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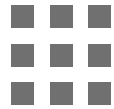

19

Preventing and Managing Healthcare Conflict and Violence

Ever since it became a hot topic in the 1990s, the term *workplace violence* has referred to violence involving one or more employees. Despite the thousands of pages written on workplace violence, there is no concise definition for it. For most security professionals, it means any act of physical violence, threats of physical violence, harassment, intimidation, or other threatening, disruptive behavior that occurs at the work site. Workplace violence can affect or involve employees, visitors, contractors, and other employees.[1]

Richard Hampton, Head of Security Management for the National Health Service (NHS) Security Management Service (SMS) noted that one of the first charges of the SMS when introducing a national strategy for healthcare security in the United Kingdom was to define *physical violence*. Before the formation of the SMS in 2003, the NHS was using approximately 20 different definitions with no standard definition of abuse and no robust process for collecting data on violence against NHS care providers.

Workplace violence is an industry-wide healthcare problem and not exclusive to any one healthcare organization. Violence threatens the safety of staff, patients, and visitors in hospitals and healthcare organizations of all sizes and settings. It demoralizes healthcare professionals, especially nurses, who are most often the victims of violence, and costs hospitals untold millions in lost time, employee turnover, reputation for quality care, and additional security measures.

Regardless of the patient care services offered, the threat of violence in the workplace is all around us. A disgruntled visitor who is asked to wait several hours in the emergency department waiting room is only a moment away from violence, an at-risk patient who has an altered mental status could create a concern for violence, and the victim of domestic violence often has no choice but to go to the emergency department to receive care for injuries sustained. The scenarios are endless and real in the healthcare industry—no healing environment is immune from having violent acts occur inside the facility or on its campus. Table 19-1 lists the wide examples of violence that can be witnessed in the healthcare environment.

The issue of violence is well known by the healthcare community, which has been seeking ways to combat it for years. But the violence continues to occur and is most prevalent in emergency departments, behavioral health facilities, waiting rooms, and geriatric units. Approximately half of the nurses responding to a 2007 survey conducted by the Emergency Nurses Association believe that violence is simply part of their everyday work environment.[2] In the survey, 9 out of 10 Emergency Department Managers cited patient

Table 19-1 Listing of Workplace Violence Examples

Workplace Violence Includes	
• Assaults	• Threats or obscene phone calls
• Stabbings	• Intimidation
• Suicides	• Harassment of any nature
• Shootings	• Being followed, sworn at, or shouted at
• Rape	• Psychological traumas
• Attempted suicides	

violence as the greatest threat to department personnel. In addition, emergency department nurses reported[2]:

- Dissatisfaction with the overall level of safety from workplace violence (89%)
- Feeling unprepared to handle violence in the emergency department given their education and training (83%)
- Reduced job satisfaction due to violence (74%)
- Impaired job performance for up to a week after a violent incident (48%)
- Taking time off because of violence (25%)

Over 75% of surveyed emergency department physicians in Michigan said they had experienced at least one violent act within the previous 12 months.[3] According to the US Bureau of Labor Statistics, nurses and other personal care workers suffer 25 injuries annually resulting in days off from work for every 10,000 full-time workers—12 times the rate of the overall private sector industry. Fifty percent of nurses surveyed by the Massachusetts Nurses Association (MNA) and the University of Massachusetts said they had been punched at least once in a 2-year period. Twenty-five percent said they were regularly punched, scratched, spit on, or had their hand/wrist twisted. Some reported being strangled, sexually assaulted, or stuck with contaminated needles.[4]

Today, the term *workplace violence* continues to be expanded to include any act of violence in the workplace regardless of the connection of the victim or perpetrator to a specific business or employer. The California Department of Industrial Relations, Division of Occupational Safety and Health (DOSH), divides events of workplace violence into four categories: Type I, Type II, Type III, and Type IV:

- Type I event (*criminal*)—the perpetrator has no legitimate relationship to the healthcare facility (HCF).
- Type II event (*patient*)—committed by someone who is the recipient of a service provided by the HCF or the victim.
- Type III event (*employee*)—committed by someone who has an employment-related involvement at the HCF, such as current or former staff members.
- Type IV event (*domestic*)—relates to interpersonal violence at the HCF and includes spouses, lovers, relatives, and friends or other visitors who have a dispute involving an employee, patient, physician, or contractor.

One of the first in-depth reviews of violence in the healthcare industry was published in 1984 by James T. Turner. His book, *Violence in the Medical Care Setting: A Survival Guide*, has served as a basic resource for healthcare security administrators.[5] In addition to Turner's book, another authoritative book on the subject is Sandra L. Heskett's *Workplace Violence: Before, During, and After*. Although it is not exclusive to healthcare settings, Heskett does open her book by describing a violent hospital incident that occurred on June 20, 1994, at Fairchild Air Force Hospital in Spokane, WA. In the incident, a man recently discharged from the military used a Chinese-made MAK-90 to kill 5 people and injured 23 others.[6]

The majority of people generally associate violence in the workplace with assault and homicide, not with intimidating postures or expressions of mild anger. It is important that the healthcare administrator break workplace violence down into *actual* violence and the *threat* of violence. Both can create a hostile and uncomfortable work environment, and even with this breakdown, healthcare workers face significantly higher risk of injury from nonfatal assaults (actual violence) than that of other workers. The threat of violence, although not adequately tracked by most healthcare organizations, is also quite high in terms of threats of violence.

