A Quality improvement Project to Provide Peer Support After a Workplace-violence Event

Carley Baghai, RN-BSN

The College of Saint Scholastica

Duluth, MN

Pamela Bjorklund, PhD, APRN, PMHNP-BC, CNS-BC

Professor, Department of Graduate Nursing

The College of St. Scholastica

Duluth, MN

Corresponding Author:

Pamela Bjorklund, PhD, APRN, PMHNP-BC, CNS-BC

218-723-6624

pblorklu@css.edu

No disclaimers/conflicts of interest to report for either author.

Abstract

Background: The study of providing peer support after a physical workplace (WPV) event has focused on providing care to workplace victims in the psychiatric setting after they have been assaulted. There appears to be no studies utilizing interventions to help victims after being assaulted in the workplace. This fact coupled with the fact that psychiatric staff are significantly more likely than the national average to become assaulted at work, warrants the need for an intervention.

Local Problem: A peer support program was implemented on an acute pediatric inpatient psychiatric unit in a 110-bed hospital in the Upper Midwest.

Methods/Interventions: A baseline level of staff was determined and compared post-intervention to determine staff retention. Secondly, a survey was sent out pre-intervention to determine staff perceived level of support, with a follow-up survey sent out post-intervention.

Results:

Conclusion:

Key Words: *peer support, peer mentoring, workplace violence, psychological first aid*

A Quality improvement Project to Provide Peer Support After a Workplace-violence Event

INTRODUCTION

Problem Description

Workplace violence (WPV) is a growing concern for healthcare organizations, with 75% of the nearly 24,000 workplace assaults occurring in healthcare setting.[1] Beyond the individual physical and emotional ramifications. WPV directly impacts an organization's culture of safety, productivity, economic health, and ultimately, impacts patient safety.[1] Occurrences of WPV in psychiatric settings was found to impact approximately 40% of staff, contributing to staff burnout and injury.[1] Research supports the use of peer-mentoring programs aimed at staff support after WPV events, thus the use of peer-mentoring after WPV events in psychiatric settings, was the focus of this quality improvement (QI) initiative. [2]

Background

WPV can be defined as any act or threat that involves physical violence, verbal harassment, intimidation, or other disruptive or dangerous behavior that occurs at an individual's place of employment.[3] Four types of WPV exist in relation to how the perpetrator is related to the victim, including a WPV incident provoked by an individual who has no previous connection to the organization or its employees, a perpetrator who is a customer or patient of the workplace, an individual who is or was an employee of the organization, and an individual who has a personal relationship with an employee of the workplace.[1] The most common type of WPV event, occurring in 93% of all hospital assaults, involves a perpetrator who has a personal relationship with the organization and becomes violent while being cared for.[1] Healthcare workers who are injured in WPV events are four times more likely to require time off from work, when compared to other types of injury in the workplace.[1]

Despite these notable rates of WPV, research shows a significant gap in the support offered for workers after a WPV event.[4,5] One study found that use of the social support theory and its tenets can buffer the effects of WPV and improve related outcomes such as staff turnover rates, staff satisfaction with their organization, and staff perception of support offered from organization.[4] The social support theory has been described in many different ways and is a multi-dimensional concept but can briefly be described as the social support available through social relationships in one's life.[4] Using social support theory, it was found that after a WPV event 63.9% of healthcare workers were *very dissatisfied* with the support they received from their employer after a WPV event.[4] Furthermore, healthcare workers have consistently been shown to receive inadequate or no organizational support after a WPV incident thereby negatively impacting their relationship with the organization.[4]

Peer-mentoring programs have shown success repeatedly, with as many as 96.7% of nurses agreeing that nurses would benefit from participating in a peer-mentoring program.[6] It was also found that studies involving peer-mentorship programs consistently enhanced new nurse retention and decreased human resource costs.[6] Formal mentorship programs benefit both the employee and the organization, however the format in which mentorship programs operate is still lacking and one tried and true method is not yet established.[6]

