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

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Abstract

Background: A quality improvement project to provide peer support after a workplace violence (WPV) event focused on providing care to workplace assault victims in the psychiatric setting. Few studies focus on post-assault interventions to support these victims, which, coupled with the fact that psychiatric staff are significantly more likely than the national average to be assaulted at work, highlights the need for such intervention.

Local Problem: A peer support program was identified as a need on an acute pediatric inpatient psychiatric unit of a 110-bed hospital in the Upper Midwest. This unit had an unacceptably high prevalence of staff assaults by patients. State statute required an incident response and preparedness plan for these events.

Methods/Interventions: A peer mentoring program was implemented over 4 weeks. Numbers of employed staff were compared pre- and post-intervention to determine staff retention. Pre- and post-intervention surveys determined any changes in staff perceived level of support.

Results: Inadequate sample size and an unexpected delay and deviation in the timeline precluded conclusions about the effectiveness of a peer mentoring program in this psychiatric setting. Findings did show increased staff perception of organizational support after WPV events.

Conclusion: Violence prevention and violence response strategies are a national and local concern, as evidenced by the State of Minnesota's statutory impact on the matter. Healthcare leaders may have to consider such programs within their organizations and jurisdictions to remain compliant with regulations as well as to demonstrate support for their staff. Further study is required to find associations between peer mentoring programs and staff retention.

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

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INTRODUCTION

Problem Description

Workplace violence (WPV) is a growing concern for healthcare organizations, with 75% of the nearly 24,000 workplace assaults occurring in generalized healthcare settings.[1] Beyond the individual physical and emotional ramifications, WPV directly impacts an organization's culture of safety, productivity, economic health, and ultimately, 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; therefore, 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 4 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 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 the organization.[4] 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] 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 found an 80% reduction in registered nurse (RN) job openings at the hospitals.[3] Mentors reported that they personally prevented 68 RNs 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 address 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 proposed to implement a peer-mentoring program as described in Latham (2013),[2] the success of which was evaluated by improvements in staff retention rates.

The program included mentors, chosen by staff, who were interested in the program and received education on how to best support WPV victims. The program involved creating a formal mentor program and WPV protocol. The mentors received training via an initial PowerPoint-assisted presentation as well as via an in-person follow-up meeting on how to function as a mentor.[2] The success of the program was measured 4 weeks post-implementation via a staff evaluation form (see Figure 3) that collected data on the effectiveness of the WPV protocol as evaluated by the staff who had experienced workplace violence (see Figure 1).

Purpose and Aims

The purpose of this project was to increase organizational support via a peer mentoring program for employees within the local organization who had been subjected to WPV. 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 took place, presumably because the unit held the most acutely ill patients. The project aligned specifically with Minnesota statute 144.566, titled *Violence Against Health Care Workers*, which states that it is a hospital's duty to have preparedness and incident response action plans in place for staff violence.[8] The project also directly overlapped with the organization's goals and needs, given the high staff turnover rate, which was roughly 50% per year, and the high rate of assaults that occurred during approximately 25% of seclusion and restraint events.

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

METHODS

The institutional review board (IRB) of the project's academic affiliate determined that the project was quality improvement rather than human subjects' research. No further review or approval was required. The methodology included a pretest/posttest design to measure staff perception of support before and after initiation of a peer-mentoring program. Educational material was based on evidenced-based materials from Johns Hopkins University Medical Center.[9] The education focused on techniques that target specific trauma symptoms and included content on how to build rapport, effective communication techniques, reflective listening skills, assessment of victim needs, and support tools for use when symptoms occur.[9] Peer-mentor

support was documented within an already existing seclusion and restraint packet that included an additional form to document whether peer-mentoring was utilized, who the peer-mentor was, and the date the event occurred. These forms were expected to be placed in a folder titled 'Peer to peer mentoring' for the unit nurse manager, who collected the forms periodically.

Setting and Sample

The peer-mentoring program was implemented at an independent pediatric psychiatric hospital in an urban Midwestern setting. The hospital had 71 beds and served pediatric patients aged 4 to18 years of age. Patient concerns covered a wide spectrum, ranging from depression and anxiety to substance abuse and psychosis. The average length of stay for patients was 7-10 days, and the most common reason for admission was suicidality. This project implemented the peer-mentoring program on the most acute unit, which was reserved for adolescents who were at the greatest risk to themselves or others. Due to the high acuity, this unit had the most seclusion and restraint events and the greatest number of staff assaults.

