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Contact Hours: **3**

Ethics for Case Managers, Part 3 Workplace Violence in Healthcare

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you will have increased your knowledge of risk factors and types of violence that occur in case management work settings in order to identify and react appropriately to workplace violence situations, as well as individual and organizational preventive measures. Specific learning objectives include:

- Discuss the definition and types of workplace violence.
- Describe the incidence and consequences of workplace violence.
- Identify risk factors and responses to risk factors, including those specific to the healthcare industry.
- Identify healthcare workers' responsibilities in responding to workplace violence and measures for de-escalation in cases of aggressive persons.
- Outline elements of a workplace violence prevention program and barriers to its effectiveness.
- Discuss effective institutional and employer initiatives to reduce workplace violence.

INTRODUCTION

Workplace violence came into public awareness in 1986 following the media attention given to the shooting of 14 postal workers by a coworker. At that time, the Federal Bureau of Investigation classified workplace violence as murder or other violent acts by an angry employee against coworkers or bosses. Since the post office killings, workplace homicide has been reported throughout the nation.

- From 1989 to 1998 in Southern California, workplace homicide incidents resulted in 29 deaths.
- In 2000, a software engineer killed seven coworkers in Massachusetts.
- In 2001, a Chicago forklift driver killed four coworkers.
- In 2011 in Georgia, a disgruntled worker killed several coworkers at a truck rental company.
- In 2014 in Oklahoma, a man recently fired from his job beheaded one former coworker and stabbed another.
- In 2015 in Virginia, two television journalists were shot to death during a live broadcast by a recently dismissed coworker.

With growing awareness, occupational safety specialists and other analysts have concluded that homicide and other physical assaults are not the only harmful behaviors in the workplace but that workplace violence is a continuum that includes domestic violence, stalking, threats, harassment, bullying, emotional abuse, intimidation, and other forms of conduct that create anxiety, fear, and a climate of distrust in the workplace. The types of perpetrators of workplace violence were also expanded to include any individual within a working environment, be it customer, family member, etc. (FBI, n.d.).

- In 2008 a nurse working in a New York hospital was awarded damages following sexual harassment by a physician. The hospital's medical director knew about the physician's misconduct but failed to take any action.
- In 2012 a woman working at a Kentucky home health services company was shot at work by her estranged husband.
- In 2013 a nurse was stabbed to death and four other people were wounded by a visitor at a hospital in Longview, Texas.
- In 2014 in a New York hospital, a patient attacked a nurse and repeatedly kicked the nurse in the head, causing brain damage and life-threatening injuries.
- In 2015 a surgeon at Brigham and Women's Hospital in Boston was shot and killed at work by the son of a deceased patient.

Reliance on violence to address any perceived threat is a characteristic of many individuals in American society. It is, therefore, no surprise that violence occurs in the workplace. It has been recognized as a public health issue that requires identifying those factors that can lead to violence and the development of strategies that can keep employees safe.



WHAT CONSTITUTES WORKPLACE VIOLENCE?

The Occupational Safety and Health Administration (OSHA, 2017) defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at any work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers, and visitors.

The National Institute for Occupational Safety and Health (NIOSH, 2016) defines a work setting as any location, either permanent or temporary, where an employee performs work-related duties. This comprises, but is not limited to, the buildings and surrounding perimeters, including the parking lots, field locations, clients' homes, and traveling to and from work assignments.

Workplace violence ranges broadly from offensive or threatening language to homicide. Elements of workplace violence include beatings, stabbings, suicides, shootings, rapes, psychological traumas, threats or obscene phone calls, intimidation, harassment of any kind, as well as being sworn at, shouted at, or followed. Instances of workplace violence also often raise legal and ethical issues that concern healthcare providers.

EXAMPLES OF WORKPLACE VIOLENCE

- Verbal threats to inflict bodily harm, including vague or covert threats
- Attempting to cause physical harm: striking, pushing, and other aggressive physical acts against another person
- Disorderly conduct, such as shouting, throwing or pushing objects, punching walls, and slamming doors
- Verbal harassment; abusive or offensive language, gestures, or other discourteous conduct toward supervisors or fellow employees
- False, malicious, or unfounded statements against coworkers, supervisors, or subordinates intended to damage reputations or undermine authority
- Vandalism
- Sabotage
- Theft
- Mugging
- Rape
- Arson

In the mid-1990s, as more researchers were becoming engaged in the study of occupational violence, the California Occupational Safety and Health Administration developed a model that describes three distinct types of workplace violence based on the perpetrator's (person



committing the violence) relationship to the victim and/or the place of employment. Later, the typology was modified to define four types of workplace violence, creating the system that remains in wide use today.

The four types of workplace violence are:

- Type 1: Violence by a stranger with criminal intent
- Type 2: Violence by a customer or client
- Type 3: Violence by a coworker
- Type 4: Violence by someone in a personal relationship

Type 1: Violence by a Stranger with Criminal Intent

In this type of workplace violence the perpetrator is a stranger without a legitimate relationship to the organization or its employees. Typically, a crime is being committed in conjunction with the violence. The primary motive is usually robbery, but it could also be shoplifting or criminal trespassing. A deadly weapon is often involved, increasing the risk of fatal injury. Crimes of violence in this category include assault, sexual assault, robbery, homicide, and acts of terrorism.

In 2014, 31% of workplace homicides were perpetrated by robbers. Workers who are at higher risk for violence by a stranger with criminal intent are those who exchange cash with customers as part of the job, work late-night hours, and/or work alone. Convenience store clerks, taxi drivers, and security guards are all examples of the kinds of workers who are at increased risk for criminal violence (Safety.BLR, 2015).

Type 2: Violence by a Customer or Client

In type 2 incidents, the perpetrator has a legitimate relationship with the organization by being a recipient of its services. This category includes customers, clients, patients, students, inmates, and any other group for which the business provides services. The violence can be committed in the workplace or, as with home healthcare providers, outside the workplace but while the worker is performing a job-related function.

About 20% of all workplace homicides result from type 2 violence and account for a majority of nonfatal workplace violence incidents. A large portion of customer/client/patient incidents occur in the healthcare industry in settings such as nursing homes or psychiatric facilities. The victims are often patient caregivers. Other service providers include police officers, prison staff, flight attendants, and bus and train operators. Teachers are also frequent victims of this type of violence (Safety.BLR, 2015).

INHERENTLY VIOLENT WORKPLACES

One category of type 2 violence involves inherently violent situations or settings, such as prisons or mental health facilities. Attacks from “unwilling” clients (those who have not chosen to be a



recipient of services), such as prison inmates on guards or crime suspects on police officers, are examples of this type of workplace violence. The risk of violence to some workers in this category may be constant or even routine.

In healthcare settings, attacks often occur from these same “unwilling” clients who are brought into emergency departments or mental health facilities by law enforcement for assessment and/or treatment.

CASE

Eric is a case manager who works part-time on the night shift at Memorial Medical Center, a mid-sized hospital in a suburb of a large metropolitan area. The hospital emergency department (ED) has eight beds and is relatively quiet unless they are treating overflow patients from the trauma unit downtown. Recently, the hospital agreed to allocate space in the ED for the local police department to admit suspected drunk drivers for assessment and short-term intervention. To date there have been only a handful of such cases.

Eric was on duty when an intoxicated 28-year-old male patient was admitted for assessment after hitting a parked car while leaving a party. The patient, who was initially cooperative while the police officer was present, was taken to one of the assessment rooms at the end of the hall by a nurse.

