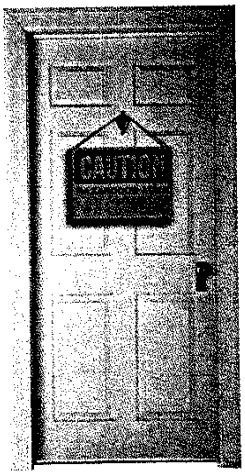
Violence Prevention in the Home Health Setting

Home care workers face an increasing risk for workplace violence. A proactive preventive approach is presented that suggests strategies to use during the previsit phase, the visit experience, and on an ongoing basis.



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Healthcare workers are at a greater risk for workplace violence than workers in the general population (Canavan, 1996). Although several studies have examined violence in healthcare institutions (Fisher, 1994; Keep & Gilbert, 1995; Lewis & Blumenrich, 1993; Lipscomb & Love, 1993; Madden, Lion, & Penna, 1976; McCulloch, Binder, & Hatcher, 1986; McNamara, 1994; McNiel & Binder, 1987; Sanchez-Galleos & Viens, 1995; Simonowitz, 1994; Sommargren, 1993; Thackrey & Bobbit, 1990; Vincent & White, 1994), violence in home healthcare is a relatively recent concern. This concern has caught the attention of the Occupational Safety and Health Administration (1996), which now requires home health agencies to have a workplace violence prevention program that provides a safe workplace for healthcare workers. When the workplace is the client's home, control of potential hazards becomes a responsibility of the client and the client's family. An effective violence prevention program requires the client's willingness to provide a safe environment and the healthcare worker's ability to assess for potential risks in this environment.

A proactive prevention approach is presented for detecting and reducing risks of violence during the home health visit. This approach can be divided into three phases: the previsit phase, the first home visit phase, and the continuing visits phrase. The first phase occurs before the first home visit and involves collecting information from the referring agency and the client and client's family. The second phase includes the first home visit when assessments of potential risks continue, including assessment of the client's own risk behaviors. Verbal contracts for safe environments are formalized into written agreements, and no-harm contracts with the client (if needed) are obtained. Phase three involves continuing assessments for changes in risk levels and updating agreements that will ensure ongoing provisions for a safe work environment. Assessment tools and suggested contracts to use in each of these phases are presented.

Previsit Phase

An important first step in detecting and reducing risks of violence involves early communication of the expectations for a safe work environment. Collecting information from the referring agency, client, and client's family before the first home visit provides the first source of data related to risks for violence in the home. The referring agency (see Table 1) can be a valuable source of information about the client's history of aggressive behaviors and any known volatile relationships.

Information from the client and family can be obtained over the phone when the first home visit is being scheduled (see Table 2). Questions must be asked about the presence of lethal weapons and any other materials in the home that could be used to inflict lethal harm. Volatile relationships are also a concern. Recently in Kentucky, a home health worker was shot at by a client's neighbor who, unknown to the worker, was feuding with the client. Knowledge of this relationship could have helped the worker plan for a safer entrance and exit from the home. The worker fortunately was not hurt.

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Table 1
Violence Prevention Information from Referring Agency[a]

1. Do you know of any overly aggressive behavior by this client or persons in his/her environment?
2. Describe these behaviors and their frequency.
3. Are there any known triggers to the violent behaviors such as when limits are set, etc.?
4. Is the violent behavior directed toward a particular person or generalized toward no one in particular?
5. If directed at a particular person, what is the likelihood of that person being in the home during a home visit?
6. Are there any known restraining orders? If yes, against whom?
7. Is there a recent divorce or separation?
8. Are there recent threats against the client? If so, from whom and does this person have access to the client at home?

Note. [a]To be asked before the 1st visit.

Other potentially violent conditions include aggressive pets and substances that can cause lethal damage (e.g., acids, etc.). Although it is impossible to control for every item in the home that might be used as a weapon, it is possible and important to identify and control the most lethal items and make the client aware of the need to discuss these issues.

When weapons or other lethal items are reported to be present in the home, the agency personnel can obtain a verbal agreement over the phone (before the first home visit) to keep these items locked up and in a separate room during the caregiver's visit (see Table 2). This verbal agreement can be followed with a written contract to be signed during the first home visit (see Table 3). One home health agency has developed a policy stating

> Any patient who displays a weapon to an ... employee in a threatening manner shall be required to: (A) Turn the weapon over to [his or her] local police department until the patient is discharged from home health — OR (B) risk losing home health services from the agency (DeCesais, 1996).

Table 2
Violence Prevention Information From Client and/or Family[a]

1. Are there any weapons or lethal items in the home (i.e., guns, bows and arrows, explosives, acids, etc.)?
2. Will these be disarmed and locked away in another room during the healthcare workers' visit?
3. Are there any vicious pets on the property or nearby?
4. Describe plans for containing these pets during the health workers' visit.
5. Are there any volatile relationships (family, friends, neighbors, persons abusing drugs, restraining orders, separated, newly divorced)?
6. Describe plans for keeping these relationships safe during the health workers' visit.

Note. [a]To be asked before first home visit.

