ANALYSIS PAPER

Workplace Violence in Hospitals: Issues, Trends, Prevention, and Response

By Boris Kalanj, Director of Programs
info@hqinstitute.org

June, 2023

Hospital Quality Institute©
Leadership in quality and patient safety

EXECUTIVE SUMMARY

Workplace violence — defined by the Occupational Safety and Health Administration (OSHA) as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at work — is one of the most complex and dangerous occupational hazards facing health care workers today.

Studies have found that health care workers are multiple times more likely to experience workplace violence than workers in other sectors and industries. In fact, while fewer than 20% of all workplace injuries happen to health care workers, health care workers suffer 50% of all assaults (OSHA, 2016). The incidence of violence-related health care worker injuries has steadily increased for at least a decade. As just one example, a 2021 study found that 44% of nurses reported being subject to physical violence, while 68% reported verbal abuse (Byon HD, 2021).

This situation was further exacerbated by the COVID-19 pandemic. A 2022 study in a hospital emergency department (ED) demonstrated that incidence of workplace violence increased during the pandemic and there was a positive association between these incidents and the COVID-19 case rate (McGuire, 2022).

California hospitals have not been immune to this national trend. Incidents of health care workers suffering serious assaults are frequently featured in the news, including two last year: a June 2022 situation in which a physician and two nurses were stabbed, and another in September 2022, when a nurse was stabbed. After interviewing emergency physicians about the problem, one news reporter wrote in a 2018 article: "Getting spit on by a patient is so common that it's hardly worth mentioning. It's the bites, punches, firearms and airborne objects that you really need to watch out for" (*San Diego Union-Tribune*).

Over the past several years, new legislation and regulations have been put in effect to address the issue of hospital workplace violence:

- Cal/OSHA's new standard for Violence Prevention in Health Care became effective on April 1, 2017, following the passage of Senate Bill 1299. Hospitals are required to have a written violence prevention plan in place and report incidents of workplace violence to Cal/OSHA.
- The Joint Commission's Workplace Violence Prevention Standards have been in effect since Jan. 1, 2022. Similar to the Cal/OSHA standard, The Joint Commission requires hospitals to have processes in place to manage safety and security risks, collect information to monitor conditions, provide education and training to staff, and have formal organizational leadership designated for managing workplace violence.
- A bill in the California Legislature, Assembly Bill (AB) 977; Rodriguez, D-Pomona, would increase the penalties for assault or battery against health care workers in the ED. It would also allow the ED to post a notice stating that assault and battery against hospital staff is a crime and may result in a felony conviction.

Recent discussions with hospital leaders statewide have emphasized that addressing workplace violence remains a top priority. This paper provides a summary of the issue of workplace violence as it currently affects hospitals.

KEY POINTS

- When it comes to non-fatal workplace violence incidents that result in days away from work, health care environments are the most represented — and these incidents most frequently occur in hospital EDs.
- It is widely acknowledged that incidences of workplace violence are underreported by the hospital staff and providers, a problem that may lie in our health care culture: While we have placed a great deal of focus on patient experience and patient safety, we have placed much less focus on worker safety.

- For both prevention of and response to workplace violence, hospitals should establish an effective workplace violence prevention program.

TYPES OF WORKPLACE VIOLENCE

According to the National Institute for Occupational Safety and Health (NIOSH), homicides and other forms of fatal workplace violence most frequently take place in industries such as sales, protective services, and transportation services — but **health care environments are the most represented among cases of non-fatal violence that result in days away from work.**

As OSHA's definition implies, workplace violence is not limited to physical assault but also includes a broad range of psychologically damaging actions such as threats, harassment, verbal abuse, and bullying. A nurse director from a community hospital in the Sacramento area recounted an experience in which a belligerent patient first yelled threats and profanities at a nurse, then pulled out a Nerf gun from his backpack and shot her in the face. Even though the projectile missed the nurse's eye and she sustained no physical injury, the aggressive nature of the encounter and the nurse's initial perception that the Nerf gun was an actual firearm left her profoundly traumatized and unable to work for a month. Co-workers who witnessed the incident were also visibly shaken for days afterward.

The most frequent source of workplace violence in hospitals is violence directed at employees by patients or those who accompany them (e.g., family, friends, and other visitors). Somewhat less represented — but still too common — is worker-on-worker violence, which may include verbal outbursts, passive aggressiveness, bullying of persons seen as being "lower on the food chain," and other forms of intimidating and disruptive behaviors among co-workers. Acts committed by outside relatives or acquaintances of employees, or by individuals who enter the facility with the intent to commit a crime, are relatively infrequent. As such, this paper focuses mostly on the violence committed by patients, their family members, or other people accompanying them.

