Past Event: 2023 NCSBN Symposium: Solutions Addressing Nursing Workforce Crisis - Workplace Safety Panel Video Transcript

Event
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Presenters
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Kristin Benton, Executive Director, Texas Board of Nursing Bogdan Catalin, Workplace Violence Coordinator, OSHA
Representative Joe Courtney, Connecticut 2nd District
Gary Lescallett, Assistant Regional Administrator for Enforcement, OSHA
Kathleen Poindexter, PhD, RN, CNE, ANEF, Interim Associate Dean of Academic Affairs Nursing, Michigan State University, College of Nursing
Tim Tull, Vice President, System Chief Safety, Security, and Emergency Preparedness, Rochester Regional Health

- [Maryann] Welcome back, everyone. We are now going to embark upon another serious conversation, violence in the workplace. I'd like to begin by having our panelists introduce themselves.

Tim.

- [Timothy] Yeah, my name is Timothy Tull. I'm the Vice President of Safety and Security at Rochester Regional Health System in New York.

- [Kathleen] I'm Kathleen Poindexter. I'm currently Interim Associate Dean for Academic Affairs at Michigan State University, College of Nursing, and Immediate Past Chair of the National League for Nursing.

- [Gary] Good morning. I'm Gary Lescallett. I'm the Deputy Regional Administrator for OSHA here in Chicago, Illinois.

- [Bogdan] Good morning. My name is Bogdan Catalin. I'm the Enforcement Programs Coordinator here in OSHA Region 5, Chicago.

- [Kristin] Good morning. My name Kristin Benton. I'm the Executive Director with the Texas Board of Nursing. We regulate over 500,000 licensed vocational nurses, registered nurses, and advanced practice nurses. And we also regulate over 200 pre-licensure nursing education programs.

- Thank you all. Before we begin, I'd like to introduce a video that was sent to us by Congressman Joe Courtney of Connecticut. He wanted to be here today, but unfortunately, his schedule conflicted, and he sent us a short message.

- [Cong. Courtney] This is Congressman Joe Courtney. I wish I could be with you in person. The issue of workplace violence is something which, as a member of the Education and Labor Committee, myself and others have been working on for a number of years. We asked, again, I think it's about eight years ago, to have a Government Accountability Office to do a study, to try and really get a clear picture of what the rates and frequency of workplace violence that's happening in this profession.

And the GAO report, which took a number of years, they're really the gold standard in terms of research, in terms of different agencies here on Capitol Hill, presented a very strong and somewhat disconcerting but clear picture about the fact that compared to other sectors of the U.S. economy, the frequency of workplace violence far exceeds, again, any other profession or occupation.

And I think many of you know the sort of depressing statistics that it's five times more frequent in the health care sector than it is in any other sectors in the economy. A totally unacceptable level of violence. There's a lot of reasons that's driving that, which many of you are familiar with in terms of behavioral health issues, the opioid crisis.

It verified the fact that we really have a situation that has to be addressed with the public policy response. And prevention is clearly the best approach in terms of avoidance of risk and avoidance of injury. And from that GAO report, we crafted legislation, the Workplace Violence Prevention for Health Care Workers and Social Workers, legislation which has been introduced and reintroduced over the last number of Congresses.

The good news is there's a huge coalition out there of folks from different parts of the health care setting that have banded together in terms of pushing this legislation forward. Another encouraging sign is that it's bipartisan and bicameral. We have had actually a number of votes in the House when Democrats were in control, which had a very respectable bipartisan tally in terms of getting the bill off the floor of the House, and up to the Senate.

And that continues today. We have introduced a bill for the 118th Congress. Again, it uses tried and true practices in terms of reducing risk in the health care setting. And we know, again, from anecdotal evidence that using smart, intelligent measures to make sure that people are not alone with high risk patients, that there's training, real training in terms of what to do, since most folks in the nursing profession are really not equipped to sort of respond to acts of violence.

And there's also good data collection in terms of really trying to find out where the hotspots are. But I believe that our bill is the swiftest way to really get a regulatory framework that is not onerous to health care providers. We've run the numbers.