Violence is a major problem in all healthcare settings in all countries. More assaults occur in the healthcare and social services industries than in any other, according to a 1998 report published by the US Occupational Safety and Health Administration (OSHA). More than one in 10 NHS workers in the United Kingdom (12%) reported experiencing physical violence from patients or their relatives in a 2008 survey conducted by the Healthcare Commission—up 2% from 2007.[7] A report from Statistics Canada found that 34% of nurses in Canada had been physically assaulted by a patient in 2005. Those working in geriatrics and long-term care facilities were most likely to experience physical abuse, while registered psychiatric nurses were also particularly at risk. The statistics are similar to numbers released in the 2005 National Canadian Survey of the Work and Health of Nurses. That survey of nearly 19,000 nurses found that more than a quarter reported they had been physically abused by a patient in the previous year.[8] A 2006 Queensland (Australia) Nurses Union survey found that 45% of nurses had experienced some form of violence in their workplace.[9]

As concerning as the above statistics are for the healthcare industry, underreporting of violence is a chronic problem as a persistent perception within the healthcare industry is that assaults are part of the job. Underreporting is a concern by the SMS of the NHS where analysts studying the issue of physical violence against their healthcare workers steadfastly believe that violence is underreported by at least half. Many US hospitals have various reporting sources (Security, Risk Management, and Employee Health Departments) and multiple avenues for reporting events but often lack coordination between the reporting sources. Security is typically most focused on the event while Employee Health is focused on the employee. If the two databases are not coordinated, a large gap in the date can occur. The MNA is on record saying that violence is substantially underreported, in part because nurses are afraid it will show up on their performance

evaluation as not being able to appropriately handle a patient.[10] Other care providers purportedly underreport incidents of violence out of fear of reprisal, isolation, and embarrassment.

Why violence is so prevalent in healthcare is a question asked by many security professionals and administrators. According to the OSHA, healthcare and social service workers face a high degree of work-related assaults owing to the following risk factors[11]:

- Rising use of hospitals by police and criminal justice agencies for criminal holds and the care of acutely disturbed persons
- The early release from hospitals of acute and chronic mental health patients who have not received follow-up care and who can no longer be involuntarily hospitalized except in extreme situations
- The availability of drugs and money at hospitals, clinics, and pharmacies, which makes them targets for robbery
- Situational factors such as open facilities with basically unrestricted movement of the public, as well as the presence of drug abusers, trauma patients, distraught family members, and frustrated clients
- Low staffing levels at various times
- Isolated work situations during client examination or treatment
- One-person workstations in remote locations
- Lack of staff training relative to recognizing and managing escalating hostile and assaultive behavior
- Long waiting times for care in emergency areas, which can lead to patient frustration
- The increased presence in healthcare setting of gang members, alcohol and other drug abusers, trauma patients, and distraught family members
- Prevalence of handguns and other dangerous weapons

Other factors that contribute to workplace violence include stress, high patient-to-staff ratios, long working hours, and power and control issues of healthcare providers themselves.

Brockton Hospital in the suburbs south of Boston, MA, is considered a model for violence in healthcare. In 2007, OSHA investigated the hospital in response to complaints it had received and found that the types of physical assaults included, but were not limited to, punching, kicking, biting, scratching, and pulling hair. The agency recommended that the hospital analyze the workplace hazard, solicit extensive comments from employees, and develop a comprehensive violence-protection plan.[12] To date, this is the first and only hospital that OSHA has investigated as a result of the guidelines published in 1996 to prevent violence in the healthcare and social work settings. It should be noted that the OSHA guidelines (OSHA 3148) address only the violence inflicted by patients or clients against staff.

There are various ways of looking at violence in order to understand its impact on healthcare organizations. In this chapter, we will approach the subject from the basic categories of who, what, why, when, and where.

The Who (Perpetrators/Visitors)

Those who are committing violence in emergency rooms are not typically gang members who are brought to the hospital after a violent confrontation with a rival gang and are looking for payback. Rather, it is citizens who are often intoxicated and upset with having to sit for hours in the waiting room.

There are four basic groups of perpetrators and victims in the healthcare environment: staff, patients, legitimate visitors, and illegitimate visitors. Figure 19-1 shows the many combinations of perpetrator to victim. The illegitimate visitor (trespasser/intruder) often is involved in stranger-to-stranger situations, while in the other groups, the perpetrator and victims are known. In the vast majority of past situations, both parties know each other, and their relationship has provided the motive for the violent act.

Patients

We have previously discussed some situational events in both the outpatient and inpatient setting in which the perpetrator of violence is the patient himself. The clinical patient is often the source of confrontation, largely due to the volume of patients, long waits, and disputes relative to services being rendered. Hospital emergency departments, along with mental health evaluation and treatment areas, intensive care units, dedicated forensic patient care centers, and closed head injury units have historically the highest potential for violence. There are cases in which patients have attacked other patients or staff ostensibly without warning or provocation.

