Sanitized Patient and Visitor Discrimination policy

Sites: All Sites

Hospital Policy and Procedure Manual

Number: XXXX

TITLE: PATIENT AND VISITOR ABUSIVE/DISCRIMINATORY

BEHAVIOR POLICY

POLICY:

1. All individuals on Hospital property merit safety, courtesy, and respect. Consistent with our professional and legal obligations, any behavior that undermines a culture of safety, respect, diversity, inclusion and belonging, and anti-racism, will not be tolerated.

2. The Zero Harm Initiative and the Respect policy reinforce our commitments to safe, respectful environments for our patients, and reinforce our commitment to support our employees, medical staff, vendors, independent contractors, volunteers and practitioners ("Workforce") who encounter abusive and/or discriminatory behavior.

3. Hospital requires that its workforce act in a professional and cooperative manner to, among other things, optimize patient care and provide a safe and professional work environment. (Policy and Procedure Manual Disruptive Behavior Policy)

4. Patients, and families, friends and other visitors ("visitors"), are also expected to speak and act respectfully.

5. Abusive, racist, and/or discriminatory behavior of any kind will not be tolerated. Any member of the workforce who encounters abusive, racist, and/or discriminatory behavior will be supported. The Hospital will continue to honor its commitment to providing compassionate, safe and high quality care, even as these situations are addressed.

6. This Policy addresses both abusive and discriminatory behavior in two sections, Part I ("Abusive behavior") and Part II ("Discriminatory behavior").

DEFINITIONS:

"Abusive behavior" includes but is not limited to verbal or physical harassment or intimidation, violence or threats of violence, stalking, sexually explicit language or behavior, and/or physical assault towards other patients, workforce, visitors or property.

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"Racist behavior" includes but is not limited to any verbal denigration or physical harassment or intimidation, violence, or threat of violence because of a person's race or ethnicity.

"Discriminatory behavior" includes but is not limited to language, requests or behaviors targeting workforce based on personal characteristics including but not limited to religion, gender, national origin, race, and/or sexual orientation.

"Personal Characteristics" of providers and workforce members include but are not limited to race, national origin/ethnicity, religion, gender, gender identity or expression, sexual orientation, age, disability, veteran or active military status, or immigration status.

PURPOSE:

1. Assist workforce in preventing, addressing, and reporting patient or visitor Abusive, Racist, and/or Discriminatory behavior;
2. Promote a safe and respectful work environment;
3. Support caregivers and workforce; and
4. Seek to optimize patient care.

APPLICABILITY:

This policy applies to all Hospital workforce including employees, medical staff, vendors, independent contractors, volunteers and other independent practitioners.

PROCEDURE:

PART I. Abusive Behavior Policy for Patients and Visitors

A. Abusive Patient/Visitor: If at any time, a patient or visitor engages in violent, abusive, unsafe and/or aggressive ("disruptive") behavior, the below actions should be followed and constitute an escalation protocol.

1. Contact security immediately and/or law enforcement as may be necessary if there is an imminent or immediate threat to a person's safety or property on any campus or facility.

2. Manage Behavior- Clinical providers and clinical supervisors/managers/nursing or clinical leadership ("clinical leaders") are the initial and primary team to intervene and attempt to de-escalate disruptive behavior. If it is not yet necessary to contact security, attempt to manage Abusive and/or Disruptive behavior utilizing nonviolent deescalation techniques. This may include tactics addressed in Appendix A and Appendix B.

3. Inform Supervisor- If behavior does not change or improve, inform a supervisor as soon as possible. Clinical leaders should support staff by monitoring the situation, assisting in its resolution, and continuously escalating to the next level leader, as needed.

4. Contact PSA or AOC- Contact Patient Services Administration ("PSA") and/or Administrator On Call ("AOC") (or other appropriate leaders e.g. overnight Nursing supervisor). PSA and/or AOC are also resources who may assess and attempt to employ various additional dispute resolution and service recovery de-escalation techniques.

5. Consult Clinical Behavioral Health Teams - If de-escalation management techniques have not succeeded in adequately addressing the behavior, consider engaging the Psychiatric Consult Liaison service of your campus or escalating to appropriate on-site Behavioral Health clinical teams.

6. Discharge or Transfer Options- If a medically stable patient is abusive or disruptive to the point that the team wishes to consider discharge or transfer options, escalate to clinical leadership and contact PSA and Legal. If patient/visitor returns to the area after discharge (following disruption):

a. Immediately inform Security that the patient/visitor has returned. If security is not available onsite in a particular campus or off-campus location, consider contacting law enforcement.

b. Security will respond to the area and involve law enforcement if needed.

c. If security is not available onsite in a particular campus or off-campus location, consider contacting law enforcement initially.

