Overview

• Define workplace violence (WV) and discuss the typologies
• Specific and unique hazards/challenges that healthcare workers face on the job
• Strategies known to work/not work for WV prevention for healthcare workers
• Key components of an effective WV prevention program for healthcare workers

Workplace Violence Definition

• Violent acts (including physical assaults and threats of assault), directed towards person at work or on duty (NIOSH, 1996).
• Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site (OSHA, 2014).
WV Typology (CAL-OSHA, 1993)

- Type I – unknown perpetrator, criminal motive
- Type II – patient, client, customer as perpetrator
- Type III – coworker, supervisor as perpetrator
- Type IV – intimate partner perpetrator

Useful for assessing prevention strategies. Risk for one type of violence likely to infer risk for other types.

Magnitude of the Problem

- 34 of 62 fatalities in HCSA industry were due to assaults and violent acts (BLS, 2010).
- 572,000 non-fatal assaults /year among all public & private sector workers (DOJ, 2011)
- Between 2003-2010, 59-67% of non-fatal assaults occur in healthcare and social services (BLS, 2013)
- Rate of non-fatal assault among HCSA industry 15.1/10,000 compared with 4.0/10,000 among all private sector workers (BLS, 2013).
- 13% and 39% of RNs experience physical and non-physical violence per year (Gerberich, 2004)

Real faces and personal cost...
Hospital-based surveillance

- Pompeii (2013) – among 17 studies reviewed
  - verbal abuse (22%-90%),
  - physical threats (12%-64%)
  - assaults (2%-32%)

- Arnetz (2011) - Incidence rates per hospital
  1.52 - 10.89/100 FTEs (2003-2008)
  - Hospital with outpatient mental health (RR = 7.16)
  - Mental health technicians (RR = 13.82)
  - Security personnel (RR = 2.25)

Exposure

Exposure = patient/client/family/visitor/public

- Dynamic and moderated by clinical management, work environment, work organization, worker skills/interactions.
- High potential for confounding of relationship between interventions and outcomes by these factors.

Exposure: Client Characteristics

- Mental illness
  - Untreated psychotic symptoms
  - Risk factors associated with illness (e.g. substance abuse, homelessness, incarceration)
- History of violence (history of trauma)
- Cognitive impairment
  - Elderly, developmentally disabled
- Substance abuse
- Individuals with access to weapons
- Fear/anxiety associated with health care experience
Workplace Violence Prevention in Healthcare Cal/OSHA Advisory Meeting

Scope/Setting (OSHA)
- Hospital
- Residential Treatment (e.g. nursing homes, and other long-term care facilities)
- Non-residential Treatment/Service (e.g. neighborhood clinics, mental health centers)
- Community Care (e.g. community-based residential facilities and group homes)
- Field work settings (e.g. home healthcare or social workers who make home visits)

Lifetime Prevalence of Violent Behavior among Persons with or without Major Psychiatric Disorders and Substance Abuse.

Friedman, NEJM 2006
Risk Factors - Job Tasks

1= Hospital, 2= Community Setting, 3= Home Visiting

- Contact with the public (1,2,3)
- Exchange of money
- Delivery of passengers, goods, or services (2)
- Working with unstable or volatile persons in health care, social service, or criminal justice settings (1,2,3)
- Working alone or in small numbers (2,3)
- Working late at night or during early morning hours (1,2)
- Working in community-based settings (2,3)

(Collins and Cox 1987; Davis 1987; Davis et al. 1987; Kraus 1987; Lynch 1987; NIOSH 1993; Castillo and Jenkins 1994)

Exposure: Setting Characteristics

(Nachreiner, 2007)

- Nursing homes/LTC (OR = 2.6)
- Emergency dept (OR = 4.2)
- Psychiatric dept (OR = 2.0)
- Across settings, cases more likely to report:
  - High levels of work stress
  - Expectation that assault is “part of job”
  - No action taken in response to assault
  - Low morale, lack of respect and trust among personnel

Literature Review:

Intervention Evaluation (1)

- Training
  - Lehman (1983) VA Hospital
  - Infantino & Musingo (1985)
  - Carmel and Hunter (1990)
  - Parks (1996)
  - Goodridge et. Al (1997)

- Post-incidence debriefing
  - Flannery et.al. (1998)
  - Matthews (1998)
Literature Review: Intervention Evaluation (2)

- Other strategies
  - Drummond et. Al. (1989) +
  - Arnetz & Arnetz (2000) -
- Comprehensive Program
  - Lipscomb et al. (2006) +/–
  - Mohr et al. (2012) +/–
- Policy/Regulation
  - Peek-Asa et al. (2007) +/–

Evidence from the Field

- Hospitals that have strong WVPP have experienced reduced staff assaults.
- Background information on patient history of violence could be life saving.
- Staff working along and/or in remote locations must have a means to summon assistance.
- Visits involving involuntary admission, removal of children from home – very high risk


- Management Commitment
- Employee Involvement
- Worksite Analysis
- Hazard Prevention & Control
- Recordkeeping
- Evaluations
Home Visiting
• Physical assaults less frequent than in institutional setting
• Risk of injury associated with driving, traveling in high crime areas
• Workers have less control over physical environment (guest in home)
• No support from coworkers
• Risk from firearms, drugs in home

Prevention Strategy Across Settings
• Recognition of link between patient/staff safety as reflected in culture of safety for both
• Comprehensive Violence Prevention Program*
  – Risk assessment and system for identifying high risk patients/encounters (e.g. flagging charts).
  – Enforce strict code of behavior and have consequences for violation of code (including pressing criminal charges)

IH Hierarchy of Controls: Applied to Workplace Violence
• Elimination/Substitution
• Engineering Controls
• Administrative Controls
• PPE
## Environmental Survey Checklist

(K. Murrett, ARI, NY)

- Lighting, noise, air quality
- Objects/furnishings as weapons
- Sharp edges, hard surfaces
- Access control
- Working in isolation, hidden areas
- Surveillance cameras
- Security hardware, alarm systems

## Environmental Risks

- Arrange furniture to prevent entrapment
- Curved mirrors at hallway intersections
- Comfortable waiting areas for clients/visitors
- Adequate lighting
- Opportunity for passive surveillance
- Panic buttons, cell phones, alarms, cameras, etc.
- Assess construction/renovation plans
Hazard Controls

- Adequate staffing and staffing mix*
- No solo work in high-risk areas/jobs
- Report/record all incidents
- Availability of patient risk information
- Reduce waiting time for clients/visitors
- Liaison with police

Administrative Controls

- Adequate staffing and staffing mix*
- No solo work in high-risk areas/jobs
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Training: Necessary But Not Sufficient

- Training should include:
  - Elements of a WVPP
  - How to report incidents
  - Risk of particular patient population/setting
  - Early intervention de-escalation techniques
  - Policy for restraint and seclusion
- Physical intervention
  - Last resort
  - When early intervention fails
  - Many questions about simulation, frequency and intensity of practice
What Workers Have Told Us

- Culture that WV is "part of the job"
- Patient rights movement creates a huge challenge to staff protection
- Resistance/reprisal for filing criminal charges against patient/client
- Inadequate staffing - very high risk situation
  - Increases patient agitation
  - Makes staff easy targets
- Lack of regulations results in lack of WVP programming, even in high risk settings

Workplace Violence Prevention: What it Looks Like in Practice

- Labor/management H & S committees/teams
- Ongoing review and synthesis of incident/injury data
- Review, analyze, revision of policies & procedures
- Collect additional data where needed (e.g. focus groups, interviews, staff surveys)
- Evaluate and modify physical work environment
- Teamwork to implement changes

Questions??