This is really just a fraction of the overhead and administrative costs of health care in terms of getting these measures put into place. And we need all the help that we can get. So to the extent that the State Council and the National Council of State Boards wants to embrace this effort, we really welcome it.

I'll just end by saying that, unfortunately, two weeks ago in my congressional district in Eastern Connecticut, a home health nurse lost her life in a home visit for someone who was on a sex offender list. She was alone at the time that she entered the dwelling. And unfortunately, it's an example of where different kinds of practices where she was not going to be alone with a high-risk patient that had been clearly identified, really could have literally meant the difference between life and death.

And it just is a reminder, like so many of these incidents, is that we can't sort of let this issue just slide by. We've really got to focus together as like-minded people to get this measure passed. And I hope this panel and this National Council meeting will really give us additional strength in terms of accomplishing this end goal.

So thank you for listening. If you or other folks have follow-up questions, please feel free to reach out to my office. Thank you for listening. And again, I hope you have a great panel discussion.

- Well, Congressman Courtney, we're certainly grateful to you for championing this very important issue. And now I'm going to turn to our panel. Gary, Bogdan, I'm going to read you some statistics. The U.S.

Bureau of Labor Statistics found that health care workers account for 73% of all nonfatal workplace injuries and illnesses due to violence. Registered nurses suffer a disproportionate share of this violence, with violent events accounting for 12% of all injuries to RNs, approximately 3 times greater than the rate of violent offense for all occupations.

Estimates suggest workplace violence causes 17% of nurses to leave their job every year. This is a significant problem. What types of violence are we seeing?

- I can share with you that just this week, Bogdan and I were on a call with our Workplace Violence coordinators from across the country. And at any one given time, we probably have...I will say maybe four to eight workplace violence incidents being actively investigated in each of our regions.

Probably the most common incidents that we see, biting, punching, scratching are not uncommon, but those go clear up to sexual assaults. Some very, very unfortunate situations with what we'll call the forgotten shift. The second shift and third shifts in the institutions.

I don't know if there are any other examples, Bogdan, that you'd like to share.

- Certainly. We see a lot of patient-on-staff violence as well as visitor-on-staff violence. That's not uncommon. And certainly we see trends in the overnight shifts and weekends when, unfortunately, there is a staff shortage.

- Kristin, is this a regulatory issue?

- Absolutely. We know that workplace violence creates an unsafe environment for practice, and can lead to errors in patient care.

- So it's really a serious problem that I think a lot of people outside the health care industry are not really aware of. So let me ask you, what is being done to prevent this? Tim, you come from a hospital setting. Tell us about the prevalence, if you experience it there, and what you're doing to prevent it.

- Yeah, if it's okay before I do, I want to touch on something that the congressman had mentioned.

- Absolutely.

- It's a complicated environment that we're dealing with. This isn't just in brick and mortar. On a daily basis, we send out about 450 nurses to home health and hospice, meaning they're out in somebody else's home. It's an uncontrolled environment for me. So in the hospital, I can add some infrastructure to make things a little safer, and we can have a sense of teamwork and support for each other.

But when you're in a home by yourself, it's a different environment. And so for us, because of that, part of our emphasis is empowering our staff. And we're doing that through a lot of training. So we're offering a de-escalation course. We're offering situational awareness, how to be aware of your environment, and understand the cues maybe that there's a violent issue potentially.

And on top of the... And we try to do that in a very practical way. The de-escalation class that we offer for all staff comes from actually my law enforcement background. I taught a tactical communication class at the police academy. We've kind of morphed that and made it practical for health care.

And then we offer a reality-based training that accompanies that de-escalation, meaning I would teach all of you, we'll talk about conceptually what de-escalation looks like, and how to do that successfully, and when to recognize that maybe it's not going to work and you need to disengage and get help. And then at the conclusion of that conversation, we send you down the hall with some role players, and we actually have you go through that process so that it's ingrained.

People learn in different ways. We want to make sure that we touch everybody as best we can.

- How long does it take to learn that?

