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WORKPLACE VIOLENCE INTERVENTIONS
Used by Home Healthcare Workers

An Integrative Review

The threat of workplace violence (WPV) is a significant occupational hazard for home healthcare workers (HHCWs). The purpose of this integrative review is to examine WPV interventions used by HHCWs to stay safe while working in the patient's home and community. The methodology used was the integrative review by Whittemore and Knafl (2005), which allows for inclusion of experimental and non-experimental research, reflecting the state of the science on interventions used by HHCWs to mitigate and prevent WPV. A total of 17 articles pertained to interventions used by HHCWs. Interventions were further categorized by WPV Type. There are a number of interventions used for Type I and II WPV. However, interventions for Type III WPV are minimal and interventions for Type IV WPV are obsolete. Safety and health training were shown to be significant in increasing HHCWs' confidence and knowledge about WPV prevention. Researchers demonstrated safety and health training are effective in promoting a safe work environment and reducing incidents of WPV. This review begins to fill the gap in the literature on interventions used by HHCWs to mitigate and prevent WPV.

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*E*xposure to workplace violence (WPV) resulting in nonfatal occupational injuries is four times greater in healthcare than in private industry alone (Occupational Safety and Health Administration [OSHA], 2015b). Defined as the "act or threat of violence ranging from verbal abuse to physical assaults directed toward persons at work or on duty" (National Institute for Occupational Safety and Health [NIOSH], 2018, para. 1), WPV includes acts of incivility, bullying, sexual harassment, and verbal and physical aggression (Gillespie et al., 2015). Workplace violence is recognized as a serious occupational hazard in the healthcare sector by both professional and regulatory organizations (American Nurses Association [ANA], 2015; OSHA, 2015a).

Workplace violence is complex for home healthcare workers (HHCWs). It comes from many different sources such as co-workers, employers, patients, family members, visitors, and other individuals in the community. To better understand the sources and causes, develop interventions,

and identify the relationship between the victim and the perpetrator, researchers organized WPV into four types (California Occupational Health and Safety administration, 1995; University of Iowa Injury Prevention Research Center [UIIPRC], 2001). Type I is criminal intent—the perpetrator is usually someone in the community, has no relationship with the organization, and commits a crime such as robbery while the HHCW is entering/exiting the home or vehicle or vandalizes the HHCW's vehicle. Type II is related to violence perpetrated by a patient, their family member, or visitors against an employee who is providing care in the home. Type III is related to violence perpetrated by an employee or employer against an employee and usually involves acts of incivility and bullying. Type IV, known as intimate partner violence, stems from personal relationships where the employee's significant other threatens or assaults them while at work (UIIPRC).

Background

In healthcare, the greatest source of WPV is the patient (Type II WPV). However, HHCWs have a greater chance of experiencing Type I WPV from the surrounding community such as robbery, car theft, and vandalism (Campbell et al., 2014; Hanson et al., 2015; Phillips, 2016; Ridenour et al., 2019). Although, HHCWs primarily work alone, they can be exposed to Type III WPV through uncivil and bullying behaviors from co-workers such as gossiping, schedule manipulations, and random changes in patient assignments (Ridenour et al.). Type IV WPV may be easier to commit at the private home of a patient versus a public institution such as a hospital. Unique characteristics associated with WPV among HHCWs include working alone, lack of social support from co-workers, exposure to guns and other weapons, care of patients with complex psychosocial and physical conditions, and working in high-crime neighborhoods (Campbell et al.; Hanson et al., 2015; Kendra et al., 1996; Phillips; Ridenour et al.). Researchers have also found lack of communication between home care agencies about patient risk information increases the risk of WPV for HHCWs (Byon et al., 2016).