The project originally intended to train a group of 5 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 1 year and who were trained in ACE, which is a program that responds to seclusion and restraint events and utilizes physical techniques to decrease the risk of violence. All 9 participants attended peer-mentor training.

Interventions

Implementation of the program began with peer-mentoring training. The project leader created a 38-minute PowerPoint-assisted presentation that included curriculum on how to

provide support to victims of workplace violence. The curriculum was created in collaboration with two of the organization's nursing educators 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. The second portion defined WPV and discussed its prevalence and ramifications. 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*. Subsequently, the steps and methods utilized within each phase of the Rapid PFA model were discussed. Lastly, practical tips (see Table 1) on how to find a peer-mentor during a shift and an overview of the peer-mentor response (see Figure 2) was provided. Beyond the training, a peer-mentor flowchart was also shared to help peer-mentors visualize the process (see Figure 1).

Peer-mentors' names were listed on staffing assignment sheets as well as within the mobile staffing application, ShiftWizard, which staff utilized for staffing information. Peer-mentors were available 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 1 hour of a WPV event to ask WPV victims if they would like support. Their response and whether 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 project outlined 8 objectives that were evaluated in various ways. Objective 1 created a group of peer-mentors by a specified date. Objective 2 created the educational curriculum for peer mentors, which was placed within the online learning portal, Relias, by a specified date.

Objective 3 developed an agency approved WPV response protocol for peer mentors by a specified due date. In subsequent objectives, curriculum/education attendance by peer mentors was evaluated by the number of participants who logged onto Relias and completed the training. Use of the WPV protocol in post-WPV events by peer mentors was measured via forms that were attached to the (paper) seclusion and restraint packets. These attached sheets (see Figure 3) were specifically created for the project and asked if peer mentoring services were offered as well as utilized. To measure the usefulness of the WPV protocol as well as the overall perception of staff support following a WPV event, post-intervention Likert style surveys asked how supported staff felt after a WPV event as well as how helpful staff found the WPV protocol and program to be at the end, amongst other questions (see Figure 3). The last objective related to staff retention. A staff roster was obtained of all staff on the pilot unit pre-implementation and again at the project's end to determine any changes in the rate of staff retention.

RESULTS

Multiple factors contributed to the project's short timeline, the most notable being organizational changes that included nursing educator staff changes (see Limitations). Even with a shortened timeline, 100% of peer mentors (n = 9) attended peer mentor training. However, a deviation from the original plan meant that not all hospital staff were shown the curriculum, as the project had to be limited to only one unit, although all hospital staff were informally advised to utilize the peer mentoring program as they desired.

On the pilot unit, peer mentoring after a WPV event occurred 50% of the time as evidenced by the return of one peer utilization form (Figure 4) submitted after two seclusion and restraint events on that unit during the abbreviated study period. Results indicated that 100% of staff found the WPV protocol useful per a Likert-style survey sent to all 9 peer mentors at the

beginning and end of the pilot project. One respondent indicated that they had to use the WPV in the past 1 month, consistent with the return of only one peer utilization form (Figure 4). Unit staff were surveyed on the helpfulness of the tool, with an average Likert score of 3.89, and 3.0 for how much the peer mentoring program impacted their professional development. Only one person filled out the section asking about how supported they felt after a WPV event and rated it a 4. No additional comments were submitted. Staff retention on the pilot unit remained at 100% from start to finish of the project.

DISCUSSION

This project proved valuable in its implementation of a new solution targeting an ongoing problem within an organization; however, the project was significantly altered due to staffing shortages at the time of the implementation phase. Thus, the scale of the project was dialed back from the entire hospital to just one unit. Results showed that with use of the program and having a WPV protocol available for staff on the unit, staff perception of support from the organization after a WPV event did increase (from a mean Likert score of 2 to 4). Furthermore, staff retention remained at 100% during the study period, which was a 50% increase from the annual retention rate. Although the project was smaller and of shorter duration than originally planned, given the positive feedback and outcomes, this project became the pilot for a larger organization-wide initiative. Several lessons were learned for future endeavors as they relate to the implementation of similar projects.

