

Workplace Violence in the Emergency Healthcare Setting:

Balancing the Needs of Behavioral Patients-In-Crisis

with the Personal Safety of Hospital Staff

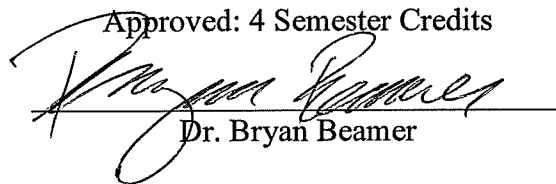
By

Benjamin R. Wood

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A handwritten signature in black ink, appearing to read "Bryan Beamer", is written over a horizontal line. The signature is fluid and cursive.

Dr. Bryan Beamer

The Graduate School

University of Wisconsin-Stout

December 2009

**The Graduate School
University of Wisconsin-Stout
Menomonie, WI**

Author: Wood, Benjamin R.

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ABSTRACT

Hospital XYZ is located in an urban area of the United States. Over the past three years, Hospital XYZ cared for an average of 668 patients per year whom required precautionary measures be taken to protect the patient and/or staff. An average of 152 of these patients were assaultive, and as a result, an average of thirteen employees per year suffered recordable injuries due to the violent behavior of these patients.

The purpose of this study is to minimize the risk of workplace violence within Hospital XYZ. Prior to the study, a literature review aimed to identify strategies available to define, evaluate and manage workplace violence within healthcare facilities. The researcher then engaged in an observational study of workplace violence incidents within Hospital XYZ. Using a targeted survey, the researcher interviewed the healthcare workers who were first exposed to each of the violent incidents observed. The data collected was subsequently analyzed to evaluate potential factors that may be used to assess workplace violence; how workplace violence is

perceived, and consequently misperceived; identify potential controls to manage workplace violence; and finally provide Hospital XYZ with recommendations to minimize the risk associated with workplace violence and further protect its employees.

The Graduate School
University of Wisconsin Stout
Menomonie, WI

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Finally, I would like to extend a most sincere recognition of all those healthcare workers who devote their lives to ensure we have a safe-haven to go to, and taking care of all of us when we are most vulnerable and at our worst. This research study is dedicated to you.

TABLE OF CONTENTS

ABSTRACT.....	i
List of Tables	vii
List of Figures.....	viii
Chapter I: Introduction.....	1
Overview and Significance	1
Background to the Problem	4
Purpose of the Study.....	6
Goals of the Study.....	6
Assumptions.....	7
Limitations	7
Definition of Terms.....	8
Chapter II: Literature Review	11
Workplace Violence in the United States	11
Workplace Violence in Healthcare Facilities	14
"Workplace Violence" Defined	16
Impact of Workplace Violence	17
Evaluating Workplace Violence	19
Role Analysis	19
Role-Relationship Analysis	20
Factors Analysis.....	21
Motivational Factors	22
General Workplace Violence Standards	23

Special Regulatory Considerations for the Healthcare Industry.....	26
Minnesota Commitment and Treatment Act.....	27
Federal Medicare/Medicaid Regulations.....	29
Right to Privacy.....	29
Right to Safe Setting.....	30
Right to be Free from Abuse.....	30
Summary.....	31
Chapter III: Methodology.....	34
Introduction.....	34
Purpose of the Study.....	34
Goals of the Study.....	35
Setting of the Study.....	35
Data Collection.....	36
Selection of Subjects.....	39
Survey Design.....	39
Analysis of Results.....	41
Goal One.....	42
Goal Two.....	45
Goal Three.....	46
Goal Four.....	46
Chapter IV: Results.....	48
Introduction.....	48
Purpose of the Study.....	48

Goals of the Study..... 48

General Findings..... 49

Goal One 51

Goal Two 61

Goal Three 76

Chapter V: Summary, Conclusions and Recommendations 87

 Summary 87

 Purpose of the Study 87

 Goals of the Study..... 88

 General Findings..... 88

 Goal One 89

 Goal Two 94

 Goal Three 98

 Goal Four 104

References..... 110

Appendix A: 113

Appendix B: 116

Appendix C: Observational-Participant Survey..... 123

List of Tables

<i>Table 1. Annual Number of Occupational Fatalities by Event/Exposure.....</i>	<i>11</i>
<i>Table 2. Workplace Homicides by Age Group and Sex.....</i>	<i>12</i>
<i>Table 3. Annual Number of Occupational Fatalities due to Assaults and Violent Acts by Age Group.....</i>	<i>13</i>
<i>Table 4. Homicides Resulting from Workplace Violence by Industry.....</i>	<i>14</i>
<i>Table 5. Acts of Violence in the Healthcare Workplace Continuum.....</i>	<i>17</i>
<i>Table 6. Factors Associated with Individuals Perpetrating Workplace Violence.....</i>	<i>22</i>
<i>Table 7. Incident Statistics for Hospital XYZ for Preceding Three Years.....</i>	<i>49</i>
<i>Table 8. Hospital XYZ's Operational Performance – August 2006 and Prior Year.....</i>	<i>50</i>
<i>Table 9. Incident Statistics for Hospital XYZ During Study Period.....</i>	<i>51</i>

List of Figures

<i>Figure 1. Number of Workplace Violence Incidents at Hospital XYZ – By Time of Day</i>	52
<i>Figure 2. Number of Workplace Violence Incidents at Hospital XYZ – By Location</i>	52
<i>Figure 3. Number of Workplace Violence Incidents at Hospital XYZ – By Number of Co-Workers in Area</i>	53
<i>Figure 4. Number of Workplace Violence Incidents at Hospital XYZ – By Role-Relationship</i>	54
<i>Figure 5. Number of Workplace Violence Incidents at Hospital XYZ – By Severity</i>	54
<i>Figure 6. Number of Workplace Violence Incidents at Hospital XYZ – By Victim Response</i>	55
<i>Figure 7. Number of Workplace Violence Incidents at Hospital XYZ – By Victim’s Work-Experience</i>	56
<i>Figure 8. Number of Workplace Violence Incidents at Hospital XYZ – By Gender of Victim</i>	56
<i>Figure 9. Number of Workplace Violence Incidents at Hospital XYZ – By Gender of Perpetrator</i>	56
<i>Figure 10. Number of Workplace Violence Incidents at Hospital XYZ – By Gender of Both Victim and Perpetrator</i>	57
<i>Figure 11. Number of Workplace Violence Incidents at Hospital XYZ – By Age of Victim</i>	57
<i>Figure 12. Number of Workplace Violence Incidents at Hospital XYZ – By Age of Perpetrator</i>	58
<i>Figure 13. Number of Workplace Violence Incidents at Hospital XYZ – Difference in Age Group of Victim and Perpetrator</i>	58
<i>Figure 14. Change in the Victim’s Level of Stress as a Result of Workplace Violence Incident</i>	59
<i>Figure 15. Change in the Victim’s Level of Anger as a Result of Workplace Violence Incident</i>	59
<i>Figure 16. Change in the Victim’s Level of Fear as a Result of Workplace Violence Incident</i>	60
<i>Figure 17. Victim’s Rating of Disruption as a Result of Workplace Violence Incident</i>	60
<i>Figure 18. Number of Workplace Violence Incidents at Hospital XYZ – Actual v. Perceived</i>	62

List of Figures (cont.)

<i>Figure 19. Accuracy of Employees to Identify Workplace Violence</i>	62
<i>Figure 20. Misperception of Workplace Violence at Hospital XYZ – By Number of Co-workers in Area.....</i>	63
<i>Figure 21. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ - By Number of Co-Workers in Area</i>	64
<i>Figure 22. Misperception of Workplace Violence at Hospital XYZ - By Severity.....</i>	65
<i>Figure 23. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – By Severity</i>	65
<i>Figure 24. Misperception of Workplace Violence at Hospital XYZ - By Victim’s Work Experience</i>	66
<i>Figure 25. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – By Victim’s Work Experience.....</i>	67
<i>Figure 26. Misperception of Workplace Violence at Hospital XYZ - By Gender Relationship.....</i>	68
<i>Figure 27. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – By Gender Relationship</i>	68
<i>Figure 28. Misperception of Workplace Violence at Hospital XYZ - By Difference in Age Group</i>	69
<i>Figure 29. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – By Difference in Age Group.....</i>	70
<i>Figure 30. Misperception of Workplace Violence at Hospital XYZ - Stress</i>	71
<i>Figure 31. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – Stress.....</i>	71
<i>Figure 32. Misperception of Workplace Violence at Hospital XYZ - Anger</i>	72
<i>Figure 33. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – Anger.....</i>	73
<i>Figure 34. Misperception of Workplace Violence at Hospital XYZ - Fear</i>	74
<i>Figure 35. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – Fear</i>	74
<i>Figure 36. Misperception of Workplace Violence at Hospital XYZ - Disruption.....</i>	75

List of Figures (cont.)

<i>Figure 37. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – Disruption</i>	<i>76</i>
<i>Figure 38. Victim’s Perceived Ability to Forecast Workplace Violence Incidents at Hospital XYZ</i>	<i>78</i>
<i>Figure 39. Victim’s Identification of Indicators to Forecast Workplace Violence Incidents at Hospital XYZ</i>	<i>78</i>
<i>Figure 40. Victim’s Perceived Ability to Minimize Workplace Violence Incidents Occurring at Hospital XYZ.....</i>	<i>79</i>
<i>Figure 41. Victim’s Perceived Preparedness for Workplace Violence Incidents at Hospital XYZ.....</i>	<i>80</i>
<i>Figure 42. Victim’s Perceived Protection from Workplace Violence Incidents at Hospital XYZ.</i>	<i>80</i>
<i>Figure 43. Victim’s Identification of Available Controls & Measures for Protection Against Workplace Violence Incidents at Hospital XYZ.....</i>	<i>83, 99</i>
<i>Figure 44. Victim’s Identification of Needed Controls & Measures for Protection Against Workplace Violence Incidents at Hospital XYZ.....</i>	<i>86, 100</i>

Chapter I: Introduction

Dr. Stone rubbed his eyes as he still saw the lingering image of the digital clock in his mind ... three o'clock a.m. "We are so understaffed and overloaded" he mumbled to himself as he perused the five charts in front of him. As he took a breath, he caught a glimpse of a nurse staring at him wide-eyed with her mouth half-open. "What is it?" Dr. Stone asked. She handed him the clipboard without uttering a word. As he began to review the documentation filled out by the police, paramedics, and triage nurse, intense images flashed through his mind as he paused at each of the words ... "homicidal," "suicidal," "methamphetamine," "combative," assaulted police," and "danger to self and others." He leaned forward, took a long swig from his coffee cup, and shuffled into the back room where his worst-case-scenario had materialized right in front of him. As Dr. Stone entered the room to introduce himself, a middle-aged man, who resembled a professional football player, towered over him with glazed eyes and a blank stare. Dr. Stone felt a chill going up his spine as the police officers patted him on the shoulder with a stinging, "call us back if you need us" as they left. His mind began to race ... three nurses for support ... homicidal ... danger to self ... he cannot be allowed to leave. As Dr. Stone sat down for his interview, the man muttered, "you have ten minutes to get me outta here."

Overview and Significance

These are all-too-common circumstances occurring in hospitals throughout the United States. In the context of occupational health and safety generally, workplace violence is a significant concern of many regulatory agencies. The United States Department of Justice estimates that one million workers per year are direct victims of some sort of violent crime in the workplace (Goetsch, 730). This represents fifteen percent of all violent crimes in America. (Goetsch, 730). On the extreme end, workplace violence accounts for "sixteen (16) percent of

6,588 fatal work injuries in the United States” (Goetsch, 726; Gray, 1), and according to the United States Bureau of Labor and Statistics, is the “second leading cause of death to American Workers” (Goetsch, 726; Schat, 5). Additionally, workplace violence is the “number one cause of death for women in the workplace” (Goetsch, 727; Gray, 1), yielding “forty percent of all fatalities of women in the workplace being classified as ‘homicides’ resulting from workplace violence” (Hammer, 139). Furthermore, workplace violence is the “number two cause of death for men” in the workplace (Gray, 1), whereby “eighty-two percent of victims in workplace homicides were men” (Hammer, 139). According to Bill Taylor, president and CEO of PLE Group, a Dayton agency which provides training to companies worldwide, these instances “include violence associated with robbery, disgruntled clients, customers, and co-workers, and domestic issues which enter the workplace.” (Gray, 2). Such a variance in the nature of workplace violence yields a diverse number of situations which can occur. According to Goetsch (2001), many of the “high risk” occupations for workplace violence involve taxi-cab drivers, retail-service workers (e.g. night service-station attendants), police officers, security officers, finance (e.g. bank tellers), insurance professionals, and community-service workers. However, one of the industries where incidents of workplace violence are of particular concern is that of public health care.

Healthcare facilities are classified in the “services” industry by the National Institute for Occupational Safety and Health, which ranks second with regard to the frequency of workplace violence incidents. According to Russell L. Colling (2001), a veteran in the security industry specializing in hospitals and healthcare facilities, “violence is a major problem in all healthcare settings” (398). Colling cites that the Occupational Health and Safety Administration (OSHA)

recognizes that “healthcare and social service workers face a high degree of work-related assaults” due to a number of risk factors (2001):

- “Hospital emergency rooms, along with mental health evaluation and treatment areas, have a high potential for violence” due to the frequent presence of mental health patients “in-crisis.”
- “Isolated work situations during client examination or treatment.”
- “The increasing use of hospitals by criminal justice agencies for criminal holds and 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 involuntary hospitalized.”
- “Lack of staff training relative to recognizing and managing escalating hostile behavior.”

The afore-mentioned risk-factors imply that the management and treatment of patients experiencing mental health issues contribute to the many instances of workplace violence within healthcare facilities. In the healthcare industry, particularly in an emergency setting, hospital employees are expected to maintain and manage potentially violent and unpredictable behavior within their respective work environments, and operate within the unique circumstances involved with maintaining the involuntary custody of these patients. A person making a statement indicative of their intent to commit suicide may warrant an intervention, which begins with an initial encounter with law enforcement and emergency medical personnel, and leading to their detention and transfer to a local healthcare facility for evaluation and treatment. These patients may be involuntarily taken into custody and admitted by local law enforcement, paramedics, emergency health care workers, and physicians. In addition, patients voluntarily seeking

treatment for and assistance with managing personal issues related to chemical dependency, mental illness, behavioral health, and ideations which may be suicidal and homicidal in nature. These patients can often exhibit behavior which is erratic, disruptive, violent, assaultive, and highly unpredictable. In some cases, patients who are under the influence of drugs or alcohol may also be transferred to a medical facility for an assessment and detoxification.. As a result, and as pointed out by Colling (2001), healthcare workers face a high frequency of work-related assaults associated with the behavior exhibited by their patients. Although the decision posed to Dr. Stone will serve as context for this paper, a qualitative analysis of an acute healthcare environment will serve as the primary focal point.

Background to the Problem

In many work environments, episodes involving workplace violence are quickly identified, contained, and managed. Local law enforcement agencies are summoned to assist and provide resolve to the incident. Persons commit the violent acts are expelled from the work-environment to minimize further risk exposure and provide for continuity of business. However, in a hospital setting, the continuity of care cannot cease, and many of the risks involving patient behavior are the primary reason necessitating treatment. The hospital may have an obligation to provide treatment for patients with mental illness to safeguard the personal well-being of the patient as well as the welfare of the community. Equally, the hospital may not simply release the patient for the primary reason of ensuring the exposure of violence to staff is minimized. Therefore, to meet the treatment-facility's obligations to the patient and community increases the potential for situations involving workplace violence, and traditional approach of "shuffling the issue out the door" is not adequate.

Congruently, hospital workers may not be able to effectively rely on the police being readily available to respond to or remain in the environment to assist in managing the patient's violent behavior. In many cases, the patient has not committed a crime, and is not placed under arrest pending criminal charges. In some cases, patients who are under the influence of drugs or alcohol are transferred to a medical facility for an assessment, detoxification, and potential admission. Even if the patient was involved in a crime, which the police officer reasonably believes is attributed to mental health, the person may be brought to a hospital for an evaluation – only later to be transported for the law enforcement records process. In many of these circumstances, police officers are not afforded the capacity to remain with these patients during the assessment process, which can last anywhere from a few minutes to a number of hours. Police Departments are often under-resourced with personnel and unavailable due to call loads. As a result, the hazard associated with the violent behavior of these patients “in crisis” is often left to be managed solely by hospital staff.

Upon examining these circumstances, healthcare workers maintain a duty to provide care to the patients within their environment. The potentially violent behavior associated with the medical conditions of many of these patients present a genuine and significant risk to the safety of the healthcare worker, as well as the patients and guests of the facility. Furthermore, the traditional approach of eliminating the risk by removing the risk from the work-environment is contradictory to the healthcare industry's obligation to retain the patient in a controlled environment if necessary, and subsequently provide treatment for the condition. The typical approach of soliciting law enforcement to manage the patient's hazardous behavior may not be feasible due to the limited resources of the law enforcement agency. Thus, this gap necessitates

healthcare facilities adopting strategies to protect the personal safety of their employees, customers, and guests while maintaining their obligation to provide medical care.

Purpose of the Study

The purpose of this study is to further evaluate the problem of workplace violence in healthcare facilities. Through a qualitative analysis, this study will capture how the healthcare worker typically defines workplace violence. In addition, this study will identify potential factors used to assess and measure workplace violence as well as strategies, both formal and informal, that healthcare facilities use to manage workplace violence and protect healthcare workers in these environments. Finally, this study will evaluate these strategies and provide recommendations to increase the safety of the healthcare worker from the risks associated with workplace violence.

Goals of the Study

1. Identify factors to assess and evaluate workplace violence in the healthcare environment by conducting a post-incident analysis of workplace violence incidents occurring within a pre-identified acute-healthcare facility using a targeted survey.
2. Assess factors which influence how healthcare workers misperceive “workplace violence” within a pre-identified acute-healthcare facility using a targeted survey for healthcare workers.
3. Identify current strategies to protect healthcare workers from workplace violence associated with patient behavior using a targeted survey for healthcare workers within a pre-identified acute healthcare facility.

4. Identify fundamental elements that may be incorporated into a healthcare facility's workplace violence safety program using a targeted survey for healthcare workers within a pre-identified acute healthcare facility.

Assumptions

1. Strategies exist which will effectively reduce the risk of workplace violence.
2. Strategies identified do not require the concerted assistance of law enforcement.
3. All incidents subjected to the study were properly reported to the interviewer.
4. Subjects responded to the surveys truthfully and honestly.

Limitations

1. This study is not intended to be an exhaustive study of workplace violence, and is limited to workplace violence as it pertains to the healthcare industry.
2. This study is reflective of the strategies practiced within the acute-care hospital of one healthcare organization. Thus the study is not accurately representative of other healthcare facilities where there are variances in the factors, considerations and strategies surrounding workplace violence.
3. This study is an evaluation of incidents occurring in August 2006. Thus, strategies practiced outside of this time-period may not be accounted for.
4. This study only assesses incidents of workplace violence occurring within the acute healthcare facility, and does not provide a comparative analysis of incidents that are not identified as workplace violence.
5. This study reflects only those incidents that the researcher was present and available, and does not reflect incidents where the researcher was not present during the study period.

6. All interviews and evaluations were personally conducted by one researcher in order to minimize variance with multiple interviewers. However, this study does not account for any impact that the sole interviewer may have had on the responses given by subjects.

Definition of Terms

Acute healthcare facility. Facility providing tertiary health-care where necessary treatment of a disease for only a short period of time in which a patient is treated for a brief but severe episode of illness. Many hospitals are acute care facilities with the goal of discharging the patient as soon as the patient is deemed healthy and stable, with appropriate discharge instructions. The term is generally associated with care rendered in an emergency department, ambulatory care clinic, or other short-term stay facility (Dictionary, 2007).

Aggravated assault. An assault where one attempts to cause serious bodily injury to another or causes such injury purposely, knowingly, or recklessly under circumstances manifesting extreme indifference to the value of human life; or attempts to cause or purposely or knowingly causes bodily injury to another with a deadly weapon (Law Encyclopedia, 1998).

Assault. An intentional act by one person that creates an apprehension in another of an imminent harmful or offensive contact (Law Encyclopedia, 1998).

Average daily census. Average number of people served on an inpatient basis on a single day during the reporting period. Calculated by dividing the total number of inpatient days by the number of days in the reporting period. (I.C.N.S.).

Emergency medicine. The branch of medicine that deals with evaluation and initial treatment of medical conditions caused by trauma or sudden illness (Dictionary, 2007).

Fatality. A death resulting from an accident or a disaster. One that is killed as a result of such an occurrence (Dictionary, 2007).

Harassment. The act of harassing, or state of being harassed; worry; annoyance; anxiety (Dictionary, 2007).

Homicide. The killing of one human being by another human being. Although the term is sometimes used synonymously with “murder”, homicide is broader in scope than murder (Law Encyclopedia, 1998).

Hospice medicine. A program that provides palliative care and attends to the emotional and spiritual needs of terminally ill patients at an inpatient facility or at the patient's home (Dictionary, 2007).

Incident rate. Calculation used to numerically represent the level of injuries and illnesses occurring within a single employer per one-hundred fulltime employees. The rate is calculated using a mathematical formula consisting of the number of injuries/illnesses occurring within a given year and the number of employee-hours worked within the same given year. The numerical value may be used to provide a level comparison among several employers within a given industry as well as an array of different industries. An incidence rate of injuries and illnesses is computed from the following formula (Bureau of Labor Statistics, 2008):

$$\text{Incidence rate} = \frac{\text{Number of injuries and illnesses} \times 200,000}{\text{Employee hours worked.}}$$

In-patient care. Pertaining to the treatment or care of such a patient or to a health care facility to which a patient may be admitted for 24-hour care. That involving a patient who has been admitted to a hospital or other health care facility for at least an overnight stay (Dictionary, 2007).

