ORIGINAL ARTICLE

Workplace violence: A call for action

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Received: July 4, 2013 **Accepted:** August 7, 2013 **Online Published:** September 23, 2013
DOI: 10.5430/jha.v3n1p34 **URL:** http://dx.doi.org/10.5430/jha.v3n1p34

Abstract

Workplace violence (WPV) is a serious threat to the nursing workforce. WPV results in decrease morale, job dissatisfaction, and increase nurse turnover and intentions to leave the profession. WPV has been associated with decrease in the quality of care rendered and could negatively affect patient safety. Given the direct and indirect financial consequences of WPV, it is critical that nursing leaders take actions to reduce WPV by establishing violence prevention programs. Nursing leaders should also reach out to the public, their professional health organization, and the scientific community to provide education and craft regulation to reduce this threat on the nursing workforce and change the perception that violence is part of the job.

Key words

Workplace violence, Nursing leadership, Policy

1 Introduction

Responding to the arrival of a trauma patient to the busy emergency department (ED), a 24-year-old male patient was seen fighting against several police officers. As the officers tried to assist the patient onto a stretcher, the patient continued to fight profusely by kicking and punching them. Fortunately, the officers dodged the assault. In collaboration with several physicians and nurses, the patient was ultimately placed into 4-point leather restraints. Quite agitated, the patient continued to spit, scream foul language, and threaten to beat the staff once free from the restraints. Since it was not safe to place an intravenous catheter in the patient's arm to administer antipsychotic therapy, a nurse attempted to administer the medication via intramuscular injection. The patient caught a glimpse of this attempt and began yelling racial slurs and demeaning verbiage at the nurse.

Incidents such as the one above are too common in healthcare, especially in the ED and psychiatric settings [1, 2]. Gerberich *et al*. (2004) conducted a large scale epidemiological study of workplace violence (WPV) with Minnesota nurses finding that about 1 in 10 registered nurses have been victimized by a patient or visitor [2]. The National Institute for Occupational Safety and Health (NIOSH, 2002) [3] defines WPV as any violent acts directed toward persons at work or on duty. Violence acts include physical assaults, physical threats, and verbal abuse. The health care and social assistance is an industry with large employment, diverse demographics, and unique occupational safety issues such as WPV. This industry accounted for the majority of all nonfatal assaults by persons and more than a third of all nonfatal workplace injuries or illnesses to

women in 2007 [4] The assault rate for the health care and social assistance industry is 5.6 per 100 full-time workers compared to 4.2 for all other industry [4]. In 2010, the healthcare and social service industry reported more injuries and illnesses than the manufacturing sector. The incidence rate for work related nonfatal injuries and illnesses for the healthcare sector were 139.9 compared to 107.7 for all other private industry [5]. Nurses, aides, orderlies, and attendants suffered most of the non-fatal assaults resulting in injury [6]. In some occupations, dealing with dangerous people is inherent in their job, as in the case of law enforcement personnel, correctional officers, and security guards [7]. For health care occupations, violent reactions by patients and visitors while understandable in some situations (*e.g*., denial of service, delays in care, anger at the quality of service rendered, patient experiencing pain, notification of patient death), the violence is never justified and certainly not part of the job [8-10].

Many nurses believe WPV is a normal aspect of patient care [10]. Regardless of the incorrect perception of WPV as part of the job, exposures to WPV can lead to negative consequences for patient care, staff, and the health care organization [8, 9]. WPV has been associated with a decrease in the quality of care rendered and could potentially and negatively affect patient safety [11, 12]. Researchers found that WPV results in increased turnover and intention to leave the profession [13]. As an organization, job dissatisfaction, decreased morale, and feeling unsafe at work could have an enormous financial impact. McGovern *et al*. (2000) [14] found that the cost for assaults to registered nurses was approximately $32,000 for lost wages, worker's compensation payment, and loss of productivity. In addition, the cost of training a new nurse can be as high as $64,000 [15]. Given the direct and indirect costs of WPV, it is critical that actions be taken to reduce this threat against the nursing workforce. The purpose of this paper is to provide recommendations for nursing leadership to create an environment safe from WPV.

2 Components of a WPV prevention program

A WPV prevention and management program is a strategy that may be effective at curbing the problem of WPV [16]. In addition, nursing and organizational leadership can exhibit support for victims of WPV by ensuring that safety measures are taken to prevent further WPV. Components of a WPV prevention program should include mandatory incident reporting, a workplace and client analysis, adoption of a zero-tolerance policy, mandatory safety and violence training, post-incident support, and program evaluation [4].

