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Contact Hours: **3**

Workplace Violence and Safety Prevention and Solution Strategies

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you will have increased your knowledge in order to prevent, identify, and respond to workplace violence. Specific learning objectives to address potential knowledge gaps include:

- Describe the various types of workplace violence.
- Discuss the impacts of workplace violence.
- Identify risk factors for workplace violence.
- Summarize how to respond to workplace violence.
- Describe employer responsibilities in responding to workplace violence.
- Identify essential components of a workplace violence program and barriers to its implementation.

INTRODUCTION

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. Such violence is a public health issue that requires identifying precipitating factors and developing strategies to keep employees safe.

Workplace violence has been federally recognized as an organizational, community, and societal issue. The Bureau of Justice Statistics National Crime Victimization Survey (NCVS) is the primary source of information on criminal victimization in the United States, and workplace violence is an integral part of this survey.

Findings from the NCVS include:

- In 2015 homicide accounted for about 9% of all fatal workplace injuries, and firearm-related workplace homicides accounted for almost 85% of all workplace homicides.
- In 2015, 61 women and 356 men were victims of homicide in the workplace. Of these women, 43% were killed by a relative or a domestic partner, compared to 2% of the men.
- In 2015, 20% of the women who were killed in the workplace were killed by a person committing a robbery, compared to 33% of the men.
- White victims reported 78% of known workplace violence victimization and 66% of non-workplace violence victimization.
- Black or African-American workers experienced 9% of violent victimization.
- Hispanic/Latino workers experienced 8% of violent workplace victimization and 15% of non-workplace violent victimization.

(BJS, 2019)

The National Safety Council (2020) reports that in 2017, workplace assaults led to 18,400 injuries and 458 fatalities. The Council notes that workers in specific industries, including healthcare, are more likely to have violent incidents than others.

In 2019, the Bureau of Labor Statistics (2019) published a news release that contained information about fatal occupational injuries in 2018. Violence and other injuries by persons or animals increased 3% in 2018 due to an 11% increase in work-related suicides from 275 to 304.

WHAT CONSTITUTES WORKPLACE VIOLENCE?

The Occupational Safety and Health Administration (OSHA, 2019) 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, 2020) defines workplace violence as “any physical assault, threatening behavior, or verbal abuse occurring in the work setting.” Violence can occur in any workplace and among any type of worker.

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 (OSHA, 2019).



EXAMPLES OF WORKPLACE VIOLENCE

- Direct physical assaults (with or without weapons)
- Written or verbal threats
- Physical or verbal harassment
- Homicide
- False, malicious, or unfounded statements against coworkers
- Bullying

(ANA, 2019a; Bartholomew, 2014)

The Centers for Disease Control and Prevention (CDC, 2016) has identified four types of workplace violence. These include:

- Type 1: Violence by a stranger with criminal intent
- Type 2: Violence by a customer or client
- Type 3: Violence by a coworker (worker on worker)
- 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, robbery, and homicide (CDC, 2016).

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 (Society Insurance, 2019). Nurses may also be at particular risk for robbery since many of them work at night and/or work in facilities that have a variety of drugs that may be targets for theft. In the healthcare professions, personnel known or perceived to have items of value in their possession or in their workplace may also be at increased risk for targeting. Examples include:

- Home health providers (nurses, OTs, PTs, and aides)
- Clinic personnel working alone or in an isolated area of a facility
- Any personnel going to/from vehicles alone and/or at times or in places when few others are around



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 organization 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 (CDC, 2016).

Violence by a customer or client is the **most common** in healthcare settings. In such settings the customer/client relationship includes patients, families, and visitors. Violence by a customer or client most often occurs in emergency and psychiatric treatment settings, waiting rooms, and geriatric settings (CDC, 2016). These attacks may be perpetrated by “unwilling” clients who are brought into emergency departments or mental health facilities by law enforcement for assessment and/or treatment.

There may also be situations with people not known to be violent who 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

Eric is a college student who works part-time on the night shift as a lab technician 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. The patient began to get agitated, denied he had done anything wrong, jumped up, and demanded to be released.

