SE 5 EO: The effectiveness of two (2) educational programs provided in SE5 (e.g., continuing education).

Patient Care Services’ commitment to education and professional development is evidenced in the vision and values statements which speak to a practice environment built on a spirit of inquiry and the guiding principles in which learning is viewed as a \textit{lifelong process essential to the growth and development of clinicians striving to deliver quality patient care} (OOD 1). Professional development is also an integral part of the Patient Care Services (PCS) Professional Practice Model (PPM) (OOD 11). Continuing education (CE) offerings, along with formal academic preparation and experience, contribute to nursing scholarship, the provision of quality health care, and achievement of professional career goals.

CE is the single most important and most robust service line of the Norman Knight Nursing Center for Clinical & Professional Development (Knight Center) as described in SE 5. The Knight Center executes its responsibility in several key ways to ensure the effectiveness of its service lines. Out of necessity, the delivery of CE takes many forms including traditional classroom lectures and presentations, experiential learning, web-based offerings, and the blended model of curriculum design. The Knight Center is able to offer a wide variety of CE courses that address the learning needs of nurses at all levels across the clinical spectrum as a result of partnerships with the unit and service-based Clinical Nurse Specialists (CNS) and other expert clinicians on the interdisciplinary team. The CNS group is a key partner with the Knight Center in assessing nursing learning needs, designing CE programs based on the latest evidence and in many cases, serving as program faculty.

In 2009, the Knight Center identified three priorities related to CE: the need to utilize web-based learning to enhance offerings; to conduct a comprehensive learning needs assessment; and to improve the evaluation of programming, specifically to measure the outcomes of learning. Improving the evaluation process for CE programs was strategically aligned with expectations set by the American Nurses Credentialing Center to identify the outcomes of CE.

The Knight Center began by revising its role in delivering “centralized” education in response to the changing health care environment and requests for programs received directly from staff. The HealthStream learning management system was implemented across PCS as a way to enhance existing programming and expand the ways in which staff could access CE. As discussed in SE 5 and OOD 9, the Knight Center conducted the Evaluation of the Professional Learning Environment Survey (PLEN) to ascertain the educational needs and preferences of nursing staff in the beginning of 2010. A few of the priority learning needs identified by staff were targeted to implement a pilot program for Level 3 evaluation. Two programs that piloted the Level 3 evaluation process are “Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace” and “Advanced Arrhythmias.” A description of the programs and their effectiveness in meeting defined learning goals follows.

Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace

1) Describe purpose and the background (or issue, practice change, program, etc.).

Disruptive behavior is any behavior that interferes with patient care or has a potential negative or untoward effect on patient safety. Historically, disruptive behavior has been most commonly seen between peers or different role groups within the health care team. In recent years, disruptive behavior has been used to describe a continuum of behaviors that range from incivility to homicide. A growing number of reports out of the American Nurses Association as well as other
organizations describe an increase in the amount of disruptive behavior directed towards nurses coming directly from patients and/or their families.

Enhancing staff skills related to managing disruptive behavior has been identified as an important learning need in the past at MGH. For approximately the last ten years, the Department of Police and Security at Massachusetts General Hospital (MGH) has offered the program “Management of Aggressive Behavior” (MOAB). This course is mandatory for the staff of the Psychiatry Unit (Blake 11) and Emergency Department (Ellison 1/Lunder 1). Beginning in late 2009, Staff Nurses working on the general medical units were more frequently caring for a patient population with complex mental health histories, often complicated by alcohol or other substance abuse and this resulted in a heightened awareness of the need to provide education in this area. In response to the requests, the Knight Center began partnering with the Department of Police and Security to offer MOAB as part of Registered Nurse (RN) Orientation. The Knight Center also made the decision to allow staff from across Patient Care Services (PCS) to attend this part of RN Orientation. In doing so, it provided the organization with an additional 15 opportunities to take the four-hour course. It also ensured that all new staff hired within Patient Care Services received content related to the management of disruptive behavior thus removing the need to schedule staff for a separate class after completing orientation.

Despite these additional classes, the topic of management of disruptive behavior was identified by staff as a priority learning need on the 2010 PLEN survey (OOD 9). In addition, a rising number of episodes of violence against nurses in the fall of 2010 prompted the Senior Vice President for Patient Care and Chief Nurse (CNO) and Senior Vice President for Quality and Safety to establish an interdisciplinary tiger team (attachment SE 5 EO.a) to develop strategies to address this issue. The Director of the PCS Office of Patient Advocacy and Chief of Psychiatry were named co-chairs of the tiger team. Members included Nursing Directors of the general medical units, Psychiatric Clinical Nurse Specialists, Psychiatrists, a Staff Nurse from the Emergency Department (Ellison 1/Lunder 1) and staff from the Knight Center, Office of Patient Advocacy, Quality and Safety, Police and Security, Employee Assistance Program, Employee Health and Admitting. Recognizing the complexity of this issue, the tiger team was divided into four teams (e.g., clinical, education, response, and systems) charged with developing strategies to address this issue.

An initial task of the tiger team was to develop and administer a survey to glean information from MGH staff to guide the work. The survey was developed between November 2010 and January of 2011 and administered to all MGH staff through their direct supervisors in February 2011. A total of 769 employees responded to the survey; 477 of the responses came from nurses. The results of the survey demonstrated that disruptive patient behavior is common, that the causes are multifactorial and that a consistent approach to management of this behavior was required. Staff education was identified as one way to prepare staff to address this problem. The purpose of any educational intervention was to increase staff awareness, comfort and skill in recognizing and responding to real or potential situations of workplace violence. A more complete review of the results of the work of the tiger team, survey results and other organizational strategies is included in TL 10.

2) Describe how the work was done (methods or approach). (If you have a project plan, please attach).

After the analysis and dissemination of the survey data in the spring of 2011, the education team met for a series of educational planning sessions in April and May 2011. The meetings were facilitated by a Professional Development Specialist from the Knight Center, who also acted as the Nurse Planner for the ONA CE process. The Professional Development Specialist utilized the
implementation plan developed to respond to the results of the PLEN survey as described in OOD 9 to facilitate the education team’s work.

The education team began with an initial assessment of the MOAB content and determined that the program teaches staff to effectively deescalate agitated or aggressive situations. However, content was needed to help staff learn how to prevent patients and others from escalating their behavior to the aggressive or potentially violent side of the continuum. To address this need, a new, four-hour educational program would be developed to introduce and increase awareness of the topic and provide information that would help staff begin to address this workplace problem. The group agreed that this would be the first program in a learning bundle (SE 5) to teach staff the multiple facets in creating, managing and evaluating a safer environment. The program was titled, “Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace.” The purpose of this new program was to increase staff awareness, comfort and skill in recognizing and responding to real or potential situations of workplace violence.

A key recommendation of the planning committee was that the faculty needed to represent multiple clinical and non-clinical disciplines to showcase the organizational commitment to meeting this learning need. Members of the planning committee who are recognized as institutional experts in the content self-selected to become part of the faculty for this program. The agenda and content of the program is presented in attachment SE 5 EO.b. The majority of the program was to be presented by expert panel members to increase the interactivity of the content. Marketing was conducted through the Knight Center website CE calendar (attachment SE 5 EO.c).

Concurrent with the 2010 PLEN survey, the Knight Center, an approved provider of nursing continuing education (CE), had been charged by the Ohio Nurses Association (ONA) to improve the evaluation of CE programs to document more measurable outcomes. The Knight Center recommended that this new educational program be included in the piloting of a Level 3 evaluation. The planning committee agreed to the evaluation plan using a pre- and post-knowledge assessment administered through HealthStream as a way of measuring the effectiveness of the program. The pilot program was slated for September 2011.

3) Discuss who (CNO, staff RNs, CFO, APRNs, pharmacists, physicians, etc.) was involved and what units participated. Was it a nurse-initiated effort? If yes, describe.

Drawing on the wide range of subject matter experts across MGH, the CNO charged a group of staff who she recognized would bring special expertise to the education team:

- Director and Professional Development Specialist from the Knight Center: nurses with significant experience designing, implementing and evaluating CE programs for nurses at all levels of experience.
- Director of Employee Assistance Program: staff who are accountable for providing short-term counseling support and referrals for MGH employees.
- Chief of Psychiatry: physician with expertise in the role that mental health and substance abuse histories contributes to the issue of violence in the workplace and how to support a nurse who is victimized by his/her patient.
- Director of Police and Security: staff member with significant background in creating and maintaining a safe work environment and supporting staff experiencing workplace violence.
- Director of Employee Health: nurse accountable for occupational health issue.
- Patient Advocates: nurse and staff member with expertise in assisting patients, families and staff with overcoming issues of concern.
• Staff Nurse, Emergency Department (Ellison 1/Lunder 1): represents the major target audience; works in an area where the issue of workplace violence is more common.

Many of the education team members self-selected to serve as faculty for the program. In addition, other institutional experts who were invited to participate include Psychiatric Clinical Nurse Specialists (CNS), a member of the Risk Management team, and the Director of Human Resources. The breakdown of the content of the program and roles involved in presenting each section follows:

• Explanation of Tiger Team
  ◦ Chief of Psychiatry
  ◦ Director, Office of Patient Advocacy

• Workplace violence
  ◦ Trends, regulatory issues, role of Police and Security – Director, Police and Security

• Panel on Spectrum of Disruptive Behavior
  ◦ Staff to Staff – Center for Quality and Safety
  ◦ Patient to Staff – Patient Advocates, Office of Patient Advocacy; Risk Manager, Department of Risk Management
  ◦ Clinical Scenarios – Psychiatric CNS, Psychiatric Nurse Consultation Service; Staff Nurse Emergency Department (Ellison 1/Lunder 1)

• Panel on Establishing a Caring Culture
  ◦ Social Worker, Employee Assistance Program
  ◦ Director, Occupational Health
  ◦ Director, Office of Patient Advocacy
  ◦ Director, Police and Security
  ◦ Director, Human Resources

The pilot program was held on September 16, 2011, with 33 participants; 27 were nurses. Participants represented a broad variety of practice areas throughout MGH including adult and pediatric inpatient units, procedural areas, ambulatory settings, health centers, nutrition and food services, practice improvement, information systems, and rehabilitation.

4) Describe the measurement used to evaluate the outcomes and the impact (show results and significance of the results). Present pre- and post-data using graphs, tables, etc. Provide analysis of data.

The education team utilized two methods to evaluate the effectiveness of the program: a pre-/post-program knowledge assessment survey conducted through HealthStream and a post-program evaluation which participants completed at the end of the education session. The pre-program survey was distributed to registrants 14 days prior to the date of the program; registrants were given 14 days to complete the survey. The post-program survey was distributed to participants three months after the pilot program; participants had 14 days to complete the survey.