When Eric entered the room, the patient denied he had done anything wrong, jumped up, and angrily demanded to be released. Startled, Eric told the patient he could not leave, grabbed onto his arm, and attempted to force him to sit down in the chair. The patient jerked loose from Eric’s grasp, picked up a small metal canister off the counter, threw it at Eric, and ran out of the room toward the entrance, where he was subdued by the hospital security guard and two additional staff members. The canister hit Eric in the face, injuring his left eye.

Discussion

This scenario is a classic example of type 2 violence, by a customer or client, involving an unwilling person taken to the emergency room by law enforcement. It also illustrates important ethical issues that may confront a case manager in such a scenario.

The fundamental ethical principle of autonomy—which refers to the ability of an individual to think, decide, and act upon one’s own initiative—requires Eric to allow a patient to make informed decisions and to honor the patient’s decisions regarding the services they receive, such as the patient’s demand to be released. The ethical principle of beneficence requires a case manager to perform in a competent, caring manner that will benefit the patient, and the principle of nonmaleficence requires the case manager to do no harm to a patient.

By grabbing the patient and attempting to force him to sit down, Eric did not adhere to these principles. Further, Eric’s actions may constitute assault (doing or saying anything that makes people fear they will be touched without their consent) and battery (touching a person without consent) by attempting to force the patient to submit to actions for which he does not consent.



Assault and battery are considered civil offenses and also likely constitute unprofessional behavior by Eric, which contradicts Standard 19 (Professional Conduct) within the Code of Professional Conduct for Case Managers.

SITUATIONAL VIOLENCE

The other category of type 2 violence involves people who are not known to be violent but can become violent in response to something present in the situation. Provoking situations may be those that are frustrating to the individual, such as denial of needed or desired services or delays in receiving such services.

CASE

Alice Adams is a 70-year-old resident at Hillcrest Manor, a skilled nursing and long-term care facility. She was admitted six months ago after she was found wandering a few blocks away from her long-time family home. She was recently diagnosed with second-stage Alzheimer's disease. Prior to her admission she lived alone with daily help from her two sons, their wives, and several grandchildren. Her husband died eighteen months ago after a fall from a ladder while cleaning leaves out of the gutters.

The older son, Jack, still feels guilty for not helping his father with the gutter clean-up and blames himself for his father's death. He was not in favor of the decision to admit his mother to Hillcrest but reluctantly agreed when the other family members and Alice's physician decided it was the best option. Jack has been a frequent caller to the facility with complaints about his mother's care. He thinks that she is not checked often enough, that she needs more help with meals, and that she should be taken for walks more frequently. He believes that his mother's health is worse and blames the facility for a decline in her mental capacity.

Today Jack arrives to find Alice dozing in her recliner chair with her supper tray sitting untouched on the table next to her. He storms out of her room into the hallway and shouts that he needs help right away. The case manager, Denise, is just down the hall and responds immediately to the shouting. Jack grasps Denise's shoulders and pushes her into his mother's room, asking why his mother has not been helped yet with her meal. He curses and states that this is the last time he is going to ask nicely.

Denise recognizes Jack and is familiar with his frequent complaints about his mother's care. She extracts herself from his grip, steps aside, and moves slowly to exit the room. Standing in the doorway, she calls him by name, calmly stating, "Mr. Adams, I can see that you are upset. I will ask an aide to come help your mother right away. It sounds like you would also like to talk with someone about your concerns, and I will be glad to meet with you." Jack visibly relaxes.

After calling a nursing assistant to help Alice with her meal, Denise suggests that she and Jack meet in her nearby office. Leaving the door open for safety, she asks Jack to describe what happened, and as he does, he acknowledges that his behavior was out of line. He apologizes for his outburst and shares how frustrated he is with his mother's health decline and not being able



to do anything to prevent it. Denise acknowledges his feelings and how difficult it must be for him to deal with the kind of changes he has been faced with. She also states that his behavior was inappropriate and that she will have to report it to the facility's security manager. She tells Jack that any additional incidents like she witnessed that evening will result in further action to ensure the safety of the residents and the employees. She reminds him that he can communicate any concerns about his mother's care to the nurse on duty or to her if it is the evening shift.

Denise then suggests that Jack may benefit from talking with the facility's counseling staff, who run a support group for families and caregivers, and she provides him with the phone number and schedule of group meetings. Jack agrees that the suggestion sounds like a good idea and returns to his mother's room to resume his visit.

Discussion

This scenario also an example of type 2, situational violence by a customer or client. Jack's frustration about a perceived lack of services for his mother led to his verbal outburst and physical violence against Denise.

Denise's calm yet decisive actions demonstrated various recommended responses to violent clients, such as moving to a safer location near the door, assisting the person to manage their emotions, remaining calm, and being respectful while firmly setting limits (all discussed later in this course).

Denise also acted in accordance with the underlying values described in the Code of Professional Conduct for Case Managers, such as "recognize the dignity, worth and rights of all people" and "understand and commit to quality outcomes for clients, appropriate use of resources, and the empowerment of clients in a manner that is supportive and objective." She was guided by the ethical principle of beneficence, or performing in a competent, caring manner that will benefit the patient.

Type 3: Coworker (Worker-to-Worker) Violence

Coworker violence occurs when an employee or past employee attacks or threatens coworkers. This category includes violence by employees, supervisors, managers, and owners. In some cases, these incidents can take place after a series of increasingly hostile behaviors from the perpetrator. The motivating factor is often one, or a series of, interpersonal or work-related disputes. The perpetrator may be seeking revenge for what is perceived as unfair treatment.

Worker-to-worker violence accounts for approximately 15% of all workplace homicides. Because some of these incidents appear to be motivated by disputes, managers and others who supervise workers may be at greater risk of being victimized. Workplaces at higher risk include those that do not conduct a criminal background check as part of the hiring process or are downsizing or otherwise reducing their workforce (Safety.BLR, 2015).



EXAMPLES OF COWORKER VIOLENCE

Examples of the most frequently encountered situations among coworkers are:

- Concealing or using a weapon
- Physical assault
- Actions which damage, destroy, or sabotage property
- Intimidating or frightening others
- Harassing, stalking, or showing undue focus on another person
- Physically aggressive acts, such as shaking fists at another person, kicking, pounding on desks, punching a wall, angrily jumping up and down, screaming at others
- Verbal abuse including offensive, profane and vulgar language
- Threats (direct or indirect), whether made in person or through letters, phone calls, electronic mail

Source: USDOL, 2017a.

The American Psychiatric Nurses Association characterizes worker-to-worker violence as either vertical or horizontal.

VERTICAL VIOLENCE

Vertical violence is defined as any act of violence that occurs between two or more persons on different levels of the hierarchical system and prohibits professional performance and satisfaction in the workplace.

Vertical violence may be directed downward (e.g., superior to subordinate) or upward (e.g., subordinate to superior). Vertical violence can reflect either an abuse of legitimate authority or abuse of informal power. Abuse of informal power by individuals or cliques of coworkers are behaviors that undermine the work of a manager or leader.

Vertical violence is prevalent among nurses and between doctors and nurses and can be connected to medical errors and preventable negative outcomes for patients. For example, a nurse may be reluctant to call a physician about a patient's worsening condition because of physician bullying, incivility, or overt or covert abuse; or a medication order may not be questioned in order to avoid the threat of intimidation.

Factors that contribute to vertical violence in healthcare between physicians and nurses include:

- Physicians are revenue generators and decision makers.



- Often, disruptive physicians are the most clinically talented and valued by hospital administration.
- Administration may give in to physician demands.
(Burkhardt, 2015)

CASE

Roland is a nurse case manager at a small, rural hospital. Among the physician staff there, Dr. Johnson is known to be difficult to work with. He has been an angry man ever since his daughter was killed in a car accident caused by a drunk driver ten years ago. He is rude and obnoxious both to staff and patients.

