Workplace Violence Toolkit – Section 1

Contents

Understanding Workplace Violence (WPV)

What is Workplace Violence (WPV)?

The Occupational Health and Safety Agency (OSHA) defines workplace violence as 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, and can involve employees, clients, customers and visitors. (OSHA, 2015).

Terms and definitions used to define WPV in occupational safety and violence literature can vary for example, violence that occurs between coworkers may be defined as bullying, lateral or horizontal violence or incivility. The definition of assault as related to criminal law also varies by state and federal judicial systems.

Workplace violence in health care can also be defined as intentional e.g., where there is intent by a patient to cause physiological, emotional and bodily harm to an employee, or 'non -

Definitions of Violence

Harassment – any behavior (*verbal or physical*) that demeans, embarrasses, humiliates, annoys, alarms, or verbally abuses a person, and that is known or would be expected to be unwelcome. This includes use of offensive language, sexual innuendos, name calling, swearing, insults, use of condescending language etc., arguments, gestures, pranks, rumors, intimidation, bullying, or other inappropriate activities.

Verbal or written threats – any expression of an intent to inflict personal pain, harm, damage, and/or psychological harm, either through spoken word or in writing.

Threatening behavior – such as shaking fists, intentionally slamming doors, punching walls, destroying property, vandalism, sabotage, theft, or throwing objects.

Physical attacks or assaults – hitting, shoving, biting, pushing or kicking. Extremes include rape, arson, and murder. Note: ORS 654.412 to 654.423 defines assault as *'intentionally, knowingly or recklessly causing physical injury'*.

Aggravated Assault - An unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. This type of assault usually is accompanied by the use of a weapon or by means likely to produce death or great bodily harm.

Source: IAHHS 2016, Boyle, 2016, OSHA 2015, EEOC 2016, Fell-Carlson. 2008

intentional' e.g., violence by individuals with cognitive impairment associated with dementia, brain injury, or a physiological reaction to anesthesia or medication. The perception of a patient's intent to cause harm and how 'intent' is defined greatly influences reporting of violence by health care workers, as discussed later in this section.

WPV incidents generally fall into four categories:

> ▸ Type I (Criminal Intent): Results while a criminal activity (e.g., robbery or property damage) is being committed and the perpetrator has no legitimate relationship to the workplace.

Tools that support content in this Section

1a. Risk factors that increase the risk of Type II WPV

1b. Comparison of Workplace Violence Laws for Health Care in Oregon and Washington States

> ▸ Type II (Customer/client): The perpetrator is a customer or client at the workplace (and becomes violent while being served by the worker e.g., patient, family or visitor assault towards the health care worker.

> ▸ Type III (Worker-on-Worker): Employees or past employees of the workplace are the perpetrators e.g., bullying/lateral violence or physical assault from a co-worker.

> ▸ Type IV (Personal Relationship): The perpetrator usually has a personal relationship with an employee e.g., domestic violence in the workplace.

(OSHA, 2015)

The focus of this toolkit is prevention and control of Type II (customer/client) violence, where violence is perpetrated by patients and visitors toward employees, contract personnel, and volunteers, who work within a hospital and/or clinic setting. However, any WPV prevention program should also incorporate policies and procedures to address risk of violence of any type and cause such as, bullying, domestic, and criminal activity including active shooter preparedness, that could in occur within a health care organization.

Research indicates that there is a relationship between poor organizational climate of safety and increase prevalence of Type II and Type III violence. Health care workers who are exposed to Type II and Type III violence suffer long-term negative health in organizations where there is lack of post exposure support (Friis et al. , 2019; Vrablik et al., 2019; Arnetz et al., 2018; Yragui, N, et.al., 2017; Phillips, 2016;).

There is new and early stage research that indicates that there is a greater prevalence of patient physical aggression to injury in behavioral health facilities where coworker bullying is prevalent and tolerated as part of the work culture. (Yragui, N, 2019).

The prevalence of Type II and Type III violence in a health care environment is also associated with poorer patient outcomes as discussed later in this section.

Therefore, it essential that health care organizations address all types of violence.

Refer to **Section 10 of** this Toolkit for information related to **Bullying and Domestic Violence**

Occurrence of WPV in Health Care

In the US, workers in health care experience substantially higher estimated rates of nonfatal injury

- In two studies of Emergency Department nurses 50-100% of respondents reported experiencing verbal or physical violence at work (ENA 2011, Phillips, 2016).

- In another study, of 762 nurses in one large hospital system, 76.0% reported experiencing verbal violence and 54.2% reported experiencing physical violence. (Speroni et al., 2014)

- In a Health Risk Appraisal survey of 3,765 registered nurses and nursing students conducted by the American Nurses Association in 2014, *21 percent* of registered nurses and nursing students reported being physically assaulted, and *over 50 percent* reported being verbally abused in a 12-month period (OSHA, 2015).

- In a more recent survey conducted by American Nurses Association as part of the Healthy Nurse, Healthy Nation™ Enterprise, more than 29% of respondents have been verbally and/or physically *threatened* by a patient or a patient's family member in the past year and **10%** have been assaulted by a patient or family member while at work (ANA, 2019).

due to workplace violence compared to workers in all other industries. Health care and social assistance workers are nearly <u>four times</u> more likely to be injured and require time away from work as a result of WPV (OSHA, 2015).

Within health care settings, approximately 24,000 workplace assaults occurred between 2010 and 2013, with most threats and assaults occurring between noon and midnight (Wyatt et. al, 2016).

The Bureau of Labor Statistics reports that while less than 20% of workplace injuries involve health care workers, 50% of workplace related assaults involve health care workers.

Data collected by the National Institute for Occupational Safety and Health (NIOSH) for 2012 through 2014, shows that injuries resulting from workplace violence appears to be *increasing* among all health care personnel and particularly among nursing assistants and nurses. The majority of these injuries result from physical assaults on nursing staff (NIOSH, 2016).

Type II violence is the most common in health care settings that is, verbal or physical abuse and assaults perpetrated by patients, their family members, and visitors, toward health care workers. Examples include, intentional and non-intentional verbal threats or physical attacks by patients, a distraught family member who may be abusive or even become an active shooter, or gang violence in the emergency department.

In one 2014 survey on hospital crime, Type II violence accounted for 75% of aggravated assaults and 93% of all assaults against employees (Phillips, 2016).

The most common causes of violent injuries resulting in days away from work across several health care occupations were hitting, kicking, beating, and/or shoving (GAO, 2016).

Quick Tip: Use the data provided in this section when educating senior leadership, the WPV committee, and other employees about the scope and impact of workplace violence in health care.

The highest rates of violence occur in emergency rooms and inpatient psychiatric or behavioral health departments or facilities, geriatric long-term care settings, and residential and day social services (OSHA, 2015).

A 2017-18 Cal-OSHA *Report on Workplace Violence Incidents,* indicated that 40 percent of workplace violence incidents occur in inpatient units, while 27 percent occur in the emergency department and 16 percent occur in behavioral health units (Cal-OSHA, 2019)

Some health care professions are more at risk for exposure to WPV than others. In 2013, Psychiatric Aides experienced more than 10 times the rate of violent injuries that resulted in days away from work than Nursing Assistants (NAs). NAs experienced more than 3 times the rate of violence than Registered Nurses (RNs) (OSHA, 2015).

In a 2018 poll of over 3,500 emergency physicians conducted by the American College of Emergency Physicians (ACEP), 47 percent of physicians reported having been physically assaulted at work and 71 percent said they had witnessed another assault. Nearly 80 percent reported that patient care is being affected, with 51 percent of those saying that patients also have been physically harmed.   Ninety-six percent of the female emergency physician respondents reported that a patient or visitor made inappropriate comments or unwanted advances toward them, and 80 percent of male physicians reported the same (ACEP, 2018).