- Oh, my goodness, I'm still working on it. It's a lifetime. I'm always trying to improve and do a little better, right? But the course we offer is a half-day course to get people, at least initially, up to speed and understand. And then there's levels from there that they can actually come and attack.

- Do nurses volunteer to come, or is it a requirement?

- That's a great question. They volunteer mostly, but we really emphasize hard for our home health staff, in particular our ED staff, we're encouraging all of them to come very strongly. Labor and delivery seems like sometimes there's some issues up there. So the hotspots that we see where we have a lot of violence, it's still voluntary, but there's an emphasis placed on it.

- Have you seen any reduction or fewer incidences because nurses are taking that course?

- I think we are. We're seeing some successful de-escalation. And part of the de-escalation process is actually teamwork. One has to recognize the de-escalation class isn't just how to calm somebody down. It's not that. It's how to recognize when there's potential violence coming.

It's how to address that violence. It's also dealing with your own biases and triggers to make sure you're not actually unintentionally escalating a problem. But it's also understanding if I'm...you and I are coworkers, and I'm hearing the language that you're using, there's triggers that are going to let me know, "Oh, you need help." Right?

And I'm going to stop what I'm doing and I'm going to help. So we have a big emphasis on teamwork as well.

- Okay. One final question.

- Please.

- Should a nurse be going into a home situation by herself or himself?

- It's such a great question. And that's a difficult thing that we wrestle with because there's...the solution is hard. We have a program right now where, one, we want them to listen to their intuition. So if you pull up to a home, and you're going to go in to see a patient, and for whatever reason you're not comfortable.

The environment's not right. It feels tense. There's other people there that you didn't expect. Whatever the thing is, we want you to listen to your intuition, we want you to call your supervisor, let them know the situation. And then we have the ability to send two people out. So an extra RN might go with you. And we also, for some of the more high-crime areas and some of the homes that we've had repeat issues, we have the ability to send security out with you actually.

But it's difficult. It's not easy. There's logistical problems. When you call and tell me, "I'm at a house and I'm not comfortable." Now I have to get somebody to you. I've got a 20-minute, half-hour delay before that person arrives where you're just waiting in the car. And meanwhile, the day has backed up.

So there's the practical application we still wrestle with. It's a little difficult. But it's an area that we are still pursuing.

- Kathleen, I'm sure your school has a community rotation where students have to go into people's homes. Do you do anything to prepare them for that?

- And again, that's a wonderful question. And we were actually discussing this prior to our meeting here. And it is a challenge. And for nursing students, we know that they're even in more of a vulnerable position. Less than 19% of violence issues are reported. And students probably report even less, and they're put in truly a power over position.

And we know that health care is moving into the communities. We're seeing more hospitals at home, and there's a lot of pressure to prepare the future workforce for that type of a workplace environment. And it is a concern, is how can we keep them safe? Talking with some of our health care partners, they have tracking systems in place where there's emergency response buttons that they can call that they're piloting at this time.

Perhaps looking at that same type of tracking system with their students. But I think most important, it's giving our students the tools to, one, recognize and the security to say...that psychological safety, to say, "It's okay to say you're not comfortable, you don't feel safe." And that we will listen and we'll respond to that concern, and provide the tools.

We know de-escalation does have some positive impact. Prevention has more. But it's really a systems organization issue, and it shouldn't be put on the individual who is essentially the victim of the violence.

And as mentioned earlier, nurses, students are under severe stress. And we know that stress, and anxiety, and potential depression also escalates it. Patients are under that same type of adverse situation. And you put those two situations together. It's a bigger systems issue that does take policy, it does take organizations, and it takes the individual as well.

- Absolutely. So I want to pick up on that word, prevention. Kristin, I know you're on a workgroup in Texas that addresses this issue. You address things about prevention and talk about... Tell us about that.

- Sure. So several legislative sessions back there was a bill passed that required our Texas Center for Nursing Workforce Studies to conduct a study on workplace violence, both from the nurse perspective and the employer perspective. And not surprisingly, the results demonstrated that this is a significant safety issue and a significant issue that can affect patient care.

So following that session, another bill was passed that now prevents a prevention grant program. And that grant program is funded through a portion of each nurse's licensure renewal fee every two years. And we're entering into the fourth cycle of that program.

It's not a huge program, but it does provide funding for facilities who may not have the resources to buy panic buttons for their staff, to put security lighting in the parking lot where they've had a violent event, embed assessment tools into the electronic health care record to identify patients who have a history of aggression toward health care workers.

So while they're not full fledged research studies, we are beginning to see some outcomes and beginning to see some differences. And each cycle of the grant program, we have all of the grantees provide a webinar to share their outcomes.

And of course, there's a...you have to have a legislative report to document the details of each project, and how it went, and what the outcomes were. And those are all available to the public on the Workforce Center's website.

- How did that group get started?

- So that group got started... The Workforce Center?

- No, no.

- The grant?

- Yes.

- So the grant program was really the result of collaborative work with the Workforce Center, the Board of Nursing, and our Nurses Association, the Texas Nurses Association. They've been looking at this issue for well over a decade, and working really hard to make some policy changes. This past session, another policy change that took place, unfortunately, on the heels of a tragic incident in Dallas where a nurse and a social worker were both killed on a labor and delivery unit by a felon on parole who cut off his ankle bracelet and entered the facility.

We now can join the other states that expand the criminal penalty from a misdemeanor to a felony in any department within a health care facility.

- So that is really something that all states could do. The Board of Nursing could join forces with the professional organizations, the workforce center, and really put a program like that into place.

- Yes, we're very proud that we're able to find such a program that has such promise to protect patients and, of course, protect health care workers.

- So I'm going to turn now to Gary, you and Bogdan. What else can be done to prevent these incidents from happening in health care?

- Well, let's just say that we can all agree that no health care employer wants to see their staff victimized or assaulted. Right? But from a regulatory perspective, I think the solution goes beyond making available mental health and stress resources, or de-escalation training, or physical restraint training.

From the investigations that we've conducted in Region 5 and nationwide, we can tell you that there are a number of deficiencies that we commonly encounter, usually with the implementation and execution of existing workplace violence prevention programs. And a lot of that focus is on the incident investigation and after action.

Allow me to offer some examples here. In terms of incident investigation, we find that incidents of workplace violence are either not investigated, or perhaps input is not solicited from all the involved parties. Management, frontline health care workers, security, hospital security, if that was summoned.

We find that incidents are not tracked, and logged, and analyzed for trends and patterns. And certainly, we find that sometimes the health care systems, the hospitals do not follow up on their own findings by allocating resources, usually in the form of additional staffing.

And again, I'm providing a general overview of areas where more can be done.

- Absolutely. Gary, do you have anything to add?

- I think one of the biggest challenges... I'd heard a panelist earlier talk about being a hero. And there are very few industries where you're trying to help someone, and while you're trying to help them, they may be coming at you for one reason or another.

The techniques to seek help, when Tim was talking about it, some facilities, the procedure is to call 911. Other procedures, it's in-house security. We've had cases where the nurses have been discouraged from reaching out to 911, and having the public perception of the police officers at their facility over and over and over again.

And so talking through those issues, and trying to come up with an internal plan can sometimes help alleviate that fear of reporting. I guess I would share that.

- Well, thank you. Kathleen...

- I am just... Go ahead.

- Is there anything that you're doing to prepare students for entering the workplace that might help prepare them for this?

- I was just going to say, and build on what he said, one is the critical importance of allowing the students who will be the future health care providers the ability to say when they feel that psychological unsafety. That they know that they can go someplace, and that they'll be heard and that they will be supported.

So not only that de-escalation training, because so often that's too late, but how can they prevent and mitigate? How can it be okay to say and recognize in yourself that you're feeling stressed, you're feeling

anxious, that you need to address these symptoms that you have? Because we know that not only impairs learning, but it also impairs our responses and reduces our tolerance to situations that may escalate quickly.

The other thing is to look at our future leaders, not just in the new nurses, but in our graduate programs. Who are our future leaders? And what is the importance of recognizing this in your future staff, or in your colleagues, or in your peers? And what can you do and implement within your programs mitigation strategies to prevent the core issues from occurring?

We are a microcosm of society. You just have to look at the news. So we're dealing with it on multiple different fronts. And we need to be able to create not only those prevention, but what can we do to address it? Where is the safety net that those nurses, or those students, or faculty can go to to know that they're okay?

- It's interesting, when I hear the wellness panel and when I hear you all talk, it seems simple a nurse to reach out and say, "I need some assistance. This scenario that I'm walking into doesn't feel right." But that is such a different mindset from what nurses have.

Nurses don't really think that way. And it really shows that we need a change in the culture, a change in education, and a change in what we teach nurses how to be and what to do. We have a few minutes left.

I want to talk about bullying because this also falls under the realm of violence in the workplace. Some of it can get pretty bad. Some of it is related to racial and ethnic issues. What can we do about that? It seems as though there should be a no tolerance policy in most institutions. But let me open it up to the group.

Anyone want to take a stab at it?

- I'll just start by saying, as you said, it needs to be a zero tolerance. And that needs to be obvious and tangible to anyone who steps foot into a facility. Signage, training, it has to be ongoing. It can't be a one-time event that checks off the box. It has to be embedded into the culture.

- I agree with that totally. You've got to have that type of training, that teamwork training, managerial training. It has to be from the top down. And it can't just be expected from those at the front line. It has to be embedded in the entire culture. And the understanding of how microaggressions can occur, and how they can be harmful, and how they can hurt and grow into bigger scenarios.

So, yes, it is not an easy answer, but it is shown to be the root cause of many of the violent episodes that we see in health care. And unfortunately, amongst our own horizontal violence in our own profession. We can start that training again in academia.

- Are you encountering any of the situations where staff actually are issue, are the problem with causing some type of issues in the workplace that are difficult for nurses to handle?

- We do see that. I don't think it's the most predominant issue for us, but we see it. And to the point made earlier, we have a mechanism of tracking workplace violence, and we divide it into various categories so that we can focus on the most predominant issues that we're seeing, and make sure we're addressing the things that are most commonly happening.

We do have a Workplace Violence committee. We have a law enforcement liaison actually that sits on that committee with us, and helps us understand, one, what's happening in the community. But it also provides us a mechanism of getting community support. And that's a difficult thing for us. A minute ago, we talked about some institutions maybe are frowning on calling 911.

We certainly aren't that group. We want them to be able to call for law enforcement or community support if they need it. But I'll draw a parallel for you. Law enforcement right now is one of the same issues that we're having. They're stressed out. They're overworked. Our local law enforcement is missing about a third of its staffing right now.

And so when we do call 911, this is important for us because when you have a home health worker, they call 911 because there's a problem, and it takes 2 hours to get an officer because they don't have anybody available. And that perception from our staff member then is, "Nobody cares because nobody came quick." Right?

And so we have to combat that. And how we do that is just through communication with that liaison. We want people to understand they're in the same environment we are. Right?

- Right. Well, thank you. I'm going to open this up now to our audience for questions.

- [Dr. Lyon] Thank you. Thank you all very much.

This has been so fascinating. But it's something we're all worried about. I have two questions I'd like to ask. Karen Lyon. I'm a regulator from the Board of Nursing in Louisiana. We had a new workplace violence law passed last year. I don't think it's as robust as Texas.

But two things we're seeing from a regulator standpoint. We have our nurses who are victims of violence who don't want to press charges. They don't want anything reported. They're worried that people are going to find them, and come, and threaten their families so they won't even report. They won't even take action. The second thing from a disciplinary standpoint, we're having more nurse-on-nurse and nurse-on-patient violence being reported to us.

And anyone on the panel can comment on either of those two things. I mean, literally where nurses are losing it and taking their microaggressions out on patients, and particularly in psych mental health units, and in our extended care facilities where we have our most vulnerable patients.

- I'll start, and I'll respond to Karen's first question. I will say that another bill that passed during our last session that was championed by a senator who is a registered nurse and also a physician, it emulates a lot of the elements in the federal bill. It requires a committee, it requires a policy.

It specifies membership to include nurses and security personnel. One element that I think is key in this legislation is that it absolutely prohibits retaliation from reporting. And it includes an enforcement section that someone who retaliates against an individual for reporting an incident of workplace violence can be disciplined by their licensure board.

And then to Karen's second question, I don't know that we've seen an increase in nurse against patient or nurse-nurse violence, but it's definitely something to watch and trend.

- Can I add a little bit to that? So we do see that occasionally. I don't know that that's necessarily a predominant issue for us, though. But one thing that we are very focused on is with everybody's level of

fatigue, and with the level of burnout right now, a big piece of the training that we offer is how to keep that in check, and how to watch your triggers when those things are happening for you.

Because it's really easy when you're in that situation, burned out, and fatigued, and tired, and maybe even a little bit ornery. Right? And it's really easy to say the right thing in the wrong tone with the wrong body language, and escalate a situation that you intended to de-escalate. Right? And so we're paying a lot of attention to that. So any time we have a workplace violence issue or something has happened, we're going all the way back to how did the conversation started?

What happened at the beginning? And paying a lot of attention to, "Can we do better in that overall process? What's causing the issue to escalate?" I hope that helps.

- Can I respond very quickly? Is we're seeing increased students from nurse-to-student violence. And that's been a major concern that we're beginning to track the number of incidents and occurrences, not only from the patients to the students but from the nurses to the students. And again, I think it's reflective of the stressful environment that they're under at the moment.

And it's unfortunate.

- Yeah, absolutely. Yes.

- [Charlie] Charlie O'Hara from the research team at NCSBN. Wanted to thank all of you for all of your insightful thoughts, and kind of all the other panelists, as I think one of the themes we've been seeing throughout all of these panels is we have a lot...nurses are understaffed.

They have to keep working, and they end up getting burnt out because there's not enough time to take a 15-minute break, or do other things. And then how do we...when we're talking about reporting workplace violence, I can imagine a lot of situations where if you're a nurse, these recordings are low because you're already burnt out.

You're already under so much workload. And now someone did something to me, but I don't have the time to fill out all of these...this report. It wasn't that big of a deal. How do we encourage nurses to have the time and improve reporting numbers in these types of situations?

- I think the time is partly an obstacle, but a bigger thing is just the culture. And when I came to health care from law enforcement, I was amazed to see this parallel between the two. When I came over to health care, it was considered part of the job.

"This is just how things are in the ED. This is what happens. We get assaulted. It's part of the deal. And life just goes on." And so they're not encouraged to report it. And so we work feverishly to help them, and encourage them to report that, and make it as easy as we possibly can, because the reporting is important. Without the data, without the information, there's nothing to address.

Right? I don't know what I'm looking at. So we need that intel. And that work gets done often through our Workplace Violence Committee, like that whole group, which is co-led, by the way, with our department lead for the ED, and our security director for each site. They co-chair those meetings.

So, yeah, we're doing the best to encourage them. I think it's more the culture than the time, to be honest.

- Yeah. And like we have said, this is all connected. And that's why we have to get to the heart of these issues to fix them.

- [Female] Just in follow up to what Maryann just said, and actually Charlie's point as well. The first two panels, the things that they were talking about, short staffing and challenges to nurses' mental wellness, that has to lower the threshold of your awareness of these threats that you're educating nurses about.

If you're too busy and you're stressed out, you're trying to get your work done, you might not be really aware of the signs and signals of someone that's going to maybe cause a problem. I'd just like to hear your comments on my perception of what I've learned today. The other thing I question I have is as a nurse, you have to be physically close to patients often.

You are approaching the patient from a perspective of care and compassion, and that makes you vulnerable. And how do we teach nurses to embrace what they need to do and who they are as nurses, and yet allow them to protect themselves?

I hope that makes sense.

- Yeah.