One study demonstrated how a peer support program for nurses impacted various metrics, including WPV incidence.[3] Findings showed that, after a 5-year peer mentoring program was employed at two hospitals, participants reported that workplace problem solving increased, the work environment was more supportive, and WPV events decreased.[3] The study also showed that there was an 80% reduction in registered nurse (RN) job openings at the hospitals.[3] Mentors reported that they personally prevented 68 RN's from leaving the hospital,

equating to a cost-savings of approximately 134 full time RN salaries after accounting for marketing and training costs.[3] In addition to implementing peer-mentor programs, one of the most effective strategies to addressing WPV is to create a robust protocol.[7]

Local Problem

These findings are applicable to the local agency, an inpatient psychiatric hospital, where employee WPV injuries occur in roughly 10% of seclusion and restraint events and no known policies or protocols are in place currently to support employees after a WPV event. Specifically, no peer-mentoring programs are available to employees who have been victims of WPV, which highlights the need for a peer-mentoring program aimed at increasing social support for personnel who have been victims of WPV in the inpatient psychiatric setting. Therefore, this project proposes to implement a peer-mentoring program as described in Latham (2013), the success of which will be evaluated by improvements in staff retention rates.

The program will include mentors chosen by staff, who are interested in the program and will have received education on how to best support WPV victims. The program will involve creating a formal mentor program and WPV protocol. The mentors will receive training via an initial PowerPoint presentation as well as in-person follow-up meeting on how to function as a mentor.[2] The success of the program will be measured 4 weeks post-implementation via a staff evaluation form (see Appendix D) which will reveal how effective the staff who have been affected by WPV feel the WPV protocol (see Appendix B) has been.

Purpose and Aims

The purpose of this project was to increase organizational support for employees within the local organization who have been subjected to WPV, via a peer-mentoring program. The unit chosen for the project implementation was the most acute unit within the hospital and it was

chosen due to the high number of WPV events that take place because of holding the most acute patients. The project aligns specifically with the Minnesota statute 144.566, titled 'Violence Against Health Care Workers' which states that it is a hospitals duty to have a preparedness and incident response action plans in place for staff violence. [8] It also directly overlaps with the organizations goals and needs given the organization's high rate of staff assault and high staff turnover rates.

The goals of this program were to educate staff on how to respond in a therapeutic manner with evidenced based practices to victims who have been assaulted physically. The education for peer-mentors was developed in conjunction with the John Hopkins Psychological First Aid (PFA) curriculum. [9] PFA is generally used for disaster response scenarios but contains evidenced based principles that are applicable to any trauma-based situation thus was appropriately applied to the organization needs. [9] The curriculum incorporated practical tips specific to the organization, as well as the theoretical evidenced principles of PFA.

METHODS

An institutional review board (IRB) reviewed the project proposal and deemed it a QI project rather than human subjects' research thus a full review was not needed. The methodology included a pretest/posttest design to measure staff perception of support after initiation of a peer-mentoring program. Educational material was based on evidenced based material by a trusted nationally recognized academic and medical institution, Johns Hopkins University Medical Center. The education focused on techniques that can target specific symptoms that occur after a traumatic event and included how to build rapport, effective communication techniques, reflective listening skills, assessment of victim needs, and support tools when these symptoms

are occurring.[9] Peer-mentor involvement in post-WPV events were measured on an already existing seclusion and restraint packet.

Setting and Sample

The peer-mentoring program was implemented at an independent pediatric psychiatric hospital in an urban Midwestern setting. The hospital has 71 beds and serves pediatric patients aged 4-18 years old. Patient concerns cover a wide spectrum ranging from depression and anxiety to substance abuse and psychosis. The average length of stay for patients is 7-10 days, and the most common reason for admission is suicidality. This project involved the peer-mentoring program being implemented on the most acute unit which is reserved for adolescents who are at the greatest risk to themselves or others. Due to the high acuity this unit has the most seclusion and restraint events and greatest number of staff assaults.

The project originally intended to train a group of five registered nurses (RNs) and psychiatric technicians (PTs) but due to organizational changes and staffing inconsistencies, a core group of acute crisis engagement (ACE) training instructors ($n = 9$) were chosen by management to be trained as peer-mentors. This sample included both RNs and PTs who had worked for the company for at least one year and who were trained in ACE which is a program aimed at responding to seclusion and restraint events and utilizing physical techniques to decrease the risk of violence. All nine of the participants attended peer-mentor training.