Eric entered the room to take a blood sample just as the nurse was responding to the patient’s angry request by grabbing onto his arm and telling him that he was not allowed to leave yet. The patient 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.

The hospital’s safety committee was asked to review the incident and make recommendations for preventing future occurrences. The committee evaluated the specific incident as well as the:



- Physical layout of the emergency department and location of the assessment rooms used for the program
- Supplies and equipment available in the assessment rooms and how they are stored
- Security provided at the entrance and within the department
- Staffing levels
- Training initially provided to the staff at the start of the program
- Program policies and procedures
- Training provided to all hospital staff members on the topic of workplace violence

The committee proposed that a better response to the situation might have included:

- A police officer present during the intake process to explain to the patient what to expect and how long he would be there and to help determine what kind of security or restraining measures would be necessary
- A second staff member in the room during the assessment process or called in right away when the patient began to show signs of anger
- The nurse acknowledging that the patient had questions about why he needed to be there, calmly stating that she will check how things are going, leaving the room quickly to get help, and not attempting to restrain the patient
- Telling Eric about the circumstances surrounding the case prior to his entering the room and checking with the nurse before going into the room to perform the blood draw

It was determined that the hospital had overlooked some of the risks involved with the new program, and they responded quickly to the committee's suggestions by implementing the following improvements:

- The assessment room used for this program will be closer to the main desk whenever possible.
- A second staff member will be present for the initial assessment process.
- Employees are to use the emergency call button located in each assessment room immediately at the first signs of an agitated patient. This will summon additional personnel and security.
- Supplies in the assessment rooms are to be stored inside cupboards rather than in loose containers on the countertops.



- Personnel are to be trained on how to recognize signs of possible violence and how to respond when faced with a variety of potentially dangerous situations.
- Training will include role-playing and a review of the program policies and procedures. Since there are a low number of admissions to the program, the training is to be provided at least twice per year to help remind staff members of program policies and reinforce how to respond to escalating situations.
- A debriefing conference will be held after any incident of workplace violence to review what happened, to offer support to the staff members involved, and to determine what can be learned from the incident.

(See also “Institutional Initiatives” later in this course.)

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 because the other family members and Alice’s physician determined it was the best option. Jack has been a frequent caller to the facility administrator’s office 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 evening shift nurse is just down the hall making rounds and responds immediately, as does the occupational therapist, who is helping a patient in the next room to use eating aids as part of his stroke rehabilitation process. Jack angrily grasps the therapist’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.

The therapist recognizes Jack and is familiar with his frequent complaints about his mother’s care. She steps aside and exits the room. Standing in the doorway, she calls him by name, calmly stating, “Mr. Adams, I can see that you are upset. I was just finishing up next door and was going to help Mrs. Adams next. It sounds like you would like to talk with someone about



your concerns. I will get the supervisor, who will be glad to meet with you.” Jack visibly relaxes and sits down.

The evening shift nurse arrives in time to see the incident and steps into the room. She helps Jack set up his mother’s dinner tray and calls a nursing assistant to help Alice with her meal. She then suggests that Jack meet with her in a nearby conference room.

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. The nurse acknowledges his feelings and how difficult it must be for him to deal with the kind of changes he has been faced with.

The nurse also states that Jack’s behavior was inappropriate and will be reported 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 administrator or to her if it is the evening shift. She then suggests that Jack may benefit from talking with the facility’s social worker, who also runs the local caregivers support group, and provides him with the phone number. Jack agrees that the suggestion sounds like a good idea and returns to his mother’s room to resume his visit.

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. Examples may be violence committed by supervisors against subordinates, physicians against nurses, subordinates against supervisors, and workers against other workers who are on the same level of the organizational hierarchy.

Worker-to-worker violence includes:

- Overt verbal and/or physical abuse
- Refusing to help a coworker who needs assistance
- Spreading malicious gossip about a coworker
- Embarrassing a coworker in front of clients and/or other workers
(Bartholomew, 2014)



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, or electronic communications

(USDOL, n.d.-a)

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 that 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 physicians 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 (Bartholomew, 2014; Falletta, 2017; Lippincott Solutions, 2016; Rainford et al., 2015).

