Cancer didn’t wait for Maurelle Wyeth to turn 65. So why does Medicare?

Waiting Game
WHAT IS so special about the age of 65 that our country has decided that everybody 65 and older gets government-sponsored Medicare, while everyone else is thrown to the wolves of health insurance corporations? As nurses know, absolutely nothing. The age of 65 is just a number that legislators agreed upon when they created the Medicare program back in 1965. As we all know, 64-year-olds need healthcare as much as 65-year-olds, as do babies, 20-year-olds, and 40- and 50-year-olds. If Medicare were actually extended to every American, regardless of age, this country could do such a better job of taking care of the health of its people.

For one thing, women like Maurelle Wyeth wouldn’t have had to skip three years of mammograms, which wouldn’t have given her breast cancer three years to grow. Wyeth, a 58-year-old from Oregon, couldn’t afford mammograms after she lost her health insurance in 2003, so she did without. Three years later, she found a big lump. Luckily, she qualified for treatment as a low-income person through Medicaid, but the cancer appears to have spread to her liver. She doesn’t understand why, as a developed nation, we don’t just provide healthcare for all. She knows she would have gotten a mammogram earlier, her cancer would have been caught earlier, everything would have cost much less, and very likely, the cancer would not have had a chance to spread.

Stories like hers underscore why improving and expanding Medicare for all is such an important part of our work as nurses and as the country’s leading nursing organization and union. Please take the time to read about and reflect upon her situation. And if you have a story you would like to share, please tell it to us at www.nationalnursesunited.org/story.

Also in this issue, our Veterans Affairs nurses sound the alarm about a dangerous new directive that poses a huge risk to the safety of our nation’s heroes and encroachment upon the RN scope of practice: The VA wants to allow unlicensed assistive personnel (UAPs) to administer a wide variety of medications, including vaccinations and injections. As nurses know, giving any kind of medication requires clinical judgment that an unlicensed person does not have. VA nurses are organizing against this policy.

There’s lots of other important news and materials in this issue, including a critical union election victory in California, defeat of a union-busting bill by Minnesota nurses, and the final segment of a workplace violence continuing education home study course. So we’ll let you get to it.

And if you’re in Chicago on May 18, join us in a rally to call for a Robin Hood tax on Wall Street. See our website, nationalnursesunited.org, for details.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN
National Nurses United Council of Presidents
Contents

4 News Briefs
Massachusetts nurses move to block closure of state mental hospital 5 | Minnesota RNs defeat union-busting bill 6 | Sutter Tracy RNs vote in union 7 | VA nurses fight directive letting UAPs give medications 8 | Tenet nurses in California win new contract; Pennsylvania nurses push for anti-workplace violence legislation

9 This Is a Hospital, Not Disneyland
How nursing scripts and patient satisfaction surveys are destroying our nursing practice.
By RoseAnn DeMoro

11 Waiting Game
Maurelle Wyeth is a perfect example of why Medicare needs to cover everyone of all ages, now.
By Lucia Hwang

14 CE Home Study Course
Workplace Violence: Assessing Occupational Hazards and Identifying Strategies for Prevention, Part 2
As any registered nurse can attest, all forms of workplace violence are on the rise. Learn more about how to prevent it through this home study CE.

ON THE COVER: Photo by Craig Alan.
Massachusetts Nurses Act to Block Closure of State Mental Hospital, Call for Study of the System

In the wake of Massachusetts Gov. Deval Patrick’s plan to close Taunton State Hospital and what many state legislators and mental health advocates are calling a “mental health crisis” in Massachusetts, more than 600 people, many of them chanting “Stop and study,” gathered in a State House auditorium in March to demand that Patrick’s administration delay the closing of the facility until a thorough study is made of the state’s mental health system.

The rally, which was organized by state Sen. Marc Pacheco and House Speaker Pro Tempore Patricia Haddad, with assistance from the Massachusetts Nurses Association/NNU, featured speeches from legislators on both sides of the aisle, mental health advocates, MNA/NNU nurses, other workers, labor leaders, and former patients of Taunton State Hospital.

Throughout the state, mental health services are inadequate and those seeking treatment are often unable to access care. Hospital emergency departments are overcrowded with psychiatric patients who cannot access needed inpatient and community services, resulting in patients boarding in hospital emergency rooms for days or even weeks waiting for care. Patients are being inappropriately admitted to medical units because there is no place for them to go, while others are languishing in homeless shelters or finding themselves trapped in correctional facilities for want of appropriate treatment and community support services. To address this crisis, legislators have crafted an amendment to the state budget that would halt the closure of Taunton State Hospital, and other inpatient services until an independent study is conducted to determine the actual need for and availability of inpatient and community services and supports.

The rally lasted nearly three hours and, on several occasions, elicited raucous applause and chants of “stop and study.” About 150 nurses, workers, and supporters held signs that read, “Save Taunton State,” and “I have a right to mental health services in my community,” along with “Mental health care for all, make parity a reality,” and “We need care in our communities, not in emergency rooms.”

The rally received widespread support from legislators not only from the Taunton region, but from central Massachusetts, Cape Cod, and the Islands.

In addition to legislators, speaking at the rally were former mental health patients, relatives of patients, a district attorney, the mayors of Taunton and Worcester, and mental health workers. They all discussed the hardship that will be created by Patrick’s plans to move Taunton State’s 169 beds to a new Worcester State Hospital and a facility in Tewksbury.

The political leaders and protesters at the rally said that it was unfair to force patients into a new facility, causing a strain on their families who would have to travel more than 55 miles to visit and participate in recovery. They said that without Taunton State, access to inpatient beds would worsen in the region, causing emergency rooms, acute-care facilities, and jails to become even more overloaded with patients who need mental healthcare.

“You are here today to stand up for individuals suffering from mental illness, people who have no voice for themselves, let us not forget that,” said Senate Majority Whip Harriette Chandler, representing Worcester.

“The closure of Taunton State Hospital is a cold-hearted and dangerous decision that will have devastating consequences,” said Karen Coughlin, who worked as a registered nurse at the hospital for 28 years and is now vice president of the Massachusetts Nurses Association.

A woman with a son at Taunton State Hospital and another with an aunt at Taunton State each spoke about what kind of hardship shipping beds to Worcester or Tewksbury would have on their loved ones and the strain it would put on their families.

Mary Clement and Timothy Grabosky, two former patients at Taunton State, each spoke fondly about the mental health facility and pointed out the importance of having it within the southeastern Massachusetts community.

“I would not be standing here today if it weren’t for Taunton State Hospital,” Grabosky said.

“If you want evidence of our mental health system’s failure, come to any emergency room at any time any day, and ask how many psychiatric patients we are treating,” Stacey McEachern, an MNA/NNU member and 12-year RN in Quincy Medical Center’s emergency room, told the crowd.

“Any official with the Department of Mental Health, from the commissioner on down, who claims that we are doing right by our mentally ill, that we are providing adequate care for our mentally ill, and worse, that we can afford to lose even one more psychiatric bed in our system, is not only lying to themselves and the public, but should be ashamed of themselves. These people shouldn’t be in our EDs, at least not for days and certainly not for a week or weeks. It’s criminal, it’s a travesty,” McEachern concluded. —David Schildmeier
Elected officials got a taste of union ire as they attempted to force-feed a “right-to-work” measure through the Minnesota Legislature in March. They came away with more than an upset stomach. Nurses blitzed the Capitol, along with 2,000 other workers, to protest at a Senate committee hearing where the bill was being heard for the first time.