Lessons Learned

Peer-mentoring and Organizational Support

This project highlighted a desire for staff to feel supported after a WPV event both anecdotally and empirically. The project involved meetings with the peer-mentors as well as the

entire WPV committee within the organization which allowed for staff to communicate their needs revolving the topic. As the project was in motion and these meetings continued, it became clear that there were several gaps throughout the organization in staff feeling supported after WPV events. One marked example that was expressed by a recent WPV victim involved having no follow-up protocol in place for management as it relates to the WPV victim. The victim shared that after a recent WPV event they had received no follow-up communication from management. Per management, it was shared that this was due to a recent change in managers. The follow-up had been lackluster, but they expressed that a plan was in place to remedy this. The magnitude of organizational structure and impact on staff and the success of interventions aimed at staff was underrealized prior to this project.

Measurement

The method for measuring the success of the WPV protocol and peer mentor response was limited but did show an increase in staff perception of organizational support after WPV events. Unfortunately, only one peer mentor utilization form was filed, which is not sufficient to evaluate the effectiveness of the peer mentor program but is not surprising given there were only two seclusion and restraint events for the duration of the project. Current requirements for WPV events are extensive and resources are not centrally located, which may have impacted use of the peer mentor utilization form. Project implementation occurred amid management changes that inevitably impacted unit processes and workflow. Nevertheless, post-survey scores indicated that staff felt more supported with the peer mentoring program and WPV protocol and staff retention remained at 100% for the 1-month project duration, which may justify a longer implementation period for future projects. Ongoing concern about staff retention and its negative organizational consequences supports further consideration of a peer mentoring program.

Limitations

The small number of participants and shortened timeline posed severe limitations to the project but were considered necessary due to high staff turnover and staffing shortages at that time. The project initially was scheduled for implementation during the height of the COVID-19 pandemic, which caused a delay in the project and a deviation from the original timeframe. The shortened timeframe and diminished resources led to project implementation on only one unit, although WPV events occurred on other units. Beyond this, other more subjective limitations are discussed below, which should be considered for future peer mentoring programs to ensure the greatest probability of success.

Organizational Challenges

This project required the marked involvement of various agencies within the organization to ensure that each agency's needs and competing agendas were addressed. This was not unique to this organization but rather is a feature of medium to large sized organizations. During the project implementation phase, it became clear that gaps in employee support after a WPV event occurred purely due to a lack of communication between agencies. A process for formal notification of management of a WPV event did not seem to exist.

Lack of Literature

A major challenge was not having previously developed, empirically tested methods for implementing a peer mentoring program into practice in a psychiatric setting. Enough related research was found to create a curriculum and peer mentoring program, but there was no indication any of the methods would translate into successful outcomes in the psychiatric setting. This became particularly evident upon considering the design of a peer mentoring curriculum as no existing curriculums were found. This led to utilization of the PFA model, which was

originally designed for disaster response.[9] Given its level of empirical evidence and heavy emphasis on the trauma response, the PFA model was translated into a peer mentoring curriculum and tailored accordingly. Since it had not been applied and studied in the psychiatric setting, it was uncertain how the PFA curriculum would affect practice in the psychiatric setting.

Implications for Future Practice

Currently, no WPV curriculums or programs target 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] Violence prevention and violence response strategies are a national and local concern, as evidenced by the State of Minnesota's statutory impact on the matter. Thus, programs of this sort are needed.[8] Healthcare leaders may have to consider such programs within their organizations and jurisdictions in order to remain compliant with regulations as well as to demonstrate support for their staff. This has been the case at the organization where this project was piloted. Therefore, the peer mentoring program will continue on an organization-wide scale as part of a larger WPV plan.

CONCLUSION

This quality improvement project unit addressed the lack of support that staff tend to feel after WPV events with a peer mentoring program piloted on a psychiatric unit. Inadequate sample size and an unexpected delay and deviation in the timeline posed severe limitations to the project, precluding conclusions about the impact of peer mentoring programs on staff retention. Several adjustments should be made in future similar projects, including a lengthened timeline, a broader population focus, and more cohesive relationships formed earlier on with multiple organizational entities so as to prevent gaps in staff support. The project does show promise for utilization of peer mentoring programs to increase staff perception of organizational support after

WPV events; however, further study is required to locate associations between peer mentoring programs and staff retention.