Contributing factors 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 working in the emergency department of a local hospital in a midsize town. 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 working in trauma room 1 and needs to obtain a piece of equipment from trauma room 3. The door to room 3 is closed, since Dr. Johnson is suturing a patient there. Roland knocks on the door and opens it slowly, excuses himself, and announces his need to obtain equipment from the room. Abruptly, Dr. Johnson gets up, walks to the door, and slams it shut, hitting Roland in the face and crushing his wire-rim glasses. As a result, Roland must delay treatment for the patient he was caring for in room 1 until he gets his extra pair of glasses from his locker and finds the necessary equipment from another room. Since he has no apparent injury or change in vision, Roland elects to continue to work.

As soon as the patient in room 1 has been discharged, Roland informs his supervisor of the incident. 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 the other nurses in the emergency department 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 ED, 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, who have also experienced similar situations. Roland and his colleagues review organizational policies and procedures pertaining to workplace violence. Policy states that if the immediate supervisor (in this case the departmental manager) does not resolve the issue satisfactorily according to policy, the complaint should be presented to the next person of authority on the hierarchical ladder.

Roland and his colleagues hesitate to do this for fear of retaliation, but after much discussion, all but one out of the five persons involved agree to file a complaint with the departmental manager's immediate supervisor, the Vice President (VP) for Critical Care Services. The VP has 10 days to investigate the complaint. While waiting, Roland and his colleagues experience their manager's resentment. The manager has limited her interaction with them and speaks to them only when absolutely necessary. Clinical assignments have remained equitably distributed.

Roland and the others are worried about whether their complaint will be taken seriously. Near the end of the 10-day response timeframe, rumors begin to surface. Gossip is that Dr. Johnson will be put on administrative leave for an indefinite period of time. The VP meets with Roland and the other complainants to confirm that Dr. Johnson is now on leave. She further explains that employee privacy requires her to maintain confidentiality regarding other details of any



disciplinary action against Dr. Johnson and emphasizes that “no information does not mean there has been no action.” Roland and his colleagues are relieved that their complaint has been taken seriously.

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 create 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, for example, and studies have arrived at the conclusion that lateral violence in the healthcare workplace is a nearly universal experience for nurses. 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 (Bartholomew, 2014; Falletta, 2017; 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. (Bartholomew, 2014; Falletta, 2017; 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 that 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, 2020)

CASE

Elizabeth, a physical therapist, 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

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 (CDC, 2016).

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 (CDC, 2016; OSHA, 2019).

CASE

Jenny is a certified nursing assistant working in a 120-bed nursing home. She has always worked the evening shift, which ends at 11 p.m., and is on her way home by 11:30. Jenny has confided in coworkers that she is in an abusive relationship with her husband of five years. She has often come to work with bruises and occasionally has been hospitalized for injuries



inflicted by her husband. Currently, she is separated from her husband and has a restraining order against him.

This evening the supervising nurse notices that Jenny is not keeping up with the scheduled routine and that she seems unusually nervous and distracted. The supervisor approaches Jenny and asks her if something is troubling her. Jenny reports that she had received a threatening phone call from her husband earlier that day and that she is afraid of him. Jenny asks the supervisor if she would walk with her out to her car at the end of her shift, and the nurse agrees.

At the end of the shift, they both leave the facility and walk out the employee entrance to the parking lot. The door of a car parked near the entrance opens; a man gets out, aims a rifle at Jenny, shoots her, and quickly drives away. The supervisor uses her cell phone to call 911 and stays with Jenny until help arrives; however, Jenny dies on the way to the hospital. The supervisor gives a statement to the police and is later subpoenaed as a witness during the trial. Jenny's husband is found guilty and convicted of first-degree murder.

As part of the post-incident response, counseling is offered for employees traumatized by the incident, and a critical-incident stress debriefing is carried out. Additional training and education are provided for early recognition of warning signs, and a standard response action plan for violent situations is included. Facility security is analyzed, and a security guard is assigned to monitor the parking lot at every change of shift. In addition, training is provided in domestic violence and the steps to be taken when a restraining order has been violated.

