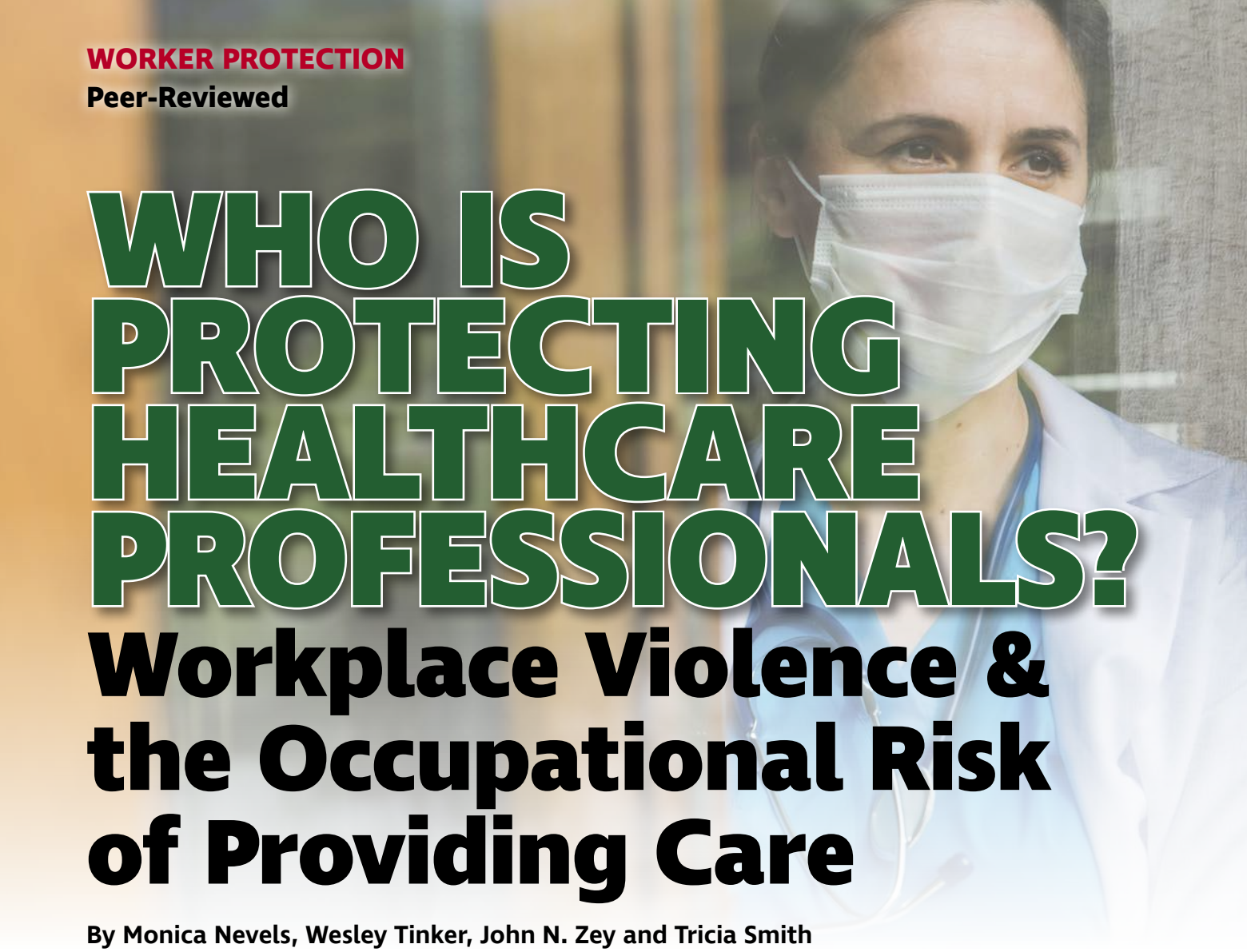

WHO IS PROTECTING HEALTHCARE PROFESSIONALS?