Interventions

Implementation of the program began with a peer-mentoring training. The project leader created a 38-minute PowerPoint presentation that entailed curriculum on how to provide support to victims after a WPV event. The curriculum was created in collaboration with two nursing educators within the organization, and the lead WPV committee chair. The curriculum was based

entirely on evidence-based practices as discussed earlier. [9] The first portion of the training entailed the rationale behind implementing the project and the benefits of peer-mentoring. Secondly, was discussion on what WPV is as well as prevalence and ramifications of WPV. Following this was an overview of PFA and what the Rapid PFA model entails including the phases: *rapport and reflective listening, assessment, prioritization, intervention, and disposition*. Next, the steps and methods utilized within each phase of the Rapid PFA model were discussed. Lastly, practical tips (see appendix A) on how to find a peer-mentor during a shift, and an overview of the peer-mentor response (see appendix C) was provided. Beyond the training, a peer-mentor flowchart was also shared to help peer-mentors visualize the process (see appendix B).

Peer-mentors names were listed on staffing assignment sheets as well as within the mobile staffing application, ShiftWizard which staff utilize to determine staffing information. There were peer-mentors on both AM and PM shifts, while no coverage was in place for the overnight shift due to staffing changes at the time of the project. Peer-mentors were asked to respond within one hour of a WPV event and ask WPV victims if they would like support. Their response and if the WPV peer mentor intervened was to be recorded on a sheet that was attached to seclusion and restraint packets. Peer-mentors were asked to place forms in a folder in the locked nursing station.

Measures and Analysis

The training was measured for success by peer-mentor attendance. Measurement of the use of tool was accomplished via unit staff and peer-mentors completing a pre- and post-survey on their views about support after a WPV event. The survey used a Likert scale in response to the question “Do you feel supported following a WPV event?“. Additionally, peer-mentors were

asked to record the number of times they were able to respond to a WPV incident. Lastly, staff retention for the unit were recorded at the beginning of the project and the end of the project. This was achieved via gathering a roster of all staff working on the specified unit at the start of the intervention phase, and a roster of all employees on the unit at the end of the project.

RESULTS

Attendance did reach the targeted outcome of 100% of unit staff attending the peer-mentor training. Of participants who did the peer support training, 100% filled out pre and post-tests which is greater than the goal originally set. The mean score of the pre-test was number, while the mean score of the posttest was number. The amount of times peer-mentoring was utilized was number. Discuss this further

DISCUSSION

This project proved valuable in its implementation of a new solution at targeting an ongoing problem within an organization. The project was altered due to staffing shortages at the time of this project thus the scale of the project was dialed back from the entire hospital to just unit. Discuss results in a general sense. Though the project was smaller than originally planned for, this was the pilot for a larger organization-wide initiative given the positive feedback and outcomes.

Pre- and Posttests

Peer-mentoring and Organizational Support

Limitations

As discussed earlier, the size of the project and the shortened timeline are the greatest limitations. This was inevitable due to turnover of staff, and staffing shortages. The generalizability was decreased significantly by only being on one unit though there are WPV

events on other units. Another limitation was there was no formal process in place for management to be notified of a WPV event, which again was impacted by staff turnover and a change of management during the project implementation phase. Staff were advised to e-mail management after a WPV event but there was no real way to measure this which shows a gap in supporting WPV victims. Discuss use of peer-mentoring and barriers

Implications for Future Practice

There are currently no WPV curriculums or programs targeted for the WPV victim in a psychiatric or healthcare setting despite ample literature suggesting staff do not feel supported following WPV incidents in hospitals [1,2] Now with violence prevention and violence response strategies becoming a greater national and local concern, as evidenced by the state of Minnesota creating a law surround this issue, there is a need for this type of program.

This project will continue to be implemented at an organization-wide scale as part of a larger WPV plan.