The Emergency Nurses Association, citing the US Bureau of Labor Statistics, revealed that 48% of all nonfatal assaults in the workplace are committed by healthcare

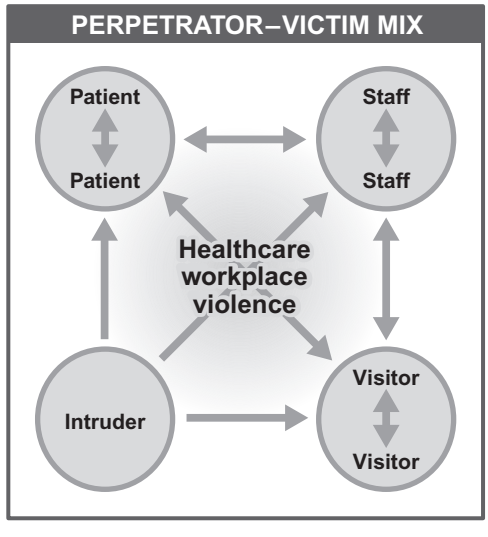

FIGURE 19-1 Healthcare workplace violence perpetrators and victims.

patients. Nurses and other healthcare workers suffer violent assaults at a rate 12 times higher than other industries.[2] Nurses are often on the receiving end of physical assaults, because they are typically the first and most frequent medical care providers by the bedside of ill and sometimes angry or frustrated patients. The ENA study showed that 86% of all emergency department nurses who responded to the survey had some form of violence committed against them while on duty over the past 3 years and one-fifth said they encountered it frequently. Much of the trend comes as more patients act out because of substance abuse or psychiatric problems. These patients have fewer treatment options following budget cuts at social service agencies. As such, the weapons used by the patient perpetrator to commit these violent acts are not knives, guns, or other weapons typically associated with violence in the community. Most often, the weapon of choice comes directly from the patient or the immediate environment. A listing of the most commonly used weapons by patients committing an act of violence is shown in Table 19-2.

A study conducted by the University of Miami has found that 1 in 20 patients have had the urge to kill their physician. Distrust of physicians is believed to be the number one cause of the problem; however, there is still a lack of understanding who is likely to have a wish to harm medical staff and why. Further evidence-based research is needed to help reduce, mitigate, or even prevent these attacks. While few physicians are actually killed by patients, thousands are attacked and injured. Involvement in a disability compensation case is, for example, a predictor of a negative attitude, as patients often become angry if they feel their physician will not support their compensation claim.

Some care providers believe part of the problem of escalating violence is that some HCFs have made security officers less conspicuous in an effort to cultivate a friendlier, service-oriented setting. A more critical concern stems from the restrictions imposed by regulatory and accreditation agencies such as CMS and TJC that require healthcare organizations to apply medical restraints or seclude patients as a means of last resort. The pendulum of managing patient behavior is deemed at risk. There was a need to swing away from its previous position of being too prone to apply medical or chemical restraints or using seclusion rooms without the appropriate regard for patient safety. However, overly strict interpretations by surveyors and healthcare organizations alike have resulted in the compromise of employee, staff, and physician safety. Care providers are rarely using the tools available to them until after an actual incident of violence occurs. The result is more

Table 19-2 Type of Weapons Commonly Used to Commit Violence in the Healthcare Environment[13]

Most Commonly Used Weapons	
• Fists/hands/fingernails	• Medical supply/ instrument
• Feet	• Food/utensils/meal tray
• Teeth/mouth	• Furniture
• Head	• Floor/door/wall/window
• Body fluids	

incidents of violence and more injuries to healthcare workers and patients alike. To correct this vicious cycle, TJC, CMS, and healthcare organizations must take a more balanced approach in its interpretation of these patient restraint and seclusion guidelines before a safe and therapeutic healing environment can be created. If not, healthcare professionals will continue to leave their occupation because of the risk of actual and threat of violence, feeding the industry-wide shortage of qualified medical professionals.

Visitors

There is a high potential for workplace violence caused by individuals or groups who are from outside the organization, which may include legitimate visitors such as patients' family members or illegitimate visitors. The illegitimate visitor is one who has no legitimate business being on the property. This type of visitor includes criminals contemplating or committing a crime (robbery, abduction, assault); gang members intent upon causing injury or harm; unwelcome friends or family members of staff or patients; protestors; terrorists; transient persons; and former patients and employees. It is almost impossible to discern the presence and intent of these persons until an overt act occurs. In fact, they often blend in with the legitimate patient, staff, or visitor.

The potential for violence from patients' family members has become a great concern for healthcare security professionals to address. The family who comes in after their loved one has been in a traumatic accident is under great stress with high anxiety levels. It can overwhelm their coping skills and be the cause of verbal abuse toward the care providers, front-desk receptionists, or other employees. However, violence against staff is not the only visitor concern.

Visitor violence against the patient is a troubling development that continues to plague the healthcare industry and threaten the reputation of many healthcare organizations that experience these often horrific events. At Baptist Hospital in Jackson, MS, a woman who was apparently overburdened with the stress of caring for her terminally ill mother killed her mother and then herself.[14] An isolated event for most hospitals, these types of violent episodes are not exceptional within the healthcare community.

In 2009, Rhonda Stewart got into an argument with her estranged husband in the Intensive Care Unit at Charleston Area Medical Center's Memorial Hospital in Charleston, WV. She was asked to leave by the hospital staff. She later returned with a gun and shot him in the head.[15]

In the parking garage at Baptist Medical Center in Jacksonville, FL, a 68-year-old husband pulled a gun and shot his wife and 11-year-old son as they were leaving the hospital and then shot himself.[16]

A Birmingham, AL, man was charged with attempted murder because he tried to drown his wife in a bathtub at Brookwood Medical Center where his wife was a patient.[17]

Untold healthcare organizations have had to manage the family member to patient cruelty associated with Munchausen by Proxy. Speaking at the 2009 IAHSS Annual

General Membership Meeting and Seminar in Baltimore, MD, Sgt. Latrice Taylor from the University of Michigan Hospital in Ann Arbor shared two actual case studies that occurred at the facility within a 1-year span in 2008. Within the audience, 10–20% had experienced a similar event. Munchausen by Proxy is reviewed in greater detail in *Chapter 12, Patient Care Involvement*.