Sixty-one percent of home care workers report workplace violence each year (The Joint Commission, 2018).

In a survey of EMS workers primarily from the US, Canada, Europe, and Australia, 65 percent of 1172 respondents reported being physically attacked while on duty. Approximately 90 percent of the perpetrators were patients and around 5 percent were patient family members. The influence of alcohol and drugs was the most prevalent causative factor associated with violence (Maguire et al., 2018).

There are very few studies that report the rate of violence to hospital security workers

Injury and staff survey data collected during the WSI indicated that:

- A majority of violence is perpetrated by patients.

- Employees reported that verbal abuse is the most common type of violence that they had experienced in the last year.

- Incidence of violence mostly occurred in the ED, Behavioral health, Intensive Care units, and Medical/Surgical units. In one hospital, violence was reported as increased in family birth and in home health units, and 2 hospitals reported an increase in violence in outpatient clinics.

however, those available report that these workers have some of the highest rates of violence-related injuries within the hospital setting, with anywhere from 2 to 5 times as many injuries as nurses. In one study, security staff had a violence-related injury rate approximately 13 times higher than the violence-related injury rate for ED nursing staff in the same facility (Gramling, 2017).

Overall, there is little data to indicate occurrence of violence in other health care units such as intensive care; and in other health care settings such as, outpatient clinics or within many job categories such as emergency medical service workers or diagnostic technologists.

Active Shooter Scenarios

The WPV related event that occurs in health care and receives the greatest media and public attention involves *active shootings* however, these events are *uncommon*.

FBI Investigations indicate an increasing trend in workplace active shooter incidents for all industries including health care, from an average of 6.4 incidents per year between 2000 and 2006, to 16.4 incidents per year between 2007 and 2013.

A study conducted by researchers at Brown University found that there were 241 incidents of hospital shootings from 2000 to 2015, with 170 occurring inside hospitals and 71 outside hospitals.

The emergency department was identified as the most common site of gun violence within a hospital (29 percent), patients' rooms (24 percent) and other locations (47%).

Reported motivation for these events include holding a grudge (33%), a result of social violence (15%), attempting to escape the facility (14%), and suicide (11%). An overwhelming majority of perpetrators are male (Gao, & Adashi, 2015).

In other studies, the most common victim of shootings in hospitals or other health care facilities is the perpetrator (45%) and about 20% of the victims were hospital staff.

In nearly 20% of the incidents, the perpetrators did not bring their own firearm to the hospital, and in 8% of all events the perpetrator took the gun from a police or security officer. In 28% of events involving firearms, a law enforcement officer shot a perpetrator in the hospital (Phillips, 2016, Aumack, 2017).

According to data from the U.S. Bureau of Labor and Statistics from

WPV in Oregon

Between 2013-2018 on average 3% (3160) work related accepted disabling claims (ADCs) were attributed to non-fatal assaults that occurred in all industries in Oregon. Of these ADCS, 10% were reported to have occurred in hospitals and 17% in nursing and residential care facilities.

Health Care and Social Assistance in the private sector accounted for 33% of these claims, which is more than any other industry. 84% of these injuries occurred as a result of health care workers being hit, kicked, bitten, or shoved. One WPV related homicide occurred between 2012-2016 in Oregon in a nursing and residential care facility (Oregon OSHA; DCBS 2019).

WPV in Washington State

In a 2018 Washington State Nurses Association survey, 86**%** of nurses in a said they've experienced or witnessed workplace violence (WSNA, 2019)
https://www.wsna.org/nursing-practice/workplace-violence

For the fiscal years 2015-2019, registered nurses experienced an average of 115 accepted workers' compensation claims that were classified as *assault and violence acts by persons* per year, with an average total incurred cost of $1,111,509. Nursing Aides and orderlies experienced an average of 321 accepted claims, with an average total incurred cost of $1,547,144 for the same time period. Note this data excludes claims filed with self-insured employers. Between 2015-2018 there were no fatalities from workplace violence in health care facilities (WA L&I, 2019).

2014-2015 there were 4 homicides that occurred in hospitals, that were committed intentionally by gun violence. There have been '0' reported for 2016-2018.

In terms of *fatal* workplace violence, the Centers for Disease Control (CDC) report a *decreasing* trend over the past ten years in all non-health care industries, while the numbers of homicides in health care have remained relatively stable (NIOSH, 2015).

Why is WPV Underreported in Health Care?

Studies indicate that violence in health care is hugely underreported. In one report, only 30% of nurses and 26% of physicians reported incidents (Philips, 2016).

Bullying and other forms of verbal abuse are more frequently underreported. In these cases, reasons for underreporting include lack of a reporting policy, lack of faith in the reporting system, and fear of retaliation (Blando, 2013).

Table 1.1 lists the factors that influence whether staff report a WPV episode or event in health care.

Employees at hospitals participating in the WSI project reported similar factors or barriers to reporting WPV incidents.

In addition to underreporting of WPV, inconsistencies in data collection and definitions of violence contributes to a lack of knowledge about the frequency and severity of WPV in health care.

Without accurate incident data, development and implementation of effective violence prevention programs and control strategies can be challenging.

Causes of WPV in Health Care

The cause of WPV in health care is often multifactorial and can be summarized in four broad categories. **Tool 1a. Risk factors that increase the risk of Type II WPV** provides more information.

1. **Clinical** related risk factors are the most common cause or contributor of violence e.g., patients with poorly managed mental illness, dementia, delirium, developmental impairment, and drug and alcohol intoxication and abuse.

Factors that influence reporting of WPV incidents

Incident type and patient condition

- The severity of the incident i.e. whether the employee suffered physical injury requiring medical treatment

- The condition of the patient – for example when violence is perceived as unintentional due to the patient's clinical condition or diagnosis e.g. dementia

- Perception of what is 'violence' by employees

Organizational Culture

- Concerns that assaults by patients and visitors may be viewed as a result of poor performance or negligence of the employee

- The intense focus on customer service in health care where the "the customer is always" right or the impact of money and profit driven management models

  Normalizing of WPV – 'it's just part of the job'

Reporting process

- Whether someone else reported the incident

- No clear reporting policy

- Complicated reporting process e.g. forms take too long to complete

Response to Reporting

- Fear of retaliation e.g., from patient and/or their family in smaller communities where everyone knows each other, stigmatization or bullying from co-workers for reporting

- Lack of action resulting from reporting e.g. informal report to a supervisor goes no further or there is no response to a formal report or preventative action is not taken

- The complexity of the legal system and response from law enforcement when reporting and/or pressing charges

  Source: ENA 2011, Blando 2015, Arnetz, 2015, OSHA 2015, Philips 2016

Table 1.1

2. **Social and economic** risk factors that contribute to violence include financial stress, domestic violence that extends into the workplace, ethnic conflict, access to weapons; neighborhoods with high crime rates and the increasing presence of gang members. The availability of drugs or money at hospitals, clinics, and pharmacies, makes them likely robbery targets. The increasing use of prescription opioids and related addiction in the general population is a newer concern for clinics and physician offices.

3. **Environmental** related risk factors include noise, crowded waiting areas, open access of the public in clinics and hospitals; poorly lit spaces and visibility.

4. **Organizational** factors include design of financial/billing services, long wait times, dehumanizing, and inhospitable environments, poor communications, staff shortages, lack of or inadequate training, lack of or inconsistent process to identify and respond to undesirable behavior, working alone, working with cash and/or narcotics, use of seclusion/restraints, lack of situational awareness, and inadequate presence of security and mental health personnel on site.