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7. Potentially Filing a Police Report/Pursuing Criminal Charges

a. Individual members of the Workforce may pursue all legal options as may be appropriate. This may include potentially filing a police report and/or pursuing criminal charges.

b. Consider contacting Security if law enforcement has been notified. Security can help to expedite contact between law enforcement and individual members of the Workforce at a campus location.

8. Report Weapons Immediately

a. Weapons are not allowed on any property or facilities at any time unless authorized by an applicable agency (law enforcement, etc.).

b. If any patient/visitor is suspected of possessing a weapon, contact Security immediately. All weapons in the possession of a patient/visitor will be confiscated by security and law enforcement will be contacted.

c. If security is not available onsite in a particular campus or off-campus location, contact law enforcement initially.

B. Professional Characteristics: Patients may request the direct and timely input of the attending physician of record, but may not exclude other members of the health care team, including but not limited to students, graduate house staff physicians, nurse practitioners and physician assistants, from participating in care, with the exception of non-discriminatory requests that are well-founded and consistent with both ethical patient care and the mission of an academic medical center.

C. Reports: Workforce members must report all incidents of physical or emotional violence in accordance with HR Policy and Procedure Manual, Workplace Violence. (See also “Worksafe” and A3 Reporting; Zero Harm Initiative)

D. Debriefings: After an event involving an abusive patient or visitor, managers should attempt to connect affected caregivers with available resources for support, which may include social work and pastoral care.

E. Team Meetings: After an event, consider whether a meeting of the clinical team is warranted to allow members to share their experiences and discuss possible means of addressing or defusing these situations. If so, these meetings should be conducted in the manner of any appropriate team clinical care discussion, with consideration of confidentiality and quality assurance privileges. Clinical leaders and PSA may seek guidance from Quality and Legal to seek to preserve any applicable privileges in communications.

Part II. Discriminatory Behavior Policy for Patients and Visitors

A. The Hospital should not accommodate racist or discriminatory requests for a specific type of provider or workforce member based on the race, ethnicity, or personal characteristics of the provider/workforce member. Accommodations may be considered as addressed below in Part II D or Part II E. Further, We will not tolerate hateful, discriminatory or bigoted speech or behavior towards a provider/workforce member based on the personal characteristics of the provider/workforce member. (Human Resources Policy and Procedure, Anti-Harassment)

B. Personal Characteristics:

Providers'/workforce members' characteristics include but are not limited to race, national origin/ethnicity, religion, gender, gender identity or expression, sexual orientation, age, disability, veteran or active military status, or immigration status.

C. Professional Characteristics: Patients have the right to request the direct and timely input of the attending physician of record, but may not exclude other members of the health care team, including but not limited to students, graduate house staff physicians, nurse practitioners and physician assistants, from participating in care, with the exception of non-discriminatory requests that are well-founded and consistent with both ethical patient care and the mission of an academic medical center.

D. Non-discriminatory Requests: Non-discriminatory requests may be considered; for example, a gender-related accommodation may be considered if the request is due to cultural beliefs regarding modesty or for victims of sexual assault or trauma. All requests should be evaluated within ethical and patient care guidelines, including accommodations for religion, culture, language or history of discrimination. Requests should be evaluated by the care team, and if warranted, escalated to supervisors, department leaders and/or PSA.

E. Ethical and Practical Factors to Consider in Decision Making: See Appendix B.

F. Steps for addressing Discriminatory Requests:

1. Continue to provide care while this issue is being addressed.

2. Discuss options with the patient and the implications of the patient's request. See Appendix C for managing discriminatory requests.

3. Limit the unacceptable conduct of the patient or visitor and set behavioral expectations.

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4 Engage other resources to assist if needed, including Security and Social Work. Security may further engage law enforcement for situations in which patient's/family become disruptive or violent, pursuant to Part I of policy herein.

5 Refer to the Patient Rights and Responsibilities and Visitor Policies when needed.

6. Document discussions and actions in the patient's health record.

7. Submit a Worksafe and A3 report, if appropriate.

8. Consider discharge or transfer of care, if appropriate. See Part IA 6.

G. If department leaders and PSA are unable to resolve the situation, or require additional support or guidance, the situation should be escalated to department and campus leadership, and senior leadership as necessary (up to and including the Chief Medical Officer, Chief Nursing Officer, and the Chief Respect Officer).

H. Debriefings: After an event involving discriminatory behavior by a patient or visitor, managers should attempt to connect affected caregivers with available resources for support, which may include social work and pastoral care.