RISK/CONTRIBUTING FACTORS

Workplace violence incidents most frequently occur in the ED, an unsurprising trend given that those patients are typically not feeling well and they, along with their families or other accompanying persons, can be under high levels of stress and anxiety. ED patients are also frequently subjected to crowded waiting rooms and long wait times surrounded by other ailing individuals. They may be cared for by rushed, multi-tasking staff who may themselves be struggling with rising workloads, staff shortages, and a plethora of other work-related pressures and stressors.

These issues have been further exacerbated by the COVID-19 pandemic. Violence in health care settings worsens during a time of emergency, disaster, or other crisis in the larger society (WHO, 2022). During the pandemic, society experienced high levels of worry, fear, and uncertainty; health care workers often became the targets for those with negative feelings. Studies have found that nurses who provided care for patients with COVID-19 experienced more physical violence and verbal abuse than other nurses. Alarmingly, they were also less likely to report such incidents during the pandemic than prior to it (Byon HD, 2021).

Other key risk factors for patient violence include previous history of violence, untreated pain, mental health issues, influence of drugs and alcohol, and cognitive impairment. As an example, an ED director from a large, urban California hospital recalled the care of a patient who arrived in the ED with a traumatic brain injury. The patient could not be

sufficiently stabilized for transfer to an inpatient floor, so he remained in the ED for 80 hours. When not sedated, he was belligerent and aggressive toward everyone around him. In the process of caring for this patient, three ED nurses sustained miscellaneous injuries.

It is important to note that, although some psychiatric diagnoses are associated with violent behavior, most people who are violent are not mentally ill, and most people who are mentally ill are not violent. Substance abuse has been found to be a major contributor to violence, regardless of the existence of co-occurring psychiatric diagnoses.

Environmental factors — such as a facility's layout, design, and appointments in the physical workspace — can also heighten the risk of workplace violence. For example:

- Unmonitored entries and blind corners can provide opportunities for people to gain entry without detection.
- Excessive heat, cold, or noise can increase stress.
- Fixtures, office supplies, and decorative items can be used as weapons.
- Inadequate security systems and alarms can limit the staff's ability to appropriately respond to violent incidents.

Other key organizational risk factors include:

- The absence of an effective workplace violence prevention program and designated leadership
- Inadequate security procedures and protocols
- Lack of staff training and preparedness
- Inadequate staffing levels, often accompanied by longer shifts and increased use of overtime

Beyond the impacts of the COVID-19 pandemic, it is important to consider how conditions in the community influence the level of workplace violence. Hospitals are not insulated from larger societal issues. Factors such as a high concentration of crime, poverty, economic instability, inadequate housing, and absence of green space can all contribute to a climate prone to violence — both outside and inside the hospital. A leader in one urban California hospital recently shared that the area surrounding the hospital has become increasingly affected by crime and homelessness, leading many staff — particularly those who work evening and night shifts — to feel increasingly uneasy when arriving or departing. Some hospitals have faced other external obstacles to ensuring safety and security. For example, a critical access hospital struggled to provide adequate security because few qualified security professionals/contractors were available in their remote part of the state.

Who Is Most at Risk?

As mentioned above, health care workers most likely to become victims of workplace violence are staff in EDs, especially nurses, physicians, paramedics, and others directly involved with patient care. Rates of workplace violence increase along with patient contact time, which makes nurses and nursing assistants especially vulnerable. In a meta-analysis of workplace violence in EDs, 56% of all ED workers who experienced workplace violence were nurses and 36% were physicians (Aljohani, 2021). Other studies have confirmed these trends, both in the U.S. and beyond. In a study of an Israeli hospital, nurses were exposed to violence almost twice as often as physicians, and nurses in the ED were five times more likely to be exposed to workplace violence than nurses in other hospital areas (Shafran-Tikva, 2017). Psychiatric units and intensive care units also tend to be disproportionally affected by workplace violence.

CONSEQUENCES OF WORKPLACE VIOLENCE

Workplace safety is inextricably linked to patient safety. Unless caregivers are given the protection, respect, and support they need, they are more likely to make errors, fail to follow safe practices, and not work well in teams.
*— **Lucian Leape Institute, 2013***

The strong relationship between workplace violence and patient safety lies at the heart of HQI's interest and attention to this issue. However, the negative impact extends to many other areas of personal, professional, and organizational functioning.