In this instance, it is determined that it would have been more appropriate for the nursing supervisor to have advised Jenny to contact the police department about the phone call received earlier in the day and to have counseled her to wait for police to arrive before leaving the facility.

IMPACT OF WORKPLACE VIOLENCE

General Workplace Violence Data

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 (2018), 2017 data on nonfatal workplace violence include:

- 18,400 workers in private industry experienced trauma from nonfatal workplace violence.
- 70% of these workers were female.
- 67% were aged 25 to 54.
- 71% worked in the healthcare and social assistance industry.



- 18% required 31 or more days away from work to recover, and 25% involved three to five days away from work.

In 2017, 458 U.S. workers were workplace homicide victims. Of these victims:

- 82% were male.
- 48% were white.
- 64% were aged 25 to 54.
- 21% were working in sales and related occupations.
- 19% were performing protective service activities.
(NIOSH, 2018)

In 2019, OSHA reported that:

- Workplace violence is the third leading cause of fatal occupational injuries in the United States.
- Of the 5,147 fatal workplace injuries that occurred in the U.S. in 2017, 458 were cases of intentional injury by another person.

Incidence of Workplace Violence in the Healthcare Setting

Violence against healthcare workers is an increasing epidemic. Data taken from recent research show that:

- About 75% of workplace assaults reported annually occur in healthcare and social service settings.
- Healthcare workers have a 20% higher chance of being a victim of workplace violence than other workers.
- 76% of registered nurses report experiencing workplace violence.
- 54.2% of nurses experienced verbal abuse from patients and 29.9% experienced physical abuse.
- Nearly 33% of nurses reported verbal abuse by visitors and 3.5% reported physical abuse by visitors.
- The most common acts of violence against nurses were shouting/yelling, swearing, and groping.
- On average, nurses report only 20% to 60% of workplace violence incidents.
- 13% of nurses' missed work days are due to workplace violence.



- 70% of emergency department physicians have reported acts of violence against them, but only 3% pressed charges.
- 80% of serious violent incidents reported in healthcare settings involved patients. (Masson, 2019; Nelson, 2019)

LAWS ADDRESSING WORKPLACE VIOLENCE IN HEALTHCARE

Laws addressing assaults in healthcare vary from state to state. A summary of felony statutes includes (Coble, 2016):

- A majority of states have criminal statutes specifically addressing assaults on emergency medical providers.
- Thirty-two states make it a felony to assault healthcare workers or emergency medical personnel.
- Seven states require healthcare employers to implement workplace violence prevention programs aimed at nurses and medical staff.
- A felony assault can be punished by long prison terms and hefty fines.

In November 2019, the U.S. House of Representatives passed HR 1309, the Workplace Violence Prevention for Health Care and Social Services Workers Act, and sent the bill to the Senate, where it was referred to the Committee on Health, Education, Labor, and Physicians. If signed into law, the bill will give employers one year to develop a provisional plan for protecting healthcare workers and 42 months to develop and implement a final plan for investigating incidents of violence, educating staff on risk management, meeting specific recording requirements, and creating a safe space for healthcare workers to report acts of violence or threats (Congress.gov, 2019; Doherty, 2019).

(For current information on state laws pertaining to workplace violence, all healthcare professionals are advised to review their respective state legislature websites.)

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
- 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)
 (AAETS, 2020; Sheely, 2019)

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
 (ECRI Institute, 2017; Sheely, 2019)



COSTS OF WORKPLACE VIOLENCE

It is estimated that workplace violence costs 500,000 employees 1.2 million workdays annually and \$55 million in lost wages. In healthcare facilities the costs of workplace violence are staggering. The estimated cost of replacing a nurse who is unable to work as the result of workplace violence ranges from \$27,000 to \$103,000. Thousands of dollars in additional costs may result from hiring temporary staffing and overtime. OSHA may also impose costly fines. For example:

- In 2017 in Pennsylvania, OSHA fined a hospital over \$32,000 for exposing employees to workplace violence, among other types of hazards. Examples of the violence included employees being grabbed, hit with objects, punched, scratched, and bit by patients.
- In 2018 at an acute care inpatient behavioral health facility in Florida, OSHA found that employees were exposed to workplace violence, including but not limited to physical assaults such as punches, kicks, bites, scratches, pulling, and the use of objects as weapons. The proposed penalties amounted to over \$71,000.