Intensive care. Medical care that is continuous and closely monitored health care that is provided to critically ill patients (Dictionary, 2007).

Intimidate. To make timid; fill with fear. To coerce or inhibit by or as if by threats (Dictionary, 2007).

Maternity medicine. Also referred to as “obstetrics”, it is the branch of medicine that deals with the care of women during pregnancy, childbirth, and the recuperative period following delivery (Dictionary, 2007).

Out-patient care. Pertaining to a patient who is admitted to a hospital or clinic for treatment that does not require an overnight stay. Care provided to a patient, who is not hospitalized, and who is being treated in an office, clinic, or other ambulatory care facility (Dictionary, 2007).

Patient days. The number of adult and pediatric days of care, excluding newborn days of care, rendered during the entire reporting period. Also referred to as “inpatient days”. (I.C.N.S.).

Recordable Injury. Any injury or illness is recordable if it results in any of the following: death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness (O.S.H.A., 2008).

Simple assault. See “Assault”.

Threat. An expression of an intention to inflict pain, injury, evil, or punishment. An indication of impending danger or harm (Dictionary, 2007).

Vicarious Violence. Violence that is experienced, felt or undergone as if one were taking part in the experience or feelings of another (Dictionary, 2007).

Chapter II: Literature Review

Workplace Violence in United States

Workplace violence is a significant concern throughout the United States in the context of occupational health and safety, and accounts for sixteen (16) percent of 6,588 fatal work injuries in the United States (Goetsch, 726; Gray, 1). According to the Bureau of Labor and Statistics, is the second leading cause of death to American Workers. (Goetsch, 726; Schat, 5). *Table 1* provides an annual comparison between occupational fatalities and those related to workplace violence.

Table 1. Annual Number of Occupational Fatalities by Event/Exposure

	Occ.Fatalities (Total)	Occ.Fatalities (Assaults)	Occ.Fatalities (Homicides)	Occ.Fatalities (Shootings)
1992	6217	1281	1044	852
1993	6331	1329	1074	884
1994	6632	1321	1080	934
1995	6275	1280	1036	762
1996	6202	1165	927	761
1997	6238	1111	860	708
1998	6055	962	714	574
1999	6054	909	651	509
2000	5920	930	677	533
2001*	5915	908	643	509
2002	5534	840	609	469
2003	5575	902	632	487
2004	5764	809	559	421
2005	5734	792	567	441
2006	5703	754	516	417

Data Provided by the Bureau of Labor Statistics (2009)

*Excludes September 11th terrorist attacks

Workplace violence has also been identified as the “number one cause of death for women”, and the “number two cause of death for men” in the workplace (Gray, 1). Of these fatalities, eighty-two percent of victims in workplace homicides were men (Hammer, 139), and eighty percent of workplace violence incidents were perpetrated by males (Goetsch, 730). *Table 2* is provided by the National Institute for Occupational Safety and Health (1995) regarding occupational fatalities involving workplace violence, and references the demographics of age and gender of the victims.

Table 2. Workplace Homicides by Age Group and Sex (U.S. 1980-1992)

Age Group	Male Workers		Female Workers		All Workers	
	Number	Rate	Number	Rate	Number	Rate
16-19	242	.55	102	.25	344	.41
20-24	796	.87	285	.35	1,081	.62
25-34	2,020	.89	591	.33	2,611	.65
35-44	1,841	.99	423	.28	2,265	.68
45-54	1,344	1.04	293	.29	1,637	.71
55-64	1,055	1.22	191	.31	1,246	.84
65+	620	2.59	115	.71	735	1.83
Total	7,935		2,001		9,937	
Average		1.01		.32		.70

Source: www.cdc.gov/niosh/violhomi.html (Accessed August 9, 2009)

In addition, *Table 3* is provided by the Bureau of Labor Statistics, and presents the age-specific demographic data relevant to victims of workplace violence incidents.

An extraordinary number of instances of workplace violence do not result in fatalities. According to the U.S. Department of Justice, sixty percent of instances involving workplace violence are classified as “simple assaults”. Goetsch points out that the perpetrator was not armed in sixty-two percent of violent crimes involving workplace violence, and thirty-six percent of incidents involved a handgun” (Goetsch (2002)). The Society for Human Resource Management cites, “Seventy-five percent were fist-fights, seventeen percent were shootings, eight percent were stabbings, and six percent were sexual assaults.” Goetsch (2002).

Table 3. Annual Number of Occupational Fatalities due to Assaults & Violent Acts by Age Group

	<16	16-17	18-19	20-24	25-34	35-44	45-54	55-64	65+	Total
1992	5	12	23	126	311	331	242	153	78	1281
1993	6	11	19	108	336	352	253	156	88	1329
1994	2	10	34	115	327	357	259	134	83	1321
1995	5	7	30	97	313	328	260	155	85	1280
1996	7	9	24	93	258	281	250	157	86	1165
1997	4	10	23	72	269	288	217	156	72	1111
1998	6	4	16	59	213	274	204	113	73	962
1999	6	11	14	69	195	226	217	101	70	909
2000	4	4	18	57	197	236	234	128	52	930
2001*	2	6	18	62	171	250	218	122	59	908
2002	3	3	13	50	183	233	206	107	42	840
2003	U/A	U/A	13	87	185	225	191	114	73	888
2004	4	U/A	11	55	148	192	203	120	73	806
2005	0	4	14	52	162	194	184	118	61	792
2006	0	3	15	50	154	197	186	121	62	788
2007	0	0	11	65	136	146	143	88	39	628

**Excludes September 11th terrorist attacks*

Data Provided by the Bureau of Labor Statistics (2009)

The most frequent and unrecognized type of workplace violence does not involve any physical assault, but rather involves verbal threats, inappropriate statements, and intimidating gestures. It is a consistent theme with many workplace violence studies that there exists a large number of occurrences, including physical assaults, verbal threats, and threatening and intimidating gestures, which go unreported. In 2000, the United States Postal Service Commission on a Safe and Secure Workplace conducted the largest survey of its kind, and found that in 1999, one in twenty American workers was physically assaulted, one in six was sexually harassed, and one in three was verbally abused (Schat (2003)). According to Bill Taylor, “the

bulk of incidents occur in the form of sexual harassment and other threats” (Gray, 2). Gray further contends that non-fatal assaults, including physical and mental abuse, often go unreported. Goetsch (2002) estimated that fifty-six percent of workplace violence incidents are not reported to the police. As presented in the next section, this lack of information presents a significant obstacle in measuring and evaluating workplace violence incidents, thus compromising an organization’s ability to effectively assess and manage them.

Workplace Violence in Healthcare Facilities

To more effectively understand and diagnose the issue involving Dr. Stone, it is important to evaluate the characteristics of workplace violence within healthcare facilities. According to Goetsch (2001), many of the “high risk” occupations for workplace violence involve taxi-cab drivers, retail-service workers (e.g. night service-station attendants), police officers, security officers, finance (e.g. bank tellers), insurance, community-service workers, and health-care workers. The National Institute for Occupational Safety and Health presented the following data (see *Table 4*) classifying the “top five” industries resulting in workplace violence fatalities.

Table 4. Homicides Resulting from Workplace Violence by Industry (% of total)

Industry	Male Workers	Female Workers
Retail Trade	36.1%	45.5%
Services	16.0%	22.2%
Public Administration	10.5%	2.9%
Transportation/communication	10.6%	3.8%
Manufacturing	7.0%	4.9%

Source: NIOSH (1995)

Healthcare facilities, categorized in the “Services” category, rank within the second-leading category. It is important to note that although the figures presented above appear

remarkably high, the “Services” category does not offer a more distinctive comparison of “trades” within each type of industry.

The Occupational Safety and Health Administration pointed out that in 1999, the Bureau of Labor Statistics estimated 2,637 nonfatal assaults on hospital workers, yielding a rate of 8.3 assaults per 10,000 workers. In comparison with other industries, Colling (398) interprets the “healthcare industry” as rating “fairly low on the number of actual violent acts compared to other industries, but quite high in terms of threats of violence.” He supports his claim by pointing out that “healthcare professionals are not among the top ten occupations who are killed or injured at work” (398).

In considering reviewing the unique conditions within a healthcare setting, it is apparent that the “already complex issue” of workplace violence becomes even more complicated; hence much more difficult to manage. According to Russell L. Colling (2001), a veteran in the security industry specializing in hospitals and healthcare facilities, “violence is a major problem in all healthcare settings ” (398). He cites that the Occupational Health and Safety Administration (OSHA) recognizes “healthcare and social service workers face a high degree of work-related assaults” due to a number of risk factors:” (2001):

- “Hospital emergency rooms, along with mental health evaluation and treatment areas, have a high potential for violence” due to the frequent presence of mental health patients “in crisis.”
- “Isolated work situations during client examination or treatment.”
- “The increasing use of hospitals by criminal justice agencies for criminal holds and 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.”
- “Lack of staff training relative to recognizing and managing escalating hostile behavior.”

“Workplace Violence” Defined

A precipitating factor for the lack reporting incidents of workplace violence is the inconsistency involved in defining and classifying the concept. Current literature demonstrates there exists ambiguity in defining “what workplace violence actually is”. The Occupational Safety and Health Administration (OSHA) has not formally adopted a definition for identifying workplace violence incidents, but does classify such incidents as “assaults and violent acts”. It is equally important to note that only those incidents resulting in a recordable injury or fatality are reported to OSHA. In contrast, the National Institute for Occupational Safety and Health defines workplace violence as “violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty” (Gray, 1998). Gray points that “NIOSH’s definition includes threats of assault, which may result in psychological trauma caused by threats, obscene phone calls, an intimidating presents, shouts or swears from others, and harassment.” Goetsch (727) concurs with the definition offered by NIOSH, and expands by recommending that workplace violence be viewed as “violent acts, behavior, or threats that occur in the workplace or are related to it”, and contends, “Such acts are harmful or potentially harmful to people, property, or organizational capabilities.” Gray further indicates that “for every employee to effectively manage it in the occupational setting, the employer must recognize it deals with more than physical harm. It may include anything from offensive language to homicide.” Colling (1998) proposes that “it is important ... to (distinguish) between actual violence and the threat of

violence.” Colling (403) characterizes workplace violence as either “direct” (e.g. physical assaults, verbal threats) and “indirect” (e.g. vicarious violence), and contends that workplace violence incidents should be viewed as part of a continuum, which is exemplified in *Table 5*.

Table 5. Acts of Violence in the Healthcare Workplace Continuum

Vicarious Violence	Threatening Gestures (Non-Verbal)	Verbal Threats	Simple Assault	Aggrav. Assault	Injury	Death
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Source: Colling (2001)

Colling (1998) also believes that “the majority of people generally tend to associate violence in the workplace with assault and homicide, and not with intimidating postures or expressions of mild anger. Yet many studies that report workplace violence count such situations as incidents.” Characterizing workplace violence even further, Schat (2) contends that workplace violence is comprised of “three components”, which entail “physical assaults and threats of assault, psychological aggression, and vicarious violence.” Schat (2003) argues that there exists an “inconsistency in what has been considered as workplace violence” that has “contributed to confusion and difficulties in comparing results across studies. Some researchers have focused only on direct physical assaults.” It is this inconsistency in defining workplace violence which renders the realm of previous studies incomparable. Therefore, this ambiguity has led to a number of non-physical incidents to go unreported, thus rendering current analysis of the aspect of workplace violence significantly under-assessed. As can be observed in the next section, this trend gravely impacts most occupational environments, and comes with a heavy price.

Impact of Workplace Violence

The most apparent impact of workplace violence is the physical injury, damage to property, and loss of resources incurred during an episode of workplace violence. Goetsch (2002) estimates that violent crime in the workplace causes 500,000 employees to miss 1.75

million workdays annually (average of 3.5 days per incident) and \$55 million in lost wages. Typically, impacts which are “tangible” in nature are measured in frequency of occurrence, dollars spent, and variance from “normal production.” However, although these physical impacts are the most apparent and serious to the employee and employer, many have indicated that it is the long-term impact of workplace violence that grossly impacts the work environment, and relatively little research has been conducted to examine the lasting impacts of workplace violence. According to a poll conducted by TIME and CNN, thirty-seven percent of respondents viewed workplace violence as a growing problem, eighteen percent personally witnessed some form of violence at work, and nineteen percent feared their own safety at work. (Goetsch, 2002). According to Schat (2003), both “direct and vicarious violence produces fear reactions.” Continuing, he cites, “These fear reactions in turn were predictive of psychological symptoms, such as depression and anxiety” as well as “predictive of somatic symptoms (e.g. sleep disturbance, gastrointestinal symptoms).” According to the Society for Human Resource Management, twenty percent of employees reported higher levels of paranoia, eighteen percent reported increased distrust among employees, and forty-one percent of the organizations reported increased stress levels in the workplace after a violent incident (Goetsch, 2002). There is also evidence which suggests that a tendency toward committing “workplace violence is associated with negative work attitudes such as job satisfaction, affective commitment, turnover intentions” (Schat, 2). Congruently, it has been contended that workplace violence impacts work-behaviors such as increased job neglect, decreased job performance, and decreased productivity (Schat, 2). As indicated previously, a great deal of further research needs to be conducted in order to establish a correlation between an employee’s experiences with workplace violence and the impact on their behavior and productivity.

Evaluating Workplace Violence

It is apparent in the previous sections that workplace violence exists and poses a serious threat to generally all occupational environments. In being an inherent and recognized hazard in all work environments, employers have an obligation to provide their employees with a work environment free of this hazard under OSHA's "General Duty Clause" (29 CFR 654 §5(a)(1)). With the afore-mentioned inconsistencies in defining and studying workplace violence, employers are currently at a disadvantage due to the relative lack of research available to identify any particular contributing factors or causes. However, there currently exists four common approaches in assessing and classifying workplace violence: Role-analysis, role-relationship analysis, factors-analysis and motivational-factors.

Role analysis. An important element to examine when assessing issues of workplace violence is the role of the perpetrator relative to the work-environment. According to Colling (2001), perpetrators of workplace violence typically fall into one of four categories: customers, employees, legitimate visitors, and illegitimate visitors.

Customers. "Customer" is defined as "an individual who receives products or services from the victim of a workplace-violence incident" (Goetsch, 2002). According to the Society of Human Resource Management, seven percent of the incidents were customers perpetrating an incident towards "an employee" (Goetsch, 2002).

Employee. "Employee" is defined as "an individual with an employment-related relationship (past or present) with the victim of a workplace incident" (Goetsch, 2002). According to the Society of Human Resource Management, fifty-four percent of the incidents were employee-employee, thirteen percent of the incidents were employee-supervisor, and seven percent were attributed to firing/layoffs (Goetsch, 2002).

Visitors – Legitimate. “Legitimate visitor” is defined as a person who has “a legitimate affiliation with the organization, its employees, or its clients, but does not maintain an employer-employee relationship or is currently seeking products/services from the organization” Goetsch (2002). According to Colling (2001), “Violence regarding these individuals is generally related to situational events occurring within the facility.”

Visitors – Illegitimate. “Illegitimate visitor” is defined as “an individual with no relationship of any kind with the victim of a workplace-violence incident or the victim’s employer” (Goetsch, 2002). According to Goetsch (2002), forty percent of perpetrators were complete strangers to the victim.

Role-Relationship Analysis. Colling (2001) presents a means of studying workplace violence by building on the “Role-Analysis”, and examining the role-relationship of the perpetrator(s) and victim(s) involved in the incident. He classifies workplace violence encounters into three “types” based on the role-relationship of the perpetrator and victim.

Type one. A “Type I” encounter, as defined by Colling (2001), is one where the “perpetrator has no legitimate relationship to the workplace,” inclusive of employees. As mentioned previously, “forty percent (of perpetrators) were complete strangers to the victim.” Goetsch (2002). Generally, Type I encounters are those which are not defined as “Type II” or “Type III” encounters.

Type two. A “Type II” encounter, as defined by Colling (2001), is one where the “perpetrator is a recipient of service provided by the workplace or victim. As mentioned previously, the Society of Human Resource Management estimates that “seven percent of the incidents were customers” perpetrating an incident towards “an employee.” Goetsch (2002). In the context of a healthcare environment, Type II encounters would typically

encompass those incidents where the perpetrator is a patient or person seeking medical services from the healthcare facility, but may also include those patients who have been recently discharged or are conducting subsequent business on medical care they previously received from the facility.

Type three. A “Type III” encounter, as defined by Colling (2001), is one where the “Perpetrator has an employment-related involvement with the workplace, such as current or former staff members; or are spouses, lovers, relatives, and friends in dispute with an employee.”

Usually, the perpetrator has some type of relationship with the employer or one (or more) of employees. According to Colling (2001), in “the vast majority of situations, both parties know each other, and their relationship has provided the motive for the violent act.” Goetsch (2002) refers to a significant majority of these perpetrators as “employee-related outsiders,” which he defines as “an individual with some type of personal relationship (past or present) with the victim of a workplace incident.” He continues by pointing out that in a study regarding the relationships between the perpetrator and victim in workplace violence incidents, the Society of Human Resources Management estimates “Thirty-five percent (were identified as) casual acquaintances,” “nineteen percent (were perpetrated) by individuals well-known by victim,” and “one percent by relatives.” Goetsch (730).

Factors Analysis. In examining for factors correlated with workplace violence, various aspects are examined within each episode in the form of “individual factors” and “environmental factors” as defined by Goetsch (2002). Individual factors involve the “intrinsic characteristics of the perpetrator” of the workplace violence, and attempt to identify a common characteristic within all perpetrators. Environmental factors encompass those characteristics within the

organization or work environment that are either referenced by the perpetrators, or are correlative with organizations that have a higher frequency of occurrences. Examples of the most common “individual” and “environmental” factors identified are listed in *Table 6*.

Table 6. Factors Associated with Individuals Perpetrating Workplace Violence

Individual Factors:		Environmental Factors:
1) Prior record of violence (Goetsch, 736)	2) Finger pointers (Refusal to accept responsibility) (Goetsch, 736; Gray, 3)	1) Dictatorial Management: Overly authoritative (Goetsch, 737)
3) History of intimidating or threatening others (Colling, 402)	4) Unusual frustration levels (Goetsch, 736; Gray, 3)	2) Role Ambiguity (Goetsch, 737)
5) Membership in hate group (Goetsch, 736)	6) Obsession with weapons ((Goetsch, 736; Colling, 402; Gray, 3)	3) Partial, inconsistent supervision (Goetsch, 737)
7) Psychotic Behavior (Goetsch, 736)	8) Drug Dependence (Goetsch, 736; Gray, 3)	4) Unattended hostility (Supervisors ignore situations) (Goetsch, 737)
9) Romantic obsessions (Goetsch, 736; Gray, 3)	10) Social Isolation - Usually Loners (Goetsch, 736; Colling, 402; Gray, 3)	5) No respect for privacy (Goetsch, 737)
11) Depression (Goetsch, 736; Gray, 3)	12) Inability to accept criticism (Gray, 3)	6) Insufficient training (Goetsch, 737)
13) Feelings of injustice or unfairness (Gray,3)	14) Controlling and demanding presence (Gray, 3)	

Sources for Each Factor are cited in each cell

Motivational Factors. Colling (2001) identifies three types of workplace violence situations relevant to the “motive” of the perpetrator: The “spontaneous event,” the “situational event,” and one where there is a “targeted victim.” Colling (2001) defines the spontaneous event as one where the “victims generally do not have a direct relationship with the perpetrators.” Although the term implies the result from a recent chain-of-events, Colling (2001) indicates that often times “the act is premeditated and may have evolved for weeks, months or years of

planning or thought.” These types of incidents may appear “spontaneous” to the organization, as there is little opportunity to “forecast” the actual occurrence. Types of incidents which fall into this classification are robberies, acts of retribution, and terrorism.

The situational event, according to Colling (2001) “generally results from a conflict between the perpetrator and the victim interacting with each other.” The circumstances regarding these incidents involve a “conflict in roles” rather than being based on a personal relationship. He cites that many of these cases are due to personality conflicts, and uses the example of a mental health patient who “may be involved in confrontational situations that lack an apparent, or outward, rational motivation.” (Colling, 2001). According to the Society of Human Resources Management, “Ten percent (of workplace violence incidents) were attributed to drug/alcohol abuse,” and “ten percent were attributed to personality conflicts” Goetsch (2002).

Events involving targeted victims are characterized by events that are “tied closely to stalking,” and involve “a previous conflict between the perpetrator and the victim” (Colling 2001). Colling cites these types of situations are “commonly related to a domestic or intimate relationship,” and entail “the vast majority of situations” as “both parties know each other, and their relationship has provided the motive for the violent act.” He extends by citing, “Violent acts in many of these cases are somewhat predictable.” According to the Society of Human Resource Management, “Fifteen percent were attributed to marital or family problems.” Goetsch (2002).

General Workplace Violence Standards

It is obvious workplace violence is a perpetual hazard in occupational environments everywhere. However, due to its unpredictability, influence by “outside factors,” and based on the personal motives of individuals, employers are often left with the impression that there is “little they can do” to protect their employees, leaving employees to “take their chances” with

the behaviors of others. It is more important to recognize that workplace violence incidents are, indeed, a recognized hazard; and employers are legally obligated to make “diligent” and “prudent” effort to manage and prevent occurrences. Guidelines have been set forth by the National Institute for Occupational Safety and Health (NIOSH), the Occupational Safety and Health Administration, and regulations involving workers’ compensation.