All CE programs must include an evaluation of the education which allows participants to provide feedback on the achievement of program objectives, the faculties’ performance, the teaching methodologies and the learning environment. In addition, space is provided to collect ideas for improvement and potential topics for other educational offerings. This Level 1 evaluation method
provides the planning committee and faculty immediate feedback on the program. Twenty-nine of the 33 participants completed an evaluation; a copy of the evaluation with collated data is included in attachment SE 5 EO.d. Overall, the Level 1 evaluation had positive results as participants responded that program objectives were met, teaching methods and learning environment were effective and conducive to learning, and faculty skill was highly rated. Multiple comments were collected that help to provide a more detailed insight into participants’ immediate impressions of the programs. Per CE requirements, the summative evaluation data along with the CE application and registration form is kept on file electronically in the Knight Center’s shared drive for a period of six years.

The pre- and post-program surveys were conducted via HealthStream; the same survey was used for both the pre- and the post-survey. The survey consisted of four questions and responses were collected on a Likert type scale (Strongly Disagree – 1 to Strongly Agree - 5). The pos-survey included a fifth question which allowed for a free text response. The questions and their purpose follow:

1. In my job I often encounter disruptive behavior with patients, families or colleagues.
   Rates participant perception of frequency of disruptive behavior.
2. I am able to recognize a potentially violent situation with a patient, family member or colleague in the workplace.
   Assess the participant’s ability to recognize workplace violence.
3. I feel confident in handling disruptive behavior in the workplace.
   Assess the participant’s confidence to handle workplace violence.
4. I am aware of my resources in dealing with disruptive behavior in the workplace.
   Assess the learner’s knowledge of resources to deal with workplace violence.
5. Please describe a recent situation where your practice changed based on attending the "Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace".
   Assess the participant’s ability to apply knowledge learned in the program in order to respond appropriately in a situation of workplace violence.

The responses of the post-survey were compared with responses from the pre-conference survey to evaluate the effectiveness of the educational program. The pre- and post-surveys with collated responses are included in attachment SE 5 EO.e and attachment SE 5 EO.f. The chart below compares the pre-/post- percentage scores of staff who answered Questions 1 through 4 with either “Agree” or “Strongly Agree”:

![Chart showing percentage of participants answering agree/strongly agree for questions 1 through 4 in a pre-survey and post-survey comparison.](attachment SE 5 EO.e)
The chart below compares the pre/post Likert Scale (range 1 to 5) mean scores for Questions 1 through 4:

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean Score</th>
<th>Pre Survey</th>
<th>Post Survey</th>
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Comparison of pre- and post-scores (percent agreement and mean values) for Questions 2, 3, and 4 demonstrates a positive increase in staff's ability to recognize potentially violent situations, confidence to handle such situations, and knowledge of organizational resources available to assist when needed. Participants’ assessment of the frequency of encountering disruptive behavior (Question 1) decreased slightly. The education team interprets this result in two ways. First, attendance at the educational program may have increased staffs’ skill in diffusing potentially volatile situations before they occur leading to a decreased frequency in the incidence of disruptive behavior. Alternately, other organizational initiatives that resulted from the tiger team as described in TL 10 may have also decreased the incidence of disruptive behavior. Regardless of the cause, the education team interprets these results in a positive manner.

Responses to Question #5 (attachment SE 5 EO.f) revealed several themes that support the quantitative data and the overall effectiveness of the program:

- Enhanced confidence in diffusing potentially dangerous situation by implementing the “Stay Safe” practice.
- Enhanced awareness and use of effective body space to help de-escalate patient agitation.
- Appreciation of resources and support.
- Open organizational recognition of the potential for workplace violence.

Although the educational planning group was pleased with the results of the pilot program, a number of areas for improvement were identified. Based on participant feedback, the program content was revised to include more case studies and was repeated 6 months later. The Level 3 evaluation was piloted with the first program but there is a need to strengthen the process for surveying participants as neither the pre- nor the post-survey was mandatory and a number of individuals who did not attend the program completed the pre-survey. There is also a need to determine the statistical significance of the data. However, the number of potential participants who completed the pre-program survey was much higher than the number who completed the post-survey. In addition, it is unknown whether or not the same individuals completed both the pre- and
post-surveys and these factors effect the ability to statistically analyze the data and understand the true effectiveness of the program. The Knight Center Professional Development Specialist accountable for the CE process is developing a proposal for enhancing the evaluation process that includes requiring all registrants to take the pre-survey in order to attend the program and to complete the post-survey in order to obtain contact hours for the program. In this way, pre-/post-data will allow for a more accurate comparison and interpretation of results.

The education committee members will continue to study the environment and make changes to the content accordingly. In the summer of 2012, all Knight Center Professional Development Specialists who serve as Nurse Planners in the CE Provider Unit began assessing their educational planning groups for scheduling of programs and to determine the need to revise content beyond the customary evaluation for contemporary evidence and/or participant feedback. The planning committee for the workplace violence program has agreed to continue to offer the program with the current content and reevaluate the need for further revisions following an assessment of the 2013 program evaluations.
Advanced Arrhythmias

Describe purpose and the background (or issue, practice change, program, etc.).

MGH serves as an international cardiac referral center. Approximately 200,000 cardiac patients are treated annually in both inpatient and outpatient settings via the MGH Heart Center. The hospital has the capability to continuously monitor all patients (i.e., one cardiac monitor per patient) on all inpatient critical care units, general care units, and step-down units as well as the Emergency Department (Ellison 1/Lunder 1) and procedural areas (e.g., Electrophysiology Laboratory (Gray 1), Hemodialysis Unit (Bigelow 10), Radiology Nursing, and Cardiac Catheterization Laboratory (Blake 9). There is also monitoring capability in the Operating Rooms (Gray 3/Lunder 2, 3, 4), Center for Perioperative Care (Wang 3), Post Anesthesia Care Units (White 3, Ellison 3, Lunder 2, 3, 4), and Cancer Center Infusion Unit (Yawkey 8). A high percent of the patients at MGH are monitored daily.

The Norman Knight Nursing Center for Clinical & Professional Development (Knight Center) is accountable for Registered Nurse Orientation (RNO). During RNO, all direct care registered nurses (i.e., Staff Nurses, Advance Practice Nurses) are assigned a blended learning Basic Arrhythmias (Level A) course consisting of an independent study online module and an interactive classroom session facilitated by a Professional Development Specialist that includes learning activities such as case study analyses and rhythm simulations. Every direct care registered nurse is required to take a basic arrhythmia post course knowledge assessment before the end of their orientation period.

Nurses who work on step down units, intensive care units, and the Emergency Department (Ellison 1/Lunder 1) are required to take the Intermediate Arrhythmias (Level B) course. This 4-hour classroom-based course is offered approximately 6 times per year to prepare nurses for the intermediate arrhythmia assessment. The content includes atrial arrhythmias, junctional rhythms, and heart blocks. Any MGH nurse may also elect to take the Intermediate Arrhythmias course to advance their cardiac knowledge; non-MGH nurses may also enroll in this course.

The Knight Center, in partnership with content experts such as the Clinical Nurse Specialists (CNS), sponsors a robust slate of cardiac-related continuing education (CE) offerings for nurses (OOD 10). Participants evaluate all CE programs and are invited to provide suggestions for additional course offerings. As an American Nurses Credentialing Center Approved Provider of CE for nurses, the Knight Center staff collates this input and uses it to inform planning for future programs. Data from CE evaluations supported the need for more advanced cardiac-related content beyond the Intermediate Arrhythmia course. In addition, this need was supported by data from both the 2010 and 2012 Evaluation of the Professional Practice Environment for Nurses (PLEN) learning needs assessments (SE 5). Nurses specifically identified caring for patients with advanced arrhythmias as a high frequency topic that required more educational preparation both in 2010 and 2012. Based on this data, the Knight Center proposed the development of a new course to address this identified learning need with the purpose of enhancing staff knowledge. Specifically, the effectiveness of the program would be measured by an evaluation of participants’ knowledge and ability to identify the ECG characteristics for axis, bundle branch block and narrow/wide complex tachycardias.
Describe how the work was done (methods or approach). (If you have a project plan, please attach).

After analysis of the 2010 PLEN results by the Knight Center CE team and the CNSs from cardiac practice areas in March, 2011, a CE planning committee was formed lead by a Professional Development Specialist with significant cardiac practice experience. At the time, the Professional Development Specialist was serving as a preceptor to an experienced MGH Staff Nurse from the Cardiac Medicine Critical Care Unit (Ellison 9). The Staff Nurse was enrolled in a graduate program in nursing education and negotiated a clinical placement in the Knight Center to complete a capstone project prior to graduation. In consultation with the director of the Knight Center and the Professional Development Specialist preceptor, the student elected to participate in the design of an advanced arrhythmia course curriculum to meet the requirements of the Capstone project.

A series of educational planning sessions held during March – June, 2011, were facilitated by the Professional Development Specialist from the Knight Center, who also acted as the Nurse Planner for the ONA CE process. The Professional Development Specialist utilized the implementation plan developed to respond to the results of the PLEN survey as described in OOD 9 to facilitate the education team’s work. Members of the planning team included the Professional Development Specialist, CNSs with cardiac expertise, and the graduate student. The group agreed that a four hour advanced cardiac arrhythmia/ECG interpretation program would be designed and include a Level 3 evaluation. The group agreed that nurses in both critical care and general care areas would benefit from this program. Based on this assessment, the group planned to repeatedly offer the program but market the sessions to either general care or critical care so that case studies could be used that were appropriate to the experience base and learning needs of the participants. In addition, the planning committee believed that the course would be better received if the participants were able to share common clinical experiences.

The planning group met to develop the content and teaching strategies. The decision was made to use active learning strategies with case studies that required ECG rhythm strip analysis and small group work designed into the learning events. A copy of the agenda for the program is included in attachment SE 5 EO.g. To meet the requirement for Level 3 evaluation, a pre-/post-knowledge assessment was designed to measure baseline knowledge and knowledge retention 3-4 months after the learning event. The learners were asked to take the online pre-assessment through HealthStream prior to the class. Participants were notified at 3 months after the program to complete the post-assessment; a reminder email was sent at 4 months after the program to encourage post-assessment completion. The participants were informed that the data was confidential and only aggregate data would be reported.

The pilot programs for the Advanced Arrhythmias program were scheduled for October 25 and November 9, 2011. A flyer used to market the program is included in attachment SE 5 EO.h.

Discuss who (CNO, staff RNs, CFO, APRNs, pharmacists, physicians, etc.) was involved and what units participated. Was it a nurse-initiated effort? If yes, describe.

This was a nurse-initiated educational effort that was developed in response to feedback from MGH nurses who attended a CE program and data from the PLEN survey. It was led by the Knight Center Professional Development Specialist, the Staff Nurse graduate student from the Cardiac Medicine Critical Care Unit (Ellison 9) and the Cardiac Clinical Nurse Specialists. Faculty included a Professional Development Specialist from the Knight Center, a Staff Nurse from the Electrophysiology Laboratory (Gray 1) and the Clinical Nurse Specialist from the Cardiac Surgery Unit (Ellison 8). A total of 35 Staff Nurses from general medicine, general surgery, step-down,
critical care, the emergency department, the post-anesthesia care unit, procedural areas and outpatient cardiac units elected to attend the program.

