


An Interdisciplinary Clinical Approach for Workplace Violence Prevention and Injury Reduction in the General Hospital Setting: S.A.F.E. Response

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Barbara E. Lakatos¹ , Monique T. Mitchell², Reza Askari³,
Mary Lou Etheredge⁴, Karen Hopcia⁵, Leslie DeLisle⁶,
Christine Smith⁷, Maureen Fagan⁸, Deborah Mulloy⁹,
Annie Lewis-O'Connor¹⁰, Margaret Higgins¹¹, and Andrea Shellman¹²

Abstract

BACKGROUND: Workplace violence is a major public health concern. According to the U.S. Bureau of Labor Statistics, from 2002 to 2013, incidents of serious workplace violence (those requiring days off) were four times more common in health care than in private industry. **AIMS:** An interprofessional committee developed, implemented, and evaluated a quality improvement project from 2012 to 2016 to reduce workplace violence and prevent staff injury. The initiative termed S.A.F.E. Response stands for Spot a threat, Assess the risk, Formulate a safe response, Evaluate the outcome. **METHOD:** An institutional review board–approved quality improvement survey was implemented and evaluated. The data were analyzed using descriptive statistics. An interprofessional committee developed and implemented a comprehensive program to prevent injury, which included (a) a mandatory eLearning educational training, (b) a S.A.F.E. Response with standardized interventions for the clinical conditions affecting safety, and (c) a clinical debriefing process. A reduction in nursing staff assault incidence rates was identified as a success. **RESULTS:** Nursing staff injury rates decreased an average of 40%. **CONCLUSIONS:** A reduction in nursing staff assault incidence rates was notable. Clinicians equipped with knowledge, skills, and resources can identify and defuse unsafe situations to prevent violence. This clinical approach shifts the focus from crisis intervention to crisis prevention, which reduces injury.

Keywords

workplace violence, staff injury, resiliency

Background

Workplace violence is a major public health concern (American Psychiatric Nurses Association [APNA], 2008; World Health Organization, 2014). According to the U.S. Bureau of Labor Statistic (2017), from 2002 to 2013, incidents of serious workplace violence, requiring days off, were four times more common in health care than in private industry. Workplace violence is defined as any physical assault, threatening behavior, or verbal abuse occurring in the work setting (National Institute for Occupational Safety and Health [NIOSH], 2002). Incidences of workplace violence have increased over the past decade and remain a major public health issue (APNA, 2016; Centers for Disease Control and Prevention, 2016; Occupational Safety and Health Administration, 2016; Phillips, 2016;

Wyatt, Anderson-Dreves, & Van Male, 2016) with health care workers in the private sector hospitals experiencing a 110% increase between 2005 and 2014 (U.S. Bureau of Labor Statistics, 2017). In terms of injuries, costs associated with health care staff are second only to law enforcement and are estimated to be in the billions (NIOSH, 2002; Papa & Venella, 2013).

Method

Preventing Workplace Violence

In a large urban teaching hospital in the northeast, the leadership team embarked on a process to improve employee wellness. While the approach had three prongs including a smoke-free environment, a healthy eating

program, and a safe workplace, this initiative focused on safety in the workplace. The purpose of this article is to share and discuss the quality improvement program that was developed and implemented to address workplace violence.

Interprofessional Task Force. Executive leaders (Chief Nursing Officer, Chief Medical Officer, Vice President for Human Resources) charged an interprofessional group, co-led by a psychiatric advanced practice nurse, emergency physician, and a trauma physician, to improve the safety of staff by decreasing workplace violence. Workplace violence is defined by Occupational Safety and Health Administration (2008) as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at work. The four types of workplace violence include the following: Type I, criminal intent; Type II, a customer, client, or patient; Type III, a worker on worker relationship; Type IV, personal relationships (NIOSH, 2016).

Programs are in place to address three out of the four types of workplace violence. Type I criminal events are addressed through a mandatory active shooter training video. Type III violence involving worker on worker events, including bullying, are addressed through a professionalism and peer support program (Shapiro & Galowitz, 2016). Type IV events involving employee personal relationships are addressed by the Occupational Health Service (OHS) services including manager training through Human Resources, domestic violence resources through Passageway, and employee referral to the Employee Assistance Program (EAP) when indicated. Security is available to provide assistance. A gap was identified in the organizational response to Type II workplace events involving violence from patients, their families, or visitors.

