Emerging Health Care Concern: Preventing Workplace Violence

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Learning Objectives

- Define workplace violence and be able to state two reasons why violence in the workplace is increasing
- Discuss risk factors which correlate with increased workplace violence
- State two tactics to help de-escalate angry patient, visitor and/or staff behavior
- Identify three resources to help prevent and mitigate violence

Workplace Violence: A Growing Concern

Workplace Violence

A violent act (or acts) including physical assaults or *threats* of assaults directed towards a person at work or while on duty

NIOSH, 2002

Patient Safety Events

Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a patient, staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital

Joint Commission Hospital Accreditation Manual, 2018

Types of Workplace Violence

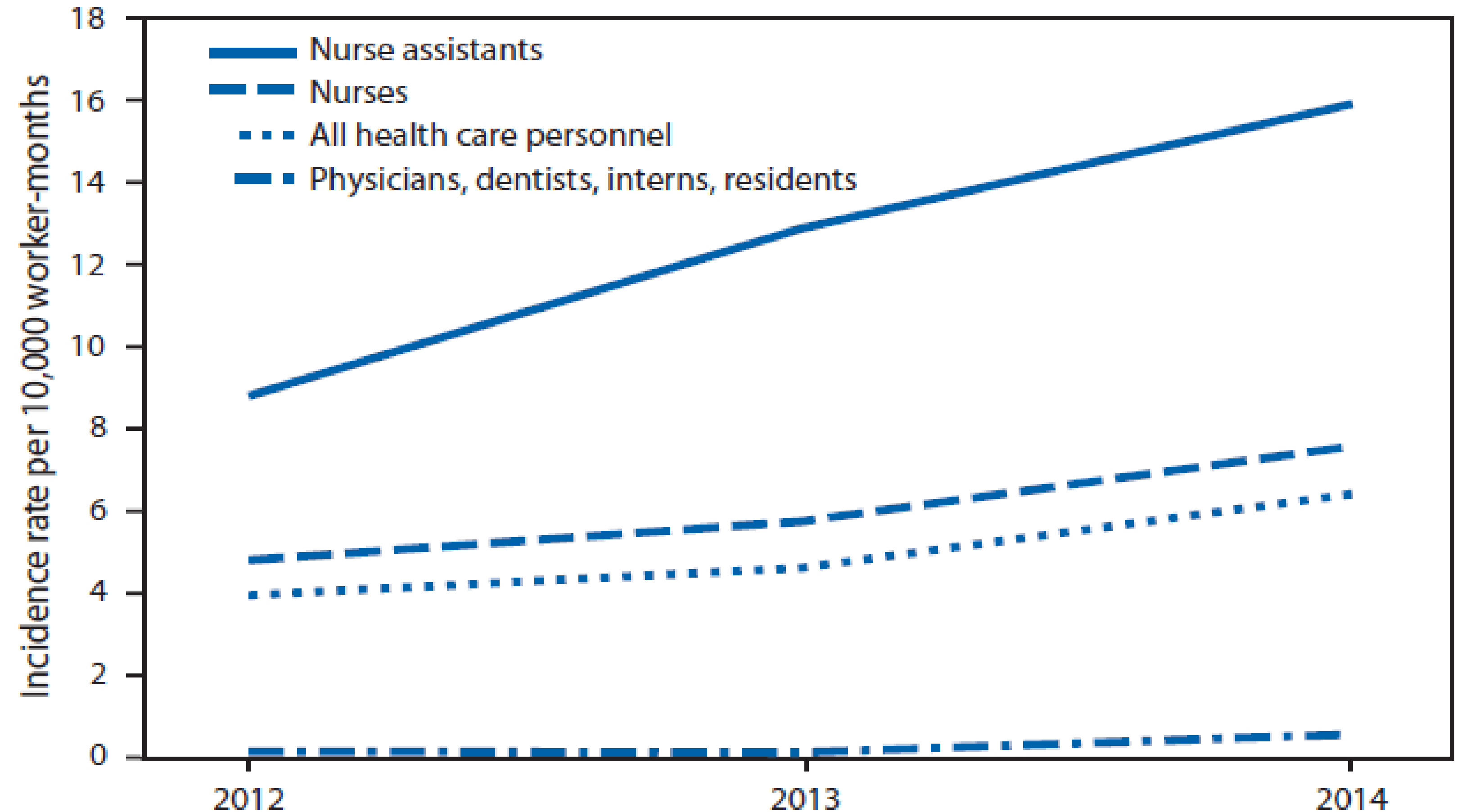
Type	Description	Example
I	Perpetrator has no association with the workplace or the employees	Person with criminal intent commits armed robbery
II	Perpetrator is a customer or patient of workplace or employees	Intoxicated patient punches nursing assistant
III	Perpetrator is a current or former employee of the workplace	Recently fired employee assaults former supervisor
IV	Perpetrator has a personal relationship with employees, none with the organization	Ex-husband assaults wife at her place of work

Source: Phillips JP. Workplace Violence against Health Care Workers in the United States. *N Engl J Med* 2016;374:1661-9.