2.1 Mandatory incident reporting

Incident reporting is paramount to an effective WPV program. Most nurses do not file a formal report for the physical violence, physical threats, or the verbal abuse they experience (ENA, 2011) [17]. However, most nurses still tend to notify security personnel, an immediate supervisor, other nurses, and/or physicians. Unfortunately, almost half (n = 3,217) of a sample of emergency nurses believe reporting incidents results in no action being taken towards the perpetrator and in some cases, the patient associated with the violence received care sooner than other patients [17]. While some hospitals employ security personnel on staff, not all nurses report WPV events to security officers, because some nurses believe that security officers are not effective at preventing or managing WPV [18]. One strategy to help increase reporting of incidents to security officers and through electronic systems is implementing an multidisciplinary safety committee with representatives from nursing administration, staff nurses, and security personnel that encourage reporting, monitor trends, and follow-up with victimized staff and witnesses. In addition, by working collaboratively, nurses and security officers can gain a better understanding of one another's roles. The importance of incident reporting can lend credence that WPV is a real problem in a particular workplace and be used to affect positive workplace changes.

2.2 Workplace and client analysis

Worksite analysis is crucial to understanding and preventing WPV. Risk assessments include identifying the types of patients being treated especially those with a history of mental illness, substance abuse, and violent crimes. Other assessments should include adequacy of health care providers and security personnel, physical design of the work

environment, the adequacy of treatment areas, and quality of lighting and surrounding areas [19]. The use of a panic button/silent alarm is associated with lower physical violence rates, while the presence of an enclosed nursing station, locked/coded entrance, security signage, and well-lit areas were associated with significantly lower verbal abuse rate [17].

2.3 Adoption of a zero-tolerance policy

Adoption of a zero-tolerance policy is of necessity as WPV will continue. However, a consensus must be achieved as to its application and enforcement. While a zero-tolerance policy has been shown in the law enforcement sector to reduce criminal recidivism rates, transferability to health care settings must be modified. The United Kingdom (U.K.) National Health Services implemented such a policy to reduce violence against staff by establishing relationships with law enforcement and prosecutorial services in order to tackle violence and prosecute offenders when indicated [20]. The U.K. government views those patients who commit violence against health care providers infringe on the providers' human rights. Resultantly, perpetrators may be denied care due to violent actions. However, refusal to care for patients is being questioned nationally due to its ethical significance [20]. The blanket application of a zero-tolerance policy is difficult, because the definition constituting WPV is not consistently interpreted and some perpetrators are deemed as not accountable for WPV due to their mental state. In recognizing this, the U.K. National Health Services prohibits the withdrawal or denial of care in cases of patients who are mentally ill or under the influence of alcohol or drugs [20]. The Australian Health System also has a zero-tolerance policy. However, much like its no smoking policy, the effectiveness of a zero-tolerance policy has been called into question, as there were no repercussions for those committing acts of violence towards health care workers [16]. While denial of care is not appropriate in some cases, organizational leaders should track these perpetrators such that appropriate staffing and other personnel can be summoned when the patients seek future health care services and can be referred to programs to help them manage their aggression. The Veterans Health Administration, in an effort to manage WPV, enacted a tracking system for patients threatening providers [21]. While banning care is not legally and morally possible in some U.S. health care settings, tracking offenders allows for readjustments of location and timing as to when these patients can receive care, as well as having the appropriate personnel present to manage potentially violent incidents.

2.4 Mandatory safety and violence training for all staff

A violence educational program should involve all employees including supervisors and managers. Visiting staff, such as physicians, should receive the same training as permanent staff. New and reassigned employees should receive initial orientation to the WPV program and associated policies before starting their duties, and all employees need to be informed of policy changes as they occur. Nachreiner *et al.* (2005) [22] reported that about 33% of nurses are unaware that WPV policies existed, and a greater proportion were unsure as to what degree these policies were enforced. Effective training programs should involve yearly refreshers and include role playing, simulations, and drills. Topics include recognition of behavior leading to violence, management of assaultive behaviors, professional assault-response training, police assault-avoidance programs or personal safety for preventing assaults, and empathetic and patient-centered communication skills to potentially deescalate violence [3, 23].

2.5 Post-incident support

Realizing that WPV may still occur even with the most effective WPV program, there needs to be post-incident WPV support. The support needs to provide comprehensive treatment for employees who are victimized personally or may be traumatized from witnessing a WPV incident [25]. Injured staff should receive prompt treatment and psychological evaluation when an incident of WPV takes place, regardless the severity. A strong post-incident support component is necessary for affected employees to be able to deal with psychological harm and prepare them to confront or cope with future incidents of WPV [24, 26].