I. Team Meetings: After an event, consider whether a meeting of the clinical team is warranted to allow members to share their experiences and discuss possible means of addressing or defusing these situations. I f so, these meetings should be conducted in the manner of any appropriate team clinical care discussion, with consideration of confidentiality and quality assurance privileges. Clinical leaders and PSA may seek guidance from Quality and Legal to seek to preserve any applicable privileges in communications.

RESPONSIBILITY:

Human Resources and Patient Experience

REFERENCES:

Whitgob, E., Blankenburg, R., & Bogetz, A. (2016). The discriminatory patient and

family: Strategies to address discrimination towards trainees.

Academic Medicine, 91(11), S64-S69; “How Should Organizations Support Trainees in the Face of Patient Bias,”

AMA Journal of Ethics, June 2019, Kimani Paul-Emile, 21(6):E513-520. Trauma-informed care; see SAMSHA guidelines and “Dealing With Racist Patients,” Kimani Paul-Emile, et al, NEJM, February 25, 2016.

POLICY DATES:

ISSUED: August 2020

APPENDIX A

TOOLS FOR MANAGING DISRUPTIVE BEHAVIOR

1. If at any time there is an imminent or immediate threat to safety on the property or facilities, notify security immediately.

2. NON-VIOLENT DE-ESCALATION TECHNIQUES FOR MANAGING DISRUPTIVE BEHAVIOR:

a. Position yourself for safety and never turn your back.

b. Appear calm, centered and self-assured even if you don't feel it.

c. Use a modulated, low, monotonous tone of voice.

d. Maintain limited eye contact.

e. Maintain a neutral facial expression. Minimize body movement. Isolate the agitated person by removing other people who are nearby or by escorting the agitated person to a private area. Consider other environmental changes to the treatment area, including removing hazards and any unnecessary equipment and furnishings.

f. Notify attending physician if not already at bedside of need to perform a medical examination.

g. Assess the patient to determine the potential cause(s) of the patient's behavior, e.g. Alcohol abuse, substance abuse, personality or psychiatric disorders, emotional upset, etc.

h. Implement the appropriate medical intervention to address the patient's behavior as applicable. Document the incident in patient's chart. Document the appropriate health assessment after interventions have been implemented. If patient refuses medical care and demonstrates capacity to make decisions related to care with appropriate assessments to determine capacity, attending and team should be consulted to consider discharge against medical advice where applicable.

3. RISK MANAGEMENT TACTICS FOR MANAGING DISRUPTIVE BEHAVIOR:

a. Watch the Learning Center Module video, "De-Escalating Aggressive Behavior"; this module provides information about specific verbal de-escalation techniques and when to use them. In addition to the above, it provides responses that can help keep you from harm. It is available to all employees.

b. Implement patient search protocols to identify any contraband or items that may be used as weapons;

c. Search, inventory and secure any personal property brought into the care location; (security and departmental staff to determine who/how best to conduct search)

d. Maximize observation and response capability to include potential assignment of additional staff such as a care provider, one-to-one or security officer;

e. Identify visible or auditory methods that alert other staff of the concern including support personnel who may interact with the patient but don't have direct access to the patient's chart;

f. Introduce and reinforce behavioral expectations including agreement by the patient; this may include notification and discussion with family members;

g. Seek medical intervention as applicable;

h. Consider restricting visitor(s) where safety and well-being of patient or staff is involved pursuant to "Restrictions on Patients

Visitors/Communication," Policy;

i. Consider consultation with ethics committees of the local campus for difficult decisions including but not limited to clinical management, family dynamics, discharge and care plans.

APPENDIX B

ETHICAL AND PRACTICAL CONSIDERATIONS FOR MANAGING THE ABUSIVE OR DISRUPTIVE PATIENT

It is helpful for the caregiver to consider these factors, among others, when engaging in negotiation, persuasion, and in some cases accommodation within the practical realities of providing effective care for all patients.

1. Patient's Medical Condition:

The patient's medical condition and the clinical setting should drive decision making. In an emergency situation with a patient whose condition is unstable, the physician should first treat and stabilize the patient.

2. Decision-Making Capacity:

Patients should be assessed for delirium, dementia, or psychosis. Reassignment requests and/or discriminatory behavior may be attributable to impaired cognition and/or decision-making capacity. Patients' preferences may change if reversible disorders are identified and treated.