(ENA, 2010, Design Council, 2011, NIOSH 2013, OSHA 2015, Philips 2016)

There is also a vicious cycle or "Revolving Door" Syndrome that sometimes links workplace violence, psychiatric treatment, and the "revolving door" (NIOSH, 2013). This occurs when patients with mental health or substance abuse issues are treated in an emergency room (ER) and released back into the community without follow-up care, so they return to the ER when another mental health or substance abuse crisis occurs.

Community based mental health care is often not available due to lack of funding. This issue also contributes to the increasing use of hospitals by police and the criminal justice system, for criminal holds and the care of acutely disturbed, violent individuals.

The Cost of WPV to Health Care Organizations and Workers

Direct costs of workplace violence injuries include cost of medical treatment for physical injuries sustained and time loss from work.

Speroni, K.G., et al., report that in one study the annual workplace violence costs for the 2.1% of nurses who reported injuries were $94,156 ($78,924 for treatment and $15,232 for indemnity).

> The Joint Commission analyzed 33 homicides, 38 assaults and 74 rapes in health care workplaces from 2013 to 2015, and reported that the most common "root causes of these events were:
>
> - Failures in communication
>
> - Inadequate patient observation
>
> - Lack of or noncompliance with policies addressing workplace violence prevention
>
> - Lack of or inadequate behavioral health assessment to identify aggressive tendencies in patients
>
> Source: Wyatt, 2016

Workplace injuries and stress are common factors that contribute to employee turnover which can be costly for a health care organization. For example, the estimated cost of replacing a nurse is $27,000 to $103,000.

Studies have shown that there is an *increase* in the rate of missed workdays, burnout, and job dissatisfaction, along with decreased productivity, and deterioration in staff health by employees involved in episodes of WPV (Philips, 2016, Pestka et. al, 2012).

There can be a short and/or long-term psychological impact to employees who are the victims of WPV. Some employees especially when exposed to Type III violence or bullying, may develop post-traumatic stress disorder (PTSD). The psychological impact of WPV is sometimes harder to quantify in terms of cost to the organization and to the affected employees.

One study estimated that incivility in health care costs more than $4 billion dollars annually due to turnover of staff, lost time, and productivity (Morphet et al., 2018).

According to the American Hospital Association, the estimated cost of community violence for U.S. hospitals and health systems was approximately $2.7 billion in 2016. $1.5 billion of that is directly related to security and medical care for injured employees (AHA, 2017)

Other organizational costs related to addressing WPV include increased security needs in terms of equipment and personnel, litigation, increased insurance costs, and property damage.

There is also an indirect relationship between WPV and patient safety. Caregiver fatigue, presenteeism, injury, and stress, are tied to a higher risk of medication errors and patient infections. In hospitals where *fewer* nurses are dissatisfied or burned out, there is *higher levels of patient satisfaction* (OSHA, 2015). Type III violence or bullying is more strongly associated with increased staff turnover, and cognitive deficits associated with PTSD than Type II violence. Both factors are contributing factors to incidence of medical errors (Morphet et al., 2018; JC 2019 and 2016; OSHA 2015).

Thus, it can be challenging for health care organizations to calculate the true cost of WPV and this is complicated by the high rate of underreporting of WPV by health care workers.

There is consensus that improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality (AHRQ, 2019.)

Creating a safety climate that embraces a culture of respect and safety for patients and health care workers is associated with improved patient outcomes and health care worker safety (TJC, 2017 & 2010).

Safety climate is a strong mitigating factor related to the prevalence and impact on worker health and safety of both Type II and III WPV (Blando et al., 2015; Arnetz, et al., 2018).

Recent research indicates that supervisory support when addressing conflict in the workplace and employee stress related to work and non-work life balance plays a role in reduce the negative effects of exposure to WPV for workers (Zaheer et al., 2019; Yragui, N, et.al., 2017).

The relationship of worker safety and morale to safe delivery of care and achievement of organizational goals cannot be overstated.

In 2014, the National Patient Safety Foundation published the white paper **"Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care"**, which highlights the importance of creating a culture in health care organizations that embraces worker and patient safety as equally important. The paper and subsequent related publications highlight the importance of creating a work environment where there is a goal of zero harm (physical and psychological) to the workforce; where there is a commitment to respect and safe behaviors; an effective system to measure, and a multidisciplinary, reliable process for responding to physical and psychological harm (NPSF, 2013, 2014).

Unfortunately, because WPV is vastly underreported in health care the full extent of the problem and its associated costs are unknown.

Solutions to Prevent and Manage WPV

When developing and implementing a WPV program, it's important to note that individual health care organizations have no or little 'control' of the social and economic factors that contribute to WPV. Nor can they prevent all the clinical factors that contribute to WPV. The goal of a comprehensive WPV program should be to minimize and eliminate where possible the organizational and environmental factors that contribute to WPV and to expedite early and accurate identification and management of clinically related and external risk factors.

Through collaboration with community stakeholders such as public health departments, law enforcement agencies, schools and social service organizations, hospitals may be able to assist in developing healthier social and safer physical environments that contribute to preventing violence in their communities (AHA, 2015).

WPV Legislation and Compliance

Oregon is one of several states that have passed legislation and has program requirements that address workplace violence.

The Oregon WPV law ORS 654.412 to 654.423, "Safety of Health Care Employees" and related (OAR) 437-001-0706, "Recordkeeping for Health Care Assaults" is only applicable to hospitals, ambulatory surgical centers, and home health care services operated by hospitals, and is aimed at preventing violence to employees from *intentional* assault. This law was revised in 2019 as recorded in Senate Bill 823 (SB 823-A).

The Oregon WPV law requires specific program components to be implemented.

The program components required in the Oregon law are incorporated into the recommendations for a comprehensive WPV program that addresses intentional and non-intentional Type II violence as described in this toolkit.

The Washington WPV law

Revised Code of Washington (RCW). Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070 (revised in 2019), is applicable to hospitals, Home health, hospice, and home care agencies, Evaluation and treatment facilities and Ambulatory surgical facilities, and is aimed at preventing any physical assault or verbal threat of physical assault with or without use of a firearm or other weapon against an employee of a health care setting on the property of the health care setting.

The program components required in the Washington law are incorporated into the recommendations for a comprehensive WPV program that addresses intentional and non-intentional Type II violence as described in this toolkit.

Both Oregon and Washington WPV laws outline a programmatic approach to addressing WPV

Refer to **Tool 1b. Comparison of Workplace Violence Laws for Health Care in Oregon and Washington** for more information about the state laws

Felony Laws related to assaulting of health care workers

Thirty-eight states have enacted laws that make it a felony to assault a health care worker. However, each state law differs, and they don't all apply to all health care workers. Oregon for example, Intentionally, knowingly or recklessly causes physical injury to an emergency medical

services provider they are performing official duties is a third-degree felony. However, the law does not apply to any other health care professional such as nurses

Washington state's Felony Assaults law does apply to licensed nurses, physicians, or health care providers who was performing his or her nursing or health care duties at the time of the assault, but not to nursing aides and emergency room technicians.

There is also little data to support that states with these laws have seen them as an effective deterrent in decreasing assault of health care workers.

Federal OSHA is currently considering a standard to protect health care and social assistance workers from violence. Until such a standard is enacted the General Duty Clause of *Occupational Safety and Health Act of 1970* (OSH Act or Act) applies as related to protection of workers against violence in the workplace. The General Duty clause *also* applies to WPV circumstances where the OR WPV law may not be applicable e.g., in cases of non-intentional assault by patients or in cases of lateral violence or bullying.