Describe the measurement used to evaluate the outcomes and the impact (show results and significance of the results). Present pre- and post-data using graphs, tables, etc. Provide analysis of data.

The planning committee utilized two methods to evaluate the effectiveness of the program: a Level 3 pre-/post-program knowledge assessment survey conducted through HealthStream and a Level 1 post-program evaluation which participants completed at the end of the education session. To meet the requirement for Level 3 evaluation, a pre-/post-knowledge assessment was designed to measure baseline knowledge and knowledge retention 3-4 months after the learning event (attachment SE 5 EO.i). The learners were asked to take the online pre-assessment through HealthStream prior to the class. Participants were notified at 3 months after the program to complete the post assessment; a reminder email was sent at 4 months after the program to encourage post-assessment completion. The participants were informed that the data was confidential and only aggregate data would be reported.

All CE programs must include an evaluation of the education which allows participants to provide feedback on the achievement of program objectives, the faculties’ performance, the teaching methodologies and the learning environment. In addition, space is provided to collect ideas for improvement and potential topics for other educational offerings. This Level 1 evaluation method provides the planning committee and faculty immediate feedback on the program. Twenty-nine of the 35 participants completed an evaluation; a sample copy of the evaluation with collated data from one session is included in attachment SE 5 EO.j. Overall, the Level 1 evaluation had positive results as participants responded that program objectives were met, teaching methods and learning environment were effective and conducive to learning, and faculty skill was highly rated. Multiple comments were collected that help to provide a more detailed insight into participants’ immediate impressions of the programs. Per CE requirements, the summative evaluation data along with the CE application and registration form is kept on file electronically in the Knight Center’s shared drive for a period of six years.

Thirty-three participants completed the pre-assessment whereas only 8 completed the post-assessment. The comparison of the pre-/post-knowledge assessment results of the Level 3 evaluation are presented in the table below and chart on the following page.

<table>
<thead>
<tr>
<th>Test Questions (Multiple Choice, True/False)</th>
<th>Pre-Assessment % Correct</th>
<th>Post-Assessment % Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The average direction of current flow during ventricular depolarization is referred to as</td>
<td>47</td>
<td>64</td>
</tr>
<tr>
<td>2. The QRS axis can be determined on ECG by looking at leads</td>
<td>29</td>
<td>55</td>
</tr>
<tr>
<td>3. Identify the QRS axis in the following ECG</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>4. When identifying bundle branch block on ECG, what is the single most useful lead</td>
<td>47</td>
<td>73</td>
</tr>
<tr>
<td>5. Causes of left bundle branch block include</td>
<td>44</td>
<td>55</td>
</tr>
<tr>
<td>6. Can asymptomatic left bundle branch block be an ECG marker of underlying heart disease</td>
<td>97</td>
<td>91</td>
</tr>
</tbody>
</table>
The planning committee had identified that the overall purpose of the program was to improve participants’ knowledge and ability to identify the ECG characteristics for axis, bundle branch block and narrow/wide complex tachycardias. Overall, the planning committee was pleased with the results of the Level 3 evaluation as participant scores improved on 9 of the 12 questions.

Questions 1-3 tested participants’ ability to identify ECG characteristics for axis. Participants’ post-scores improved on all 3 questions. Participants’ post-test scores improved on 3 of the 4 questions that tested their ability to identify bundle branch block. Of particular note for these first two areas (i.e., axis and bundle branch block) is that participants’ ability to retain factual information generally improved and they were able to apply this knowledge by correctly analyzing and identifying the rhythm strips. Questions 8-12 tested knowledge retention related to the ability to identify narrow and wide complex tachycardias and post-scores were higher on 3 of the 5 questions. In this content area, the participants scored lower on one question that required recall of a fact and another that required application of knowledge in the analysis and identification of a rhythm strip.

As the post-test was administered 3-4 months after the participant attended the program, the results demonstrated that the majority of knowledge was retained over time and this is seen as a
very positive result. However, all of the scores must be interpreted in light of the fact that the number of Staff Nurses who completed the pre-test (n = 33) was significantly higher than those who completed the post-test (n = 8). The difference is most likely due to the fact that completion of the pre-/post-test was not mandatory. The planning committee has recommended that the pre-/post-test be incorporated into the CE application as a requirement for awarding contact hours to improve the Level 3 evaluation process. This change would allow for pre-/post-comparison of individual as well as aggregate scores as well as a statistical analysis of the data. With this improvement, the Knight Center would be able to more accurately measure the effectiveness of education programs on participants’ knowledge and retention over time.

Although the planning committee was pleased with the results of this Level 3 evaluation pilot, the findings validate the need for ongoing course development in the area of advanced cardiac rhythm interpretation. As shown in SE 5, the 2012 PLEN data showed an improvement in staff preparedness in basic arrhythmias however advanced arrhythmias remains a priority leaning need as identified by staff.
Disruptive Patient Behavior Tiger Team

Executive Sponsors: Gregg Meyer, MD and Jeanette Ives Erickson, RN, DNP
Co-Chairs: Robin Lipkis-Orlando, RN and Anthony Weiss, MD, MBA
Adm. Staff: Alex Brayton and Akin Demehin

<table>
<thead>
<tr>
<th>Clinical Team</th>
<th>Education Team</th>
<th>Response Team</th>
<th>Systems Team</th>
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<tbody>
<tr>
<td>Kathleen Finn, MD</td>
<td>Gino Chisari, RN</td>
<td>Bonnie Michelman</td>
<td>Nancy Connery</td>
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<tr>
<td>Shamim Nejad, MD</td>
<td>Sheila Golden-Baker, RN</td>
<td>Karen Leary</td>
<td>Cole Dowalby-Riley</td>
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<tr>
<td>Colleen Gonzalez, RN</td>
<td>Andrea Stidsen</td>
<td>Maureen Schnider, RN</td>
<td>John Driscoll</td>
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<tr>
<td>Katelyn Roche, RN</td>
<td>John Herman, MD</td>
<td>Sara Macchiano, RN</td>
<td>Kristen Trites</td>
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<tr>
<td>Sara Fisher, RN</td>
<td>Bonnie Michelman</td>
<td>Lela Holden, RN</td>
<td>Alexandra Kimball, MD</td>
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<tr>
<td>Mary Lussier-Cushing, RN</td>
<td>Andrew Gottlieb, RN</td>
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<td>Jen Repper-Delisi, RN</td>
<td>Diann Burnham, RN</td>
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<td>Steve Reardon</td>
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<td></td>
<td>Lorraine Jacobsohn, RN</td>
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**Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace**  
September 16, 2011, 7:30 am to 12:00 pm  
O’Keeffe Auditorium

**Purpose:** Increase staff awareness, comfort and skill in recognizing and responding to real or potential situations of workplace violence.

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker</th>
<th>Topic</th>
</tr>
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</table>
| 7:30 – 8:00 am   | • Tony Weiss MD  
• Robin Lipkis-Orlando, RN MS              | Tiger Team                                      |
| 8:00 – 8:30 am   | • Bonnie S. Michelman, CPP, CHPA             | Workplace violence: trends, regulatory issues, role of Police & Security |
| 8:30-10:55 am & 15 minute break | **Panel members:**  
• Ruth J. Bryan MSN, RN  
• Diann Burnham, RN, BSN, MM,  
• Steve Reardon, MPH  
• Marilyn McMahon, JD  
• Mary Lussier-Cushing, RN, PC, PMHCNS-BC  
• Jen Repper-DeLisi, MSN, RN, PMHCNS-BC  
• Lorrie Jacobsohn, RN, MSN, PMHCNS-BC | Panel presentation on Spectrum of Disruptive Behavior |
| 10:55-11:55 am   | **Panel members:**  
• Allison C. Lilly, MSW, LICSW, CEAP  
• Andrew Gottlieb, MSN/MPH, FNP-BC  
• Robin Lipkis-Orlando, RN, MS  
• Bonnie S. Michelman, CPP, CHPA  
• Steven Taranto, M.A | Panel on Establishing a Caring Culture |
| 11:55 am -12:00 pm | Complete evaluations, distribute nursing contact hours |                                                   |
Disruptive Behavior Tiger Team

Staff Survey

February, 2011

Alex Brayton
Akinlua Demehin
Robin Lipkis-Orlando, RN
Cindy Sprogis
Tony Weiss, MD

Purpose

- To get a general understanding of current staff concerns and experiences with regards to disruptive behavior at MGH
- To shed light on current trends in staff perception, so that committees and decisions going forward can incorporate staff feedback and input
- To understand the populations within the hospital that staff believe to be at high risk for displaying disruptive behavior
- To develop guidelines and care plans to support staff in safely caring for patients

What is “Disruptive Patient Behavior”? 

Disruptive patient behavior includes words or actions that:

- Threaten the safety of others in the care environment (e.g., physical aggression or violence)
- Create, or have the potential to create, an intimidating, hostile, offensive, or potentially unsafe care environment (e.g., verbal abuse, sexual or other harassment, threatening or intimidating words)
- Prevent or interfere with the care of oneself or others, or impede the ability of the care team to collaboratively achieve intended outcomes

Adapted from GB Hickey, Center for Patient and Professional Advocacy, Vanderbilt University Medical Center, 2010

Members

Co-Chairs – Robin Lipkis-Orlando, RN and Anthony Weiss, MD
Adm. Staff - Alex Brayton and Akin Demehin

<table>
<thead>
<tr>
<th>Clinical Team</th>
<th>Response Team</th>
<th>Education Team</th>
<th>Systems Team</th>
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<tbody>
<tr>
<td>Kristinn Finn, MD</td>
<td>Bonnie Michelman</td>
<td>Gise Choeat, RN</td>
<td>Nancy Costerly</td>
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<td>Najia Shamim, MD</td>
<td>Karen Leary</td>
<td>Sheila Goldfar-Baker, RN</td>
<td>Dona By Riley</td>
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<td>Colleen Gonzalez, RN</td>
<td>Maureen Schneider, RN</td>
<td>Andrea Shihem</td>
<td>John Driscoll</td>
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<td>Kendra Reath, RN</td>
<td>Sara MacKenzie, RN</td>
<td>John Hernes, MD</td>
<td>Kristen Trites</td>
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<td>Sara Fisher, RN</td>
<td>Lea Holden, RN</td>
<td>Bonnie Michelman</td>
<td>Alexandra Kimble, MD</td>
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<td>Mary Laszlo-Cushing, RN</td>
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<td>Andrew Gattie, RN</td>
<td>Beth LaRosea</td>
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<td>Jen Bopp-Delei, RN</td>
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<td>Diane Burtch, RN</td>
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<td>Steve Braddock</td>
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<td>Loraine Jacobson, RN</td>
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Qualtrics Survey

- Sent to all MGH staff through directors and supervisors
- 769 responses
- 4 Questions:
  1. What is an example of disruptive patient/family behavior which you have encountered?
  2. What would it take to eliminate all disruptive patient/family behavior?
  3. What would be most helpful to you as a response, following a critical incident involving disruptive patient/family behavior?
  4. There are several clinical indicators that increase the risk of disruptive patient behavior, such as alcohol withdrawal, delirium and dementia. In addition to these, what other high risk groups have the potential for disruptive behavior?