This evening, Roland is assigned to assist in the discharge of the patient in room 3. Roland knocks on the closed door and then opens it slowly, announcing he is here to assist with the discharge. Dr. Johnson, who is in the room speaking with the patient, abruptly walks to the door and slams it shut, hitting Roland in the face. Shaken but not seriously injured, Roland waits down the hall until he sees Dr. Johnson leave the room and then returns to the room to assist the patient.

As soon as the patient has been discharged, Roland informs his supervisor of this workplace violence incident. By now, a bruise is beginning to form on his forehead where he was struck by the door. He follows policy and completes and submits an incident report before he leaves. When he gets home, he writes down the sequence of events.

No action has ever been taken in regard to Dr. Johnson's violent behavior despite Roland and other nurses having reported such behavior many times before. The department manager has told the nurses that Dr. Johnson is dealing with grief and that they should understand what he is going through. After all, it is hard to find doctors to staff the hospital, and dealing with such situations is just "part of the job." As a result, the nurses have become resigned to this physician's behavior and try to avoid any interaction that might cause him to abuse them. After this latest incident, Roland complains to his coworkers.

Seeing too many such scenarios go unreported or get reported and be swept under the rug, another nurse decides to contact the new medical director, Dr. Bachhuber. The next day, Dr. Bachhuber calls Roland into her office and asks about the recent incident with Dr. Johnson. She reviews the incident report completed at the time the event occurred. The medical director tells him there will be an investigation carried out to determine the extent of the problem and offers to have Roland evaluated medically.

HORIZONTAL (LATERAL) VIOLENCE

Horizontal, or lateral, violence refers to workplace conflict in which confrontational behavior is targeted at one person by another employed at the same level of responsibility across time in repeated instances of emotional, psychological, physical, or sexual abuse. It is meant to reach a



power relationship in which the victim is controlled emotionally by the abuser. The practitioners of lateral violence characteristically demonstrate impatience, condescension, anger, threatening posturing, and even physical aggression.

Horizontal violence is prevalent in the nursing profession. Nearly all nurses experience this type of violence in their careers. One study showed that 97% of nurses surveyed reported lateral violence in their healthcare workplace as a common occurrence. Studies have arrived at the conclusion that lateral violence in the healthcare workplace is a nearly universal experience for nurses (Rainford et al., 2015).

A negative work environment affects a hospital financially when it must replace each nurse experiencing burnout. Lateral violence by nurses is estimated to cost more than \$4 billion dollars each year due to lost time, lost productivity, and turnover of trained staff (Rainford et al., 2015).

Attempts to explain the high incidence of horizontal violence in the nursing profession are traced to the history of nursing, where oppression was once the norm between the male medical profession and female nurses. Members of the nursing profession have been described as an oppressed group, and according to Feier's theory of oppression (1970), the oppressed group internalizes the values, norms, and behaviors of the dominant group as the most appropriate, while the characteristics of their own group become negatively valued and suppressed.

Contributing factors to horizontal or lateral violence in the nursing profession include:

- The field of nursing is predominantly female (studies document that male nurses feel more valued than female nurses do).
- Nurses are under the dominance of a patriarchal system.
- Nursing managers are marginalized.
- Displaced frustration from perceived oppression is played out toward coworkers. (Burkhardt, 2015)

By extension, other healthcare professions or professional specialties may face similar issues if they practice under a patriarchal system and with a high proportion of women.

WORKPLACE BULLYING

Workplace bullying is defined as frequent or repeated personal attacks that are emotionally hurtful or professionally harmful. Bullying is a deliberate attempt to undermine a coworker's ability to carry out work, to injure the person's reputation, to undermine the person's self-esteem and self-confidence, or to remove personal power from that coworker.

Bullying can be both obvious and subtle. The following are examples of bullying:

- Spreading malicious rumors, gossip, or innuendo



- Excluding or isolating someone socially
- Intimidating a person
- Undermining or deliberately impeding a person's work
- Physically abusing or threatening abuse
- Removing areas of responsibilities without cause
- Constantly changing work guidelines
- Establishing impossible deadlines that will set the person up to fail
- Withholding necessary information or purposefully giving the wrong information
- Making jokes that are obviously offensive by spoken word or email
- Intruding on a person's privacy by pestering, spying, or stalking
- Assigning unreasonable duties or workload which are unfavorable to one person in a way that creates unnecessary pressure
- Assigning too little work (underwork), creating a feeling of uselessness
- Yelling or using profanity
- Criticizing a person persistently or constantly
- Belittling a person's opinions
- Unwarranted or undeserved punishment
- Blocking applications for training, leave or promotion
- Tampering with a person's personal belongings or work equipment (CCOHS, 2017)

CASE

Elizabeth, a case manager, moved from Chicago to a small town in Montana and now works at the local hospital there. This is her second job since graduating two years ago. Elizabeth has not been having good experiences with her coworker Margaret. Margaret often makes snide remarks about Elizabeth being “a big city girl with little experience” and belittles her when she speaks up at staff meetings.

Several times over the past month, Elizabeth asked for assistance from Margaret and was told she needed to “learn to set priorities better.” At times when she asked for information about a patient or situation, Margaret rolled her eyes, ignored her, and walked away.



Elizabeth recognized she was being bullied and needed to take steps to stop it. She began keeping a journal, objectively recording specific behaviors, including date, time, who else was present, and any other details surrounding each incident. When she felt she had enough documentation, Elizabeth sought out another coworker who was very supportive and asked if she would accompany her when she decided to talk to Margaret about her concerns. The coworker agreed.

Elizabeth made an appointment with Margaret. At their meeting, Margaret asked the coworker to leave, but Elizabeth said she had a right to have someone with her because she wanted to feel safe discussing how Margaret was treating her. During the meeting Elizabeth presented her journal to Margaret, told her she was being bullied, and said she wanted it to stop. She also handed Margaret a memo stating that Margaret's behavior was unacceptable, distracts from her work, and that if the behavior continued, she would need to go to the next level of authority. Elizabeth left the meeting, thanked the other coworker, and documented the meeting in her journal.

Over the next few days, Margaret never mentioned Elizabeth's complaint, but her behavior changed and the bullying stopped. Elizabeth's confidence returned and she began to enjoy her work.

Type 4: Violence by Someone in a Personal Relationship

Type 4 workplace violence accounted for about 7% of all workplace homicides in 2014. It is often the greatest threat to female employees and is most likely to occur in organizations with large female populations where there is easy access by outsiders during business hours (Safety.BLR, 2015).

In this type of workplace violence, the perpetrator usually has or has had a personal relationship with the intended victim and does not have a legitimate relationship with the workplace. The incident may involve a current or former spouse, lover, relative, friend, or acquaintance. The perpetrator is motivated by perceived difficulties in the relationship or by psychosocial factors that are specific to the situation and enters the workplace to harass, threaten, injure, or even kill.

Type 4 violence is often the spillover of domestic violence into the workplace. In some cases, a domestic violence situation can arise between individuals in the same workplace. These situations can have a substantial effect on the work environment. They can manifest as high absenteeism and low productivity on the part of a worker who is enduring abuse or threats, or the sudden, prolonged absence of an employee fleeing abuse.

IMPACT OF WORKPLACE VIOLENCE

Specific data related to workplace violence is collected by the National Institute for Occupational Safety and Health (NIOSH), which records reported workplace injuries and fatalities, including assaults, violent acts, and homicides. According to NIOSH (2017), 409 workers in private



industry and government were homicide victims in 2014. Of those victims, 83% were male, 49% were white, and 32% were working in a retail establishment.