(Creighton, 2019; First Healthcare Compliance, 2019)

RECOGNIZING AND RESPONDING TO WORKPLACE RISK FACTORS

A number of actions can be taken to minimize the risk of violence in the workplace. These precautions acknowledge that violence should be expected but can be avoided or mitigated through preparation, which 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 cell phone or pager
- Using the locks and security systems that are available
- Reporting security hazards promptly to a supervisor
- Not using a cell phone 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
- (Columbia University, 2020; Next Avenue, n.d.; Office on Violence Against Women, 2019)

Identifying Risk Factors

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.

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

- Altered mental status of clients due to dementia, delirium, substance intoxication, or decompensated mental illness
- Lack of community mental health care and increasing numbers of mental health clients discharged without adequate follow-up care
- Stressful patient conditions, such as long wait times, crowding in the clinical environment, being given upsetting news related to a diagnosis or prognosis
- Lack of training for security and staff to recognize and deescalate hostile and assaultive behaviors
- Unrestricted public access to hospital rooms and clinics
- Easy movements by clients and visitors in healthcare facilities
- Providing care for clients in police custody or gang members
- Domestic disputes among clients or visitors
- The presence of firearms or other types of weapons
- Inadequate security and mental health personnel on site
- Understaffing, especially during times when clients have visitors



- Staff working in isolation or in situations in which they can be trapped without an escape route
- Isolated work environments with clients, patients, and families
- Poor lighting or other factors restricting vision in corridors, rooms, parking lots, and other areas
- No access to emergency communication, such as a cell phone or call bell (TJC, 2018)

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 (CDC, 2016)

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
- Lack of adequate security systems
- Early-morning or night-time hours of employment
- Unknown person(s) loitering outside workplace
- Easy access to potential weapons, such as knives or scissors (NIOSH, 2016)



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)
(ECRI Institute, 2017)

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, n.d.)

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

RISK FACTORS FOR HOME CARE EMPLOYEES

For persons who work in home care, patient’s homes are often in unfamiliar and/or unsafe neighborhoods. 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
(Lynch, 2020)

Working in any community setting outside a traditional office building increases the risk of coming in contact with potentially violent situations. Research indicates that perhaps as many as 61% of home care nurses have experienced some type of workplace violence. Prevention measures for “field” workers include consideration of the following:

- Participating in training regarding environmental awareness and how to prevent and/or respond to workplace violence
- Trusting one’s instincts; if circumstances do not feel “right,” seeking a safe location
- Reporting to supervisory staff when observing or hearing something that is unsafe
- 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 and/or traveling with another employee or security escort 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
- Carrying a fully charged cell phone
- Using telecommunication devices such as access buttons or voice activation tools on ID badges
- 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 (Lynch, 2020)

CASE

Janice is working part-time as a home health aide two evenings per week and on weekends. She shares an apartment with two housemates and commutes 30 minutes to the Visiting Nurse Care home health agency for work. She is required to check in at the main office before her shift starts to pick up her assignments, attend occasional staff meetings and training sessions, and restock her patient care supplies. 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 home health aide. The training is repeated on an annual basis for each home care worker at the agency. Janice remembers hearing about a case in a nearby city in which a home health aide 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 home care 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 trusts her instincts, avoiding situations that do not “feel right.”
- 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 the car’s 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 her home care supplies and equipment and personal belongings out of sight in the trunk of the car.
- She carries a cell phone 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.
- In the home setting, she sits or stands near the door.
- She keeps her shoes on; if asked to remove them, she says that it is a healthy and safety policy that her shoes remain on.
- She uses diversional tactics to help agitated persons to calm down if a threatening situation develops.
- If she is threatened and unable to gain control of the situation, she leaves immediately and goes to a safe place.
- She calls 911 if help is needed.