2.6 Program evaluation

Following the implementation of the WPV program, the program needs to be evaluated at regular intervals to determine effectiveness for program adoption, compliance, and ability to decrease WPV incidents. Policies and procedures may need

modification based on evaluation findings. Additionally, nursing leadership should present program evaluation data and reports, discuss program changes, and solicit further change recommendations with nursing staff and other stakeholders.

Ideal components of program evaluation include reviewing incident reports and minutes from staff meetings addressing safety and security issues; analyzing trends and rates of illnesses, injuries, and fatalities associated with WPV; and measuring staff perceptions of personal and environmental safety [3]. Arnetz *et al*. (2011) [27] recommend keeping a continuous tracking of WPV utilizing a standardized system to allow for epidemiological analysis of the cause of violence, identification of the offender and victim, and the trends of such occurrences. Establishment of population surveillance can lead to policy changes within the organization that will enhance staff safety and reduce the incidence of WPV. Nursing leaders should also obtain input from employees before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness and keeping abreast of new strategies available to manage WPV in the health care and social service fields as they develop [3].

3 Public health policy on WPV

Nursing leaders are positioned to lead the charge for speaking out against WPV and educating consumers on what constitutes WPV and the potential consequences to the health care experience when WPV occurs. The American Hospital Association's Patient's Bill of Rights is posted throughout hospitals to inform patients of their rights while receiving care [28]. In an effort to reduce or prevent WPV, nursing leaders should also inform patients, visitors, and health care providers of expectations for patient behaviors. Nurses are entitled to provide care to patients in a violence-free environment so that the provision of care is quality and patient-focused. The American Nurses Association (2001), in its Nursing Bill of Rights, believes that all nursing personnel have the right to work in healthy work environments free of abusive behavior [29]. Likewise, the American Association of Nurse Executives supports a healthy working environment [30]. The American Association of Critical-care Nurses believes that there is an increase in violent incidents in the health care workplace and that the tolerance to violence towards nurses and other health care workers "undermines the healing mission of the healthcare organization, jeopardizes the physical and emotional safety of patients and caregivers and interferes with the ability of the healthcare team to optimally contribute to positive patient outcomes" [31].

3.1 Advocating for regulations on WPV

Nursing leaders have a responsibility to track and trend incidents of WPV and to support employees reporting incidents to local law enforcement authorities. Nursing leaders can also advocate for legislation against WPV. Legislation that mandates and regulates safety standards and controls for WPV prevention should be strengthened and supported. Currently, there are no federal laws, other than the General Duty Clause, that protect nurses from WPV, impose penalties for offenders, or mandate WPV prevention programs [32].

Some states enacted legislation in the form of requiring health care organizations to establish WPV prevention programs or strengthening penalties to offenders to protect health care workers from WPV. California enacted its Hospital Safety and Security Act requiring facilities to implement a comprehensive security plan [33]. The plan has both a preventive and response intervention, which addresses the physical layout of the facility, staffing, availability of security personnel, employee education and training on WPV, and reporting of violent incidents. Casteel *et al*. (2008) evaluated the effectiveness of the California WPV law finding that from 1996 to 2001 the rate of assaults in California EDs decreased from pretest to posttest periods and was significantly lower than rates in New Jersey where there is no WPV legislation [34].

While some states have legislation to address WPV, the legal consequences are usually minimal; typically a fourth degree felony with a maximum sentence of 12 months imprisonment [32]. Felony legislation and penalties for WPV, including assault or battery against nurses and their health care colleagues, should be established or strengthened, and supported in every state. Stronger legislation endorsed by nursing leaders enacted to protect nurses that have been victims of WPV helps reinforce the standard that violence is not part of the job [10]. Meanwhile, it should be the organizational leaders'

responsibility as part of the violence prevention training program to educate staff of any state legislation protecting them against WPV and advocate for such legislation when none exists.

3.2 Reaching out to the public

Nursing leaders can also reach out to their local and regional communities to curb WPV and create a safe work environment. The use of social media to inform the public of WPV may be an effective tool to educate patients and families of the consequences of violence in the workplace. Many patients are turning to social media as a source for gathering and sharing information about their health, health care, and their experiences with health care providers [35]. The interactivity of social media allows for "crowdsourcing" which creates an open call to a community. Patients can crowd-source second opinions on their diagnosis, obtain options for treatment, and find support groups [35]. Likewise, nursing leaders can crowdsource the social media and share accounts of WPV and how the violence affects nurses' provision of care to patients.