Occupational Traumatic Injuries Among Workers in Health Care Facilities

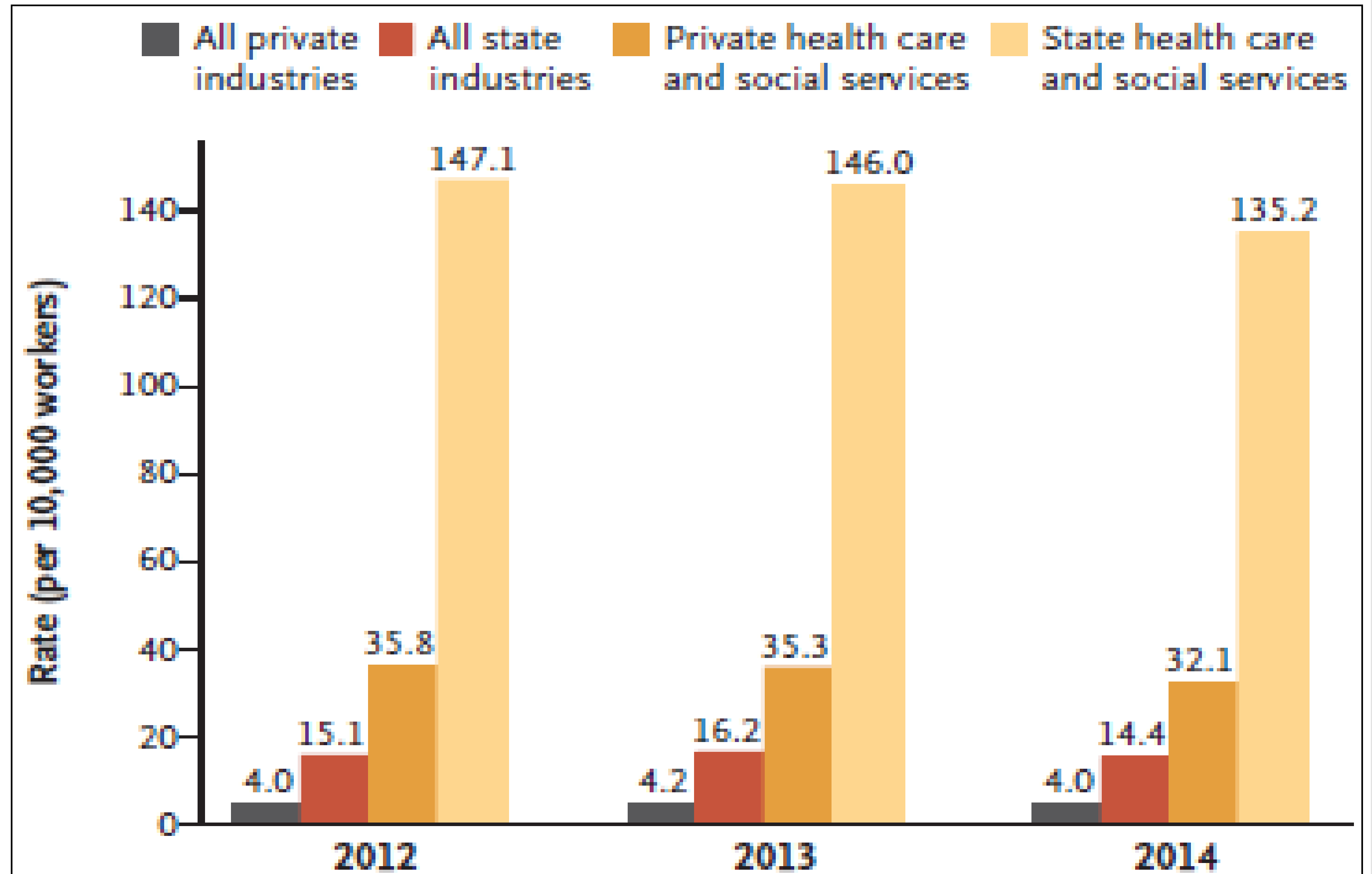
United States 2012-2014

Comparison of OSHA-recordable injury incidence rates per 10,000 worker-months by 112 U.S. health care facilities.
Jan. 1, 2012 – Sept. 30, 2014



Gomaa AE, et al. Occupational Traumatic Injuries Among Workers in Health Care Facilities – United States, 2012-2014. CDC Weekly. April 24, 2015, 64(15);405-410.

Rates of Workplace Violence with Injury Requiring Missed Workdays



Source: Phillips JP. Workplace Violence against Health Care Workers in the United States. *N Engl J Med* 2016;374:1661-9.

Workplace Violence Statistics and Nurses

- 5,910 incidents occurred in hospitals (15.6 per 10,000)
- 8,990 incidents in nursing or residential care facilities (37.1 per 10,000)
- 1,790 incidents (3.7 per 10,000) in ambulatory care centers and offices
- In 2012, a total of 2,160 episodes of workplace violence were reported against registered nurses
- 780 episodes against LPNs were reported

US Department of Labor, US Bureau of Labor Statistics. Table R12. Number of nonfatal occupational injuries and illnesses involving days away from work by occupation and selected events or exposures leading to illness or injury, private sector, 2012. http://www.bls.gov/news.release/osh2.nro.htm Accessed February 23, 2015

Workplace Violence Statistics and Nurses

(continued)

- **80%** of nurses do not feel safe in their workplace (Peek-Asa, et al, 2009)
- **82%** of ED nurses had been physically assaulted at work in one year (May and Grubbs, 2002)
- **25%** of psychiatric nurses experienced disabling injures from patient assaults (Quanbeck, 2006)
- Between **35-80%** of hospital staff have been physically assaulted at least once during their careers (Clements, et al, 2005)

“Iceberg” of Workplace Violence Reporting

Disruptive and Violent Behavior Incident Reporting

Challenge

20% Reporting Rate

- Similar Rate internationally across heath care systems
- Multiple probable cases
  - Competing demands – reporting takes time
  - Not want to "label"
  - Concern for own reputation
  - Beliefs as to whether reporting will do any good

Solution

Successful Reporting Systems

- Accessible
- Short and Simple
- Trusted and Secure
- Optional Anonymity
- Results in Identifiable Outcomes
- Labor and Management Supports

Mario Scalora, PhD
Association of Threat Assessment Professionals, 2014

Abstract

Introduction

Workplace violence against nurses is a serious problem. Nurses from a US urban/community hospital system employing more than 5,000 nurses researched the incidence of workplace violence against nurses perpetrated by patients or visitors in their hospital system.

Methods

Survey research and retrospective database review methods were used. Nurse participants (all system-employed nurse types) completed a 34-item validated survey in electronic format. Retrospective database review provided annual nurse workplace violence treatment and indemnity charges. Institutional review board approval was received.

Speroni KG et al. Incidence and Cost of Nurse Workplace Violence Perpetrated by Hospital Patients or Patient Visitors. Journal of Emergency Nursing, Volume 40, Issue 3, 218-228.

Abstract

(continued)

Results

Survey research participants (N = 762) were primarily white female registered nurses, aged 26 to 64 years with more than 10 years of experience. Over the past year, 76.0% experienced violence (verbal abuse by patients, 54.2%; physical abuse by patients, 29.9%; verbal abuse by visitors, 32.9%; and physical abuse by visitors, 3.5%), such as shouting or yelling (60.0% by patients and 35.8% by visitors), swearing or cursing (53.5% by patients and 24.9% by visitors), grabbing (37.8% by patients and 1.1& by visitors), and scratching or kicking (27.4% by patients and 0.8% by visitors). Emergency nurses (12.1%) experienced a significantly greater number of incidents ($P < .001$). Nurses noted more violence incidents (n = 595, 78.1%) were physical (63.7%) (60.8% by patients and 2.9% by visitors), verbal (25.4%) (18.2% by patients and 7.1% by visitors), and threatened physical assault (10.9%) (6.9% by patients and 4.0% by visitors). Perpetrators were primarily white male patients, aged 26 to 35 years, who were confused or influenced by alcohol or drugs. Per database review, annual workplace violence charges for the 2.1% of nurses reporting injuries were $94,156 ($78,924 for treatment and $15,232 for indemnity).

OSHA: Regulatory Authority

- Original Act (1970), General Duty Clause, Section 5(a)1:
  - “Employers are required to provide a place of employment that is ‘free from recognized hazards that are causing or are likely to cause death or serious harm’”
- New rule-December 1, 2017: “Improve Tracking of Workplace Injuries and Illnesses”
- Considering publishing standards to prevent violence in health care & social assistance settings; Request for Information (RFI) solicited from the field

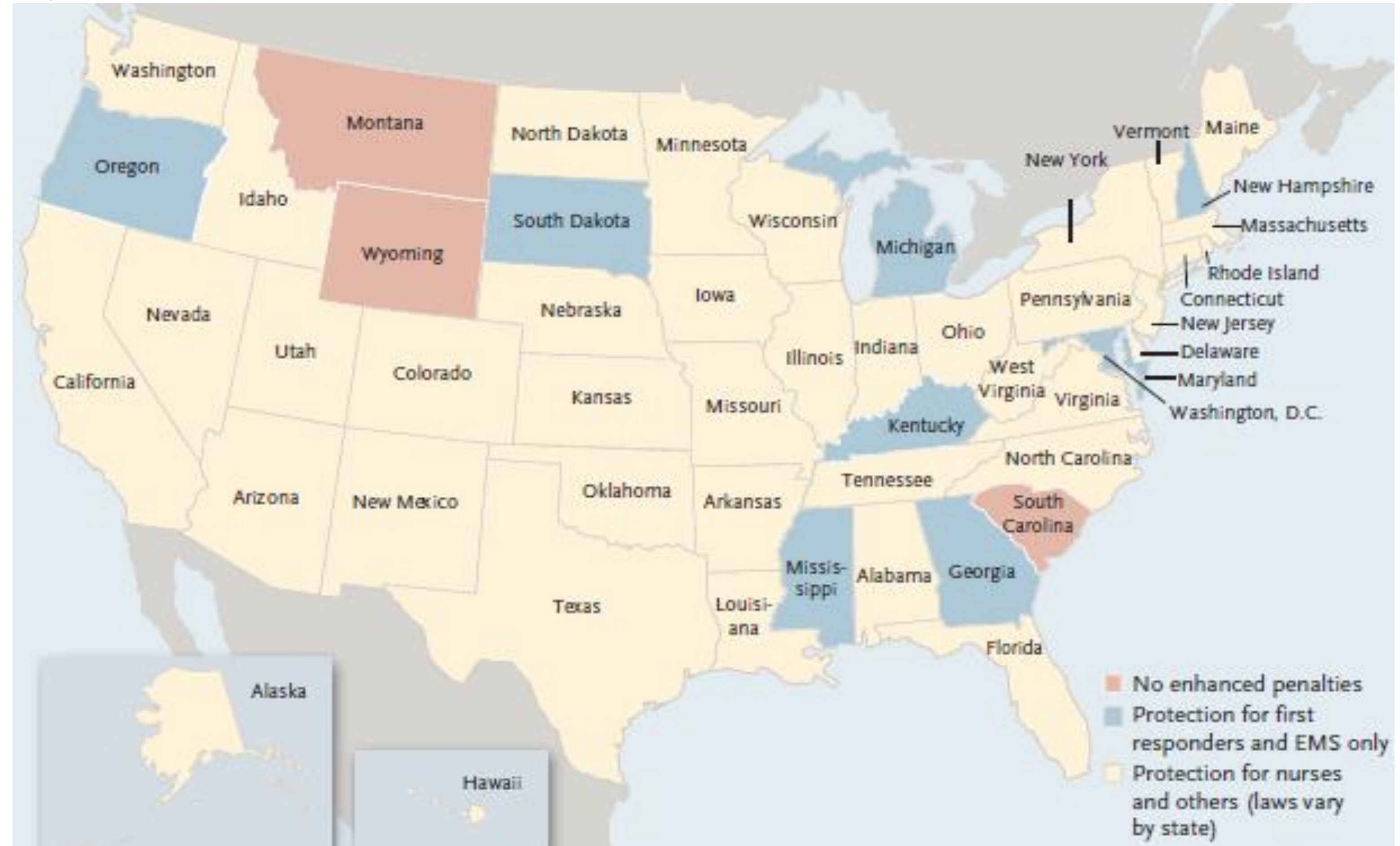
OSHA

OSHA requires employers to mitigate or prevent "recognizable hazards" which include workplace violence by:

- Insuring employees are involved and educated on the processes
- Evaluate worksites to ensure safety requirements are met
- Use hazard prevention devices such as "panic alarms" or metal detectors
- Provide Safety and Health Training
- Document compliance with the program; OSHA fined a hospital $78,000 for 'dozens' of incidents involving patients and staff, where one nurse sustained severe brain injuries

Workplace Violence Against Health Care Workers in the US

States with Enhanced Penalties for Violence against Health Care Workers



Source: Phillips JP. Workplace Violence against Health Care Workers in the United States. *N Engl J Med* 2016;374:1661-9.

Science of Violent Behavior

Recent discoveries have been made about the invisible workings of the brain in the fields of social psychology, neurology, and epidemiology that have shed some light on how violent behaviors are formed.

Source: © 2011-2016 Cure Violence. Accessed 02-25-2016.
http://cureviolence.org/understand-violence/science-of-violent-behavior/.

What does science tell us about the causes of violent behavior?

1. Most behaviors – including violent behavior – are actually acquired or learned.
2. Most of this learning is not intentional or classroom-based; rather, they are learned. Behaviors come from modeling, observing, imitating or copying. (This is sometimes call "social learning.")
3. Most of this social learning is unconscious – meaning behaviors are picked up without our awareness of it.

Source: © 2011-2016 Cure Violence. Accessed 02-25-2016. http://cureviolence.org/understand-violence/science-of-violent-behavior/.

What does science tell us about the causes of violent behavior?
(continued)

4. **Exposure to violence increases one's risk of becoming violent**, transmitting from one person to another in the same manner as a contagious disease.
5. Neurological events mediate this contagion and there are additional physiological effects from both witnessing and experiencing trauma that accelerate the contagion.
6. Social norms, scripts, and perceived social expectations further exacerbate this contagion by encouraging violent behavior to spread.

- Source: © 2011-2016 Cure Violence. Accessed 02-25-2016. http://cureviolence.org/understand-violence/science-of-violent-behavior/.

Risk Factors for Violence in Health Care

- The prevalence of handguns and other weapons among patients, their families, or friends
- The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals
- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care

Source: OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, 2004

Risk Factors for Violence in Health Care (continued)

- The availability of drugs or money at hospitals, clinics, and pharmacies, making them likely robbery targets
- Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas
- The increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members

Source: OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, 2004

Risk Factors for Violence in Health Care (continued)

- Low staffing levels during times of increased activity such as mealtimes, visiting times, and when staff are transporting patients
- Isolated work with patients during examinations or treatment
- Solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems

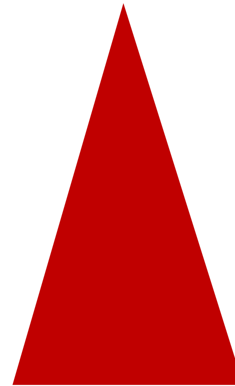
Risk Factors for Violence in Health Care (continued)

- Lack of staff training in recognizing and managing escalating hostile and assaultive behavior
- Poorly lit parking areas

Balancing Staff Safety and Patient Rights

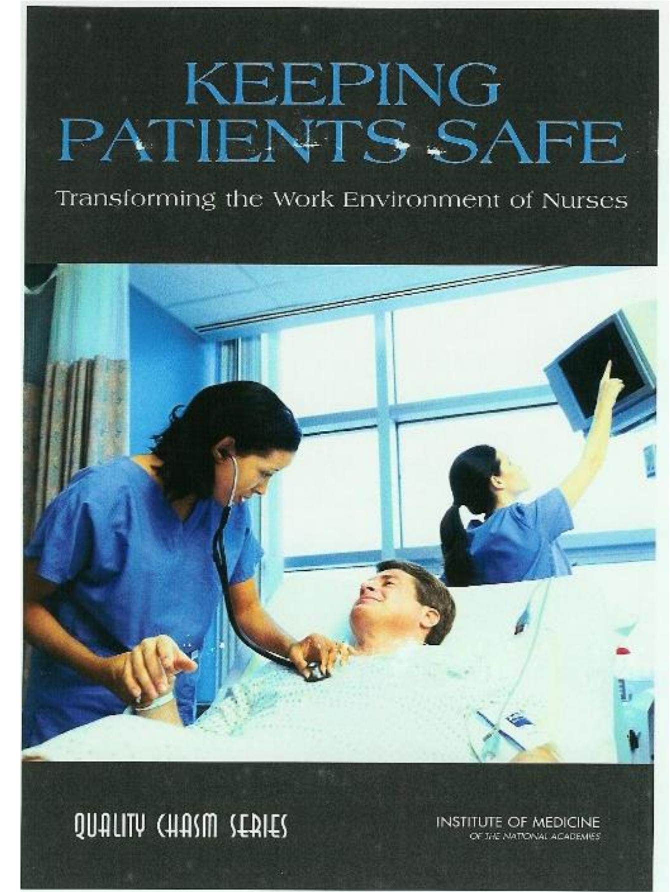
Patient Rights & Restraint-Free Environment

Staff Safety (and Other)



The link between the work environment and patient safety is not a new concept
(IOM Report, 2004)

The IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, emphasizes the importance of the work environment in which nurses provide care



Restraining Violent Patients: Joint Commission Standards

- Standard PC.01.02.13 applies to patients receiving treatment for emotional and behavioral disorders states that the patient receives an assessment that would include "maladaptive or other behaviors that create a risk to patients or others."
- PC.03.05.03 states: For hospitals that use Joint Commission accreditation for deemed status purposes: The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.

CMS Position On Weapons

There is no standard regarding tazers. CMS CoP 482.13 (e) states: CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term "weapon" includes, but is not limited to, pepper spray, mace, nightsticks, tazers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. ***However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion.***

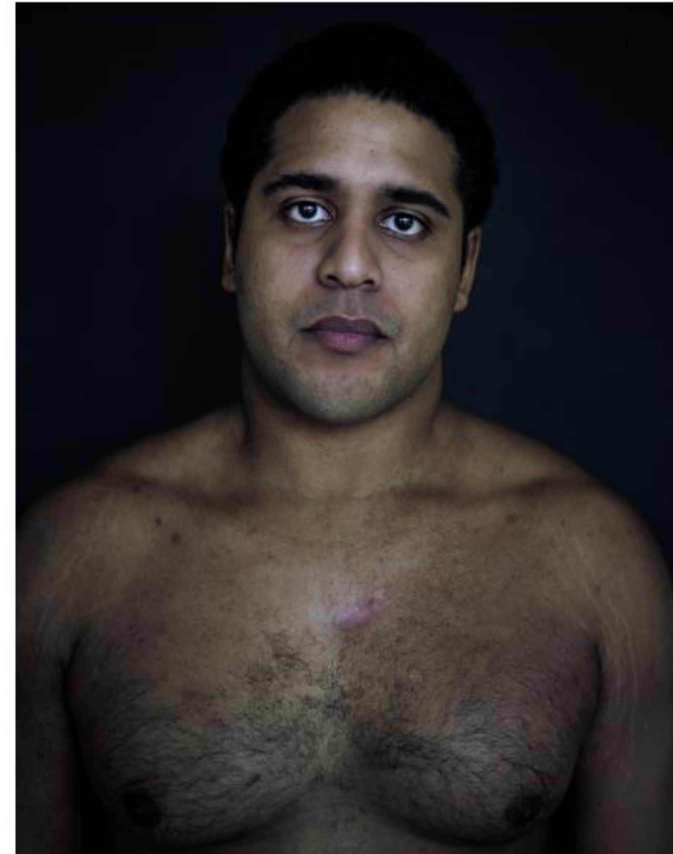
Balancing Staff Safety and Patient Rights

The New York Times | U.S.

When the Hospital Fires the Bullet

More and more hospital guards across the country carry weapons. For Alan Pean, seeking help for mental distress, that resulted in a gunshot to the chest.

By ELISABETH ROSENTHAL FEB. 12, 2016



In the center of Alan Pean's chest is the scar left by a hospital security officer's bullet last August.
Chad Batka for The New York Times

Managing the Media: Prepare in Advance

Joint Commission Safety Alerts

Quick Safety - Issue Four, July 2014
July 28, 2014

Preparing for active shooter situations

Quick Safety - Issue Five, August 2014
August 28, 2014

Preventing violent and criminal events

Sentinel Event Alert, Issue 45: Preventing violence in the health care setting
June 3, 2010

Download This File

Once considered safe havens, health care institutions today are confronting steadily increasing rates of crime, including violent crimes such as assault, rape and homicide. As criminal activity spills over from the streets onto the campuses and through the doors, providing for the safety and security of all patients, visitors and staff within the walls of a health care institution, as well as on the grounds, requires increasing vigilant attention and action by safety and security personnel as well as all health care staff and providers.