Steering Committee. A 60-member steering committee was assembled to develop, implement, and evaluate a

program to address Type II workplace violence. Our goal was to prevent workplace violence from occurring during the provision of necessary clinical care in the acute care setting. A quality improvement project previously implemented to improve the care of patients at risk for delirium, alcohol withdrawal, and suicide harm (Lakatos et al., 2015) provided the clinical foundation. Evidence-informed and team-based approach to care (Lakatos, Kenefick, Mitchell, Etheredge, & Mylott, 2012) worked well within our organization and provided the structural foundation for building a program to impact safety.

Subgroups. The steering committee met monthly, and membership split into three subgroups to facilitate the work of the committee. The groups met weekly to review current and best practice, internal policies and procedures, and evidence-based literature. They recommended the steering committee (a) develop education and training on violence management and prevention including de-escalation techniques, (b) establish a clinical response to address threats, (c) standardize interventions for the clinical conditions affecting safety, and (d) establish a debriefing process. While the purpose of the quality initiative was to decrease all staff injuries, for the purposes of this article, only nursing incidents were analyzed. The mnemonic “S.A.F.E.” was chosen to reinforce the active process needed to prevent violence. S.A.F.E stands for Spot a threat, Assess the risk, Formulate a plan, and Evaluate the outcome. Using “S.A.F.E.” language aligned with the wellness and prevention focus of the organization. The final recommendations by all subgroups were accepted by the executive sponsors and vetted through various hospital committees.

Data. De-identified data from occupational health, security, and employee safety reporting systems were reviewed. Violent patient incidents involving nursing staff from the occupational health data were analyzed, and 90% of all injuries were sustained while providing

¹Barbara E. Lakatos, DNP, PMHCNS-BC, APRN, Brigham and Women’s Hospital, Boston, MA, USA

²Monique T. Mitchell, MS, PMHCNS-BC, APRN, Brigham and Women’s Hospital, Boston, MA, USA

³Reza Askari, MD, Brigham and Women’s Hospital, Boston, MA, USA

⁴Mary Lou Etheredge, MS, PMHCNS-BC, APRN, Brigham and Women’s Hospital, Boston, MA, USA

⁵Karen Hopcia, ScD, CNP, ANP-BC, COHN-S, FAAOHN, Brigham and Women’s Hospital, Boston, MA, USA

⁶Leslie DeLisle, MS, PMHCNS-BC, APRN, Brigham and Women’s Hospital, Boston, MA, USA

⁷Christine Smith, RN, MSN, Brigham and Women’s Hospital, Boston, MA, USA

⁸Maureen Fagan, DNP, FNP-BC, FAAN, Brigham and Women’s Hospital, Boston, MA, USA

⁹Deborah Mulloy, PhD, RN, CNOR, Brigham and Women’s Hospital, Boston, MA, USA

¹⁰Annie Lewis-O’Connor, NP-BC, MPH, PhD, Brigham and Women’s Hospital, Boston, MA, USA

¹¹Margaret Higgins, MSN, RN, Brigham and Women’s Hospital, Boston, MA, USA

¹²Andrea Shellman, MHSA, CPPS, Brigham and Women’s Hospital, Boston, MA, USA

Corresponding Author:

Barbara E. Lakatos, Brigham and Women’s Hospital, 75 Francis Street, Nursing Office Tower I, Boston, MA 02115, USA.
Email: blakatos@bwh.harvard.edu

Table 1. Occupational Safety Reports ($n = 40$) Filed by Nurses From January to September 2014.