Workplace Violence & the Occupational Risk of Providing Care

By Monica Nevels, Wesley Tinker, John N. Zey and Tricia Smith

KEY TAKEAWAYS

- **Healthcare providers are one of the highest risk groups for workplace violence.**
- **The healthcare industry is one of the fastest growing industries in the U.S. and in need of the expertise of multidisciplinary teams that include OSH professionals.**
- **Despite efforts to push this issue into the spotlight, the tenacity of those passionate about prevention will be needed for a federally mandated rule to come to fruition.**
- **To make measurable and meaningful impact, employers must also respond to this risk as it impacts not only employees, but those they serve.**

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IN RESPONSE TO THE INCREASING NUMBER of violent incidents resulting in fatalities, injuries and lost workdays in the healthcare industry (Figure 1, p. 40), several unions and National Nurses United (NNU, 2019) petitioned OSHA for a standard to prevent workplace violence. OSHA (2020a) granted the petition on Jan. 10, 2017, which has since been on the unified agenda in the pre-rule stage with the public comment period closing April 6, 2017. Although no federal rule is currently in place to directly address this exposure, nine state OSHA plans have developed workplace violence prevention rules (OSHA, 2020a). In the past few years, OSHA has taken several actions, moving closer to a workplace violence prevention standard. Early in 2016, OSHA (2016a) published an advisory document titled "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" that updated the voluntary guidelines of 1994 and 2004. In January 2017, the public comment period opened and OSHA (2017) published an enforcement directive updating the enforcement procedures and scheduling for enforcement of occupational exposure to workplace violence. Although practitioners, labor unions and governmental agencies have conducted studies on violence in the workplace, specifically in the healthcare sector, the issues are still largely governed by use of the General Duty Clause of the OSH Act of 1970. Despite General Duty Clause citations being issued for workplace violence exposure in healthcare, the industry continues to experience one of the highest numbers of related injuries compared to all other private industries (OSHA, 2016a).

Size of the Problem

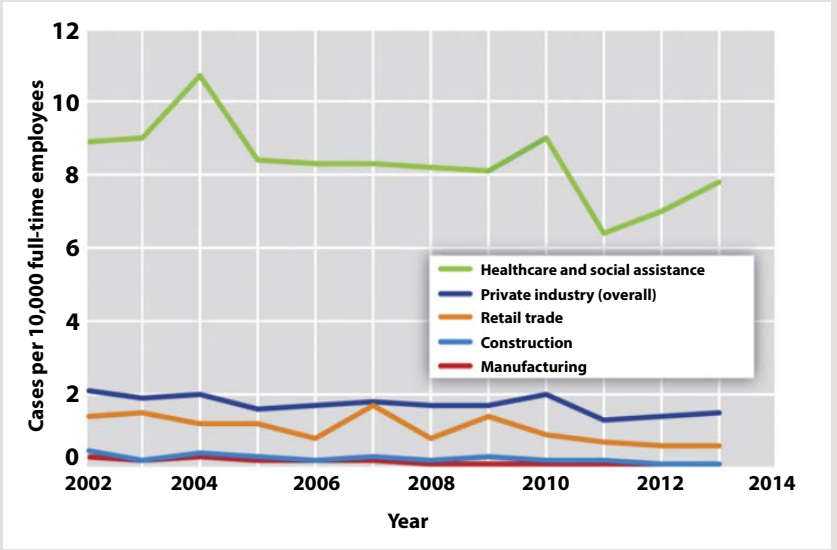
Since understanding vulnerabilities is part of improving employee safety, it is important for employers to be made aware of the scope of the problem. According to Bureau of Labor Statistics (BLS, 2017; 2019b), in 2018 alone, 16,890 workers in private industry experienced trauma from nonfatal workplace violence.

Of those victims who experienced trauma from workplace violence:

- 70% were female;
- 67% were aged 25 to 54;
- 70% worked in the healthcare and social assistance industry;
- 21% required 31 or more days away from work to recover, and 19% involved 3 to 5 days away from work.

