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Individual, relationship, workplace, and societal recommendations for addressing healthcare workplace violence

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Abstract.
BACKGROUND: Workplace violence from coworkers, patients, and visitors is a problem affecting every occupational group in the health and social service sector [1–3]. Workplace violence is demonstrated by coworkers through bullying behaviors and by patients and visitors through physical threats and assaults.
OBJECTIVE: The purpose of this article is to highlight the special issue authors' and guest editors' recommendations for protecting healthcare workers from being victimized and incurring the negative consequences of having experienced workplace violence.
METHODS: Recommendations from the special issue were categorized and discussed in relation to the Social-Ecological Model and the prevention efforts targeting individuals, relationships, communities, and society.
RESULTS: Individual-level recommendations focused on the personal risk reduction for healthcare workers. Relationship-level recommendations addressed the problem of bullying between coworkers and physical violence derived from patients and visitors. Workplace-level recommendations discussed a multi-faceted systems approach to violence management. Societal-level recommendations centered on a universal health policy approach.
CONCLUSIONS: The use of a model such as the Social-Ecological Model can be helpful in planning violence prevention efforts in the healthcare setting.

Keywords: Healthcare, workplace violence, bullying, patient, coworker

1. Introduction

Workplace violence from coworkers, patients, and visitors is a problem affecting every occupational group in the health and social service sector [1–3]. Workplace violence is demonstrated by coworkers through bullying behaviors and by patients and visitors through physical threats and assaults. This special issue addressing workplace violence against healthcare workers begins with the issue contributors describing the problem of bullying by coworkers against nurses as it relates to prevalence, intent to leave, and quality of care. Next, authors provide various research findings and case study descriptions of violence against healthcare workers from patients and visitors, and a model for an educational intervention to reduce violence from patients and visitors is discussed. Finally, authors identify the importance of a universal violence incident reporting system and describe the environmental changes that occurred in one emergency department related to patient and visitor violence.

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Ongoing themes throughout this special issue include findings regarding the actual or potential consequences of violence including intent to leave, decreased perception of personal safety, and a decreased quality of patient care. Multiple recommendations to protect workers and reduce the negative consequences of workplace violence are also identified. The purpose of this article is to highlight the special issue authors' and guest editors' recommendations for protecting healthcare workers from being victimized and incurring the negative consequences of having experienced workplace violence. The recommendations are categorized based on the Social-Ecological Model, a framework posited by the Centers for Disease Control and Prevention as a useful framework for preventing violence [4].

2. Social-Ecological Model

The Social-Ecological Model identifies the effective prevention efforts that simultaneously target individuals, relationships, communities, and society [4]. Individual-level interventions relate to the personal attitudes, beliefs, and behaviors of each worker that may reduce the risk of being victimized. Relationship-level interventions pertain to an employee's social network of peers and friends, coworkers, and interactions with patients and visitors. The community-level interventions address the larger context in which relationships occur such as the workplace, school setting, and neighborhoods. The societal-level interventions reflect the broadest context of humanism such as social and cultural norms as well as public policies that may prevent or permit violence to occur. The following sections provide specific recommendations for each level of the Social-Ecological Model as it relates to bullying from colleagues and/or violence from patients and visitors.

3. Individual-level recommendations

Prevention measures for violence against healthcare workers can start with a reduction of individual risk factors [4]. One method to reduce personal risk when working with patients and visitors is to conduct a violence screening assessment to identify persons more likely to become violent [5,6]. Hill, Lind, Tucker, Nelly, and Daraiseh in this issue describe the P3Southwest Initial Assessment violence screening assessment tool that can be performed by a social worker or registered nurse [5]. The first component of this tool lists and classifies patients' violent events during the preceding six months in terms of specific violent acts, frequency of violent acts, and intensity of each violent act. The second component of this tool is a structured interview with the patients' families to determine "the patients' approximate level of cognitive functioning, means of communication, activity and food preferences, and level of independence with specific self-care activities". It is important for employees to be aware that these screening assessments may reduce their risk, but will not totally eliminate the risk [7].