In 2016, there were 20,030 occupational injuries related to WPV involving days away from work for the Healthcare and Social Service sector. Of these injuries, 930 were experienced by HHCWs (Bureau of Labor Statistics [BLS], 2016). Unfortunately, BLS data underestimate the extent of WPV in the home care setting primarily due to underreporting and the common belief among HHCWs that violence is part of the job (Hanson et al., 2015; Nakaishi et al., 2013; Quinn et al., 2016). Therefore, rates of WPV against HHCWs are best described across several research studies. Nakaishi et al. (2013) conducted a mixed method study to examine sexual harassment and WPV against HHCWs. Researchers found HHCWs reported incidents of workplace physical violence (44%), psychological abuse (65%), sexual harassment (41%), and sexual violence (14%). In a study of 1,214 HHCWs about WPV and the negative outcomes associated with WPV, HHCWs reported exposure to verbal aggression (50.3%), physical assault (23.6%), and sexual harassment (25.7%) (Hanson et al., 2015). More recently, Karlsson et al. (2019) found HHCWs experienced verbal abuse more often than physical abuse (22% vs. 7.4%, respectively).

For HHCWs, the worksite is the private homes of patients, which can be located in unfamiliar and high-crime neighborhoods and the threat of violence is a significant occupational hazard. What's even more concerning is that WPV prevention training for HHCWs is limited or obsolete. Policies and procedures are underdeveloped or nonexistent, and HHCWs lack the benefit of immediate co-worker support with disruptive behaviors from the patient, patient's family, and people in the community (Campbell et al., 2014; Gross et al., 2013; Hanson et al., 2015; Nakaishi et al., 2013).

Traditional safety measures and interventions such as video surveillance, security guards, controlled entry practices, metal detectors, and co-worker support are used to manage exposure to WPV and improve safety for healthcare workers in the hospital setting (Campbell et al., 2014; Phillips, 2016). However, these safety measures and interventions are not feasible in the home care setting and any access to similar strategies are impractical, delayed, or limited at best (Byon et al., 2016; Campbell et al.; Phillips). Therefore, it is important to identify interventions and resources that can be used to mitigate and prevent WPV against HHCWs.

The purpose of this integrative review is to examine available evidence on interventions and resources used by HHCWs to stay safe while conducting home visits. The knowledge from this review can assist employers, employees, and stakeholders in understanding the importance of interventions and resources for HHCWs and to

inform future policy development for the mitigation and prevention of WPV against HHCWs.

Methods

The method used to conduct this integrative review was the five stages for conducting an integrative review by Whittemore and Knafl (2005). The five stages include: problem identification, literature search, data evaluation, data analysis, and presentation. Quality appraisal of articles were conducted using the Fineout-Overholt et al. (2010) levels of evidence.

Literature Search

Inclusion and exclusion criteria. Runyan et al. (2000) identified interventions for WPV prevention organized by WPV Type. Since 2000, there has not been a review of literature identifying WPV interventions using the WPV Typology. Inclusion criteria consist of articles published between 2000 and 2019, in English, that discussed interventions and resources used by HHCWs to mitigate and prevent WPV. Exclusion criteria included articles focused on healthcare workers employed by institutional settings such as hospitals.

   Search outcome. Articles selected for this review were identified by PRISMA guidelines (Supplemental Digital Content 1, available at http://links.lww.com/HHN/A134). In coordination with a health sciences librarian (E.K.), database-specific search strategies were developed, including a combination of subject headings (MeSH, CINAHL, and Emtree) and keywords. The following key search terms and words were used: home healthcare, home health aides, violence, aggression, sexual harassment. Search strategies can be reproduced for Embase, CINAHL, PsycINFO, Agricultural and Environmental Science, NIOSHTIC, and NIOSHTIC-2 databases. Databases searched included PubMed/MEDLINE, Elsevier Embase, EBSCOhost CINAHL, PsycINFO, NIOSHTIC, and NIOSHTIC-2. There was a total of 1,332 results deduplicated in EndNote using the Bramer et al. (2016) method, resulting in a total of 1,127 articles, which were screened using the Rayyan screening tool, designed to assist with the initial screening of titles and abstracts for literature reviews (Ouzzani et al., 2016). Two articles were identified using the ancestry approach, yielding 1,129 articles for the initial review. After screening, 182 articles were included for a full review. Of these, 17 articles were included in this integrative review.