Injury total	Body part	Example of employee narrative
7	Arm	Agitated patient bit and scratched right lower arm.
6	Back	The patient became agitated and combative; grabbed me by both wrists and pushed me up against the wall of the room. Low to mid back strain right and left side.
5	Shoulder	Patient dumped pitcher of water onto floor, I leaned over between bed and tray table and patient kicked me in the left shoulder, neck, and abdomen.
4	Finger	I was trying to re-tape and secure patients NGT and the patient bit me.
3	Abdominal	Kicked in right lower quadrant abdomen/pelvis by agitated combative patient.
3	Hand	Patient grabbed my left hand and pulled it to get out of bed.
3	Neck	Patient was violent upon waking up and thrashing. We needed to hold patient down. She hit and pushed me. Sore neck and back.
3	Wrist	Patient was combative trying to get out of bed pulling on NGT/IV and Foley, pushing RN away while grabbing my left wrist.
2	Head	Patient became verbally abusive and combative. Slapped my arm and hit my head with table.
1	Chest	Several staff were restraining a seizing patient while I attempted to give IM injection; patient kicked his left leg striking me in the ribs on the right with his knee.
1	Eye	While pulling patient with draw sheet to patient's bed. Patient grabbed my face with her left hand, one finger poked my left eye.
1	Face	Patient was agitated when entered the room and spit in face.

Note. The incidents are listed in descending order from the most frequent body part (arm) injured, to the least frequent body part (chest and eye) injured.

care to patients. Additionally, most injuries received during the assault were defensive in nature and include upper body parts. The employee narratives provided at the time of injury suggest patients were cognitively impaired. Examples of these narratives are provided in Table 1.

Provider Survey. Clinicians were engaged to better understand the issues they were facing with workplace violence. To begin improvement efforts, a survey using questions from the Attitudes toward Aggression Scale created by Deans (2001, 2004) was developed to assess staff attitudes for managing aggression. Nine experts with knowledge of workplace violence from within the system assisted in development of the survey to improve content validity and reliability. The survey was approved by the institutional review board as one component of a quality improvement initiative (Goodman et al., 2016).

Inpatient clinicians were invited by email to voluntarily and anonymously participate (Harris et al., 2009) in the survey. Completion of the survey served as consent to participate in the study. A total of 1,866 employees responded, of which 46% were female and 50% male (4% did not answer). Sixty-one percent identified their role (42% nurse, 7% physician, 2% social work, 10% other), whereas 39% did not identify their role. Survey respondents answered positively when asked if they were interested in participating in a quality improvement initiative designed to reduce incidents of workplace violence. Improvement efforts were prioritized for attitudes that less than $\leq 70\%$ of survey respondents endorsed.

These involved (a) understanding of communication and its effect on aggressive behavior including de-escalation techniques and (b) the adequacy of peer and management support following an unsafe event.

eLearning Course. Staff survey results revealed only 66% of staff agreed that the way they communicate can contribute to aggressive behavior. De-escalation techniques (American Organization of Nurse Executives, 2014; Bowers, 2014; Hardin, 2012; Horn & Dubin, 2013; Nordstrom et al., 2012) focus on communication as one of the most impactful ways to diffuse a potentially dangerous situation, and the results of the survey identified that our staff did not feel competent in this area. We collaborated with the Crisis Prevention Institute (2016; Place, 2014) to develop an e-learning program combining de-escalation training along with our clinical best practice for patients with delirium, alcohol withdrawal, or suicide/harm called DASH (Lakatos et al., 2015). The clinical assessment tools used with DASH were embedded in the training and provided the clinical foundation for the S.A.F.E. The Cognitive Assessment Method for the Intensive Care Unit (CAM-ICU; Ely et al., 2001) was modified (with author permission; Ely et al., 2001; Lakatos et al., 2015) and is used to assess all patients for delirium every 8 hours. The Alcohol Use Disorders Identification Test (AUDIT-C), developed by the World Health Organization (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001), is used to assess all patients admitted to the hospital for risk of alcohol withdrawal. The Richard Agitation-Sedation Scale

(Sessler et al., 2002) is a 10-point scale used to assess the level of agitation-sedation in patients each shift.

The interactive online education de-escalation training presents modules on communication, clinical assessment, intervention, and de-escalation of a threat. Clinicians view common clinical scenarios in which there is a risk for workplace violence. The patient's journey from point of entry to the hospital (admitting or emergency department) through admission to the unit (cardiac, trauma medical, surgical, or labor and delivery) to discharge is acted out by clinicians at the hospital. The scenarios include (a) a young woman with domestic violence whose husband threatens staff, (b) an older woman with delirium and combative behavior who poses a threat while staff are providing care, and (c) a young man who is angry, agitated, and threatening in the setting of acute pain and an opiate misuse disorder. More resources are available to review electronically and/or to print (S.A.F.E. policy, leadership guide following a traumatic event, and outline of roles and responsibilities). To evaluate the learning processes, there are interactive questions the learner must answer to advance to the next module. Learners could pause and resume the eLearning at any time and complete the entire training in an average of 1 hour. The e-learning was assigned to all inpatient clinicians, achieving a 94% completion rate within 3 months (September 2014 to December 2014).