The scope of workplace violence is addressed by the National Institute for Occupational Safety and Health (NIOSH), which “developed guidelines for categorizing an injury as being work-related” for both on-premises and off-premises (Goetsch, 2002). According to NIOSH guidelines, “If the violent act occurred on the employer’s premises, it is considered an on-the-job event if one of the following apply: 1) The victim was engaged in work-activity, apprenticeship, or training, 2) The victim was on break, in hallway, restrooms, cafeteria, or storage area, or 3) The victim was in the employer’s parking lots while working, arriving at, or leaving work.” Goetsch (2002). Furthermore, “If the violent act occurred off the employer’s premises, it is still considered an on-the-job-event, if one of the following criteria apply: 1) The victim was working for pay or compensation at the time, including working at home, 2) The victim was working as a volunteer, emergency services worker, law enforcement officer, or fire-fighter, 3) The victim was traveling on business, including to and from customer-business contacts, 4) The victim was engaged in work-activity in which the vehicle is part of the work-environment (e.g. taxi driver, truck driver, etc.)” Goetsch (2002).

An employer’s obligation to identify and manage the workplace for violent incidents is also entailed in guidelines set forth by the Occupational Safety and Health Administration. According to OSHA, “Workplace violence such as physical assaults, threatening or violent behavior, are a growing problem in the workplace.” (2002). Although there are no specific

standards addressing workplace violence, Tweedy (1997) indicates that “citations will be issued under the OSHA Act General Duty Clause (29 CFR 654 §5(a)(1)).” Reilly (1999) further indicates that “To prove a violation of the general duty clause, OSHA must establish the following four factors: 1) A condition or activity in the workplace exists, presenting a hazard to employees; 2) The condition or activity is recognized as a hazard by the employer or industry; 3) The hazard is likely to cause death or serious harm; and 4) A feasible means of eliminating or materially reducing the hazard exists.” Due to the fact that workplace violence is such a significant, yet ambiguous, concern, OSHA has developed a number of workplace violence guidelines for the night-retail and healthcare industries. A general summation of the “Workplace Violence Tool for Healthcare Industry” is presented in Appendix A.

State-established workers’ compensation laws also recognize the inherent risk associated with workplace violence. According to Antonetti-Zequeira, Esq. (2002), “A state’s workers’ compensation laws form the framework for identifying an employer’s responsibilities to employees injured as a result of workplace violence, and may provide the exclusive remedy for injuries suffered by employees during the course of their employment.” Antonetti-Zequeira continues by citing that with these inherent responsibilities exist the “bargain reached between the employer and employees. On one hand, “the employer assumes liability for industrial personal injury or death without regard to fault in exchange for limiting the amount of its liability to a fixed premium” Antonetti-Zequeira, Esq. (2002). On the other hand, “the employee is given payment of benefits without the necessity of proving fault, but in exchange for that benefit gives up the full range of tort damages that would ordinarily be available” Antonetti-Zequeira, Esq. (2002). Aside from implying a legal obligation, this “Exclusivity Provision” provides an incentive for employers, as outlined by Goetsch (2002):

“This provision makes worker’s compensation the employee’s exclusive remedy for injuries that are work-related. This means that even in cases of workplace violence, as long as the violence occurs within the scope of the victim’s employment, the employer is protected from civil lawsuits and the excessive jury verdicts that have become so common.”

However, this “agreement” is not iron-clad, as Antonetti-Zequeira points out, “In most jurisdictions, the exclusivity provision of workers' compensation has a statutory exception for intentional torts committed by the employer.” Thus, if an employer is intentionally negligent in fulfilling the obligation of making “prudent and reasonable efforts” in minimizing the potential for workplace violence, the exclusivity provision does not apply. Antonetti-Zequeira, Esq. (2002). According to Goetsch (2002), “failure to act prudently (i.e. take immediate action to prevent the violent act) in this regard can subject an employer to charges of negligence.” Gray (1998) emphasizes this point by indicating, “employers can be held liable and must take steps to lessen violent incidents to ensure safer surroundings for all employees ... if an increased risk of violence from an employee or outside factor exists and is not properly addressed, an employer may become responsible for such a situation.” Gray (1998) provides the example of an employer who “may be held liable for negligent hiring, retention, supervision, or training if the employee’s conduct was foreseeable.”

Special Regulatory Considerations for the Healthcare Industry

In the preceding section, the various regulatory approaches applicable to workplace violence generally were briefly discussed, and were primarily oriented towards the employer-employee relationship. However, it is also necessary to recognize there are unique considerations for the healthcare environment, particularly with the rights of the community at large as well as

the patient. Therefore, we must also examine some additional considerations addressing these aspects.

Minnesota Commitment and Treatment Act. According to the Minnesota Commitment and Treatment Act, “A person who is ‘mentally ill¹ and dangerous’ to the public is a person (a) who is mentally ill; and (b) who as a result of that mental illness presents a clear danger to the safety of others as demonstrated by the facts that (i) the person has engaged in an overt act causing or attempting to cause serious physical harm to another and (ii) there is a substantial likelihood that the person will engage in acts capable of inflicting serious physical harm on another.” Minn. Stat. § 253B, subd. 17 (2004). In the event that a health officer² or examiner³ recognizes a person is deemed “mentally ill and dangerous,” they have a professional obligation to admit that person for emergency treatment⁴, inclusive of all medical, psychological, and behavioral aspects of the condition. Some common criteria used in evaluating persons for emergency treatment is if the person “is incapable of self-management,” demonstrates “a substantial likelihood of physical harm to self or others,” or has acted out in a “recent attempt or threat to physically harm self or others.”

¹ Defined, according to Minn. Stat. § 253B.02, subd.13, as “any person who has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason to understand, which is manifested by instances of grossly disturbed behavior or faulty perceptions and poses a substantial likelihood of physical harm to self or others ...” (2004).

² Defined, according to Minn. Stat. § 253B.02, subd.9, as “a licensed physician, licensed psychologist, licensed social worker, registered nurse working in an emergency room of a hospital ...” (2004).

³ Defined, according to Minn. Stat. § 253B.02, subd.7, as “a person who is knowledgeable, trained, and practicing in the diagnosis and assessment or in the treatment of the alleged impairment, and who is 1) a licensed physician; or 2) a licensed psychologist who has a doctoral degree in psychology ...” (2004).

⁴ Defined, according to Minn. Stat. § 253B.02, subd.2., as “the treatment of a patient ... which is necessary to protect the patient or others from immediate harm” (2004).

In the event the patient is not agreeable or refuses to submit to treatment, the designated health officer or examiner maintains the statutory authority to issue an emergency hold⁵ and admit them into a treatment facility.⁶ The statute empowers medical professionals not only to assess and diagnose treatment, but impose it if the patient is unwilling to cooperate by confining them to a controlled environment therapeutic to the patient's treatment. As cited in Minn. Stat. § 253B.05, subd. 3(c), "If a person is intoxicated in public and held under this section for detoxification, a treatment facility may release the person ... as soon as the treatment facility determines the person is no longer a danger to themselves or others." In short, the hospital is legally obligated to keep the patient ... a recognized risk for violence ... within the therapeutic environment – that which is the same occupational environment of the healthcare employees.

While in the environment, the ultimate goal of treatment is to re-empower the patient to a stage of independent self-management. As indicated by Minn. Stat. § 253.017 subd.1 (Active Psychiatric Treatment), treatment must be designed to:

1. Stabilize the individual and the symptoms that required hospital admission;
2. Restore individual functioning to a level permitting return to the community;
3. Strengthen family and community support;
4. Facilitate discharge, aftercare, and follow-up as patients return to the community.

The statute acknowledges the potential for staff having to physically restrain and control the patient in the event the (s)he exhibits behavior endangering the "safety to self or others," implying not only that the potential for actual physical violence exists, but staff will have to

⁵ Authority granted, according to Minn. Stat. § 253B.05, subd.1, "any person may be admitted or held for emergency care and treatment" if "the person is mentally ill, mentally retarded, or chemically dependent, and is in danger of causing injury to self or others if not immediately detained ..." (2004).

⁶ Defined, under Minn. Stat. § 253B.02, subd.19 as "'a hospital, community mental health center or other treatment provider to provide care and treatment for persons who are mentally ill, mentally retarded, or chemically dependent'" (2004).

engage in physical measures to address it. In addition, the statute also recognizes the need to consider balancing the physical control of the patient with their personal right to dignified and respectful treatment, as evident in addressing the issues of restraints⁷ and neuro-leptic medication.⁸ Thus, the employees within the therapeutic environment are exposed not only the patients who exhibit potentially violent and harmful behavior, but also maintain some obligation to minimize the risk associated with that behavior through physical restraint and control.

Federal Medicare/Medicaid Regulations. The Centers for Medicare & Medicaid Services (CMS), an agency within the United States Department of Health and Human Services, has established a set of federal regulations, which are applicable to all hospitals which participate in the federally-funded Medicare & Medicaid programs. 42 CFR § 482 set forth regulations for the various aspects of a healthcare facility such as patient-rights, medical processes, functions of services, and the safety and condition of the environment. Appendix B offers insight regarding the “privacy and safety” component of 42 CFR §482.13, which acknowledges the potential for unsafe physical behavior on the part of the patient, and establishes general standards guiding hospitals to appropriately manage such behavior. The following are segments of relevant regulations applicable to violent behavior in a hospital setting:

Right to Privacy. Under 42 CFR §482.13(c)(1), a patient maintains a statutory right to personal privacy. However, 42 CFR §482.13(c)(1) also recognizes that this right is not

⁷ According to Minn. Stat. § 253B.03, subd.1, “A patient has the right to be free from restraints. Restraints shall not be applied to a patient unless ... determines they are necessary for the safety of the patient or others” (2004).

⁸ According to Minn. Stat. § 253B.03 subd.1, “A treating physician may administer neuroleptic medication to a patient who does not have the capacity to make a decision regarding the administration of the medication if the patient is in an emergency situation” (2004). According to Minn. Stat. § 253B.092 subd.3, such medication may be administered “if the treating physician determines the medication is necessary to prevent serious, immediate physical harm to the patient or to others” (2004). According to Minnesota Statute § 253B.092 subd.8 (i), “If physical force is required to administer the neuroleptic medication, force may only take place in a treatment facility or therapeutic setting where the person’s condition can be assessed and appropriate medical staff are available” (2004).

without limits. Under 42 CFR §482.13(c)(1), “A patient’s right to privacy may be limited in situations where a person must be continuously observed, such as when restrained or in seclusion when immediate and serious risk to harm self (such as when the patient is under suicide precautions or special observation status) or others exists.”

Right to Safe Setting. Under 42 CFR §482.13(c)(2), a patient maintains a statutory right to receive care in a safe environment. 42 CFR §482.13(c)(2) provides, “The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, ... Additionally, this standard is intended to provide protection for the patient’s emotional health and safety as well as his/her physical safety.”

Right to be Free from Abuse. Under 42 CFR §482.13(c)(3), a patients maintains a statutory right to be free from conduct which is abusive or harassing in nature. Although the statute does not specifically define what constitutes “abuse”, the Interpretive Guidelines provided under 42 CFR §482.13(c)(3) clarify that “‘Abuse’ is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect, for the purpose of this requirement, is considered a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.” The statute further clarifies that this right not only extends to the conduct of staff, but also other patients and visitors. 42 CFR §482,13(c)(3) provides,

“The intent of this requirement is to prohibit all forms of abuse, neglect (as a form of abuse) and harassment whether from staff, other patients or visitors. The hospital must ensure that patients are free from all forms of abuse, neglect, or harassment. The hospital must have mechanisms/methods in place that ensure patients are free of all forms of abuse, neglect, or harassment. “

Summary

In evaluating the issue presented before Dr. Stone, the preceding sections clearly outline the concern involved surrounding workplace violence in a healthcare facility. The behavior associated with violent patients clearly indicates a high-potential for a workplace-violence incident. As pointed out by Colling, the frequent presence of mental health patients, isolated work situations, increasing use of hospitals by law enforcement, and lack of staff training compound the risk to hospital staff. In addition, many of the “individual factors” presented previously under Colling’s “factors-analysis” are prominent with many behavioral patients, including such characteristics as controlling and demanding presence, psychotic behavior, depression, unusual frustration levels, drug-dependence, and social isolation. Finally, the United States Bureau of Labor Statistics has validated that this risk is, in fact, an unfortunate reality to healthcare workers.

The current regulatory scheme also exposes hospital workers to the risk of managing violent behavior within their environment. In most other industries, the objecting in mitigating the impacts of this type of behavior is to immediately isolate and remove it from the environment. Releasing the patient would be most effective in avoiding the risk involving a potential workplace violence incident as well as preserving the personal safety of hospital staff. However, this alternative contains many forms of liability exposures, defined by Williams Jr.

(1998) as “obligations imposed by the legal system.” The hospital is not only discouraged from discharging dangerous persons, but maintains an inherent obligation to confine the person to the environment and manage their care. Under 42 CFR §482 (Federal Medicare/Medicaid Regulations), a healthcare facility maintains obligations to provide a safe environment for patients within their facility, and protect every patient from violent behavior – specifically that of other patients and visitors. Thus, 42 CFR § 482 contemplates that certain patients may present with conditions where violent behavior is commonly symptomatic – and hospital staff maintain an obligation to control the behavior in order to protect the patient. In addition, the regulations set forth under Minn. Stat. § 253B (Minnesota Commitment and Treatment Act) also provide certain public health and safety professionals the authority to confine patients which exhibit violent behavior which is symptomatic of a medical condition – and impose medical treatment within a controlled environment. Thus, hospital workers who work to fulfill these rights and obligations to their patients find themselves directly managing and controlling the risk associated with violent behavior to protect the patients within the healthcare environment.

In contrast, although this risk is a reality, there exists an ambiguous regulatory scheme to protect hospital workers from this risk. Although the Occupational Safety and Health Administration has recognized this risk and issued guidelines in an attempt to lessen these occurrences, enforcement of these guidelines is limited merely to the “Workplace Violence Tool for Healthcare Industry”. In addition, the current scheme under various workers’ compensation statutes limits an employee’s ability to hold an employer accountable by limiting the employee to recover costs associated with treatment for injuries. Thus, the harsh reality is that healthcare workers must expose themselves to instances involving violent patient behavior to protect their

patients, but have no regulatory protection to ensure that adequate safeguards are provided to minimize their own risk.

Thus, although retaining the patient poses the greatest risk for human asset exposures, defined by Williams Jr. (1998) as “the human resources of the organization,” the hospital maintains an inherent obligation to both the patient and community. The risks common with these conditions yield the need for “alternative measures” to enable hospital workers to safely work under these conditions. The intent of this study is to evaluate workplace violence programs within the healthcare industry, whether established or informal, in order to identify methods and strategies used to manage the hazard of workplace violence. The objectives of this study involve attempting to identify and evaluate current methods of assessment, identification, control, and monitoring. The goals of this research are to improve worker safety and reduce costs as they relate to workplace violence incidents by identifying the effective program elements which are used to manage workplace violence in acute healthcare environments.

Chapter III: Methodology

Introduction

This chapter will provide an overview of the process involved in conducting this study, and includes site-selection, data-collection, subject-selection, the survey-tool, and analysis of the data. This study will attempt to examine the problem of workplace violence in an acute healthcare setting through a qualitative analysis of Hospital XYZ. Through first-hand observation, the researcher will assess workplace violence incidents as they are managed, and evaluate methods of managing the hazard of workplace violence as well as minimizing the risk to healthcare workers within the environment. The researcher will conduct post-incident interviews with the staff directly involved in the incident in attempt to gauge staff perception of workplace violence, identify common factors and variables used to assess workplace violence incidents, and identify potential controls used to both manage and mitigate workplace violence.

Purpose of the Study

The purpose of this study is to further evaluate the problem of workplace violence in healthcare facilities. This study will capture how the healthcare worker typically perceives workplace violence. In addition, this study will identify potential factors used to assess and measure workplace violence as well as strategies, both formal and informal, that healthcare facilities use to manage workplace violence and protect healthcare workers in these environments. Finally, this study will evaluate these strategies and provide recommendations to increase the safety of the healthcare worker from the risks associated with workplace violence.

Goals of the Study

1. Identify factors to assess and evaluate workplace violence in the healthcare environment by conducting a post-incident analysis of workplace violence incidents occurring within a pre-identified acute-healthcare facility using a targeted survey.
2. Assess factors that influence how healthcare workers misperceive “workplace violence” within a pre-identified acute-healthcare facility using a targeted survey.
3. Identify current strategies used within a pre-identified acute healthcare facility to protect healthcare workers from workplace violence associated with patient behavior using a targeted survey.
4. Identify fundamental elements that may be incorporated into a healthcare facility’s workplace violence safety program using a targeted survey.

Setting of the Study

The setting for this study, Hospital XYZ, was identified due to the array of characteristics that tend to be associated with incidents of workplace violence. Hospital XYZ is an acute healthcare facility located in the downtown area of a large city located in the Midwest region of the United States. Hospital XYZ is nested in a neighborhood comprised of many bars, restaurants, businesses and government establishments; a sports arena and entertainment complex; and facilities providing charitable services to the local community. Hospital XYZ maintains a bed-count capacity within the 200-300 range, provides general in-patient and out-patient services, and maintains an average monthly occupancy rate of seventy-two percent. Hospital XYZ includes medical units focused on providing emergency, critical, maternity, and hospice care. In addition, Hospital XYZ also provides psychiatric in-patient and out-patient services for patients identified with mental illness, behavioral disorders and chemical

dependency. Finally, Hospital XYZ provides out-patient services for laboratory, radiology, nuclear-medicine, and surgical procedures and treatment. To support these services, the hospital employs approximately 2,500 employees, credentials approximately 1,100 physicians, and enlists over 200 volunteers.

Hospital XYZ was also selected for this study due to the eagerness of Hospital XYZ's executive leadership to support this research. During the previous three years, Hospital XYZ experienced a significant number of staff injuries, a considerable percentage of which were attributed to workplace violence incidents. Hospital leadership also expressed concern that workplace violence incidents were leading to decreases in staff morale, disruptions in service, and concerns for patient and staff safety.

Data Collection

At the onset prior to the study period, the researcher established relationships with the executive and administrative levels of management, line-supervisors, and various employees of Hospital XYZ. Pursuant to a Confidentiality Agreement, the researcher was provided access to statistics, measures, policies, and procedures. The intent, nature, and methodologies involved in the study was disclosed only to executive management, and was not shared nor discussed with other management, supervisors, employees, volunteers, patients, or visitors of Hospital XYZ.

Every injury that was experienced by Hospital XYZ staff during the course of their employment with Hospital XYZ, and that was reported in accordance with Hospital XYZ's reporting procedures, had been recorded by Hospital XYZ's Employee Occupational Health Department in the employee's medical file. The information maintained included the employee's name, title, department and contact information; nature and description of the injury; date, time and location of the incident leading to the injury; and circumstances and conditions causing the

injury. In addition, Hospital XYZ's Employee Occupational Health Department also maintained the facility's OSHA Log of Employee Injuries and Illnesses. To protect the privacy and confidentiality of the employees involved, the information provided to the researcher was provided in aggregate to reflect only the nature and description of the injuries; date, time, and location of the incident leading to the injury; and circumstances and conditions causing the injuries. Personal identifiers such as name, date of birth, address, hire date, and employee number was withheld to preserve the anonymity of the employees involved.

In addition, every incident of workplace violence that occurred within Hospital XYZ, and that was reported in accordance with Hospital XYZ's reporting procedures, was recorded by Hospital XYZ's Security Department. The information maintained included the contact information of the victims and witnesses; date, time, and location of the incident; nature of the incident; actions taken by Hospital XYZ staff; and circumstances surrounding the incident. To protect the privacy and confidentiality of the employees and patients involved, the information provided to the researcher was provided in aggregate to reflect only the nature and description of the incidents; date, time, and location of the incident; and circumstances and conditions surrounding the incident.

The researcher was also limited to reviewing details of incidents occurring between August 2003 and July 2006, the three years immediately preceding the study period. In reviewing the documentation provided by Hospital XYZ's Employee Occupational Health Department, the researcher tallied the number of employee injuries reported, the number of OSHA Recordable Injuries reported, the number of injuries reported resulting from assaultive behavior, and OSHA incidence rates. In reviewing the documentation provided by Hospital XYZ's Security Department, the researcher tallied the number of incidents where patients were

placed on behavioral holds and required monitoring by Hospital XYZ Security staff, patients who were assaultive or threatening, or patients who were involuntarily placed in restraints. Finally, the researcher also tallied the number of incidents involving violent acts, threats and harassment perpetrated by persons who were not classified as patients of Hospital XYZ at the time of the incident.

Subsequent to the analysis of previous incidents, the researcher conducted an on-site qualitative study of Hospital XYZ during a calendar month. The researcher scheduled shifts to provide for equal representation of day, evening, and night shifts. In addition, the researcher scheduled shifts to provide for equal representation of weekdays and weekends. While on site, the researcher either shadowed an employee of Hospital XYZ's Security Department, or was positioned in Hospital XYZ's Emergency Services Department, Behavioral Unit, Chemical Dependency Unit, or main lobby while in constant communication with Hospital XYZ's Security Department. Upon the being notified of a report of a potential workplace violence incident occurring, the researcher would respond to the location of the incident, observe the behavior of the patient and response of the staff from a safe-and-distant location, and document any relevant observations in field notes. To preserve the integrity of the study, the researcher did not play an active role within any of the incidents. At the conclusion of the incident, the researcher interviewed the primary staff member who first encountered the incident. Interviews with Hospital XYZ staff were conducted using the *Observational-Participant Survey* (See Appendix C). All data collected was limited to the researcher's field notes and completed *Observational-Participant Survey* tool. Due to concerns with confidentiality, privacy, security and liability, the researcher was not permitted to use media involving video-recording, audio-recording, or photography.