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Table 1

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

Figure 1

Post-WPV Process

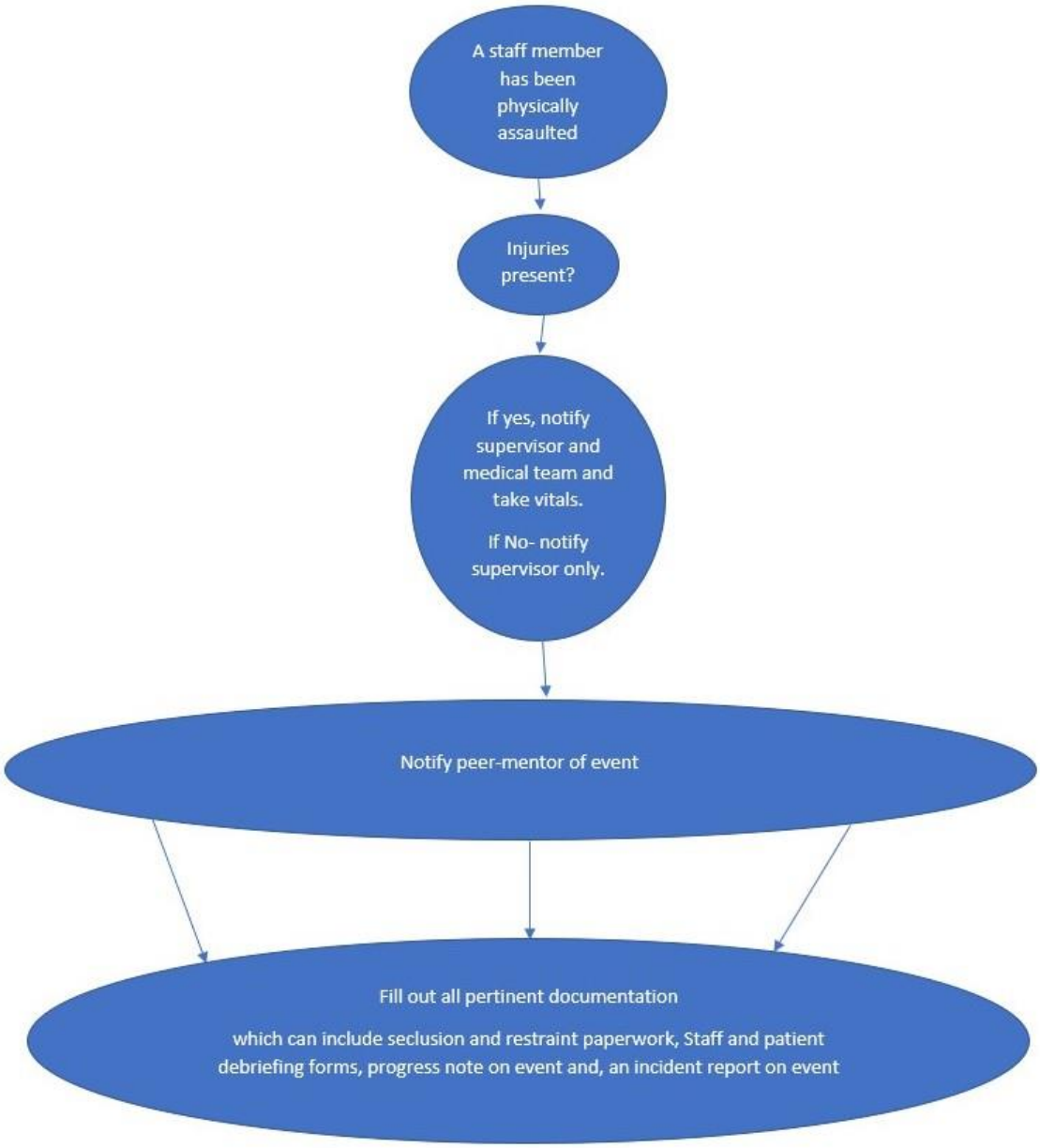

Figure 2

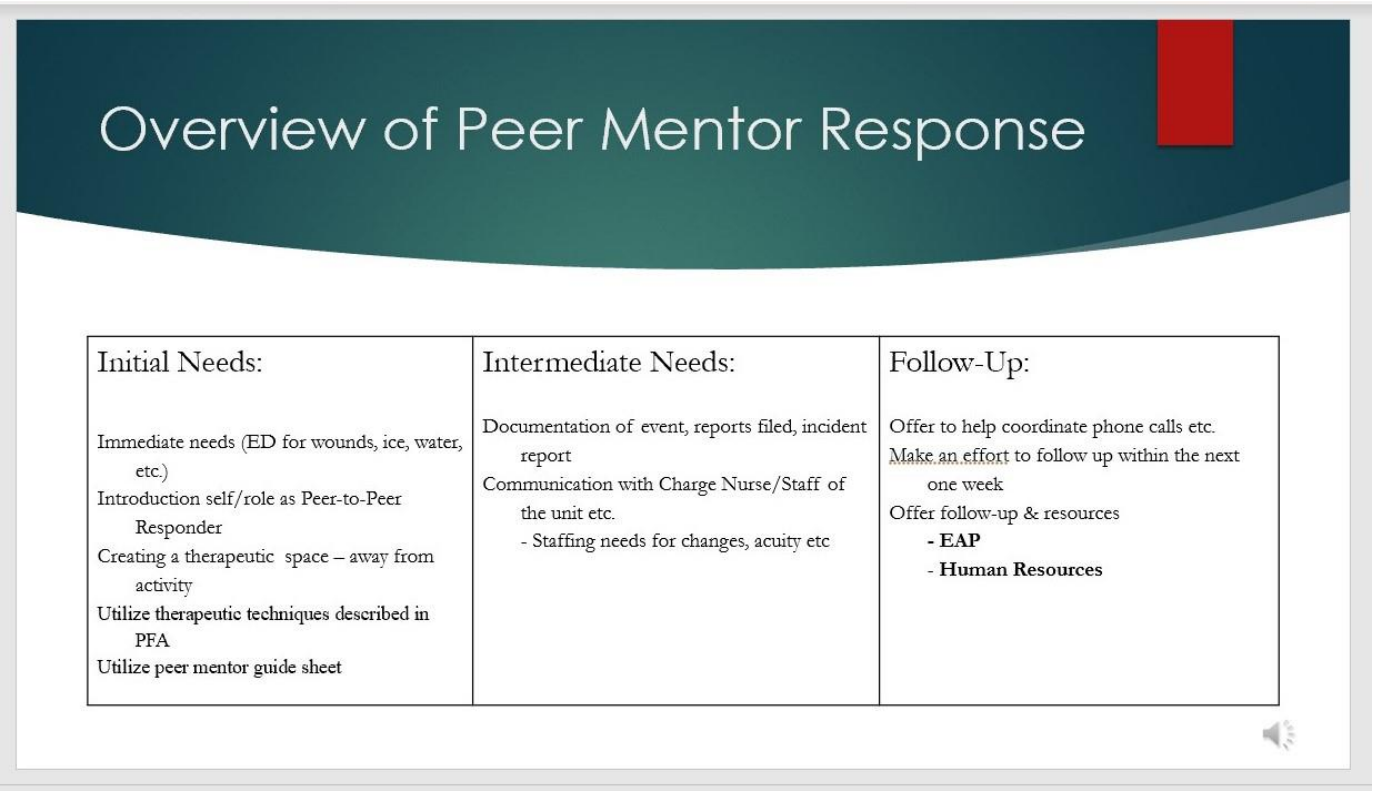
Overview of Peer Mentor Response
Initial Needs:
Immediate needs (ED for wounds, ice, water, etc.)
Introduction self/role as Peer-to-Peer Responder
Creating a therapeutic space – away from activity
Utilize therapeutic techniques described in PFA
Utilize peer mentor guide sheet
Intermediate Needs:
Documentation of event, reports filed, incident report
Communication with Charge Nurse/Staff of the unit etc.
- Staffing needs for changes, acuity etc
Follow-Up:
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

Figure 3

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 one month? (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?	

Figure 4

Peer Mentor Utilization

Date: _____

Peet Mentoring services offered?: Yes No

Peer Mentoring services utilized? Yes No

Comments: