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From Verbal Insults to Death: The Reality of Workplace Violence in Healthcare

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Workplace violence is a significant issue across many industries. The Occupational Safety and Health Administration (OSHA) says that "Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide."[1]

Media headlines over the past several years show evidence that this issue is prevalent in healthcare settings. For example:

- January 2018 — Shooting at St. Louis Hospital Spurs Debate on the Use of Armed Security In Hospitals
- May 2017 — Nurse Sexually Assaulted During Hostage Ordeal at Geneva Hospital
- May 2017 — Paramedic Shot While Responding to a Call
- July 2017 — Doctor Fatally Shoots One, Wounds Six at NYC Hospital Before Killing Himself
- September 2017 — Dartmouth Hospital on Lockdown Amid Active Shooter Scare
- November 2017 — Email Threats Lead to Hospital Lockdown
- November 2017 — Active Shooter Call at Alabama Hospital Turns into Stolen Ambulance Police Chase
- December 2017 — Security Officer Wounded, Suspect Dead After Hospital Shooting

- December 2017 — Miami Valley Hospital Nurse Reports Assault by Patient
- December 2017 — Patient Arrested for Attack, Sexual Assault on Oklahoma Metro Nurse

The unfortunate reality is that healthcare workers are vulnerable to violence. It can occur in any geographic location and any type of facility, and violence can affect patients, doctors, allied health professionals, administrative staff, and families/caregivers. Although the previous examples from the media are extreme, and many incidents do not rise to the level of gunfire, they are considered violence nonetheless.

Further, according to the Centers for Disease Control and Prevention (CDC), underreporting of workplace violence is a problem.[2] For example, verbal assaults, threats, and assaults that do not cause permanent injuries (like spitting, slapping, pinching, kicking, etc.) might not be reported for various reasons, such as:

- Many healthcare workers accept violence as one of the risks of the job.
- Often times, patients or their families are under extreme levels of stress, creating an element of acceptance of bad behavior.
- Reporting structures are either not in place or are prohibitive because they are so complex and time consuming.
- Healthcare workers may fear the possibility of negative effects on their licenses, reputations, and/or employment.

The seriousness of this issue has prompted some states to pass laws that make the consequence of physical assault on a healthcare worker a felony. However, laws do not stop these situations from occurring and do not address all types of violence. Therefore, healthcare organizations — regardless of size — must be prepared for hostile or aggressive situations.

This article discusses important elements of a violence prevention program and offers strategies for preventing or managing violence before, during, and after an incident.

Key Elements of a Violence Prevention Program

In 2015, OSHA issued an updated version of its *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. OSHA's five major elements of an effective workplace violence prevention program include:

- **Management commitment and worker participation.** Teamwork is essential in a crisis situation. A well-trained team needs to be in place before an incident occurs so that team members are able to effectively execute the plan as needed.
- **Worksite analysis and hazard identification.** Worksite analysis consists of a methodical evaluation of the hazards within your environment, which may include hazards related to human factors and the physical building. Every facility has a unique set of hazards that should be addressed. Simply put, ask yourself "Where am I vulnerable?"
- **Hazard prevention and control.** After the worksite analysis is completed, a team should review the information and develop a response plan to address vulnerabilities. The plan might include fixing a broken lock, making staffing modifications, installing video surveillance, developing policies, educating staff, implementing drills, or even changing workflow patterns. Again, each facility is different — what works for one might not be appropriate for another.
- **Safety and health training.** All staff should be properly trained on the security measures developed for your facility. Staff members need to be familiar with their roles and have an opportunity to practice. Table top drills have some value in educating staff initially, but physically practicing with drill activity is where the most value lies. Your goal is to save lives, and you need everyone to be prepared. As Gandhi said, "An ounce of practice is worth more than tons of preaching."
- **Recordkeeping and program evaluation.** Recordkeeping is an essential element of any business. Accurate recordkeeping allows your organization to stay on top of relevant issues. Whether it is incident reports, training history, or drill records, you need to have an accurate pulse on your facility to properly plan for the safety of your patients

and staff. Program evaluation should be incorporated into the plan to capture the things you can improve on and the things you are doing well.[3]

As the ECRI Institute explains, "It is impossible to eliminate workplace violence in healthcare settings; however, there are ways to reduce the potential for violent occurrences and minimize the impact of any violent situation that may arise."[4]

The next few sections of this article will cover some strategies to consider when developing or evaluating violence prevention policies and plans.

Risk-Reduction Strategies: Before an Incident

The key to handling a violent incident is being prepared. Preparation involves assessing your facility, developing a response plan, educating your staff, and practicing your response.

Assess Your Facility

When assessing your facility, having a realistic view of the processes that are already is important. Reviewing policies, historical data, and community data related to violence can help you understand challenges and limitations as you begin developing a response plan.

However, you should not stop there. A physical assessment of your building and the established workflow also are very important in identifying your risk exposures. More details about the value, focus, and components of a worksite analysis are available in OSHA's *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*.

Including staff that work in particular areas is vital during the assessment. They will be able to provide insight on risk exposures that might not be apparent while doing a walkthrough.

Develop a Response Plan

Research what other organizations similar to yours have done to respond to violent situations. Many good resources are available — but remember, you need to adapt them to meet your organization's needs. For example, some facilities have "panic buttons" and have incorporated the use of those buttons into their response plans.

Although this is a good resource to incorporate into a plan, you may not have the funds or technology to implement panic buttons. In this situation, try to think outside the box on how to make a "panic button" concept work in your facility, and then modify your plans accordingly. As you develop a response plan, include all levels of staff on your team. This will foster engagement as you implement the plan.

Educate Your Staff

You can have a very well-written plan, but if you do not educate your staff on the process, it is meaningless. In an emergency situation, staff members need to be able to respond without having to look up policies or read the violence prevention plan. The aggressor will not wait as your staff learns how to respond. Preparing your staff in advance is your best defense.

Practice Your Response

Practicing your response goes hand-in-hand with educating your staff. Once your staff members have been taught the concepts, give them the opportunity to work through the scenarios using a hands-on approach.

As noted earlier, table top exercises are good for learning concepts, but drills are where the real learning begins. Often times, steps are skipped or not well thought out when talking out a plan using the table top technique. Hands-on drills are valuable in (a) determining whether the plan has gaps, (b) identifying logistical issues, and (c) testing equipment along the way.

Simulation Scenarios

MedPro's Patient Safety & Risk Solutions Team has developed a booklet of sample scenarios for simulation training, which includes a behavioral health de-escalation scenario and an aggressive patient in an office practice scenario. Download the booklet to see these scenarios and incorporate them into drill activities.

If staff members have the opportunity to walk through the scenario, there is a greater chance they will identify shortcomings in the response and retain the skills for when they are needed most.

Risk-Reduction Strategies: During an Incident

Understanding that no single response will work in every situation is crucial. An article from the *Western Journal of Emergency Medicine* notes four main objectives when working with an agitated person. They include:

- Ensuring the safety of the patient, staff, and others in the area
- Helping the patient (a) manage his/her emotions and distress, and (b) maintain or regain control of his/her behavior
- Avoiding the use of restraint when possible
- Avoiding coercive interventions that escalate agitation[5]

De-escalation is one technique that staff can be trained to use. The aforementioned article lists 10 domains of de-escalation, as follows:

1. Respect personal space while maintaining a safe position.
2. Do not be provocative.
3. Establish verbal contact.
4. Be concise; keep the message clear and simple.
5. Identify wants and feelings.
6. Listen closely to what the person is saying.
7. Agree or agree to disagree.
8. Lay down the law and set clear limits.
9. Offer choices and optimism.
10. Debrief the patient and staff.[6]

Details related to these domains can be found in the *Western Journal of Emergency Medicine* article noted in the Violence Emergency Resources box on page 8.

In the event that a situation does become violent, the response should be twofold: (1) isolation of the aggressor in as limited an area as possible (such as locking the waiting room door to prevent access to the patient care area), and (2) evacuation as quickly as possible by all means of egress available. Determining a location to regroup is not necessary in this situation; escape from the dangerous environment is the goal.

If possible, the police should be called before a potential situation turns violent. This should be done sooner rather than later to allow the police time to respond to the scene.

For more information on planning for violent incidents, including active shooter situations, see the resources in the Violence Emergency Resources box on page 8.

Risk-Reduction Strategies: After an Incident

After an incident, it is essential to bring the involved staff together to talk about what happened. This not only offers a cathartic element by allowing staff to talk freely about the situation, but it also is a valuable method for improving your incident response in the future.

The Agency for Healthcare Research and Quality has developed a debrief method that can be applied to any incident response situation.[7] The essential questions to ask during a debriefing include:

- Was communication clear?
- Were roles and responsibilities understood?
- Was situational awareness maintained?
- Was the workload distribution equitable?
- Was task assistance requested or offered?
- Were errors made or avoided?
- Were resources available?
- What went well?
- What should improve?

The effects of violence can be earth shattering and linger for those involved. "Violent incidents can affect staffing as a result of lost work time from injuries, decreased job satisfaction leading to absenteeism and turnover, low employee morale, and fear of an unsafe workplace."[8]

Providing for the physical safety and emotional support of staff members involved in a violent incident is an essential part of recovering from the incident and retaining these employees.

Conclusion

Healthcare organizations need to have well-defined plans to address hostile/aggressive behavior. Preparation for violence emergencies requires an investment of time to develop and implement a comprehensive program. The program does not need to be complex or expensive to implement, but it should be thorough and practiced regularly. This investment of time far outweighs the loss that can occur if staff members are not alert and prepared to respond appropriately.

Violence Emergency Resources

- Centers for Disease Control and Prevention: Workplace Violence Prevention for Nurses
- Hospital Association of Southern California: Active Shooter Drill Materials
- International Association of Emergency Medical Services Chiefs: *Active Shooter Planning and Response*
- Occupational Safety and Health Administration: *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*
- Occupational Safety & Health Administration: Hospital eTool
- U.S. Department of Homeland Security: Active Shooter Preparedness
- *Western Journal of Emergency Medicine*: Verbal De-Escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup
- U.S. Department of Health and Human Services, U.S. Department of Homeland Security, U.S. Department of Justice, Federal Bureau of Investigation, Federal Emergency Management Agency: *Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans*
- Crisis Prevention Institute: Create a Culture of Safety: How to Reduce Intimidation and Violence in Health Care Facilities

Endnotes

[1] Occupational Safety and Health Administration. (n.d.) Workplace violence. Retrieved from www.osha.gov/SLTC/workplaceviolence/

[2] National Institute of Occupational Safety and Health. (2013). Workplace violence prevention for nurses. CDC Course No. WB1865, NIOSH Pub. No. 2013-155. Retrieved from www.cdc.gov/niosh/topics/violence/training_nurses.html

[3] Occupational Safety and Health Administration. (2015). *Guidelines for preventing workplace violence for healthcare and social services workers* (OSHA 3148-04R 2015). U.S. Department of Labor. Retrieved from www.osha.gov/Publications/osha3148.pdf

[4] ECRI Institute. (2011, March). Violence in healthcare facilities. *Healthcare Risk Control, 2.*

[5] Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P. . . . Ng, A. T. (2012, February). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine, 13*(1), 17–25.

[6] Ibid.

[7] Agency for Healthcare Research and Quality. (2014, January). *Pocket guide: TeamSTEPPS: Team Strategies & Tools to Enhance Performance and Patient Safety*. Retrieved from www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.html

[8] ECRI Institute. (2013, July). Patient violence. *Healthcare Risk Control, 4.*

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