Sentinel Event Alert

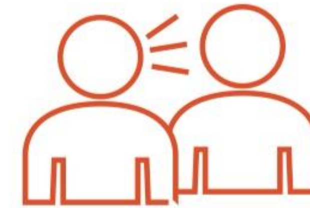
The Joint Commission
Issue 59, April 17, 2018

Take a stand: No more violence to health care workers

Forms of violence to health care workers

- Biting
- Kicking
- Punching
- Pushing
- Pinching
- Shoving

- Scratching
- Spitting
- Name calling
- Intimidating
- Threatening
- Yelling



- Harassing
- Stalking
- Beating
- Choking
- Stabbing
- Killing

Statistics on violence against health care workers

- 25 percent of nurses reported being physically assaulted by a patient or a patient's family member, and about half reported being bullied (ANA)
- Workers in health care settings are four times more likely to be victimized than workers in private industry (SIA and IAHSSF)
- Health care workers have a 20 percent higher chance of being the victim of workplace violence than other workers (National Crime Victimization Survey)
- Violence-related injuries are four times more likely to cause health care workers to take time off from work than other kinds of injuries (BLS)

75 percent of nearly **25,000** workplace assaults reported annually occurred in health care and social service settings (OSHA)

Sentinel Event Alert

The Joint Commission
Issue 59, April 17, 2018
(continued)

Violence against health care workers is grossly underreported

Only **30** percent of nurses report incidents of violence

Only **26** percent of emergency department physicians report violent incidents

Health care workers

- think that violence is "part of the job"
- are sometimes uncertain what constitutes violence
- often believe their assailants are not responsible for their actions due to conditions affecting their mental state

Factors associated with perpetrators of violence

- Altered mental status or mental illness
- Patients in police custody
- Long wait times or crowding
- Being given "bad news" about a diagnosis
- Gang activity
- Domestic disputes among patients or visitors
- Presence of firearms or other weapons

What to do when violence occurs

Report it! Notify leadership, security and, if needed, law enforcement.

AONE-ENA Mitigating Violence in the Workplace

Guiding Principles

1. Recognition that violence can and does happen anywhere
2. Healthy work environments promote positive patient outcomes
3. All aspects of violence (patient, family and lateral) must be addressed
4. A multidisciplinary team, including patients and families, is required to address workplace violence

AONE-ENA Mitigating Violence in the Workplace

5. Everyone in the organization is accountable for upholding foundational behavior standards, regardless of position or discipline
6. When members of the health care team identify an issue that contributes to violence in the workplace, they have an obligation to address it
7. Intention, commitment and collaboration of nurses with other health care professionals at all levels are needed to create a culture shift
8. Addressing workplace violence may increase the effectiveness of nursing practice and patient care

AONE-ENA Mitigating Violence in the Workplace

Five Priority Focus Areas

1. Foundational behaviors to make this framework work:
   - Respectful communication, including active listening
   - Mutual respect demonstrated by all (i.e., members of the multidisciplinary team, patients, visitors and administrators)
   - Honesty, trust and beneficence

AONE-ENA Mitigating Violence in the Workplace

Five Priority Focus Areas

2. Essential elements of a zero-tolerance framework:
   - Top-down approach supported and observed by an organization's board and C-Suite
   - Enacted policy defining what actions will not be tolerated, as well as specific consequences for infractions to the policy
   - Policy is clearly understood and equally observed by every person in the organization (e.g., leadership, multidisciplinary team, staff, patients and families)
   - Lateral violence is prohibited, regardless of role or position of authority (i.e., the standard of behavior is the same for doctors, nurses, staff and administration)

AONE-ENA Mitigating Violence in the Workplace

Five Priority Focus Areas

3. Essential elements to ensuring ownership and accountability:
   - Personal accountability, meaning everyone in the organization is responsible for reporting and responding to incidence of violence
   - Zero-tolerance policy is developed with input from staff at every level in the organization, thus ensuring staff co-own the process and expectations
   - Universal standards of behavior are clearly defined and every person in the organization (including patients and families) is held equally accountable
   - Incidents of violence are reported immediately to persons of authority, through the chain of command, to ensure immediate enforcement of the zero-tolerance policy

AONE-ENA Mitigating Violence in the Workplace

Five Priority Focus Areas

4. Essential elements of training and education on workplace violence
   - Organizational and personal readiness to learn
   - Readily available, evidence-based and organizationally-supported tools and interventions
   - Skilled/experience facilitators who understand the audience and specific issues
   - Training on early recognition and de-escalation of potential violence in both individuals and environments
   - Health care specific case studies with simulations to demonstrate actions in situations of violence