With just a few days’ notice, union activists hustled to issue the warning of what could happen if the bill progressed in the legislative process. So-called “right-to-work” legislation allows workers to avoid paying their fair share for the bargaining and representation work of the union. Workers lined the room and the hallways, some in full work gear or uniform, and sent chants ringing into the ears of officials and aides. At times, testimony in support of the proposed constitutional amendment was drowned out by the voices, but the room fell silent when Minnesota Nurses Association member Ursula Tuttle, a registered nurse at Abbott Northwestern Hospital in Minneapolis, stepped up to the microphone. Speaking of her experience in a right-to-work state, she described a situation where nurses didn’t speak up against horrific conditions.

“I think they were afraid of retaliation,” she said. “A culture of fear existed because they didn’t have the collective protection of a union contract.”

Outside the Senate hearing room, MNA Economic and General Welfare Commission Chair, Jennifer Michelson, RN explained why she will always fiercely fight to defeat any right-to-work legislation. “With a union behind me, I know I can advocate for my patients,” said Michelson. “If I see trends in patient care that aren’t correct, I can go to the Legislature and say ‘This is not right; this is just a cost-cutting measure of a corporation.’ If my patient at the worksite has a problem where I believe the care is not appropriate, I have committees I can go to. I can advocate for that patient without worrying that I would be fired because I’m a squeaky wheel.”

In addition to the rally, nurses set the Internet abuzz with hundreds of missives sent through MNA’s web-based Grassroots Action Center. Legislators were pounded by emails from nurses at all hours of the night and day—whenever nurses could get a break. The notes were spontaneous and powerful. Registered nurse Michelle Donovan wrote, “I could not have a stronger opinion about this issue. I am an RN and I just returned to MN after working for 4 years in a ‘right to work’ state [without a union]. I have never in my ENTIRE nursing career felt so powerless to protect my patients. We all worked grueling hours, had grossly inadequate numbers of staff, and absolutely no support network. It was made clear by non-medical management that we were to do the job and not complain. The message was clear: ‘You are not valued as an employee and we don’t care about the patient’s welfare. Just keep them alive until discharge. If you cannot put up and shut up then leave and we will replace you.’”

The bill moved out of committee by a one-vote margin, but senators and representatives alike took a sobering lesson from the rally—and nurses’ messages. By late March, the conservative Senate majority leader publicly declared “the votes aren’t there for right-to-work.” —Jan Rabbers
Nurses at Sutter Tracy Vote in Union

By voting in March to join the California Nurses Association, nurses at Tracy Sutter Community Hospital enjoyed an extremely hard-fought organizing victory over Sutter Health, one of the biggest and wealthiest hospital chains in California.

CNA now represents 6,200 RNs at 16 Sutter Health facilities. Most of those RNs are currently engaged in bitter contract negotiations with Sutter, during which the Sacramento-based corporation has demanded hundreds of concessions. In response, nurses have gone out on strike three times to defend their patients and standards.

“Nurses stood up for our patients and our profession, and we won,” said Dotty Nygard, an emergency room RN. “We can now share in the vision of a better and healthier future for our patients, our profession, and our community with CNA representation.”

The key issues that galvanized the RNs to organize centered on patient protection provisions that already exist in other CNA-represented Sutter hospitals.

Some of these issues include making sure there are enough nurses dedicated to caring for patients while others are on much-needed breaks during their 12-hour shifts, as well as bonus pay for required certifications and enhanced sick leave.

What the nurses accomplished wasn’t easy. Sutter Health, which bills itself as a not-for-profit company but amassed more than $4 billion in profits since 2007, launched an aggressive anti-union campaign of surveillance and harassment once it learned of the nurses’ plans to unionize.

Nygard said she and other nurses attempted to defuse the tense situation so the RNs could exercise their democratic rights and communicate the case for a union during non-working hours. “It’s not like we were performing some radical act, we were just attempting to join a union that more than 60,000 RNs already belong to in California.”

Nygard says she and seven other nurses attempted to meet with Sutter Tracy CEO Dave Thompson. Thompson refused, walking out of his office. And while the hospital was busy abridging the nurses’ First Amendment rights, Thompson made sure he got the Sutter message across, publishing “The Straight Talk,” a newsletter which made the hospital’s case against unionization. “The Straight Talk” had its own dedicated space in the nurses’ break rooms.

“It was really a dark atmosphere,” Nygard said. “We didn’t feel safe posting on Facebook, on email, so 90 percent of our communication was over text messaging. We would call meetings over text, send encouraging notes; it was really our own text message revolution.”

All the hard work paid off. Nurses voted 83 to 70 to join CNA. After the election results were announced, nurses hugged one another and cried tears of joy.

“This is a dream come true. It’s been very oppressive since 2005 when Sutter came in to this hospital. Now with the union representing us there will be democracy and equality in our workplace,” said Clarissa Concepcion, an RN who works in the medical surgical unit. —Joe Rubin
VA Nurses Fight Directive Allowing Unlicensed Personnel to Give Medications

According to the VA nurses, the administration claims that UAPs are currently allowed to administer some medications, but when they asked for systemwide and sitespecific data about this practice, the VA was not able to provide any documentation. “They don’t know who’s giving it where or what,” said Westmoreland. “We asked, ‘What facilities?’ They couldn’t tell us. ‘What medications?’ They couldn’t tell us. They don’t have anything in place to control or track it at all,” said Westmoreland. The VA nurses say that, as far as they know, no UAPs at their facilities are giving medications or injections.

The VA nurses are now crafting a memorandum of understanding with VA that they do not support this directive and do not plan to participate in it, whether that means delegating to UAPs or documenting medications that UAPs have given. Further, the nurses plan to organize against this directive by lobbying each facility’s medical director, who, under the directive, has the authority to implement this directive, or not. “We want our nurses to tell the director, ‘We do not want this used in our facilities,’” said Westmoreland.

All the nurses emphasized that our nation’s veterans deserve the highest standard of care, and that allowing UAPs to administer medications is a disaster waiting to happen. “If I had a relative in the hospital, I would want to make sure their medication was administered by someone with the proper education,” said Ruby Rose Hutchinson, an RN who works at the Miami VA. “I wouldn’t want just anyone giving my loved ones medication.” —Lucia Hwang
California

Registered nurses at six Tenet Healthcare hospitals in California approved a new four-year contract in March that protects health coverage for their families, wins improvements in patient care and nurses’ standards, and provides for important economic gains.

The agreement affects 2,700 RNs at Desert Regional Medical Center in Palm Springs, Doctors Medical Center in Modesto, Los Alamitos Medical Center, San Ramon Regional Medical Center, Sierra Vista Regional Medical Center in San Luis Obispo, and Twin Cities Community Hospital in Templeton.

Nurses were able to protect existing health coverage under which they will continue to pay no out-of-pocket costs for their premiums and no increases in co-pays or deductibles; win improvements such as contract language guaranteeing full compliance with California’s new law, sponsored by CNA, to assure safe patient life practices; and raises of 10.5 percent over the next three years, with an additional 3 percent retroactive increase for 2011.

“Tenet nurses are proud to hold up this agreement as an example of what we can accomplish together when we stay united,” said Sierra Vista Regional Medical Center RN Sherri Stoddard, chair of the CNA Statewide Tenet RN Council. “We are moving forward as a profession without sacrificing a single protection for our patients or our families.”