In another study, check in/out was embraced and reassured the employees someone would come looking for them if they did not check in/out at a prearranged time.

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Results

Data Evaluation

Articles in this review were published from 2000 to 2017, with 15 articles published in the United States and 2 articles published internationally. There are 11 qualitative studies and 6 quantitative studies, including 1 randomized control trial. Study methods included case control, cross-sectional surveys, and expert opinion (Supplemental Digital Content 2, available at http://links.lww.com/HHN/A135).

Data Analysis

There were four overarching themes: 1) Safety and health training; 2) Assessment of home visit safety; 3) Tools and protective characteristics; and 4) Violence prevention policies. Supplemental Digital Content 3 (available at http://links.lww.com/HHN/A136) displays interventions identified in each overarching theme and are categorized using the WPV Typology. The majority of articles discussed a combination of primary, secondary, and tertiary interventions. Most of the interventions are relevant to Type I and II WPV. Only one article addressed Type III. There were no interventions identified for Type IV WPV.

Safety and Health Training

The majority of articles discussed the importance of safety and health training as an essential intervention. Although HHCWs cannot control their

environment, given the appropriate education and training, they should be able to respond to potential threats in the environment and implement interventions for personal safety (Arshad et al., 2000; Beaver, 2014; Brilliant et al., 2004; Fazzone et al., 2000; Fitzwater & Gates, 2000; Glass et al., 2017; Morris et al., 2004; Morris & Yaross, 2013; Sylvester & Reisener, 2002; Vladutiu et al., 2016).

Safety committees and advisory boards. To devise a comprehensive safety and health training intervention, safety committees and advisory boards inclusive of HHCWs, clinical coordinators, and clinical and security managers were established. Sylvester and Reisener (2002) wanted to promote a culture of safety. Therefore, a performance improvement safety committee was established to assess safety concerns, develop interventions to decrease safety risks, and provide safety education to HHCWs. An important function of members of safety committees and advisory boards is to help develop safety and health training content, safety manuals, and safety tip sheets for HHCWs (Glass et al., 2017; Morris et al., 2004; Morris & Yaross, 2013; Sylvester & Reisener, 2002). Morris et al. (2004) found the safety committee was pivotal in developing an escort service program for keeping HHCWs safe in the community.

Provision of training. Some researchers found training was not mandatory and was provided to HHCWs during orientation and annually (Beaver, 2014; Fazzone et al., 2000; Fitzwater & Gates, 2000; Vladutiu et al., 2016), although others found training was mandatory and provided during orientation and annually (Morris & Yaross, 2013). Fazzone et al. (2000) identified an inequity in education and training among professional staff (i.e., nurses, therapists), who received training, and support staff (i.e., home care aides), who did not receive training. Vladutiu et al. (2016) found 71.7% of respondents reported receiving training within 3 weeks of new hire, annually (n = 76.2%), and ongoing (n = 66.1%). Vladutiu et al. reported 38.9% of home health and hospice branches did not offer training to HHCWs and 33.5% of HHCWs did not receive training.

Training content. Safety and health training included modules about topics related to the home care environment such as detecting danger in the home and community, home healthcare violence, detecting dangerous situations, self-defense and personal safety, duress word procedure, verbal conflict resolution, identifying illegal drugs and drug paraphernalia, body language interpretation, incident reporting/debriefing, and dealing with difficult people (Beaver, 2014; Brilliant et al., 2004; Distasio, 2000a, 2000b; Fazzone et al., 2000; Fitzwater & Gates, 2000; Mathiews & Salmond; 2013; Morris et al., 2004; Morris & Yaross, 2013; Glass et al., 2017; Sylvester & Reisener, 2002; Vladutiu et al., 2016). Beaver (2014) recommended safety and health training include recognizing verbal abuse, signs associated with impending violence, and deescalation techniques. According to Morris and Yaross (2013), safety and health training included guest lectures, and discussions about personal, driving, and weather safety, and reviewing safety policies and procedures. Glass et al. (2017) included training content on defining work boundaries, identifying warning signs for unsafe workplaces, how and where to access support and resources, and responding safely to physical and sexual harassment. Fazzone et al. (2000) asserted training content was irrelevant to the home care setting.

