

CPH News and Views

A semi-monthly column on emerging topics related to healthy workplaces

Issue #62: The Role of Safe Handling and Mobilization in Reducing Type II Workplace Violence in Healthcare Settings

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Type II Workplace Violence in Healthcare

Violence against healthcare workers - perpetrated by clients and/or their friends and families - is a growing problem that can severely impact healthcare delivery, but there is limited evidence on the impact of workplace violence (WPV) prevention interventions. In 2015, the American Nurses Association (ANA) issued position statements^{1, 2} emphasizing creating and sustaining “a culture of respect, which is free of incivility, bullying, and workplace violence.” They included recommendations for primary, secondary, and tertiary prevention of WPV.

The Centers for Disease Control and Prevention define Type II workplace violence as “client-on-worker.” In healthcare settings, clients include patients and their family members or visitors. U.S. Bureau of Labor Statistics data (2002-13) indicated that, on average, WPV injuries to healthcare workers were four times more frequent than those of all workers in private industry. Eighty percent of these incidents were client-initiated. Antecedents of Type II WPV can be patient characteristics (e.g. history of violence or mental health condition), staff characteristics (e.g. lack of training), environmental risk factors (e.g. lack of security, layout/design, poor lighting), and work organization factors (e.g. staffing, scheduling, safety culture).³

Safe Handling and Mobilization Intervention Evaluation

The CPH-NEW ProCare study (2006-2016) evaluated a large nursing home corporation’s Safe Resident Handling Program (SRHP). This program began with needs assessment of all residents, to inform the numbers and types of portable mechanical handling devices purchased. A three-year schedule of staff training/retraining included use of devices, protocols for resident assessment and reassessment, equipment maintenance/battery charging, and sling laundering. The program led to notable reductions in workers’ compensation claims from resident handling.⁴

Effects of Safe Handling and Mobilization on Type II Workplace Violence

Over the course of the 10-year study, many worker surveys were collected with information about Type II WPV. About 50% of the clinical staff in this population reported being assaulted at least in the prior three months. Separate analyses showed associations of assault with single site and multi-site musculoskeletal pain⁵ and low back pain⁶.

An unexpected finding was that worker claims for ‘aggression’ injuries were reduced by about 12% following the SRHP and for at least six years afterwards. Although the SRHP was not designed to prevent WPV, we can picture several ways in which it may have done so. Handling equipment puts physical distance between worker and resident/patient during transfers, thus modifying the interaction in a way that protects the worker from resident aggression. Furthermore, the assessment component of the SRHP provided workers with comprehensive background on resident status and characteristics that might have facilitated more proactive WPV prevention. Last, the SRHP components of staff training and environmental and work organization changes may have empowered individual staff members or enhanced the safety culture in a way that reduced the occurrence of aggression.

About two-thirds of survey participants reported using handling devices 'often' or 'always.' However, even with this comprehensive SRHP, there were barriers to equipment use. In particular, employees reporting more frequent physical assaults were also less likely to say that they used equipment frequently. Resident dislike of the equipment was one of the main reasons that they reported for not using equipment, and this barrier persisted over the first six years of the program⁷. It is easy to imagine that if an employee was assaulted by a resident while using the equipment, s/he would be less likely to use equipment with that resident in the future.

Coordinating Training for Type II WPV Prevention with Safe Handling and Mobilization

Policy and organizational-level interventions are needed to minimize healthcare workers' exposure to WPV. Identifying risky clients through assessment is one common strategy, but not sufficient. Our findings suggest that safe handling programs may be a possible vehicle for violence prevention. Integrating WPV prevention content into safe handling training may increase awareness of handling and mobilization as high-risk activities for violent episodes. Including methods to minimize risk for assault would also be important. Additionally, including safe handling practices into trainings for WPV prevention could reinforce this link.

In long-term care facilities, attention should also be paid to resident/family education programs as opportunities to accustom residents and their visitors to the handling equipment. This might also lead to fewer assaults during handling and mobilization activities.

Future research should assess the feasibility and impact of integrating a comprehensive WPV prevention program with safe handling and mobilization programs.

References

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