Acts of workplace violence can exact a heavy physical and emotional toll on hospital staff, with both short- and long-term consequences including minor to serious physical injuries, psychological distress, and temporary or permanent disability. Financial impacts can include lost time at work, costs of care, and even legal expenses.

Beyond the negative impact on employee health and well-being, workplace violence often results in low morale and productivity due to perceptions that the work environment is hostile and dangerous, the loss of team cohesiveness, or lack of trust in management. Some caregivers have resigned from their jobs and changed their careers in the aftermath of workplace violence.

Today's health care workforce is subject to high levels of work stress, burnout, turnover, and staff shortages. Workplace violence can add insult to injury in that it can make the subjective experience of violence even worse for a person who is already struggling with burnout and low morale. At the same time, incidents of workplace violence can increase stress, absenteeism, and disengagement of individuals from their jobs.

These ramifications extend far beyond those who are directly targeted by a violent act. Witnesses, bystanders, and co-workers often suffer emotional and psychological trauma that is not any less significant than the victim's.

Ultimately, a safe working environment is a prerequisite for safe and effective patient care. Workplace violence undermines the therapeutic environment of the hospital. Providers and caregivers exposed to workplace violence are less able to perform to standards of care, which places patients at risk for adverse outcomes. The patient experience is also affected, which can place the hospital at a reputational and/or financial risk in the community.

THE ISSUE OF UNDERREPORTING

It is widely acknowledged that the incidence of workplace violence is underreported by the hospital staff and providers. A 2015 study found that the majority of health care workers who experienced a violent event did not report it via their hospitals' formal electronic incident reporting systems (Arnetz, 2015).

Representatives from several HQI-member hospitals confirmed this. Between patient safety events, work-related injuries, cases of workplace violence and various other types of reportable incidents, hospital staff often find their reporting systems confusing to use. A workplace violence program manager from a multi-hospital system described her organization's electronic incident reporting system as elaborate and complicated, and reporting into it as onerous and time-consuming. She stated this was a major reason only a fraction of workplace violence incidents is captured by the incident reporting system.

This organization has compared the number of workplace violence incidents reported in the incident reporting system with the number of incidents logged by the security staff (incidents involving security are logged and tracked separately). Out of all the violent incidents logged by security staff, only about one-third were reported in the incident reporting system. Providers and staff who were the actual targets of violent behavior were much less likely to report it than were the security staff who were called on to help. Part of the problem, the manager suggested, is that hospital staff often erroneously believe that filing an incident report is tantamount to pressing criminal charges.

Another reason for underreporting is that hospital staff and providers are often reluctant to hold patients accountable for violent behavior. Hospital leaders have told us that this has helped create an impression among the public that the same kind of violence that would get a person arrested on the street will be tolerated in the ED.

Several hospital leaders have noted that the problem may lie in our health care culture: While we have placed a great deal of focus on patient experience and patient safety, we have placed much less focus on worker safety.

"We are all too quick to excuse the violent behavior of our patients," asserted an ED director.

Many staff and providers have been acculturated into thinking that violence is simply "part of the job." This is especially true when it comes to patients who appear to not be fully in control of their faculties, such as those with a diagnosis of psychosis, substance use disorder, or dementia. In a national survey of ED nurses, 76% said their decision to report would be based on whether the patient was perceived as being responsible for their actions (NACNEP, 2007).

The relationship with first responders — especially law enforcement — can also complicate reporting. ED staff frequently describe police officers as unwilling to get involved when violent incidents occur in the ED. One hospital leader described instances in which law enforcement dissuaded the staff from filing charges against violent persons on account of the low likelihood that district attorneys would press charges against a patient in an ED.

PREVENTION AND PROTECTIVE MEASURES

To deal with the problem of workplace violence, hospitals should establish an effective workplace violence prevention program. Key elements of such a program are management commitment, worksite analysis, incident prevention, incident control, staff training and involvement, recordkeeping, and program evaluation (OSHA, 2016).