Training on communication. Fitzwater and Gates (2000) recognized communication among peers, managers, patients, and providers as critical to HHCW safety. Communication about patients and safety issues were perceived as effective in keeping HHCWs safe (Fitzwater & Gates, 2000). Check in/out was used by HHCWs to communicate their whereabouts with the employer (Arshad et al., 2000; Fazzone et al., 2000; Malone, 2001). However, some HHCWs believed the "check in/out system" was a way for the employer to micromanage employee work activities. Therefore, HHCWs referred to the check in/out system as a "checkup" and was not helpful in reducing violent exposures (Fazzone et al.). In another study, check in/out was embraced and reassured the employees someone would come looking for them if they did not check in/out at a prearranged time (Arshad et al.). Glass et al. (2017) included training on assertive communication and documentation, verbal assertiveness, and boundaries using "I" statements.

Technology used to deliver training. In a randomized control trial, researchers examined the effectiveness of a WPV prevention training intervention among female HHCWs (n = 255) using computer-based training (CBT) only (n = 126) and CBT plus peer support (n = 129) at baseline, 3 months, and 6 months (Glass et al., 2017).

Knowledge of WPV significantly improved in both groups, confidence in responding to WPV was significantly greater in the CBT plus peer group, and the incidence of all forms of WPV and harassment (i.e., workplace aggression, verbal aggression, WPV, and sexual harassment) decreased significantly in both groups. Stress, depression, and sleep were measured using the Copenhagen Psychosocial Questionnaire (COPSOQ II) and burnout was measured using the Copenhagen Burnout Inventory. There were no significant changes for negative health and work outcomes such as stress, depression, sleep, and burnout experienced by HHCWs. All participants reported a decrease in verbal aggression and sexual harassment over time (Glass et al.). In addition, Vladutiu et al. (2016) found CBT was a primary modality used to deliver safety and health training to HHCWs.

Deescalation and self-defense training. Deescalation technique is a clinical intervention involving the use of self to defuse an escalating patient and to prevent the progression of violence. Deescalation involves reducing stress, providing respect, acknowledging to the person that you recognize they are upset, and use of nonverbal and verbal cues to help the person gain control (Distasio, 2000b). Beaver (2014) recommended verbal deescalation techniques be provided and used for management of angry patients. Glass et al. (2017) included content on how to deescalate and escape a threatening situation that included the four "R's" (reassure, reorient, redirect, and repeat).

Use of deescalation techniques should be used when the patient is in the preassaultive phase (Distasio, 2000b). HHCWs should be educated and trained to recognize preassaultive behavioral indicators exhibited by patients and individuals in the community. Also, HHCWs should be taught to leave the patient's home when patients are imminently dangerous (Distasio, 2000a, 2000b). Morris and Yaross (2013) trained HHCWs on self-defense techniques using interaction situations. Fazzone et al. (2000) found self-defense training did not meet staff needs. Vladutiu et al. (2016) reported the majority of training content focused on reporting a violent event and factors predicting violence and aggression but lacked self-defense.

Incident reporting. Several articles discussed the importance of reporting violent incidents that occurred in the community and the patient's home. Morris and Yaross (2013) recommended establishing guidelines for incident reporting and conducting follow-up analysis to determine "lessons learned" and to improve safety and health training. Fazzone et al. (2000) discussed recommendations for management to support HHCWs in reporting WPV incidents by providing clear guidance and compassion when an assault or violent incident is reported. However, HHCWs did not always report incidents to their employers because WPV was not clearly defined, there was no process for reporting an incident, fears of accusations of incompetence, and WPV was viewed as part of the job (Beaver, 2014; Fazzone et al., 2000; Fitzwater & Gates, 2000).