FIGURE 1

VIOLENT INJURIES RESULTING IN DAYS AWAY FROM WORK, BY INDUSTRY, 2002-2013



Note. Adapted from "Workplace Violence in Healthcare: Understanding the Challenge," by OSHA, 2015.

In that same year, 500 U.S. workers were workplace homicide victims (BLS, 2017; 2019a). When compared to other industries, workplace violence in healthcare ranks as one of the highest, second only to transportation (Ricci, 2017). Healthcare is one of the fastest growing sectors of U.S. industry, with women representing 80% of the workforce (Ricci, 2017). With more than 18 million working in the healthcare industry and many at risk daily, it is reasonable to expect employers and legislators to experience an increase in the demand for effective workplace violence prevention programs by employees, labor unions and insurance carriers (Ricci, 2017). The annual comprehensive cost to businesses, including estimated losses, is now more than $130 billion and is expected to rise (AlertFind, 2020).

Healthcare Professionals Most at Risk

Those most at risk for a violent event include emergency room staff, mental health facility staff and workers in drug dependency care units (CDC, 2019). A less recognized, but largely unprotected group includes those providing in-home patient care. One of the main concerns with these higher risk jobs includes the perception of this risk. When asked, employers and employees alike state that violence is "part of the job" (Phillips, 2016). This perception can lead to underreporting, lack of awareness and limited engagement in risk assessment processes. According to OSHA (2015), 80% of serious violent incidents reported in healthcare settings were caused by interactions with patients (Figure 2). With in-home violence toward the healthcare provider being a crucial attribute affecting statistics, a simple control measure could possibly minimize exposure to attacks (Phillips, 2016). One recommendation the authors support is administering a buddy system in high-risk visits, not solely providing care to combative patients, to greatly reduce the probability of incidents.

Cost, Risk & Employer Intervention Strategies

Aside from regulatory encouragement, the motivation for risk treatment should be rooted not only in the moral obligation of the employer, but in the realm of cost reduction. Workers' compensation costs alone are a motivator for change, but it is well known that the direct cost of a claim represents only a fraction of the overall cost of an injury or fatality. In 2016, a consulting firm researched and estimated that "hospitals spent $2.7 billion on both proactive and reactive violence response efforts" (Minemyer, 2017). When considering the total cost of an incident, risk treatment becomes of paramount concern. Risk treatment can take many forms, ranging from personal alarms and access control to an increase in security presence. Regardless of the specific control measures applied, the authors believe that a layering or multipronged, multidisciplinary approach is most effective. According to case reports (TSS, 2017), strategies of a successful workplace violence prevention program include the installation of metal detectors at emergency department entrances, the establishment of a violent patient database, the hiring of department-based security officers, and placing limitations on visitor access to specific floors or areas via GPS tracking devices (OSHA, 2015a). Personal staff alarm devices have also increased security for staff, according to Association of Occupational Health Professionals in Healthcare (AOHP, 2017). Employee training has been of paramount concern when establishing a workplace violence prevention program. Communication to the employee regarding personal safety and a zero-tolerance policy is vital to a successful training program (Ferguson, 2016). A strong message of employee safety as the primary concern has been adopted by many healthcare employers to aid in the reduction of exposure and an increase in personal safety awareness (Hackethal, 2016). Clear, consistent communication with staff is an important part of the training strategy as it reinforces overall employer expectations and solicits critical information from those most at risk (OSHA, 2020b).

Recent Cases of Violence & Employer Recognition

Although layering of control measures is a widely accepted approach to risk reduction, healthcare employees are still regularly left vulnerable to many forms of violence. During an interview with the authors, a first-year medical school resident in Salt Lake City, UT, noted that she received little to no training from her employer, and that any useful risk-reduction measures were received from attending physicians and were treated as an afterthought. Another interview was conducted by the authors with a nursing school student working as a certified nurse assistant at one of the largest hospitals in Denver, CO. That student stated that very limited training was provided during the new employee orientation, and aside from a staff assist system button in patient rooms, the only other measure provided by her employer was a verbal warning about turning her back

on aggressive patients. Lastly, a pharmacist in St. Louis, MO, employed with one of the largest retail pharmacies in the U.S., indicated that workplace violence prevention training was not provided; however, prevention information was communicated not from her employer, but from law enforcement after a customer verbally threatened her life.