Selection of Subjects

Due to the unpredictability over when and where each individual incident occurred, incidents evaluated were limited to those occurring within the time frames that the researcher was present at Hospital XYZ. In addition, Hospital XYZ staff, patients, and visitors were subjected to the inherent unpredictability and apparent randomness of workplace violence incidents. Thus, the subjects interviewed were Hospital XYZ staff, and limited to those that were involved in the incident or merely observed or witnessed the event.

Survey Design

The survey tool used in this study was comprised of eight sections, and developed by the researcher based on findings contained in the review of literature. The “Incident Information” section provided a unique incident number, and identified attributes surrounding the incident such as day, time, and location of the incident. The “Demographics of Victim” section identified the age, gender, and experience of the victim involved, as well as the number of co-workers present in the working environment of the victim. Information in this section was gathered directly from the victim during the interview. The “Demographics of Perpetrator” section noted the age, gender, and role of the perpetrator of the workplace violence incident. This section also categorized the role of the perpetrator as a patient/customer, employee, legitimate visitor, or illegitimate visitor in accordance with the Russell Colling’s Role-Analysis. Information in this section was gathered directly from the victim during the interview. The “Demographics of Relationship Between Victim and Perpetrator” section classified the workplace violence incident according to Russell Colling’s Role-Relationship Analysis, and was based upon the relationship between the victim and the perpetrator. Information in this section was gathered directly from the victim during the interview. The “Type – Continuum” section classified the severity of the

workplace violence incident according to Russell Colling's *Acts of Violence in the Healthcare Workplace Continuum* presented in *Table 5*. The classification of severity on the continuum in *Table 5* were defined by actions and behavior of the perpetrator as observed by or reported to the researcher. Upon assessing the actions and behavior of the perpetrator, the incident was classified as compliant-cooperative, verbal-inappropriate (non-physical), verbal-threats/intimidation (non-physical), passive-resistance (physical), active-resistance (physical), simple assault (physical), or aggravated assault (physical). The "Participant's Response" section categorized the response of the victim/employee in accordance with the victim's actions in response to being exposed to the workplace violence incident. The classification of the victim's response was defined by the actions of the victim as observed by or reported to the researcher. Upon assessing the actions and response of the victim, the incident was classified as no action taken, called for assistance (no intervention), maintained presence (no intervention), verbally addressed behavior (intervened), applied physical control (intervened), applied physical restraints (intervened), formal charges/arrest (intervened), called for police assistance (intervened). The "Outcome" section noted the victim's individual psychological and emotional response to the incident. During the interview, the victim was asked to assess the changes in their levels of stress, anger, fear, and disruption in response to the incident, and prompted to rank them on a numeric scale ranging from "zero" to "five", with the value zero representing "no change", and five representing "significant change". The final "Subjective Questioning" section provided a series of open-ended questions aimed to solicit the victim's perception of whether the victim was prepared to respond to the incident; whether the victim was adequately protected from the incident; victim's identification of available and needed controls; victim's perception of factors used to forecast the incident; and the victim's perception of whether they could have prevented

the incident from occurring. The last question prompted the victim to identify whether they perceived the incident as a workplace violence incident. The researcher reviewed, compiled, and analyzed responses to the completed surveys.

Analysis of Results

The analysis of the completed surveys involved the identification of a single variable, identifying various subcategories within the variable, and classifying the response of each individual survey to its respective subcategory. For example, in classifying a completed survey in accordance with the variable “gender of the victim”, each survey was classified into either the “male” or “female” subcategory. In addition, variables involving a rating according to a numeric scale were comprised of subcategories of the numeric values within the scale (e.g. zero, one). Every survey was evaluated in the light of an identified variable, and classified within one of the subcategories of the respective variable. After all surveys were reviewed and classified, each subcategory was tallied to reflect a total number of responses from all surveys, and each variable was analyzed for distribution among its subcategories. Variables used in the analysis will be identified in the subsequent paragraphs.

After all surveys were tallied with respect to a single variable, identified variables were then compared with respect to their relationship to each other. The comparison of each pair of variables yielded a number of subcategories based upon the subcategories contained in each individual variable. For example, in comparing the variable “gender of the victim” with the variable “gender of the perpetrator”, the subcategories identified were “male/male”, “male/female”, “female/male”, and “female/female”. Every survey was evaluated in the light of an identified pair of variables, and classified within one of the subcategories of the respective pair of variables. After all surveys were reviewed and classified, each subcategory was tallied to

reflect a total number of responses from all surveys, and each pair of variables was analyzed for distribution among its subcategories. Pairs of variables used in the analysis will be identified in the subsequent paragraphs.

Goal one. Variables such as time of day, location, role-relationship, severity of workplace violence incident, victim response, gender, age, and work-experience of victim were evaluated as potential factors used to evaluate workplace violence incidents in Hospital XYZ.

Time-of-day. The time that the incident was first reported to, identified, or observed by the researcher was recorded in the first section of the *Observational-Participant Survey* as the time associated with the incident. The time-of-day variable was divided into six subcategories consisting of four-hour time-frames beginning at 2:00 am, 6:00 am, 10:00 am, 2:00 pm, 6:00 pm, and 10:00 pm. The time that the incident was first reported was used to categorize the incident to its respective time-of-day subcategory.

Location. The location of where the incident first occurred, was identified or observed was recorded in the first section of the *Observational-Participant Survey* as the location associated with the incident. The location subcategories consisted of the various units, departments, or geographical locations relative to Hospital XYZ.

Role-relationship. As this study was limited to interviewing employees as participants, the role of the victim in every incident, in accordance with the Colling's Role-Relationship analysis, was that of "employee". Thus, the role-relationship variable was classified into four subcategories: Employee - Employee, Patient - Employee, Legitimate Visitor – Employee, and Illegitimate Visitor – Employee. The role-relationship of the incident was recorded in the fourth section of the *Observational-Participant Survey*.

Number of co-workers: Each incident was also classified according to the number of co-workers in the surrounding work-environment at the time of the incident. In analyzing each incident according to this variable, each incident was classified into one of six subcategories: No co-workers, one or two co-workers, three to five co-workers, six to ten co-workers, eleven to fifteen co-workers, or more than fifteen co-workers present in the victim's work area at the time of the incident.

Severity. The variable of severity was divided into the following seven subcategories: Compliant-cooperative, verbal-inappropriate, verbal-threats, physical-passive resistance, physical – active resistance, physical – simple assault, and physical – aggravated assault. Each incident was classified into one of the afore-mentioned subcategories based upon the actions/behavior of the perpetrator.

Victim response. The variable of victim response was divided into the following ten subcategories: No intervention – Not recognized, No intervention – Dismissed, No intervention – Called for assistance, Intervention – Maintained presence, Intervention – Verbally addressed, Intervention – Assembled team, Intervention – Physical Control, Intervention – Restraint, Intervention – Police Assistance, and Intervention – Arrest. Each incident was classified into one of the afore-mentioned subcategories based upon the response of the victim who initially encountered the incident.

Work-experience. The number of years that the victim worked in an acute healthcare environment was recorded in the second section of the *Observational-Participant Survey* as the years of healthcare work experience. The years-of-experience variable was divided into eight subcategories: Less than one year, one or two years, three to five years, six to ten years, eleven to fifteen years, sixteen to twenty years, twenty-one to twenty-five

years, and greater-than twenty-five years. The years of experience disclosed by the victim was used to categorize the incident to its years-of-experience subcategory.

Gender. The genders of both the victim and perpetrator were categorized into the common subcategories of male and female. Each incident was separately classified according to the gender of the victim, and the gender of the perpetrator. The gender of the victim was recorded in the second section, and the gender of the perpetrator was recorded in the third section, of the *Observational-Participant Survey*. Subsequently, the genders of both the victim and perpetrator were paired to create subcategories of male - male, male - female, female - male, and female - female.

Age. The ages of both the victim and perpetrator were categorized into the following subcategories: Less than eighteen years, eighteen to twenty-one years, twenty-two to twenty-five years, twenty-six to thirty-five years, thirty-six to forty-five years, forty-six to fifty-five years, and more than fifty-five years. Each incident was separately classified according to the age of the victim, and the age of the perpetrator. The age of the victim was recorded in the second section, and the age of the perpetrator was recorded in the third section, of the *Observational-Participant Survey*. Subsequently, the ages of both the victim and perpetrator were paired to create subcategories consisting of the aforementioned age-groups. Finally, subcategories were created that reflected the relationship between the age-group of the victim and that of the perpetrator, and the incident was classified accordingly. For example, if the victim was classified into the twenty-six to thirty-five age group, and the perpetrator was classified into the twenty-one to twenty-five age group, the victim was one age-group older than the perpetrator, and the incident was classified in the “one older” subcategory.

Subjective Self-Assessments. During the interview, each victim was prompted to assess changes in their levels of stress, anger, fear and disruption as a result of the incident. Upon assessing, victims were requested to rate their respective levels on a numeric scale, “zero” representing “no change at all”, “five” indicating a “significant change”, and values on through four representing scaled increases, and the responses were noted in section seven of the *Observational-Participant Survey*. Stress, anger, fear and disruption were identified as the variables, and the response-rating was the subcategory associated with each incident.

Goal two. First, each incident was either identified or disqualified as a workplace violence incident in accordance with its severity classification. Incidents that were classified at the lowest end of the severity continuum (i.e. Compliant - cooperative) were disqualified as workplace-violence incidents, and classified as such. Incidents classified in any of the other six subcategories were classified as workplace violence incidents. Second, each incident was classified according to the victim’s “yes” or “no” response to the final question (i.e. “Please rate whether you believe this incident is classified as “workplace violence”) in section eight of the *Observational-Participant Survey*. Third, the severity classification and the victim’s classification of the incident were paired, thus yielding four subcategories:

1. Workplace violence incidents where the victim correctly perceived the incident as workplace violence;
2. Workplace violence incidents where the victim misperceived the incident as non-workplace violence (i.e. Under-inclusive).
3. Non-workplace violence incidents where the victim correctly perceived the incident as non-workplace violence.

4. Non-workplace violence incidents where the victim misperceived the incident as workplace violence (i.e. Over-inclusive).

Fourth, the instances where the victim misperceived the incident were classified and tabulated separately with respect to the following variables: Number of co-workers in the area, role-relationship, severity, work-experience of victim, gender and age. In addition, the victim's subjective ratings of stress, anger, fear and disruption in section seven of the *Observational-Participant Survey* were also classified and tabulated separately where the victim misperceived the incident. Finally, the distribution for each variable involving instances where the victim misperceived was compared to the total instances involving each variable.

Goals three and four. Similar to above, each incident was either identified or disqualified as a workplace violence incident in accordance with its severity classification. Incidents that were classified at the lowest end of the severity continuum (i.e. Compliant - cooperative) were disqualified as workplace-violence incidents, and classified as such. Incidents classified in any of the other six subcategories were classified as workplace violence incidents. Second, each incident was classified according to the victim's "yes" or "no" response to the final question (i.e. "Please rate whether you believe this incident is classified as "workplace violence") in section eight of the *Observational-Participant Survey*. Third, the severity classification and the victim's classification of the incident were paired, thus yielding four subcategories:

1. Workplace violence incidents where the victim correctly perceived the incident as workplace violence;
2. Workplace violence incidents where the victim misperceived the incident as non-workplace violence (i.e. Under-inclusive).

3. Non-workplace violence incidents where the victim correctly perceived the incident as non-workplace violence.
4. Non-workplace violence incidents where the victim misperceived the incident as workplace violence (i.e. Over-inclusive).

Fourth, the instances where the victim misperceived the incident were classified and tabulated separately with respect to the following: variables provided in section eight of the *Observational-Participant Survey*: Whether the victim believed they could have forecasted the incident, whether the victim believed they could have minimized the chances of the incident from occurring, whether the victim believed they were adequately prepared, and whether the victim believed they were adequately protected. Finally, the distribution for each variable involving instances where the victim misperceived was compared to the total instances involving each variable.

Finally, victims were asked three open-ended questions as set forth in section eight of the *Observational-Participant Survey*. Victims were asked to identify any factors which the victim used, or could have used, to forecast the workplace violence incident that the victim encountered. Victims were also asked to identify any measures or controls in place to protect persons from the risk associated with the workplace violence incident they encountered. Finally, victims were asked to identify measures and controls that were needed to increase their protection, thus decrease the risk, associated with workplace violence incidents similar to the incident the victim encountered. Upon completion of the survey period, the responses to all three open-ended questions were grouped by similarity and compiled.

Chapter IV: Results

Introduction

The results of the observational study, data collection and targeted surveys at Hospital XYZ will be outlined in this chapter. Specifically, the results will be presented to specifically address the first three goals of this study. Discussion of the fourth goal will be reserved for Chapter V, where analysis of the data will yield recommendations that acute healthcare facilities may use to further improve efforts in developing workplace violence management plans.

Purpose of the Study

The purpose of this study is to further evaluate the problem of workplace violence in healthcare facilities. This study will assess various factors that influence how the healthcare worker typically perceives workplace violence. In addition, this study will identify potential factors used to assess and measure workplace violence as well as strategies, both formal and informal, that healthcare facilities use to manage workplace violence and protect healthcare workers in these environments. Finally, this study will evaluate these strategies and provide recommendations to increase the safety of the healthcare worker from the risks associated with workplace violence.

Goals of the Study

1. Identify factors to assess and evaluate workplace violence in the healthcare environment by conducting a post-incident analysis of workplace violence incidents occurring within a pre-identified acute-healthcare facility using a targeted survey.
2. Assess factors which influence how healthcare workers misperceive “workplace violence” within a pre-identified acute-healthcare facility using a targeted survey for healthcare workers.

3. Identify current strategies to protect healthcare workers from workplace violence associated with patient behavior using a targeted survey for healthcare workers within a pre-identified acute healthcare facility.
4. Identify fundamental elements that may be incorporated into a healthcare facility's workplace violence safety program using a targeted survey for healthcare workers within a pre-identified acute healthcare facility.

General Findings

A statistical representation of the incidents occurring and reported during the three years preceding the study is provided in *Table 7*.

Table 7. Incident Statistics for Hospital XYZ for Preceding Three Years

Measure	3 Years Prior	2 Years Prior	1 Year Prior
Employee Injuries Reported (Recordable and Non-Recordable)	268	242	337
Employee Injuries Reported (Recordable Only)	119	119	155
Incident Rate (Recordable Injuries Only)	20.30	19.44	25.27
Recordable Injuries Reported (Assaults Only)	24	7	9
Incident Rate (Recordable Assault Injuries Only)	4.10	1.14	1.47
Number of Patients on Behavioral Holds Requiring Security Precautions	903	843	559
Incidents Involving Patient Restraint (Behavioral Only)	324	443	619
Incidents Involving Patients Who Were Assaultive/Threatening	150	138	168
Violent Acts (Non-Patients)	5	11	3
Threats (Non-Patient)	7	5	2
Harassment (Non-Patient)	12	3	11

Source: Hospital XYZ (2006)

Subsequent to the analysis of previous incidents, the researcher conducted an on-site qualitative study of Hospital XYZ between August 1, 2006 and August 31, 2006. Hospital XYZ's operational performance is illustrated below in *Table 8*, as depicted by average daily census, total adjusted cases, patient days, and total employee hours worked.

Table 8. Hospital XYZ's Operational Performance – August 2006 and Prior Year

Measure	August 2006	Monthly Average of Twelve Months Prior
Average Daily Census	185	179
Total Adjusted Cases	1594	1172
Patient Days	5736	5441
Total Employee Hours	104471.2	102236.5

Source: Hospital XYZ (2006)

During the study period, the researcher was on site for a total of 220 hours, consisting of five ten-hour shifts per calendar-week. *Table 9* illustrates the number of incidents evaluated in the study, as well as the total number of incidents reported during the month of August 2006 which includes incidents that occurred and were reported when the researcher was off-site.

In addition, the study revealed that Hospital XYZ maintained a policy on Hospital XYZ's general position prohibiting violence within the workplace as well as a general process for reporting workplace violence incidents as they occur. However, Hospital XYZ maintained no comprehensive plan to define workplace violence; no objective means of identifying workplace violence; no measures to evaluate trends and patterns of incidents; no collective identification of controls and measures; and no formal process to evaluate incidents individually or collectively.

Goal One

During the study period, the researcher directly observed eighty-nine of the total 117 incidents which fell within the realm of workplace violence. The following sections provide a synopsis of the incidents with respect to the following variables: Time of day, location, number of co-workers present in the victim's work environment at the time of the incident, role-relationship between victim and perpetrator, severity, response of the victim, work-experience of the victim, genders and ages of the victim and perpetrator, and the victim's self-assessments of changes in stress, anger, fear and disruption as a result of their encounter.

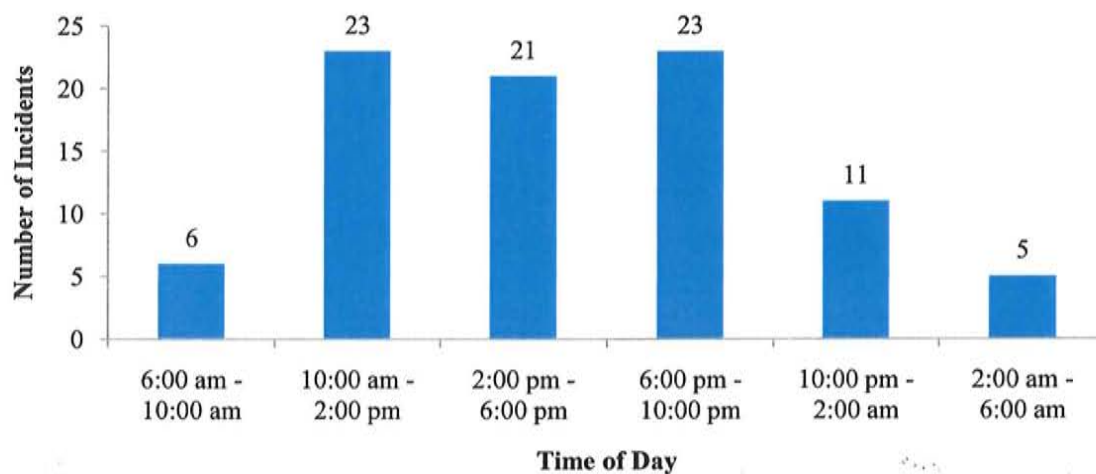
Table 9. Incident Statistics for Hospital XYZ During Study Period

Measure	Incidents Involved in Study	Total Incidents Reported (August 2006)*	*1 Year Prior
Total Number of Incidents	89	117	1183
Number of Patients on Behavioral Holds Requiring Security Precautions	55	76	559
Incidents Involving Patient Restraint (Behavioral Only)	32	39	619
Incidents Involving Patients Who Were Assaultive/Threatening	9	15	168
Violent Acts (Non-Patients)	1	1	3
Threats (Non-Patient)	1	1	2
Harassment (Non-Patient)	0	0	11

*Source: Hospital XYZ (2006)

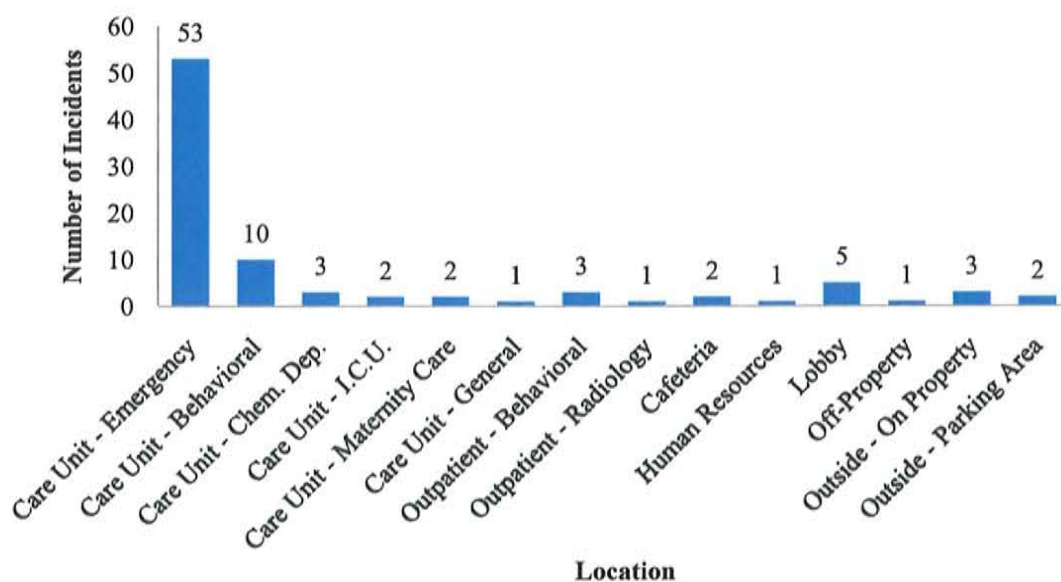
Time of day. As set forth in *Figure 1*, workplace violence incidents were found to have occurred at all time-periods of the day. However, seventy-five percent of the eighty-nine incidents occurred between the hours of 10:00 a.m. and 10:00 p.m.