Pennsylvania

While workplace violence has always been present in the work of nurses and other healthcare professionals, Pennsylvania nurses have noticed a significant increase over the last few years. In an attempt to gauge the reach of workplace violence in health facilities across Pennsylvania, the Pennsylvania Association of Staff Nurses & Allied Professionals (PASNAP) teamed up with the Massachusetts Nurses Association to sponsor a CE conference on the subject in November 2010.

The response was staggering: more than 200 nurses, members and those not yet unionized, from dozens of facilities across the state came together to speak out about what was happening to them while trying to care for their patients. District attorneys from several counties came and listened to shocking stories of how mentally ill, intoxicated, or merely frustrated patients and family members have punched, kicked, bitten, spit at, threatened or otherwise assaulted caregivers, changing their lives and often ending their careers.

PASNAP reacted immediately, setting up a Workplace Violence Task Force that would raise public awareness of the issue, hold hospitals accountable for security, and get laws passed to protect nurses at work. With MNAs language as a model, PASNAP drafted a bill that would require hospitals to proactively develop and implement programs to prevent workplace violence. House Bill 1992 was introduced in November 2011 by state Rep. Nick Micozzie, a pro-union Republican and cosponsor of PASNAP’s safe staffing bill.

Since the introduction of HB 1992, PASNAP members have been working hard to win the support of legislators, successfully assembling a broad array of lawmakers to cosponsor the bill. While nurses expect the hospital industry to resist the anti-violence bill, they are hopeful to win passage by the conclusion of the legislative session.

—Staff report
Hello, Mr. Smith. My name is Joanne. I am your nurse. Are you experiencing any pain today? No? That’s good. Do you need help getting to the bathroom? (check script) “Can I fluff your pillow, bring you a magazine, turn on your TV, move your water bottle closer?” (check script) “I am so happy to be of service, this is all part of the excellent care we provide here at Happy Homes Medical Center and Resort.”

“We know you have choices when you go to the hospital, thank you for choosing Happy Homes.” (check script) “You will be receiving a survey from us after you leave Happy Homes, and I hope you will remember this excellent service when filling it out. Have a nice day, Mr. Smith.”

If this scenario seems far fetched, you’re probably not a nurse who has worked in a hospital recently. Strict adherence to scripts derived from exorbitantly paid consultants like the Studer Group and Press Ganey for every interaction between the RN and her patient is increasingly a job expectation.

Can’t recall it all? Not to worry, the hospital will provide acronyms and “important key words,” also known as the “Five Fundamentals of Service,” to help RNs remember their script, helpfully reinforced by their managers, as we noted in a 2010 NNU CE home study course and feature story (National Nurse, October, November 2010).

Scripting is one element, another is “rounding,” guaranteeing that every nurse document a visit to every patient at least once every hour, even if the nurse checks on the patient more frequently, as is typically the case, or misses the hour by a few minutes because another patient happens to be coding.

And, what happens if you fail to meet the scripting and rounding requirements? For the nurse, especially in a non-NNU hospital, it can lead to docked pay or other discipline. For the hospital, it can lead to reduced Medicare reimbursement, for which it will certainly exact punishment on the nurses.

Welcome to the not-so-Brave New World of faux patient satisfaction.

About 15 years ago, during an earlier wave of hospital restructuring, we told the story about a hospital where nurses being required to put lip gloss on a patient to improve their color before a family visit so that family members would think their loved one was receiving appropriate care. Even as the hospital was replacing RNs with unlicensed personnel, all that mattered was the perception of care.

As the years have evolved, so have the reengineering methods. And the hospitals have an added incentive to substitute service and the appearance of care for the actual delivery of quality care.

It pays. A lot. The Centers for Medicare and Medicaid Services announced last October that patient satisfaction survey results will be one significant factor in determining Medicare reimbursements, and for those executives lucky enough to meet the contrived guidelines, bonuses.

To make matters worse, patient satisfaction surveys are fully integrated into the 2010 Affordable Care Act, through healthcare quality initiative measures.


If this sounds like something out of Disneyworld or the hospital and hospitality industry, that’s not an coincidence. Hospitals now use the same consultants and the same formulas. Call it Goofy on steroids.

Consultant-driven reengineering blueprints are destructive enough in the service and entertainment industry. In healthcare they can be deadly.

Witness a study, “The Cost of Satisfaction,” just published in February in the Archives of Internal Medicine. Correlating patient satisfaction surveys with outcomes, the study said the risk of death for the most highly satisfied “healthy” patients was 44 percent higher than their less “satisfied” counterparts. The article sparked a bevy of medical blogs and news accounts with titles like, “Do you like your doctor? It could be the death of you,” and a furious rebuttal from Press Ganey statisticians arguing the surveys are “here to stay.”

Just making the patient happy, with inappropriate care for example, has no bearing on quality of care, wrote columnist (Continued on page 10)
Do you feel good about your highly skilled profession when the nursing process is subjugated to the Disney-designed perception of care?

If your patient is smiling when he dies (even though he would not have died if the hospital had safe RN staffing ratios), do the consultants and CEO believe that you have done a good job? (Assuming they can get someone else to fill out the satisfaction survey, to the CEO’s satisfaction.)

NNU recently uncovered some sample survey questions that did not make the final cut in the consultant manual, “How to Win Friends (in the CMS reimbursement office) and Influence People (patients deceived by the phony appearance of care).”

1. A diabetic patient asks for a piece of chocolate cake. Which is the correct answer?
   a) Politely say “no.” Explain it’s not in his best interest and that it could cause him significant harm, such as sending him into diabetic shock. Remember, however, that with this answer, you are taking the risk that he might feel unhappy or “dissatisfied” with you and the hospital, thereby risking a negative patient satisfaction response from him later.
   b) Give him the piece of chocolate cake, thereby decreasing the risk of a negative patient satisfaction survey response from the patient when he checks out of our state-of-the-art five-star quasi-hotel (remember, never tell him he’s in a hospital), and then hope and pray he doesn’t go into shock or worse.

2. Your case manager has asked you to discharge a bulimic patient two days early. You:
   a) Do 15-minute bedside education and refer her to a dietician, therapist, and support group.
   b) Give her a gift certificate for a huge box of See’s candies and refer her to a dentist.

3. Your post-op knee replacement patient is crying and doesn’t want to walk because it hurts. You say:
   a) “Sit up and dangle your feet. I’ll be with you every step of the way.”
   b) “Let’s do it tomorrow when you feel better. Linda will be here then. She’s a great nurse with 10 years of experience. Everyone loves Linda.”

4. Your proud mother-to-be lost her baby unexpectedly. Do you:
   a) Sit down with her and the family and just be there.
   b) Say, “Can you reach the ice water? I washed my hands so you know they’re clean. What’s your birth date? Please confirm your allergies. I’ll be back in one hour to ask you the same questions.”

5. A teenage patient who is terrified as she is dying from terminal cancer and is also blind asks you to sing to her and hold her hand so she can get to sleep at night. Do you tell her?
   a) “Yes, of course,” or,
   b) “Sorry, that is not in the script, but will you please ask your parents to give us a good recommendation for the excellent care you received at our Magnet medical center in the survey the hospital sends them after you expire?”

RN bonus questions

1. The hospital CEO discovers an extra million dollars in his budget. He will spend it on:
   a) Increasing RN salaries and benefits.
   b) Hiring more nurses’ aides so that patients will get more attention.
   c) Upgrading old and outdated equipment at the bedside.
   d) Hiring a consultant to tell him how to improve patient satisfaction.
   e) His bonus

2. You’ve had an incredibly difficult, but very rewarding day. You saved a patient’s life by noticing a change in a critical lab value. You helped a patient and family discuss end-of-life care. You mentored a new graduate nurse through challenges of her own. But at the end of the day, you were behind on your charting and stayed a half hour after your shift to finish up. Which response is more likely:
   a) Your manager thanks you for a job well done
   b) Your manager disciplines you for excess overtime and “poor time management.”