Incident debriefing. Debriefing sessions occur after management has knowledge of a HHCW being victimized or witnessing violence while at work. Victims are provided follow-up support and an opportunity to discuss their feelings in a supportive environment and referred to specialists for psychological and physical care (Fazzone et al., 2000). During debrief sessions, the victim should be provided with feedback on helpful strategies to mitigate and prevent assaultive and violent behaviors against them (Morris et al., 2004; Morris & Yaross, 2013).

Assessment of Home Visit Safety

Interventions and resources used to assess the worksite for HHCWs include conducting a risk assessment, developing protocols, reviewing incident reports, and collaborating with community liaison such as local police officers and experts in crime and violence (Arshad et al., 2000; Beaver, 2014; Lundrigan et al., 2010; Mathiews & Salmond, 2013; McPhaul et al., 2010; Morris et al., 2004; Morris & Yaross, 2013).

Screening and risk assessment tools. Risk assessment tools can be used to estimate home visit risk, to make effective safety decisions during the home visit, and provide an identified safety concern to other HHCWs. Findings related

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to the risk assessment tool can be shared with the agency or HHCW providing care to the patient during hand-off report (Arshad et al., 2000; Lundrigan et al., 2010; Mathiews & Salmond, 2013; McPhaul et al., 2010). Likewise, when intake screening identifies a potential risk of admitting a violent patient, the chart should be flagged, and the supervisor and assigned HHCWs notified (Distasio, 2000a, 2000b).

Arshad et al. (2000) developed a risk assessment protocol and a safety schedule, which encompassed a review of emergency department notes prior to conducting home visits. For some patients, additional information was gathered about their surrounding community. The protocol considered potential risks posed by the patient, other individuals living in the home, and potential risks of the community. Lundrigan et al. (2010) developed a risk assessment screening tool that can be used by HHCWs for conducting home visits in urban and rural communities. The Western Health Risk Assessment Screening Tool (WHRAST) is used with a check in/out system and the buddy system. It assists HHCWs with identifying and managing potential risks for WPV (Lundrigan et al., 2010).

McPhaul et al. (2010) developed three risk assessment scales that are specific to home care: the Home Visit Risk Scale (HVRS), personal safety decision scale (PSDS), and workplace violence safety climate (WVSC). The HVRS includes questions about the number of encountered risks associated with violence in home care. The PSDS included questions about decisions the HHCWs make regarding their own safety. The WVSC included questions about employer safety strategies. The HVRS and the WVSC had Cronbach's alpha of 0.77 and 0.86, suggesting reliability of the scales to assess risks for violence in home care and the importance of employer provided strategies for decreasing WPV incidents in the home care setting. Unfortunately, the PSDS was found to have low reliability with a Cronbach's alpha of .58, which resulted in elimination of this scale.

Mathiews and Salmond (2013) identified the need for a comprehensive workplace protection intervention that included activities before, during, and after the visit. Prior to the first visit, a prevention risk assessment and violence identification should be completed, and a risk management plan developed. The Protection Matrix Risk Assessment and Management tool was developed to assess home visiting risk prior to the first visit. This tool included five questions with yes or no answers which designated risk to the red zone (i.e., high risk), the yellow zone (i.e., moderate risk), or the green zone (i.e., low risk). Once a zone is designated red, yellow, or green, an intervention can be planned for the home visits. Home visits deemed unsafe are declined by the manager, intake nurse, or the HHCW. When a visit is declined, the manager determines if the patient can be cared for in a controlled setting such as the hospital or an outpatient clinic where resources are readily available (Mathiews & Salmond, 2013).

Protocols. The development of a suicidal and homicidal protocol can be used as an intervention by both management and HHCWs to assist with decision making when patients threaten the safety of themselves and/or HHCWs. A suicidal and homicidal protocol should guide activities implemented by management and HHCWs, and may include consulting a psychiatric specialist for a hands-on patient evaluation and providing recommendations to the agency and the HHCW (Distasio, 2000b).