Figure 1. Number of Workplace Violence Incidents at Hospital XYZ – By Time of Day



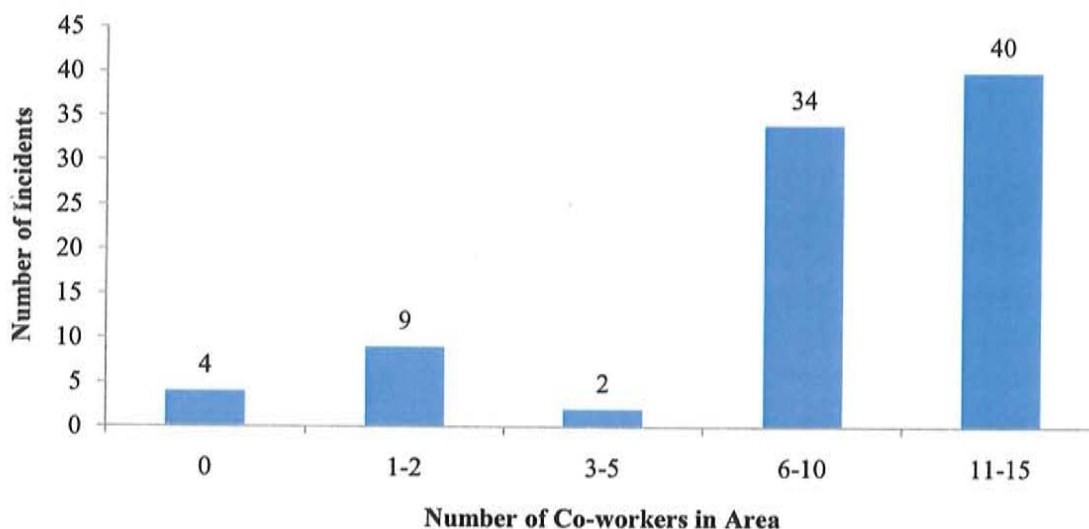
Location. Within the study period, workplace violence incidents were found to have occurred in many of the locations commonly trafficked by the public. In addition, incidents were found to have occurred in many areas where behavioral services and acute medical treatment was provided. As depicted in *Figure 2*, sixty percent of incidents occurred in the patient care area providing emergency medical services.

Figure 2. Number of Workplace Violence Incidents at Hospital XYZ – By Location



Number of co-workers. *Figure 3* illustrates the number of co-workers in the immediate work area of the victim at the time the workplace violence incident occurred. Eighty-three percent of the incidents observed occurred in areas where the victim was accompanied by at least six other hospital workers.

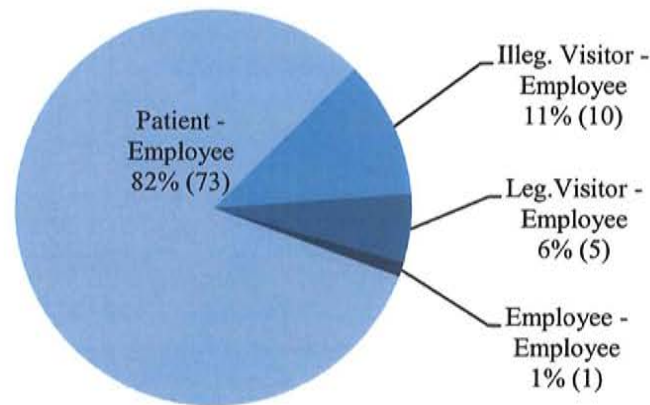
Figure 3. Number of Workplace Violence Incidents at Hospital XYZ – By Number of Co-workers in Area



Role-relationship. Incidents observed during the study period included one employee-employee conflict, disruptive family members, and the disruptive conduct of illegitimate visitors. However, as presented in *Figure 4*, over eighty percent of incidents involved a hospital worker being exposed to the violent behavior of patients within the environment.

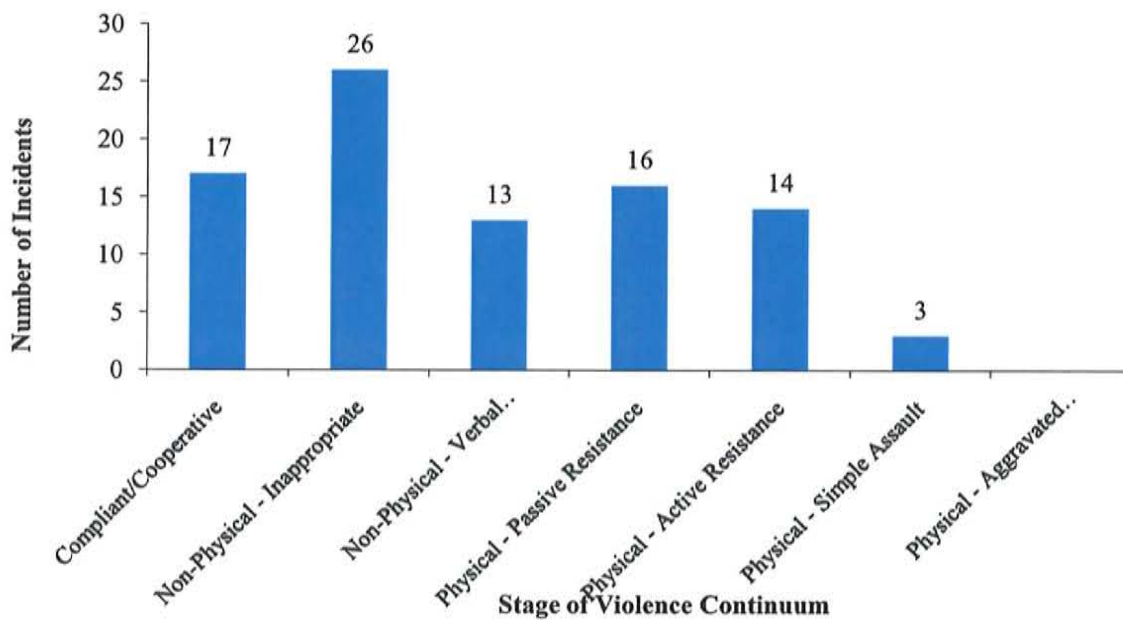
Severity. *Figure 5* represents the classification of the workplace violence incidents within the violence-continuum. Nineteen percent of incidents involved the perpetrator engaging in behavior which was not directed at any staff member, but was merely disruptive (e.g. “venting”). The majority of incidents involved non-physical interaction between the victim and perpetrator, where the victim was exposed to abusive, threatening, or intimidating behavior. In

Figure 4. Number of Workplace Violence Incidents at Hospital XYZ - By Role-Relationship



addition, nineteen percent of incidents involved some physical aggression on the part of the perpetrator towards the victim, resulting in three workers being physically assaulted.

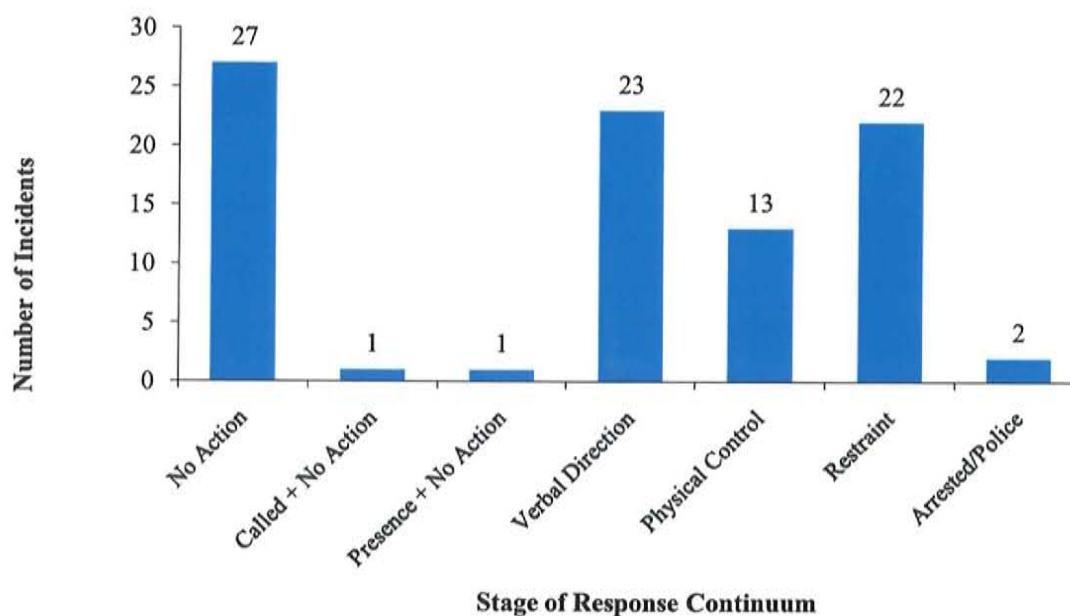
Figure 5. Number of Workplace Violence Incidents at Hospital XYZ - By Severity



Victim response. Figure 6 represents a summary of the victim's response upon initially encountering the workplace violence incident. Although thirty percent of victims took no action

upon being initially exposed to the incident, the vast majority of victims responded by personally interacting with the perpetrator and verbally addressing the behavior.

Figure 6. Number of Workplace Violence Incidents at Hospital XYZ - By Victim Response



Work-experience. Ninety-four percent of victims involved in the study had at least three years of work-experience in the healthcare industry, with no victim having more than one year and less than three years work experience. In addition, as presented in *Figure 7*, twenty-seven percent of victims had between six and ten years of experience, and thirty percent having more than fifteen years of work experience.

Gender. As illustrated in *Figure 8*, the vast majority of victims were female. Although males comprised the majority of perpetrators, as shown in *Figure 9*, the gender of the perpetrator appears to consist of an equal number of males and females. The typical gender-relationship between the victim and perpetrator involved a male perpetrator and female victim, as found in thirty-four percent of the incidents. Twenty-nine percent of incidents involved both a victim and perpetrator that were both female.

Figure 7. Number of Workplace Violence Incidents at Hospital XYZ - By Victim's Work-Experience

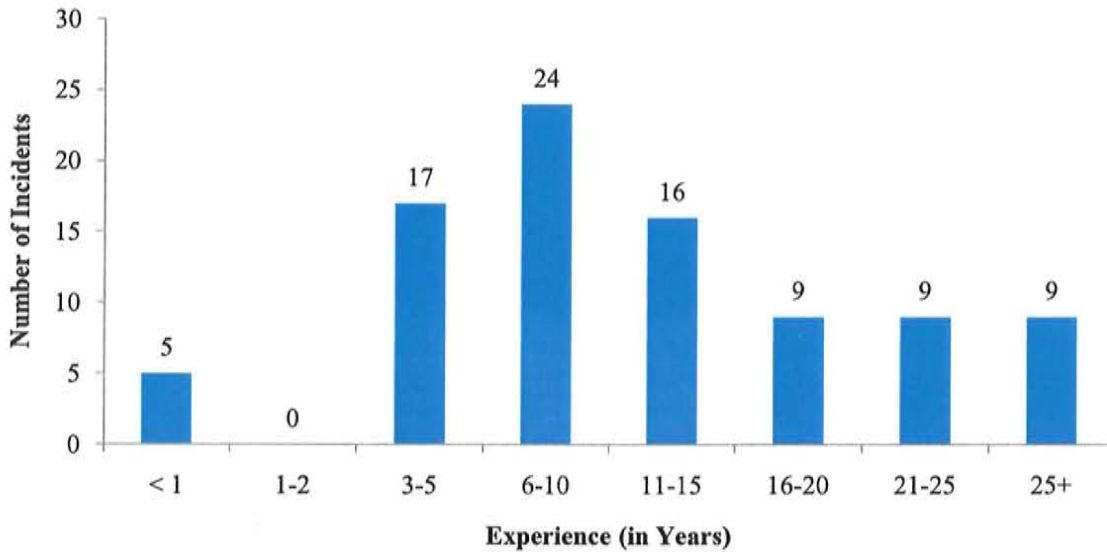


Figure 8. Number of Workplace Violence Incidents at Hospital XYZ - By Gender of Victim

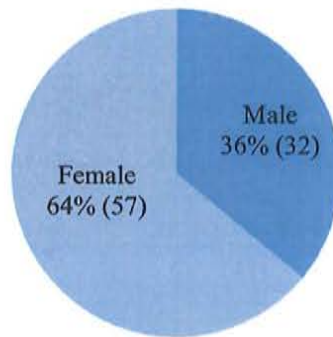


Figure 9. Number of Workplace Violence Incidents at Hospital XYZ - By Gender of Perpetrator

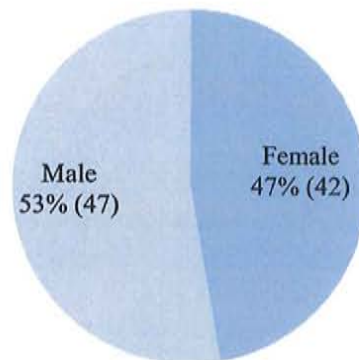
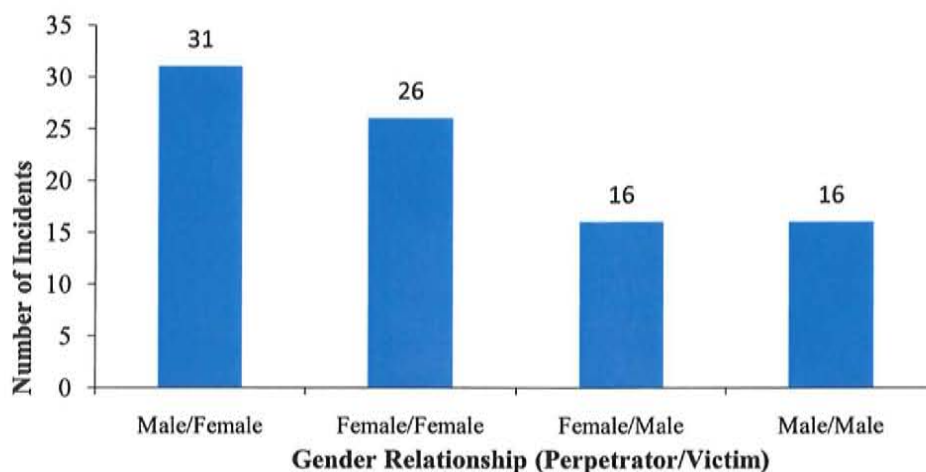


Figure 10. Number of Workplace Violence Incidents at Hospital XYZ - By Gender of Both Victim and Perpetrator



Age. Figure 11 depicts the representative age-group associated with the victims involved in the study, and illustrates that seventy-three percent of victims were between twenty-six and forty-five years old. One victim was a hospital volunteer under eighteen years old. Congruently, as shown in Figure 12, sixty percent of perpetrators were also between the ages of twenty-six and forty-five. Thirty-one percent of incidents represented the majority where the victim was one age-group older than the perpetrator, as observed in Figure 13.

Figure 11. Number of Workplace Violence Incidents at Hospital XYZ - By Age of Victim

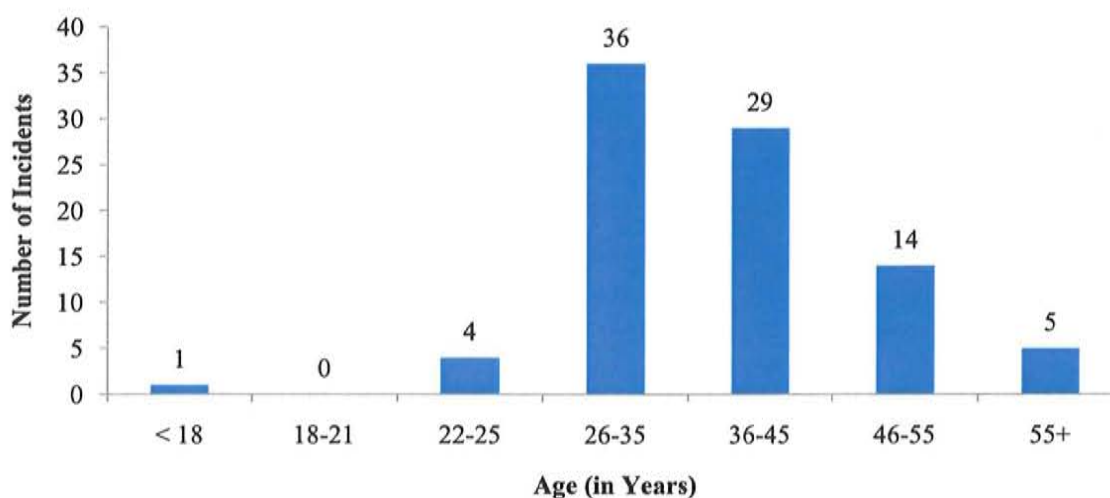


Figure 12. Number of Workplace Violence Incidents at Hospital XYZ - By Age of Perpetrator

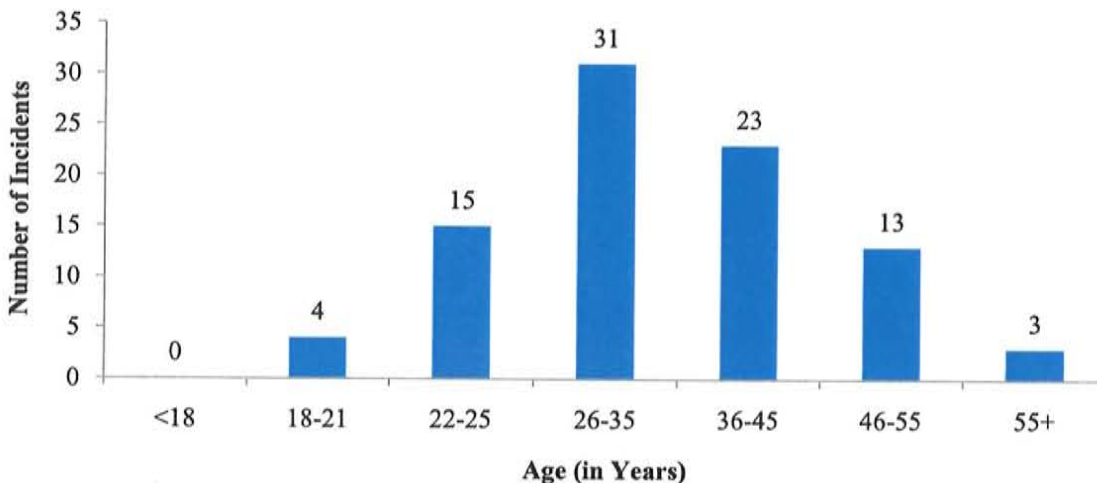
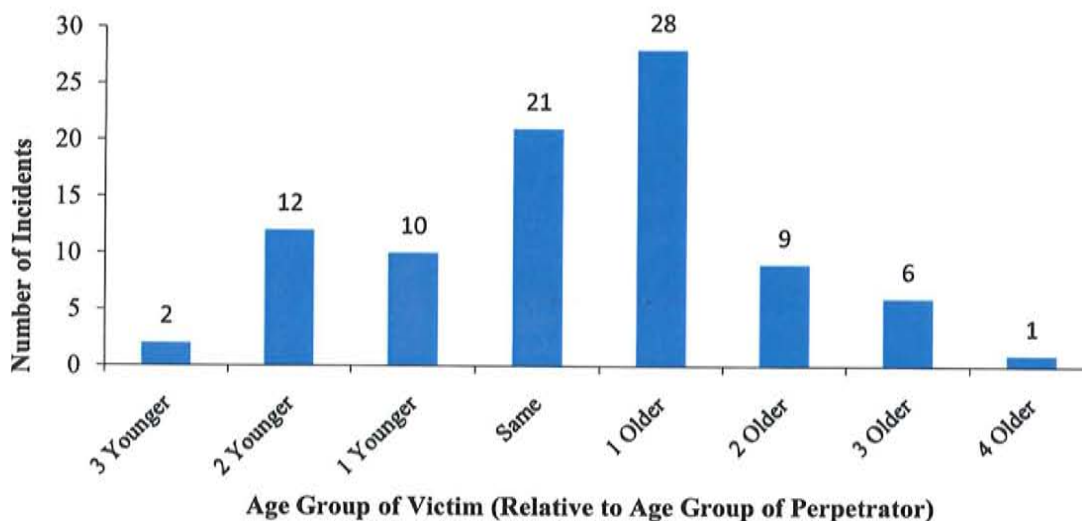
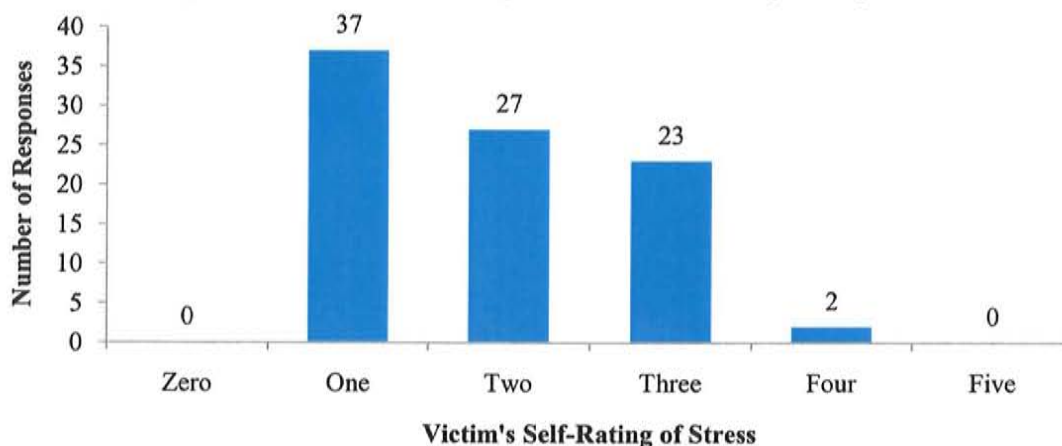


Figure 13. Number of Workplace Violence Incidents at Hospital XYZ - Difference in Age Group of Victim and Perpetrator



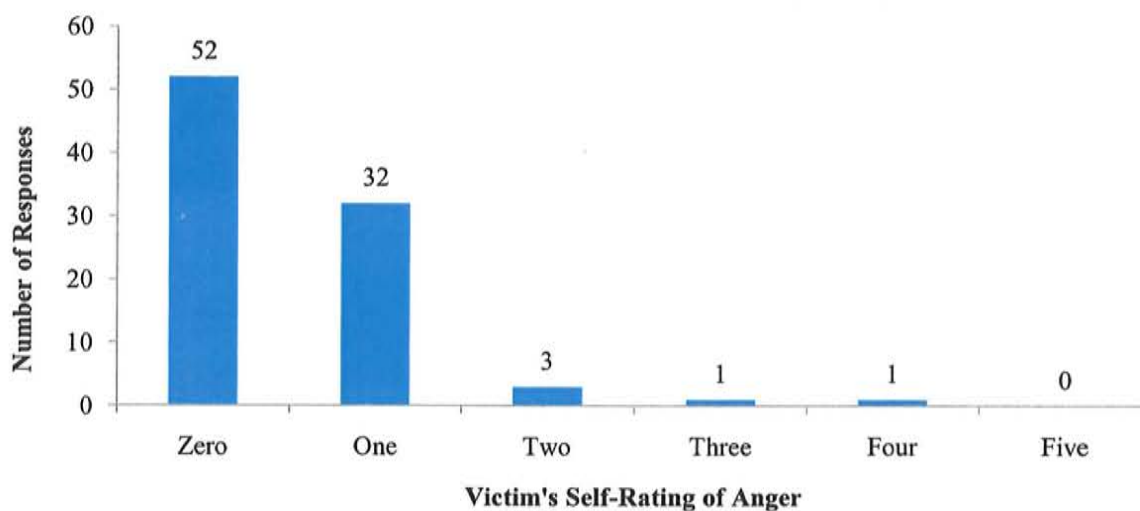
Stress. As represented in *Figure 14*, all victims indicated that they experienced some change in their stress level as a result of their exposure to workplace violence. However, ninety-eight percent of victims also indicated that they did not experience a significant change in their stress level by providing a rating of four or five.