Do you have a suggestion for the stupidest scripting question of all time? Tell it to us at www.nationalnursesunited.org/silly or you can post the question on NNU’s Facebook page at www.facebook.com/nationalnurses. If you win, you’ll receive a prize. Deadline to enter is May 31, 2012.
If Medicare covered everyone regardless of age, Maurelle Wyeth wouldn’t have skipped three years of mammograms. Now she doesn’t know if she’ll make it to 65. By Lucia Hwang

Waiting Game
s a 52-year-old woman any less deserving of a mammogram than a 49-year-old woman? And if that 52-year-old woman is diagnosed with breast cancer, is she any less deserving of treatment than at age 65?

These are the kinds of questions that Maurelle Wyeth has asked herself over the past six years because, you see, she was that 52-year-old woman.

Wyeth, now 58, like nearly 51 million other uninsured Americans, has lived most of her life without health insurance coverage. At various times in her life, depending on the job she held, Wyeth enjoyed health insurance and was able to go to the doctor when she needed to, to get her cholesterol checked out, or to get an old cavity filling replaced. It’s hard for her recall now, but she thinks that in her 20s and 30s, she had coverage here and there when she worked in publication production at a variety of magazines and publishing houses. But she definitely remembers the early 2000s with fondness, for that was when she and her husband, Al, were able to access regular healthcare through her job at the Mail Tribune newspaper in Medford, a small community on the southern edge of Oregon where they live.

“It was wonderful,” said Wyeth. “We got everything taken care of that we needed to. We got tests done. We got our teeth done. I hadn’t been to a dentist in 10 years and the teeth were starting to fall out of my head.”

After she left her job at the paper, the Wyeths continued to pay for COBRA coverage, but just couldn’t keep up with the nearly $600 per month payments. So they had to drop the plan in 2003. Her next job was as an in-home caregiver for an elderly woman named Shirley, a job that paid no benefits like health insurance. Around that time, Wyeth looked into purchasing insurance on their own.

“We would have loved to have had health coverage,” she said. “We were both getting older and starting to worry. But the cost was just beyond our reach.” She estimates that the most she ever made in one year was about $24,000 when she worked at the newspaper.

A college graduate who originally earned her bachelor’s degree in art history, Wyeth says that she has worked hard all her life, but the types of jobs she was able to get just didn’t provide healthcare or wealth. As a young woman, she also struggled with depression, which affected her ability to build stability or a career. “I didn’t choose poverty,” she said. “I would have loved to have health insurance all along the way.”

Today, she and her husband get by on a combination of loans, gifts from family, and food stamps, and they earn their rent by acting as caretakers for the property where they live.

In 2006, while she was still taking care of Shirley, Wyeth decided to go back to college at Southern Oregon University and study Spanish, a longtime dream of hers. She was a model student, earning all As her first quarter.

As is always the case with such stories, things would have been fine if nobody had gotten sick. But that’s not how life works. On Nov. 28, Wyeth was in the shower when she found a sizeable lump in her right breast. It was large enough to create a big divet in her skin. The last time she had a mammogram was three years before, when she was still covered by her Mail Tribune health insurance, but she had not had her annual checkups since for lack of money. Wyeth panicked. “I thought, ‘Holy shit!’ I was really scared. Our godson’s mother had died of inflammatory breast cancer and I thought, ‘I have inflammatory breast cancer,’” said Wyeth.

A few weeks before, she had gone to see the school nurse and mentioned that, at age 52, she hadn’t had a mammogram in three years. The nurse had recommended that she go to the county clinic for a free mammogram funded by a prominent breast cancer foundation. Once she found the lump, Wyeth made an appointment right away. After a screening and biopsy, the bad news came back: Yes, Wyeth definitely had breast cancer. The lump was near the end of stage 2 and quite large, about 5 cm. “I was terrified,” said Wyeth.

At that point, Wyeth luckily got connected to the right resources. As a low-income woman with breast cancer, she qualified for treatment under the Oregon Health Plan, which is that state’s version of Medicaid. Starting January 2007, Wyeth went through four rounds of chemotherapy to shrink and kill the cancer. Then in early May, surgeons removed the remaining mass. In June, she began six weeks of radiation. After that, she began an anti-cancer medication regimen.

Wyeth responded well to all the therapies. Everything looked great. She had faced death and told him to get lost. She returned to school, studied Spanish furiously, and graduated in June 2011.
But two months after graduating, Wyeth underwent a CT scan for some digestive issues she was having. The results were not good: The scan showed a lump in her liver, and after further tests, it was determined to have all the same markers as her breast cancer. It had spread. She is now taking various medications to treat the liver cancer and discussing with her doctors her next course of action.

Wyeth often wonders how things would have turned out differently if she hadn’t skipped three years of mammograms, if she had been able to get regular mammograms through a national healthcare program like all other industrialized nations have. Most Americans don’t realize it, but the United States already has such a program. It’s called Medicare, but the problem is it is only available to those 65 and older.

“If I had been on Medicare, I would have gotten a mammogram much earlier, we would have caught [the cancer] much earlier, and everything would have cost less,” said Wyeth. “My mom and dad both died of cancer, so, yeah, not getting mammograms was one thing I worried about. I’m feeling sort of angry about it.”

While she’s grateful to qualify for treatment through Medicaid, Wyeth is constantly afraid that, with conservative attacks on the program in the name of balancing the budget and eliminating entitlements for the poor, she could lose the precious healthcare she has at any moment. Furthermore, if Wyeth found a decent-paying job (certainly a goal of hers), she might no longer qualify for Medicaid. “I’m always afraid of getting kicked off for whatever reason,” she said. “It’s always in the back of my mind. It’s terrifying to me.”

Because of her own situation, Wyeth has thought a lot about American healthcare reform and the contradictions inherent in offering healthcare to seniors, and often to children, but not everyone else. A self-described political person and advocate, Wyeth said that she talks about expanding Medicare or healthcare for all to people whenever she gets the chance. Improving and expanding Medicare to cover everyone, regardless of age, is a longtime goal of National Nurses United, and the organization will be campaigning for it with renewed vigor in 2012.

“One thought that struck me is that there’s medical care for children and old people, but if you happen to be the parent and get sick and die, you leave orphans!” said Wyeth. “There should be a solution. Every other developed nation has figured it out. Charities can only do so much. Government is about people helping each other.”

Though Wyeth is an upbeat person, she still has her worries. She has no formal job, she has $32,000 of student loan debt that she can’t keep deferring forever, and she’s still seven years away from qualifying for Medicare. “It will be an incredible relief, a huge relief, to be able to participate in Medicare,” she said. “That is, if I make it that far.”

Lucia Hwang is editor of National Nurse.
CE Home Study Course

Workplace Violence
Assessing Occupational Hazards and Identifying Strategies for Prevention, Part 2

This home study CE is part two of a two-part series. The first installment appeared in the January-February 2012 issue of National Nurse and is required reading for successful completion of this home study course.