Tools and Protective Characteristics

Gadgets for HHCWs. Gadgets such as mace, pepper spray, and weapons are not routinely supported for protection from violence. Most often, the perpetrator has more experience and comfort with them than the HHCW and can use them against the HHCW during an altercation (Malone, 2001). Gadgets require skill and practice, something most HHCWs don't have. The only time a gadget should be used is when the HHCWs has had training and does not hesitate to quickly and aggressively use it when provoked (Malone).

Lifelines for HHCWs. Cell phones, pagers, and personal alarms are considered "lifelines" (Beaver, 2014; Brilliant et al., 2004; Malone, 2001). Cell phones should be kept in the HHCWs' pockets at all times and programmed to dial 911. Cell phones should be provided by the employer and convey to the HHCWs that the employer cares about their safety (Fazzone et al., 2000; Morris & Yaross, 2013).

Characteristics for personal safety. HHCWs should trust and rely on their internal instinctive cues to make safety decisions (Beaver, 2014; Distasio, 2000a, 2000b; Fitzwater & Gates, 2000). Most perpetrators look for "easy" victims and situations. Therefore, HHCWs must make it inconvenient for a perpetrator to victimize them by staying calm and confident (Malone, 2001). HHCWs should avoid a submissive posture, instead stand straight, head upright, arms swinging, wear flat shoes with good traction, and take confident strides (Malone). Other characteristics that played a key role in keeping HHCWs safe are self-reliance, self-motivation, flexibility, and self-assurance about their own personal judgment (Fazzone et al., 2000).

Preparedness, awareness, and avoidance. HHCWs must be prepared, aware, and know when to avoid a potentially dangerous situation (Beaver, 2014; Brilliant et al., 2004; Distasio, 2000a, 2000b; Fazzone et al., 2000; Fitzwater & Gates, 2000; Malone, 2001). Being prepared begins with the appropriate mind set, meaning the HHCW must rehearse how they will respond in a "what if" situation given the worst-case scenario (Morris & Yaross, 2013). Part of being prepared includes management and employee participation in WPV violence prevention drills in case a threatening situation arises (Browning et al., 2013).

In training sessions, HHCWs must be taught through visualization to believe and see themselves responding to a violent incident with a positive outcome and that nothing will keep them from surviving the incident (Morris & Yaross, 2013). Awareness is the first defense, meaning all HHCWs need a high index of suspicion while working in the home care environment. Avoidance is a result of awareness and requires knowledge of dangerous situations and personal safety tips to avoid danger (Morris & Yaross).

Violence Prevention Policy
Policies to assist with preventing WPV. Comprehensive safety policies and procedures specific to home care must be developed, implemented, and evaluated several times yearly (Fazzone et al., 2000). Arshad et al. (2000) proposed to develop a policy on risk assessment to identify possible risks from the patient, other individuals living in the home, and individuals living in the community. Likewise, Mathiews and Salmond (2013) found that providing a safe environment free from known hazards requires assessment of unknown hazards

through risk assessments that further support the need for policy development.

There are limited policies and procedures to protect HHCWs against Type IV WPV, known as intimate partner violence. According to Gross et al. (2013), researchers found only 3 (7.5%) of the 40 agencies in their study had policies and procedures to protect HHCWs from intimate partner violence while at work. There is a dire need for a policy to standardize and centralize a process for collecting and analyzing data for incidents of violence and threats to personal safety. Policies should be developed for mandatory safety and health training, provided to HHCWs, and specific to home health situations (Fazzone et al., 2000; Glass et al., 2017; Mathiews & Salmond, 2013; Vladutiu et al., 2016). Researchers who investigated the effectiveness of safety and health training proposed to implement a policy to make safety and health training a mandatory requirement for the patients and their families prior to employing HHCWs (Glass et al.).

