the activity, with 76% of medical students and 100% of residents feeling that it was very good or excellent. Full results are noted in [Figure 1](#).

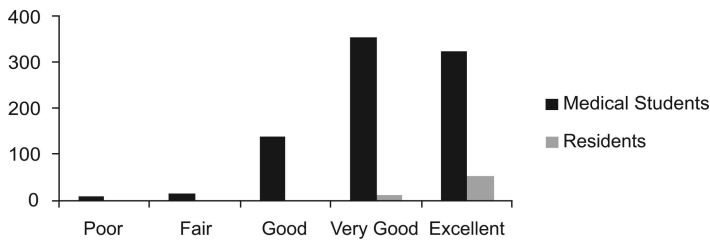


Figure 1. Number of medical students and residents who rated the overall exercise on a continuum from poor to excellent.

Medical student participants during the first 3 academic years ($n = 600$) also evaluated the relevance and importance of the material to their understanding of psychiatry, with approximately 68% finding the material to be above average or best, as noted in [Figure 2](#).

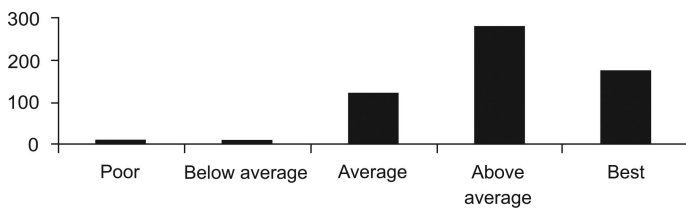


Figure 2. Number of medical students versus ratings on a continuum from poor to best for relevance and importance of material to an understanding of psychiatry.

The survey question (Figure 2) was discontinued when the institution changed electronic evaluation and educational administrative systems. Thus, the sample size is larger for the first question.

The discussion and reflection assignments were deemed very valuable by nearly all the residents, with many commenting on the utility of the exercise itself as a means of support and others suggesting it would help them be better prepared for future at-risk situations. The residents also commented on what they had learned about themselves in the patient encounter, identified systems-level opportunities for improvement, and appreciated the opportunity to share experiences in hopes of preventing colleagues from having future incidents.

Medical students did not complete a reflection assignment, but their comments, with few exceptions, were positive:

- “Very informative lecture and gave me a lot to think about going into my rotations.”
- “Good lecture, brought up a lot of things that I hadn’t considered before.”
- “I appreciated being made aware of situations I may find myself in that may be dangerous.”
- “Helpful information for upcoming rotation, something I hadn’t thought about for this rotation and is very important.”
- “Helpful topic and presentation, good job highlighting practical things students could do to stay safe e.g. surveying room, making sure we’re not cornered.”

Discussion

This session is intended to augment learners’ awareness and ability to address personal safety within the hospital setting. It is designed to proactively supplement existing responses to events compromising safety within health care systems, such as utilization of 1:1 sitters, restraint, or involvement of security or police officers. Given overarching goals of protecting the safety of all team members and the patient and preserving patient autonomy, use of least restrictive interventions, including verbal de-escalation and skills learned through this session, can be applied to the clinical setting.

This educational session dedicated to personal safety in the health care setting has been easy to implement, inclusive, and well received by learners. The experience provides opportunities for participants to obtain education about this important topic, to reflect on their own difficult patient encounters, and to better prepare themselves for future untoward events.

The challenges of this activity include varying levels of engagement by participants. While attendance was required and participants were generally engaged, the relevance of the topic as perceived by students varied. Additionally, some students had very little exposure to difficult patient situations, and so they viewed the content as helpful but anticipated that it would rarely have practical utility.

While we were fortunate to have the same instructors throughout the duration of the seminars, we did add components in an effort to enhance the experience for learners. Specifically, adding the postsession assessment questions was done in an effort to quantify take-home knowledge, although this potentially could have altered the value or utility of the experience for participants.

We readily acknowledge that residents in other specialties face similar day-to-day occupational hazards; however, psychiatry residents were the focus group purely due to priorities of the course instructors. Specifically, we believe that this subject is exceedingly important to cover annually, despite residents gaining experiences with hostile or upset patients over the course of their residency. Nonetheless, some of the feedback from residents (overall rating of exercise) was captured more than once, since residents in their first through fourth years participated annually.

Additionally, it is necessary to concede that perhaps one of the greatest barriers to overcome with implementing a personal safety curriculum is that medical schools or residency programs have well-defined priorities for accreditation that generally speak to well-being and safety, although not typically or explicitly defining instruction on personal safety of trainees among their objectives. In other words, similar to the evolution of educational theory on physician professionalism emerging as a process as opposed to being a nonmodifiable trait, the safety of trainees is implied, as opposed to being recognized as a responsibility to be developed as an obtainable skill.