This is a good policy, but it may not totally prevent a problem. An earlier, more proactive approach would not wait until the patient "displays a weapon in a threatening manner." Holy Name Home Care in Teaneck, New Jersey, requires guns to be "locked up" and out of sight while caregivers are in the home. Employees are instructed to leave if the guns are visible in the bed or wheelchair or otherwise evident (DeCesais, 1996). Jennifer Jenkins, Vice President of Healthcare Concepts, Inc., in Memphis, Tennessee, recognizes it is impossible to totally prevent irrational behavior but "policies like these that are shared between the agency and its patient up front are an important step in minimizing it" (DeCesais, 1996).

After collecting all the relevant information from the referring agency and the client and family and after obtaining a verbal contract for a safe work environment over the phone, the healthcare worker can prepare for the first home visit.

Table 3
Safe Environment Contract[a]

1. Ask client/family to:
   a) List lethal items in the home and acknowledge they will be locked away during the home visit.
   b) Explain any volatile relationships and how these will be managed during the home visit.
   c) List any pets in the home and how they will be managed during the home visit.
2. Write these items out and have the family sign an agreement to neutralize these risk factors during each home visit.

Note. [a]To be obtained during first home visit.

The First Home Visit

The most important risk factor, the clients themselves, must be assessed for their own risk behaviors. Characteristics of persons committing violent acts have been studied among patients in the hospital and among known abusers (Blair & New, 1991; Bloomhoff, Seim, & Friis, 1990; Convit, Isay, Otis, & Volavka, 1990; DeCesais, 1996; Lanza, 1988; Lowenstein, Binder, & McNeil, 1990; Sheridan, Henrion, Robinson, & Baxter, 1990; Smith et al., 1994; and Stuart & Sundeen, 1995). From the factors found in these studies, a correlation with violent behavior can be identified. When 125 nurses were asked to rate the relevance of defining characteristics of the nursing diagnosis potential for violence (Smith, et al., 1991), they identified 9 major and 20 minor characteristics. These characteristics concur with previous studies of characteristics of persons with violent behaviors. The risk factor found to most consistently correlate with violent behavior is a history of violent behavior (Bloomhoff et al., 1990; Blair & New, 1991).

Although studies have been able to identify significant risk factors for violent behavior, absolute predictors have not been identified. The significant risk factors from the literature have been incorporated into an assessment tool, *Aggression Toward Others Assessment Scale* (Hunter, 1995), for home health workers to use. These significant risk characteristics are organized into three levels of severity, mild, moderate, and severe, with a

Aggression Toward Others Assessment Scale

Assessment Areas	I Low Risk(1)	II Moderate Risk(2)	III High Risk(3)
1. Client's violent behaviors	☐ One known episode of property damage ☐ Violence specific to one trigger, i.e. drugs, argument	☐ More than once destroyed property without injury to others	☐ History of actual assaults with injury to others
2. Client threats of violence	☐ Threats of violence in past year	☐ Recent* verbal threats	☐ Recent* physical threats
3. Client history of abuse	Observed or received verbal abuse ☐ As a child ☐ Recently*	Has observed physical/ sexual abuse ☐ As a child ☐ Recently*	Has been a victim or perpetrator of physical/ sexual abuse ☐ As a child ☐ Recently*
4. Aggressive thought content	☐ Mild thoughts of aggression	☐ Strong paranoid and/or hostile thoughts toward specific person/object/ event	☐ Strong, generalized paranoid and/or hostile thoughts ☐ Expanding personal space
5. Feelings of fear or rage	☐ Monthly ☐ Mildly intense ☐ Can be refocused in less than 5 min.	☐ Weekly ☐ Moderately intense ☐ Can refocus client in 5–10 min.	☐ Daily ☐ Highly intense ☐ Takes 10 min. or more to refocus client
6. Substance abuse	☐ History of abuse	☐ Recent* abuse	☐ Currently under influence or frequently under influence
7. Impulsivity	☐ History of physical impulsivity	☐ Verbally impulsive	☐ Physically impulsive ☐ Intense affect/mood swings
8. Agitation	☐ Occasional (monthly) episodes of agitation	☐ Intermittent bursts of hyperactivity weekly	☐ Constant pressured physical activity
9. Sensorium		☐ Some memory impairment but is oriented	☐ Disoriented ☐ Memory impairment
10. Availability of weapons	☐ Lethal items in locked containers in another room	☐ Lethal items in locked containers	☐ Lethal items in unlocked containers
11. Willingness to contract "no-harm"	☐ No-harm contract agreed to with no hesitation	☐ Ambivalent/hesitant about no-harm contract	☐ Refuses no-harm contract
Scores 0	Mild 14	Moderate 42	Severe 93

Figure 1. *Aggression Toward Others Assessment Scale.* Note. **Recent = within last month.*

Table 4
Treatment Strategies for Potentially Aggressive Clients

With Low to Moderate Risk Scores of 0–15:

1. Obtain/renew no-harm contract.
2. Obtain/renew safe environment contract.
3. Carry cellular phone or beeper.
4. Teach stress reduction techniques to use when feeling tense.
5. Teach needs-negotiation techniques to use in place of aggression.
6. Teach nonviolent conflict-resolution techniques.
7. Teach management of triggers to aggression.