In that same year, 15,980 workers in the private industry experienced trauma from nonfatal workplace violence. Of these individuals who experienced trauma, 67% were female, 69% worked in the healthcare and social assistance industry, 23% required 31 days or more away from work to recover, and 20% required three to five days away from work.

OSHA (2017) reported workplace violence as:

- The fourth leading cause of occupational injuries in the United States
- The number one cause of death for women in the workplace

A study reported in 2015 comparing the number of actual events with the number entered into a central electronic database showed that 88% of those experiencing workplace incidents had not documented it in the system while more than 45% had reported violence only informally (e.g., to their supervisors). If employees were injured or lost time from work, they were more likely to make a formal report. Such data supports the contention that workplace violence is underreported (Arnetz et al., 2015).

Incidence of Workplace Violence in the Healthcare Setting

People in the healthcare setting are working in the most violent industry in the United States outside of law enforcement. Violence in the workplace against healthcare workers has been reported as being “rampant.” Although healthcare workers comprise just 13% of the U.S. workforce, between 2011 and 2013, 75% of workplace assaults occurred in healthcare settings. The majority of these incidents are verbal, but many others constitute assault, battery, domestic violence, stalking, or sexual harassment (Hackethal, 2016; Phillips, 2016).

A majority of states have criminal statutes specifically addressing assaults on emergency medical providers, and the following states make it a felony to assault a healthcare worker or emergency medical personnel:

- Alabama
- Arizona
- Arkansas
- Connecticut
- Delaware
- Florida
- Hawaii
- Idaho
- Illinois



- Iowa
- Kentucky
- Maine
- Michigan
- Minnesota
- Mississippi
- Missouri
- Nebraska
- Nevada
- New Mexico
- New Jersey
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- Texas
- Washington
- West Virginia
- Wisconsin

(Jacobson, 2014; Coble, 2016)

Various studies of workplace violence in healthcare settings have shown the following:

- In **prehospital** settings, 4.5% of violent encounters were against emergency services personnel. Patients accounted for 90% of this violent behavior.
- The career prevalence of physical violence toward **emergency department (ED)** personnel was 80%. Emergency departments and psychiatric wards in hospitals are the most violent, with nurses and nursing aides victimized at the highest rates. ED nurses had the highest rates, with 100% reporting verbal assault and 82.1% reporting physical assault during the previous year. Nationwide, 78% of ED physicians reported being targets of workplace violence in the prior year; 75% reported verbal threats, 21% physical assaults, 5% confrontations outside the workplace, and 25% stalking.



- Healthcare providers working in **inpatient psychiatric** environments are at higher risk for targeted violence than in other settings: 40% of psychiatrists report physical assault, the annual incidence for all staff members was 70% for physical assault; and psychiatric aides have 69 times the national rate of violence in the workplace.
- Among **nursing home** aides, 59% reported being assaulted weekly and 16% daily, particularly those who work in dementia units. Slightly over 50% reported they had been physically injured by a patient, with 38% of this number requiring medical attention.
- Surveys of **home healthcare** workers shows that 61% report workplace violence annually. Homicide is the second leading cause of workplace death in this group, exceeded only by motor vehicle crashes.
- One third of **pediatric** residents reported being assaulted by families of patients during their training.
(Furin et al., 2015; Perrin et al., 2015; Phillips, 2016)

Consequences of Workplace Violence

Workplace violence extracts a significant toll on everyone involved. This includes physical, emotional, and mental effects on the **individual**, such as:

- Physical injury (minor to severe disability)
- Psychological trauma (short- and long-term)
- Emotional distress/anxiety
- Lowered self-esteem
- Posttraumatic stress disorder (PTSD)
- Death by suicide
- Chronic stress-related illness
- Intent to leave the job
- Feelings of incompetence, guilt, powerlessness
- Fear of returning to work
- Fear of criticism by supervisors
- Loss of confidence in ability
- Changes in relationships with coworkers
- Secondary impact on personal life (daily activities, emotional issues, economic issues)
(NIOSH, 2016)



Negative consequences for **institutions** can include:

- Decreased productivity
- Low employee morale
- Increased job stress
- Absenteeism and lost work days
- Restricted or modified duty (secondary to injury)
- Increased employee turnover with retention issues
- Recruitment challenges
- Distrust of management
- Financial loss resulting from insurance claims
- Legal expenses
- Property damage
- Increased security measures
- Diminished public image

The cost to American businesses from workplace violence has been estimated at \$120 billion each year. The average jury award was \$3.1 million per person per incident in cases where the employer failed to take proactive, preventive measures. It is estimated that the cost of reacting to a serious incident is 100 times more costly than taking preventive action (Papa & Venella, 2013).

COSTS OF WORKPLACE VIOLENCE TO HEALTHCARE FACILITIES

Workplace violence in healthcare facilities has been shown to be very costly. In one hospital system in one year, 30 nurses required treatment for violent injuries at a total cost of \$94,156 each—\$78,924 for treatment and \$15,232 for lost wages. Other costs include replacing a nurse who has become dissatisfied or burned out. This is estimated to be \$27,000 to \$103,000, which includes separation, recruiting, hiring, orientation, and training (OSHA, 2015a).

RECOGNIZING AND RESPONDING TO WORKPLACE RISK FACTORS

NIOSH (2016) offers a number of actions that can be taken to minimize the risk of violence in the workplace and refers to them as “universal precautions.” These precautions acknowledge that violence should be expected but can be avoided or mitigated through preparation that includes:



- Paying attention to physical surroundings
- Trusting personal instincts
- Presenting a strong, confident image by posture, stride, and eye contact
- Leaving an uncomfortable situation, if possible
- Avoiding locations that are poorly lit or have poor visibility, if possible
- Carrying and using a flashlight if the surroundings are poorly lit or when traveling at night
- Working with a partner or having an effective means of communication, such as a cellphone or pager
- Using the locks and security systems that are available
- Reporting security hazards promptly to a supervisor
- Not using a cellphone or personal music system while en route to or from the workplace
- Taking a self-defense class or requesting that the facility offer one
- Dressing for safety
 - Removing anything that can be used as a weapon or grabbed by someone
 - Tucking long hair away
 - Not wearing earrings or necklaces that can be pulled
 - Avoiding overly tight clothing that can restrict movement
 - Avoiding overly loose clothing or scarves that can be grabbed
 - Using breakaway safety cords or lanyards for glasses, keys, or name tags

Nothing can guarantee that an employee will not become a victim of workplace violence. However, every employee should be aware of the risk factors that contribute to workplace violence and what can be done to avoid it.

Identifying Risk Factors

Healthcare and social service workers face an increased risk of work-related assaults stemming from several risk factors. These include:

- Working with people who have a history of violence or who may be delirious or under the influence of drugs
- The increasing use of hospitals by police and the criminal justice system for criminal holds
- Care of acutely disturbed individuals



- Increasing number of acute and chronically mentally ill patients being released from hospitals without follow-up care (these patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others)
- The unrestricted movement of the public in clinics and hospitals
- Long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly
- The increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members
- Low staffing levels during times of increased activity, such as mealtimes, visiting times, and when staff are transporting patients
- Isolated work with clients during examinations or treatment
- Working alone in remote locations, with no backup or way to get assistance (i.e., communication devices or alarm systems); this is particularly true in high-crime settings (OSHA, 2015a)

Cultural factors unique to the healthcare setting include:

- Putting oneself at risk to help a patient because of a professional and ethical duty to “do no harm”
- The belief that violence is just “part of the job,” routine, and unavoidable
- The unintentional nature of patient violence and unwillingness to stigmatize patients due to their illness or impairment
- Increased use of emergency departments rather than specialized facilities for treatment of severely ill patients with violent tendencies due to lack of funding for mental health services (OSHA, 2015a)

RISK FACTORS IN THE PHYSICAL ENVIRONMENT

Early recognition of risk factors calls for enhanced awareness of the security hazards in the physical environment that isolate employees, allow others easy access to buildings and work sites, or place potential weapons within reach.