Description
This home study course examines conditions in the healthcare environment associated with workplace violence. Included is a review of key terms, relevant definitions, practices, standards, and regulatory policies so registered nurses (RNs) can more quickly identify threatening behaviors and situations where the potential for lateral, horizontal, and physical violence exists. It further examines the scope of the problem of workplace violence and how RNs can be proactive in their practice settings to promote workplace security and mitigate the potential for harm to themselves and their patients. RNs will learn strategies for taking action and, as circumstances require, changing administrative policies that encumber their ability to provide safe, therapeutic, and effective patient care. Selected highlights of publicly reported assaultive and violent incidents which resulted in harm or death to healthcare workers will help nurses formulate a corrective action plan for effectively dealing with the aftermath.

What then, must we do? Conduct an Environmental Assessment and Take Control
Though numerous studies illustrate the scope of violence against nurses, and many comprehensive guides exist to implement workplace violence prevention programs and state laws and regulations governing workplace violence, hospitals still fail their employees in implementing violence prevention programs. Whether domestic or workplace violence follows an employee into the workplace, employers should support, protect, and help the abused worker and not punish her or him. When an employee is being stalked, harassed, or abused at work by a domestic partner, other personal acquaintance, a patient, patient's relatives/significant others, or other providers or management personnel, the employer should take steps to separate the victim from the abuser, keep the abuser out of the workplace, and make the victim's work space physically more secure. An employer should have sufficient, specially trained staff and/or law enforcement personnel present and available to protect the staff nurses, patients, visitors, and other employees.

In some cases, regretfully, an employer seeking the quickest and easiest way to avoid responsibility in the event of a violent incident is to fire the employee. In cases where a patient has acted out unexpectedly, or assaulted and injured a nurse or other healthcare employee, employers should NOT be allowed to escape accountability for failure to implement effective workplace violence prevention program by blaming the patient. To have the patient arrested and charged with committing a felonious assault may be unjustified and unethical. Discrimination against victims should NOT be tolerated. Relevant laws and policies should be reviewed regularly as a form of primary prevention, to see if there are ways to improve employee safety without jeopardizing individual victim or patient rights.

Law enforcement agencies should adopt a preventive approach to violence in the workplace. In recent decades, many police departments have changed attitudes and traditional practices in domestic and workplace violence cases, intervening earlier and paying increased attention to protecting the victim as well as arresting and prosecuting the alleged perpetrator. Clear, comprehensive, and uniform workplace and legal guidelines should be discussed and widely disseminated to inform employers how they can strengthen violence-prevention measures within existing laws, without infringing on due process, privacy, defamation laws, victims’ rights, or other employee rights.

Over the past decade, hospital corporate governance and compliance has been the subject of increasing attention and scrutiny. Continuing examples of questionable behavior by individual employees and executives give rise to critical questions of how corporate ethics efforts can be improved and can address the underlying causes of workplace violence and misconduct, as well as the growing demand for proactive, socially responsible, and sustainable business practices.

Corporate responsibility refers to the fulfillment of obligations that a healthcare employer owes its employees, patients, the community and the various licensing and accreditation bodies and other stakeholders. Corporate compliance officers and programs are often criticized for falling short of respecting the letter and spirit of the law and their employees’ concerns. Managers should take an active role in communicating the workplace violence policy to all healthcare employees. This helps to create globally consistent “fixed reference points,” which arms employees with the information needed to act in order to hold their employers accountable.

There are actions that RNs can take, starting with an overview of existing state laws, OSHA, NIOSH,
and The Joint Commission guidelines to enforce a responsible workplace violence prevention policy.

The Joint Commission

In July 2008, JCAHO issued a Sentinel Event Alert that increases the accountability of accredited facilities for disruptive conduct by their staff, titled: “Behaviors that undermine a culture of safety” Issue 40. Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction, allow preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. To assure quality and to promote a culture of safety, healthcare organizations must address the problem of behaviors that threaten the performance of the healthcare team.

Organizations that fail to address unprofessional behavior through formal systems indirectly promote an unsafe work environment. Intimidating and disruptive behavior stems from both individual and systemic factors. In the Joint Commission’s view, verbal outbursts, physical threats, and condescending language can undermine health team effectiveness and ultimately compromise safety.

The Joint Commission release notes a history of “tolerance and indifference” to intimidating and disruptive behavior that exists in the healthcare community. Individual factors such as self-centeredness, immaturity, and defensiveness as well as institutional demands, including productivity demands, cost containment requirements, embedded hierarchies, and litigation fears all contribute to the problem. A survey by the Institute for Safe Medication Practices revealed that “40% of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.”

Beyond the official accreditation standards, the Joint Commission also suggests certain actions, including educating all team members; holding team members accountable for modeling desirable behaviors; developing and implementing “zero tolerance” policies; protecting those who report or cooperate in the investigation of intimidating, disruptive, and other unprofessional behavior; provide skills-based training and coaching for all managers; and developing and implementing a reporting/surveillance system for detecting unprofessional behavior.

Joint Commission suggested actions for developing and implementing processes appropriate to the organization:

“Zero tolerance” for intimidating and/or disruptive behaviors by any professional designation.

Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive, and other unprofessional behavior.

Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors.

How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).

Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.

Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.

Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior.

Document all attempts to address intimidating and disruptive behaviors.

RNs should note: Given that these are “guidelines and recommendations,” not “mandates,” they don’t have the force of law so employers can choose to ignore them. And the vast majority do! More than 70 percent of United States workplaces do not have a formal program or policy that addresses workplace violence.

OSHA

The Occupational Safety and Health Administration encourages organizations to have written workplace violence prevention programs. OSHA says these programs should, at a minimum:

Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats, and related actions. Ensure that managers, supervisors, coworkers, clients, patients, and visitors know about this policy. Ensure that no employee who reports or experiences workplace violence faces reprisals.

Encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and measure progress.

Outline a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.

Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. Ensure that adequate resources are available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in healthcare and social services.

Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.

Set up a company briefing as part of the initial effort to address issues such as preserving safety, supporting affected employees, and facilitating recovery.

Usually, a supervisor is the first contact to report violence, followed closely by the workplace security service. However, depending on the severity and duration of the incident, nurses might choose to call 911 first or shortly after asking coworkers to put in a call to the supervisor. If help from supervisors or facility security does not arrive promptly, an employee definitely should call local police. Recommended practice points include:

Report any impending and actual acts of violence at work to your supervisor immediately, regardless of who is the victim and whether injuries have occurred. Reports must be written as well as verbal.

Call the police immediately. If necessary, file a police report as soon as possible. Take someone with you when you file the police report, preferably coworkers who are familiar with the event.

If the assault is from a patient, document the patient’s behavior in the medical record. This is the most essential legal documentation.

Seek medical attention even if there are no “obvious injuries.” Be sure to document any physical injuries and your emotional state.
Follow the healthcare provider’s recommendations for treatment and work restrictions.

Workplace Violence Legislation: Nursing Considerations and Critical Thinking

The bedside RN’s experience, judgment, and authority to control the nursing process in the environment of care should be given great consideration and weight when designing and evaluating systems to minimize or eliminate hazards for the protection of patient and professional interests. Critical incident analysis is required to examine a significant or pivotal occurrence to understand where the system failed.

Researcher Phyllis L. Crocker of the Cleveland-Marshall College of Law writes that “the nexus between poverty, childhood abuse and neglect, social and emotional dysfunction, alcohol and drug abuse, and crime is so tight in the lives of many capital defendants as to form a kind of social historical profile.” Historically, nurses have recognized the organic connection between the socio-economic determinants of health and behavior.