It would be desirable to believe that these examples are anomalies, and do not represent a true picture of workplace violence prevention measures in the U.S., but the BLS (2017) case rate points to a different story. Between 2011 and 2013, 75% of all workplace assaults occurred in healthcare settings (Phillips, 2016). Adding to the complexity of the problem, underreporting has been cited as a persistent problem. According to Phillips (2016), only 39% of nurses report verbal assaults and 19% report physical assault even though healthcare workers are "approximately four times as likely" to suffer lost time from assault than other types of occupationally related injuries. Numerous reasons for underreporting exist, including a fear of losing employment, being perceived as incompetent, and general compassion for confused or disoriented patients (Ferguson, 2016). To address these gaps, employers must view this loss opportunity as worthy of attention and financial investment. The tolerance level for exposure must be such that employers do not wait for regulatory enforcement or unionization of employees before they take substantive action.

NNU was founded in 2009 and has repeatedly cited workplace violence as a primary concern for nurses and other healthcare providers. This organization is one of the strongest voices for nurses, but other sectors of the industry that are also unionizing (e.g., SEIU United Healthcare East, National Union of Healthcare Workers) cite exposure to workplace violence as the one of the most compelling reasons for organization (NNU, 2019). The collaboration of labor groups, unions, insurance carriers and governmental agencies will be a vital part of addressing the problem and raising awareness.

Future Needs & Current Legislative Action

U.S. healthcare workers are exposed to the risk of workplace violence with many commenting that it is a daily concern. To make measurable and meaningful impact, employers must respond to this risk as it affects not only employees, but those they serve. With the U.S. facing one of the biggest crises in history, opioid addiction, it is reasonable to expect an increase in workplace violence as well as the need for prevention measures. The development of risk-reduction strategies by employers and regulatory enforcement systems by legislators are significant primary steps toward improvement. Many attempts have been made over the past 10 years to push this issue into the spotlight, but support is presently needed from many disciplines to continue to move this legislative process forward. As of Nov. 21, 2019, H.R. 1309, the Workplace Violence Prevention for Health Care and Social Service Workers Act, was passed in the House Committee on Education and Labor. The act requires OSHA to create a federal workplace violence prevention standard and mandates that employers develop comprehensive, workplace-specific plans to prevent violence. It covers a wide variety of workplaces and sets a quick timeline on implementation to ensure timely protection for healthcare workers (Thew, 2019). The act also sets minimum requirements for the standard and for employers' workplace violence prevention plans among other important provisions (Thew, 2019). It is comprehensive in nature, and addresses specific concerns, unlike the weaknesses cited by critics of the General Duty Clause. Although this is a significant step toward the development of a proposed rule, there is much work ahead. There was strong bipartisan support in the House of Representatives, which provides hope that this will stay on OSHA's regulatory agenda. The tenacity of those passionate about prevention will be paramount for this attempt, and any other federally mandated rules that specifically address workplace violence, to come to fruition.