SAFE Response. A S.A.F.E. Response was developed to allow for rapid recognition of evolving safety threats to prevent them from evolving into crisis. The S.A.F.E. Response was modeled after an established process already in place, the rapid response (Stolldorf & Jones, 2015). A nurse initiates a rapid response (Maharaj, Raffaele, & Wendon, 2015; Stolldorf, Havens, & Jones, 2016) when a patient's medical status requires immediate attention. Clinicians are paged to the bedside to assess the patient and implement a plan to address the etiologies and prevent further decline in medical status. Similarly, a S.A.F.E. Response is a clinical response designed so staff can call for assistance when a threat is spotted, in order to reduce the possibility of violence.

S.A.F.E. Response activation occurs when any member of the interprofessional team *Spots* a potential or actual threat involving a patient or a patient's visitor. A call to the stat line to request a S.A.F.E. Response triggers the emergency paging system. The patient's provider (MD/PA/NP), nursing leadership, and security are notified to arrive at the patient's bedside to collaboratively *Assess* the patient or visitor situation with the clinical nurse. Additional consults may be paged to respond to the S.A.F.E. Response depending on the situation (e.g., chaplaincy, geriatrics, pain and palliative care, patient family relations, psychiatry/addictions, psychiatric nursing

resource service, social work, rehabilitation services). The response shifts the focus from security responding in isolation to a threat, to a team clinical response to identify an etiology and put a plan in place to address the threat. The clinical response includes an Assessment of risk that is guided by patient's history and current assessment of mental status, including evaluation of delirium using CAM-ICU-Modified (Ely et al., 2001; Lakatos et al., 2015). The team responding to a S.A.F.E. Response call determines if a patient has a diagnosis causing the change in affect, behavior, and/or cognition such as delirium, primary psychiatric disorder, dementia or traumatic brain injury, or maladaptive coping (Supplementary Attachment 1; available in the online version of the article). Once an etiology has been identified, they *Formulate* a plan. Each diagnosis has a related plan of care with interventions for treatment and management to improve safety. The S.A.F.E. Response is completed with an *Evaluation*, which includes a postincident clinical debriefing to promote staff resiliency (Thompson & Dobbins, 2018; Wax, Pinette, & Cartin, 2016). The team documents the S.A.F.E. Response (Supplementary Attachment 1) using the Situation, Background, Assessment, Recommendation (SBAR) process (Martin & Czurzynski, 2015; Stewart & Hand, 2017). The clinical debrief provides an opportunity to offer support following a threat to decrease anxiety, fear, and agitation.

S.A.F.E. Response interventions. The interventions during a S.A.F.E. Response are brief and focused on defusing the potential crisis (much like the rapid response is to prevent a respiratory or cardiac arrest). The evidence-based approaches and interventions were designed to improve safety when caring for each high-risk group (APNA, 2016; Capezuti et al., 2012; Ely, 2017; Girard, 2007; Rabinowitz & Levin, 2014; Rossi, Swan, & Isaacs, 2010; Simpson, Joesch, West, & Pasic, 2014). Clinicians ensure that the plans of care are activated in the electronic record for each of the etiologies identified during the S.A.F.E. Response. Additional resources available on the intranet include care tips and an online Libguide library resource for many populations of patients (alcohol withdrawal, challenging care situations, cognitively impaired patients, traumatic brain injury, delirium, opiate use disorders, psychosis, and suicidal patients).

The team meets to gather information about what has occurred and to clarify the threat that was identified. A plan is put in place using least restrictive measures (Joint Commission, 2010) to maintain safety. The environment of care is made safe using policies to guide practice such as belonging search to remove potential weapons, room search to remove extra equipment, and potentially unsafe objects (sharps box, ceiling lift, removable chairs/tables). Communication is streamlined to ensure everyone is

informed of any safety threats and clear boundaries are identified and known by staff. When clinically appropriate, a select group of S.A.F.E. Response members meet with patients and/or families to review the identified threat, interventions, and clarify expected behaviors to ensure safety for all.