Responses by Role

- RN
- MD
- OA
- Social Worker
- ND/CNS
- NP
- PCA
- Medical Assistant
Responses by Unit

Q1: What is an example of disruptive patient/family behavior which you have encountered?

- 72 examples dealt with patient wait times and 32 dealt with wayfinding.
- Not every example of physical abuse was experienced by the person completing the survey, but rather was witnessed by that person.
- Example of a disorderly/disobedient patient is one who enters a clinical area when told not to.

Q1: Verbatim Examples of Disruptive Behavior

• “I witnessed an acutely psychotic patient hit my attending.” – MD
• “I have been physically assaulted by a patient, being punched with a closed fist in the face” – Bigelow 11 RN
• “Patient hung all his clothing from his suitcase all over the railings in the lobby. With repeated requests to remove the clothing, he did not comply. Finally had to have Security come up and stand there while he complied.” – Information Associate
• “Patients shouting obscenities at nursing, physician and administrative staff. Patients stating they will sue the staff member or hurt them, asking when they get off work.” – ED MD

Q2: What would it take to eliminate all disruptive patient/family behavior?

- Education deals with staff education and training with regards to disruptive patients
- Standards and Guidelines deals with communication to patients and families
Q2: Verbatim Responses On What it Would Take to Eliminate All Disruptive Behavior:

- “I am not sure disruptive behavior can be eliminated; staff education on management of disruptive situations is key.” – CNS
- “Establishment of strict guidelines that are applied in the same way to all patients/guests, and consistently enforced. Patients or family members who do not behave need to be asked to leave.” – RN
- “More security and more prompt response to security. Posted signs with a zero tolerance policy towards aggressive behavior towards staff, similar to what some airlines have (i.e. British Airways).” – MD
- “ZERO tolerance, immediate removal from ER with a ban on further visits, or a security flag about behavior for future visits” – ED RN

Q3: Most Helpful Response to Disruptive Event

**RN Responses by Category (N=472)**

<table>
<thead>
<tr>
<th>Leadership Support</th>
<th>Security Support</th>
<th>Debrief Sessions</th>
<th>Proactive Measures</th>
<th>Other</th>
<th>No Response</th>
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<td>145</td>
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<td>103</td>
<td>65</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>30</td>
</tr>
</tbody>
</table>

Q3: Verbatim Responses to What Would Be the Most Helpful Response to an Incident

- **Leadership Support:** “Knowing that management is behind me.” - RN
- **Security Support:** “Security presence at all times. The ED is a very unpredictable environment. Some days coming to work is frightening...” – ED RN
- **Debrief Sessions:** “Debriefing of incident, honest look at incident and how it was handled. Was there a better way of handling the situation, could it have been prevented if intervention came earlier?” - Social Worker
- **Proactive Measures:** “Conduct daily huddles to discuss potential disruptive patients.” - MD

Q3: What would be most helpful to you as a response, following a critical incident involving disruptive patient/family behavior?
Q4: High Risk Groups (other than alcohol withdrawal, delirium and dementia)

- Created 4 main categories of high-risk groups as described by staff
  - Clinical Causes
  - Personal / Family Issues
  - MGH Operational Issues
  - General (Other) Responses

Q4: Clinical Causes for Disruptive Behavior (other than Alcohol Withdrawal, Delirium or Dementia)
Prevalence of Responses (n>5)

- Clinical Causes
- Personal / Family Issues
- MGH Operational Issues
- General (Other)

Q4: MGH Operational Issues
Prevalence of Responses (n>4)

- Notes:
  - Wait times almost entirely mentioned ED patients
  - Dissatisfaction included clinical issues as well as environmental or process
  - “Wrong” Unit typically referred to psych patients placed on non-psych floors

Q4: Personal / Family Issues Causing High Risk
by Prevalence of Response (n>5)

- Notes:
  - Socioeconomic Issues Includes
  - Homelessness
  - Financial Issues
  - “Rich” patients who feel entitled
  - Shock from Diagnosis deals specifically with patients, not family

Q4: Examples of General / “Other” Responses

- “Unfortunately, I believe that a significant amount of this behavior comes from non high-risk groups. We are finding that many patients are operating with a sense of entitlement and feel they are within their rights to treat office staff badly.” – Outpatient RN
- “Some people are just plain rude and abusive and we should address that for what it is.” – OA
- “Patients who are generally angry for whatever reason” – RN
- “Frustrated every day people.” – Interpreter Services Coordinator

Q4: What are some high risk groups which have the potential for disruptive behavior?
Addendum II – Patient “Flag” Examples

- Patient X has a history of assaultive and threatening behavior. On two occasions, this patient struck a caregiver while being an inpatient (May 2009, June 2010). IM Haldol was effective in reducing aggression.

- Patient Y has significant history of making threats (e-mail, telephone) and disruptive behavior towards healthcare providers. Y was terminated as a patient from the Pain Clinic after multiple episodes of inappropriate behavior.

- Patient Z was terminated as a patient at MGH on January 10, 2011 due to numerous threats (threats to kill), harassment and assaultive behavior. Z is only able to receive medical treatment through the Emergency Department.

- Patient A has a history of dementia and is prone to assaultive behavior. Use caution with each interaction as there is no discernable pattern to his escalation. Often times redirecting the patient helps gain compliance.

Summary of Initial Findings from Tiger Team Review

- Disruptive patient behavior is common, even when strictly defined.
- Disruptive patient behavior undermines a culture of safety by:
  - Direct physical or emotional harm to staff and other patients
  - Indirect harm to patient via:
    - Poor caregiver morale and high turnover
    - Avoidance behaviors toward patient
    - Neglect of other patients
    - Caregiver distraction → human error
  - The cause of disruptive patient behavior is multifactorial, but often involves some interaction between impaired brain function and stress.
- Some causes of disruptive patient behavior may be a result of poor quality care, and may in fact be preventable with better clinical or operational management.
- Many staff feel unsupported after an event, and post-event management is widely variable across different sites of care.
- There are largely unappreciated opportunities for quality improvement from closer review of these events.
- Communication about safety risks and the associated care plan is poor, leading to repeat events and the need to “recreate the wheel.”

Tiger Team Subdivisions

- **Clinical Team**: Identify and improve clinical processes for high-risk patients, with a goal of preventing disruptive patient behavior.
- **Education Team**: Develop educational programs to teach staff how to better recognize and defuse difficult interactions, with a goal of preventing disruptive patient behavior.
- **Response Team**: Develop a standardized approach (checklist) to the post-event follow-up, with goals of:
  - Course correction in patient care
  - Support of affected clinicians
- **Systems Team**: Develop an icon in the electronic medical record to enhance communication about risk and improve care coordination for high-risk patients.
### Disruptive Patient Icon - Details

- Icon may be activated on a 24/7 basis by a staff physician or nursing supervisor working in conjunction with a security supervisor.
- Activated icons will be reviewed within 7 days by a peer-review protected committee which includes representation from Physician staff, Patient Care Services, Practice Support, Center for Quality and Safety, Police & Security, Office of Patient Advocacy, and the Office of General Counsel.
- Icons will be reviewed for accuracy and appropriateness. A brief factual statement regarding the incident prompting the alert, any actions taken as a result of the incident, and any relevant guidance to caregivers regarding ongoing care of the patient (including formal care plans/behavioral contracts) will be developed.
- All icons will be reviewed on a biannual basis by the committee for new information which would prompt renewal, discontinuation or modification of the wording within the icon.
- Aggregated data will be presented to the Medical Policy Committee for review on a biannual basis.
- The alert will be a Blue Police Badge icon, activated in PATCOM and fed to EMPI for visibility across all EMR interfaces used by Partners staff.
- The icon itself, including the associated text, will not be considered part of the formal medical record. Access of the icon will be tracked for auditing purposes.
**WORKPLACE & DOMESTIC VIOLENCE AND CONFLICT**

**Staying Safe: How to Manage the Spectrum of Disruptive Behaviors**

BONNIE S. MICHELMAN CPP, CHPA  
Director, MGH Police Security and Outside Services  
Security Consultant, Partners HealthCare, Inc.

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**Agenda**
- Overview
- Events, reasons for threats and harassment: Cues
- Actions that can be taken

**Message:** Take action, don’t ignore the situation

---

**The Bottom Line**

- **QUESTION**
  - What can you do?

- **INDIVIDUAL**
  - Listen and trust your instincts
  - Be proactive
  - Get out of your comfort zone

- **ORGANIZATION**
  - Teach respect
  - Encourage open communication
  - Ask for involvement

---

**Take Action Don’t Ignore**

- What percent of coworkers suspected or knew there was a problem when workplace violence occurred?  
  - Almost 100%

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**Definition: Workplace Violence and Conflict Behavior**

- Creates a work environment that a reasonable person would find intimidating, threatening, violent or abusive
- Affects a person’s psychological or physical well being

---

**Types of Workplace Violence and Conflict**

- Domestic Violence
- Assault and Battery
- Verbal Abuse
- Threats and Harassment
- Intimidation
- Stalking
- Homicide
- Suicide
- Sexual Assault
- Hate Crimes
### Why Increased Violence and Conflict?
- Mass Layoffs
- Bankruptcies
- Anxiety About Future
- Substance Abuse
- Family Structure
- Less Corporate Paternalism
- Geriatric Issues
- Anticipation of War
- Terrorism
- Economic Issues

### Types of Violent Incidents
- Employees having conflict with other employees or management
- Customer-patient-family angry with management or hospital
- Outside violent person attacks a place of business or takes hostages

### Study of 170 Teaching Hospitals

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
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<tbody>
<tr>
<td>92%</td>
<td>One verbal threat each day</td>
</tr>
<tr>
<td>18%</td>
<td>Weapons are displayed as a threat to staff once each month or more</td>
</tr>
<tr>
<td>43%</td>
<td>Physical attacks on medical staff of one or more per month</td>
</tr>
<tr>
<td>77%</td>
<td>One act of violence in the emergency department in the last five years that resulted in death</td>
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</tbody>
</table>

### Year Statistics
- 1,751,000 Days Lost of Work
- Lost wages: $60 million
- Employer costs: $3-$5 billion
- Reported to police: ½
- Armed offenders: 30%
- Medical care required: 10%
- Federal, state and local government employees: 30%
- Men attackers: Stranger
- Women attackers: Someone they know

### Unique Characteristics in Healthcare
- 80% female population
- Open access to public 24x7
- Numerous points of ingress/egress
- Vulnerable areas
- Microcosm of city
- Crisis mentality
- Staffing shortages
- Unpredictability
- High tension environment
- Higher psychiatric populations
- Substance abuse issues
- Space constraints

