

VA OIG Podcast Transcript 20180222-10  
Combined Assessment Program Summary Report – Management of Disruptive and  
Violent Behavior in Veterans Health Administration Facilities  
February 22, 2018

[Mike Nacincik] I'm Mike Nacincik, the OIG's public affairs officer.

With me is Julie Watrous, Director of the Healthcare Inspections Quality Improvement Program, to talk about the OIG report – *Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities*.

Julie, this report is about providing a safe medical care setting and workplace. Unfortunately, sometimes VA has patients who are disruptive and even violent in its healthcare facilities that it has to manage. The OIG found that VA does many things well in this area, but there are still ways in which it can improve.

[Julie Watrous] Yes. This is an issue that must be addressed by all healthcare systems and VA is no exception.

[Mike Nacincik] We all know that this is an important topic that often makes headlines. I wanted to talk with you today about the problems identified in the report that are specific to VA. But first, what exactly do you mean by workplace disruption or violence?

[Julie Watrous] Workplace violence is any act or proposed act of physical violence, harassment, intimidation, or other menacing disruptive behavior that occurs at the facility or work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It affects employees, customers, and visitors. We have all seen reports of incidents that include acts of violence in government and corporate workplaces, and private healthcare settings, as well as at VA facilities.

Most workplaces cannot, and would not want to, lock down all entrances and ask everyone to go through metal detectors. Many VA facilities are sprawling properties with garden-like atmospheres. Managers need to take the least restrictive and commonsense actions to minimize the risk of disruption to healthcare provision to prevent injuries to employees, customers, and visitors. These actions typically include implementing clear policies, posting codes of conduct, and training employees to increase their awareness and to use calming techniques.

[Mike Nacincik] Why was the OIG interested in examining this topic in healthcare settings?

[Julie Watrous] Healthcare workers are more likely to be affected by violent or disruptive acts in their workplaces than workers in many other industries. Employees at VA healthcare facilities are not immune to the risks associated with caring for patients who

February 22, 2018

are in emotional distress. They must balance the rights and healthcare needs of these patients with the health and safety of other patients, visitors, and staff (many of whom are also veterans), which is a significant challenge for VA.

The OIG reviewed this topic in 2011, and I'm happy to say that VA made several improvements in its policies, review and reporting processes, and training.

[Mike Nacincik] What specific problems still need attention?

[Julie Watrous] VA requires all its facilities to have committees to review incidents of troubling patient behavior. The OIG found that almost all of the facilities we reviewed had these patient-centered committees, known as Disruptive Behavior Committees or Boards. In order to have thorough, robust conversations, it's important for all the necessary committee members to attend. We found, however, that some key members were not attending regularly. Also, since incidents of disruptive or violent behavior perpetrated by employees should not be discussed in the patient-centered committee, each facility needs to have an employee-centered group known as an Employee Threat Assessment Team. The OIG found that only about one-third of the facilities we reviewed had functioning Employee Threat Assessment Teams.

[Mike Nacincik] How do facility staff and care providers know about patients who are prone to outbursts?

[Julie Watrous] That's a great question! VA healthcare facilities are often large and sprawling, with patients receiving care in many different locations. Fortunately, VA's electronic health record allows staff to make a note on the records of patients who have shown that they might exhibit troublesome behavior. The notation pops up on a screen when clinicians anywhere in the facility access the patients' records.

[Mike Nacincik] How does VA engage patients who have exhibited disruptive or violent behavior?

[Julie Watrous] VA recognizes that these individuals need care and support. VA's policy is not to refuse care to any veteran. However, for the safety of patients and staff, VA can limit the way patients access care in several ways. One way is to provide services to the patient at a facility with a security presence rather than, let's say, a community-based clinic where there is no security presence. The patient may also be escorted by someone, such as a security guard, during the visit. This kind of limitation is called an Order of Behavioral Restriction. It's a serious matter to limit the way veterans access care, so facility chiefs of staff need to approve the order and don't do so lightly. Patients

February 22, 2018

should be formally informed about the order and their right to appeal it. We found room for improvement in consistently informing patients about these restrictions.

[Mike Nacincik] What level of behavior triggers an Order of Behavioral Restriction and who is the decision maker?

[Julie Watrous] If a patient poses a severe safety threat, it may be appropriate for an Order of Behavioral Restriction to be placed as a first level of intervention. However, that should be a rare occurrence. The Disruptive Behavior Committee assesses the person's behavior in the context of what is going on in the person's life and his or her intent. For example, bringing a weapon onto VHA grounds could pose a significant threat. But, it is important to know if the individual is going through a difficult time and meant to use the weapon to threaten or harm others, or had just forgotten it was in his or her vehicle. It's the same behavior—bringing a weapon on station—but different situations due to context and intent. An Order of Behavioral Restriction may be warranted in the first case, but only a warning to not bring the weapon to the VA in the second scenario. The facility Chief of Staff reviews the committee's assessment and makes the decision.

[Mike Nacincik] How does the VA provide its employees with the knowledge and skills to effectively deal with these kinds of situations?

[Julie Watrous] First, employees with knowledge of safety and logistics rate each area for its risk of experiencing violence. For example, reporting shows that inpatient psychiatry units and emergency departments are at high risk for violence. Staff working in higher-risk areas need more training and techniques than staff working in lower-risk areas.

VA requires all employees to have a basic level of training that emphasizes preventing and calming disruptive behavior. Newly hired staff should complete this training within 90 days. Additional training for staff who work in higher-risk areas also need to be completed within 90 days. We found room for improvement in complying with this requirement. Facilities do a really good job of providing new employee orientation, so those that included training on preventing and managing disruptive behavior at orientation were better able to meet this requirement.

[Mike Nacincik] Can you give me some examples of the types of issues included in the training?

February 22, 2018

[Julie Watrous] Sure—the training emphasizes using the least restrictive options, starting with verbal intervention procedures to calm people down. In extreme cases, to protect patients and staff, the training provides physical interventions for when it is necessary to restrain and control someone.

[Mike Nacincik] What should we take away from the OIG report, and what were the recommendations?

[Julie Watrous] VA has made progress, but can do a better job to provide a safe environment for its employees, visitors, and patients. The OIG made four recommendations that will help VA to improve. The groups that discuss disruptive and/or violent incidents – one for patients and a separate one for employees – must have the key members present at the meetings. Restrictions to patients' access to facilities or care providers need to be communicated to patients, who have the right to appeal the restrictions. Finally, VA needs to ensure that employees receive training in the techniques that will help to keep them and others safe.

[Mike Nacincik] Julie, thank you.

[Julie Watrous] Thank you, for the opportunity to talk about this important issue.

[Mike Nacincik] The OIG podcast is produced by VA OIG staff and is available on the VA OIG's website.

To report fraud, waste, abuse, or possible criminal activity visit our website at W-W-W dot V-A dot G-O-V backslash O-I-G.