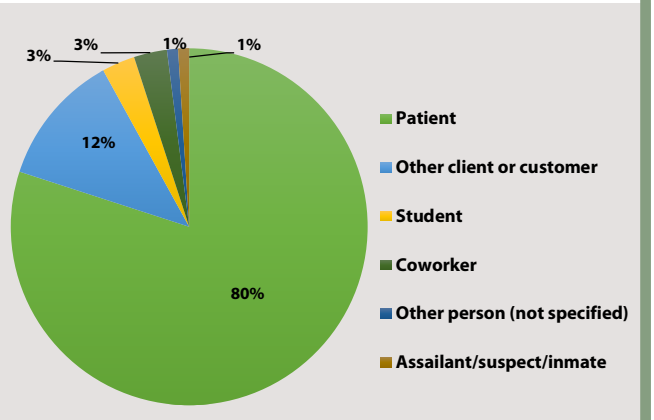
Control Measures

When reviewing the statistics regarding workplace violence within the healthcare industry, it is easy to overlook contributing factors, such as gender, race, ethnicity, whether the incidents are inside or outside the facility, and even the political climate that currently exists. Starting with out-of-facility incidents, we can examine paramedics, emergency medical service (EMS) and in-home care. According to CDC (2019), violence contributes to at least 16% of injuries sustained by EMS workers; of those injured, 64% were men and 36% were women. In-facility incidents are similar regarding the statistics between female verses male violence.

For the safety professional, whose duty is to protect workers, patients and visitors on and off site, following the hierarchy of controls (i.e., elimination, substitution, engineering controls, administrative controls and PPE) can be useful when attempting to minimize the probability and severity of violence within the healthcare industry. Completely eliminating the risk of violence would be nearly impossible for any industry and most likely is not realistic in healthcare. Substitution methods of control available in other industries are not generally useful in a service-oriented industry. Because the first and preferred choices of control are not useful in healthcare, we must start analyzing the three control attributes that could hold the most promise in reducing the probability of incidents.

Risk reduction using engineering controls is the most widely used method when addressing workplace violence. Part of these control measures include addressing parameter security with fencing, walls, outdoor locking egress doorways and metal detectors, which all have proven to be successful for restrict-

FIGURE 2
VIOLENT INJURIES TO HEALTHCARE WORKERS, BY SOURCE



Note. Adapted from "Workplace Violence in Healthcare: Understanding the Challenge," by OSHA, 2015.

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The topic of workplace violence has been and will continue to be important for OSH professionals for the foreseeable future.

ing entry. The next layer includes a thorough examination of the healthcare facility's interior. Many providers are using closed-circuit television in conjunction with security staff, employee panic buttons, and illumination improvements to provide better workplace oversight and emergency communication. All have been successful in reducing the number of violent events (TSS, 2017).

Although engineering controls are helpful in many settings, this type of control measure may not be appropriate for some healthcare occupations. This includes the groups of professionals working outside a facility setting. The ability to engineer out the risk is extremely difficult due to the dynamic and unstable environments. EMS personnel are expected to operate in unknown conditions that pose considerably higher levels of risk. To reduce the risk of violence to these types of personnel, safety professionals should utilize the final two control measures within the hierarchy: administrative controls and PPE.

One administrative control that can be used for EMS personnel as well as for in-house personnel is a technique known as verbal judo. Appropriate use of this skill has been shown to be effective in reducing conflict and calming patients. This technique was developed by the late George Thompson, founder of the Verbal Judo Institute (PoliceOne, 2020). This method has been used by law enforcement and healthcare professionals for several years to de-escalate and resolve an attempted assault. Learning basic situational awareness is a skill that is paramount when working in high-risk environments. Being aware of one's surroundings and recognizing when a situation is unraveling is the most critical part of preventing violence.

Although generally considered the least desirable and last choice when controlling risk, the use of PPE can provide a significant advantage in EMS-related violent events. The use of clothing made from materials such as Kevlar when responding to highly unstable scenes has been useful as it provides an effective barrier to attacks and reduced severity of an incident. Even though this approach is normally used in environments outside a facility setting, innovative possibilities exist for use in all sectors of the healthcare industry.

Security parameters, while effective in preventing the probability of violence in the healthcare profession, are not as effective today as in previous eras. To address the need for a strategy change, the healthcare industry as a whole has been focusing on preventing hostile individuals from entering critical areas of facilities by training employees in distinct situational awareness, teaching them to recognize the radical and extreme behaviors of individuals before the situation evolves out of control. Such situational awareness can be one of the best control measures these employees can demonstrate. This prevention-by-observation technique is also widely used in law enforcement. Establishing a system that helps identify previous patient or visitor violence can support awareness and staff while improving overall facility or scene security.