The General Duty Clause requires employers to provide their workers with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm; and broadly states that employees cannot be discriminated against if they file a complaint related to work safety or reporting a work-related fatality, injury or illness.

Employers also have an *ethical* responsibility to promote a non-violent work environment that fosters a climate of trust and respect.

The Joint Commission's Sentinel Event Alert, Issue 59, March 2018*,* expands on the Joint Commission's prior communications that require health care facilities to comply with certain criteria for the security of patients, staff and visitors (The JC, 2010, 2018). This publication recommends specific activities that health care organizations are encouraged to complete and 'address the growing problem of WPV by looking beyond solutions that only increase security' (TJC, 2018).

The Joint Commission recommendations for addressing WPV.

1. Clearly define workplace violence and put systems into place across the organization that enable staff to report workplace violence instances, including verbal abuse.

2. Recognizing that data come from several sources, capture, track and trend all reports of workplace violence – including verbal abuse and attempted assaults when no harm occurred.

3. Provide appropriate follow-up and support to victims, witnesses and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary.

4. Review each case of workplace violence to determine contributing factors. Analyze data related to workplace violence, and worksite conditions, to determine priority situations for for intervention.

5. Develop quality improvement initiatives to reduce incidents of workplace violence.

6. Train all staff, including security, in de-escalation, self-defense and response to emergency codes.

7. Evaluate workplace violence reduction initiatives.

These criteria have also been incorporated into this toolkit. In addition, there are several Joint Commission 'Leadership, Environment of Care, Emergency Management and Rights and Responsibilities of the Individual' standards that directly and indirectly apply related to how a hospital should manage and control violence. These can be found in the Sentinel Event Alert, *Issue 59,* March 2018.

Links to other compliance related considerations can be found in the Toolkit *'Introduction'*.

Other professional organizations such as, the American Nurses Association (ANA) and the American Association for Occupational Health Professionals in Health Care (AOHP), have published position statements that state that there should be a Zero Tolerance for incivility, bullying and violence in the workplace, and in 2019 the American College of Emergency Physicians and Emergency Nurses Association have launched a Stop ED Violence Campaign (ANA, 2015, AOHP, 2017, ENA, 2019).

WPV Program Components

The box on the right lists the components of a comprehensive WPV program that provide the foundation to prevent (where feasible), reduce, and control the risk of violence in the workplace.

These program components are explored further in other sections of this toolkit as they relate to prevention of Type II violence. Program recommendations are incorporated from Oregon OSHA, Federal OSHA, The Joint Commission, and other professional associations, in addition to the lessons learned from partner hospitals in the WSI project.

Studies show that occupational injury prevention programs more effective and sustainable when they are multifaceted in nature, incorporated into an organization's overall safety and health program, and into the organization's culture, and assist to meet service delivery goals.

WPV Program Components

A. Management Leadership

B. Employee Participation

C. Written Violence Prevention Policy

D. Program Management Organization

E. Communications Structure

F. Hazard Identification & Assessment

G. Hazard Control and Prevention

H. Education & Training

I. Ongoing Program Evaluation and Improvement

However, there is little supporting evidence to indicate which WPV prevention program elements, or combination of program elements are more effective in preventing and managing violence in health care. This is likely because workplace violence in health care is a relatively 'new' topic which has been openly discussed for the past few years, as compared to other occupational hazards such as needlestick exposure or manual patient handling. In addition, designing experiments to test interventions is challenging in a clinical setting and risk factors for violence can vary from facility to facility.

Fortunately, there is a growing body of published case studies related to best practices for WPV prevention, and an increasing number of research activities are examining the effectiveness of WPV prevention programs.

WPV Hazard Control and Prevention

The approach taken to prevent hazards in many occupational safety, health and ergonomics programs is to first try to eliminate or substitute or replace the hazard before turning to engineering controls that are designed to isolate or protect workers from the hazard. However, in the case of preventing workplace violence, elimination and substitution, while most effective at reducing hazards are extremely challenging. Therefore, a combination of engineering and

Most effective

Least effective

Hierarchy of Controls

Elimination — Physically remove the hazard

Substitution — Replace the hazard

Engineering Controls — Isolate people from the hazard

Administrative Controls — Change the way people work

PPE — Protect the worker with Personal Protective Equipment

Source: NIOSH

administrative controls is primarily used within a WPV program to prevent and manage the risk of violence. An example of personal protective equipment (PPE) is the use of gowns, bite guards, gloves and face masks and shields to protect employees from blood and body fluid exposure that can occur when a patient is physically violent.
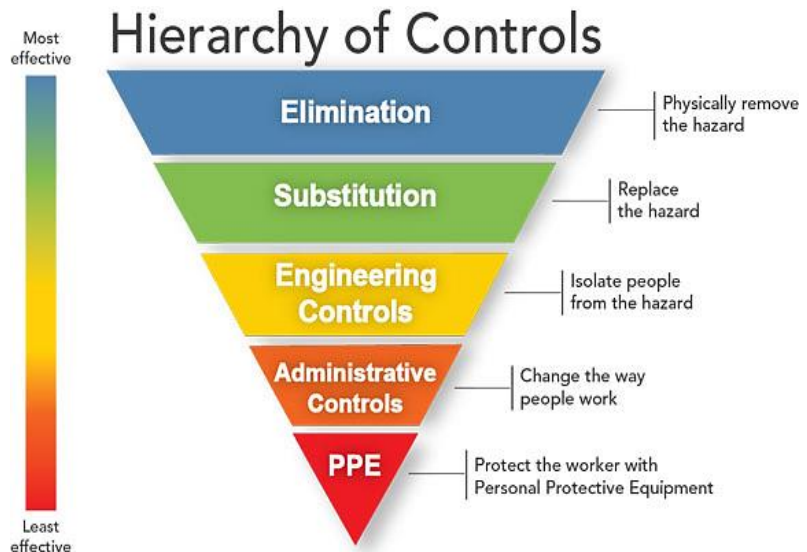
Engineering controls that are designed to isolate the worker from the hazard include:

- Improved worksite lighting

- Physical barriers at admitting/reception area

- Controlled access to buildings and units and monitored surveillance systems

- Panic alarms

- Design of waiting area to mitigate noise and overcrowding

Administrative controls which require the worker to change the way they work include:

- Procedures to:

  – Identify, assess and communicate patients/visitors at high risk for violence

  – Respond to incidents of violence and support systems for employees involved in violence

- Facilitate employee reporting of incidents and processes for effective response management

- Investigate incidents and correct hazards or work processes to prevent reoccurrence of a similar incident

- Security systems e.g. use of security personnel and surveillance systems

- Processes to track employees who work alone or with patients at high risk of violence

- Education & Training of all employees that is customized to their job responsibilities and role within the WPV program

- Recordkeeping and documentation

Engineering controls are preferred over administrative and PPE because they are designed to remove the hazard at the source.

Administrative controls and PPE programs may be less expensive to implement than engineering controls but over the long term, can be costly to sustain and require constant monitoring or 'supervision' to ensure desired changes to work practices and processes are maintained.

More information about specific engineering and administration controls to prevent and manager WPV can be found in *Section 5* of this toolkit.

A more recent approach to worker safety and health that is starting to be embraced within health care is Total Worker Health®(TWH). TWH not only incorporates traditional safety principles to prevent and reduce risk of occupational injury or illness to workers through design and organization of work, tasks performed and organizational culture, but also considers the overall well-being of the worker. TWH considers other factors such as, the impact of shift work, wages, access to benefits, interactions with coworkers, nutrition and fitness. (NIOSH, 2016).