- **Leadership Commitment**: Effective hospital workplace initiatives rely on leadership prioritizing and making a visible commitment — and workplace violence is no exception. Leaders provide resources, set goals, assign responsibility, motivate, and lead by example. Their ongoing engagement is critical for success. Executive leaders may appoint a steering team/committee to operationalize the work of building the safest possible environment for receiving and providing care.
- **Worksite Risk Analysis**: Once leaders' commitment is established, hospitals should undertake a worksite analysis to find existing or potential hazards for workplace violence. This should include reviewing specific procedures or operations that contribute to hazards and specific areas where hazards may develop.
- **Developing and Implementing Interventions**: Risk analysis should be followed by appropriate interventions, practices, and policies.
    - Administrative and workflow changes can help prevent violent incidents from occurring. This may include revisiting staffing coverage in the riskiest areas and at the riskiest times, making sure no one is working

alone, and developing systems for communicating problematic patient history and behaviors across all direct staff and all shifts.

As an example, in the hospital where nurses have expressed concerns about coming to work because of the perceived unsafe external environment, the hospital has provided security escorts to accompany staff to the parking lot and/or public transit stations. Employees have also received enhanced training on situational awareness and safety practices.

Another California hospital established a behavioral crisis response team, staffed by trained physicians and nurse practitioners, that is equipped to intervene rapidly in emerging behavioral crises.

- Engineering interventions can remove hazards from the workplace or create barriers between the worker and the hazard. This could include installing walk- through metal detectors at hospital entrances or enclosing nurses' stations and reception areas.

  Decisions about implementing such barriers require careful balancing of sometimes competing priorities, such as providing smooth patient access, creating an environment of openness and healing, ensuring safety of employees and patients, and managing costs.

  For example, installing walk-through metal detectors may prevent dangerous objects from entering hospital environments, but this equipment is costly to buy and keep operational. The initial purchase cost is only a fraction of the total resources needed to operate a metal detector. They require additional space and staffing (one or, ideally, two operators), in addition to significant maintenance. At a minimum, there must be space for patients and visitors to queue up, space beyond the detection equipment for security personnel to search bags and people, and space for a separate pathway for patients and visitors to bypass the detectors on their way out.

  One of the key drawbacks is that metal detectors force people to wait in line. During busy times this can create bottlenecks, which can frustrate patients and visitors. Metal detectors can also provide a false sense of security, as the evidence of their effectiveness is not unequivocal. A 1999 study found that the implementation of a security system in a hospital ED, consisting of metal detectors, cameras, limited access, and a staffed security booth at the entrance, did not significantly change the number of assaults. The authors concluded that additional enhanced training of personnel in the management of violent patients and potentially violent situations was necessary to truly have an impact on the volume of assaults (Rankins, 1999).

- **Staff Training and Education**: All staff should become aware of established policies and procedures, potential security hazards, and methods of personal protection. Initial training should be supplemented with periodic "booster" training. Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with their unit or job.
- **Reporting and Recordkeeping**: Reliable and accurate reporting of violent incidents can help gauge the extent of the problem and whether interventions have been effective. In conversations with hospital leaders, HQI has learned that most hospitals could improve their reporting practices. Overall, hospitals can focus on two key areas to increase reporting of workplace violence:
  - Reporting mechanisms and processes should be clear, simple, and intuitive.
  - Staff who are involved in the incident and/or the filing of the report should be included in the review process and receive timely feedback on the status of the investigation, anticipated actions, and any policy or

procedural changes that may result from the incident. Ensuring that staff feel there is a benefit to reporting — that their reports are taken seriously and acted upon — increases the likelihood that they will report violent incidents.

Besides a review of individual incidents, hospitals should regularly review data on trends of workplace violence and use these data to evaluate hospital environments and adequacy of staff training, as well as policies and processes meant to prevent and respond to violent incidents. Hospital leaders should regularly share workplace violence evaluation reports with all employees.

- **Caring for the Caregivers**: Several hospitals have established programs to provide emotional support, counseling, and debriefing for employees who have experienced or witnessed assaults and other violent incidents. Such programs can provide substantial relief of suffering to the victims and others affected. At ChristianaCare, a multi-hospital system in Delaware, support for victims of workplace violence has been rolled into a comprehensive *Care for the Caregiver* program. It also includes a similar type of support for "second victims" — staff who may need emotional support in the aftermath of patient harm events.