CONCLUSION

References

1. Phillips JP. Workplace violence against health care workers in the United States. *N Engl J Med*. 2016;374(17):1661-1669. doi: 10.1056/nejmra1501998

2. Latham CL, Ringl K, Hogan M. Combating workplace violence with peer mentoring. *Nursing Management*. 2013;44(9):30-39. doi:10.1097%2F01.numa.0000434333.54035.6c
3. Flynn J. Workplace Violence prevention: Liability recommendations. *Natl Med Leg J*. 2019;30(2):24-29. doi:10.30710%2Fjlnc.30.2.2019.24
4. Zhao S, Liu H, Ma H, Jiao M, Li Y, Hao Y, et al. Coping with workplace violence in healthcare settings: Social support and strategies. *Int J Environ Res Public Health.* 2015;12(11):14429-14444. doi:10.3390/ijerph121114429
5. Park M, Cho S, Hong H. Prevalence and perpetrators of workplace violence by nursing unit and the relationship between violence and the perceived work environment. *J Nurs Scholarsh*. 2015;47(1):87-95. doi:10.1111/jnu.12112
6. Verret G, Lin V. Easing the transition: An innovative generational approach to peer mentoring for new graduate nurses. *J Pediatr Nurs*. 2016;31(6):745-756. doi:10.1016%2Fj.pedn.2016.08.003
7. Tenley C, Bergmar NM, Moore M. Facing workplace violence and best practices for prevention. *Employee Relat Law J*. 2019;45(3):62-66. doi:
8. 2021 Minnesota Statutes. Minnesota Legislature. Accessed on March 1, 2022. https://www.revisor.mn.gov/statutes/cite/144.566#:~:text=144.566%20VIOLENCE%20AGAINST%20HEALTH%20CARE%20WORKERS.&text=(b)%20%22Act%20of%20violence,in%20sections%20609.221%20to%20609.2241
9. The Johns Hopkins Guide to Psychological First Aid. Credo Reference. Accessed on January 19, 2021. https://search-credoreference-com.akin.css.edu/content/title/jhupjhpfa?tab=contents

10. Metcalf AY, Stoller JK, Habermann M, Fry TD. Respiratory therapist job perceptions: The impact of protocol use. *Respir Care.* 2015;60(11):1556-1559. doi:10.4187/respcare.04156
11. Mission, vision, & values PrairieCare. 2021. Accessed on January 19, 2021. https://www.prairie-care.com/about-us/mission-vision-values/
12. Wright, TE. A novel nesting protocol to decrease readmission and increase patient satisfaction following congenital heart surgery. *JPediatr Nurs*. 2018;43:1-8. doi:10.1016/j.pedn.2018.07.009