### Violence and Conflict in Healthcare
  - diffusing verbal and physical confrontations / workers should be counseled to avoid risking physical harm
  - managing assaultive behavior / professional assault response
  - personal safety and / or police-style assault avoidance
  - emergency response teams should be trained and on call to intervene
A study by the Department of Medicine at the University of Louisville School of Medicine queried 170 teaching hospitals and summarized these findings:

- 32% reported at least one verbal threat each day
- 18% noted that weapons are displayed as a threat to staff once each month or more
- 43% reported a frequency of physical attacks on medical staff of one or more per month
- 77% described an act of violence in the emergency department in the last five years that resulted in death

### Areas of Vulnerability

- Obstetrics / Pediatrics
- Psychiatric Units
- Cash Handling Areas
- Parking Garages
- Pharmacy
- Research
- Operating Rooms
- Women’s Health
- Locker Rooms
- Main Lobbies
- Emergency Departments
- Information Systems

### ED Security Issues

- Growing number of family disputes
- Increased numbers of homeless and psychiatric patients
- Disturbed persons do not necessarily have any business there
- Long waits
- Staff shortages
- Overcrowding
- Availability of drugs and cash
- Easy hospital access
- Availability of handguns
- Prison and jail releases
- Increased gang activity
- Ethnic conflict
- Domestic violence

### Conflict Avoidance in the ED

- Greater Access Control
- Metal Detectors
- Emergency Alert & Alarm Systems
- Comfort of Emergency Department
- Closed Circuit Television
- Special Secure Rooms
- Gun Lockers
- Special Response Teams
- Patient Separation
- Training

### What Constitutes A Threat

- Any words or actions that create a perception that there may be intent to harm oneself, others or property
- An indication of impending danger or harm

#### Direct threat

- “I am going to kill you!”
- “I’m going to punch you in the face!”
- “I will come in with a gun shooting!”

#### Veiled threat

- “____ will pay for this!”
- “It will be a sorry day for him if I don’t get my money!”
- “The last boss who told me to do this wasn’t happy”
- “This place will look like Disneyland if a doctor doesn’t see my brother soon!”

### What Constitutes Harassment

- Words, conduct or action, usually repeated or persistent
- Directed at a specific person that annoys, alarms or causes substantial emotional distress

#### Systematic annoyances, threats or demands

- Family manipulates staff through threats or demands
- Staff feels pressured to conform or if reported to supervisors there is a fear of retribution by family
- Overtime demands become verbal threats of physical harm

#### Inflict distress

- Patient care impeded
- Staff afraid to work with patient or family
- Personal and professional lives severely affected due to stress, anxiety and fear
Domestic Violence and Conflict

- Pattern of coercive control exercised by one partner over the other

Patterns

- Sexual and physical assault
- Economic and psychological abuse
- Threats and harassment

Statistics

- Single leading cause of injury to woman
- Over 10 women per day are killed by their current or former husband or partner
- A woman is beaten every 7.4 seconds by her husband or boyfriend

The “Workplace Terrorist”

- 92% Men, Usually White In 30’s Or 40’s Who Feel Betrayed By A Long Time Employer
- Driven By Sense of Entitlement, Blame Everyone Else For Their Problems
- They Feel Isolated/Little Support System
- They Brood Over The “Wrongs” Done Them
- They Are Methodical And Selective - They Rarely Kill “Customers”
- Motive is revenge often followed by suicide because they have nothing to lose – often previously depressed
- Short fuse, pent-up-rage
- Prone toward firearms/easy access to weaponry
- They are trying to “kill the company or organization”

Precipitating Events

- Loss of job: Laid off, retirement
- Passed over for promotion
- Rejection, office romance, divorce
- Fatal attraction
- Discrimination
- “No personal phone calls please”
- Repeated physical injuries

Cues For Potential Violence and Conflict

1. Overreaction to change, corporate policy
2. Threatening statements: weapon
3. Continuous violation of organization policies / rules
4. Attitude: “Everyone is against me” or “solve everything”
5. Emotional distress: Angry, aggressive, depressed
6. Substance / alcohol impairment
7. Excessive / unexplained absences / tardiness
8. Adverse reaction to phone calls
9. Changes in work performance

Perpetrators of Violence and Conflict

Ask: Is this normal behavior?

- Co Workers
- Strangers
- Workplace “Terrorist”
- Customers
- Personal Relations
- Domestic

What Are The Potential Impacts?

**Victim**
- Health
- Isolation from friends and family
- Compromised performance
- Absenteeism / tardiness
- Workplace interruptions
- Safety concerns
- Self destructive behaviors

**Workgroup**
- Concern for the victim
- Resentment for the victim
- Trauma from witnessing violence
- Concern for personal safety
- Impact on interpersonal relationships
- Decreased productivity
- Work stops
What Are The Potential Impacts?

<table>
<thead>
<tr>
<th>Organization</th>
<th>Liability</th>
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<tbody>
<tr>
<td>• Compromised safety</td>
<td></td>
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<tr>
<td>• Increased threats of violence</td>
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<tr>
<td>• Increased healthcare costs</td>
<td></td>
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<tr>
<td>• Turnover and recruitment costs</td>
<td></td>
</tr>
<tr>
<td>• Decreased productivity</td>
<td></td>
</tr>
<tr>
<td>• Work stops</td>
<td></td>
</tr>
<tr>
<td>• Negligent hiring and retention</td>
<td></td>
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<tr>
<td>• Failure to warn employees</td>
<td></td>
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<tr>
<td>• Exposing employees to violent misconduct</td>
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</tr>
<tr>
<td>• Juries rarely award punitive damages when a “good faith” effort is shown by the employer</td>
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</tbody>
</table>

1996 OSHA Healthcare Training Guidelines

Learn how to...
- Diffuse verbal and physical confrontations
- Avoid risking physical harm
- Manage assaultive behavior
- Set up emergency response teams who are on call

What The Organization Can Do

7-step prevention plan
1. Do pre-employment screening
2. Train managers
   • Practice “golden rule” of employee treatment
   • See early warning signs
   • Deal with the after effects of a difficult situation
3. Teach managers the “golden rule” of employee treatment
4. Do incident response programs
5. Offer counseling services
6. Set up proper security measures

Set Up Better Screening

- Spend more time with patients
- Set up privacy for interviewing and intervention
- Reduce communication barriers
- Know services available for identified patients

Other Prevention Methods

- Covert investigations
- Utilization of forensic techniques
- Liaison with external law enforcement agencies
- Interviews of persons of interest
- Information and referrals to internal resources

Post-Event Management

- Arrests for violations of law and restraining orders
- Comprehensive follow up investigation
- Customized home and workplace security plan
- School and daycare safety plans
- Physical security improvements in the workplace
- Court assistance

Employees Are The First Line of Defense
Dealing With Dangerous People
- Recognize the warning signs
- Take threats seriously
- Prevent escalation and avoid counter threats
- Threat them with dignity
- Seek professional help
- Train managers and supervisors
- Develop a referral policy
- Plan for emergencies

Security Department Protocol
- Initial contact
- Threat assessment
- Anonymity / confidentiality for employee / patient
- Investigative activities
- Customized safety plan
- Management of the perpetrator (If necessary)
- Liaison with appropriate individuals / agencies
- Follow-up

Security Response and Services Offered
- Customized security plan
  - Gang members
  - Executives
  - Prisoners
  - Dignitaries
  - Domestic violence
  - Religious sects
- Risk assessment
- Court assistance, escort, liaison, safety

Security Response and Services Offered
- Security surveys (Home & Work)
- Handwriting analysis
- Personalized travel plans
- Liaison Local, State, Federal Police, FBI
- Investigation / Surveillance Perpetrators Activities
- Systems modification
- Legal assistance
- Prosecution

What Human Resources and Security Can Do
Screen Job Applicants
- Criminal history
- Driving record
- SSN verification
- Worker’s compensation search
- Credit report
- Education verification
- Really listen
- Watch body language

What A Manager Can Do
Communicate to gain rapport with staff
- Tell employees who to report to
- Explain what behaviors to report
- Make statements about the value of a report
- Talk about confidentiality so no fear of reprisal
- Tell stories about how organization has acted
- Engage employees in social action
- Talk about the Employee Assistance Program (EAP)
What A Manager Can Do

Responding to a disclosure
- Inform Security immediately
- Respond helpfully and non-judgmentally
- Maintain confidentiality
- Communicate safety concerns
- Partner with internal departments
- Have DV information available
- Take action when indicators are present

Why Employees Don’t Act
- Lack of awareness of resources
- Fear of losing job
- Fears about confidentiality
- Desire to keep personal life separate from work
- Fear of co-workers and supervisors' response
- Fear of being wrong

What An Employee Can Do
- Be aware of your surroundings
- Report all suspicious activity
- Wear your hospital I.D. badge
- Lock your doors
- Secure your valuables
- Think “crime prevention”
- Believe you can make a difference
- Trust your instincts
- Know and use all services

Finally……

Pay Attention
- Don’t ignore the cues

Communicate
- Talk to someone you trust

Train Yourself
- Seek training and education

Listen
- Listen for what’s being said and not said: Act accordingly

What are You Up Against??
The Company Culture:
- “Aren’t we overreacting here?”
- “Nothing like that could happen here.”
- Legal vs. HR vs. Security vs. Union vs. …
- “It would cost too much to do that.”
- “You can’t stop somebody with a gun, so why bother?”

The Common Thread …
In almost EVERY instance of workplace violence and conflict, coworkers suspected or knew there was a problem

THE QUESTIONS:
- What Did Management Know?
- When Did They Know It?
- What Did They Do About It?
**Ultimately**

The Best Strategy To Prevent Workplace Violence and Conflict Involves Developing The Right Corporate Culture, One That Engenders:
- Respect
- Open Communication
- Effective Supervision
- Employee Involvement, Participation And Development Rather Than Power And Authority

PREVENTING WORKPLACE CONFLICT = ZERO IGNORANCE
Spectrum of Disruptive Behavior:
Employee to Employee

Ruth J. Bryan MSN, RN
Patient Safety Staff Specialist
Edward P. Lawrence Center for Quality and Safety

Joint Commission
Sentinel Event Alert -- July 9, 2008 - Issue # 40:
Behaviors that Undermine a Culture of Safety
Intermittently disruptive behaviors can:
- Foster medical errors
- Decrease satisfaction and outcomes
- Increase cost
- Decrease retention
- Degrade teamwork
- Occur across all disciplines and among all staff

http://www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety

What is meant by disruptive behavior?