Hill et al. as well as Bresler and Gaskell in this issue recommend the adoption of universal precautions wherein workers presume that all persons with whom they have an encounter have the potential to be violent [5,7]. The use of universal precautions can facilitate prevention of severe violent incidents even when no perceived risk is initially identified. This practice requires employees to be cognizant of their risk for workplace violence and hyper-vigilant with the goal of preventing violence. Universal precautions are demonstrated in a number of ways, for example by having a chaperone present during interactions with high risk patients and/or visitors and maintenance of a safe distance from patients and visitors unless close proximity is necessary, such as when conducting a patient physical assessment. Other precautions include ensuring that no person or object blocks the exit door if an immediate egress is warranted and enforcing visitor restriction policies [5,7,8]. When a patient is a known offender, for instance when he or she is flagged as having been previously violent when receiving patient care or as being under arrest for violent assault, it is critical that employees not interact with this individual alone. Being alone with a patient who has a previous history of violence against healthcare workers increases one's risk for being physically assaulted by that patient. Employees should have an escort when entering the patient's room or a chaperone during home care visits [9,10].

When violence from patients or visitors occurs, each employee must be proactive in preventing worsening violent behavior or future incidents of violence by being alert to detect signs that a patient or visitor is accelerating towards being violent. Signs include pacing, mumbling, and persistent staring. Intervening early can help prevent a violent event [6]. For instance, employees can ask patients or visitors, "Is there something that I can do to help you?" rather than allow patients

and visitors to become more upset about something that could be easily addressed by a healthcare worker. Healthcare workers also should be attuned to how their efforts to curb the violent situation might be ineffective or perceived as threatening [7,10]. For example, prolonged eye contact, speaking loudly, speaking with an angry tone, and standing over a patient or visitor could be perceived as aggressive, thereby worsening the volatile situation [7,11]. Monitoring the nonverbal cues displayed by patients and visitors can help to evaluate the effectiveness of de-escalation efforts. Cues such as relaxed shoulders, nodding head in agreement, and termination of pacing, mumbling, and staring indicate that efforts were effective at reducing patient and/or visitor violence.

Workers that have experienced physical violence from patients and visitors can later reflect on the incident and work with prevention experts to identify strategies to prevent future occurrences. It is important that employees recommend strategies to their supervisors so that the safety of the workplace can be strengthened to prevent future incidents [12]. Recommendations could include an enhanced notification system for alerting coworkers when a violent person is in the department, an improved procedure for responding to violent events, and a more effective process of caring for victimized workers.

Prevention or amelioration of violence at the individual level also applies when a healthcare worker has been the target of bullying behaviors by one or more coworkers. It is important that this individual develop an awareness of his or her behavioral response when confronted by a bully, particularly if it is characterized by distraction, anger, or avoidance. A severely distressful behavioral response could lead a targeted worker to act inappropriately or unprofessionally with his or her coworkers [13]. For example, the targeted worker could react against the bully by countering with bullying behaviors or by amplifying the incident so that it leads to physical violence. By recognizing his or her characteristic responses, the worker can learn to take a respite from the situation [14]. The worker can then address the negative actions of others once he or she is calm and able to do so professionally. This delayed response might mitigate further bullying behaviors.

4. Relationship-level recommendations

Individual level strategies can help a healthcare employee to deal effectively with workplace bullying, but support and commitment from the workers themselves at the relationship level is what makes prevention of bullying behaviors between coworkers most feasible. Commitment can be shown by not participating in gossip, disrespect, sabotage, exclusion, and criticism of coworkers and by intervening when witnessing these acts initiated by other coworkers. Workers can help prevent bullying behaviors by learning and using conflict resolution skills during stressful interactions with coworkers such as active listening, paraphrasing, and acknowledging the emotional impact of the discourse [13,15]. Participating in team-building exercises also helps to build strong interpersonal relationships [13].

The use of support groups and mentorship programs was found to be potentially helpful in reducing the incidence of bullying [15]. New employees can operationalize Armmer and Ball's recommendation, described in this issue, by seeking a mentor who is from their same discipline but works in another unit [15]. The mentor can provide valuable insight for understanding the nuances of the particular work culture, patient care practices, organizational policies and procedures, and any unspoken social norms. Purpora, Blegen, and Stotts, also in this issue, found a significant negative correlation between the effectiveness of peer relationships and the incidence of workplace bullying [13]. This finding reinforces the need for new employees to be oriented to and learn the rationale for any social norms that would not be discernible during a typical orientation. For example, is it expected that all staff will order carryout lunches on Fridays? New employees will not likely understand that the purpose of the Friday lunch started as a team building exercise and is now ingrained as a social norm into the workplace culture. By choosing to not order a carryout lunch on Fridays, new workers could be perceived as not wanting to be part of the team, thus increasing their risk for being bullied.