Figure 14. Change in the Victim's Level of Stress as a Result of Workplace Violence Incident



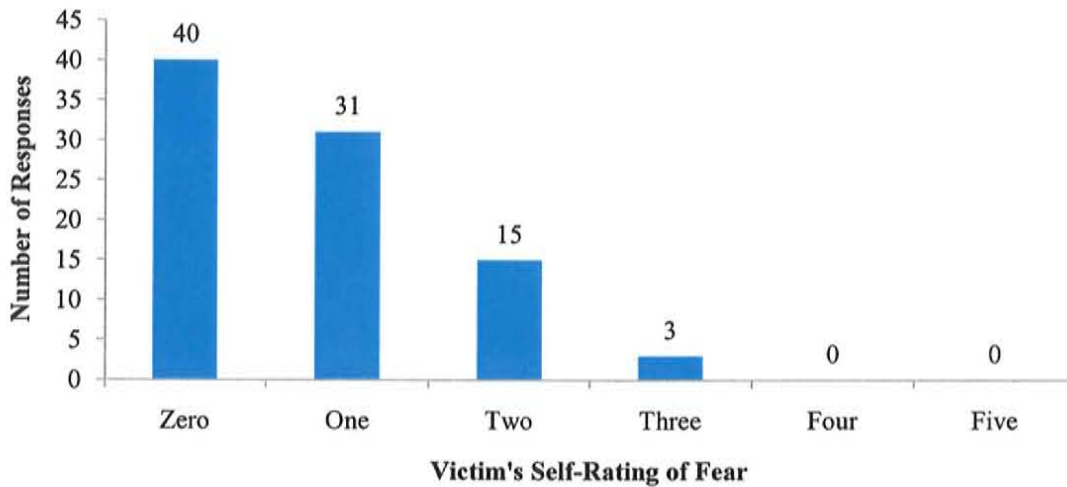
Anger. As illustrated in Figure 15, ninety-four percent of victims expressed either no change or a nominal change in their level of anger as result of their encounters. In addition, all three victims who were physically assaulted by their perpetrator scored a two, three, or four.

Figure 15. Change in the Victim's Level of Anger as a Result of Workplace Violence Incident



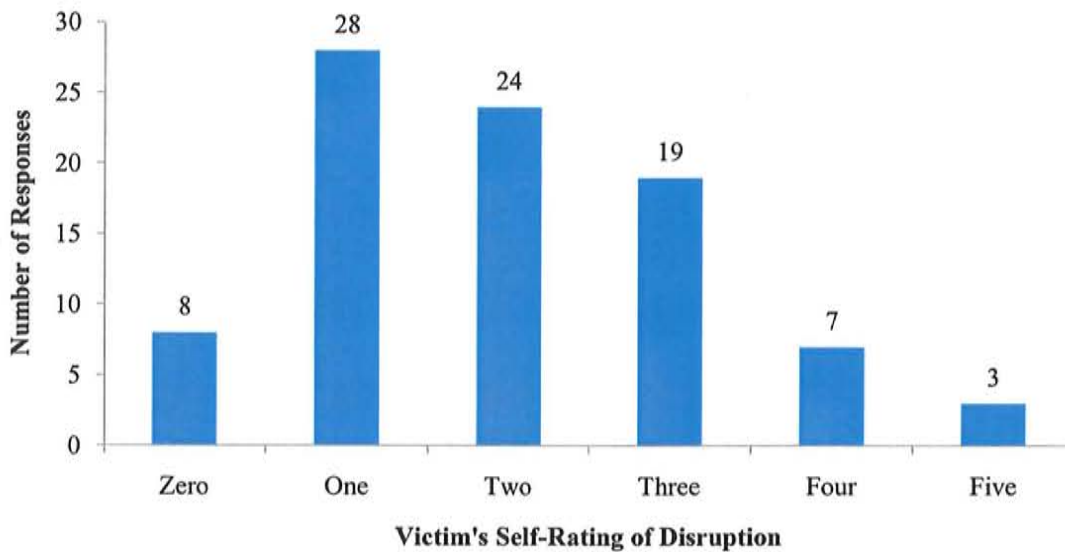
Fear. Eighty percent of victims indicated they experienced little change, if any, in their level of fear as result of their exposure. In addition, the three victims who were physically assaulted during their encounter provided the highest score of three. See Figure 16.

Figure 16. Change in the Victim's Level of Fear as a Result of Workplace Violence Incident



Disruption. As shown in *Figure 17*, ninety-one percent of victims acknowledged some level of disruption within their work-environment as a result of their respective incidents, with fifty-eight percent rating a one or two. Only nine percent of victims did not perceive a disruption within their work environment as a result of an incident.

Figure 17. Victim's Rating of Disruption as a Result of Workplace Violence Incident



Goal Two

The following sections will attempt to examine the relationship between the variables in the afore-mentioned sections and the victim's perception of whether their encounter was an incident involving workplace violence. The first section will identify those incidents where the victim either perceived a workplace violence incident where none existed, or did not perceive a workplace violence incident where one actually existed. The subsequent sections will provide data involving the relationship between the victim's misperception of the incident and the following variables: Number of co-workers in the area, severity of the incident, years of work-experience, genders and ages of both the victim and perpetrator, and the victim's subjective rating of stress, anger, fear, and disruption.

Perception and accuracy. *Figure 18* provides a contrast between incidents actually identified as workplace violence, indicated in light-blue, and those instances where the victim perceived a workplace violence episode having occurred, represented by dark-blue. The seventeen incidents involving perpetrators whose behavior was classified as "cooperative and compliant" were not recognized as actual workplace violence incidents for the purpose of assessing the accuracy of the victim's perception. Of the eighty-nine total incidents involved in the study, seventy-two incidents were actually classified as workplace violence according to the workplace violence continuum. As presented in *Figure 19*, twenty-eight victims accurately perceived workplace violence where it was identified, and fifteen victims accurately perceived no workplace violence where none had occurred, resulting in a forty-eight percent accuracy rate. More significantly, ninety-six percent of the remaining forty-six victims who "misperceived" the incident did not recognize a workplace violence incident where one had actually occurred.

Figure 18. Number of Workplace Violence Incidents at Hospital XYZ - Actual vs. Perceived

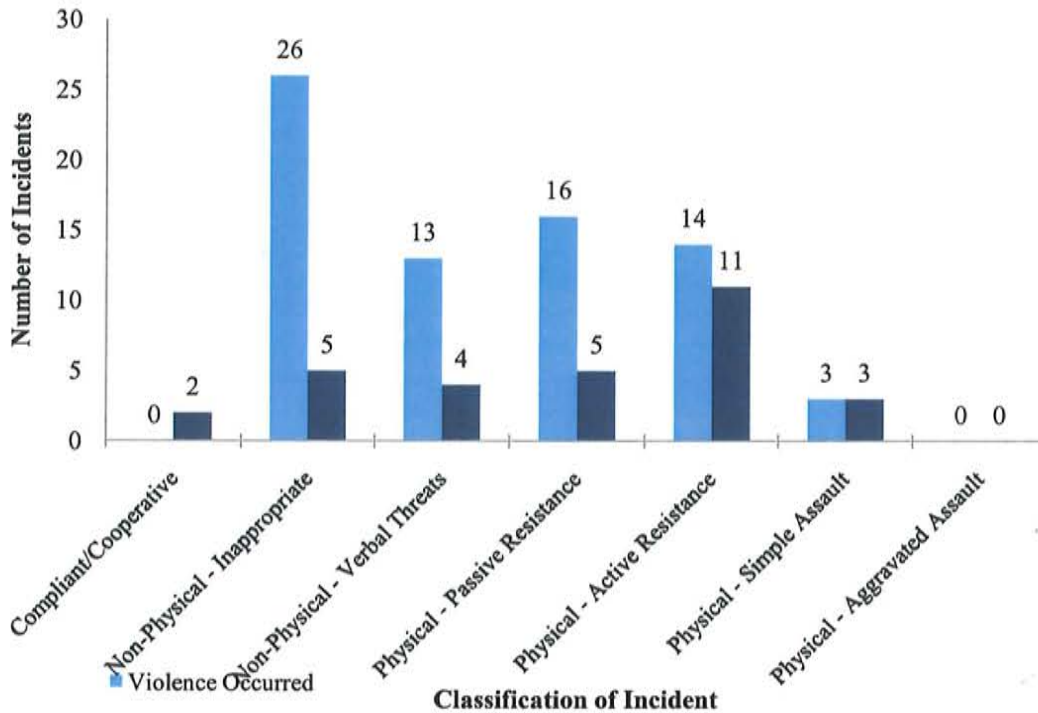
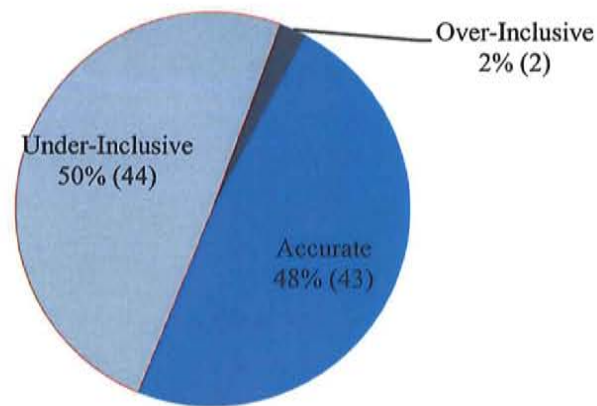


Figure 19. Accuracy of Employees to Identify Workplace Violence



Perception and number of co-workers. Figure 20 illustrates the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the number of co-workers in the victim's work area. Adjacent to each representation is the number of victims who misperceived the incident, depicted in dark blue. As

represented by *Figure 20*, where the victim was either working alone or with less than six co-workers in their area, the rate of misperception was 44% or less, where the rate increased to sixty-five percent as the number of co-workers increased to a range of six to ten. However, the rate of misperception decreased to forty-eight percent as the number of co-workers was more than ten. *Figure 21* symbolizes the distribution in each subcategory involving the variable of “number of co-workers”, and distinguishes between the victims who accurately identified the workplace violence incident and those who misperceived their encounter.

Figure 20. Misperception of Workplace Violence at Hospital XYZ - By Number of Co-Workers in Area

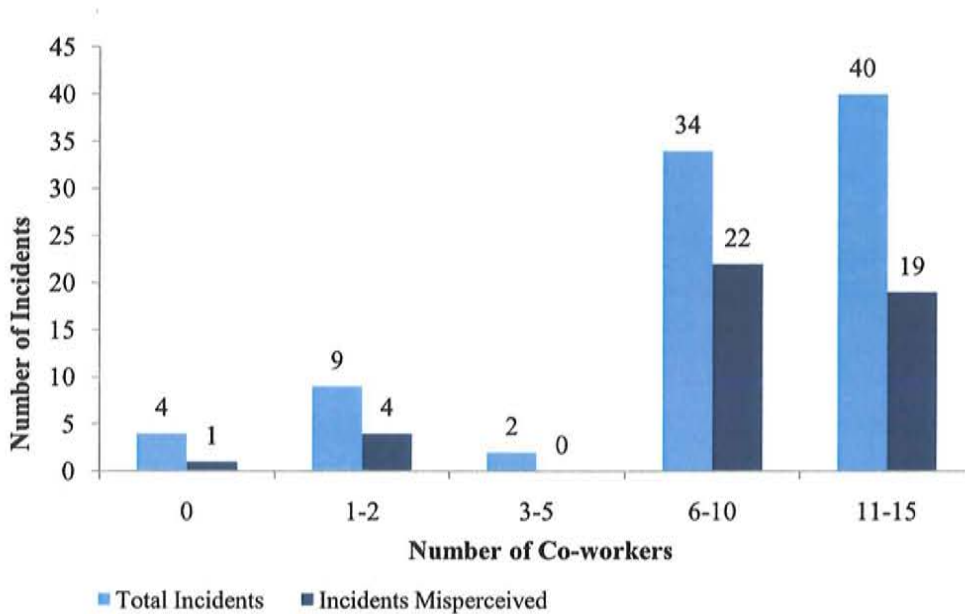
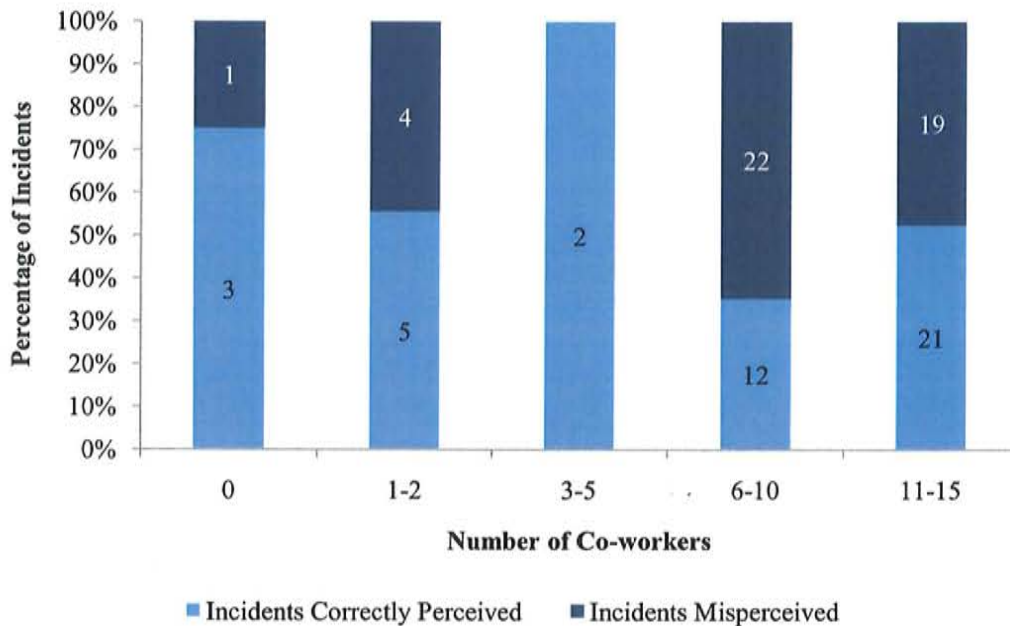


Figure 21. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ - By Number of Co-Workers in Area



Perception and severity. Figure 22 depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the severity of the workplace violence incident in accordance with the workplace violence continuum. Adjacent to each representation is the number of victims who misperceived the incident, depicted in dark blue. Where the victim was exposed to an incident involving a perpetrator who was classified as complaint and cooperative, and the incident was not identified as workplace violence, the victim's rate of misperception was twelve percent. In the remaining subcategories where the incidents were identified as workplace violence incidents with some severity, the victim's rate of misperception was higher. The highest rate, eighty-one percent, involved those instances where the perpetrator was engaged in non-physical conduct. As the subcategories increased in severity, the rate of misperception decreased from eighty-one percent to sixty-nine percent, sixty-nine percent to twenty-one percent, and finally decreasing to zero percent where the severity associated with the subcategory was highest (i.e. simple assault). See Figure 23.

Figure 22. Misperception of Workplace Violence at Hospital XYZ - By Severity

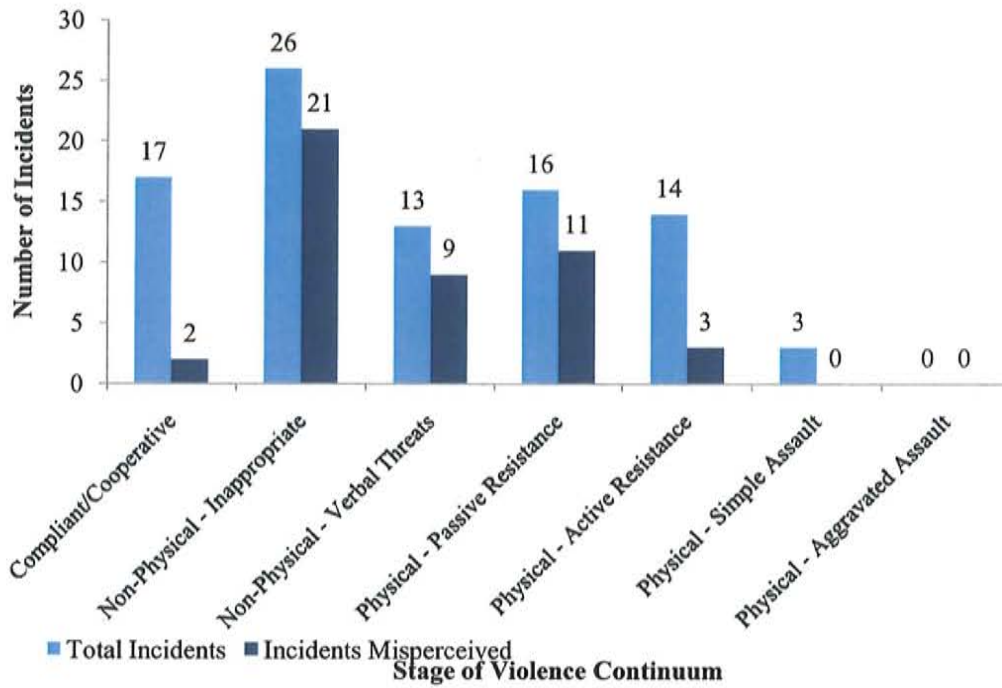
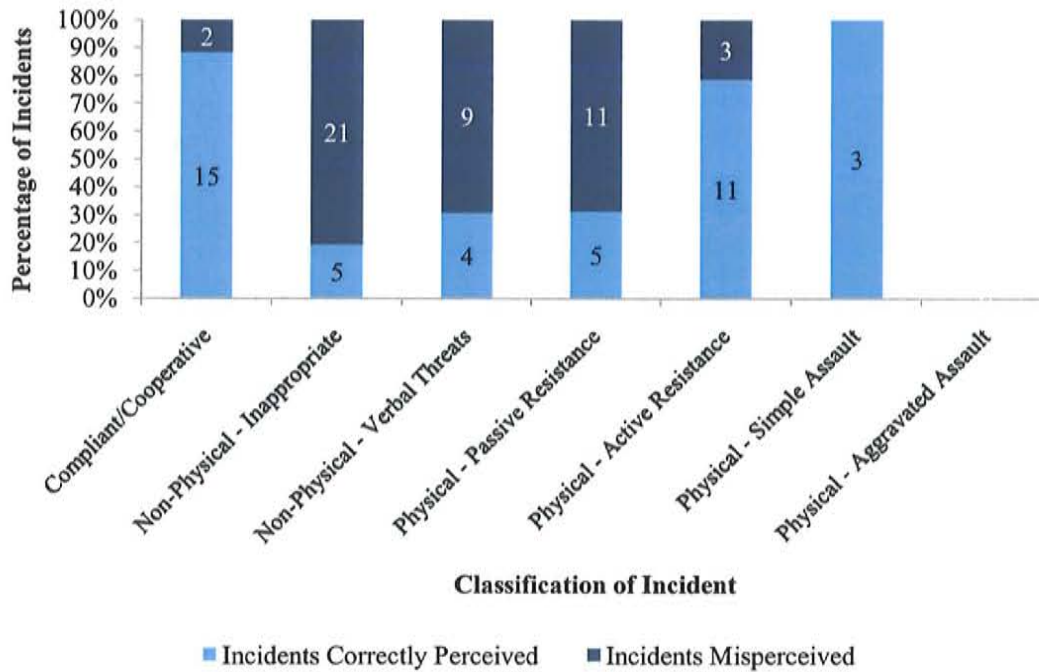


Figure 23. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ - By Severity



Perception and work-experience. *Figure 24* depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the number of years of healthcare work-experience the victim had at the time of the incident. Accordingly, the number of victims who misperceived the incident is depicted in dark blue. Upon examining the subcategories, those victims with less than one year of work experience yielded a rate of misperception of forty percent. As the years of work experience increased to three to five years, the rate of misperception increased to sixty-five percent, decreased to fifty percent for victims with six to ten years of experience, and again increased to sixty-three percent for victims with eleven to fifteen years of work experience. However, victims with greater than fifteen years of work experience were found to have a rate of misperception of forty-four percent or less. *Figure 25* symbolizes the distribution in each subcategory involving the variable of “years of work experience”, and distinguishes between the victims who accurately identified the workplace violence incident and those who misperceived their encounter.