Joint Commission-Sentinel Event Alert -- July 9, 2008 - Issue # 40

- Overt actions
  - Verbal outbursts, yelling, swearing, condescending/disrespectful comments and physical threats
- Passive activities
  - Refusal to perform assigned tasks/not completing assignments
  - Unacceptable attitudes: indifference, sarcasm, ignoring
  - Reluctance or refusal to answer questions, return calls or page, condescending language, voice intonation and impatience with questions

Current Reporting at MGH

- 40 events reported from November 1, 2009 through December 31, 2010.
- 42 events reported Jan. 1-Aug 15, 2011
- More than half involve nurses and physicians
- Negative interactions within the team including words or behaviors affecting an individual’s ability to perform as expected
  - Intentional vs. unintentional
  - Actual vs. perceived
- Reported examples involving interactions among various caregivers and disciplines
  - Doctors and Nurses
  - Surgeons and Anesthesia
  - Nurses and Dietitians
  - Radiologists and Technologists

We knew we had issues....

- Isolated safety reports from various areas
- Range of people/professionals involved
- Anecdotes
  - “Nothing ever changes”
  - “That's just how he/she is”
  - “Bad behavior tolerated for income generators.”
  - “I’ll talk to him.”
- We really needed a process... it was time to address as a system not silo by silo

Current Process for Employee-Employee Disruptive Behavior reporting at MGH

- 3-Stage Model:
  - REPORT: Encourage reporting of these events in electronic safety reporting system. Surveillance method is essential
  - INVESTIGATE: Empower local/unit leadership and the Quality Assurance chairs in the applicable departments; encourage collaboration across departments
  - RESTORE TEAMWORK: Encourage, facilitate interaction of individuals involved
Current Process, more details:

- Safety report is submitted
- Triaged to appropriate QA chairs and unit leadership
- QA chairs take initiative to begin discussion with respective staff members and with one another:
  - Understanding what happened from all points of view
- To restore teamwork and resolve conflict, QA Chairs:
  - Explain MGH CQS goals related to follow up
  - Explore staff willingness to participate in meeting
  - Arrange meetings at appropriate levels

MGH Credo: Code of Conduct

- Development of Credo & Boundaries statement for all staff
  - At the time of employment
  - Ongoing review and reappointment of physicians
  - Built into annual evaluation for all staff (HR)
- As a member of the MGH community and in service of our mission, I will never:
  - Speak or act disrespectfully toward anyone
  - Engage in or tolerate abusive behaviors
  - And incidentally… I will never
    - Criticize or take action against any member of the MGH community raising or reporting a safety concern


1. Surveillance: Creating a safe process

- Identify behaviors that undermine teamwork as critical breeches in professional duty
- Communicate broadly that it is safe to report these events: no retribution or retaliation to reporter
- Make it easy to report: easy to access and complete
- Categorize these events consistently, not just “communication” issue
- Track the numbers and categories of personnel
- Report regularly to hospital leadership

2. Analysis: Get the facts & the feelings

- Does the event involve a potentially criminal act?
  - If not, then proceed.
- Address event follow-up within quality process, not as personnel issue through Human Resources
- Involve/assign QA Chairs, well-respected leaders
- Investigate disruptive behavior events as any other safety event:
  - Listen to the story; recognize there are always 2 or more sides
  - Focus on facts; avoid turf issues and defensive posturing
  - Engage in conversation with other QA Chairs involved
  - Plan and facilitate an interdisciplinary meeting

Four Levels of Intervention

- No large meeting: Individuals follow up with each other:
  - encourage staff to resolve conflict, …soon
- Meeting of unit leadership and service QA chairs with or without facilitation by CQS staff
- Meeting of individuals involved with unit leadership and QA chairs, coached in advance by Center for Quality & Safety (CQS) staff
- Meeting of individuals involved with unit leadership and QA chairs, meeting facilitated by CQS staff

3. Conflict resolution: Make it safe

- Planning is key; anticipate any and all possible reactions
- Determine needs and willingness of those involved to participate
- Discuss goals and realistic expectations of session: to resolve issue and restore teamwork
- Clarify ground rules in advance – no villains; no mandated apologies but free exchange
- Schedule and conduct an agenda-driven session
Face-to-Face Meeting Goals
- Understand others’ perspectives of event & issues
- Assure staff safety in the work environment
- Improve communication, respect, and teamwork
- Apologize as appropriate and genuinely offered
- Identify systems issues to be addressed later by QA Chairs and Center for Quality and Safety staff

The Dialogue: there are no villains…
- In advance of the meeting, the individuals involved are asked to come prepared to address these questions:
  - What happened from my perspective?
  - What would make this go better in the future for the patient and the team?
  - What could I have done differently to make things go better?
  - What can I commit to changing or doing differently in the future?

Conducting the session
- Begin with introductions and goal of session
- Acknowledge different perspectives and need for mutual exchange
- Allow each individual to provide their views (first from individual involved followed by QA Chair perspectives)
- Encourage identification of risk factors including communication, system issues that may be a source of frustration.
- Establish consensus and summarize discussion about how to move forward

Staff who have participated in these discussion what they have said about meetings?
- “I was impressed by how blame was not placed on either side. People were brought together to solve an issue, talk it through and discuss ways to prevent it from happening again. Everyone’s self esteem was kept intact.”
- “… how simple communication up front & timely follow-through can make a huge impact on quality of patient care and safety”
- “Conflicts like the one I was in cannot be solved in the heat of the moment. It’s better to calm yourself down then deal with the problem in a formal fashion.”

Vanderbilt Disruptive Behavior Pyramid

What can you do to create a better and safer working environment?
- Raise awareness—no longer accept acts of “disruptive behavior”—call person’s attention to this and cite MGH Credo and Boundaries
- Engage your peers in discussion of MGH Credo expectations and what is disrespectful behavior
  - We can make a change one staff member at a time
- Work with your unit leadership to promote safe and healthy work environment (see Silence Kills reference)
- Report via safety reporting system and encourage fellow staff to report as well
- Remember patient safety is at risk by not addressing unacceptable behavior and acts.
- Be proactive for your patients and your practice setting!
<table>
<thead>
<tr>
<th>References</th>
</tr>
</thead>
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NORRAN KNIGHT NURSING CENTER FOR CLINICAL & PROFESSIONAL DEVELOPMENT

Professional Development

Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace

Program Description
Increase staff awareness, comfort and skill in recognizing and responding to real or potential situations of workplace violence.

Prerequisites: None

Intended Audience: Focus is on all clinical staff, and all others welcome

Contact Hours: TBA

Cost: Free for MGH employees, Partners Affiliates $100, all others $150

Registration & Information Requests: To register please call 617-726-3111 or email: lpcce@partners.org

Class Dates, Times & Location Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
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<tr>
<td>Friday, September 16, 2011</td>
<td>7:30 registration, 8:00 am - 12:00 pm</td>
<td>CK Nichols Auditorium</td>
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Massachusetts General Hospital (D4238490-01-14) is an approved provider of continuing education by the Ohio Nurses Association (OB16001-91), an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

Criteria for successful completion include attendance at the entire event and submission of a complete evaluation form.

Home | About Us | Orientation Programs | Continuing Education | Professional Development | Regulatory Compliance Education | Healthstream | Educational Consulting | Educational Resources | Contact Us |


Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace

September 15, 2011

Your responses and comments will help us improve future educational programs; as well as assess how much knowledge you have acquired in attending this continuing education offering. Please mark your rating on each item below.

### Relevance of Objectives to Overall Purpose/Goals of Educational Activity

<table>
<thead>
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<th>(List overall purpose/goal)</th>
<th>Yes, related</th>
<th>Yes, partially related</th>
<th>No, not related</th>
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### ACHIEVEMENT OF OBJECTIVES

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<th>Not Met</th>
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<td>1. Describe spectrum of disruptive behaviors</td>
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<tr>
<td>2. Identify two high risk indicators of disruptive patient behavior</td>
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<td>O</td>
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<td>3. Describe current MGH reporting process for disruptive behavior among clinical staff members</td>
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<td>O</td>
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<tr>
<td>4. Discuss two effective interventions to manage disruptive behavior in the clinical setting</td>
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<td>5. Identify three situations that could lead to disruptive behavior</td>
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<td>6. Identify three strategies to maintain safety with patients at risk for disruptive behavior including violence</td>
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<td>7. Describe the purpose and outcomes of multi-disciplinary Disruptive Behavior Rounds in the ED</td>
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<tr>
<td>8. Describe current definitions and types of workplace violence</td>
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<tr>
<td>9. Discuss trends in workplace violence, regulatory mandates and their objectives</td>
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<tr>
<td>10. Describe the procedures for diminishing, preventing and responding to violence</td>
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<td>O</td>
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<tr>
<td>11. Describe all services offered by Police and Security</td>
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<tr>
<td>12. Describe the services offered by the five departments represented on the panel</td>
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### To the right fill in the circle complete where applicable.

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<th>Neutral</th>
<th>Disagree</th>
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<td>1. Content related to both the program goals and specific session objectives.</td>
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<tr>
<td>2. Teaching methods enhanced the session/s.</td>
<td>25</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>3. The site for the session/s was/were conducive to learning.</td>
<td>28</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>4. This presentation met my personal objective for attending and satisfied my learning needs related to the topic.</td>
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SPEAKER (S) EVALUATION: To the right fill in the circle complete where applicable.

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<td>2</td>
<td>Robin Lipkis-Orlando,RN MS</td>
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<td>3</td>
<td>Bonnie S. Michelman, CPP, CHPA</td>
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<tr>
<td>4</td>
<td>Ruth J. Bryan MSN, RN</td>
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<tr>
<td>5</td>
<td>Diann Burnham, RN, BSN, MM</td>
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<td>6</td>
<td>Steve Reardon, MPH</td>
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<tr>
<td>7</td>
<td>Marilyn McMahon, JD</td>
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<td>8</td>
<td>Mary Lussier-Cushing, RN/PC,PMHCNS-BC</td>
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<tr>
<td>9</td>
<td>Jen Repper-DeLisi, MSN, RN,PMHCNS-BC</td>
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<td>Lorrie Jacobsohn, RN, MSN, PMHCNS-BC</td>
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<td>2</td>
<td>O</td>
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<tr>
<td>11</td>
<td>Allison C. Lilly, MSW, LICSW, CEAP</td>
<td>26</td>
<td>2</td>
<td>O</td>
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<tr>
<td>12</td>
<td>Andrew Gottlieb, MSN/MPH, FNP-BC</td>
<td>26</td>
<td>4</td>
<td>O</td>
</tr>
<tr>
<td>13</td>
<td>Steve Taranto, MA</td>
<td>26</td>
<td>4</td>
<td>O</td>
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</table>

A. Please suggest topic/program for future presentations that will meet your specific learning need.
   - Rights (pt/staff) re; searching patient belonging, staff rights surrounding refusing to care for patient indentified violent, aggressive, etc.
   - Psych unit rational/methods that could be shared/utilized by staff on a medical floor, as most patients awaiting psych beds are on medical units
   - Focus should be on both inpatient and outpatient- less resources outpatient (Risk for danger reassurance and planning for outpatient population is vital ( Next step – code silver)
   - Pedi concern- with parents plus with children being abusive to nurse more patient examples on how to deal with abusive patient warning Icon – pop Icon in EDK – indicator safety log