Relationship level prevention is also applicable when the risk of violence from patients and visitors is present. It is essential that workers communicate these potential dangers to their colleagues [5,6]. Allowing others to be forewarned about situations where they might be in jeopardy can reduce their violence exposure. Likewise, early involvement of protective services including onsite security officers and local police is an important step in preventing violence from patients and visitors. It is essential that healthcare workers maintain a positive working relationship with protective services [9,12]. A positive relationship will al-

low workers to tailor the response of these key personnel so that the incident is effectively mitigated and does not further escalate and end in physical injury.

5. Workplace-level (community) recommendations

Violence prevention strategies aimed at the workplace-level, which can also involve the community, require a multi-faceted approach that includes at minimum a zero-tolerance policy, education, surveillance, and program evaluation [6,9,10,12,15,16]. All workers, patients, and visitors in the organization should be educated as to the zero-tolerance policy. The policy can include a list of unacceptable behaviors and consequences to offenders when the behaviors occur. Organizational leaders must be educated and prepared to weigh the facts and circumstances of violent incidents, so that when offenses occur, corrective actions outlined in the zero-tolerance policy are leveled against patients, visitors, or employees based on the severity of the offenses [6,15,17]. Additional workplace-level strategies to further promote employee safety are conducting environmental assessments and adapting the work setting to reduce violence risk [6,12]. Adaptations include installing panic buttons, locked doors, and closed-circuit cameras [18].

Optimal violence prevention program evaluations at the workplace- or community-level include methods to review each violent incident stemming from patients, visitors, and coworkers and to analyze overall trends in the violence rates. One assessment technique is a root cause analysis process to determine why individual incidents occurred [5,7,10,19]. Another approach to assessment involves determining any trends in workplace violence, particularly with regard to enduring effects. Noteworthy trends can relate to incidence, injuries, and changes in the quality of care delivered to patients [9,13,16,19]. Certain identified trends in violence, for example the discovery that incidents are happening at shift changes or during medication rounding, need to be communicated from supervisors to employees [12,13]. Efforts to curb workplace violence, which might include policy, process, and environmental changes, also should be routinely communicated to staff so that workers will be informed and feel valued by employers [12].

6. Societal-level recommendations

Societal-level interventions can potentially have a universally positive effect toward a reduction in the violence that occurs in all healthcare settings. For example, the contributions in this issue by Ridenour, Hendricks, Hartley, Rierdan, Zeiss, and Amandus and Hartley, Ridenour, Craine, and Morrill identify a major risk factor for violence in patients who are under the influence of drugs and alcohol [9,10]. Increased community outreach programs for the treatment and reduction of alcohol and drug related disorders could reduce the incidence of this risk factor in healthcare settings. Hartley, Ridenour, Craine, and Morrill also recommend in the current issue that state legislation be passed to prevent workplace violence [9]. While state legislative advocacy that increases penalties to offenders and mandates employers to establish violence prevention programs is important, addressing workplace violence may also require that the Occupational Safety and Health Administration enact an administrative policy that clearly articulates a national standard for violence prevention programs in the workplace. Essential components of a national administrative policy are a formal written violence prevention program, policy to protect employees who report violence, management commitment and employee involvement in all aspects of a violence program, regular worksite analyses, hazard prevention and control, violence prevention and management training, record keeping, and program evaluation [20].

Workplace violence is often accepted as a cultural norm in healthcare [9,12]. It is vital to ensure that this cultural perception changes before healthcare workers enter the workforce. Students in the healthcare professions can learn in their classes about the violence they will potentially encounter in the workplace [14]. They need to be taught that violence, whether from coworkers, patients, or visitors, is not acceptable, is not "part of the job," and cannot be tolerated. A core component of the education is teaching healthcare students how to adopt practices that promote their safety, physical health, and psychological health, and educating them on their rights to a safe workplace and to appropriate care by colleagues when violence occurs. Safety and physical health can be promoted by proactively preventing physical violence and intervening when physical violence from patients and visitors occurs. Psychological health can be promoted by conducting peer defusings and group debriefings after any violence by patients, visitors, or coworkers.

7. Conclusion

Workplace violence will continue to be a problem for healthcare workers in the future. The use of a

model such as the Social-Ecological Model, which includes interventions at multiple levels, can be helpful in planning prevention efforts in the healthcare setting. Changes made at the individual and relationship level can have an immediate impact at increasing safety for healthcare workers. Workplace and societal interventions take longer to implement; however, they are likely to be significant in their impact at moderating and preventing workplace violence. Future research is warranted to evaluate the effects of individual-, relationship-, workplace- (community), and societal-level interventions for their ability to promote a workplace free from workplace violence.

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