Figure 24. Misperception of Workplace Violence at Hospital XYZ - By Victim's Work Experience

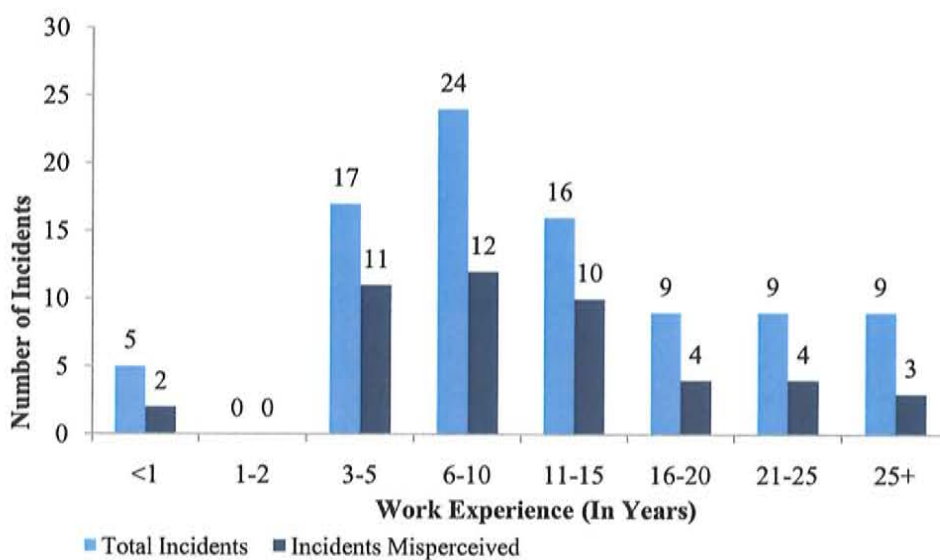
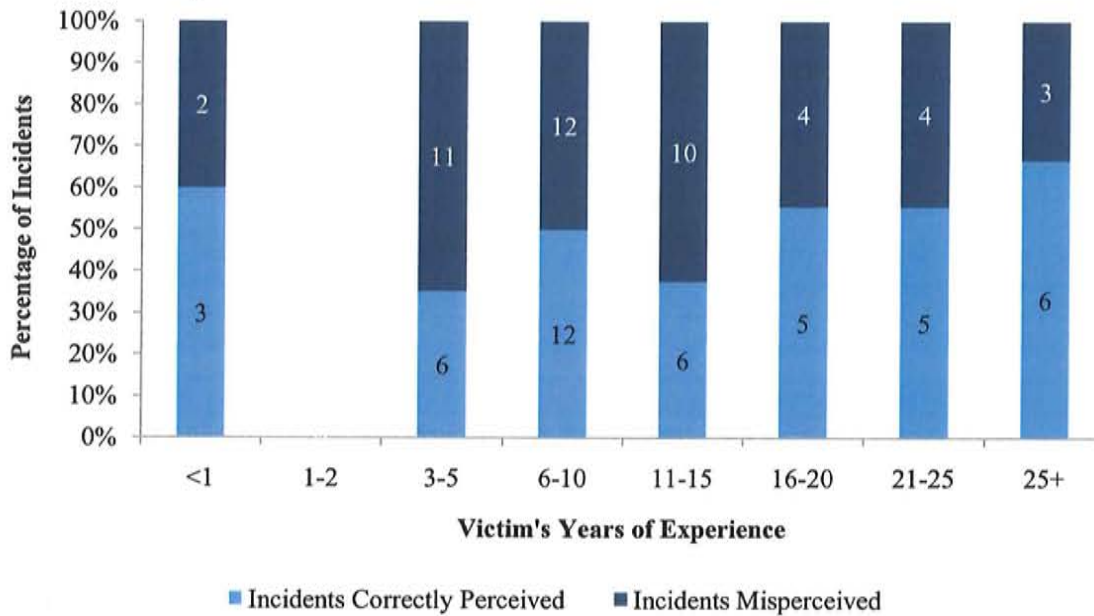


Figure 25. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ - By Victim's Work Experience



Perception and gender. Figure 26 depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the gender relationship between the victim and perpetrator. As established, the number of victims who misperceived the incident is depicted in dark blue. Upon examining the four gender-relationships, the study revealed that where both the victim and perpetrator were male, the rate of misperception was highest at sixty-three percent. In contrast, where both the victim and perpetrator were female, the rate of misperception was lowest at thirty-five percent. The remaining subcategories involving mixed-gender relationships between the victim and perpetrator resulted in a rate of fifty-six to fifty-eight percent. These distinctions are directly presented in Figure 27.

Figure 26. Misperception of Workplace Violence at Hospital XYZ - By Gender Relationship

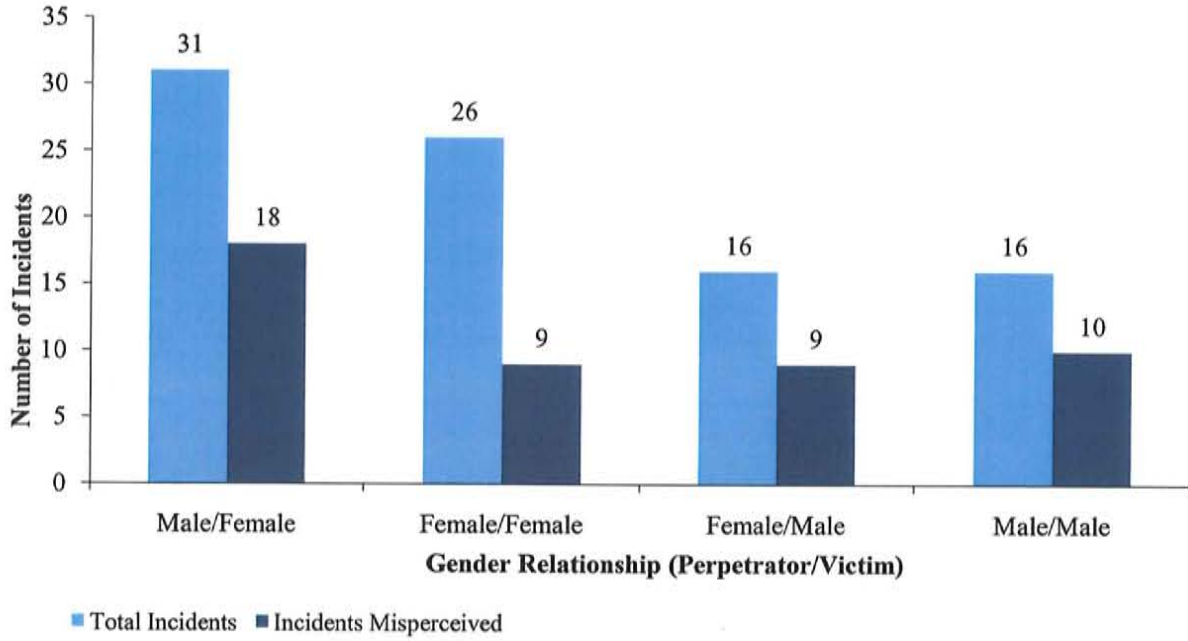
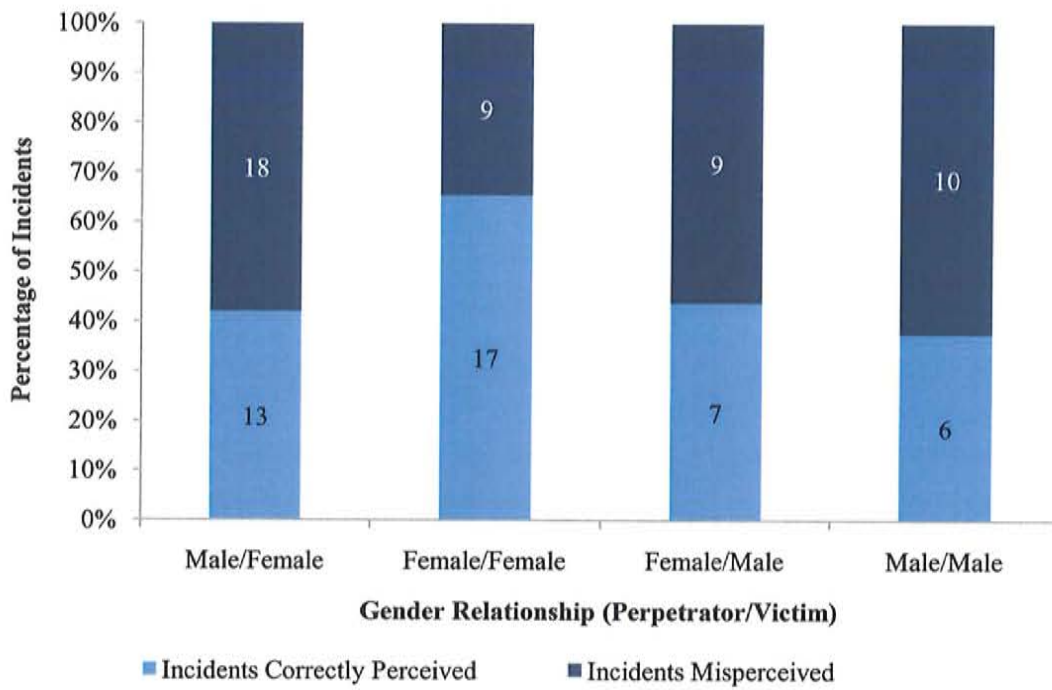


Figure 27. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ - By Gender Relationship



Perception and age. *Figure 28* depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the difference in age groups between the victim and perpetrator. Again, the number of victims who misperceived the incident in each subcategory is depicted in dark blue. First, upon examining the instance where the victim was significantly older (i.e. four age groups older), the study revealed that the victim correctly identified the encounter as one of workplace violence. Where the victims were significantly younger (i.e. three age groups), both misperceived the incident. However, the number of encounters with these extreme disparities was too few to consider significant. In contrast, as depicted in *Figure 29*, where both the victim and perpetrator were within the same age group, the rate of misperception was seventy-one percent. Where they were one age group apart, the rate of misperception decreased to fifty percent. Where they were two or more age groups apart, the rate of misperception continued to decrease.

Figure 28: Misperception of Workplace Violence at Hospital XYZ - By Difference in Age Group

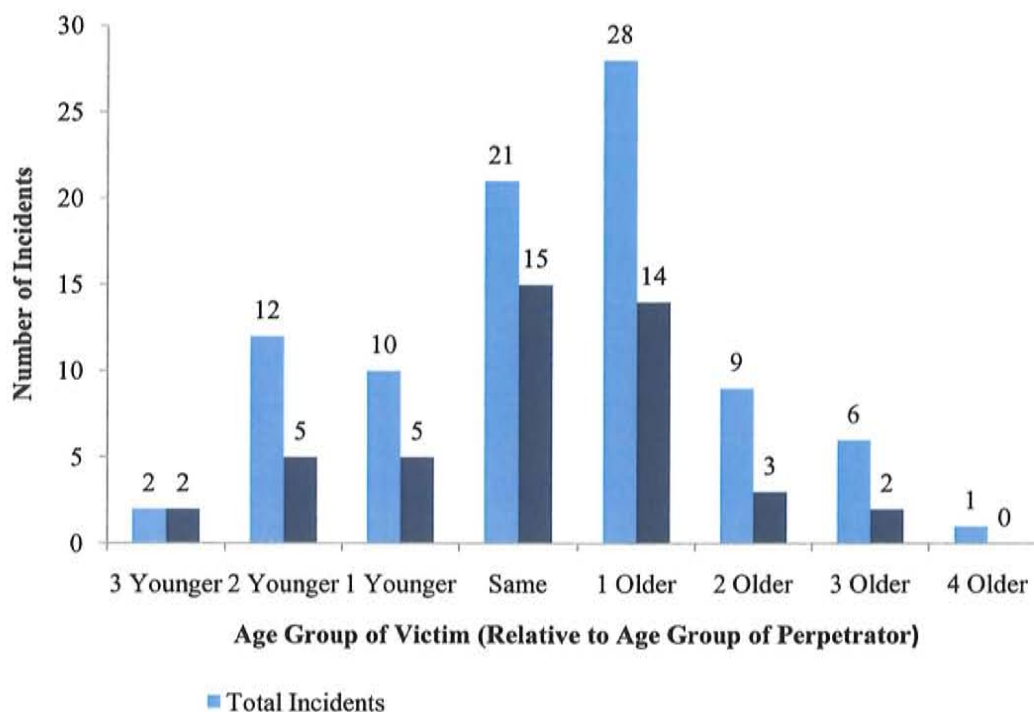
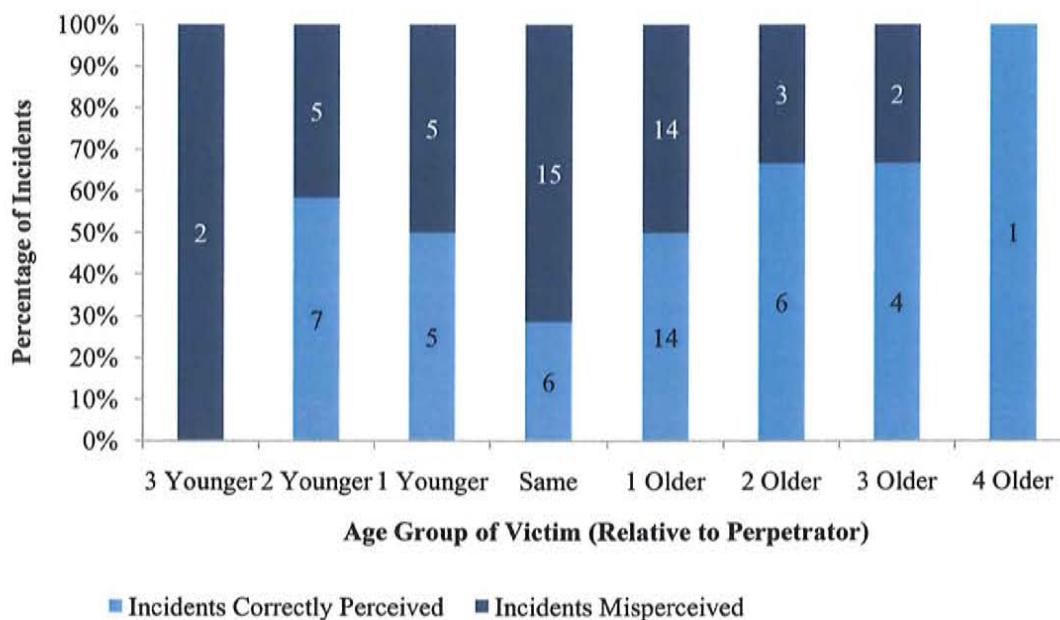


Figure 29. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ - By Difference in Age Group



Perception and stress. *Figure 30* depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the victim's subjective rating of the change in their own stress level as a result of the incident. The number of victims who misperceived the incident in each subcategory is depicted in dark blue. As previously noted, all victims identified some change in their stress level due to their encounter. Victims who indicated a minimal change in their stress level by scoring one or two maintained a rate of misperception of approximately fifty-five percent. Victims who rated a three yielded a rate of misperception of approximately forty-eight percent. A comparison of these rates is presented in *Figure 31*.

Figure 30: Misperception of Workplace Violence at Hospital XYZ - Stress

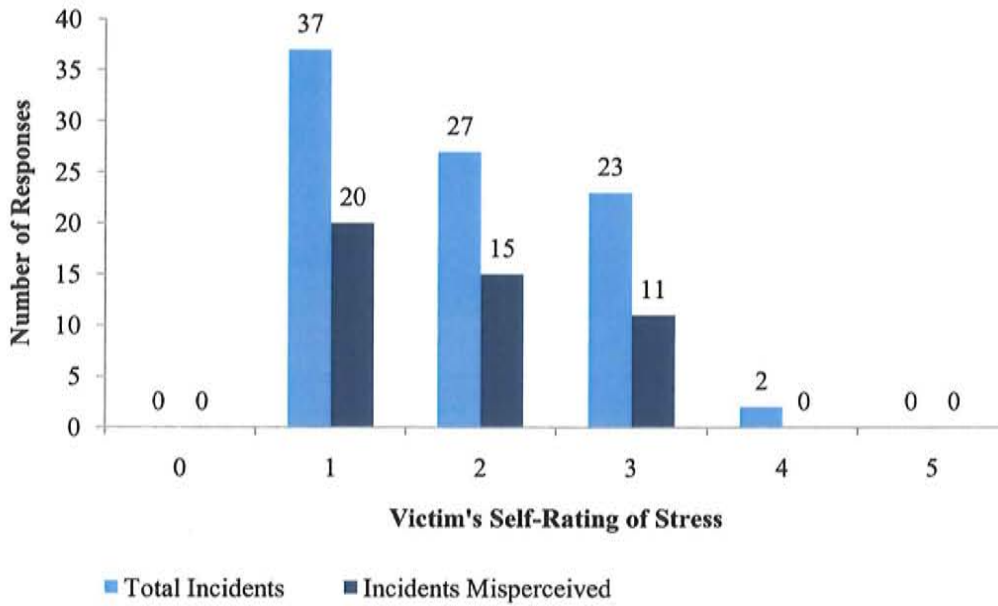
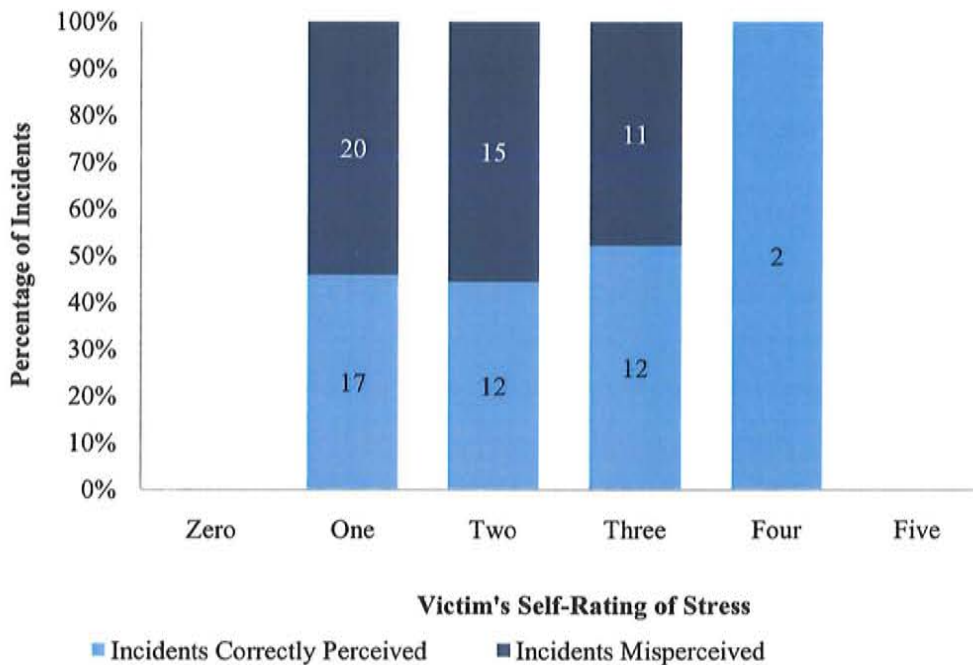


Figure 31. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – Stress



Perception and anger. *Figure 32* depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the victim's subjective rating of the change in their level of anger due to the encounter. The number of victims who misperceived the incident in each subcategory is depicted in dark blue. The group of victims who identified no change in their anger level scored a rate of misperception of approximately fifty-four percent. The group of victims who identified a nominal change in their anger level maintained a rate of fifty percent. Victims who scored a two maintained a rate of sixty-six percent, and victims who scored higher maintained a one-hundred percent accuracy. *Figure 33* provides a comparison of the rate of misperception with the respective ratings.