General workplace security hazards include:

- Isolated location or job activities
- Numerous points of entry and exit and uncontrolled access to the building



- No locks on doors or between work areas
- Lighting problems, such as dark hallways and parking lots
- Lack of phones or means of communication between employees
- Early-morning or night-time hours of employment
- Unknown person(s) loitering outside workplace
- Easy access to potential weapons, such as knives or scissors

COMMON SECURITY-SENSITIVE AREAS

Security-sensitive areas in healthcare organizations are areas that require a higher level of security than others and are identified as such because of either the types of materials used or stored in the area or the level of security or confidentiality needed for patient care. These include:

- Birthing center (maternity, nursery, labor and delivery, postpartum)
- Pediatrics
- Emergency department
- Behavioral health (inpatient and outpatient) and detox units
- Nuclear source material storage areas
- Pharmacy
- Health information services (medical records)
- Human resources
- Operating rooms
- Cash handling areas (business office, food service)

Source: Warren, 2015.

The **unique characteristics** of hospitals, clinics, and other healthcare settings add to the potential of environmental security hazards. These may include:

- Hospitals being open 24 hours a day, 7 days a week, 365 days a year
- Availability of drugs or money in the pharmacy or medication area, making them likely targets for robbery
- An 80% female population (staff and patients)



- Open visiting hours and the presence of large numbers of persons who may or may not be connected to a patient (e.g., patients’ families or friends, volunteers, repair persons, outside vendors, outpatients, students, persons making financial inquiries, and other members of the public)
- Lack of security personnel in open clinics and hospitals
- Treatment areas not prepared for violent patients (e.g., moveable furniture that could be used as weapons or to entrap employees, possible items on countertops that could be thrown at workers)
- Crisis mentality/high-tension environment
 (Warren, 2015)

RISK FACTORS IN THE BEHAVIOR OF OTHERS

No one can predict human behavior, and there is no specific profile of a potentially dangerous individual. There are, however, “red flags” that can alert others to a potentially threatening and violent person in the workplace. There are three levels of warning signs, which include:

Level One (early warning signs). The person is:

- Intimidating/bullying
- Discourteous/disrespectful
- Uncooperative
- Verbally abusive

Level Two (escalation). The person:

- Argues with customers, vendors, coworkers, and management
- Refuses to obey facility policies and procedures
- Sabotages equipment and steals property for revenge
- Sends threatening note(s) to coworker(s) and/or management
- Sees self as victimized by management

Level Three (emergency response usually required). The person displays intense anger resulting in:

- Suicide threats
- Physical aggression



- Destruction of property
- Extreme rage
- Utilization of weapons to harm others
(USDOL, 2017a)

(See also “Recognizing and Responding to Workplace Violence” later in this course.)

RISK FACTORS FOR COMMUNITY-BASED EMPLOYEES

Community-based employees are at risk for violence in the home by patients or family members. Workers can be victims of violence themselves, or they can experience vicarious trauma after witnessing domestic abuse or violence among family members. Verbal abuse is the most common form of violence, with abuse by patients more common than by relatives.

When the workplace is a private home, employer safety policies and programs are not in place. Community-based employees must rely on their own resources to deal with abuse and violence, evaluating each situation for possible violence by being alert and watching for signs of impending violent assault. These include:

- Verbally expressed anger and frustration
- Threatening gestures
- Signs of drug or alcohol abuse
- Presence of weapons

Any unsecured weapon observed in a client’s home should be reported to the employer as soon as the employee is out of hearing of the occupants of the home.

Working in any community setting outside a traditional office building increases the risk of coming in contact with potentially violent situations. Prevention measures for “field” workers include consideration of the following:

- Preparing a daily work plan/itinerary, including both locations and estimated times of arrival and departure
- Including an itinerary of anticipated public transport routes if such transport will be used and sharing that itinerary with a supervisor
- Avoiding traveling alone into unfamiliar locations or situations whenever possible
- Varying travel routes (both in and out of a vehicle) when making repeat visits to a location
- Maintaining periodic contact with others throughout the day
- Using a buddy system



- Using telecommunication devices
- Carrying minimal money and payment cards and carrying them in a variety of places in clothing and equipment
- Carrying required identification, also in varied places
- Recognizing potentially dangerous situations ahead of time and initiating backup

CASE

Janice is working part-time as a case manager for a home hospice agency two evenings per week and on weekends. She shares an apartment with two housemates and commutes 30 minutes to the hospice office for work. She is required to check in at the main office before her shift starts to pick up her assignments and attend occasional staff meetings and training sessions. She is not required to return to the office at the end of her shift. Rather, she can go home after she finishes with her last client.

Janice attended hazard assessment and safety training when she was hired for the job as a case manager. The training is repeated on an annual basis for each worker at the agency. Janice remembers hearing about a case in a nearby city in which a case manager was assaulted by an angry family member, and the story has stuck with her. The injured employee was the same age as Janice. She does not need to be talked into attending the training sessions when they are offered.

Janice readily follows the safety protocols that have been established by the hospice agency and has added a few of her own.

- She shares a copy of her scheduled home visits with her supervisor, including the client's name, phone number, and street address.
- She takes a few minutes prior to leaving for the first client visit to familiarize herself with the locations she will be visiting and determine if there are known high-risk areas in the vicinity; she plans the routes she will use to travel from one client home to the next, avoiding any potentially dangerous areas.
- She makes sure her car is in good repair and the gas tank is full. She carries a spare key in her supply bag and hides another one in a purpose-made device on her bumper.
- She travels with her car doors locked and windows rolled up.
- She parks in the client's driveway or in well-lighted areas located as close to the client's home as possible.
- She locks any supplies and personal belongings out of sight in the trunk of the car.



- She carries a cellphone and makes sure the batteries are fully charged at the beginning of each shift.
- She is familiar with the emergency notification system at work and the number to call to request back-up.
- She arranges to use the buddy system put in place by the agency whenever her instincts tell her it would be a good idea. She has done this for her coworkers and does not hesitate to ask for help for herself.
- She confirms with her clients ahead of time by telephone so that her arrival is expected.
- Before getting out of the car, she checks the surrounding area and does not leave the car if she feels uneasy.
- She calls one of her roommates at the end of her last client home visit to report where she is and when she will be home.

By following these steps, Janice feels comfortable that she is taking the necessary precautions to avoid finding herself in a potentially dangerous situation.

In the Home Healthcare Setting

The home healthcare worker should follow the same measures as described for those working in a healthcare facility. In addition, home healthcare workers should be instructed to:

- Avoid situations that do not “feel right”; trust personal instincts and judgment.
- Sit or stand close to the door.
- Keep a cellphone in a pocket or attached to clothing.
- Use diversional tactics to help an agitated person calm down (offer something to drink, for example).
- Keep shoes on. If asked to remove them, explain it is a safety and health policy that they be worn.
- When threatened and unable to gain control of the situation, leave as quickly as possible and go to a safe place.
- Call 911 if necessary.
- Always document and report the incident.
(NIOSH, 2014a)



RECOGNIZING AND RESPONDING TO WORKPLACE VIOLENCE

Although it is important to be able to identify risk factors for workplace violence, it is equally important to know how to respond to the three levels of violence should they occur.

Responses to **Level One** (early warning signs) include:

- Observe the behavior.
- Report concerns to the supervisor to seek help in the assessment and response to the situation.
- If the offending person is the reporting employee's immediate supervisor, notify the next level of supervision.
- If the offending person is not an employee, report it to the supervisor, who should provide the initial response.
- Document the observed behavior.