Patients may have a diminished decision-making capacity and moral culpability within the context of a change in their health status, which can trigger emotional volatility and behavioral impulsivity. They may lack the judgment and foresight of consequences due to significant neurological and cognitive deficiencies. While not excusing violent behavior per se, these limitations can set the psychological stage for violence; at the same time they make patients less morally culpable for their actions.

The ultimate punishment of charging a patient with a felony (felonious assault) is considered contrary to the idea of fairness in our justice system, which accords the greatest punishments to the most blameworthy. Patients, because of their impairments, by definition may have diminished capacities to understand and process mistakes, to engage in logical reasoning, and to understand the intentions and reactions of others. Improving safety for patients and staff requires a systems approach that includes holding the owners, administrators, and managers accountable for modifying unsafe conditions in institutional settings.

The following states have laws in place requiring Violence Prevention Programs: California, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, and Washington. In addition, the following states have laws that increase penalties for those convicted of violence against healthcare workers: Alabama, Arizona, Colorado, Hawaii, Illinois, Massachusetts, Nevada, New York, North Carolina, New Mexico, and West Virginia.

In July 2010, Massachusetts enacted a law that increased penalties for those who assault nurses and other healthcare workers. The bill was filed by the Massachusetts Nurses Association, who conducted a major study of workplace violence in response to the increase in workplace violence in healthcare settings. Existing Massachusetts law treated assaults on emergency medical technicians while they are providing care as a crime with penalties. The new law extended this protection to nurses and other healthcare providers. Thoughtful disagreement and controversy has ensued regarding the ultimate effectiveness of this legislation in preventing assaults in healthcare settings and protecting healthcare workers.

The Maine State Nurses Association (MSNA) / National Nurses United RNs were instrumental in securing passage of workplace violence prevention legislation in response to the increasing incidence of violence in hospitals. MSNA nurses sponsored and won legislation to address and prevent this growing problem. "An Act to Enhance Security of Hospital Patients, Visitors, and Employees" was signed into law summer 2010. The bill requires hospitals to adopt a safety and security plan that includes a process for hospitals to receive and record incidents and threats of violent behavior as well as protections for employees who report them.

“This is a step in the right direction,” according to Terryllyn Bradbury, an emergency room nurse at Millinocket Regional Hospital. “Hospitals need to take every measure possible to protect nurses and employees from violence at work. In our Professional Practice Committee (PPC), we are now working on implementing a workplace violence prevention training program.”

At Calais Regional Hospital in northeastern Maine, nurses have been concerned about their safety and the safety of other employees. This is especially true in the special care unit, which is behind closed doors. There is potential for a dangerous situation to occur if a nurse is unable to get out of the room to ring the staff assist bell. The PPC has won approval to order personal alarms the nurses can carry in their pockets, assuring that timely help is never out of reach.

“I supported this legislation, and campaigned to get it passed, so all Maine nurses would be safer at work,” said Anne Sluzenski, an RN at Calais Regional Hospital. “Passing this bill was a good first step, but we must remember there is always room for improvement when it comes to making ourselves and our patients safe.”

National Nurses United staff is working with U.S. Sen. John Kerry of Massachusetts on introducing a federal bill to address violence against healthcare workers. The bill would be similar in intent and language to one introduced this year into the California Legislature by the California Nurses Association titled: The Healthcare Worker Protection and Workplace Violence Prevention Act.

Specifically, the bill would:

- Toughen existing statutes requiring hospitals to have safety and security plans in place by expanding the types of security considerations hospitals must make when developing and updating their plans; requiring better employee training and education on how to prevent and respond to violent acts; and, requiring hospitals to have systems to adequately respond to, investigate, and report acts of violence against employees.
- Protect employees who have been victims of workplace violence by ensuring they are provided evaluation and treatment, and retain the right to seek assistance and intervention from local law enforcement.
- Require hospitals to report incidents of workplace violence to the state.
- Authorize the state to impose administrative penalties against hospitals that fail to comply with workplace violence laws.
- Require the Correctional Standards Authority to develop standards for safety and security plans designed to protect healthcare personnel in state and local correctional facilities, including correctional treatment centers, from aggression and violence.
- Prohibit a hospital from prohibiting an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance from local emergency services or law enforcement when a violent incident occurs.
Professional Assessment and Evaluation of Risk Factors

Risk factors are not diagnostic. They should not be used to label patients, clients, relatives, and friends; nor should they cause professionals to jump to conclusions. However, risk factors are significant and when present in combination, they may indicate that a patient or client needs a referral for evaluation by an appropriate therapist or healthcare provider. In workplace settings, it’s important for nurses to be vigilant and consult with their colleagues and document that they have notified attending providers of their assessment, request for treatment orders, triage, and/or transfer to a specialty unit or higher level of care.

In addition, direct-care nurses have a responsibility to notify management of the need for additional staffing and/or a change in workplace accommodations to enhance the safety of patients and staff. Such requests should be documented in writing, for purposes of accountability and to eliminate the possibility of administrative deniability.

Nurses’ Health and Safety Tool Kit:
The National Institute for Occupational Safety and Health defines occupational stress as “the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker.” In addition to psychological distress, other outcomes of job stress include burnout, absenteeism, employee intent to leave, reduced patient satisfaction, and treatment errors. In general, studies of nurses have found the following factors to be linked with stress: work overload, time pres-

References


sure, sleep deprivation, exposure to infectious diseases, needle stick injuries, lack of social support at work (especially from supervisors, head nurses, upper management), and exposure to work-related violence or threats.

The DANGEROUS Behavior Screening Guide was developed from the literature and designed to be used purely as a guide to screening for violence risk factors. According to the author, Mary Muscari, PhD, CRNP, this guide is an acronym-labeled list that helps practitioners remember the elements of an assessment for disruptive behavior and violence. It has not been empirically tested, and it should not be used to diagnose patients, families, or other coworkers. However, the guide is instructive because it reminds nurses to consider potential social and demographic determinants of impulsive behavior and diminished reasoning capacity. Using the guide, the following risk factors can be elicited during routine psychosocial assessment:

The DANGEROUS Behavior Screening Guide (Muscari, 2009)

D — Deviant thinking: homicidal or suicidal ideation; feelings of persecution; paranoia; projection of blame onto others; intolerance for differences or prejudicial attitudes; entitlement; narcissism; low frustration tolerance

A — Alienation and rejection: loner; social isolation; no friends; victim of bullying; acts/dresses in manner that adds to alienation; feelings of rejection or failure; depression and despair

N — Negative home environment: family values violence as a way
to deal with problems; family dysfunction; poor emotional attachment to parents or caregivers; lack of supervision

G — Gang affiliation or preoccupation with street gangs; admits to being in gang (potential for drive-by, retaliatory, felony-related shootings); wears “colors” (black or blue typical of Crip-related gangs, red typical of Blood-related gangs) or logos (BK-Blood killers, CK-Crip killers); graffiti/tattoos on books/body; use of hand signals

E — Exposure to and/or history of violence: exposure to domestic violence, child abuse, community violence; history of violence against animals, humans (especially intimate partner), or property

R — Rebellion and poor socialization skills: intimidating and bullying behaviors; uncontrolled anger; narcissistic, antisocial, paranoid, and/or schizoid personality traits; terrorist threats

O — Obsession with violence: preoccupation with music, movies, video games, writing and/or art with violent themes; violence-related apparel; weapons collection; frequents a firing range or owns firearm; stockpiling ammunition; committing acts of violence; “warrior” (pseudo-commando) mentality

U — Underachievement and other school/work problems: low interest in school/work, poor academic/work performance; history of discipline problems; truancy; job-related difficulties

S — Substance abuse: alcohol, marijuana, abusing heroin, cocaine, amphetamine, LSD, PCP, or inhalants

RN Template for Problem Solving

CNA/NDOC/NNU contracts have created new standards for RNs and patient protection. A crucial part of quality patient care is ensuring adequate hospital staffing to avoid putting patients at risk and driving nurses out of the profession. CNA/NDOC/NNU representation provides RNs with the tools to have a real voice in patient care decisions, which we use to create safer healthcare facilities to protect our patients, our licenses, and ourselves.