The TWH approach that aims to protect workers and advance their health and wellbeing should be considered when addressing workplace violence concerns.

References

Guidelines for preventing workplace violence for healthcare and social service workers (2015). Occupational Safety and Health Administration (OSHA). Retrieved from https://www.osha.gov/Publications/osha3148.pdf

Types of Discrimination - Harassment. U.S. Equal Employment Opportunity Commission (EEOC) Retrieved from https://www.eeoc.gov/eeoc/commission.cfm

Working safely in health care: a practical guide (2007). Fell-Carlson, D. Cengage Learning.

Working towards a definition for workplace violence actions in the health sector (2016). Boyle, M. J., & Wallis, J. Safety in health, 2(1), 4.

Long-term adverse health outcomes of physical workplace violence: a 7-year population-based follow-up study (2019). Friis, K., Pihl-Thingvad, J., Larsen, F. B., Christiansen, J., & Lasgaard, M European Journal of Work and Organizational Psychology, 28(1), 101-109. **New 2020**

Identification of processes that mediate the impact of workplace violence on emergency department healthcare workers in the USA: results from a qualitative study (2019). Vrablik, M. C., Chipman, A. K., Rosenman, E. D., Simcox, N. J., Huynh, L., Moore, M., & Fernandez, R. BMJ open, 9(8), e031781. **New 2020** https://bmjopen.bmj.com/content/9/8/e031781.abstract

Organizational determinants of workplace violence against hospital workers (2018). Arnetz, J., Hamblin, L. E., Sudan, S., & Arnetz, B. Journal of occupational and environmental medicine, 60(8), 693-699. **New 2020**

Linking workplace aggression to employee well-being and work: The moderating role of family-supportive supervisor behaviors (FSSB) (2017). Yragui, N. L., Demsky, C. A., Hammer, L. B., Van Dyck, S., & Neradilek, M. B. Journal of business and psychology, 32(2), 179-196. **New 2020**

Workplace violence against health care workers in the United States (2016). Phillips, J. P. New England journal of medicine, 374(17), 1661-1669.

Violence Prevention Climate in Health care: A Team Approach (2019). Yragui, N. PowerPoint presentation at the 2019 Washington State Governor's Industrial Safety and Health **New 2020**

Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors (2014). Speroni, K. G., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. Journal of Emergency Nursing, Vol. 40, Issue 3, p218–228.

Healthy Nurse, Healthy Nation™ (HNHN) Year Two Highlights (2019). American Nurses Association (ANA) Enterprise. **New 2020**

http://www.healthynursehealthynation.org/globalassets/all-images-view-with-media/about/2019-hnhn_highlights.pdf

Preventing Workplace Violence in Healthcare. Understanding the Challenge (2015). Occupational Safety and Health Administration (OSHA). Retrieved from

https://www.osha.gov/dsg/hospitals/workplace_violence.html

Injury Trends from healthcare facilities throughout the US. NIOSH Occupational health safety network (OHSN). Retrieved from https://www.cdc.gov/niosh/topics/ohsn/default.html
NIOSH science blog - Violence in Healthcare 2015. Retrieved from https://blogs.cdc.gov/niosh-science-blog/2015/03/27/violence-in-healthcare/

Workplace violence in health care: A critical issue with a promising solution (2016). Wyatt, R., Anderson-Drevs, K., & Van Male, L. M. Jama, 316(10), 1037-1038.

Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. GAO-16-11: Published: Mar 17, 2016. Publicly Released: Apr 14, 2016. Retrieved from http://www.gao.gov/products/GAO-16-11

Workplace Violent Incidents at Hospitals October 1, 2017 through September 30, 2018. Cal-OSHA. Annual Report Posted in February 2019. **New 2020**

https://www.dir.ca.gov/dosh/Reports/Annual-Report-WPV-Incidents-2017-2018.pdf

ACEP Emergency Department Violence Poll Research Results (2018). American College of Emergency Physicians September 2018. **New 2020**

https://www.emergencyphysicians.org/globalassets/files/pdfs/2018acep-emergency-department-violence-pollresults-2.pdf

Physical and verbal violence against health care workers. (April 16, 2018). Sentinel Event Alert Issue, (59). Joint Commission. **New 2020**

https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-59-physical-and-verbal-violence-against-health-care-workers/

International survey of violence against EMS personnel: physical violence report (2018). Maguire, B. J., Browne, M., O'Neill, B. J., Dealy, M. T., Clare, D., & O'Meara, P. Prehospital and disaster medicine, 33(5), 526-531. **New 2020**

Protecting the protectors: Violence-related injuries to hospital security personnel and the use of conducted electrical weapons(2017). Gramling, J. Dissertation. University of Minnesota 2017. **New 2020**

https://conservancy.umn.edu/bitstream/handle/11299/188828/Gramling_umn_0130E_18010.pdf?sequence=1&isAllowed=y

An Analysis of Active Shooters in the Hospital Setting, 2000 - 2015 (2015). Poster Presentation. Gao, H & Adashi, E. Alpert School of Medicine at Brown University, Providence, RI. **New 2020**

https://repository.library.brown.edu/studio/item/bdr%3A581443/PDF/

Firearm discharges in hospitals: an examination of data from 2006-2016 (2017). Aumack, T et. al. Journal of Healthcare Protection Management. 33:1, 1-8.

Accepted disabling workers' compensation claims data – claims characteristics 2014-2018. Oregon Department of Consumer and Business Services. Retrieved from Department of Consumer and Business Services, OR **New 2020**

https://www.oregon.gov/dcbs/reports/protection/Pages/disabling-claims.aspx

Workplace violence Can it happen where you work? (2016) Oregon OSHA. Retrieved from http://osha.oregon.gov/OSHAPubs/2857.pdf

Workplace Violence webpage. Washington State Nurses Association. **New 2020**

https://www.wsna.org/nursing-practice/workplace-violence

L&I Workers' Compensation Claims. Washington Labor & Industries **New 2020**

https://lni.wa.gov/claims/for-employers/workers-compensation-injury-data/injury-data

Barriers to effective implementation of programs for the prevention of workplace violence in hospitals (2015). Blando, J., Ridenour, M., Hartley, D., & Casteel, C. Online journal of issues in nursing, 20(1).

Underreporting of workplace violence: Comparison of self-report and actual documentation of hospital incidents (2015). Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. Workplace health & safety, 63(5), 200-210.

Workplace Violence Prevention for Nurses Workplace Violence Prevention for Nurses CDC Course No. WB2908 – NIOSH Pub. No. 2013-155. Retrieved from http://www.cdc.gov/niosh/topics/healthcare/default.html

Reducing Violence and Aggression in A&E: Through a Better Experience (2011). Council, D. Design Council. Retrieved from

https://static1.squarespace.com/static/50730747e4b00907bc1cdda3/t/529494fbe4b006d906127e20/1385469179391/DESIGN+COUNCIL_EVALUATION+SUMMARY.pdf

Enhancing safety in behavioral emergency situations (2012). Pestka, E. L., Hatteberg, D. A., Larson, L. A., Zwygart, A. M., Cox, D. L., & Borgen Jr, E. E. Medsurg nursing, 21(6), 335.

Prevention and management of occupational violence and aggression in healthcare: A scoping review (2018). Morphet, J., Griffiths, D., Beattie, J., Reyes, D. V., & Innes, K. Collegian, 25(6), 621-632. **New 2020**

Cost of Community Violence to Hospitals and Health Systems (2017). The American Hospital Association, July 2017. **New 2020** https://www.aha.org/guidesreports/2018-01-18-cost-community-violence-hospitals-and-health-systems

Bullying has no place in health care (2016). Quick Safety. The Joint Commission **New 2020** https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission-online/quick_safety_issue_24_june_2016pdf.pdf?db=web&hash=84E4112AB428AD3CA1D5B9F868A1AD10

Culture of Safety. A Patient Safety Primer (2019). The Agency for Healthcare Research and Quality (AHRQ) **New 2020** https://psnet.ahrq.gov/primer/culture-safety

The essential role of leadership in developing a safety culture (2017). Sentinal Event Alert ssue 57, March 1, 2017. The Joint Commission. **New 2020** https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_57_safety_culture_leadership_0317pdf.pdf

Improving patient and worker safety: opportunities for synergy, collaboration and innovation (2012). Joint Commission, & Joint Commission. Oakbrook Terrace, IL: The Joint Commission, 171. https://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf

Turnover intention of hospital staff in Ontario, Canada: exploring the role of frontline supervisors, teamwork, and mindful organizing (2019). Zaheer, S., Ginsburg, L., Wong, H. J., Thomson, K., Bain, L., & Wulffhart, Z. Human resources for health, 17(1), 1-9. **New 2020**

Through the eyes of the workforce: Creating joy, meaning, and safer health care (2013), and Getting Started on Workforce Safety (2014). Lucian Leape Institute at the National Patient Safety Foundation. Retrieved from http://www.ihi.org/resources/Pages/Publications/Through-the-Eyes-of-the-Workforce-Creating-Joy-Meaning-and-Safer-Health-Care.aspx

Health Research & Educational Trust. Hospital Approaches to Interrupt the Cycle of Violence (2015, March). American Hospital Association. Chicago, IL. Retrieved from www.hpoe.org

ORS 654.412 to 654.423, 'Safety of Health Care Employees' Retrieved from
https://www.oregonlaws.org/ors/654.412

OAR 437-001-0706, 'Recordkeeping for Health Care Assaults'. Retrieved from
http://osha.oregon.gov/Pages/re/healthcare-assault-log.aspx

Revised Code of Washington (RCW). Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070. https://app.leg.wa.gov/RCW/default.aspx?cite=49.19

Felony Assault Laws related to healthcare workers– Oregon, Washington and Alaska **New 2020**

Oregon
ORS 163.165: Assault in the third degree for intentionally assaulting EMS workers.
https://www.oregonlaws.org/ors/163.165

Washington
RCW 9A.36.031: Assault in the third degree for assault of a nurse, physician, or health care provider who was performing his or her nursing or health care duties at the time of the assault. https://app.leg.wa.gov/RCW/default.aspx?cite=9A.36.031

Alaska
HB312 (2018). http://www.akleg.gov/PDF/30/Bills/HB0312Z.PDF and
AS 12.55.135. Sentences of Imprisonment For Misdemeanors. provides definition of a medical professional.
https://touchngo.com/lglcntr/akstats/Statutes/Title12/Chapter55/Section135.htm

Workplace Violence Prevention and Related Goals. The Big Picture (2015). Occupational Safety and Health Administration (OSHA). Retrieved from
https://www.osha.gov/dsg/hospitals/workplace_violence.html

Position statement incivility, bullying, and workplace violence (2015). American Nurses Association (ANA): Workplace Violence. Nursing World. Retrieved from
http://www.nursingworld.org/workplaceviolence

Position Statement Workplace Violence (2017). Association of Occupational Health Professionals in Healthcare. Retrieved from www.aohp.org

Fundamentals of Total Worker Health® Approaches Essential Elements for Advancing Worker Safety, Health, and Well-Being (2016). National Institute for Occupational Safety and Health NIOSH. Retrieved from https://www.cdc.gov/niosh/docs/2017-112/pdfs/2017_112.pdf

Resources Related to this Section – Articles

Information about WPV for specific healthcare worker professions or specialties

Refer to Section 10 for WPV information related to Long Term Care and Home Health Services

Emergency Departments

Addressing Risks of Violence against Healthcare Staff in Emergency Departments: The Effects of Job Satisfaction and Attachment Style (2019). Berlanda, S., Pedrazza, M., Fraizzoli, M., & de Cordova, F. BioMed Research International, 2019. **New 2020**

A survey of workplace violence across 65 US emergency departments (2008). Kansagra, S. M., Rao, S. R., Sullivan, A. F., et al. Emergency Medicine. 15 (12):1268–1274. http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2008.00282.x/epdf

Nothing changes, nobody cares: Understanding the experience of emergency nurses physically or verbally assaulted while providing care (2014). Wolf, L. A., Delao, A. M., & Perhats, C. Journal of Emergency Nursing, *40*(4), 305-310.

The experiences of registered nurses who are injured by interpersonal violence while on duty in an emergency department (2016). Wright-Brown, S., Sekula, K., Gillespie, G., & Zoucha, R. Journal of forensic nursing, 12(4), 189-197. **New 2020**

Stressful incidents of physical violence against emergency nurses (2013). Gillespie, G.L. et. al. Online J Issues Nurs. Jan 31;18(1):3. http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Stressful-Incidents-of-Physical-Violence-against-Emergency-Nurses.html

Workplace violence and perceptions of safety among emergency department staff members: Experiences, expectations, tolerance, reporting, and recommendations (2017). Copeland, D., & Henry, M Journal of trauma nursing, 24(2), 65-77. **New 2020**

Workplace violence prevention programs in hospital emergency departments (2007). Journal of Occupational & Environmental Medicine, 49(7):756-763, Peek-Asa et al.

Emergency Services Workers

A national description of violence toward emergency medical services personnel (2016). Gormley, M. A., Crowe, R. P., Bentley, M. A., & Levine, R. Prehospital Emergency Care, 20, 4, 439.

EMS, Care in A Hostile Environment (2019). Koser, B. W., & Lee, B. H. In StatPearls [Internet]. StatPearls Publishing. **New 2020**

Nurses (Also refer to Emergency Depts. above)

Antecedent factors in different types of workplace violence against nurses: A systematic review (2019). Nowrouzi-Kia, B., Isidro, R., Chai, E., Usuba, K., & Chen, A. Aggression and violent behavior, 44, 1-7. **New 2020**

Determinants of workplace injuries and violence among newly licensed RNs (2018). Unruh, L., & Asi, Y Workplace health & safety, 66(10), 482-492. **New 2020**

New poll finds alarming rates of violence against nurses. (November 2017) Campus Safety. https://www.campussafetymagazine.com/hospital/new-poll-violence-against-nurses/

Nursing and aggression in the workplace: a systematic review. Edward K.L. et al. Br J Nurs. 2014 23(12):653-4, 656-9.

Violence against nurses and its impact on stress and productivity (2011). Gates, D. M., Gillespie, G. L., & Succop, P. Nursing Economics. The Journal for Health Care Leaders. 29(2), 59-66.

Verbal Abuse and Ambulatory Care Nurse Safety (2019). AAACN Viewpoint, 41(5), 1-13. Kinsley, K., & Pritchett, W. **New 2020**

Violence against new graduated nurses in clinical settings: A qualitative study (2016). Ebrahimi, H., Hassankhani, H., Negarandeh, R., Jeffrey, C., & Azizi, A. *Nursing ethics*, 0969733015624486.

Violence toward nurses, the work environment, and patient outcomes (2010). Roche, M., Diers, D., Duffield, C., & Catling-Paull, C 42(1):13-22. Journal of Nursing Scholarship, *42*(1), 13-22.

Violence against nurses: An assessment of the causes and impacts of violence in nursing education and practice (5th Report 2007). National Advisory Council on Nurse Education and Practice (NACNEP). https://www.hrsa.gov/advisorycommittees/bhpradvisory/nacnep/reports/fifthreport.pdf

Nursing Assistants

Workplace hazards faced by nursing assistants in the United States: a focused literature review (2017). Walton, A. L., & Rogers, B. International journal of environmental research and public health, 14(5), 544. **New 2020**

Physicians

368 reassessment of violence against emergency physicians (2018). Omar, H., Yue, R., Amen, A. A., Kowalenko, T., & Walters, B. L. Annals of Emergency Medicine, 72(4), S144.

Interventions to prevent aggression against doctors: a systematic review. (2019). Raveel, A., & Schoenmakers, B. BMJ open, 9(9), e028465. **New 2020**
https://bmjopen.bmj.com/content/9/9/e028465

Manifestations of verbal and physical violence towards doctors: a comparison between hospital and community doctors (2019). Nevo, T., Peleg, R., Kaplan, D. M., & Freud, T. BMC health services research, 19(1), 1-7. **New 2020**

Workplace Violence: Experiences of Internal Medicine Trainees at an Academic Medical Center. (2019). Southern medical journal, 112(6), 310-314. Lowry, B., Eck, L. M., Howe, E. E., Peterson, J., & Gibson, C. A. **New 2020**

Psychiatric staff

Incidence and risk factors of workplace violence on psychiatric staff (2015). Ridenour, M., Lanza, M., Hendricks, S., Hartley, D., Rierdan, J., Zeiss, R., & Amandus, H. *Work*, *51*(1), 19-28.

Information about WPV - All Other

Addressing workplace violence with the Pathway to Excellence® framework (2019). McCright, M., Blair, M., Applegate, B., Griggs, P., Backus, M., & Pabico, C. Nursing management, 50(8), 10-13. **New 2020**

Can work-unit social capital buffer the association between workplace violence and long-term sickness absence? A prospective cohort study of healthcare employees (2019). . Török, E., Rod, N. H., Ersbøll, A. K., Jensen, J. H., Rugulies, R., & Clark, A. J. International archives of occupational and environmental health, 1-10 **New 2020**

Clinically assessed consequences of workplace physical violence (2015). De Puy, J., Romain-Glassey, N., Gut, M., Pascal, W., Mangin, P., & Danuser, B. International Archives of Occupational and Environmental Health, 88, 2, 213.

Cutting the Yellow Tape with 42 CFR PART 2: A Health Care–Based Approach to Combating Gun Violence (2018). Sweeney, M. A. Journal of Legal Medicine, 38(3-4), 437-447. **New 2020**

Defining and classifying aggression and violence in health care work (2018). Hills, D. J. Collegian, 25(6), 607-612. **New 2020**

Ensuring workplace safety: evidence supporting interventions for nurse administrators (2019). Bromley, G., & Painter, S. JONA: The Journal of Nursing Administration, 49(11), 525-530. **New 2020**

Healthcare managers' perceptions of patient perpetrated aggression and prevention strategies: A cross sectional survey (2016). Baby, M., Swain, N., & Gale, C. Issues in Mental Health Nursing, 37, 7, 507

Healthcare managers' perceptions of patient perpetrated aggression and prevention strategies: A cross sectional survey (2016). Baby, M., Swain, N., & Gale, C. Issues in Mental Health Nursing, 37, 7, 507

Healthcare Executives' Role in Mitigating Workplace Violence Policy Statement (Nov 2018). American College of Healthcare Executives **New 2020** https://www.ache.org/about-ache/our-story/our-commitments/policy-statements/healthcare-executives-role-in-mitigating-workplace-violence

Healthcare staff wellbeing, burnout, and patient safety: a systematic review (2016). Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. *PloS one*, *11*(7). e0159015. doi:10.1371/journal.pone.0159015 **New 2020**

Hospital-based shootings in the United States: 2000 to 2011 (2012). Kelen, G.D., Catlett, C.L., Kubit, J.G., and Hsieh, Y.H. Annals of Emergency Medicine. 60(6):790-798.

Individual, relationship, workplace, and societal recommendations for addressing healthcare workplace violence (2015). Gillespie, G. L., Gates, D. M., & Fisher, B. S. Work, 51(1), 67-71. **New 2020**

It takes two to tango: public attitudes toward prevention of workplace violence against health care staff: a mixed-methods study (2019). Warshawski, S., Amit Aharon, A., & Itzhaki, M Journal of interpersonal violence, May 3, 2019 **New 2020**

Leading a culture of safety: a blueprint for success (2019). American College of Healthcare Executives. **New 2020** http://safety.ache.org/blueprint/

Managers' experiences of prevention and management of workplace violence against health care staff: A descriptive exploratory study. (2019). Morphet, J., Griffiths, D., Beattie, J., & Innes, K. Journal of nursing management, 27(4), 781-791. **New 2020**

Measurement and monitoring of health care worker aggression exposure (2013). Lennaco, J. D., Dixon, J., Whittemore, R., & Bowers, L. OJIN: The Online Journal of Issues in Nursing, 18(1). **New 2020**

Measuring Best Practices for Workplace Safety, Health, and Well-Being. The Workplace Integrated Safety and Health Assessment (2018). **New 2020**
Sorensen, G., Sparer, E., Williams, J. A., Gundersen, D., Boden, L. I., Dennerlein, J. T., ... & Pronk, N. P. Journal of occupational and environmental medicine, 60(5), 430-439.
https://dl.uswr.ac.ir/bitstream/Hannan/69246/1/2018%20JoEM%20Volume%2060%20Issue%205%20May%20%284%29.pdf

Occupational injury among hospital patient-care workers: What is the association with workplace verbal abuse? (2014). Sabbath, E. L., Hurtado, D. A., Okechukwu, C. A., Tamers, S. L., Nelson, C., Kim, S. S., Wagner, G. & Sorenson, G. American Journal of Industrial Medicine, 2014, 57, 2, 222.

Occupational traumatic injuries among workers in health care facilities—United States, 2012–2014 (2014). Gomaa, A. E., Tapp, L. C., Luckhaupt, S. E., Vanoli, K., Sarmiento, R. F., Raudabaugh, W. M., & Sprigg, S. M. Health Care, 2012.

Organizational determinants of workplace violence against hospital workers (2018). Arnetz, J., Hamblin, L. E., Sudan, S., & Arnetz, B. Journal of occupational and environmental medicine, 60(8), 693-699. **New 2020**

Overview and summary: Patient and visitor violence: What do we know? What can we do? (2013). Rosen, J. Online J Issues Nurs. Jan 31;18(1):1.
http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Overview-and-Summary-Patient-and-Visitor-Violence.html

Prevention of workplace violence among health care workers (2019). Robinson, I. Workplace health & safety, 67(2), 96-96. **New 2020**

Promoting Civility in Healthcare Settings (2019). Conner Black, A. International Journal of Childbirth Education, 34(2), 64-67 **New 2020**

Quality improvement project to manage workplace violence in hospitals: lessons learned (2019). Schwartz, F., & Bjorklund, P. Journal of nursing care quality, 34(2), 114-120. **New 2020**

Reducing the risk of patient-generated violence in healthcare: a case study (2016). Puttkammer, J., & Moreno, C. Journal of healthcare protection management: publication of the International Association for Hospital Security, 32(2), 114-120. **New 2020**

Reducing violence in healthcare facilities (2013). Vellani, K. H. Journal of healthcare protection management: publication of the International Association for Hospital Security, 30(1), 21-29.

Patient safety and quality: An evidence-based handbook for nurses (Vol. 3) 2008. Hughes, R. (Ed.). Rockville, MD: Agency for Healthcare Research and Quality. https://archive.ahrq.gov/professionals/clinicians-providers/resources/nursing/resources/nurseshdbk/nurseshdbk.pdf

Physical assault, physical threat, and verbal abuse perpetrated against hospital workers by patients or visitors in six US hospitals (2015). Pompeii, L. A., Schoenfisch, A. L., Lipscomb, H. J., Dement, J. M., Smith, C. D., & Upadhyaya, M. (2015). American journal of industrial medicine, 58(11), 1194-1204.

Safeguarding health care workers (2014). Benton, D. The American Journal of Nursing, 114(12), 61.

Stopping the pain: The role of nurse leaders in providing organizational resources to reduce disruptive behavior (2013). Yragui, N., Silverstein, B., & Johnson, W. American Nurse Today, 8(10). **New 2020**

The American Academy of Neurology position statement on abuse and violence (2012). Schulman, E. A., & Hohler, A. D. Neurology, (2012). 78(6), 433-435. **New 2020**

The American organization of nurse executives and American hospital association initiatives work to combat violence (2018). Wray, K. JONA: The Journal of Nursing Administration, 48(4), 177-179. **New 2020**

The effects of exposure to psychological violence in the workplace on commitment and turnover intentions: the moderating role of social support and role stressors (2019). Courcy, F., Morin, A. J., & Madore, I. Journal of interpersonal violence, 34(19), 4162-4190. **New 2020**

Underreporting of workplace violence: Comparison of self-report and actual documentation of hospital incidents (2015). Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. Workplace health & safety, 63(5), 200-210.

Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports (2015). Arnetz, J. E., Hamblin, L., Essenmacher, L., Upfal, M. J., Ager, J., & Luborsky, M. Journal of Advanced Nursing 71(2), 338–348.

Utilizing a Systems and Design Thinking Approach for Improving Well-Being Within Health Professional Education and Health Care (2018) NAM Perspectives. Kreitzer, M. J., K. Carter, D. S. Coff ey, E. Goldblatt, C. Grus, P. Keskinocak, M. Klatt, T. Mashima, Z. Talib, and R. Valachovic Commentary, National Academy of Medicine, Washington, DC. **New 2020**
https://nam.edu/utilizing-a-systems-and-design-thinking-approach-for-improving-well-being-within-health-professions-education-and-health-care/

US acute care hospital shootings, 2012–2016: A content analysis study (2019). Wax, J. R., Cartin, A., Craig, W. Y., & Pinette, M. G. Work, 64(1), 77-83. **New 2020**

Violence in healthcare facilities - updated 2017. ECRI Institute**.**
https://www.ecri.org/components/HRC/Pages/SafSec3.aspx

Workplace assessment of violence risk: Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports (2015). Arnetz, J. E., Hamblin, L., Essenmacher, L., Upfal, M. J., Ager, J., & Luborsky, M. J Adv Nurs Feb; 71(2):338-348.

Workplace violence against health care workers in the United States (2016). Phillips, J. P. New England Journal of Medicine, 374(17), 1661-1669.

Workplace violence and the meaning of work in healthcare workers: A phenomenological study (2017). Lamothe, J., & Guay, S Work, 56(2), 185-197. **New 2020**

Workplace violence in healthcare settings: risk factors and protective strategies (2010). Gillespie, G.L., et al. Rehabil Nurs. 2010 Sep-Oct; 35(5):177-84

Workplace Violence Prevention: Liability Recommendations (2019). Flynn, J. Journal of Legal Nurse Consulting. 30(2):25-29. **New 2020**

Workplace violence and occupational stress in healthcare workers: A chicken-and-egg situation—Results of a 6-Year follow-up study (2014). Magnavita, N. Journal of Nursing Scholarship, 46:5, 366–376

Workplace violence prevention: Improving front-line health-care worker and patient safety (2013). Lipscomb JA & El Ghaziri M. New Solut. 23(2):297-313**.**

Workplace Violence Toolkit – Section 1

Books

(Re)Thinking Violence in Health Care Settings Hardcover (2012). Holmes, D., Rudge, T., & Perron, A. Ashgate January 1, 2012.

Workplace Violence in Mental and General Health Settings (2011). Privitera, M.R., Jones & Bartlett Learning 2011.

Resources Related to this Section – Other

Cost of Community Violence to Hospitals and Health Systems. Report for the American Hospital Association July 26, 2017. Van Den Bos, J, et. al. Milliman Research Report. http://www.aha.org/content/17/community-violence-report.pdf

Centers for Disease Control and Prevention (CDC)

- **Occupational Violence** http://www.cdc.gov/niosh/topics/violence/

- **Occupational Violence: Research on Occupational Violence and Homicide** https://www.cdc.gov/niosh/topics/violence/pubs.html

American College of Emergency Physicians and Emergency Nurses Association ^{**New 2020**}

- Stop ED Violence Campaign (Nov 2019)
  https://stopedviolence.org/

IHI Framework for Improving Joy in Work (2017). IHI White Paper. Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. http://www.ihi.org/Topics/Joy-In-Work/Pages/default.aspx

Occupational Safety and Health Administration (OSHA)

- **Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (2015)** https://www.osha.gov/Publications/osha3148.pdf

- **Preventing Workplace Violence in Healthcare. Understanding the Challenge (2015)** https://www.osha.gov/dsg/hospitals/workplace_violence.html

- **Workplace Violence Prevention and Related Goals. The Big Picture (2015)**
  https://www.osha.gov/dsg/hospitals/workplace_violence.html

- **Facts About Hospital Worker Safety (September 2013). OSHA**
  https://www.osha.gov/dsg/hospitals/documents/1.2_Factbook_508.pdf

- **Workplace Violence – Website** https://www.osha.gov/SLTC/workplaceviolence/

The Joint Commission

- **Workplace Violence Prevention – From the Field** New 2020
  https://www.jointcommission.org/wpv_healthcare_the_field'

- **Physical and verbal violence against health care workers**. (April 16, 2018). Sentinel Event Alert Issue, (59). Joint Commission. New 2020
  https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-59-physical-and-verbal-violence-against-health-care-workers/

- **Bullying has no place in health care (2016) Quick Safety. The Joint Commission** New 2020
  https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission-online/quick_safety_issue_24_june_2016pdf.pdf?db=web&hash=84E4112AB428AD3CA1D5B9F868A1AD10

- **Questions & Answers: Hospital Accreditation Standards & Workplace Violence** November 17, 2017.
  https://www.jointcommission.org/questions_answers_hospital_accreditation_standards_workplace_violence/

- **Workplace Violence Resources** New 2020
  https://www.jointcommission.org/workplace_violence.aspx

- **Workplace Violence Update.** Presentation on recent incidents in workplace violence. The 23rd State Hospital Association Forum 2016
  https://www.jointcommission.org/assets/1/6/illinois_hospital_assoc_wpv_slides.pdf

- **Developing resilience to combat nurse burnout (2019).** The Joint Commission. Quick safety Issue 50, July 2019 New 2020 https://www.jointcommission.org/-/media/tjc/newsletters/quick_safety_nurse_resilience_final_7_19_19pdf.pdf?db=web&hash=552B3D44D99B02373F48D1FF464BFF27

Public Services Health and Safety Association (PSHSA) Ontario, Canada **New 2020**

- **Workplace Violence Prevention Resources – Hospital, Community Care and Long Term Care** https://www.pshsa.ca/emerging-issues/issues/workplace-violence-in-healthcare/workplace-violence-leadership-table-phase-2

World Health Organization

- **Violence against health workers** https://www.who.int/violence_injury_prevention/violence/workplace/en/