- 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.
- She documents and reports any incidents.

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

CASE

Zoe is a home health aide working for a private home care agency. She has been assigned 6-hour shifts providing care for Eleanor, an elderly woman who experienced a stroke and requires assistance with daily activities. A care plan describes Zoe's duties, which include bathing, dressing, feeding, toileting, changing bed linens, and straightening Eleanor's bedroom.

Eleanor's daughter Kathy has agreed to come to the house regularly to do the laundry and cleaning. She also is going to do Eleanor's grocery shopping. When Zoe meets Kathy, she quickly becomes aware that Kathy is angry and resentful over having to take care of these things for her mother. As time passes, Kathy begins to complain that she is tired of doing these tasks for her mother and that Zoe is "lazy" and not "worth the money."

Soon, Kathy tells Zoe she wants her to clean the house and do the laundry. Zoe politely informs Kathy that these duties are not her role in Eleanor's care plan and that she will not be able to do them. Kathy immediately becomes angry, shouting, "We'll see about that!" She begins picking up things and throwing them about, yelling that she has had enough of caring for that "old bat."

With the situation seeming to spiral out of control, Zoe begins moving toward the door. She sees Kathy reach for a knife from the kitchen counter. Zoe quickly runs out the door toward her car, pulling her cell phone from her pocket. Once safely in her car, she calls 911.

When the police arrive, they subdue Kathy and ensure that Eleanor is safe. Kathy is arrested for assault. Zoe calls her supervisor to report what has happened and is told a replacement will be sent right away. Zoe informs the police officer that she is willing to go to the police station to make a statement as soon as her replacement arrives. While waiting, she returns to the home and reassures Eleanor that they are both safe and that she is there to assist her.

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 (see "Risk Factors in the Behavior of Others" earlier in this course).



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 a 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, n.d.)

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 otherwise 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; an agitated individual is typically 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 stating, "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 (U.S. DoL, 1970).

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 (U.S. DoL, 1970).

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 often ignored. 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 (ANA, 2019b; Docksai, 2020).

OSHA Workplace Safety Standards

In 1989, OSHA published the Safety and Health Program Management Guidelines, and in 2016 these guidelines were updated to reflect changes in the economy, workplaces, and evolving safety and health issues. OSHA **standards** are mandatory, enforceable rules that must be followed. OSHA **guidelines**, however, are voluntary recommendations for compliance with general workplace safety and training initiatives. The guidelines are intended for use by employers that are seeking to provide a safe and healthful workplace through effective workplace violence prevention programs (McKay, 2020).

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.

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. The building blocks for developing an effective workplace violence prevention program include:

- Management commitment
- Employee participation
- Worksite analysis
- Hazard prevention and control
- Safety and health training
- Record keeping and program evaluation
(OSHA, 2016)

The 2016 guidelines place great emphasis on worker participation and collaboration between managers and workers to find, fix, and prevent incidents (OSHA, 2016).

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 is to establish that all reports of incidents will be taken seriously and will be dealt with appropriately. Management commitment should include:

- Acknowledging the value of a safe and healthful, violence-free workplace and equal commitment to the safety and health of workers and patients/clients
- Allocating appropriate authority and resources to all responsible parties
- Assigning responsibility and authority for the various aspects of the workplace violence prevention program
- Maintaining a system of accountability for involved managers, supervisors, and health committees
- Supporting and implementing appropriate recommendations from safety and health committees
- Establishing a comprehensive program of medical and psychological counseling and debriefing for workers who have experienced or witnessed assaults and other violent incidents and ensuring that trauma-informed care is available
- Establishing policies that ensure the reporting, recording, and monitoring of incidents and near misses and that no reprisals are made against anyone who does so in good faith
(OSHA, 2016)



EMPLOYEE INVOLVEMENT

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

- Participating in the development, implementation, evaluation, and modification of the workplace violence prevention program
- Participating in safety and health committees that receive reports of violent incidents or security problems, make facility inspections, and respond to recommendations for corrective strategies
- Providing input on additions to or redesigns of facilities
- Identifying the daily activities that employees believe put them most at risk for workplace violence
- Participating in discussions and assessments to improve policies and procedures, including complaint and suggestion programs designed to improve safety and security
- Being aware of and following employer policies on reporting incidents and near misses
- Taking proactive approaches to ensure incidents are addressed
- Actively participating in employee training and continuing education programs (OSHA, 2016)