Clinical debrief. The S.A.F.E. Response ends with a clinical debrief, facilitated by nursing leadership (Lakatos, Delisle, Mitchell, & Etheredge, 2014; Wax et al., 2016) to promote staff resiliency and address any lingering questions. The clinical debrief includes a review and update of the clinical facts of what occurred to ensure everyone is on the same page, an evaluation of the outcome of the S.A.F.E. Response to ensure resolution of the threat, a review of any patterns or triggers to the threat to prevent future occurrences, an identification of lessons learned, and an adjustment to the plan of care as necessary. The debrief concludes with a brief check-in to ensure everyone feels safe and in control and has the resources. Nursing leadership asks everyone involved in the S.A.F.E. Response how they are feeling. The goal is to ensure everyone is feeling back in control with a plan in place to manage their own emotional responses and to deploy resources they needed to manage. Some examples include calling a resource nurse to reduce the workload of an affected nurse for the remainder of the shift, arranging for EAP to provide self-care tips during change of shift, and deploying a security guard to provide frequent rounds on the unit.

In some situations, the S.A.F.E. Response and/or the violence triggers emotional responses from staff members that make it challenging for them to resume work. Individual are encouraged to follow-up with the EAP. Sometimes there are occasions when a larger and more formal debriefing is arranged. The larger formal debrief occurs 1 to 2 weeks following the event and is led by the EAP. Nursing leadership offers additional supports for staff, such as Reiki, which is provided by hospital volunteers; Tea for the Soul, which is provided by the hospital Spiritual Care department; and soothing music offered by the volunteer harpist. There are also several units with rooms devoted solely to staff healing and meditation where staff can spend time before, during, or after a shift to rejuvenate.

Implementation of S.A.F.E. Response, January 2015

In January 2015, the inpatient S.A.F.E. Response was implemented throughout the inpatient areas. The executive sponsors recommended an accelerated implementation to ensure completion well before a planned conversion to an electronic medical record in May 2015.

The S.A.F.E. Response launch date was communicated through a series of email blasts, intranet postings, internal publications, and videos. Leaders from each department and members of the steering committee facilitated implementation (Blando, Ridenour, Hartley, & Casteel, 2015). Train the trainer in servicing, informational posters, and mock demonstrations were provided. Expert guidance was provided by the psychiatric nurse resource service as needed.

S.A.F.E. Response Activation

We tracked the incidence of assaults (U.S. Bureau of Labor Statistics, 2013) on nursing staff to examine whether there was reduction in the year and a half since the S.A.F.E. Response project was initiated. A S.A.F.E. Response was activated on average three times per month ($N = 54$). The majority was initiated during the day shift (80%), followed by 16% on the evening shift and 4% on the night shift. Delirium was the most frequent clinical reason for initiating a S.A.F.E. Response (56%), followed by maladaptive coping by patient or visitor (24%), primary psychiatric illness (16%), and dementia or traumatic brain injury (4%).

The S.A.F.E. Response provided a framework for clinical teams to come together, complete assessments, diagnosis underlying etiologies, identify safety concerns, and develop plans of care to mitigate safety issues while delivering care. One unexpected outcome of the S.A.F.E. Response was an increase in safety discussions during daily huddles. We see this as a positive culture shift from a formal activation toward a more organic prevention model.

Prior to the S.A.F.E. Response, clinicians had not always understood and/or appreciated the treatable etiologies underlying the safety issues they encountered. When a behavioral threat occurred, the clinician would call security for help. Typically, security would be the first to come into the room to contain the threat, and staff would enter once the threat was contained. This could happen several times and did not involve a formal clinical evaluation for the acute change. Following implementation of the S.A.F.E. Response, clinicians spotted a threat as an opportunity to call for help, assess for etiologies, and implement a comprehensive treatment plan to prevent a crisis. This approach required modification in nurse and physician routines. For example, when a medical rapid response is activated, responding clinicians rush into the patient's room to provide emergency care. In a S.A.F.E. Response the opposite is expected, instead of rushing into the patient's room, they meet as a team to assess and devise an approach to diffuse the situation. This simple modification in approach has great impact on making the environment less threatening. It