Safety First

One weakness of healthcare violence prevention programs lies in the balance between patient satisfaction and employee protection. To receive federal funding, many hospitals are required to have acceptable scores on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys. Healthcare staff are encouraged to support the effort of achieving acceptable scores so the institution will continue to receive federal support. Although the system was designed to ensure institution accountability and transparency, its impact on reporting has been mentioned by healthcare workers as being somewhat counterproductive in the prevention of workplace violence. In addition to the pressure of providing good customer service, staff also cite patient empathy as another reason to either not report violent events or accept patient violence as "part of the job" (Phillips, 2016). Since these attitudes and goals might at times conflict with control measures and reduce reporting, it is vitally important for management to emphasize employee safety. Employee safety must be recognized by management as just as valuable as patient safety during training and educational events. Training efforts by the employer and proper goal-setting strategies by management are necessary to keep the message consistent, clear and delivered with the support of the caregivers in mind.

The issue of workplace violence prevention in the healthcare industry has recently made it to the regulatory agenda and caught the attention of labor groups and other healthcare organizations. Accreditation bodies and labor unions have also targeted the issue, providing support for the passage of statutory requirements that hold employers accountable for protecting employees. If passed in its original form, this legislation will require risk to be identified and effective controls put in place. Although a workplace violence prevention rule would be a significant step toward providing greater protection for healthcare providers, it will be the actions of OSH professionals and others that facilitate improvement. Because OSH professionals realize the sluggish nature of the legislative process and the principles of risk assessment, the establishment of multiple, independent layers of control and the increase of overall organizational awareness will be vital in risk reduction. The authors believe that the control measures expressed may assist in reducing risk and prevent injuries for healthcare providers and other services industries. If the organizational culture is built around safe work practices and solid management leadership, integration of an effective workplace violence prevention program should

garner the support of its stakeholders and protect the safety and health of the healthcare professional.

Conclusion

The topic of workplace violence has been and will continue to be important for OSH professionals for the foreseeable future. Until there is a standard, companies must implement suggested components of a good program. The actions discussed in this article can serve as a guide. To date, this issue for healthcare workers has received less attention than in most workplaces. Hopefully, this will change in the future; if not, more lawsuits will likely result as workers or family members of workers who are injured or killed will demand compensation. **PSJ**

References

AlertFind. (2020). Workplace violence statistics 2018: A growing problem. Retrieved from https://alertfind.com/workplace-violence-statistics

Association of Occupational Health Professionals in Healthcare (AOHP). (2017). Position statements. Retrieved from www.aohp.org/aohp/Portals/0/Documents/ToolsForYourWork/Position%20Statements/PositionStatements%20Jul%202017.pdf

Beck, D.L. (2018, Dec. 1). Hazardous to your health: Violence in the health-care workplace. *ASH Clinical News*. Retrieved from www.ashclinicalnews.org/spotlight/hazardous-health-violence-health-care-workplace/

Bureau of Labor Statistics (BLS). (2017). Hospital workers: An assessment of occupational injuries and illnesses. Retrieved from www.bls.gov/opub/mlr/2017/article/pdf/hospital-workers-an-assessment-of-occupational-injuries-and-illnesses.pdf

BLS. (2019a). Table A-2. Fatal occupational injuries resulting from transporation incidents and homicides, all United States, 2018. Retrieved from www.bls.gov/iif/oshwc/cfoi/cftb0323.htm

BLS. (2019b). Table R4. Number of nonfatal occupational injuries and illnesses involving days away from work by industry and selected events of exposures leading to injury or illness, private industry, 2018. Retrieved from www.bls.gov/iif/oshwc/osh/case/cd_r4_2018.htm

CDC. (2019). Emergency medical services workers: Injury data. Retrieved from www.cdc.gov/niosh/topics/ems/data.html