4 Conclusion

WPV is a serious occupational risk for the nursing workforce. It is essential to investigate the actual extent of WPV and determine targeted responses from employers, law enforcement, professional organizations, and the community. A significant amount of WPV is preventable with the implementation of a violence prevention program. Because of the complexity of WPV, a multidisciplinary approach may achieve more attention and advocacy. Nursing leaders should work collaboratively within and amongst health care organizations to develop a WPV prevention program. All health care providers, especially nursing leaders, need to reach out to the public, their professional associations, and the scientific community to provide education, craft regulations, and enact change to reduce violence in the health care workplace.

Acknowledgment

Dr. Gillespie's time for coauthoring the manuscript was supported by the Robert Wood Johnson Foundation Nurse Faculty Scholars program.

References

[1] Gacki-Smith J, Juarez AM, Boyett, L, *et al*. Violence against nurses working in US emergency departments. JONA 2009; 39(7/8): 340-349. PMid: 19641432. http://dx.doi.org/10.1097/NNA.0b013e3181ae97db

[2] Gerberich SG, Church TR, McGovern, PM, *et al*. An epidemiological study of the magnitude and consequences of work related violence: the Minnesota nurses' study. Occupational and Environmental Medicine. 2004; 61: 495-503. PMid: 15150388. http://dx.doi.org/10.1136/oem.2003.007294

[3] Violence occupational hazards in hospitals. National Institute for Occupational Safety and Health (NIOSH). Available from: http://www.cdc.gov/niosh/docs/2002-101/ (5 August 2013, date last accessed).

[4] Occupational Safety & Health Administration. Workplace violence. Available from: http://www.osha,gov/SLTC/healthcarefacilities/violence.html (5 August 2013, date last accessed).

[5] Janocha, JT, Smith, RT. Workplace safety and health in the health care and social assistance industry, 2003-07. Available from: http://www.bls.gov/opub/cwc/sh20100825ar01p1.htm (5 August 2013, data last accessed).

[6] Findorff, MJ, McGovern, PM, Wall, MM. Reporting violence to a health care employer: a cross-sectional study. AAOHN 2005; 53(9): 399-406.

[7] Patterson, E. Security services in the healthcare organization. In E. Meserve & N. B. Williams (Eds.), Basic training manual for healthcare security officers (4th ed.). Glendale Heights, IL:International Association for Healthcare Security and Safety. 2007: 21-27.

[8] Gillespie GL, Gates DM, Miller M, *et al*. Violence against healthcare workers in a pediatric emergency department. Advanced Emergency Nursing Journal. 2010; 32(1): 68-82. doi:10.1097/TME.0b013e3181c8b0b4.

[9] Gillespie GL, Gates DM, Miller, M, *et al*. Workplace violence in the healthcare settings: risk factors and protective strategies. Rehabilitation Nursing. 2010; 35(5): 177-184. PMid: 20836482. http://dx.doi.org/10.1002/j.2048-7940.2010.tb00045.x