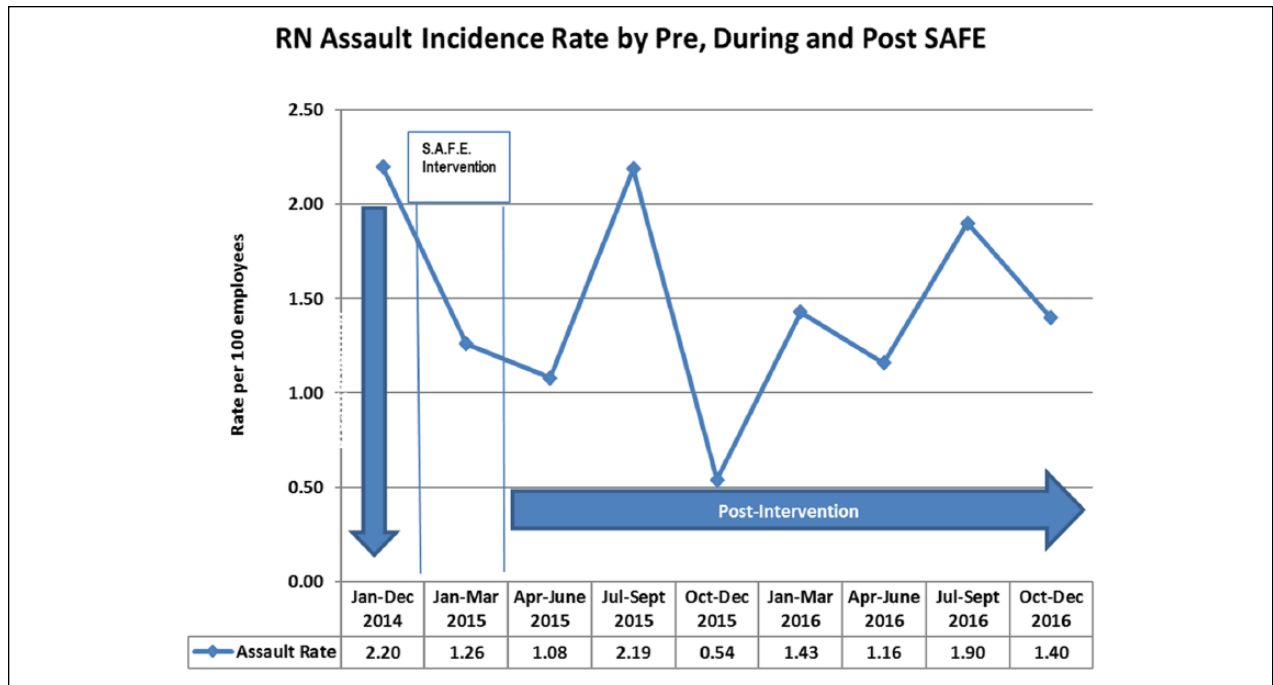


Figure 1. RN assault incidence rate by pre, during, and post S.A.F.E.

is, however, a different approach for medically focused clinicians who are used to responding to medical emergencies. Formulating a plan that is part of a S.A.F.E. Response often requires the team to adjust their work flow. These modifications may include moving team discussions away from the bedside, providing a verbal cue before touching the patient, and modifying their approach when providing care (physical exams, administration of medication, personal care) to provide patient more personal space.

Implementation Challenge

There were two unexpected Type I (criminal intent) safety events that occurred during the period S.A.F.E. Response was being developed. The first event was a terrorist bombing attack (Vitello-Cicciu & Quin, 2013) followed by an active shooter event (Goralnick & Walls, 2015; Rosenbaum, 2015). These two criminal events affected everyone, resulting in acute stress reactions and heightened safety awareness. These events facilitated the speed and focus of the S.A.F.E. Response and increased staff engagement. Of note, the quality improvement survey that served as a baseline of clinicians' attitudes and competence was completed 1 week prior to the first event. These Type I acute criminal events made it extremely difficult to focus on prevention. Our challenge was to move the organization through the crises and focus again on prevention.

