Reducing Violence

in Healthcare Facilities

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INTRODUCTION & DEFINITION

Hospitals have historically enjoyed reputations as places of refuge where workers, patients, and visitors are safe from crime. While that perception remains true more often than not, there has been increasing attention on violence in hospitals, particularly against healthcare workers. Part of the concern is that is driven by media reports, healthcare industry associations and accreditation organizations, and the Occupational Safety and Health Administration (OSHA). The increased attention is also based on a widespread revision to the definition of workplace violence. Historically, a required element of workplace violence was physical contact. The definition of workplace violence has been expanded in recent years to include not only the act of, but also the threat of physical violence, harassment, intimidation, or other threatening disruptive behavior. Consider the rather broad range of incidents that OSHA now considers: "[Workplace violence] ranges from threats and verbal abuse to physical assaults and even homicide."

"In 2010, the Bureau of Labor Statistics data reported healthcare and social assistance workers were the victims of approximately 11,370 assaults by persons; a greater than 13% increase over the number of such assaults reported in 2009." While this statistic may be factually correct, it does not tell the whole story. In 2010, there were approximately 14 million people employed in the healthcare sector. 11,370 assaults is a rate of 0.8 per 1,000 employees. So while there has been an increase in workplace violence incidents in healthcare environments, the reality is that these incidents directly impact a small percentage of employees.

The objective of this article is not to dispel workplace violence myths, but rather to use the heightened awareness as an opportunity to improve workplace violence prevention efforts. Healthcare administrators and security professionals may use this opportunity to collaborate on comprehensive plans to manage the workplace violence, not only to reduce the direct impact of workplace violence incidents, but also to mitigate the indirect impacts such as employee morale degradation, fear of workplace violence, and costs of workplace violence.

Hospital campuses are typically open environments in which employees, patients, and visitors move about the campus unfettered is most areas. Healthcare facilities cannot be locked down in the manner of closed environments such as prisons or nuclear facilities. As such, target hardening measures can only go so far before they begin to impede patient care. Patients are present because they need care and barriers to rapid patient care are inherently problematic. Moreover, the demeanor or patients and visitors may change while at the hospital due to increasing stress and frustration. Increasingly, disruptive and combative patients are suffering from behavioral

health issues, substance abuse issues, or both.

The response to workplace violence should begin with an understanding that all workplace violence incidents are not alike and that not all workplace violence incidents involve violence. Perpetrators and their motives are different, as are their targets, and each type is not equally likely to occur. In most hospitals, the majority of violent episodes are driven by combative behavioral health and substance abuse patients, not third-party attackers or co-workers. The Federal Bureau of Investigation provides a good framework for classifying workplace violence:

- Type 1: Violent acts by criminals who have no other connection with the workplace, but enter to commit robbery or another crime.
- Type 2: Violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.
- Type 3: Violence against coworkers, supervisors, or managers by a present or former employee.
- Type 4: Violence committed in the workplace by someone who doesn't work there, but has a personal relationship with an employee—an abusive spouse or domestic partner.

Because of their frequency relative to other types of workplace violence incidents, hospitals are primarily focused on Type 2 incidents where these incidents are typically referred to as patient-on-staff assaults. This framework should form the basis for workplace violence policies as well as record keeping efforts in the hospital.

Recordkeeping is important not only because regulatory bodies such as OSHA require it, but also because it is crucial to program evaluation. Descriptive statistics, identifying the nature of workplace violence incidents (e.g. Type 1, Type 2, etc.) are useful in designing appropriate mitigation efforts and evaluating program effectiveness. Management and the safety committee should review the program regularly and with each incident to measure the program's success and to highlight needed revisions. Sharing evaluations with employees increases cooperation and future success.

POLICY & PREVENTION

OSHA provides guidelines on preventing workplace violence in healthcare by way of their publication entitled Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers. The guidelines call for management commitment and employee involvement, worksite analysis, hazard prevention and control, training, and program evaluation. Hospital administrators should implement a top-down commitment to managing workplace violence and create a

collaborative environment for all levels of the organization to work together as a team. No one knows more about patients than those directly involved with their care. Clinical staff knowledge of day-to-day operations, weaknesses in the prevention protocols, and specific knowledge of particular patients (i.e. frequent flyers) make their input invaluable. A multi-disciplinary workplace violence prevention team or safety committee should engage in a comprehensive review of all policies, procedures, and operations to identify and respond to hazards that exist currently and plan for future threats. The team should represent a cross section of the organization - management, human resources, legal, security, patient care, and other operational groups - and should also be responsible for implementing appropriate security measures for the threats that they identify, beginning with the creation of the workplace violence prevention policy.

Policies and procedures are the logical starting point for an effective workplace violence prevention program. Lack of enforced policies and non-compliance may reduce the effectiveness of the program. Employee training on workplace violence helps to ensure that policies are clearly understood, uniformly followed, and that staff are aware of existing mitigation efforts. It is often recommended that the workplace violence policy prohibit the following behaviors:

- Direct threats or physical intimidation
- Implications or suggestions of violence
- Stalking
- Possession of weapons of any kind inside company property or at company sponsored events, unless such possession or use is a requirement of the job
- Physical assault of any form
- Physical restraint, confinement
- Dangerous or threatening horseplay
- Loud, disruptive or angry behavior or language that is clearly not part of the typical work environment
- Blatant or intentional disregard for the safety or well-being of others
- Commission of a violent felony or misdemeanor on company property
- Any other act that a reasonable person would perceive as constituting a threat of violence.