With Moderate Risk Scores of 15–40, continue with strategies 1–7 plus:

8. Call immediately before making home visits to reassess the situation.
9. Reassess risk behaviors during each visit.
10. Avoid limit setting or threatening attitudes.

With High Risk Scores of 41–94, continue with strategies 1–10 as appropriate plus:

11. Consult with supervisor about making a home visit.
12. Consider an emergency petition to hospitalize.
13. If client is making threats toward others, must consider "duty to warn."
14. Contract to have another person in the home during the visit or two healthcare workers go together.
15. Terminate visit if weapon-like items are nearby.

range of scores established for each level (see Figure 1). The score is calculated by giving a value of 1 for each item checked in the low-risk column; a value of 2 for items checked in the moderate-risk column; and a value of 3 for each item checked in the high-risk column. The sum of these values is placed on the score continuum at the bottom of the scale to determine the person's level of risk.

Table 5
No-Harm Contract[a]

1. Ask the client to agree to and repeat the following statement: "No matter how bad things get, I will not do anything to hurt myself or others. When things get so bad I can't stand it, instead of getting aggressive, I will *"call someone," "talk to someone," or "calm myself with relaxation techniques," etc.*
2. Ask client to sign a written version of this statement.
3. If the person is unable to agree to these statements for an unspecified amount of time, the healthcare worker can add a time frame to the agreement and renew the agreement each time this period ends.

Note. [a]To use with potentially aggressive clients.

The scores have been established to overpredict any potential for violence, alerting the healthcare worker of potential problems. There are some individual characteristics significant enough to place a person in the high-risk category regardless of the total score. These characteristics are bolded in the assessment tool. This tool was developed to provide early detection of potential risks for violence and to alert the healthcare worker of subtle changing conditions.

Treatment strategies related to each risk level are suggested in Table 4. These treatment strategies include "no-harm" contracts (see Table 5) that ask the client to agree to take a nonviolent action when feeling overwhelmed, angry, or rageful. These contracts have been used successfully with patients with psychiatric conditions to prevent suicidal behaviors and can provide a measure of protection from aggressive acts. Behavioral contracts are successful because they activate the "adult ego" or decision-making portion of a person's personality. By involving this part of a person's personality during angry episodes, persons are more capable of delaying an impulsive, "child ego state" response and choose a less aggressive response. This provides a buffer against automatic impulsive acts. Suggestions for options of what to do when feeling overwhelmed include contracting with clients "to agree to tell the caregiver when they feel they cannot 'stand it' anymore," or to tell when "they have had enough," or

to ask the caregiver to leave when they feel their tension and rage increasing. Clients may have their own suggestions of nonviolent behaviors they are willing and able to implement when feeling tense.

If clients are hesitant to complete a no-harm contract, this is a significant and added risk factor. Agencies may want to develop a policy that states they will not work with clients who do not agree to a no-harm contract. If the client seems hesitant when agreeing to a no-harm contract, the caregiver can then negotiate a time limit to which the person can agree. For example, a client may be hesitant to agree to no-harm behaviors for an indefinite period but can agree to no-harm behaviors during the home visit 1 week at a time. In these cases, a new contract will need to be negotiated each week before the home visit occurs. All no-harm contracts should be renewed at least monthly, when factors change in the home that increase the risk levels, or when the designated time expires.

Continuing Visits

There are psychiatric diagnostic categories that include aggressive behavior as one of their defining characteristics. These diagnosis include intermittent explosive disorder, organic personality syndrome, explosive type, conduct disorder, and sexual sadism (American Psychiatric Association, 1994). Four other psychiatric diagnoses frequently include a history of aggressive behaviors, and the healthcare worker should be warned to be vigilant of the client's rapidly changing moods. These include the antisocial personality disorder, borderline personality disorder, alcohol idiosyncratic intoxication, and attention-deficit hyperactivity disorder (American Psychiatric Association, 1994). If a client receives one of these diagnoses, the informed healthcare worker should know that the person has a history of aggressive episodes and is at risk for future episodes. An appropriate policy when working with clients with these diagnostic categories is to require additional persons in the home during the visit who can assist if the client becomes agitated or aggressive.

Some studies have identified triggers to aggressive episodes, such as the attitude of the healthcare worker and when limitations are placed on the client (Blair & New, 1991; and Lanza, 1988). All healthcare workers must be aware of the attitude they convey and of any activities clients may perceive to be contradictory to their wishes (which can also be perceived as a form of limit setting). These activities should be considered high risk and volatile, capable of triggering violent episodes in a questionably stable client.

Finally, healthcare workers should pay attention to any hunches regarding tensions or dangers in the home. There may be factors present not previously addressed that alert them to potential dangers preconsciously. Steps to establish a safe environment, or to exit an environment until its safety has been secured, should be taken without embarrassment or hesitation and with the full support of agency management, reinforced with formal, written policies. ■

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