- So I'll take a stab at the second part of her question. More from a regulatory perspective, again, we feel that there is a lot of opportunity to reduce or mitigate the risk of workplace violence through a worksite analysis, and hazard identification and control. And you look at the working environment where nurses are, whether that means redesigning the nurse stations, or providing them an opportunity to escape in case they're being cornered.

Whether that means a triage room that has two exits. Whether it means installing security cameras and mirrors to avoid having a blind spot, or having the nurse stations in a central location with direct line of sight to every room or every patient care area.

Or mobile stations, right? That can be located in the hallways. Clinicians that do not see each other cannot help each other. Right? And then we go back to communications, and panic buttons, and the radio communications. We've encountered situations where we had [inaudible 00:39:08]

You guys are familiar with it. I had to educate myself as to what they are. That had radio dead zones in the facility. So they could not call for help. Like Gary mentioned, we've seen sometimes challenges with the communication protocols.

Who actually summons security? Right? And then we find instances where the security is actually located closer to the emergency room department, not closer to, say, the mental health unit of the hospital. So security would have to jump in a car, drive all the way around in the camp. So there are a lot of opportunities there.

Now, we like to call them engineering controls. There is also administrative controls like, let's just say, avoiding the feeling of negative progress. As a patient, when you move through the facility, you're being triaged, and then you're being brought back into the waiting area. That tends to generate negative feelings as a patient.

So these are some of the things we've observed. None of the things I said are a one size fits all. It won't fit every single medical unit. What works for ICU may not work for a mental health unit.

- So what you're saying is each institution should assess their own circumstances and address their unique problems?

- Absolutely.

- Can I expound on it a little bit, too? For us, the situational awareness class that we teach is really an added piece that I don't think RNs typically get in their educational process. Right? And so what we want to talk to them about is identifying a weapon. And it's not always...it's not the weapon that you would think, right? Like what in this room is a weapon to you?

And we help them understand that. We want them to change the concept of their environment. Are you always paying attention to your ingress and egress? What are proxemics to the patient? You can still take care of the patient while maintaining a route of egress. But all of those things are important to us. And I don't think that it's training that is mandatory, or typical in an RN's education.

And so we're offering that to everybody so that when you come into the room, you're already thinking, every day, every moment you're thinking about your own personal security. To his point about the position of security on the campus, I've got an enormous campus and I've got 8 or 12 security guys on on a daily basis.

It's impossible for me to be everywhere all the time. And so we empower our staff because it's everybody's responsibility to maintain safety and security on that campus. Security can't do it alone. So I hope that helps.

- Thank you. We have one minute left. I want to once again go around to this panel, and allow you to say one lasting thing, one thing you want the audience to remember from this discussion.

- Yeah. For me, it's all about collaboration, and teamwork, and empowering our staff. So I would focus on those goals.

- Kathleen.

- I would say the same thing. It's all about preparing them, providing them with the tools to support and protect themselves. But also knowing that they are in an environment that cares about their psychological and physical safety, and we'll be there to support them.

- My message would be, one, the whistleblower and retaliation. People are afraid to communicate and report some of these incidents. Almost every incident investigation that we do, when we interview the staff, there's generally several other incidents that have occurred that didn't get recorded. It's almost, I would say, 90% plus of the cases.

- So for me, I recognize that it's a challenge to address workplace violence, but that doesn't mean it cannot be mitigated through certain engineering, administrative controls, removing weapons of opportunity, to go back to the previous question. But it takes a team to address it.

- Kristin.

- I think it's important to keep in mind that workplace violence is not an individual problem. It's a holistic, systemic problem. And it is our ethical and moral imperative to make a health care facility a

safe place. We need our patients to know that they can get treatment, and they can walk out safely, and that their staff are professionals and treated as such.

- Thank you all very much. I really think, to sum up all our panels today, what this all comes down to is awareness. And we want every institution in this country to be aware of these problems, to assess what is going on in their own environment, and take the necessary steps to help retain our nursing workforce and make it better for the future.

So with that, I would like to thank each and every one of you for being here, and to all of our attendees, and those watching digitally. Thank you.