Responses when a situation has escalated to **Level Two** (escalation) include:

- Secure one's own safety and the safety of others, including contacting people who are in danger.
- Immediately contact the supervisor and, if necessary, the supervisor will contact other appropriate officials.
- Document the observed behavior.

Responses when situation is a **Level Three** emergency (emergency response required) include:

- Secure personal safety first.
- Call 911 and other appropriate emergency contacts.
- Remain calm and contact the supervisor.
- Cooperate with law enforcement personnel when they have responded to the situation.
- Document the observed behavior.
- Prepare to provide a description of the violent or threatening individual.
(USDOL, 2017a)



Managing the Aggressive Person

When confronted with an aggressive person in any setting, it is important to utilize **de-escalation techniques** in an attempt to prevent harm to the person or to others. The objectives of such techniques are to:

- Ensure the safety of the person, the staff, and others in the area
- Assist the person to manage emotions and regain control of behavior
- Avoid coercive interventions that could increase agitation

Verbal de-escalation techniques involve three things—self-control, physical stance, and de-escalation communication.

SELF-CONTROL

Recommendations for self-control include:

- Appear calm and do not show fear. Relax facial muscles and look confident. Anxiety can make the aggressive person feel anxious and unsafe, which can escalate aggression.
- Speak in a modulated, low, monotonous tone of voice. A high-pitched, tight voice conveys fear.
- Be aware of body language. Nonverbal communication (gestures, facial expressions, tone of voice, and movements) is extremely important in exhibiting a calm and respectful attitude.
- Do not be defensive. Even if the comments or insults are directed at you, they are not about you. Do not defend yourself or anyone else from insults, curses, or misconceptions about their roles.
- Do not point or shake your finger at the person.
- Do not touch or attempt to touch the person, even if some touching is generally appropriate in the setting. Touching may be misinterpreted to be hostile or threatening.
- Be aware of the back-up assistance that is available and crisis response procedures.
- Be very respectful even when firmly setting limits or calling for help. The agitated individual is very sensitive to feeling shamed and disrespected.

(Daud, 2015; NASW, 2017)



PHYSICAL STANCE

Recommendations for physical stance include:

- Never turn your back to the person for any reason.
- Respect others' personal space. The amount of personal space people require to feel comfortable may vary greatly, and anxiety rises when that space is entered by others. Maintain extra physical space at about four times the usual.
- Be aware of body position. Avoid toe-to-toe positions, as they may be considered challenging. Stand at an angle to an aggressive person and off to one side so you can sidestep away if needed.
- Have an escape route. Stand between the door and the individual.
- Always maintain the same eye level. Encourage the person to be seated. But if the person needs to stand, you stand up also.
- Do not smile. This could be interpreted as mockery or anxiety.
- Keep hands out of your pockets, up, and available to protect yourself.
(Daud, 2015; NASW, 2017)

DE-ESCALATION COMMUNICATION

Recommendations for de-escalation communication include:

- Do not get loud or try to yell over a person who is screaming. Wait until the person takes a breath and then talk.
- Do not try to convince or argue with the person.
- Respond selectively. Answer all informational questions no matter how rudely asked. Do not answer abusive questions.
- Do not criticize, act impatient, belittle, or make an aggressive person feel foolish.
- Use active listening. Empathize with the person's feelings but not with the behavior. Try not to judge or patronize the person. Using silence and being supportive can be more important than what is said.
- Do not solicit how a person is feeling or interpret feelings in an analytic way.
- Explain and enforce reasonable limits with persons who become defensive, disruptive, or belligerent. Offer simple and clear choices and consequences to the person, ensuring that they are reasonable and enforceable.



- Do not attempt to bargain with a threatening person.
- Never lie to the person and do not make promises that cannot be kept.
- If possible, try to tap into the person’s cognition by asking, “Help me to understand what it is you’re saying (or wanting).” This may distract them from attacking in order to teach you what you want to know.
- If the person has a weapon, do not try to disarm him/her. Evacuate the area and call 911. (Daud, 2015; NASW, 2017)

EMPLOYER RESPONSIBILITIES

Federal and state job safety laws require employers to make reasonable efforts to provide a safe workplace. Employers may be liable for negligence if they fail to exercise ordinary care to avoid potential violence. No federal law explicitly establishes an employer’s duty to prevent or remedy workplace violence against employees. However, the Occupational Safety and Health Act (OSH Act) of 1970 states that employers have a “general duty” to provide a place of employment that is free from recognized hazards causing, or likely to cause, death or serious physical harm, including the prevention and control of workplace violence.

The OSH Act also prohibits employers from retaliating against employees for exercising their rights under the law, including the right to raise a health and safety concern or report an injury. Employers can be cited and fined when incidents of worker illness or injury are attributed to the workplace (USDOL, 2017b).

The OSH Act, however, often fails to provide protection to employees subjected to workplace violence because it is not well enforced. As a result, some states have responded by enacting workplace violence legislation. As of August 2015, nine states require certain healthcare facilities to have some type of workplace violence prevention program. As these requirements are established by state law, they are enforced by the states and not by OSHA. These nine states are:

- Washington
 - Illinois
 - New York
 - Maine
 - Oregon
 - Connecticut
 - California
 - New Jersey
 - Maryland
- (OSHA, 2015b)



TOLERANCE TOWARD VIOLENCE IN THE HEALTHCARE SETTING

In the healthcare setting, workplace violence has been underreported, ubiquitous, and persistent. It has been tolerated, considered “part of the job,” and basically ignored (Phillips, 2016). A serious problem involving violence in the healthcare setting is the lack of support from hospital administrations and the judicial system. Police and prosecutors do not necessarily feel that this is a big issue unless an individual is very severely injured, even though there are felony laws in place. Healthcare workers who report attacks often say that acceptance of and tolerance for violence runs through the hospital administration as well as the judicial system.

A recent study of ED nurses described supportive and sympathetic supervisors but passive hospital administrations. About half the nurses in the study said the hospital took no action after they were assaulted. In another 20% of cases, the perpetrator was only issued a warning. Ten percent of nurses said they were blamed for the incident. Other studies suggest more than half of physical assaults on nurses and up to 80% of verbal abuse goes unreported (Speroni et al., 2014).

Hospitals with mandatory reporting policies experience half the rate of physical violence as those without such policies. The Veterans Health Administration electronically flags high-risk offenders and has successfully reduced assaults. These individual are treated with extra precautions (VA, 2016).

Workplace Safety Standards

In 1989, OSHA published the Safety and Health Program Management Guidelines, and in 2015 these guidelines were updated to reflect changes in the economy, workplaces, and evolving safety and health issues. The guidelines, while not mandatory, are intended for use by employers that are seeking to provide a safe and healthful workplace through effective workplace violence prevention programs.

OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees can be reduced.

In 2015, OSHA issued Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. However, there is no federal statute requiring hospitals to adopt them (OSHA, 2015b).

Workplace Violence Prevention Programs

A workplace violence prevention program demonstrates an organization’s concern for employee emotional and physical safety and health. The updated OSHA recommended guidelines present a step-by-step approach to implementing a safety and health program built around seven core elements that make up a successful program.



These core elements are:

- Management leadership
- Worker participation
- Hazard identification and assessment
- Hazard prevention and control
- Education and training
- Program evaluation and improvement
- Communication and coordination for host employers, contractors, and staffing agencies

The guidelines also provide recommended practices for starting such a program. These include:

- Making safety and health the top priority at all times
- Leading by example
- Putting a reporting system in place
- Offering training
- Conducting inspections
- Asking workers to provide ideas on controlling hazards
- Setting up hazard controls
- Creating instructions for emergency situations
- Gathering worker feedback about workplace changes

The updated guidelines place greater emphasis on worker participation and collaboration between managers and workers to find, fix, and prevent incidents (OSHA, 2015b).