B. Additional comments about this program:
   - I didn’t realize there were so many options available to support staff
   - Didn’t really seem that microphones were working
   - Overall great conference
   - Provide mandatory training to nursing, administrative and physician staff
   - Putting in place an icon on LMR similar to what we have for precautions as ACS would be helpful before the pass off of a patient from the EB nurse to sue is different assessment to what is seen. It need to be easy for a nurse to see past issues with out 30mins of searching, often we do not have that
   - Very helpful covered wide range of topics
   - Very good
   - Excellent program. Every employee should attend
• Providing mike to the floor to ask questions. Much time cannot hear
  the questions posed from the floor. Noise interruptions from outside
  environment. Ensure door of auditorium is closed
• Great program – expand
• Very well done great panel
• Great program – expand to 8 hours with case studies and attendees breaking stories
• First speaker read from outline would have preferred more spontaneous presentation
• This program was helpful especially with detailing how to access resources.
• Access small work place areas – safety outpatient setting – guidelines – for MD staff to
  follow

C. The goal of this program was: To educate staff to recognize early warning signs, how to manage
  the spectrum of difficult behaviors and what is available for staff support.
  • Based on the information you learned today, please identify a specific change that you
    will implement in your nursing practice.
    o Take a step back
    o I won’t carry the stress from a previous interaction with a patient into the next
      patient
    o Change of shift, exciting RN introducing on –coming RN to patient identified at risk
      for disruptive behavior
    o Use Cal Stat time to debrief and reconnect prior to entering another patient’s room
    o Transition times with patients change of team introduction of staff on the next shift-
      also manage patient unrealistic expectation by having team meeting and consistency
    o IU will take advantage of my cal stat time
    o Listening and evaluating patient remarks
    o To bring back information about Icons coming soon, to identify disturbing behavior
      patient, also reconfirm our other services available as always very resourceful
    o The 4 step helpful outlined by psyche, RN’s were reporting more to security when
      they are uneasy or concerned about other employees are very helpful
    o Use all resources available to me
    o Speak with co-worker about disruptive behavior as it occurs ( using tactics learned –
      possibly suggest EAP to 2 coworkers
    o Trading on patient’s rights – training on expected chains and respect per MGH credo
    o Reinforce practice of taking time to briefly pause, not bring energy form prior
      encounter to new patient situation
    o The program made me much more aware of the many resources available – their
      abilities to help ( EAP, Human Resources etc)
    o Outpatient setting – situations where patient and staff are unlike space – especially
      with patient who are already upset concern on opening office w/ other staff in the
      office - what id the protocol on off site office,

D. What was your experience with the Knight Nursing Center "Going Green”
  • Nothing
  • Positive able to access material and read over before class
  • This eval could have been printed double – sided single sheet
• Great idea!!
• It would be nice if the slices were broken up into sections so that they could be printed according to need. I like that the slide are now online, ie. in an email, so they can easily be referred to when needed
• Fine
• Great!
• Great idea
• No problem with registration Website is difficult to find
• Great
• Thank you for not printing for event, if staff need, they can prevent – as I did recycle paper
• Thumbs up. But it will be helpful if we could retrieve or upload all the information for all the speakers presentations
• Didn’t released – would probably have printed out
• I was not aware so did not know to get the powerpiont

E. Did you have any difficulty retrieving online materials?
• None
• NO
• It would be great if you would please forward all power point presentation to program participants
• None
• Didn’t realized these were available
• Not a problem
• No
• No
• No
• No
• No
• No
• No
• N/A
• I did not get them

F. What would make the process better?
• Extra material day of class
• Include nursing stories on this panel and allow ways to address the issues differently so that they can be avoided in the future
• Reminder day before to print out slides
• Maybe feedback button like LMR - ?? or knight OTR
• Nothing
• First speaker read form slides – nor very engaging
• Reminder email
**Pre-Conference Survey**

**Course:** Pre-Conference Survey Questions, Staying Safe, How to Manage the Spectrum of Disruptive Behavior  
**Version:** 1  
**Evaluation Owner:** PH Corporate-Partners HealthCare  
**Last Updated By:** Sheila B. Golden-Baker on 9/1/2011  
**Completion Date Range:** 9/16/2010 through 9/15/2011

**Data as of Aug 08, 2012 1:00 AM ET**  
**Report Date:** Aug 08, 2012

### Reporting On

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<td>Total Unique Students: 22</td>
</tr>
<tr>
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<td>Total Evaluation Completions: 23</td>
</tr>
<tr>
<td>All</td>
<td>Disciplines Included: All</td>
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</table>

### RESPONSE COUNTS

Answer counts can vary among questions. This happens because:
- A question's text was edited,
- An answer's text was edited,
- An answer choice was added to or removed from a question.

**Question Group:** Default Group  
**Description:**

<table>
<thead>
<tr>
<th>1. encounter disruptive behavior (Likert Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my job, I often encounter disruptive behavior with patients, families or colleagues.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
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<th>Responses</th>
<th>Response Value</th>
<th>% of Students</th>
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<tr>
<td>Strongly Disagree</td>
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<td>Disagree</td>
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<tr>
<td>Somewhat agree</td>
<td>3</td>
<td>3</td>
<td>13.04%</td>
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<tr>
<td>Agree</td>
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<td>43.48%</td>
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<tr>
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<td>5</td>
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</tr>
<tr>
<td>No Response</td>
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<td>0.00%</td>
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| Totals: | 23 | 100.00% |

**Mean Score:** 3.39
2. recognize potential violence (Likert Scale)
I am able to recognize a potentially violent situation with a patient, family member or colleague in the workplace.

<table>
<thead>
<tr>
<th>Mandatory Question</th>
<th>Responses</th>
<th>Response Value</th>
<th>% of Students</th>
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<tr>
<td>1. Strongly Disagree</td>
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<tr>
<td>2. Disagree</td>
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<td>3. Somewhat disagree</td>
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<td>4. Agree</td>
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3. Confidence (Likert Scale)
I feel confident in handling disruptive behavior in the workplace.

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<td>3. Somewhat disagree</td>
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4. resources (Likert Scale)
I am aware of my resources in dealing with disruptive behavior in the workplace.

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<th>Mandatory Question</th>
<th>Responses</th>
<th>Response Value</th>
<th>% of Students</th>
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<td>0.00%</td>
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<td>2. Disagree</td>
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Post Conference Survey
Course: Post Conference Survey Staying Safe How to Manage the Spectrum of Disruptive Behavior in the Workplace
Evaluation Owner: GHC-Massachusetts General Hospital
Last Updated By: Sheila B. Golden-Baker on 11/29/2011
Completion Date Range: 1/10/2011 through 1/9/2012

REPORTING ON
Student Data for this Report
Answers Displayed by: Presentation Order
Include Inactive Students: No
Question Types: All
Total Unique Students: 26
Total Evaluation Completions: 26
Disciplines Included: All

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<th>Responses</th>
<th>Response Value</th>
<th>% of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Strongly disagree</td>
<td>1</td>
<td>1</td>
<td>3.85%</td>
</tr>
<tr>
<td>2 Disagree</td>
<td>6</td>
<td>2</td>
<td>23.08%</td>
</tr>
<tr>
<td>3 Somewhat disagree</td>
<td>6</td>
<td>3</td>
<td>23.08%</td>
</tr>
<tr>
<td>4 Agree</td>
<td>10</td>
<td>4</td>
<td>38.46%</td>
</tr>
<tr>
<td>5 Strongly agree</td>
<td>3</td>
<td>4</td>
<td>11.54%</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
<td></td>
<td>0.00%</td>
</tr>
<tr>
<td>Totals:</td>
<td>26</td>
<td></td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Mean Score: 3.19
2. recognize disruptive behavior (Likert Scale)
I am able to recognize a potentially violent situation with a patient, family member or colleague in the workplace.

<table>
<thead>
<tr>
<th>Mandatory Question</th>
<th>Responses</th>
<th>Response Value</th>
<th>% of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Strongly disagree</td>
<td>0</td>
<td>1</td>
<td>0.00%</td>
</tr>
<tr>
<td>2 Disagree</td>
<td>0</td>
<td>2</td>
<td>0.00%</td>
</tr>
<tr>
<td>3 Somewhat disagree</td>
<td>1</td>
<td>3</td>
<td>3.85%</td>
</tr>
<tr>
<td>4 Agree</td>
<td>18</td>
<td>4</td>
<td>69.23%</td>
</tr>
<tr>
<td>5 Strongly agree</td>
<td>7</td>
<td>5</td>
<td>26.92%</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Totals:</td>
<td>26</td>
<td></td>
<td>100.00%</td>
</tr>
<tr>
<td>Mean Score:</td>
<td></td>
<td></td>
<td>4.23</td>
</tr>
</tbody>
</table>

3. confidence (Likert Scale)
I feel confident in handling disruptive behavior in the workplace.

<table>
<thead>
<tr>
<th>Mandatory Question</th>
<th>Responses</th>
<th>Response Value</th>
<th>% of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Strongly disagree</td>
<td>0</td>
<td>1</td>
<td>0.00%</td>
</tr>
<tr>
<td>2 Disagree</td>
<td>1</td>
<td>2</td>
<td>3.85%</td>
</tr>
<tr>
<td>3 Somewhat disagree</td>
<td>7</td>
<td>3</td>
<td>26.92%</td>
</tr>
<tr>
<td>4 Agree</td>
<td>13</td>
<td>4</td>
<td>50.00%</td>
</tr>
<tr>
<td>5 Strongly agree</td>
<td>5</td>
<td>4</td>
<td>19.23%</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Totals:</td>
<td>26</td>
<td></td>
<td>100.00%</td>
</tr>
<tr>
<td>Mean Score:</td>
<td></td>
<td></td>
<td>3.65</td>
</tr>
</tbody>
</table>

4. resources (Likert Scale)
I am aware of my resources in dealing with disruptive behavior in the workplace.

<table>
<thead>
<tr>
<th>Mandatory Question</th>
<th>Responses</th>
<th>Response Value</th>
<th>% of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Strongly disagree</td>
<td>0</td>
<td>1</td>
<td>0.00%</td>
</tr>
<tr>
<td>2 Disagree</td>
<td>0</td>
<td>2</td>
<td>0.00%</td>
</tr>
<tr>
<td>3 Somewhat disagree</td>
<td>1</td>
<td>2</td>
<td>3.85%</td>
</tr>
<tr>
<td>4 Agree</td>
<td>17</td>
<td>4</td>
<td>65.38%</td>
</tr>
<tr>
<td>5 Strongly agree</td>
<td>8</td>
<td>5</td>
<td>30.77%</td>
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<tr>
<td>No Response</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Totals:</td>
<td>26</td>
<td></td>
<td>100.00%</td>
</tr>
<tr>
<td>Mean Score:</td>
<td></td>
<td></td>
<td>4.23</td>
</tr>
</tbody>
</table>
5. example of lessons learned (Free Text)

Please describe a recent situation where your practice changed based on attending the “Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace”.