Centers for Medicare and Medicaid Services (CMS). (2020). HCAHPS: Patients' perspectives of care survey. Retrieved from www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS

Ferguson, D. (2016, April 29). Workplace violence in healthcare: Underreported and often ignored. Fierce Healthcare. Retrieved from www.fiercehealthcare.com/healthcare/workplace-violence-healthcare-underreported-and-often-ignored

Hackethal, V. (2016, April 26). Workplace violence rampant in healthcare. Medscape. Retrieved from www.medscape.com/viewarticle/862562

Jenero, K.A. (2010, Oct. 18). United States: Union organizing trends in the healthcare industry. Retrieved from www.mondaq.com/unitedstates/healthcare/113112/union-organizing-trends-in-the-healthcare-industry

Minemyer, P. (2017, Aug. 2). Violence cost hospitals $2.7B in 2016, AHA report finds. Fierce Healthcare. Retrieved from www.fiercehealthcare.com/finance/violence-cost-hospitals-2-7b-2016-aha-report-finds

National Nurses United (NNU). (2019, June 11). House committee votes to advance bill to protect health care, social service workers from epidemic of workplace violence [Press release]. Retrieved from www.nationalnursesunited.org/press/house-committee-votes-advance-bill-protect-health-care-social-service-workers-epidemic

OSHA. (2015a). Preventing workplace violence: A road map for healthcare facilities (Publication No. OSHA 3827). Retrieved from www.osha.gov/Publications/OSHA3827.pdf

OSHA. (2015b). Workplace violence in healthcare: Understanding the challenge (Publication No. OSHA 3826). Retrieved from www.osha.gov/Publications/OSHA3826.pdf

OSHA. (2016a). Guidelines for preventing workplace violence for healthcare and social service workers (Publication No. OSHA 3148-06R 2016). Retrieved from https://www.osha.gov/Publications/osha3148.pdf

OSHA. (2016b). Prevention of workplace violence in healthcare and social assistance. Retrieved from www.regulations.gov/document?D=OSHA-2016-0014-0001

OSHA. (2017). Enforcement procedures and scheduling for occupational exposure to workplace violence (Directive No. CPL 02-01-058). Retrieved from www.osha.gov/sites/default/files/enforcement/directives/CPL_02-01-058.pdf

OSHA. (2020a). Unified agenda—Current agenda. Retrieved from www.osha.gov/laws-regs/unifiedagenda/currentagenda

OSHA. (2020b). Healthcare wide hazards: Workplace violence. Retrieved from www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/viol.html#violenceprevention

OSHA. (2016c). Preventing workplace violence in healthcare. Retrieved from www.regulations.gov/docket?D=OSHA-2016-0014

Policeone. (2020). Dr. George Thompson: Verbal judo tactics and techniques. Retrieved from www.policeone.com/columnists/George-Thompson

Ricci, M. (2017, May 12). Bill would increase pay for Massachusetts home healthcare worker. Nexstar Broadcasting. Retrieved from www.wwlp.com/news/bill-would-increase-pay-for-massachusetts-home-healthcare-workers

Schillaci, W.C. (2018, Oct. 10). Workplace violence: OSHA enforces general duty violations in health care. *EHS Daily Advisor*. Retrieved from https://ehsdailyadvisor.blr.com/2018/10/workplace-violence-osha-enforces-general-duty-violations-in-health-care

Thew, J. (2019, Nov. 21). Workplace violence legislation moves forward. Health Leaders. Retrieved from www.healthleadersmedia.com/nursing/workplace-violence-legislation-moves-forward

Total Security Solutions (TSS). (2017, Feb. 6). The ugly truth about violence in the healthcare industry. Retrieved from www.tssbulletproof.com/blog/ugly-truth-violence-healthcare-industry

World Health Organization (WHO). (2020). Violence against health workers. Retrieved from www.who.int/violence_injury_prevention/violence/workplace/en

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