Partnership for Work, Health and Safety

Research BRIEF

Does it make a difference? Evaluating violence prevention education in BC healthcare

December 2020

Background

Violence against healthcare workers from patients, clients, long term care residents, and visitors negatively affects not only the health and wellbeing of workers but also the quality and cost of care. Like in most jurisdictions internationally, in British Columbia (BC) the main intervention to address this violence has been to educate healthcare workers to prevent and manage violence. Developed together by health sector unions and employers in 2010 and revised in 2015, the BC Provincial Violence Prevention Curriculum (PVPC) includes both online and classroom education. Although the PVPC has been widely implemented across BC, evaluating its effectiveness is difficult as many factors influence why violence occurs, why and how participants learn from the curriculum, and whether the knowledge and skills are applied.

This brief summarizes an evaluation conducted by University of BC researchers that utilized an innovative realist approach to understand how, why and in what contexts the PVPC is effective in preventing violent incidents and related injuries. Collaborating with Advisory Group members from three participating BC health authorities and

Based on research presented in:

Provost S, MacPhee M, Daniels M, McLeod C. (2020). Realist Evaluation of Violence Prevention Education in BC Healthcare. Final Report to WorkSafeBC. Vancouver: Partnership for Work, Health and Safety, University of BC.

Key points

- Violence prevention education is only part of a violence prevention strategy
- Content specific to clinical areas and credible trainers using real stories increases learning and retention
- Relevant clinical content and a prevention focus increases confidence and awareness of risk
- Workload that allows time with patients, support from mentors and role models, and a non-blaming culture increases use of prevention skills
- A work environment that promotes physical safety, a cohesive team approach, and support during violence increases confidence to prevent and manage violence
- Acknowledgment and emotional support after violence, team debriefing, and learning from incidents decreases psychological injury
- User friendly processes and consistent non-blaming follow-up increases violence reporting

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WorkSafeBC, nine urban tertiary, community and rural emergency departments participated as research sites.

What we did

Between January and October of 2019 interviews and focus groups were held in one urban tertiary, one community, and one rural hospital emergency department in each of three regional health authorities. As a literature review indicated factors in both the education and workplace influenced program effectiveness, the 136 volunteer participants (Figure 1) were asked what they thought was most important to help individuals both learn and apply violence prevention knowledge and skills. Cycles of reviewing, analyzing, and synthesizing more than 3,000 pieces of data revealed patterns of explanations of how and why education and workplace contexts affected the PVPC effectiveness. The refined explanations were tested against the data for accuracy and against existing theories of human social behaviour and learning for whether they were plausible.

Figure 2 | Number of participants in interviews and focus groups (total=136)

58 interviews with front line emergency department workers

25 focus groups with violence prevention educators, JOHS committee members, and emergency department/acute care leaders

What we found

The aim of this evaluation is to provide evidence to inform violence prevention actions and findings need to be practical and reasonable in number. The initial 35 theories were distilled to 15 explanations indicated as most important which can be grouped into three areas (Figure 2):

1. Formal education;
2. Learning and applying in the workplace; and
3. Support, reporting and follow-up.

The evaluation confirmed three theories about violence prevention (VP) education from the literature review:

1. It needs to be supported by a larger VP strategy;
2. It needs to include applicable clinical content; and
3. It needs to be supported in practice through mentoring, debriefs, and a non-blaming culture.

Although in other contexts gender has been associated with increased risk for violence, consistent with other studies on violence against healthcare workers no pattern related to gender was found. New graduates and less experienced staff, however, were identified as more at risk for violence due to lack of experience and confidence, and more likely to fear looking incompetent.

The importance of a strong team who is "on the same page", has each other's "back" during violence, and supports each other after incidents contributes to use of the skills and decreased physical and emotional injury. Education that leverages a clinical model of discussion of real stories, practice, and refreshers

with new information increases engagement. Leaders checking in with individuals after violence and consistent follow-up to prevent future incidents decreases normalization of violence as just part of the job and decreases psychological injury.

