March Ethics for Lunch: Balancing Patient Experience and Staff Safety

Moderator & Panelist:

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Objectives

1. Identify the ethical tensions in balancing the interests of patients and clinicians when disrespectful or violence is experienced.
2. Discuss the legal framework for responding to situations where patient and clinician interests are in conflict.
3. Apply seven ethical precepts to guide the development of solutions to balance patient experience and staff safety.
4. Explore strategies for addressing the ethical conflicts in situations where disrespect or violence are experienced by either patients or clinicians.

Clinicians dedicated to patient/family focused care can experience moral stress when patients in their care create unsafe or disrespectful situations. Instances of violence against healthcare workers have escalated, especially during the pandemic. Using a clinical example, our panel explored the experience of frontline clinicians in addressing disrespect and/or violence against healthcare workers. The clinical exam involved a 54-year-old man who was admitted with COVID complications and suffered a respiratory arrest requiring resuscitation. He was admitted to the ICU where he experienced agitation and violent and impulsive behaviors related to a hypoxic brain injury. Staff were concerned for their safety as many were kicked or hit when the patient was agitated and violent. They were also verbally abused by the patient and his family, including yelling and threats of reporting staff to authorities.   Staff did not feel comfortable caring for him and reported being

distressed and fearful at work. Staff contacted the RISE team (Resilience In Stressful Events) and placed safety reports almost daily. Safety measures, such as a security guard, were put into place to protect staff. The case highlighted the complexity of interests of clinician and patients in the context of delivering patient care and the ethical conflicts that can arise.

1. Summary

The Joint Commission defines workplace violence as "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors" (JCO, 2022).

Over 20,000 workers in private industry experienced trauma from nonfatal workplace violence in 2019 (Bureau of Labor Statistics, 2018).Of those victims who experienced trauma from workplace violence:

- 68% were female
- 65% were age 25 to 54
- 70% worked in the healthcare and social assistance industry
- 21% required 31 or more days away from work to recover, and 20% involved 3 to 5 days away from work

For nurses:

- 21 % of registered nurses and nursing students reported being physically assaulted (ANA, 2014)
- Over 50% were verbally abused in a 12-month period (ANA, 2014)
- During the pandemic, 44.4% nurses experienced physical violence and 67.8% experienced verbal abuse (Byon et al, 2021)
- During the COVID pandemic, only 10% of nurses reported the abuse they experienced. The underreporting was attributed to nurses' high threshold for asking for help in managing these situations (Byon et al, 2021)

The costs of workplace violence include lost wages, treatment of emotional and physical injuries, increased caregiver stress, fatigue, and medication errors--all of which contribute to higher turnover.

Factors that have contributed to violence in health care settings include increased prevalence of guns in our communities along with increased psychiatric patients, substance use, criminals or gang members being held in emergency rooms, and unrestricted movement of the public in clinical areas. Recently an additional factor was the increased anger by families about hospital policies, especially during the COVID pandemic. Staff shortages, lack of training, high risk areas such as parking garages and remote clinics have also been identified as factors contributing to violence in health care settings.

The legal landscape is complex. Efforts to make violence against healthcare workers a felony have been successful in only 15 states. Similar proposals within Maryland continue but have not been successful. The panel discussed that staff who are the victims of violence, assault or battery should be encouraged to file criminal complaints, although the fears in doing so were acknowledged. Ideally a partnership with the hospital legal team can offer support to those who choose to file charges.

Cases like the one described create sustained distress for nurses at the point of care. Nurses may request reassignment or avoidance of repeated shifts assigned to an abusive patient to reduce the cumulative impact. The accumulation of the stress associated with perceived unsafe working environments can contribute to burnout, moral suffering, and turnover. When the distress escalates, the executive management team, security, ethics team, and the RISE team may need to become involved.

Balancing patient experience with staff safety is a core issue in responding to situations where violence occurs. Under-reporting is influenced by factors such as nurses explaining patient behavior as a reflection of the patient's disease or injury-as in the case presented where there had been brain injury. While true, panelists asserted that boundaries to protect both patients and staff must be maintained. Normalizing negative and abusive behaviors contributes to an unsafe workplace for everyone. Panelists reflected on the assumption that the staff must tolerate these behaviors to maintain the hospitals HCAP scores. These issues are not present for the majority of patients (less than 2%). When they do occur, there is agreement that they need to be addressed proactively, consistently, and equitably. Patients, like staff, have corollary rights and responsibilities. Staff were encouraged to speak up about their concerns.

Based on work by the Beryl Institute, seven ethical precepts were proposed (Rushton et al, 2021):

1. Persons must be safe and secure to live and effectively function.
2. Everyone (patients, families and health care workers) is treated with respect to honor their inherent dignity as persons.
3. Violence and threat toward persons (patients/family members or loved ones or health care workers) are ethically impermissible.
4. Achieving and maintaining a safe and healing environment is a responsibility equitably shared among patients, family members or loved ones, healthcare workers and leaders.
5. Policies, practices, and decisions must be transparent, clearly communicated and consistently applied.
6. Reporting mechanisms are confidential, timely, responsive, and occur without retaliation, discrimination, or blame.
7. Education and resources to support patients, family members, loved ones and healthcare workers are available, accessible, and proactively offered.

Recommendations

- Re-calibrate norms of behavior and responses in the acute care setting
  - *No one should be treated disrespectfully or endure violence or aggression*

- Institute transparent disclosure of expectations and mechanisms for upholding them
- Maintain bi-directional responsibilities and clear boundaries that support safety of everyone
- When there are concerns about safety—Speak up! Early and often.
- Encourage ongoing and inclusive communication
- Proactively identify high-risk situations using a visitor management system
- Train staff in and adoption of de-escalation techniques
- Encourage early referral to patient relations
- Report when instances of violence or disrespectful or abusive behavior occurs so that patterns can be identified and tracked.
- Refer abusive situations to Executive Management Team (ERT) when initial efforts are ineffective
- Use resources, ethics, risk management, security, RISE, psychiatry, behavioral health, social work, or chaplains to mitigate the risk of violence and support staff
- Monitor work of the Behavioral Safety Steering Committee

Resources and references

American Nurses Association (2015) Incivility, bullying and workplace violence. Position Statement. Silver Spring, MD. The Association. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/incivility-bullying-and-workplace-violence/

Byon HD, et al. Nurses' Experience With Type II Workplace Violence and Underreporting During the COVID-19 Pandemic. Workplace Health Saf. 2021 Aug 3:21650799211031233. doi: 10.1177/21650799211031233.

Jones, M. (2021) Preventing workplace violence in healthcare. https://www.aacn.org/blog/preventing-workplace-violence-in-healthcare

Rushton CH et al. Rebuilding a foundation of trust: A call to action in creating a safe environment for everyone. Patient Experience Journal. 2021; 8(3):5-12. doi: 10.35680/2372-0247.1651.

Gooch K. After attack on nurse, Ochsner CEO advocates for making healthcare violence a felony. https://www.beckershospitalreview.com/workforce/after-attack-on-nurse-ochsner-ceo-advocates-for-making-healthcare-violence-a-felony.html

Paavola A. Travel nurse allegedly sets colleague on fire at New Jersey hospital. https://www.beckershospitalreview.com/nursing/travel-nurse-allegedly-sets-colleague-on-fire-at-new-jersey-hospital.html

The Joint Commission. Workplace Violence Prevention Resources. https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/