MANAGEMENT COMMITMENT

Management commitment provides the motivating force for dealing effectively with workplace violence. Policies should be established to clearly communicate that violence, threats, harassment, intimidations, and other disruptive behavior in the workplace will not be tolerated. Another key element of organizational policy should establish that all reports of incidents will be taken seriously and will be dealt with appropriately. Management should to be committed to:

- The emotional as well as physical health of the employee
- Appropriate allocation of authority and resources to responsible parties
- Equal commitment to worker safety and health and patient/client safety



- A system of accountability for involved managers and employees
- A comprehensive program of medical and psychological counseling for employees experiencing or witnessing violent incidents
- No employee reprisals for reporting incidents
- Consideration of a “zero-tolerance” policy for intimidating and/or disruptive behaviors

EMPLOYEE INVOLVEMENT

Employee involvement enables workers to develop and express their commitment to safety and health. Employee involvement should include:

- Understanding and complying with the workplace violence prevention program and other safety and security measures
- Participating in employee complaint or suggestion procedures covering safety and security concerns
- Reporting violent incidents promptly and accurately
- Participating in safety and health committees or teams that receive reports of violent incidents or security problems
- Making facility inspections and responding with recommendations for corrective strategies
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, high-risk behavior, or criminal intent and discusses appropriate responses

WORKSITE ANALYSIS

A key element of a workplace violence prevention program is the threat assessment team, or safety committee. The primary function of the team is to provide a thorough workplace security/hazard analysis and establish prevention strategies. An effective team will:

- Assess the organization’s vulnerability to workplace violence
- Make recommendations for preventive actions
- Develop employee training programs in violence prevention
- Establish a plan for responding to acts of violence
- Evaluate the overall workplace violence prevention program on a regular basis



Barriers to Implementation of Workplace Violence Prevention Programs

A recent qualitative study was conducted to determine the effectiveness of workplace violence prevention programs in healthcare settings. The study indicated seven primary themes, some of which are both problems within the program itself and/or are related to broader healthcare industry and societal issues. These barriers were found to be:

- Lack of action resulting from reporting
 - Varying perceptions of what constitutes violence
 - Bullying
 - Impact of money- and profit-driven management models
 - Lack of management accountability
 - Intense focus of healthcare organizations on customer service
 - Weak social service and law enforcement approaches to mentally ill patients
- (Blando et al., 2015)

CASE

Downtown Free Clinic is located in the center of the city and is slated for renovation. This clinic has been a long-time staple walk-in medical care facility for inner-city residents. Downtown Clinic is open six days a week from 6 a.m. to 10 p.m. The clinic sees an average of 120 patients per day. The clinic has just been acquired by a large hospital system.

Cynthia works as a nurse manager and has been selected to represent the clinic as a member of the hospital's safety committee. As part of the threat assessment team, her assignment for the upcoming meeting is to lead a workplace violence hazard assessment for the clinic. She has worked at the facility for six years and has never felt threatened, nor has she had any complaints from her staff. She anticipates a quick assessment.

To prepare for the assignment, Cynthia decides to review the hospital's existing workplace violence prevention plan. The policy statement includes a commitment to zero tolerance for violence in the workplace and further commits all managers and supervisors to implement all aspects of the program, thus ensuring a safe environment for all employees.

Cynthia has been charged with analyzing and reviewing existing records related to assault incidents, inspecting the workplace, and evaluating all work tasks to determine the presence of hazards or situations that may place workers at risk for violent acts. She begins by reviewing the following records for the last three years:

- OSHA 300 logs (injury and illness recordkeeping forms)
- Incident reports dealing with assault or near-assault incidents



- Insurance records
- Police reports
- Accident investigations
- Training records
- Filed grievances

She finds the following:

- Several incidents involving verbal threats to receptionists from clinic patrons
- Ten incidents involving pushing/shoving in the parking lot in which police were called to intervene
- No staff training records
- Twenty insurance claims for damages to cars in the parking lot

Cynthia also interviews managers and staff of the clinic, asking about all instances of violence that they may have witnessed over the past six months but which were not reported. Surprised by the number of unreported incidents, Cynthia proceeds to conduct an inspection of the workplace areas assigned to her. She discovers that:

- Access through the main entrance to the clinic is not controlled. The door is unlocked for all hours of operation.
- There is no lock on the door between the reception area and the treatment area.
- The parking lot is not well lit, and unidentified persons often loiter there.
- There is no method of communication between the reception desk and the treatment area of the clinic.
- There is no security camera in the parking lot or on the route to it.

Concerned with the hazards from the inspection, she further reviews the tasks of the receptionists and identifies the following concerns:

- Money is kept behind the main reception desk in an unlocked drawer.
- One receptionist works alone during the early-morning and late-night hours.
- The clinic is in a high-crime area.

After careful consideration, Cynthia decides that the building, work area design, and staffing will need to change and that written policies and procedures must be instituted to address the security hazards she has identified. Her initial recommendations to the hospital safety committee include:



- Improve lighting in the parking lot and main entrance to the clinic.
- Install security cameras along the route employees take from the clinic to the parking lot.
- Hire a security guard—minimally for the early-morning and evening hours.
- Lock the main entrance during early-morning and evening hours.
- Install a buzzer for patients to use when the door is locked.
- Secure the door between the reception area and the clinic.
- Install communication between the clinic area and reception desk.
- Limit the amount of cash kept in the reception area and remove excess cash on a varying schedule.
- Review staffing and hours of operation for the reception area and revise as needed.
- Develop policy, procedures, and training for:
 - Use of security equipment
 - Diffusing hostile or threatening situations
 - Summoning assistance in an emergency
 - Medical follow-up
 - Availability of counseling and referral
 - Incident reporting and investigation
 - Incident recordkeeping

From this exercise, Cynthia was surprised to discover a significant number of incidents involving violence to employees or patients at the clinic. Many of these incidents could have been prevented with an effective violence prevention program. It is reassuring to have the hospital concerned with the safety and health of the employees by committing authority and budgetary resources to the managers and supervisors so that an effective program can be implemented.

Employee Assistance Programs (EAPs)

An EAP is a voluntary, work-based program offering free and confidential assessments, short-term counseling, referrals, and follow-up services to employees with personal and/or work-related problems.

Employee assistance programs first started in the 1940s to help employees with alcohol addiction. Today EAPs address a wide range of issues affecting mental and emotional well-being. EAPs offer confidential, behavioral counseling as well as help in a personal/family crisis



or something that affects the workplace or a person's effectiveness in the workplace. Depending upon size, 75% to 97% of companies provide EAPs for their employees and families at no cost.

Employee assistance programs are evolving and adapting to changing technology and to the needs of younger workers. Services are becoming more accessible. Online interactive assessment may be available. Webinars or other online information for employees, online training for supervisors, and the use of text messaging and emails to facilitate communication and support are now being utilized (APA, 2016).

Post-Event Response

An institution's response to incidents of workplace violence should reflect an organizational commitment to overall employee health and safety. Post-incident actions should include:

- Providing medical care to the victim
- Debriefing the victim
- Providing counseling
- Reporting the incident
- Assisting with injury claims
- Prosecuting perpetrators when indicated

Institutional Initiatives

Although there are no federal standards requiring workplace violence protection, the prevalence of workplace violence in the healthcare sector has prompted studies and organizational initiatives aimed at addressing the problem. Nursing and other healthcare professional organizations and unions are advocating for federal standards and regulations that require healthcare institutions to practice effective violence prevention and response.