  Heather Farley, MD, chief wellness officer at ChristianaCare, shared a story of a staff nurse who had recently been subject to a particularly traumatizing incident of workplace violence and, as a result, was intent on resigning from her job. A few years ago, there would have been little in place to stop this nurse from resigning. However, as part of the *Care for the Caregiver* program, the organization has recently established a peer support program. Through the program, trained peer supporters provide emotional first aid to providers and staff after traumatic events, including workplace violence. As a result of this intervention, complemented by a supportive management and care team, this person changed her mind and decided to stay.
- **Patient Conduct Expectations**: A growing number of hospitals nationally have publicly posted expectations for patients and visitors to help contribute to safe, caring, dignified, respectful, and inclusive environments in all hospital spaces. These expectations may be included in documents about Patient Rights and Responsibilities, or declarations of Patient Codes of Conduct, which state that disrespectful, hostile, discriminatory, or harassing actions are not welcome and will not be tolerated. These documents may explicitly list behaviors such as:
  - Physical or verbal assaults and threats
  - Sexual or vulgar words or actions
  - Offensive comments about others' race, accent, gender, sexual orientation, or personal traits
  - Refusal to see a clinician or other staff member based on these personal traits
  - Disrupting another patient's care or experience

HOW HQI, CHA, AND YOUR REGIONAL ASSOCIATIONS CAN HELP

Recognizing workplace violence as a serious current issue affecting hospitals, Hospital Quality Institute, California Hospital Association and our allied regional hospital associations strive to provide valuable assistance to hospitals in their quest for solutions.

Hospital Quality Institute

In response to member hospitals' needs, HQI is developing the following strategies regarding workplace violence:

- HQI will facilitate a Community of Practice (CoP) for hospital leaders of workplace violence programs. Harnessing the power of a professional collaborative network, the CoP will provide regular, structured opportunities for leaders

to interact, learn from each other, share best practices, and problem-solve together — advancing hospitals' capacity to prevent and respond to workplace violence.

- HQI will continue to provide education and training for hospitals on various salient topics related to understanding and eliminating workplace violence. These opportunities will be both virtual (e.g., via HQI's bimonthly webinars and safe tables) and in-person (e.g., via sessions at HQI's Annual Conference.)
- Finally, HQI will work with hospitals to identify ways to improve surveillance, monitoring, and reporting of workplace violence incidents.

California Hospital Association

CHA is at the forefront of legislative and regulatory advocacy for safer hospital environments.

- CHA's Workplace Violence Prevention Task Force, which includes hospital leaders, has been helping inform CHA's responses to proposed legislation on behalf of member hospitals.
- CHA's guidebook on Healthcare Workplace Violence Prevention remains a valuable resource for hospitals navigating the Cal/OSHA Healthcare Workplace Violence Prevention Regulation, which stemmed from the passage of SB 1299.
- CHA's 2023 Disaster Planning Conference has a track dedicated to workplace violence.

Regional Hospital Associations

The Hospital Association of Southern California, the Hospital Association of San Diego and Imperial Counties, and the Hospital Council, Northern & Central California, complement the efforts of HQI and CHA to help member hospitals address workplace violence.

- Regional associations provide local education and training opportunities for hospitals on critical topics such as: threat awareness, prevention, and response; organizing crisis response teams; building high performing security teams; de-escalation methods; and others.
- HASC regularly convenes a Safety and Security Committee where issues of workplace
- violence are discussed in-depth.
- Endorsed Business Partner programs managed by regional associations provide exposure to vetted high-quality products and services, including those in hospital security and workplace violence prevention.

CONCLUSION

Comparing hospital performance on quality metrics to peers can be helpful to achieve quality goals. While various existing peer comparison groups are already available in HQIP, the addition of HQI's Hospital Similarity Clusters provides for more comparable peers identified by grouping hospitals across multiple characteristics, such as inpatient admission volume and hospital type.

Although no comparison point is perfect due to the uniqueness of each hospital, this analysis paper demonstrated how hospitals can be grouped into clusters based on characteristics of the populations they serve. These characteristics can be used in combination to build clusters representing various data points, facilitating the creation of comparison groups designed to identify the most similar hospitals. These groupings enable high-quality comparisons of performance metrics, which is important for a variety of reasons, including that such comparisons allow for more meaningful evaluation of

performance, help identify whether poor outcomes are possibly due to hospital performance vs. population factors, and help identify realistic benchmarks and achievable goals, to name a few.

ABOUT US

The Hospital Quality Institute (HQI) is dedicated to advancing patient safety and quality of care for all Californians. Through strategic partnerships and innovative programs, HQI supports hospitals in achieving excellence by providing data analytics, educational resources, and statewide initiatives focused on performance improvement. HQI oversees and coordinates the Collaborative Health Care Patient Safety Organization (CHPSO).