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 to establish prevention strategies. An effective team will:

- Assess the organization's vulnerability to workplace violence
- Ensure communication between workers and employers
- 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 (OSHA, 2016)



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 (DFC) 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. DFC 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 at DFC and has been selected to represent the clinic as a member of the hospital system'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

An employee assistance program (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.



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. After the immediate danger has passed post-incident actions should include:

- Providing medical care to the victim
- Debriefing victims and witnesses
- Evaluating the impact on the victim(s) and witnesses
- Helping employees process events by using, for example, counseling, emotional support, referral to mental health professionals
- Communicating with employees to alleviate feelings of fear and uncertainty
- Taking control of incident communication to ensure that accurate, objective information is disseminated
- Conducting a thorough review of workplace violence policies and procedures (Employer Flexible, 2019)

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, 2018).

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, 2014).

In 2015, the American Nurses Association released a position statement calling on healthcare employers to implement violence prevention programs. The statement declared 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 called on RNs and employers to share responsibility to create a culture of respect and to implement evidence-based strategies (ANA, n.d.).

THE JOINT COMMISSION AND A CULTURE OF SAFETY

The Joint Commission (2018) 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. The Joint Commission 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.

(TJC, 2016, 2018)



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 risks 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

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/clients, coworkers, and:
 - a. Someone in a personal relationship.
 - b. Criminals.
 - c. Business owners or co-owners.
 - d. Intruders.

3. Which term describes 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. Which is **true** concerning the incidence of workplace violence in the United States?
 - a. There is no system to collect data related to workplace violence in the United States.
 - b. The majority of nonfatal workplace violence incidents involve male victims.
 - c. Workplace violence is one of the leading causes of fatal occupational injuries.
 - d. All incidents of workplace violence are reported because of legal mandates.

5. The most common acts of violence against nurses are shouting, swearing, and:
 - a. Attempted homicide.
 - b. Physical abuse.
 - c. Stalking.
 - d. Groping.



6. 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.
7. 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 verbally abusive
 - A client refuses to obey facility policies and procedures
 - A manager shouts at an employee in a state of extreme rage
8. The **first** step when responding to a **Level Three emergency** situation is to:
- Secure personal safety.
 - Observe the behavior.
 - Attempt to restrain the person who is violent.
 - Document the observed behavior.
9. 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.
10. When confronted by an aggressive person who has a weapon, it is important to:
- Attempt to calm the person through touch and reassurance.
 - Stand confidently in front of the person and quietly tell them to calm down.
 - Move forward and try to physically restrain the person.
 - Evacuate the area and call 911.
11. The Occupational Safety and Health Act (OSH Act) general duty clause states that employers must:
- Pay a minimum wage for employees.
 - Report all unhealthful employee habits.
 - Provide a safe working environment.
 - Counsel violent employees.



- 12.** A successful workplace violence prevention plan includes management commitment, worksite analysis, safety and health training, program evaluation, and:
- Counseling for angry clients.
 - Employee participation.
 - Limited night-shift work.
 - Effective discipline for violence.
- 13.** Which is **not** a responsibility of an **employee** as part of developing an effective workplace violence prevention program?
- Allocating appropriate authority and resources to all responsible parties
 - Providing input on the designs or redesigns of facilities
 - Identifying the daily activities that put employees at most risk for workplace violence
 - Participating in education and training
- 14.** Which has **not** been found to be a barrier to the implementation of workplace violence prevention programs?
- Bullying
 - Varying perceptions of what constitutes violence
 - Lack of management accountability
 - Strict law enforcement approaches to mentally ill patients
- 15.** Which is a program begun in the 1940s to help employees address issues affecting mental and emotional well-being?
- Employee assistance program
 - Post-event response
 - Worksite analysis
 - State-sponsored counseling service