Efforts to manage identified threats should be mitigated through a combination of physical and procedural controls. Measures that mitigate the workplace violence risk at one hospital may not have the same impact at another hospital. Likewise, some measures may be a cultural fit at one hospital, but may not fit at another. Workplace violence responses should be

tailored to address the unique threats identified at each hospital. While OSHA identifies specific security measures, research into various measures has not always provided evidence of prevention or deterrence. For example, recent studies have found that unmonitored security cameras do not little in violence prevention. Moreover, irrational behaviors exhibited by behavioral health, substance abuse, and other traumatized patients are often not deterred by cameras.

Given the awareness of active shooter events across the country and specifically at hospitals, metal detectors have become a consideration for some hospitals. While metal detectors may reduce the prevalence of weapons in the hospital, it should be remembered that the vast majority of Type 2 workplace violence events do not involve the use of a weapon. Recent active shooter research regarding the use of metal detectors found the following:

- Shootings that occurred after peaceful entry into the hospital were generally considered to be preventable had the perpetrator been screened by a magnetometer [metal detector]. Individuals who rushed or stormed into the hospital, seized a weapon carried by security or police, were motivated by grudge, or initiated the shooting event outside the hospital were considered "determined" shooters, unlikely deterred by metal detectors.

- …only 30% to 36% of events were likely preventable by use of a metal detector.

Employee training is among the most commonly recommended workplace violence measures. Practical considerations aside, workplace violence training should include all employees, though to varying degrees. Not all employees need an eight hour training course. At minimum, all employees should be provided with a workplace violence orientation that includes a review of the hospital's workplace violence prevention policy, warning signs, and reporting procedures. The International Association for Healthcare Security and Safety (IAHSS) calls for all staff to be provided orientation within thirty (30) days of employment with periodic reviews and updates of information at least annually. A more advanced orientation may cover the workplace violence prevention policy must be covered in depth, including all identified threats, risk factors, warning signs, response, and reporting requirements with updates as needed. Because of their unique role in responding to violent incidents, security personnel may also receive additional training in the proper handling of aggressive individuals.

VISITOR AND PATIENT MANAGEMENT

Visitor and patient management can have a significant impact on reducing workplace violence incidents. Maintaining calm waiting rooms in the hospital lobby and Emergency Department can assist people in keeping their emotions under control. Waiting in a hospital, especially in emergency circumstances, is inherently

stressful. People are often short-fused and prone to losing control more easily than they typically would be, and this problem is compounded when the environment is noisy and chaotic. Providing quiet, peaceful waiting areas can help to prevent verbal and physical outbursts, and keeping emergency patients and those with them apprised of wait times will reduce frustration and help to keep emotions on an even keel. The simple act of making eye contact and welcoming visitors to the facility—letting them know that someone is aware of their presence—may deter an individual who is ambivalent and not fully committed to carrying out a violent act. Staff should also inform visitors if there is a visitor limit in the Emergency Department's treatment area. IAHSS recommends that healthcare facilities "establish policy and procedures that define authorized visitor access to patients in the facility. The policy and procedures should make specific reference to visitor access to patients and contain restrictions on visiting hours and number of visitors, by unit, as applicable. The policy should balance the security needs of the facility with the healing value provided to patients through support from family and friends."

Registration personnel are often assigned with the responsibility of encouraging and maintaining a calm Emergency Department. These staff members should establish good communications and professional working relationships with Emergency Department staff. Emergency Departments that have experienced a significant occurrence of violence should have additional measures in place. For example, staff could be trained in de-escalation techniques, security personnel may be dedicated to the department, etc. Health Information Management systems can include, where feasible, a mechanism for flagging patients with a history of disruptive or combative behavior. Employees, particularly those in the Emergency Department and Security, should always be alerted to the presence of a high risk patient. If a patient is known to have exhibited such behavior in the past, staff will be more alert for potential warnings signs and should give more weight to them. With or without a flag, however, staff should always be attentive to warning signs exhibited by any patient or visitor. As with all protected health information (PHI), protecting the information in public areas (e.g. visitor management post, Emergency Department registration, Admissions, etc.) is necessary.

Hospital employees should be familiar with the warning signs that may indicate the potential for Type 2 workplace violence. Early warning signs of possible violence and escalating tension may include foul language, resisting reasonable requests, talking to self, sweating, pacing, staring, crying, raised voice, silence, withdrawn behavior, closed posturing, wringing of hands, and self-injurious behavior (mild). Early warning signs of imminent violence may include threatening or verbally assaultive, screaming, refusing reasonable requests, stalking, increased respiratory rate/heavy breathing, increased vital signs, increased sweating (visible), self-injurious behavior (moderate), and

medication/treatment refusal. The above list is useful because it weights the probative value of each warning sign; however, the mere presence of any one sign may or may not indicate impending violence when the stress of medical treatment, particularly emergency medical treatment, is considered. On the other hand, behavioral health and substance abuse patients may not display any signs in the moments leading up to a violent event.

A procedure on the use of patient sitters should be developed. Patient sitters should be trained in all facets of the workplace violence prevention program. Security personnel should be used sparingly for one-on-one patient observation unless security staffing allows for this time consuming effort. If insufficient security personnel are available, patient observations may detract from other security duties. The Security Department should track all time spent on patient observation duties to ensure adequate resources. It is also advisable to develop written criteria for the use of security personnel for patient observations.

CONCLUSIONS

Workplace violence prevention cannot operate in a vacuum nor is it a single Department responsibility. Prevention efforts are more effective when a multi-disciplinary approach is taken. Similarly, security measures alone do not comprise a holistic workplace violence solution. Increasingly, Type 2 workplace violence is a result of increasing behavioral health, drug seeking, and substance abuse patients. Managing these types of patients requires a clinical and organizational approach with assistance from the Security Department.

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