AONE-ENA Mitigating Violence in the Workplace

Five Priority Focus Areas

5. Outcome metrics of the program's success
    - Top ranked staff and patient safety scores
    - Incidence of harm from violent behavior decreases
    - Entire organization (staff) reports feeling "very safe" on the staff engagement survey
    - Patients and families report feeling safe in the health care setting
    - Staff feels comfortable reporting incidents and involving persons of authority
    - The organization reflects the following culture change indicators: employers are engaged, employees are satisfied, and HCAHPS scores increase

Everyone's Three Roles

- First: Learn the signs of a potentially volatile situation and ways to prevent an incident
- Second: Learn the best steps for survival when faced with an *active shooter* situation
- Third: Be prepared to work with law enforcement during the response

International Association of Emergency Medical Services Chiefs, 2017

When Interacting With An Agitated Person . . .

- If possible, before interacting with the agitated person, call for help so that help is on the way
- Place yourself (always keep yourself) between the person and the exit

Source: Crisis Prevention Institute, Inc., 2016

Tactical Emergency Casualty Care (TECC) Active Shooter

THREAT algorithm (adapted from the military)

- Threat suppression
- Hemorrhage control
- RE-rapid extrication to safety
- Assessment by medical providers
- Transport to definitive care

Jacobs, Hartford Consensus, 2014

Tips for Creating a Safe and Caring Hospital

- Encourage and promote courteous interactions
- Pay attention to behavioral warning signs
- Consider objects that could be used as weapons
- Practice and promote a team approach
- Assess your environment
- Trust your instincts
- Educate staff about relevant response protocol

Source: Crisis Prevention Institute, Inc., 2016

CPI's Top 10 De-escalation Tips

1. Be Empathic and Non-judgmental
   Keep in mind that whatever the person is going through, it may be the most important thing in their life at the moment.
2. Respect Personal Space
   If you must enter someone's personal space to provide care, explain your actions so the person feels less confused and frightened.
3. Use Non-threatening Non-verbals
   Keeping your tone and body language neutral will go a long way toward defusing a situation.

CPI's Top 10 De-escalation Tips

4. Avoid Over-reacting
   Positive thoughts like "I can handle this" and "I know what to do" will help you maintain your own rationality and calm the person down.
5. Focus On Feelings
   Watch and listen carefully for the person's real message.
6. Ignore Challenging Questions
   Ignore the challenge, but not the person. Bring their focus back to how you can work together to solve the problem.

CPI’s Top 10 De-escalation Tips

7. Set Limits
   A person who’s upset may not be able to focus on everything you say. Be clear, speak simply, and offer the positive choice first.
8. Choose Wisely What You Insist Upon
   If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations.

CPI's Top 10 De-escalation Tips

9. Allow Silence For Reflection
   Believe it or not, silence can be a powerful communication tool.

10. Allow Time For Decisions
    A person's stress rises when they feel rushed. Allowing time bring calm.

Source: ©2016 CPI. Crisis prevention.com. Accessed 02-25-2016. http://www.crisisprevention.com/media/CPI/resources/CPI-s-Top-10-De-Escalation-Tips/CPI-s-Top-10-De-Escalation-Tips

Safety and Health Management System: Summary

Safety and Health Management System	Overview	Work Place Violence Prevention Element
Management and Leadership	Communicate commitment to safety and health, document performance, make WPVP a top priority, establish goals and objectives, provide resources and support and set a good example.	Management commitment and worker participation
Employee Participation	Employees are involved in all aspects of the program, feel free to communicate and report safety concerns to management.	Management commitment and worker participation
Hazard Identification and Assessment	Policies and procedures are in place to continuously evaluate risks. There are initial and ongoing assessment of hazards and controls.	Work site analysis and hazard identification
Hazard Prevention and Control	Processes, procedures and programs are implemented to eliminate or control work place violence. Progress is tracked.	Hazard prevention and control
Education and Training	All employees have education and training on hazard identification and controls and their responsibilities under the program.	Safety and health training
System Evaluation and Improvement	Processes are established to monitor the systems performance, verify implementation, identify deficiencies and opportunities for improvement and take actions to improve overall safety and health performance.	Record keeping and program evaluation

Source: OSHA "Work Place Violence and Related Goals: The Big Picture" 2016

Summary

- Improve understanding of violence in health care settings
  - No universal strategy exists to prevent violence
  - Risk factors vary from facility to facility
- Review current standards and tools
- Consider new alliances (police, crisis centers, FBI)
- Disseminate prevention strategies and toolkits
- Collaborate with other stakeholders (providers and community resources)

Selected References*

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