Recommendations

The practical nature of the evaluation findings can be translated into a checklist of recommended actions (Figure 3). Each unit or site can use the checklist as a menu for determining their priority focus depending on its strengths and gaps. For example, a site or unit where mentoring for violence prevention exists may place more effort into debriefing or team response if those areas are less developed.

The research team also identified two areas of focus to guide an implementation strategy: decreasing vulnerability and decreasing normalization. Prioritizing actions that support these aims can increase use of VP knowledge and skills, demonstrate a commitment to worker safety, and help address chronic underreporting of violence to increase availability of reliable data to evaluate program effectiveness.

Figure 2 | Findings from the PVPC evaluation: explanations of how and why the education is effective

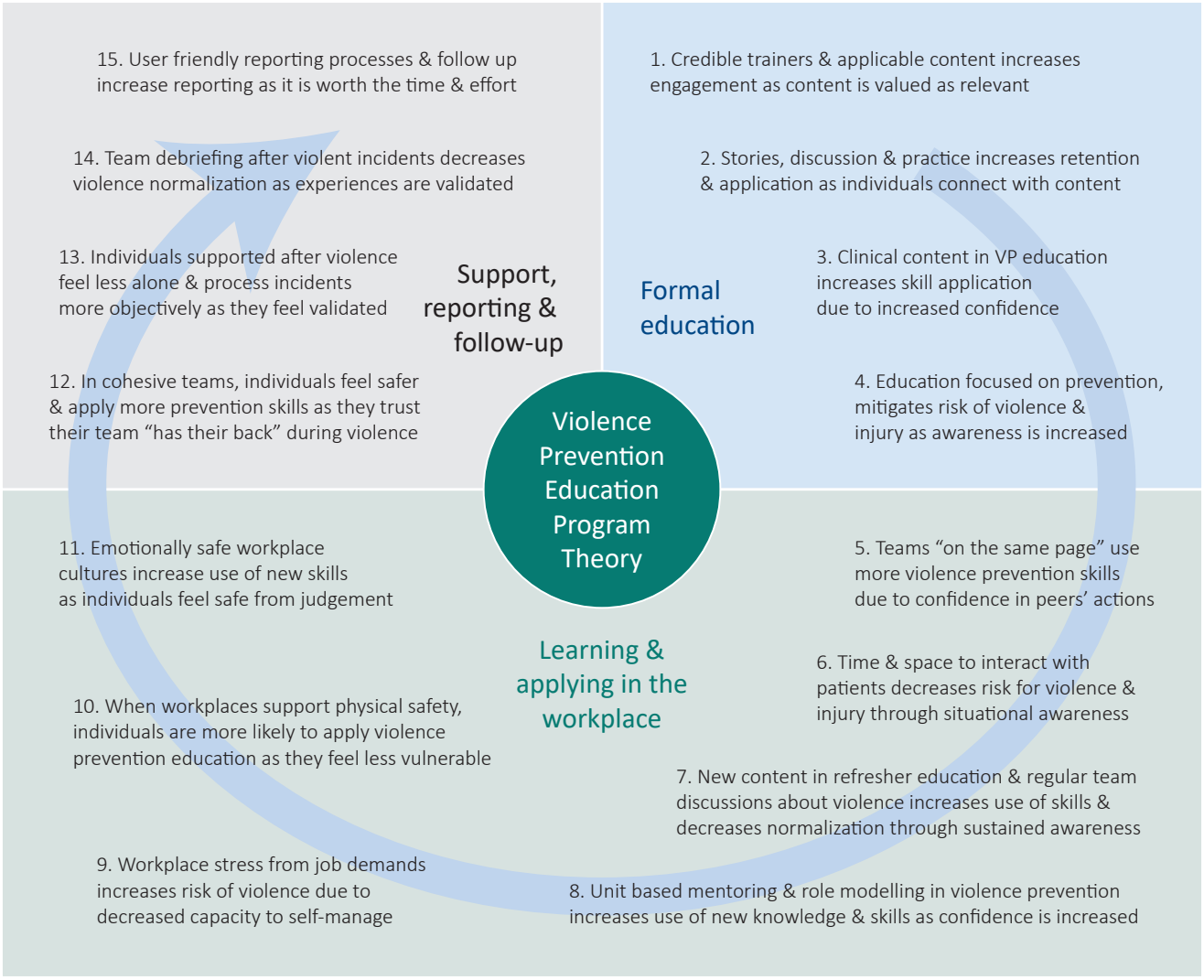

Figure 3 | Recommendations from the evaluation of the PVPC education

Formal education	1	☐ Content and examples specific to participants' clinical area, role, experience level and site/unit resources.
		☐ Trainers teach from experience and understand participants' work setting and the violence they face.
	2	☐ Interactive sessions with discussion.
		☐ Actual lived stories of incidents as examples.
		☐ Psychologically safe practice of actual previous events.
	3	☐ Clinical education specific to patient population cared for and violence experienced e.g. MHA, dementia, trauma informed care.
		☐ Appropriate to role and experience level.
	4	☐ Focus on prevention: communication, de-escalation, decision making for safety. Do not include release/defense techniques.
Learning & applying in the workplace	5	☐ Train as a team, at worksite where possible.
		☐ Practice like other codes, team discussions and incident reviews.
	6	☐ Employ strategies to address workload and decrease task focus.
		☐ Review physical spaces for privacy/quiet to de-escalate violence.
		☐ Identify contributing factors for violence through debriefing.
	7	☐ Refresher sessions like clinical in-services: interactive and includes new information.
		☐ Discuss safety as part of culture: e.g. huddles, staff meetings, incident reviews.
	8	☐ Unit/site violence prevention support: formal mentors, Violence Prevention Champions, accessible site or unit instructors.
		☐ Support for young less experienced staff and role modelling by supervisors and senior staff.
	9	☐ Non-blaming incident review to identify contribution of fatigue and stress.
		☐ Consistent support to take breaks especially post violence; review workload and overtime hours.