The Professional Practice/Performance Committee (PPC) is a staff RN-controlled committee with the authority to research, analyze, and document unsafe practice issues. The PPC has the authority to recommend specific actions to management to resolve problems and power to make real changes. The PPC is an elected, staff RN committee with representatives from every major nursing unit that meets in the facility on paid time and tracks conditions of concern to RNs through an independent documentation system called the Assignment Despite Objection (ADO). The PPC is a forum through which nurses and nursing concerns can be translated into effective action. If your facility does not have a PPC, you should discuss your concerns with your peers and make sure your facility implements an effective violence prevention program.

PPC Collective Advocacy in Action

Prepare a violence prevention care plan for staff nurses:

Recognize and name the experience of abuse, assault, lateral and/or horizontal violence, bullying, coercion, and moral distress

Affirm the personal and professional obligation to act and commit to addressing the experience.

Actively participate in professional activities to expand knowledge and understanding of the impact of assault and workplace violence.

Develop skill, through the use of mentoring and resources, to decrease the risk that you and your colleagues will experience assault, workplace abuse, and violence.

Implement strategies to accomplish desired changes in the work environment while preserving the personal integrity, and credibility from which nurses derive their authentic power.

Become familiar with and use your professional, institutional, and union’s resources to address, mitigate, and prevent workplace violence.

PPC Documentation: Educate and Mobilize

RN must educate and advocate for their profession and their patients by reporting to their PPC, through use of the Assignment Despite Objection form (ADO), all acts of violence, whether intimidation, verbal threats, or actual physical attack. Also RNs must notify their employer using issue reports, incident reports, and other verbal and/or written reporting to put management on notice and give them the opportunity to correct the unsafe situation. Be sure to keep a copy for your own records. Notify the police, and enlist the support of your labor representative to alert the appropriate regulatory, licensing, and accreditation agencies as circumstances require. Documentation establishes a database and
The Nursing Process: Assessment, Planning, Implementation, Evaluation, and Advocacy

Assessment of factors that may contribute to tragic incident of workplace violence

- Insufficient nursing and security staff to observe potential violence?
- Insufficient staff to de-escalate or physically prevent an attack?
- Insufficient education and training in causes of violence, prevention through communication techniques, violence avoidance techniques, and how to restrain a violent person?
- Was there a root cause analysis of the system?

Planning to mitigate and limit the risks of harm

- Educate all staff in recognizing a potentially violent situation.
- Advocate for management to be active in supporting violence prevention.
- Use existing state law, OSHA, JCAHO, and NIOSH guidelines to enforce a responsible workplace violence prevention policy. This includes policies that make it clear that intimidation is never OK. Not from managers, physicians, staff, security, visitors, or patients.
- Have direct-care staff, especially ER and mental health personnel, recommendations included in the updated policies and procedures. These must include the need for sufficient staff.

10 Actions a Nurse Should Take if Assaulted at Work

GET HELP. Get to a safe area.
CALL 911 for police assistance.
GET RELIEVED of your assignment.
GET MEDICAL ATTENTION.
REPORT THE ASSAULT to your supervisor and union representative.
GET COUNSELING or assistance for critical incident stress debriefing (CISD) to address concerns related to post-traumatic stress disorder (PTSD).
EXERCISE YOUR CIVIL RIGHTS as circumstances require. File charges with the police.
GET COPIES OF ALL REPORTS and keep a diary of events. Take photographs of your injuries.
RETURN TO WORK ONLY when you feel safe and supported and have been cleared by your healthcare provider.

“Code Grey” is not a substitute for sufficient staff to prevent a violent incident.

Implementation of the Action Plan

- Enforce contract provisions
- Employer response to PPC plan of correction monitored by staff nurses
- Monitor employer compliance with JCAHO, OSHA, and NIOSH Standards
- Advocate for the adoption of “Workplace Violence Prevention” legislation

Evaluation of the Results

- Were the policies implemented?
- Are verbal, intimidation, and actual attacks being reported?
- Is the plan adequate?

An Advocacy Success story

Lorraine Sandoval, RN led a yearlong effort to achieve prevention of violence in the ER at Ventura County Medical Center, California. As in other healthcare settings, violence had been increasing over the years. RNs and others had filled out the hospitals incident reports but management failed to respond and take action on the RNs’ documented concerns. The RNs then began keeping their own records using both assignment despite objection forms (ADOs) and other written reports.

The violence continued to escalate. There were so many violent incidents the police were called at least twice a day and often more often than that.

One of the many examples: a patient suffering from psychosis pulled out his intravenous line and threatened nurses with scissors, police were called and drew guns in the emergency department. Patients and others had brandished firearms and knives in the waiting room and patient care areas. Patients were found to have a weapon on their person.

The RNs requested a meeting with management. They wrote a petition asking for:
- Training in de-escalation and how to restrain a violent person.
- Metal detectors
- A police officer assigned to the emergency department.

Hundreds of hospital staff signed the petition in solidarity with nearly 100 percent of the RNs and physicians. The RNs took their documentation to the Board of Supervisors, the governing body of this hospital. The supervisors were told, “Someone is going to die if nothing is done. You are aware.”

Thanks to the collective actions of the nurses, RNs at the facility are now offered a six-hour class in de-escalation and restraint techniques. They were supplied with a metal detector wand and a “walk-through” metal detector was installed at the entrance to the ER.

The RNs were successful in achieving their goals because they:
- Consistently documented their concerns
- Organized their fellow workers to sign their petitions
- Lobbied and educated the governing body of the hospital and explicitly identified what was needed and required to maintain a more secure work environment for the provision of safe, therapeutic, and effective patient care.

In addition, a Ventura County Police Officer is now assigned to the ER 24 hours a day. RNs report that just having the officer present has been a huge factor in preventing assaultive behavior.

Compare and Contrast: Vulnerable Patient vs. Corporate Goliath
Who’s ultimately responsible if a nurse is assaulted at work?

As opposed to a blanket determination of anyone assaulting a nurse be treated as a felon, there is a strong argument for holding the hospital to a high standard of corporate responsibility in preventing the assault in the first place. Hospital administration must provide a safe environment for both nurses and patients. Assault occurs when the defendant’s acts intentionally cause the victim’s reasonable apprehension of immediate harmful or offensive contact.

Of the grade or quality of a felony, as for example, a felonious assault, such as an assault upon a person, would subject the party making it, upon conviction, to the punishment of a felony which is imprisonment. “Felonious” is a technical word of law which means “done with intent to commit a crime, i.e., criminal intent.”

Patients may enter the hospital, and for a variety of reasons (e.g., drug interactions, allergy, fear, anger, sadness, anxiety), experience diminished capacity negating the traditional definition of intent as it relates to criminal assault. Intent and motive should not be confused. Motive is what prompts a person to act, or fail to act. Intent refers only to the state of mind with which the act is done or omitted.

