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Contact Hours: **2**

Ethics for Case Managers, Part 3
Workplace Violence and Safety in Healthcare

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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 in case management work settings. Specific learning objectives to address potential knowledge gaps include:

- Describe the various types of workplace violence.
- Identify risk factors for workplace violence.
- Summarize how to respond to workplace violence.

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). Instances of workplace violence also often raise legal and ethical issues that concern healthcare providers.

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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

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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 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.

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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.

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.

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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, 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. 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

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- 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).

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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 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.

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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

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- 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 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

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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).

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

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- 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

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- 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

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- 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:

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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)

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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 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.

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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 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 any supplies 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.

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- 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.

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.

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- 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.

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- 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)

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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)

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

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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. Case managers 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.

As part of their commitment to ethical practice, case managers 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.

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RESOURCES

Code of Professional Conduct for Case Managers (Commission for Case Manager Certification)
https://ccmcertification.org/sites/default/files/docs/2017/code_of_professional_conduct.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

[Take the test online at wildirismedicaleducation.com]

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. Risk factors for assaults of healthcare workers include:

a. Restricted movement of the public in healthcare clinics and facilities.
b. Decreased numbers of mentally ill clients discharged without follow-up care.
c. Isolated work environments with clients and patients.
d. Increased staffing levels during times of visiting hours.

5. Which is an example of an **early (Level One) warning sign** that can alert others to a potentially threatening situation?

a. A coworker sabotages equipment
b. A patient is verbally abusive
c. A client refuses to obey facility policies and procedures
d. A manager shouts at an employee in a state of extreme rage

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6. The **first** step when responding to a **Level Three emergency** situation is to:

a. Secure personal safety.
b. Observe the behavior.
c. Attempt to restrain the person who is violent.
d. Document the observed behavior.

7. Which stance, posture, or action is recommended when dealing with a potentially violent individual?

a. Stand directly in front of the person.
b. Sit down and remain below the person's eye level.
c. Smile in a friendly manner.
d. Keep hands free, up, and available to protect yourself.

8. When confronted by an aggressive person who has a weapon, it is important to:

a. Attempt to calm the person through touch and reassurance.
b. Stand confidently in front of the person and quietly tell them to calm down.
c. Move forward and try to physically restrain the person.
d. Evacuate the area and call 911.

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