Results and Outcomes

Staff Assault Incidence Rates

A reduction in nursing staff assault incidence rates (IR) was identified as the measure of success. The number of assaults was converted to a rate so that the assaults could be compared over time regardless of a change in the number of staff at the institution. An IR is the number of new incidents over a specific period of time. The IR is calculated using the equation number of assaults divided by employee full-time equivalents times 100 (U.S. Bureau of Labor Statistics, 2013). Full-time equivalents are calculated as hours worked (rather than number of employees) in order to standardize full- and part-time employees. Overall, the Occupational Health data revealed a 40% decrease in nurse injuries related to patient assaults between the preintervention and postintervention periods with some variability within quarters (Figure 1).

As expected, security responses increased (20% per year) as they responded to each S.A.F.E. response.

Limitations of the Data

A variety of influences can affect reporting and the accurateness of nursing assault IRs. The period for data collection was based on the organizational time frame provided by the executive sponsors for completion. The postimplementation period was measured in 3-month increments. Heightened awareness after implementation

of an intervention can lead to an increase in event reporting. However, the 40% decrease in nursing injury rates occurred despite heightened awareness of S.A.F.E. events and the potential for a spike in reporting in the months following S.A.F.E. Response implementation. It is difficult to compare the assault data to regional or national benchmarks because the definition of assault and reporting mechanism differ from study to study. The rate of assault incidents at this institution was about half the IR rate of local comparable institutions (one academic medical center and three local community hospitals). The IR at this institution was approximately half the rate of local comparable institutions within network (Partners Health System, 2016).

The smaller the increment, the more variable the data appear based on the randomness of reporting injuries. Two reported incidents involved several nurses reporting injury at the same time. The first incident involved a patient who was agitated and entered an elevator to leave against medical advice. Several registered nurses tried to stop the patient from leaving resulting in multiple staff being injured. The second incident involved a patient attempting to get out of bed who was delirious, agitated, and a fall risk. Several registered nurses were injured trying to stop the patient from pulling out an intravenous line and ambulating to the bathroom.

A review of the data collection process for adverse events involving patients and employees revealed separate and distinct databases for each department collecting data including Occupational Health, Security, and Quality and Safety. While each database functioned for the department it was designed, a comprehensive review of the workplace injury could not be constructed due to a lack of a common data element connecting the individual database reports. Our ability to compare and cross reference information was limited to analysis of aggregate data and description of themes.

Conclusion

The S.A.F.E. Response was instituted for inpatients beginning in January 2015 as part of the organizational initiative to improve safety and decrease nursing staff injury rates. Executive sponsorship and support was critical to the success of the organizational change and interprofessional participation created a culture where safety and a healthier work environment was everyone's responsibility. The S.A.F.E. Response directly affects patient, visitor, and staff safety through early identification of threats and underlying clinical conditions and implementation of specific interventions tailored to address the etiologies. When an actual or potential threat to safety is spotted, a S.A.F.E. Response is initiated, resulting in an interprofessional team responding to the patient's bedside

to assess risk, formulate a clinical response, and evaluate the outcome. Close interprofessional collaboration in developing and implementing a S.A.F.E. Response resulted in a 40% reduction of nursing injury rates.

Because of this quality improvement initiative, S.A.F.E. Response elements were approved for inclusion in a future version of the electronic medical record. This is expected to improve the completeness, accuracy, and consistency of documentation and break down the silos that exist between the clinical, safety, and security reporting systems. Understanding the connection between the clinical etiologies and staff injuries will provide more robust opportunities to develop preventive models of care. In 2018, we are implementing a S.A.F.E. program for our ambulatory settings to address workplace violence in the outpatient setting.

We must prepare the work force with the skills and knowledge to assess and treat patients' affective, cognitive, and behavioral impairments that coexist with the medical/surgical conditions that bring them into the general hospital. The S.A.F.E. Response ensures staff receive education and training to identify potential threats and intervene early to mitigate their risk for injury. National efforts to standardize assessments and clinical interventions to treat evolving clinical conditions that affect patient and staff safety are critical. Research efforts in identifying patient presentations, clinical interventions, specific education, and approaches to care to prevent staff injury are important in advancing safety and reducing overall national nursing injury rates.

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Author Roles

All authors were involved in the research and writing of the article.

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ORCID iD

Barbara E. Lakatos  <https://orcid.org/0000-0002-5833-7234>

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