In contrast, hospital management should proactively safeguard the nurses’ workplace. An affirmative duty should attach to corporate responsibility — providing RN staffing and ancillary personnel based on the determination of the direct-care RNs accountable for the patients; appropriately trained security personnel; functioning security measures such as locked doors/units, hallway cameras as appropriate, alarms/panic buttons, and emergency response/paging systems; and ongoing education and training programs.

The employer should not escape its corporate duty to provide a safe workplace because of budgetary and financial concerns. Corporate responsibility manifests as a proactive environment of nurse safety, rather than a reactive, after-the-fact patchwork of remedial measures. Rather than assign blame to individual patients, primary responsibility for a safe working environment rests with the owner/holder of the environment: the corporate hospital/workplace owner and management.

It is a corporate responsibility to be in compliance with licensing and accreditation guidelines and regulations. Charging a patient with a felony with resulting jail time upon conviction doesn’t change the environment of care and mitigate the risk of workplace violence. In effect, it lets corporations off the hook, and thus becomes a de facto exoneration and cover-up of management’s failure to hold itself accountable.

Direct-care RNs are the last line of defense between vulnerable patients and the employer’s bottom line. RNs have a duty to act, as circumstances require, to change conditions that are against the interests of patients.

Summary and Conclusions

“Knowing is not enough, we must apply. Willing is not enough, we must do.” —Goethe

NATIONAL NURSES UNITED (NNU) has been very active in educating nurses and the community about the frequency of violence in the healthcare setting and the fact that a great deal of it is preventable and underreported. Historically, nurses may have bought into a commonly held belief that violence is just a part of the job. NNU is working to banish this belief from our profession.

While increased risk is associated with the perception that administrators consider assaults to be part of the job, receiving assault prevention training, annual staff review and competency validation, together with the presence and availability of specially trained security and/or law enforcement personnel mitigates the risk. Increased awareness and active surveillance of the environment for hazards, and effective communication and implementation of “zero tolerance” policies regarding lateral and physical violence reduces the rate of assaults.

News media have trumpeted urgent concerns about hospital understaffing and research has shown that a high turnover of hospital nursing staff may be linked to unrealistic nurse workloads. Forty percent of hospital nurses have burnout levels that exceed the norms for healthcare workers. When taken together with the fact that violence in healthcare settings occurs at a rate of four times the national average, it’s no wonder that job dissatisfaction among hospital nurses is four times greater than the average for all U.S. workers. According to a study conducted by nurse researcher Martha Griffin, 60 percent of new nurses leave their first places of employment within six months because of lateral violence against them!

Environmental and organizational factors are associated with patient and family assaults on healthcare workers, including understaffing, (especially during times of increased activity such as admission, transfer, discharge, and meal times), poor workplace security, unrestricted movement by the public around the facility, and a high patient/nurse-staffing ratio. Although mental health and emergency departments have been the focus of attention and research on the subject, no department within a healthcare setting is immune from workplace violence. Consequently, violence prevention programs would be useful for all departments.

OSHA, NIOSH, and Joint Commission guidelines provide a framework for addressing the problem of workplace violence and include the basic elements of any proactive health and safety program: management commitment and employee involvement, worksite analysis, hazard prevention and control, and training and education. Investigators who’ve studied the effectiveness of such training have generally found improvement in nurses’ knowledge, confidence, and safety after attending in-service education programs on aggression/behavior-management. However, implementation of comprehensive violence prevention programs that go beyond staff training will improve safety of the healthcare workplace for all workers. These advanced programs include the use of currently available engineering and administrative controls such as security alarm systems, adequate training, and staffing.

Compassion, Caring, Community, Courage, and the Social Contract

It’s been said that culturally competent advocacy is rooted in the commitment to preserve and protect fundamental human rights. A human rights framework informs ethical behavior in RNs, and compels them to act with fundamental moral authority and courage, to facilitate access to services that promote survival, decrease suffering, prevent injury and death, and promote their own security as well as that of the other members in their community.

Compassion has been identified as the motivation that compels RNs to act on behalf of others. It is the desire to help that is intimately linked with an empathetic understanding of the suffering and distress of others. Belief in the collective identity and interdependence of all human beings promotes the empathy and advocacy inherent in the social contract between the public and the profession of nursing.
Workplace Violence

For continuing education credit of 4.0 hours, please complete the following test, including the registration form at the bottom, and return to: NNU Nursing Practice, 2000 Franklin St., Oakland, CA 94612. We must receive the complete home study no later than June 30, 2012 in order to receive your continuing education credit.

1. Intimidation, abuse, and threats are seen as violence by both the Occupational Safety and Health Administration (OSHA) and the Joint Commission for the Accreditation of Hospitals (JCAHO).
   - True  ❑  False

2. The Federal Bureau of Investigation has expressed concern that there is a likely over-reporting of violence and a persistent perception within the healthcare industry that tolerating assaults are just part of the job.
   - True  ❑  False

3. Institutional factors including increased productivity and workload demands, cost containment and restructuring, short-staffing, embedded hierarchies, fear of retaliation and litigation, and lack of employee training and support do not contribute to the problem of increasing violence in the workplace.
   - True  ❑  False

4. According to the Joint Commission’s Sentinel Event Alert # 40, intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and increased risk of preventable adverse outcomes, increase the cost of care, and turnover of employees.
   - True  ❑  False

5. The Health Care Worker Protection and Workplace Violence Prevention Act would authorize the state to impose administrative penalties against hospitals that fail to comply with workplace violence laws.
   - True  ❑  False

6. According to OSHA, psychological hazards found in hospitals are defined by OSHA as “factors and situations encountered or associated with one’s job or work environment that create or potentiate stress, emotional strain, and/or other interpersonal problems.”
   - True  ❑  False

7. The Occupational Safety and Health Administration (OSHA) mandates key components of a Workplace Violence Prevention Program; therefore all United States workplaces have a formal program or policy that addresses workplace violence.
   - True  ❑  False

8. There is no need to notify your supervisor and document violent acts (including physical assaults, threats of assaults, and verbal abuse) by filling out an ADO form or incident report unless there was physical injury.
   - True  ❑  False

9. Violent workplace incidents account for 18 percent of all violent crime in the United States. The healthcare industry constituted 45 percent of the incidents of workplace violence that occurred.
   - True  ❑  False

10. Research has shown that 60 percent of new nurses leave their first place of employment within six months because of lateral violence against them.
    - True  ❑  False

11. Patients seek care at hospitals for a variety of reasons and may have “diminished capacity” negating the traditional definition of intent as it relates to criminal assault.
    - True  ❑  False

12. Corporate responsibility manifests as a proactive environment of nurse safety. Healthcare employers have an affirmative duty under the law to be in compliance with OSHA, NIOSH, Joint Commission guidelines, and licensing regulations.
    - True  ❑  False
In this, the wealthiest nation in the world, millions of Americans go without adequate healthcare. **As caregivers, you hear the economic horror stories from your patients every day.** You see the chronic symptoms that could be prevented. Poverty and near-poverty are consuming the population, and people are getting sick from it.

As working Americans, you see the effects of an unhealthy economy and a broken healthcare system on your families, your communities, and on you individually.

How is the economic crisis impacting your life at home, in your hospital, and in your community? **Submit your story to Tell Us Where It Hurts at www.NursesHealAmerica.org**

Your stories will form the heart of the Nurses Campaign to Heal America, and will power the engine that drives a renewed effort to ensure access to affordable quality healthcare through Medicare for All.

All stories remain confidential unless we have your written consent to publish.

The Nurses Campaign to Heal America is a project of National Nurses United.

**TELL US WHERE IT HURTS**
America's Nurses are Listening