The legitimate visitor can also include outside service workers, construction workers, and vendors. While on occasion these people are responsible for violence, they do not present a major danger. Violence regarding these individuals is generally related to situational events occurring within the facility or in parking areas.

Employees

Employees and staff members have been the source of many violent acts, especially against other employees or staff members. The day-to-day supervision, work evaluations, disciplinary actions, and terminations all set up situations that can be confrontational and that can provide the motivation of employee and ex-employee violence.

There is common agreement among human resource managers and security administrators that individuals who have committed violent acts in the past are potential perpetrators for further violence. Steve Millwee, CPP, author of *The Threat from Within: Workplace Violence*, is a leading authority on workplace violence and has found many similarities with employees prone to instigating workplace violence. Table 19-3 lists many of the common characteristics and warning signs of the perpetrator of workplace violence.

A preventive approach to employee workplace violence requires recognizing that acting out may be the end result of an invisible process. No single characteristic or seemingly innocent experience can accurately predict violence. An individual may perceive that he or she has been unfairly treated, discriminated against, harassed, or purposely exposed to stress by a supervisor. Other mental factors such as stress, discrimination, and harassment can have a cumulative effect on the individual and lead to a traumatic event.[19]

Table 19-3 Characteristics and Warning Signs of the Typical Workplace Violence Perpetrator[18]

Profile of the Workplace Violence Perpetrator	
• Usually a loner; socially isolated without good support system	• History of violence; made threats or acted out violently before
• Long history of frustration and failure	• History of intimidating or threatening others; defiant, or blatantly violates organization procedures
• Experienced some precipitating event, such as being fired or divorced	• History of illegal drug and/or alcohol abuse
• Difficulty handling defeat or rejection	• Criminal history
• Unusual fascination with weapons	
• Places blame for problems elsewhere; blames others for failure	

Courtesy of Steven C. Millwee, CPP, SecurTest.

The healthcare industry is not immune to these types of violent acts even if the media attention provided to these incidents is minimal. In November 2005, anesthesiologist Marc Daniel stabbed Lori Dupont, a nurse at Hôtel-Dieu Grace Hospital in Calgary, Alberta, and then killed himself. During a 3-month coroner's inquiry, the jury heard how the hospital allowed Daniel to continue practicing, despite complaints about Daniel's threatening behavior, such as breaking a nurse's finger and destroying hospital equipment, and Dupont's complaints that Daniel harassed her.[20]

In April 2009, a hospital worker shot and killed two employees and killed himself at Long Beach Memorial Medical Center in Long Beach, CA.[21] Believed to have followed a recent downsizing, this event brought to life the importance of having an "active shooter" contingency plan as hospital workers were screaming and witnessed fleeing the facility in a panic. The active shooter and other security-related emergency contingency plans are discussed in greater detail in *Chapter 24, Emergency Preparedness—Planning and Management*.

The What and the Why

The "what" of violence pertains to the specific act itself in terms of the severity or type of crime. The type of crime can be viewed on a continuum, as shown in Figure 19-2.

There are at least three different categories of a violent act viewed from the causation or perpetrator viewpoint. These are the targeted victim, situational event, and the spontaneous event. The targeted victim is tied closely to stalking and generally involves a previous conflict between the perpetrator and the victim. The most common scenario in this regard is related to a domestic or intimate relationship. Violent acts in many of these cases are somewhat predictable, thus providing an opportunity to implement a number of possible prevention strategies.

The situational event generally results from a conflict between the perpetrator and the victim in the course of their interacting with each other. In the medical care setting, such conflicts often revolve around delivery of care issues. Patients may feel that they are not receiving the treatment they deserve or that their treatment is not timely. Sometimes it is not the patient but visitors who perpetrate the violence, whether it is at a hospital, clinic, physician's office, dentist's office, or long-term care facility. Violent acts resulting from such situational

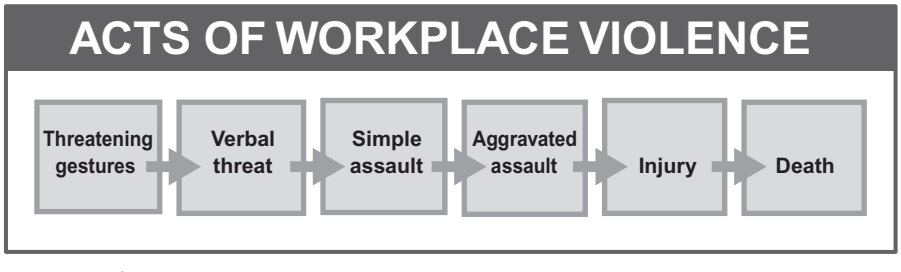

FIGURE 19-2 The acts of violence in the healthcare workplace.

conflicts are often fueled by drugs or alcohol. The mental health patient may be involved in confrontational situations that lack an apparent, or outward, rational motivation.

In spontaneous acts of violence, victims generally do not have a direct relationship with the perpetrators, and there is no forewarning of the danger. The act is premeditated and many have involved weeks, months, or years of planning or thought. The motive for these acts is usually general in nature and directed toward a cause, organization, or controversial issue. Unfortunately, the open healthcare environment is conducive to providing the opportunity for carrying out spontaneous violent acts.

One example of a spontaneous violent act occurred when a gun-wielding 57-year-old woman entered an eye clinic at the Henry Ford Hospital in Detroit, MI, and started shooting, severely wounding two technicians who she thought were physicians. Investigations revealed that she blamed physicians for the death of her mother, which had occurred over 4 years earlier. There was no evidence that she had previously complained of wrongdoing in her mother's death, had ever visited or been in Henry Ford Hospital, or had ever met the two technicians she shot.

The When and the Where

Of course, there is no way to penetrate the minds of violent persons so that we can predict the time and location of an act. We do know that in the medical care setting, there are certain times and locations in which acts are more likely to occur. The most severe acts generally occur during the regular business day, when things are busy, facilities are open, and many potential victims are in close proximity to each other. For example, a disgruntled employee holding a grudge against the Human Resources office would not be able to act out his anger against department staff unless the office was open. On the other hand, employees and patients in the behavioral health unit and the emergency department are possible targets of violence 24 hours per day, 7 days a week.

While certain areas of the HCF present a higher risk than others for violence, no area can be considered immune. History has provided examples of violence in hospice units, admitting rooms, physician offices, stairwells, business offices, intensive care units, other patient care areas, cafeterias, materials management areas, and even in surgery areas. In the latter, an estranged husband shot and killed his former wife, a surgical technician, in the surgery area of a Louisville, KY, hospital. In Miami, FL, a hospice patient beat two nurses at a nurses' station so severely that both were hospitalized with serious injuries; neither returned to the career in nursing.

The Management of Healthcare Violence

Not all violence occurring in the healthcare environment can be prevented; however, many acts can be prevented and managed to minimize injury, death, and damage to property. The three phases of managing violence in the workplace are before, during, and

after. The after phase provides information and lessons that help healthcare professionals to consistently improve preventive measures and intervention. The IAHSS has established a basic industry guideline to help healthcare organizations address the issues of violence in healthcare.

IAHSS—HEALTHCARE BASIC SECURITY GUIDELINE, #02.02

Violence in Healthcare
STATEMENT: Healthcare facilities (HCFs) will implement an interdisciplinary protocol on workplace violence prevention and response.

INTENT:

a. The protocol should elaborate on the five main components of an effective safety and security program, whose components also apply to preventing workplace violence:
   1. Management commitment and employee involvement
   2. Worksite analysis
   3. Hazard reduction and response
   4. Training
   5. Record keeping and program evaluation
b. A multidisciplinary team should be appointed to develop and maintain the workplace violence program. The team should have express support of the facility's CEO along with authority for the program.
c. Security staff should have a clearly defined role in the HCF's workplace violence program. Security often takes the lead role in coordinating the team. The team should receive orientation and training in evaluating and responding.
d. Each HCF should establish a system such as patient record flags, electronic warning, chart tags, logbooks, or verbal census reports that identify patients and clients who may present assaultive or threatening behavioral challenges.
e. Each HCF should establish policies and procedures prohibiting the carrying of firearms and other weapons onto the facility with the exception of authorized law enforcement officers, weapons carried by the facility's security officers, and others specifically authorized, such as armored care personnel.
f. Each HCF is encouraged to post "No Weapons"–type signage at entrances to the facility.
g. Each HCF should incorporate Targeted Violence protocols into its Violence in the Workplace policy or create a separate policy for preventing and responding to targeted violence (this would include domestic violence).

REFERENCES/GENERAL INFORMATION:

– Violence Occupation Hazards in Hospitals, DHSS (NIOSH) Publication No. 2002-101, April 2002.

- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, U.S. Department of Labor Occupational Safety and Health Administration, OSHA 3148-01R, 2004.
- IAHSS Targeted Violence Guideline 02.02.01.

Approved: January 2006
Last Revised: October 2008

Preventive and Management Steps

There are three specific steps of preparation and response that organizations must implement to properly address workplace violence. The first step is to provide a reasonable level of security for the overall environment and especially to areas of probable conflict. This includes an organized security program that includes access control plans, proper physical security safeguards, enforced security policies and procedures, staff training and empowerment, and an effective critical incident response capability. To adequately plan and implement these essential elements, there must be strong commitment from top management and the board of directors to provide a high level of philosophical and management support. This support includes adequate funding of the protection program. Alan Butler, CHPA, a leading healthcare industry expert on violence prevention and mitigation, shares that effective workplace violence strategies include:

- Establishing a workplace violence prevention policy
- Establishing and maintaining security policies
- Examining and improving hiring practices
- Implementing prescreening techniques
- Conducting employee background investigations
- Encouraging employees to report threats or violent behavior
- Establishing termination policies
- Providing posttermination counseling
- Training all employees in the warning signs of aggressive or violent behavior
- Training management in threat assessment and de-escalation techniques
- Conducting formal workplace violence risk assessment
- Increasing security as needed
- Developing contingency plans
- Developing crisis and media communications plans
- Reviewing insurance coverage and verifying coverages and exclusions
- Identifying a defensive strategy

The Threat Policy

The foundation of a successful violence prevention program is the organization threat policy, which is an everyday working document. The policy should state clearly that threats of any kind are not tolerated, that the staff is responsible for reporting all threats,

and should indicate the procedures for reporting such threats. In small organizations, the Human Resources department may be the central reporting point; in larger organizations, this may be the security department's responsibility. Regardless of size, there should be a central reporting department that has responsibility for initiating follow-up actions.

In very large organizations, there may be two or three different threat policies with some limited fragmentation for reporting and follow-up. For example, there may be a policy specifically for threats to employees and another one for threats to patients, visitors, and others. It is suggested that organizations preparing threat policies seek out such policies from other organizations as a valuable resource. In general, threat policies should include the following key points:

- Zero tolerance for threats against anyone on the property
- Mandated staff reporting of threats and reporting procedures
- Responsibility for immediate response and/or investigative action (24 hours per day)
- Staff obligation to report any application or knowledge of protective/restraining order naming the property of the organization as a protected area
- Statement of confidentiality of reporting party

Response to Threats

The key to responding to violent events is having an effective system for recognizing, understanding, reacting to, and managing events as they develop and escalate.

There are two distinct types of threats in terms of response and follow-up action. The first type of threat is one in which time is of the essence and immediate response is required. The organization's critical response element should be empowered to take whatever steps are necessary to protect life and property in an immediate intervention. Take, for instance, the patient with a behavioral problem or a large group of loud and difficult visitors. The team leaders, e.g., lead physician, charge nurse, and security, can quickly huddle and decide whether to adjust the security response plan in anticipation of a potential problem.

In most situations of reported threats, there will be a window of time for planning, developing, and implementing the actions required. The degree and severity of the threat will be somewhat of a subjective judgment in terms of actions to be taken. All threats must be taken seriously. It is better to err on the side of taking too much action than doing too little too late.

Threat Response Team

There should be a specific response team that evaluates and plans actions concerning all threats. The team should comprise the security administrator, director of Human Resources, nursing administrator, and in some cases the risk manager. The coordinator or leader of this team should initially decide the team member or combination of team members responsible for the management of the threat. A minor dispute between employees, resulting in a mild threat, might be handled by the director of Human

Resources and the affected department supervisor. In the case of a threat to a patient by a person outside the organization, there would possibly be a need to involve the entire team. In some emergency situations, a team member may immediately implement preconceived action protocols relative to the specific type of threat. A typical preconceived protocol may involve the domestic violence patient who has reason to believe that his or her assailant will come to the facility to cause further physical harm. Common steps in this regard may include:

1. Removing the patient's name from the list of inpatients (specifically from the switchboard and information desk and nursing station).
2. Assigning a room away from a stairwell.
3. Restricting patient visitation.
4. Changing room location so that the patient can be seen from the nursing station.
5. Using a private duty nurse.
6. Hiring a special security officer and/or requesting law enforcement services.

In extraordinary situations, the team would develop a specific plan for the situation. There should be a definite, identified authority for increasing, modifying, and ending the specific precautions implemented.

Another common threat that presents itself is the threatened staff member. These threats are often domestic-related and require preventative steps such as escorts to and from parking areas, work shift and/or location reassignment, restraining orders, or a change in work functions.

Preventing Violence in the Workplace

All organizations need a strategy and plan to deal with workplace violence so that they can reduce the number of violent incidents and minimize the severity of these incidents to a large extent. The best means of managing workplace violence is to have a strong protection program in place that can be expanded to include specific facets of workplace violence. A program of preventing and managing workplace violence, in addition to a sound day-to-day security program, will include:

- A strong commitment from top management that preventive workplace violence is a priority both in terms of administrative and funding support
- Organization threat policy and procedures
- Staff training and education relative to staff responsibilities, early warning signs of escalating danger, de-escalation techniques, and general security awareness
- Encouraging employees to promptly report incidents and to suggest ways to mitigate or eliminate risk
- Reviewing workplace layout to find existing or potential hazards; installing and maintaining alarm systems and other security devices such as duress buttons or noise devices, cellular phones, and private channel radios where risk is apparent or

may be anticipated; and arranging for a reliable response system when an alarm is triggered

- The identification of criminal justice agencies, social agencies, and other community services as a resource to managing potential violent incidents
- Reporting of all incidents of violence
- Providing local law enforcement with floor plans of facilities to expedite emergency response or investigations
- The utilization of in-house resources such as employee health and employee assistance programs
- Setting up a system to use chart tags, logbooks, or other means to identify patients and clients with assaultive behavior problems
- Instituting a sign-in procedure with passes for visitors and compiling a list of "restricted visitors" for patients with a history of violence
- Proper screening of employee applicants
- Consistent enforcement of organization workplace rules and regulations including the facility access control policy
- Prosecution of perpetrators (serves as a deterrent and holds perpetrators accountable)

The NHS has put together a zero-tolerance initiative that requires trusts and health authorities to have systems in place for recording incidents of violence and aggression and to set targets for reducing the event of physical assaults against staff.

Training

Fundamental to any workplace violence prevention strategy is conflict resolution training. However, no violence prevention education program is effective unless it gains employee involvement and support. There are many types of violence prevention and aggression management training programs. Ranging in length, some sessions are only an hour long, while other programs can extend to multiple full-length days. Some are lectures delivered by internal staff, while others are interactive programs conducted by outside contractors. Some new employees participate right away, others not until months (or years) after their hire. Only a few are tailored to the specific healthcare environment in which participants work. In short, there is little consistency in the conduct, content, and applicability of these programs, which are major contributing factors to their general ineffectiveness in violence prevention. However, all employees should receive training on the management of aggressive behavior and include physicians, volunteers, clerical staff, clergy, and contract employees of all job categories. By training together, staff members gain a better understanding of everyone's role and develop a strong sense of teamwork, which will enhance communication and consistency in program administration. Medical staff will be more comfortable calling on security, for example, when they feel threatened or uncomfortable, and security will feel they are part of the patient care team.

Baystate Health, a three-hospital, multiple treatment center system in Massachusetts with nearly 10,000 employees, introduced new training for nurses, physicians, and care providers about how setting boundaries can be reconciled with customer service to help prevent workplace violence. The boundary-setting training teaches staff that it is okay not to share information or to say that while they are glad to be helpful, they do not have the requested information. Another major point is that customer service does not include accepting disrespect or aggression. If staff encounter abusive behavior, they are taught to express the desire to help but to be firm that the person asking for help must be respectful. The training also advises nurses to listen to their own bodily clues as a way to determine when a boundary needs to be set.[22]

Before they can recognize and respond to escalating tension in their work environment, however, healthcare staff must understand the basics of an effective response. Training should focus on evaluating each situation for possible violence when they enter a room or begin to deal with a patient or a visitor. If a violent situation is sensed, healthcare workers should never isolate themselves with the patient (or visitor). In these cases, staff should practice the concept of keeping an open exit pathway—never allowing a patient or visitor to stand between them and the door. If a situation cannot be diffused quickly, the care provider should be trained to remove himself/herself from the situation and call for assistance.

While there is no program that can train healthcare staff to handle every type of violent situation, most healthcare security administrators agree that it is possible to train them on the commonalities that occur in these situations. Most crisis intervention training programs include these lessons and help the employee look for physiological clues that an individual's aggressive behavior might escalate. Clues, for example, can be expressing anger and frustration verbally, nonverbal body language such as sweating or a lack of eye contact, or signs (smell) of alcohol or other drug use. Psychological skills needed by healthcare employees to manage conflict and aggressive situations include:

- *Understanding personal feelings about conflict*. Recognizing "triggers"; words or actions that immediately provoke an emotional response like anger.
- *Empathic listening*. Acknowledging the other person's feelings and going beyond hearing just words. Attempting to understand what is really being said by asking reflective questions, and using both silence and restatements. Not being judgmental of the individual's feelings. They are real—even if not based on reality—and must be attended to.
- *Generating options for resolving conflict*. Many people, even trained healthcare professionals, can think of only two ways to manage conflict—fighting or avoiding the problem. Working to resolve disagreements and discussing the pros, cons, and consequences are very useful tools. Matching threats or giving orders is discouraged.
- *Behaviors to avoid*. Shouting, sarcasm, power struggles, aggressive body language, profanity, degrading remarks, and disrespect. Violence and disrespect breed violence and disrespect. It is important to present in a nonthreatening, nonviolent manner

and avoid any behavior that may be interpreted as aggressive; for example, moving too fast, getting too close, touching, or speaking loudly.
- *Positive behavior and interaction techniques.* Intermittent eye contact, relaxed body posture and gestures, maintaining a calm demeanor, and listening. Maintaining a calm and caring attitude. The response will directly affect the individual.

As incidences of gang-related violence have increased, there has been an effort to teach healthcare professionals ways to avoid such conflicts. In 2006, the New Jersey Hospital Association teamed up with the New Jersey State Parole Board to develop a training program to teach hospital employees across the state how to recognize potential street gang affiliation through signs, colors, marking, and language. More than 20 hospitals across the state have taken advantage of the gang awareness program since its inception.[23]

Armed with that information, healthcare staff can build the confidence to take ownership in their role as a safety specialist as well as caregiver or caregiver support and work with other staff to manage the situation.

Legislative Action

In 1995, the state of California introduced the Hospital Safety and Security Act (AB 508) to decrease the amount of violence being committed against hospital employees. The Act requires all acute care hospitals in California to conduct a security and safety assessment and to use the findings to develop a security plan with specific performance measures to protect personnel, patients, and visitors from aggressive or violent behavior. The plan includes specific security components such as[24]:

- Environmental controls to include physical layout and design, use of alarms and other physical security safeguards
- Staff-to-patient ratios
- Availability of security personnel who are trained in the identification and management of aggression and violence
- Specific violence prevention and response policies to include aggression and violent behavior management training
- Individual or committee responsibility for development of the security plan
- Reporting requirements

Hospitals in California are expected to track violent incidents that occur at the facility and analyze for trends as part of an annual quality-improvement process. In 2002, the University of Iowa's Injury Prevention and Research Center studied the hospital employee assault rates and violent events before and after the enactment of the AB508 and found the policy to be an effective method to increase the safety of healthcare workers.[25]

In 2009, the state of New Jersey introduced the "Violence Prevention in Health Care Facilities Act." Similar to AB 508 in California, the revised state statute requires hospitals, nursing homes licensed by the New Jersey Department of Health and Senior Services,

state and county psychiatric hospitals, and state-owned developmental centers to have in place a detailed, written violence prevention plan. The legislation declares that violence is an escalating problem in many healthcare settings in New Jersey and across the nation, and although violence is an increasing problem for many workers, healthcare workers are at a particular high risk.

The states of Washington and Tennessee have also developed similar legislation to help assure patients, visitors, and care providers of a reasonably safe and secure work environment.

Prosecuting Perpetrators

Holding perpetrators of violence accountable for their action has become a focus of much attention from US and Canadian nurse and physician associations, the NHS, and many other entities. In 2008, tough new legislation was introduced in the United Kingdom, called the Criminal Justice and Immigration Act of 2008. In short, anyone causing actual violence in the healthcare setting could face fines of up to £1,000 and sentencing guidelines instruct judges that violence against care providers should lead to longer prison sentences.

The MNA introduced a bill that addresses the issue of workplace violence by increasing criminal penalties for those who commit assaults against care providers. The nurses association is ramping up a legislative campaign to criminalize assaults on healthcare workers in the line of duty—similar to a Massachusetts state law that protects ambulance crews, firefighters, and other public employees. It is also pushing a proposal that would require hospitals to identify factors that contribute to violent incidents and minimize them.

The West Virginia Hospital Association along with the state chapter of the American College of Emergency Physicians lobbied successfully to get the West Virginia Health Care Protection law into effect. The legislation places stiffer penalties on anyone who commits a violent act against any healthcare professional. The law applies to healthcare workers in hospitals as well as care providers in county or district health departments, long-term care facilities, physician offices and clinics, outpatient treatment facilities, and home health settings.

An ardent complaint of the Ontario Nurses Association with new legislation in Canada that requires employers to develop violence and harassment protocols and to take "reasonable precautions" to protect workers from domestic violence that may occur at work is that nothing in the legislation outlines punishment.

Orderlies at Perth's (Australia) Sir Charles Gardiner Hospital organized a strike over the issue of violent patients, demanding better legal support and training to deal with violent situations. At the heart of the bargaining was better training to deal with aggressive and violent patient situations. At the time of the strike, the employees were provided only 2 hours in how to deal with and restrain violent patients.[26]

Figure 19-3 shows a sample language used in signs posted in patient rooms at a Jacksonville, FL, hospital.

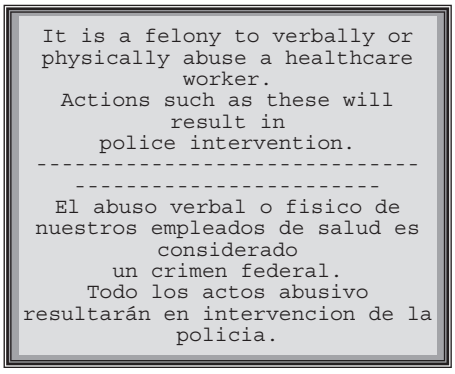

FIGURE 19-3 Sample violence signage language.

Restraining Orders

In dealing with targeted victim situations, the utilization of court-ordered restraining orders is a fairly common safeguard. These orders may be available to the individual and to the organization. The restraining order has two specific purposes. One is to prohibit specific conduct by a specific individual and to order the individual to maintain a specific distance from the victim. In some cases, an organization may be able to obtain a restraining order without legal action. In these cases, the organization must prove that the conduct caused the individual to believe there was a threat of death or serious bodily injury. In all cases, a restraining order is only one element of managing a potential incident and should not be overly relied on in the course of business. Some of the most major crimes of workplace violence have been perpetrated by individuals who were under a restraining order. The IAHSS has established a basic healthcare industry guideline for addressing the issue of targeted violence.

IAHSS—HEALTHCARE BASIC SECURITY GUIDELINE, #02.02.01

Targeted Violence
STATEMENT: Healthcare facilities (HCFs) will develop a policy and procedure to provide an appropriate response to manage targeted violence, through the provision of safety/security measures. Procedures are required to manage the risk of violence against a specific target, usually an individual, individuals, or group and should include a threat assessment component.

INTENT:

a. Definition: Targeted Violence—a situation where an individual, individuals, or group are identified at risk of violence, usually from another specific individual such as in cases involving domestic violence. Often the perpetrator and target are known prior to an incident.

b. The three major functions of a threat assessment program are identification of a potential perpetrator, assessment of the risks of violence posed by a given perpetrator at a given time, and management of both the subject and the risks that he or she presents to a given target.
c. The HCF policy should identify responsibility of staff to report a risk of targeted violence as quickly as possible so that the threat can be assessed and preventative measures can be initiated as required.
d. Mechanisms should be in place to encourage reporting of threats where personal safety may be at risk.
e. All identified threats of targeted violence will be treated seriously and assessed through a process that analyzes the threat and recommends the appropriate level or type of intervention to be initiated.
f. Security should play a lead role in the threat assessment process and design of any required safety plan. Security staff should be fully informed of all targeted violence situations and have a defined role in the procedure.
g. HCF staff involved in the process of assessing the threat to determine the appropriate level and type of intervention required should receive training for this role.
h. Where warranted by risk in specific circumstances, HCFs should employ preventative measures to protect the potential target. Measures could include:
    1. If a patient, no information/privacy block on patient information system or, if a worker, protecting information related to work location.
    2. Communicating with security to provide information.
    3. Information to be shared with workers or other individuals in the area as appropriate.
    4. Involvement of staff or family members for support as necessary.
    5. Consideration of moving the person at risk to another care area or another site.
    6. Restriction on visitors or access to the potential target, including lockdown of the area if required.
    7. In appropriate circumstances, notify law enforcement.
    8. Document risk and preventative measures initiated. These measures should be considered, in sum or in part, on the basis of specific circumstances. The level of threat will determine the scope and timing of the response.
i. The safety of the potential victim will be of paramount concern at all times.

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Approved: July 2008
Last Revised: October 2008

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