		☐ Preventative personal and life coaching and access to employee counselling services.
	10	☐ Explore/address what makes staff feel physically vulnerable e.g. controllable access.
		☐ Ensure safe egress, escape space, clear reliable protocols to access help (security, code white, RCMP).
	11	☐ Non-blaming role modelling and response by leaders to all events including errors, violence, critical incidents, staff injuries.
		☐ Non-blaming discussions about violence and purposeful support for new and less experienced staff for new skills.
Support & follow up	12	☐ Education/refresher training focuses on team response and support during violence.
		☐ Team approach to violence protocol and role modelling role modelling by supervisors and senior staff.
	13	☐ Education for managers/supervisors on support after violence: acknowledging without blame; emotional check-in and support.
		☐ Team inclusion in discussions and debriefs, offer employee support services.
	14	☐ Standard violence debriefing process like other codes; document debriefs and recommendations.
		☐ Focus debriefs on support, sharing , learning and prevention.
	15	☐ Accessible efficient reporting: single place, minimal time and effort required, support to complete during work hours.
		☐ Timely response, consistent communication and follow-up preventative actions to individual/team/organization.

About us

The Partnership for Work, Health and Safety (PWHS), between WorkSafeBC and the University of BC, is an innovative research unit that combines rigorous work and health research with effective knowledge translation.

PWHS brings together policy-makers, researchers and data resources from national and international organizations to address current and emerging issues of work-related health in Canada. Our research is aimed at improving understanding of the causes and consequences of injuries and illness, identifying high-risk industries and occupations, and investigating the effectiveness of interventions that improve worker health, prevent occupational illness and injury, and reduce work-related disability.

Our collaboration, based on best practices of knowledge transfer, enables researchers and decision-makers to work together to identify relevant questions, understand data, and produce useful information to effectively inform policy and practice.

More information

Please visit ***http://pwhs.ubc.ca/research/revpe/*** or contact Sharon Provost, PhD Candidate at UBC, at ***sharon.provost@ubc.ca*** with questions about the methods or findings of this study. Direct general enquiries to Suhail Marino, Partnership for Work, Health and Safety Director of Privacy and Operations, at ***suhail.marino@ubc.ca.***

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