The International Association for Healthcare Security and Safety Industry Guidelines and Design Guidelines are intended to assist healthcare administrators in providing a safe and secure environment and support national, state, county and local requirements. They are also intended to be in agreement with all regulatory, accreditation, and other healthcare professional association requirements (IAHSS, 2015).

The American Organization of Nurse Executives and the Emergency Nurses Association in 2015 jointly released Guiding Principles on Mitigating Violence in the Workplace. These principles provide a framework to systematically reduce lateral and patient and family violence in hospital settings (AONE & ENA, 2015).

Recommendations from NIOSH are that a written workplace violence policy should clearly indicate a zero-tolerance of violence at work, whether the violence originates inside or outside



the workplace. Workplaces must develop threat assessment teams to which threats and violent incidents can be reported. The team is to assess threats of violence and to determine what steps are necessary to prevent the threat from being carried out (NIOSH, 2014b).

In 2015, the American Nurses Association released a position statement calling on healthcare employers to implement violence prevention programs. The statement declares that the nursing profession “will no longer tolerate violence of any kind from any source. Taking this clear and strong position is critical to ensure the safety of patients, nurses and other health care workers.” The statement calls on RNs and employers to share responsibility to create a culture of respect and to implement evidence-based strategies (ANA, 2017).

THE JOINT COMMISSION AND A CULTURE OF SAFETY

The Joint Commission (TJC) (2016) recognizes that uncivil, disrespectful, threatening, and intimidating behaviors in the healthcare environment undermine a culture of safety, increase medical errors, decrease patient satisfaction, increase adverse outcomes, and incur higher costs and loss of qualified staff. TJC has stated that such behaviors are unprofessional and will not be tolerated.

Leaders especially have a critical role to play in battling such behaviors and establishing a safety system that does not tolerate these behaviors. Such a system must be made a core value of all leaders in the organization. The Joint Commission’s *Sentinel Event Alert* recommends that all healthcare facilities should take the following safety actions:

- Educate all team members on appropriate professional behaviors that are consistent with the organization’s code of conduct.
- Hold all team members accountable for modeling desirable behaviors.
- Develop and implement policies and procedures or processes that address:
 - Bullying
 - Reducing fear of retaliation
 - Responding to patients and families who witness inappropriate behaviors
 - Beginning disciplinary actions (how and when)
- In developing these policies and procedures, solicit input from an interprofessional team that includes representation of medical and nursing teams, administrators, and other employees.

Source: TJC, 2008.



CONCLUSION

Violence in the workplace is prevalent in the United States, and workplace violence has become one of the most serious occupational hazards facing personnel working in today's healthcare environment. Healthcare workers should not be expected to accept violence as "part of the job," and employers must take appropriate steps to ensure that the chances for violence are minimized. It is necessary for employers to create an environment in which employees are safe, secure, and productive. Systems must be put in place that address violence and promote risk-assessment and prevention.

Healthcare professionals must become educated in the recognition of and response to workplace violence, including effective de-escalation communication techniques and appropriate ways to manage an aggressive individual. Employees must also make a commitment to safety and health by making themselves accountable for modeling appropriate behaviors among coworkers.



RESOURCES

Code of Professional Conduct for Case Managers (Commission for Case Manager Certification)
http://ccmcertification.org/sites/default/files/downloads/2015/0000.%20Code%20of%20Professional%20Conduct_FINAL%20%26%20APPROVED_January%202015.pdf

National Institute for the Prevention of Workplace Violence
<http://workplaceviolence911.com>

Workplace Bullying Institute
<http://www.workplacebullying.org>

Workplace Violence (OSHA)
<https://www.osha.gov/SLTC/workplaceviolence/>

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TEST

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1. Which is an example of workplace violence?
 - a. An auto accident occurring while commuting to the office
 - b. Malicious statements intended to damage a coworker's reputation
 - c. A fall in the company parking lot due to accumulated ice on the pavement
 - d. A union strike to protest a proposed cut in wages and benefits

2. Researchers define the four types of workplace violence as violence by strangers, customers or clients, coworkers, and:
 - a. Someone in a personal relationship.
 - b. Criminals.
 - c. Business owners or co-owners.
 - d. Intruders.

3. Which is a type 3 form of workplace violence that involves frequent or repeated personal attacks that are emotionally hurtful or professionally harmful?
 - a. Situational violence
 - b. Domestic violence
 - c. Workplace bullying
 - d. Inherent violence

4. The majority of workplace violence incidents in the healthcare setting are:
 - a. Assault.
 - b. Battery.
 - c. Stalking.
 - d. Verbal.

5. Which is **true** concerning the incidence of workplace violence?
 - a. There is no system to collect data on workplace violence in the United States.
 - b. Physicians have the highest risk for workplace violence in the healthcare setting.
 - c. Workplace violence is the fourth leading cause of occupational injuries in the U.S.
 - d. All incidents of workplace violence are reported.



- 6.** Which is a **true** statement about workplace violence in the healthcare setting?
- Nursing aides working in inpatient psychiatric environments are at low risk.
 - Emergency departments and psychiatric wards are the most violent settings.
 - There is no risk for homicide for home healthcare workers.
 - Nursing home aides are at very low risk for physical injury due to violence.
- 7.** Risk factors for assaults of healthcare workers include:
- Restricted movement of the public in healthcare clinics and facilities.
 - Decreased numbers of mentally ill clients discharged without follow-up care.
 - Isolated work environments with clients and patients.
 - Increased staffing levels during times of visiting hours.
- 8.** Which is an example of an early (Level One) warning sign that can alert others to a potentially threatening situation?
- A coworker sabotages equipment.
 - A patient is uncooperative.
 - A client is physically aggressive.
 - A manager argues with customers.
- 9.** The **first** step when responding to a Level Three emergency situation is to:
- Secure personal safety.
 - Report concerns to the supervisor to seek help in the assessment and response to the situation.
 - Call 911 and other appropriate emergency contacts.
 - Document the observed behavior.
- 10.** Which stance, posture, or action is recommended when dealing with a potentially violent individual?
- Stand directly in front of the person.
 - Sit down and remain below the person's eye level.
 - Smile in a friendly manner.
 - Keep hands free, up, and available to protect yourself.
- 11.** When confronted by an aggressive person, it is important to:
- Attempt to calm the person through touch and reassurance.
 - Stand confidently in front of the person and quietly tell him/her to calm down.
 - Move forward and try to physically restrain the person.
 - Stand between the door and the individual.



12. The Occupational Safety and Health Act (OSH Act) general duty clause states that employers must:

- a. Pay a minimum wage for employees.
- b. Report all unhealthful employee habits.
- c. Provide a safe working environment.
- d. Counsel violent employees.

13. Which is **not** a responsibility of an employee in developing an effective workplace violence prevention program?

- a. Developing a system of accountability for involved managers and employees
- b. Reporting violent incidents promptly and accurately
- c. Making facility inspections and responding with recommendations for corrective strategies
- d. Taking part in a continuing education program

14. A successful workplace violence prevention plan includes management commitment, worksite analysis, training, program evaluation, and:

- a. Counseling for angry clients.
- b. Employee involvement.
- c. Limited night-shift work.
- d. Effective discipline for violence.

15. Barriers to implementation of workplace violence prevent programs include:

- a. Lack of employee accountability.
- b. Strong social service approaches to mentally ill patients.
- c. Impact of charity-driven management models.
- d. Intense focus of healthcare organizations on customer service.

16. Which is a program begun in the 1940s to help employees with alcohol addiction?

- a. Employee assistance program
- b. Post-event response
- c. Worksite analysis
- d. State-sponsored counseling service