Limitations

The evaluation approach does not examine future behavioral change, reflecting only attitudes at the time of the session. Thus, although trainees rated the educational sessions as valuable, participation may or may not translate into tangible application of skills during critical situations that trainees later encounter.

It is also possible that learners could experience heightened anxiety or distress; no instances of this were reported, although similarly, there is the potential for a distressed student to not come forward.

In addition, the strategies presented may be beneficial, but we acknowledge that a major limitation of the training itself is that it should not provide a false sense of security. In other words, the training will not prevent violence from occurring, nor is it intended to be a compendium of resources. Its purpose is to create awareness, improve preparedness, and augment sound clinical judgment prioritizing safety that is necessary for all to exercise during these challenging situations.

Lessons Learned

Violence itself is a sensitive topic as learners or instructors may be victims of or witnesses to health care-related or other violence. Thus, the session may be emotionally challenging for some. Nonetheless, the survey and free responses from participants suggest learners viewed the activity as highly positive and valuable, with many expressing gratitude for the proactive stance of the medical center in providing this educational session.

Initially, only 1 hour was allotted for this educational session. Following the first academic year (when sessions typically ran over), it was evident that additional time for discussion would be necessary, and a 2-hour block was made available thereafter.

Learners have been highly engaged in the course and have found it relevant and appropriate for their level of understanding, despite some refinements to the course over time. The course has been successfully deployed over the last 5 years and is occurring at a time when greater awareness and proactive interventions by health care workers are necessary.

Conclusion

This required educational session on personal safety in the clinical environment is extremely valuable, offering low-cost, high-yield material that is widely applicable across health care settings. It provides a tangible and practical introduction to personal safety for learners new to the health care workplace and to those having limited experience (e.g., residents). Arguably, this topic or similar curricular content should be a prerequisite for all learners in the early stages of their careers, ideally in professional, nursing, and allied health schools, and even for other workers (patient care technicians, receptionists, etc.) in health care settings. Future studies could provide further focus on this topic as well as use clinical vignettes or other skills-based encounters to allow learners to demonstrate competence.

Julie Niedermier, MD: Associate Professor, Department of Psychiatry, Ohio State University College of Medicine

David Kasick, MD: Associate Professor, Department of Psychiatry, Ohio State University College of Medicine

Disclosures

None to report.

Funding/Support

None to report.

Ethical Approval

Reported as not applicable.

References

1. Preventing workplace violence in healthcare. Occupational Safety and Health Administration website. https://www.osha.gov/dsg/hospitals/workplace_violence.html
 2. Nelson R. Tackling violence against health-care workers. *Lancet*. 2014;383(9926):1373-1374. [https://doi.org/10.1016/S0140-6736\(14\)60658-9](https://doi.org/10.1016/S0140-6736(14)60658-9)
 3. Iozzino L, Ferrari C, Large M, Nielsens O, de Girolamo G. Prevalence and risk factors of violence by psychiatric acute inpatients: a systematic review and meta-analysis. *PLoS One*. 2015;10(6):e0128536. <https://doi.org/10.1371/journal.pone.0128536>
 4. Phillips JP. Workplace violence against health care workers in the United States. *N Engl J Med*. 2016;374(17):1661-1669. <https://doi.org/10.1056/NEJMra1501998>
 5. Physical and verbal violence against health care workers. *Sentinel Event Alert*. 2018;(59).
 6. Rosenman ED, Vrablik MC, Charlton PW, Chipman AK, Fernandez R. Promoting workplace safety: teaching conflict management and de-escalation skills in graduate medical education. *J Grad Med Educ*. 2017;9(5):562-566. <https://doi.org/10.4300/JGME-D-17-00006.1>
 7. Ey S, Moffit M, Kinzie JM, Brunett PH. Feasibility of a comprehensive wellness and suicide prevention program: a decade of caring for physicians in training and practice. *J Grad Med Educ*. 2016;8(5):747-753. <https://doi.org/10.4300/JGME-D-16-00034.1>
 8. Slavin SJ, Schindler DL, Chibnall JT. Medical student mental health 3.0: improving student wellness through curricular changes. *Acad Med*. 2014;89(4):573-577. <https://doi.org/10.1097/ACM.0000000000000166>
 9. Mospan CM, Hess R, Blackwelder R, Grover S, Dula C. A two-year review of suicide ideation assessments among medical, nursing, and pharmacy students. *J Interprof Care*. 2017;31(4):537-539. <https://doi.org/10.1080/13561820.2017.1301900>
-

Received: February 20, 2018 | **Accepted:** May 20, 2018 | **Published:** June 7, 2018