[10] Trossman S. Not "part of the job": nurses seek to end workplace violence. The American Nurse. 2010; 42(6): 16.
[11] Arnetz JE, Arnezt BB. Violence towards health care staff and possible effects on the quality of patient care. Social Science and Medicine. 2001; 52: 417-427. http://dx.doi.org/10.1016/S0277-9536(00)00146-5
[12] Gates DM, Gillespie GL, Succop P. Violence against nurses and its impact on stress and productivity. Nurs Econ. 2011; 29(2): 59-66. PMid: 21667672.
[13] Canton AN, Sherman MF, Magda, LA, *et al*. Violence, job satisfaction, and employment intentions among home healthcare registered nurses. Home Health Care Nurses. 2009; 27(6): 364-373. PMid: 19509522. http://dx.doi.org/10.1097/01.NHH.0000356828.27090.bd
[14] McGovern PM, Kochevar L, Lohman W, *et al*. The cost of work-related physical assaults in Minnesota. Health Services Research. 2000; 35(3): 663-686. PMid: 10966089.
[15] Stibal M. Emergency Department Nurse Recruitment and Retention. Available from: http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2008/06/emergency-department-nurse-recruitment-and-retention.html. (11 February 2013, date last accessed).
[16] Pich J, Hazelton M, Sundin D, *et al*. Patient-related violence at triage: a qualitative descriptive study. International Emergency Nursing. 2009; 19: 12-19. PMid: 21193163. http://dx.doi.org/10.1016/j.ienj.2009.11.007
[17] Emergency Nurses Association. Emergency Department Violence Surveillance Study (2011). Available from: http://www.ena.org/IENR/Pages/WorkplaceViolence.aspx (11 February 2013, date last accessed).
[18] Gillespie GL, Gates DM, Miller M, *et al*. Emergency department workers' perceptions of security officers' effectiveness during violent events. WORK: A Journal of Prevention, Assessment, & Rehabilitation. 2012; 42(1): 21-27. doi:10.3233/WOR-2012-132.
[19] Kowalenko T, Cunningham R, Sachs CJ, *et al*. Workplace violence in emergency medicine: current knowledge and future directions. The Journal of Emergency Medicine. 2012; 43(3): 523-531. PMid: 22633755. http://dx.doi.org/10.1016/j.jemermed.2012.02.056
[20] Paniague H, Bond P, Thompson A. Providing alternative to zero tolerance policies. British Journal of Nursing. 2009; 18(10): 619-620, 622-623.
[21] Hodgson MJ, Mohr DC, Drummond DJ, *et al*. Managing disruptive patients in health care: necessary solutions to a difficult problem. The American Journal of Industrial Medicine. 2012; 55: 1009-1017. PMid: 22911609. http://dx.doi.org/10.1002/ajim.22104
[22] Nachreiner NM, Gerberich SG, McGovern PM, *et al*. Relationship between policies and work related assault: Minnesota nurses' study. Occupational and Environmental Medicine. 2005; 62: 675-681. PMid: 16169912. http://dx.doi.org/10.1136/oem.2004.014134
[23] Hahn S, Hantikainen V, Needham I, *et al*. Patient and visitor violence in the general hospital, occurrence, staff interventions and consequences: a cross sectional survey. Journal of Advanced Nursing. 2012; 68(12): 2685-2699. PMid: 22381080. http://dx.doi.org/10.1111/j.1365-2648.2012.05967.x
[24] Clements PT, DeRaneiri, JT, Clark K, *et al*. Workplace violence and corporate policy for health care settings. Nurs Econ. 2005; 23(3): 119-124. PMid: 16033140.
[25] Gates DM, Gillespie GL, Smith C, *et al*. Using action research to plan a violence prevention program for emergency departments. Journal of Emergency Nursing. 2011; 37(1): 32-39. PMid: 21237365. http://dx.doi.org/10.1016/j.jen.2009.09.013
[26] Gillespie GL. Bresler S, Gates DM, *et al*. Symptoms of posttraumatic stress in emergency department workers following workplace aggression. 2012.
[27] Arnetz JE, Aranyos D, Ager J, *et al*. Development and application of a population-based system for workplace violence surveillance in hospitals. The American Journal of Industrial Medicine. 2011; 54: 925-934. PMid: 21739469. http://dx.doi.org/10.1002/ajim.20984
[28] American Hospital Association. The Patient's Bills of Rights. Available from: http://www.patienttalk.info/AHA-Patient_Bill_of_Rights.htm (11 February 2013, date last accessed).
[29] American Nurses Association. Nurses' Bill of Rights. Available from: http://nursingworld.org/MainMenuCategories/WorkplaceSafety/Work-Environment/NursesBillofRights. (11 February 2013, last date accessed).
[30] American Organization of Nurse Executives. AONE Position Statement and Guiding Principle for Diversity Available from: www.aone.org/resources/leadership%20tools/Docs/AONE.DiversityGuidingPrinciples.Final.doc. (11 February 2013, last date accessed).
[31] American Association of Critical-Care Nurses. Position statement on workplace violence prevention. Available from: http://www.aacn.org/WD/Practice/Docs/Workplace_Violence.pdf. (11 February 2013, last date accessed).
[32] Stokowski LA. Legislative solutions to healthcare workplace violence. 2010. Available from:

http://www.medscape.com/viewarticle/727144_5. (11 February 2013, last date accessed).

[33] California Health and Safety Code Section 1257.5. Available from: www.cdph.ca.gov/cert/ic/facilities. (11 February 2013, last date accessed).

[34] Casteel C, Peek-Asa C, Nocera M, *et al*. Hospital employee assault rates before and after enactment of California hospital security and safety act. Annal of Epidemiology. 2008; 19(2): 125-133. PMid: 19185807. http://dx.doi.org/10.1016/j.annepidem.2008.10.009

[35] Lober WB, Flowers JL. Consumers empowerment in healthcare amid the internet and social media. Seminars in Oncology Nursing. 2011; 27(3): 169-182. PMid: 21783008. http://dx.doi.org/10.1016/j.soncn.2011.04.002