<table>
<thead>
<tr>
<th>Mandatory Question</th>
<th>Responses</th>
<th>% of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Click Here to Read Student Responses...</td>
<td>26</td>
<td>100.00%</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Totals:</td>
<td>26</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
5. example of lessons learned (Free Text)

Please describe a recent situation where your practice changed based on attending the "Staying Safe: How to Manage the Spectrum of Disruptive Behavior in the Workplace".

1. Diffused a potential dangerous situation by implementing the Stay Safe practice.
   I found out that my patient had changed the programing for his PCA pump. When I asked him about changing the settings, he became angry and threatening. I had to call security when the patient became angry because he stood up and came very close to me in a threatening manner. I immediately left the room and waited at the desk until security came up to speak to the patient.

2. As of yet, no significant changes made.

3. Using better body space—not as close to patient help de-escalate patient.

4. I am very happy to know the resources I have if I encounter a problem. I haven’t had one yet.

5. We had a very persistent family member, wanting to come into the recovery room earlier than we may have wanted, but I let him in and reassured him all was well and he was less disruptive and more compliant as a result.

6. I have not had a disruptive situation recently.

7. A patient was angry, and became destructive. She locked herself in the exam room, and dumped the trash all over the floor. My manager had Police and Security come talk to us, as well as Patient Advocacy. It was extremely helpful!!

8. Sorry, I do not have one at this time. thanks

9. We are fortunate, that we have not encounter any issues in our office. Our MDs and Staff are well capable of handling situations. And police and security are quick to respond when needed. Thank you

10. I was able to use it when I had a disagreement with a colleague in approaching the situation and dealing with it one on one.

11. No recent situation.

12. I received a call from a colleague who was very upset about something that had happened. I let him vent and validated his feelings and then pointed out a way to reframe the situation in a more positive light. This helped him reflect on his reaction and move forward in a calmer manner.

   An elderly lady for some reason was making negative remark about my facial expression. So I acknowledged the remark (even though it wasn’t my fault) and made an instant apology to her. However
| 14 | she wasn't happy still and decided to complaint to another nurse. She followed up with her complaints and asked me for details. In the end, I was told not to have direct verbal contact other than my work involvement with her. |
| 15 | Patient presenting with SI/ETOH withdrawal who was calm and cooperative then suddenly became agitated and violent, verbally cursing and swinging arms. Patient brought into a quieter room and police and security was called to reinforce safety. |
| 16 | Recently, a gentleman was slumped at our office doorstep. Rather than attempt to wake him, I called Police and Security for assistance. It turns out the gentleman required an ambulance. |
| 17 | There was mis-communication between two staff members. By pulling each aside to listen to their thoughts then meeting with both as a group to discuss the situation was extremely helpful. We kept the discussion behind close doors and prevented a disruptive situation from occurring. |
| 18 | I haven't experienced disruptive behavior since attending. |
| 19 | There has not been a specific instance, but the take home message was clear on the resources that are available to us. |
| 20 | A patient came to the practice seeking narcotics and started to become angry and yelling at the staff nurse. I was paged by the staff nurse who did not know what to do. When I arrived I removed the nurse from the immediate danger and pressed the security button for security. With two MGH police officers present I was able to calm the patient down and we sent him to the ED. |
| 21 | Calling security more often |
| 22 | Had a patient who was getting agitated in the waiting room because the procedure room was delayed. Because of the course I was aware that they could potentially escalate and took the patient aside (keeping a good distance) and listened to their concerns and explaining to them why there was a delay. I think it helped them calm down by being able to vent their frustration and knowing the reason for the delay. |
# Advanced Arrhythmias: General Care
**November 9, 2011**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:45</td>
<td>11:00 Registration</td>
<td></td>
</tr>
</tbody>
</table>
| 11:00 | 11:15 Pre-assessment and Course Overview   | Mary O’Brien, RN, MSN, APRN-BC  
*Professional Development Specialist  
The Norman Knight Nursing Center for Clinical and Professional Development* |
| 11:15 | 11:45 Electrical Axis                      | Ann La Pierre, RN, BSN  
*Staff Nurse, Electrophysiology Lab* |
| 11:45 | 12:45 Bundle Branch Block: Part I          | Kathryn G Whalen, MSN, RN, FAHA  
*Clinical Nurse Specialist, Ellison 8* |
| 12:45 | 1:00 BREAK                                 |                                                |
| 1:00  | 1:30 Bundle Branch Block: Part II          | Kathryn G Whalen, MSN, RN, FAHA  
*Clinical Nurse Specialist, Ellison 8* |
| 1:30  | 2:55 Supraventricular Tachycardias         | Ann LaPierre, RN, BSN  
*Staff Nurse, Electrophysiology Lab* |
| 2:55  | 3:00 Evaluation                            | Mary O’Brien, RN, MSN, APRN  
*Professional Development Specialist  
The Norman Knight Nursing Center for Clinical and Professional Development* |
NEW ADVANCED ARRHYTHMIA COURSES

This course will focus on the identification, assessment and management of axis deviation, bundle branch block and supraventricular tachycardias including wide complex tachycardias.

ADVANCED ARRHYTHMIAS: GENERAL CARE

**Intended Audience:** General care nurses

**OCTOBER 25, 2011**
Founders 325
7:00 am - 11:00 am

**NOVEMBER 9, 2011**
Haber Conference Room
11:00 am - 3:00 pm

ADVANCED ARRHYTHMIAS: CRITICAL CARE

**Intended Audience:** Critical care, step-down, emergency department nurses

**OCTOBER 25, 2011**
Founders 325
11:00 am - 3:00 pm

**NOVEMBER 9, 2011**
Haber Conference Room
7:00 am - 11:00 am

Pre-Registration required through email: KPCS@partners.org
or Call The Norman Knight Nursing Center for Clinical & Professional Development at 617.726.3111

Massachusetts General Hospital (OH-239/10-1-14) is an approved provider of continuing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center’s Commission on accreditation.

Criteria for successful completion includes attendance at the entire event and submission of a complete evaluation form.
The average direction of current flow during ventricular depolarization is referred to as

Answers
- the hexaxial reference system
- electrical axis
- bipolar leads
- QRS vectors

The QRS axis can be determined on ECG by looking at leads

Answers
- I and AVL
- VI and V6
- II and VI
- I and AVF

Identify the QRS axis in the following ECG

Answers
- right axis deviation
- left axis deviation
- indeterminate axis
- normal axis
**Question 4 of 12**
When identifying bundle branch block on ECG, what is the single most useful lead?

**Answers**
- O VI
- O V6
- O II
- O I

**Question 5 of 12**
Causes of left bundle branch block include (check all that apply)

**Answers**
- O coronary artery disease
- O hypertensive heart disease
- O cardiomyopathy
- O may be a normal variant

**Question 6 of 12**
Can asymptomatic left bundle branch block be an ECG marker of underlying heart disease?

**Answers**
- o True
- o False

**Question 7 of 12**
Identify the type of bundle branch block on this 12 lead ECG
Answers

- complete
- right complete left
- left anterior hemiblock
- left posterior hemiblock

Question 8 of 12
In atrial tachycardia, the P wave is likely to be
Answers

- absent
- a normal rounded shape
- intermittent
- an irregular shape

Question 9 of 12
In SVT, the initial stimulus begins in
Answers

- the SA node
- the pericardium
- above the ventricles

Question 10 of 12
When looking at a wide complex tachycardia, your first assumption should be that it is ventricular tachycardia
Answers

- True
- False

Question 11 of 12
Which rhythm usually has a ventricular rate of 150 beats per minute
Answers

- Atrial flutter 3:1
- block Atrial flutter 2:1
- block Atrial Fibrillation
- Sinus Tachycardia
Question 12 of 12
Identify the rhythm in the following 12 lead ECG

Answers
- ventricular tachycardia
- atrial fibrillation
- atrial flutter
- AV nodal reentry tachycardia
Advanced Arrhythmias: General Care and ICU  
November 9, 2011

Your responses and comments will help us improve future educational programs; as well as assess how much knowledge you have acquired in attending this continuing education offering. Please mark your rating on each item below.

Relevance of Objectives to Overall Purpose/Goals of Educational Activity

<table>
<thead>
<tr>
<th>Yes, related</th>
<th>Yes, partially related</th>
<th>No, not related</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of this program is to identify the ECG characteristics for axis, bundle branch block and narrow/wide complex tachycardias and discuss the clinical implications</td>
<td>14</td>
<td>2</td>
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</table>

ACHIEVEMENT OF OBJECTIVES: To the right fill in the circle complete where applicable.

<table>
<thead>
<tr>
<th>Met</th>
<th>Partially Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describe a systematic approach for determining the electrical axis of the heart</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>2. Identify on 12 lead ECG normal axis, right axis deviation, left axis deviation and indeterminate axis</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>3. Describe three mechanisms for arrhythmias: reentry, automatic, triggered</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>4. Differentiate on 12 lead ECG between ventricular tachycardia, aberrantly conducted wide complex supraventricular tachycardia (SVT) and narrow complex SVT</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>5. Apply the major criteria with 12 lead ECG review for identifying right and left bundle branch block</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>6. Identify the single most important ECG lead for interpreting right versus left bundle branch block</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>7. Discuss the clinical implications of right and left bundle branch block</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>8. Describe the mechanism for anterior and posterior hemiblocks</td>
<td>19</td>
<td>6</td>
</tr>
</tbody>
</table>

To the right fill in the circle complete where applicable.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contents were related to both the program goals and specific session objectives.</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>2. Teaching methods enhanced the session/s.</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>3. The site for the session/s was/were conducive to learning.</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>4. This presentation met my personal objective for attending and satisfied my learning needs related to the topic.</td>
<td>16</td>
<td>1</td>
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</tbody>
</table>

SPEAKER(S) EVALUATION: To the right fill in the circle complete where applicable.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Fair</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ann LaPierre, RN, BSN</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>2. Kathryn Whalen, RN, MSN</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>

A. Please suggest topic/program for future presentations that will meet your specific learning need.
   - Sheaths, Vascular anatomy
   - More time on atrial and ventricular arrhythmias more strips for practice interpretation

B. Additional comments about this program:
   - I am a visual learner and loved all the graphs/chart that Ann used. Kate went a bit too fast and lost me a few times. Overall class was great.
   - I was expecting more of actual arrhythmias
C. The goal of this program was: To identify the ECG characteristics for axis, bundle branch block and narrow/wide complex tachycardia’s and discuss the clinical implications
   - Based on the information you learned today, please identify a specific change that you will implement in your nursing practice.
   - Will be able to differentiate RAD vs. LAD
   - Feel more comfortable identifying EKG
   - I will be able to look at my monitored patients alarms and better understand why the monitor a alarmed and where the flow of electric is going
   - Look at leads more closely with new importance
   - Understand Axis Deviation much better now. Put more worth on BB and understand clinical implications