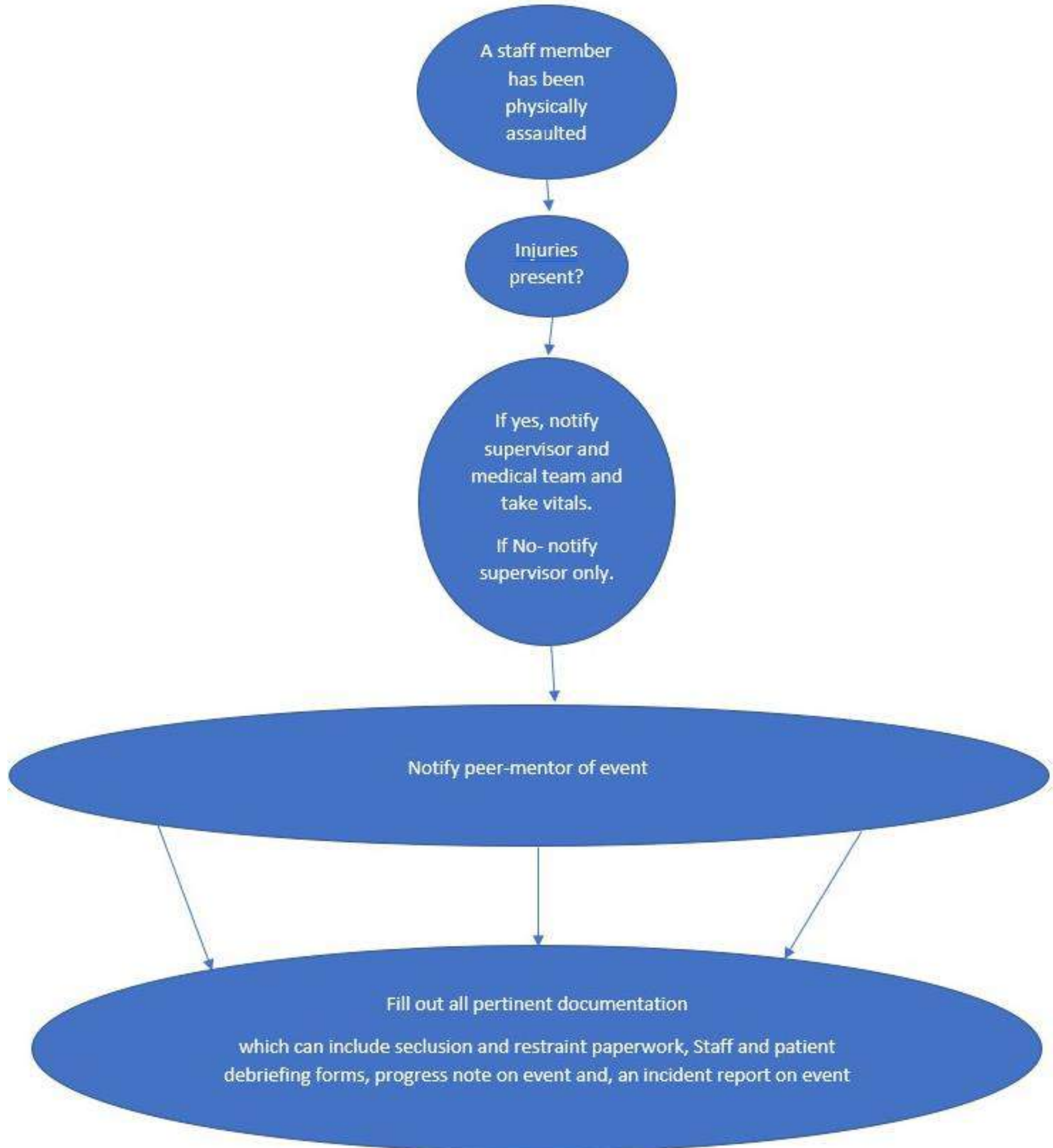
Appendix A

Peer to Peer Response

1. Respond within 1 hour of WPV event.
2. Utilize PFA model during interaction with victim
    a. Establish Rapport and practice reflective listening to show empathy
    b. Assess the needs of the victim
    c. Prioritize their needs
    d. Intervention phase: Utilize Maslow's Hierarchy
        i. First, to meet basic needs (snack, water, rest in break room etc;)
        ii. Next, help victim restore feeling secure/safe by
            1. Empower them – give information factually. Acknowledge guilt, betrayal, or other feelings.
            2. Guide them on what to anticipate – "you might experience difficulty sleeping", "you might not want to go to the area the incident happened" etc;
            3. Help reframe maladaptive thinking patterns.
            4. Ask what stress management strategies worked in the past?
            5. Offer social support. The following questions can be utilized as a guide:
                a. **Do you currently feel fearful because of the WPV event?**
                b. **If so, what are ways that can help you feel safer?**
                c. **What are ways you could feel more supported during this time?**
                d. **How can PrairieCare help you in feeling more supported?**
                e. **Do you feel you need additional support beyond what is provided herein, at this time?**
    e. Disposition/Plan going forward:
        i. Provide encouragement
            1. Offer to call someone if needed.
            2. Connect with supervisor to fill out appropriate paperwork
            3. Provide additional resources as needed
                a. Employee assistance line
                b. Provide HR contact information
        ii. Follow up within one week to check up on individual
    f. Sign incident report indicating a peer mentor was present

Appendix B

Post-WPV Process



Appendix C

Overview of Peer Mentor Response

Initial Needs:	Intermediate Needs:	Follow-Up:
Immediate needs (ED for wounds, ice, water, etc.) Introduction self/role as Peer-to-Peer Responder Creating a therapeutic space – away from activity Utilize therapeutic techniques described in PFA Utilize peer mentor guide sheet	Documentation of event, reports filed, incident report Communication with Charge Nurse/Staff of the unit etc. - Staffing needs for changes, acuity etc	Offer to help coordinate phone calls etc. Make an effort to follow up within the next one week Offer follow-up & resources **- EAP** - **Human Resources**

Appendix D

Workplace Violence (WPV) Staff Evaluation Form
Rate answers 1-5
1= not at all, 5 = absolutely

Have you had to use the WPV protocol in the past three months? (yes or no)	
How helpful have you found the tool?	
How much has the tool impacted your professional development?	
How would you rate the level of support you've received from the organization post- WPV event?	
Any additional comments?	