Discussion
There are a variety of interventions that could be used to mitigate or prevent Type I, II, and III WPV against HHCWs, but interventions for Type IV WPV are lacking. There was one intervention shown to be effective in reducing WPV incidents against HHCWs, safety and health training. Safety and health training was one intervention shown to be effective in reducing WPV incidents against HHCWs. While this alone is not enough, it is an essential step in promoting awareness and safety while conducting home visits. Developing, implementing, and enforcing relevant policies for conducting safe home care visits are equally important.

Safety and Health Training
Researchers have demonstrated safety and health training can improve knowledge, confidence, and promote safety during home care visits (Glass et al., 2017). Both regulatory and professional organizations have published the importance of addressing WPV with the use of safety and health training (ANA, 2015; OSHA, 2015a). In an attempt to address WPV, OSHA (2015a) published a set of voluntary guidelines for preventing WPV against all healthcare workers, including HHCWs. These guidelines highlight the need to increase employee knowledge and awareness of WPV through training.

The Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers recom-

mend employers provide WPV prevention programs that include safety and health training for healthcare and social service workers (OSHA, 2015a). Safety and health training that is provided to HHCWs should be tailored to the population they serve, their identified occupation, and the workplace environment.

The ANA (2015) published a position statement addressing incivility, bullying, and WPV with recommendations for primary, secondary, and tertiary interventions that can be used to mitigate and prevent the occurrence of violence against healthcare workers. For WPV, primary prevention focuses on the need for employees to learn how to anticipate, prevent, and respond to a crisis. Therefore, employees should actively participate in WPV prevention training and education.

Violence Prevention Policy

A variety of policies have been recommended to mitigate and prevent WPV in the home care setting. In 1996, OSHA published its first guidelines on WPV prevention in the Healthcare and Social Service Sector. These guidelines are voluntary in nature and provide recommendations for interventions that can be implemented in the home care setting. OSHA also published voluntary guidelines for WPV prevention in 2004 and 2015.

Under the Occupational Safety and Health act of 1970, General Duty Clause, Section 5(a)(1), employers have a legal responsibility to provide employees with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm to employees (Department of Labor, 1970). OSHA's voluntary guidelines fail to enforce policies to protect HHCWs who are not afforded a controlled working environment with the timely availability of support and resources. Employers have a duty to develop and implement policies to protect HHCWs from occupational hazards. It is important that regulatory agencies, such as OSHA, oversee employer policies and establish standards at the federal level to enforce laws to protect HHCWs. One example is the U.S. Congress to pass the Workplace Violence Prevention for Health Care and Social Service Workers Act H. R. 1309, charging OSHA to develop a WPV standard such that WPV prevention can be implemented and enforced nationally.

Limitations

This integrative review was conducted by one author and may be subject to bias. To mitigate bias, this review was guided by a committee of WPV experts. Limiting the search criteria to English language may have resulted in missed articles pertinent to this review. Search strategies and key terms and words may have failed to identify some articles related to interventions and resources used by HHCWs.

The majority of articles included in this review discussed safety and health training. But, there were inconsistencies related to training content, how often training should be offered to HHCWs, mandatory or nonmandatory training, and the provision of training to professional or nonprofessional HHCWs. The majority of studies did not discuss the effectiveness of the interventions. Only one article investigated the effectiveness of safety and health training for HHCWs.

Conclusion

For this integrative review, interventions were identified for HHCWs. The majority of studies discussed safety and health training as a useful and effective intervention for reducing WPV incidents and increasing HHCWs confidence and knowledge about WPV. Safety and health training are essential to keeping HHCWs safe and will equip HHCWs with the skills necessary to manage and prevent WPV effectively, versus haphazardly. Similar to other healthcare settings, verbal and physical abuse is rife in the home care setting. The lack of interventions for Type III and Type IV WPV in the home care setting is disappointing. WPV is an important topic among HHCWs and every Type of WPV can have a detrimental impact on HHCW safety. Future research studies should focus efforts on Type III and IV WPV interventions for HHCWs and WPV intervention effectiveness in the home care setting. ♠

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