3. Options for Responding to the Request and/or Behavior:

Respectfully acknowledge the request for care change or concerning behavior and ascertain why the patient is making the request or behaving in said manner.

a. The care team member should communicate:

i. The Hospital's commitment to a respectful environment and intolerance for discrimination; and

ii. The Hospital's reliance on a talented workforce and that the physician or care team member has been assigned based on their qualifications to care for the patient.

b. Attempt to employ strategies and communication tips that may be helpful when engaging the patient. (See Appendix C)

c. Inform your supervisor as soon as possible. Supervisors should support staff by monitoring how the situation is being addressed and intervening and assisting in its resolution, as needed. Intervention may include acknowledgement of the patient/family member's improper conduct and addressing whether the caregiver wishes to handle the situation by herself or himself and whether the caregiver wishes to remain involved in the care of the patient. 1

1 "How Should Organizations Support Trainees in the Face of Patient Bias," AMA Journal of Ethics, June 2019, Kimani Paul-Emile

4. Reasons for the Request and/or Behavior:

The reasons for the request or behavior may be clinically and ethically important. Rejection or preference of a clinician that is motivated by bigotry will not be accommodated. Other requests and/or behavior may be considered in context of trauma-informed and ethical patient care. All requests must be well-founded and consistent with both ethical patient care and the mission of an academic medical center.

5. Effect on the physician/caregiver:

Caregivers must balance several ethical obligations. Patient care is a priority, but reasonable limits may be placed on unacceptable patient conduct; it is the goal of the hospital to support patients and workforce members, and to encourage resolutions that provide quality patient care and staff support when handling these situations. This may include assessment of how best to engage care while not acceding to biased demands, debriefings, team meetings, and/or Worksafe physical/emotional harm reporting.

The following are examples of strategies and responses that may be helpful when presented with a situation where you believe a patient or family member is requesting or demanding a change in care provider/workforce member based on the characteristics listed in the policy statement.

1. Establish a therapeutic relationship and explore the patient/family request/demand:

- "Help me understand why you don't want (person's name) to care for you."
- "What are the things that you're concerned about?"
- "Tell me what you're afraid of."
- "What concerns you?"

2. Agree in truth or in principle with the statement:

- "You're right. You're different than I am, and what's important is that you're here seeking care and I'm here to help you."
- "You're right. You're different than I am. I'd like to get to know you. Tell me what's important to you."
- 3. Redirect the conversation:
- "All team members are appropriately qualified. Our top priority is that you receive appropriate care and I know that our team members can provide that."
- "I recognize that this team may be different than what you anticipated. I also know you are very worried about (problem/person). With your help, I'd like to think about how we can (fix this problem) (help NAME feel better)."
- "Let's make sure we're focused on doing what's best for you."
- "I'm worried about you/your child. With your help, I would like to focus on how we can help you/him/her."

4. Promote a safe environment for all workforce members:

- "We want to provide you with appropriate care and believe that (name) is a good person to do so."
- "I would trust this physician/nurse/therapist etc. to care for my own child/family member."
- "I agree with this physician/nurse/therapist etc. What other questions do you have?"
- "We are a teaching hospital and we believe strongly that our team provides outstanding care and everybody participates in your care."
- "We are here to help you as a team. We do not change (doctors, nurses, etc.) because of their (race, ethnicity, religion, etc.)."

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5. Educate and reinforce behavioral expectations:

- "We will not tolerate you speaking to our workforce that way. Being a patient at this hospital means treating people respectfully."
- "This Hospital hires the most qualified people to care for our patients regardless of their race, ethnicity, gender, sexual orientation, etc."

6. Supervisors should assess and discuss with the Provider first:

-- "The patient's conduct is not acceptable; would you first like to intervene and address with the patient yourself? Or would you like my assistance in engaging with the patient and family?"

-- The provider should be given an opportunity to discuss with the supervisor whether he or she wishes to remain involved in the care of that patient (opt out).

-- If the provider requests assistance, the supervisor should again intervene with the patient, employing the tools described above.

7. How to encounter interpersonal racism with "Questions":

(adopted from "Being Anti-Racist," https://nmaahc.si.edu/learn/talkingabout-race/topics/being-antiracist)

A commitment to being antiracist manifests in our choices. When we encounter interpersonal racism, whether obvious or covert, there are ways to respond and interrupt it. Asking questions is a powerful tool to seek clarity or offer a new perspective. Below are some suggestions to use in conversations when racist behavior occurs:

- Seek clarity: "Tell me more about _____."
- Offer an alternative perspective: "Have you ever considered _____."
- Speak your truth: "I don't see it the way you do. I see it as _____."
- Find common ground: "We don't agree on _____ but we can agree on_____."
- Give yourself the time and space you need: "Could we revisit the conversation about _____ tomorrow."
- Set boundaries. "Please do not say _____ again to me or around me.