Figure 32: Misperception of Workplace Violence at Hospital XYZ - Anger

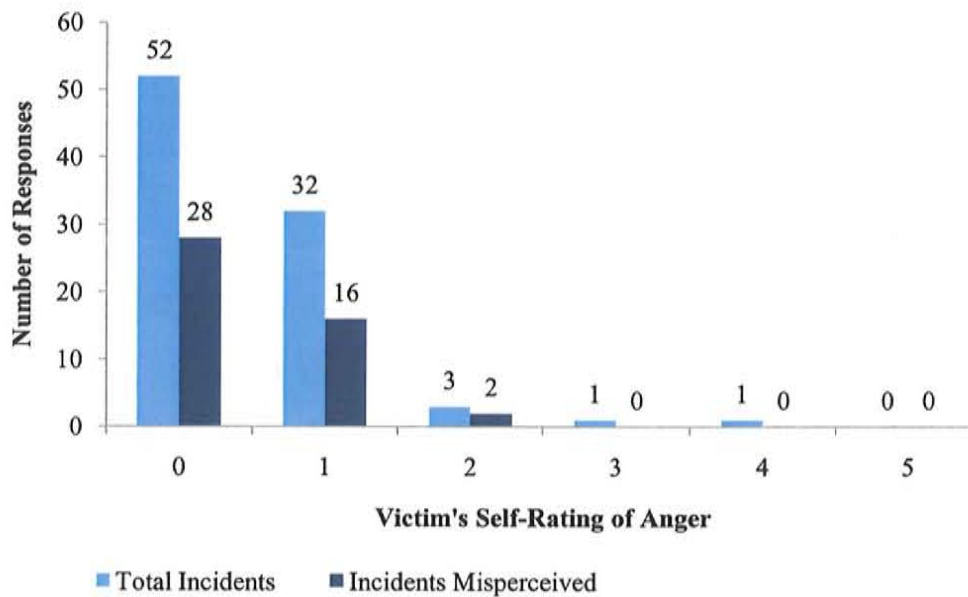
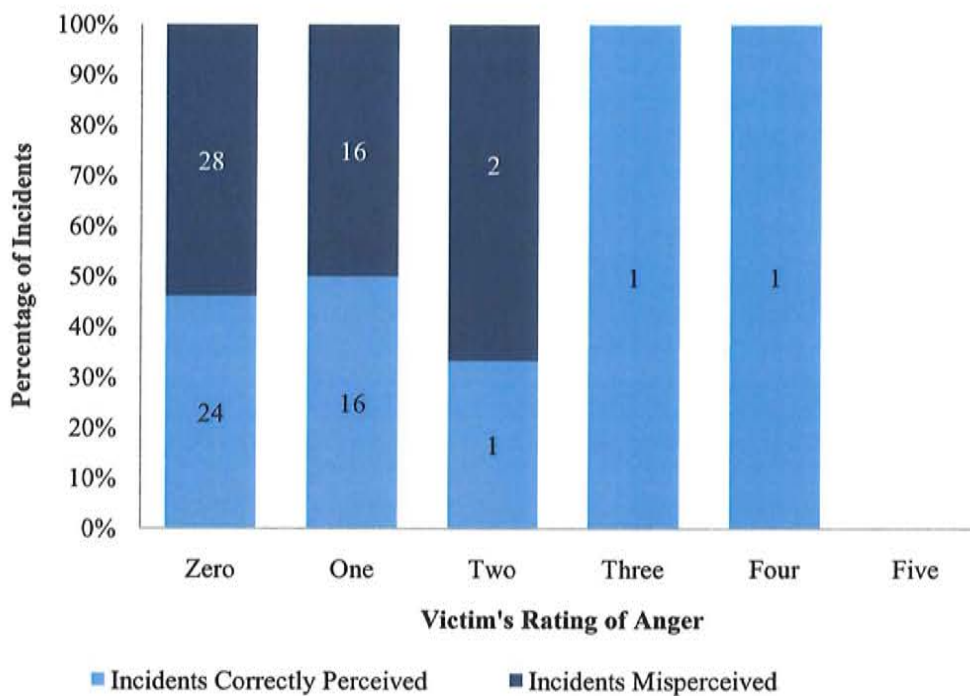


Figure 33. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – Anger



Perception and fear. Figure 34 depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the victim's rating of the change in their level of fear. The number of victims who misperceived the incident in each subcategory is depicted in dark blue. Fifty percent of the victims who identified no change in their level of fear misperceived their encounter with respect to workplace violence. Sixty-one percent of victims who scored a one misperceived their encounter. This rate of misperception decreased to forty percent for victims who scored a two, and decreased again to thirty-three percent for victims who scored a three. Figure 35 presents this distribution.

Figure 34: Misperception of Workplace Violence at Hospital XYZ - Fear

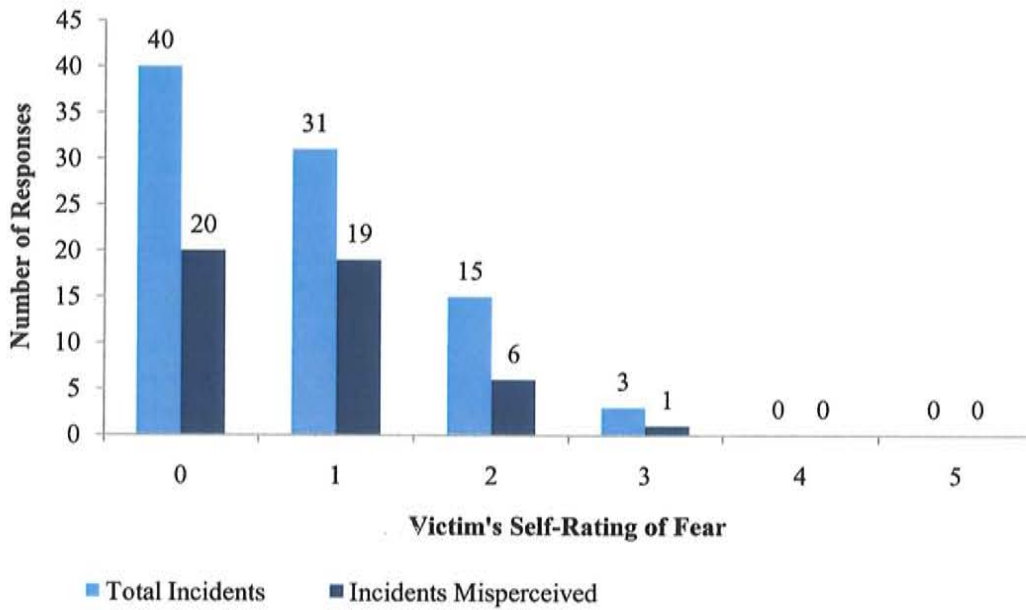
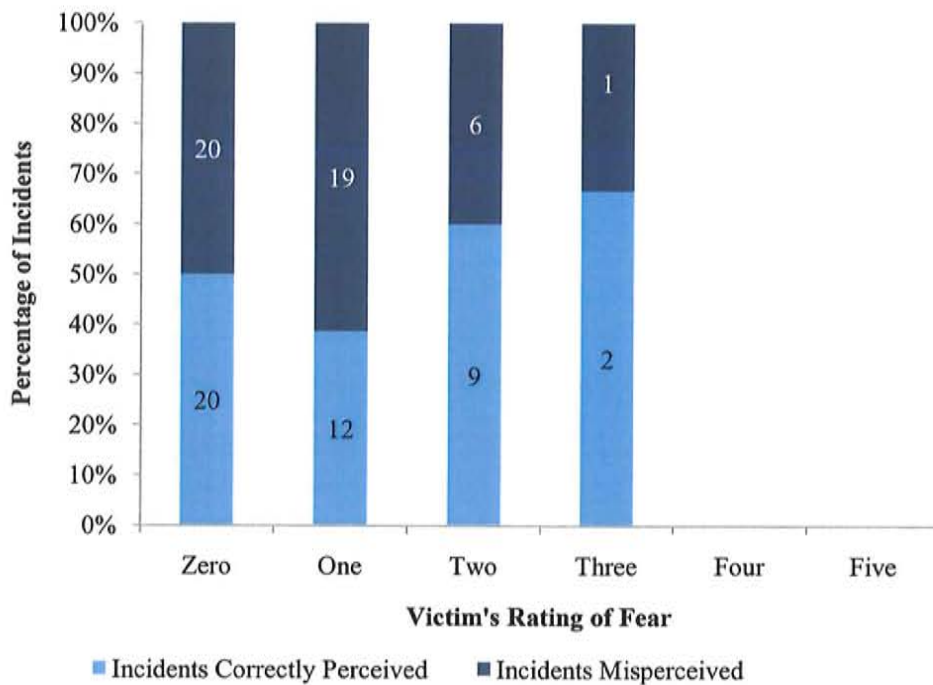


Figure 35. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ – Fear



Perception and disruption. *Figure 36* depicts the distribution of workplace violence incidents identified, represented in light-blue, by the subcategories associated with the victim's rating of the disruption within the environment due to the incident. The number of victims who misperceived the incident in each subcategory is depicted in dark blue. Fifty-four percent of victims who scored a nominal disruption misperceived the incident relative to whether or not it was a workplace violence incident. Victims who scored a two relative to disruption maintained a fifty-eight percent rate of misperception. Victims who scored a three yielded a sixty-three percent rate of misperception. However, victims who identified a high level of disruption by scoring a four or five scored a lower rate of misperception, scoring forty-three percent and thirty-three percent, respectively. *Figure 37* presents a comparison of these rates.

Figure 36: Misperception of Workplace Violence at Hospital XYZ - Disruption

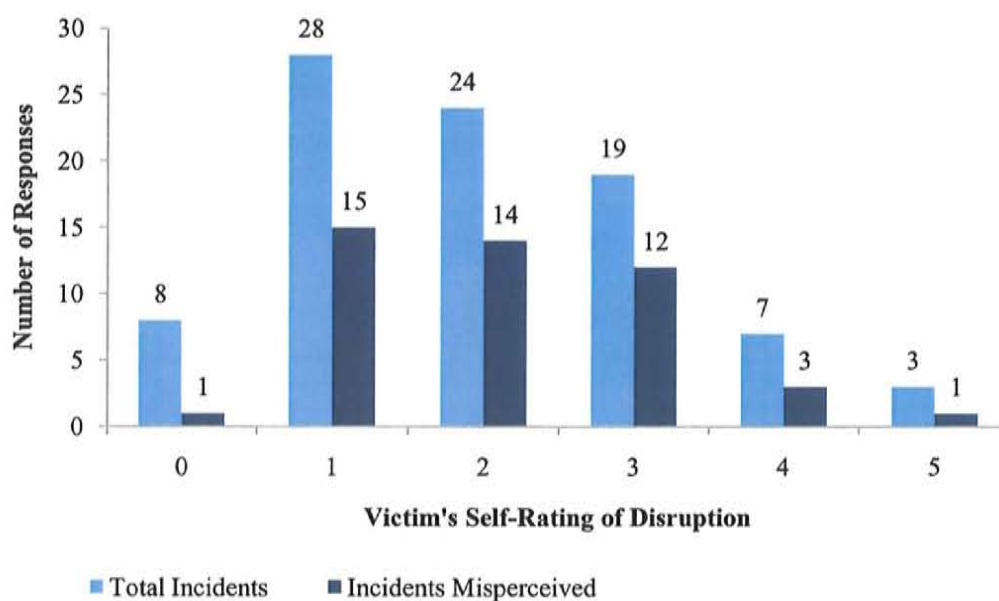
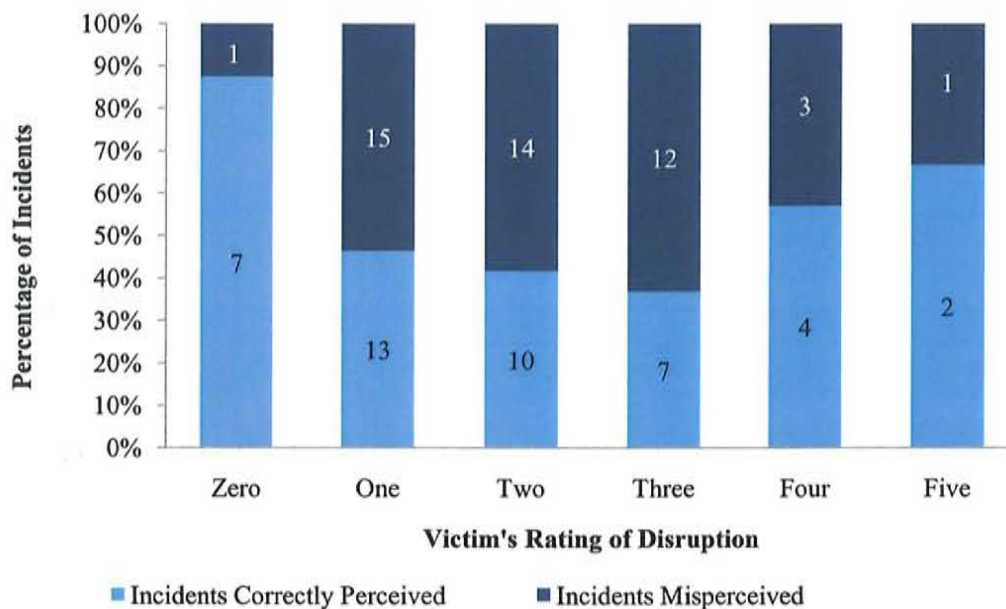


Figure 37. Correctly Perceived vs. Misperceived Workplace Violence at Hospital XYZ - Disruption



Goal Three

The following sections will present the findings involving the victim's perceived effectiveness of Hospital XYZ's measures to protect its hospital workers from the risk of workplace violence within their work environment. The focus of the following sections will attempt to assess the victim's perception of not only whether they believed they could have forecasted the workplace violence they encountered, whether they felt adequately prepared for and protected from such incidents, and identify the current controls and measures in place to manage the hazard of workplace violence – as well as controls and measures that are needed.

Perception and forecasting. As illustrated in *Figure 38*, eighty percent of victims surveyed reported a perceived ability to forecast workplace violence incidents, whereas twenty percent of victims believed that they could not forecast such incidents at Hospital XYZ. When victims who believed they were able to forecast workplace violence incidents were prompted to

identify indicators that they used to forecast such incidents, they identified the following factors (Percentages of respondents identifying each factor are represented in *Figure 39*).

Person's behavior. Sixty-eight of victims identified that nuances in the perpetrator's behavior (e.g. raised voice, pacing, finger-pointing) were symptomatic of the perpetrator being violent.

Medical report. Fifty-seven percent of victims identified behaviors (e.g. suicidal ideation, aggressiveness towards responders) in the perpetrator's medical report received from emergency medical personnel, public safety officials, and other healthcare workers.

Under the influence. Forty-two percent of victims identified that perpetrators who were under the influence of alcohol, pharmaceuticals, narcotics or other substances were more likely to exhibit violent behavior.

Expressed by patient. Twenty-seven percent of victims noted that the patient expressly informed healthcare staff of their intention to commit violence.

Expressed by family. Nineteen percent of victims noted that the family or friends accompanying the patient expressed the violent tendency of the patient.

Medical History. Sixteen percent of victims identified a previous encounter or interaction with the perpetrator where the perpetrator had committed past violence.

Security history. Nine percent of victims expressed that hospital security staff informed them of the violent tendency of the perpetrator due to previous interactions.

Reported by employee. Six percent of victims forecasted a violent tendency on the part of the perpetrator due to reports or information received from other hospital workers with previous encounters with the perpetrator.

In restraints. Five percent of victims indicated that the perpetrator was secured in behavioral restraints upon the perpetrator's arrival to the healthcare facility.

Reported by visitor. Two percent of victims forecasted a violent tendency on the part of the perpetrator due to reports or information received from other non-hospital workers or patients with previous encounters with the perpetrator.

Figure 38. Victim's Perceived Ability to Forecast Workplace Violence Incidents Hospital XYZ

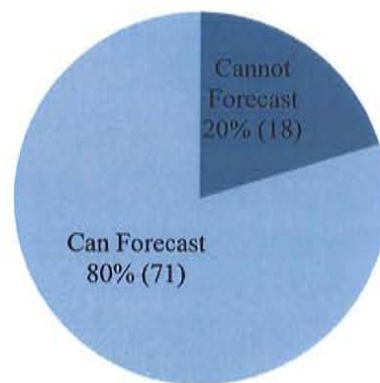
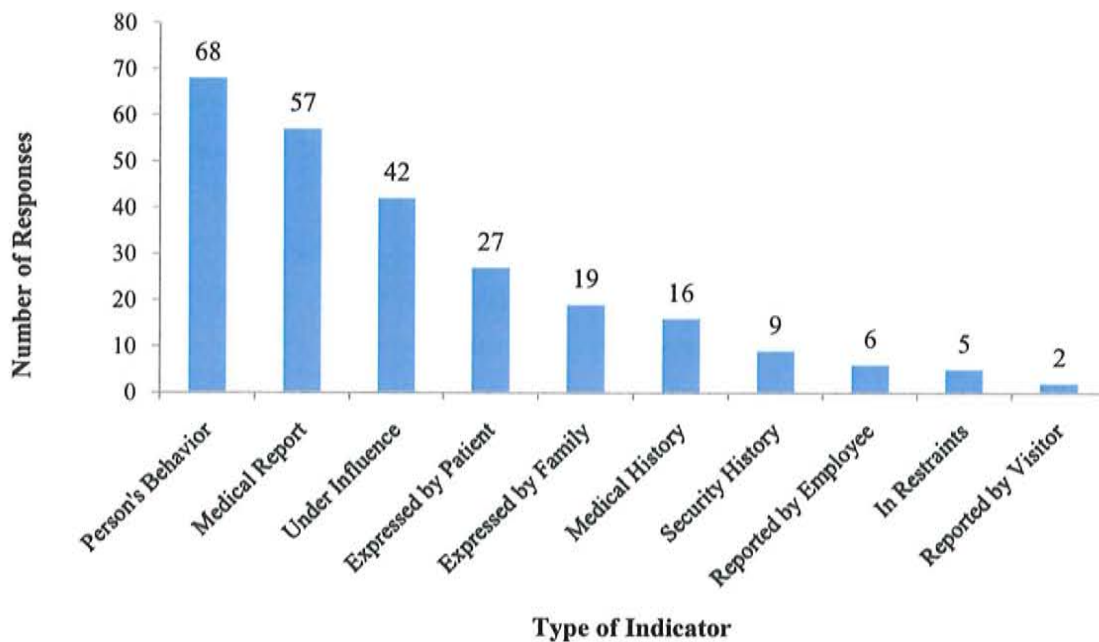


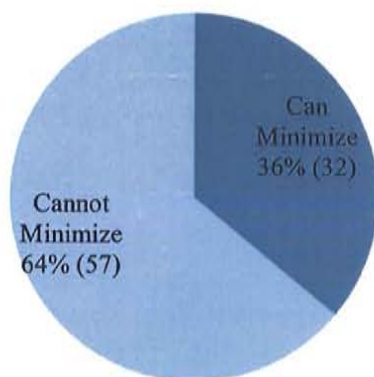
Figure 39. Victim's Identification of Indicators to Forecast Workplace Violence Incidents at Hospital XYZ



Perception and prevention. As illustrated in *Figure 40*, sixty-four percent of victims reported that they believed they could not prevent or minimize the probability of workplace violence incidents occurring at Hospital XYZ, where a little over one-third of victims indicated they did have some control or influence to reduce the likelihood of workplace violence incidents occurring.

Perception of preparedness. As presented in *Figure 41*, fifty-four percent of the eighty-nine victims surveyed believed they were adequately prepared to manage and mitigate workplace violence incidents within their work-environment, whereas forty-six percent of victims believed they were not adequately prepared to encounter the risk of workplace violence.

Figure 40. Victim's Perceived Ability to Minimize Workplace Violence at Hospital XYZ



Perception of protection. *Figure 42* illustrates that of the victim's surveyed, fifty-four percent of victims believed they were adequately protected from the risk associated with workplace violence in their work-environment, whereas forty-seven percent of victims believed that current measures did not provide them adequate protection.

Figure 41. Victim's Perceived Preparedness for Workplace Violence Incidents at Hospital XYZ

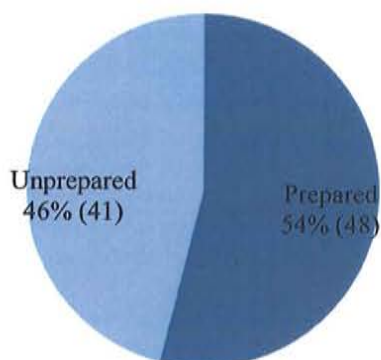
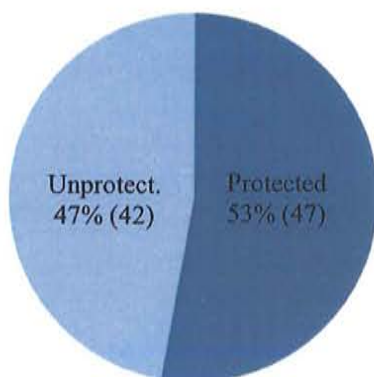


Figure 42. Victim's Perceived Protection from Workplace Violence Incidents at Hospital XYZ



Available controls. Each of the eighty-nine victims were asked to identify controls and measures in place to protect them from, and decrease their risk to, the exposure associated with workplace violence. As presented in *Figure 43*, victims surveyed identified the following controls and measures:

Crisis team. Seventy-two percent of the eighty-nine victims interviewed established that the trained crisis-response team designated within Hospital XYZ to respond to a workplace violence incident was the most prevalent control used to minimize the risk associated with workplace violence incidents.

Security personnel. Sixty-seven percent of victims identified hospital security personnel as a significant control in protecting hospital workers from workplace violence.

Panic alarms. Sixty-one percent of victims identified silent “panic” or “hold-up” alarms as important controls to protect them from workplace violence. Such devices were essential to summon immediate response of support personnel.

Adequate staff. Fifty-two percent of victims believed that an increased number of co-workers and support staff was essential to both minimizing the risk of workplace violence as well as effectively managing workplace violence incidents.

Surveillance cameras. Forty-nine percent identified that surveillance equipment to effectively monitor both inside and immediately outside their work-environment was important to detect and manage workplace violence.

Physical restraints. Forty-seven percent of victims believed that the availability and use of restraint devices to limit, restrict, and control the movement of patients was an effective means to minimize the risk associated with workplace violence.

Police on site. Forty-two percent of victims believed that employing licensed law enforcement personnel to be on-site within the work environment was an effective means of minimizing workplace violence.

Sedation. Forty-one percent of victims believed that medication and sedation for patients was an important measure to manage workplace violence.

Training. Thirty-two percent of victims identified that training received involving crisis-intervention, workplace violence, and personal safety were significant factors to minimize workplace violence.

Searches. Thirty-one percent of victims believed that establishing a policy and consistent practice in searching patients and visitors was important in reducing the risk associated with workplace violence.

Access control. Twenty-four percent of victims identified that limiting and controlling the access of persons into the work-environment, unit, or facility was important in minimizing the risk of workplace violence.

Patient attire. Twenty-three percent of victims felt that mandating that all patients wear hospital-issued gowns, robes, and garments – and be prohibited from wearing personal clothing was an effective measure in reducing the risk of workplace violence.

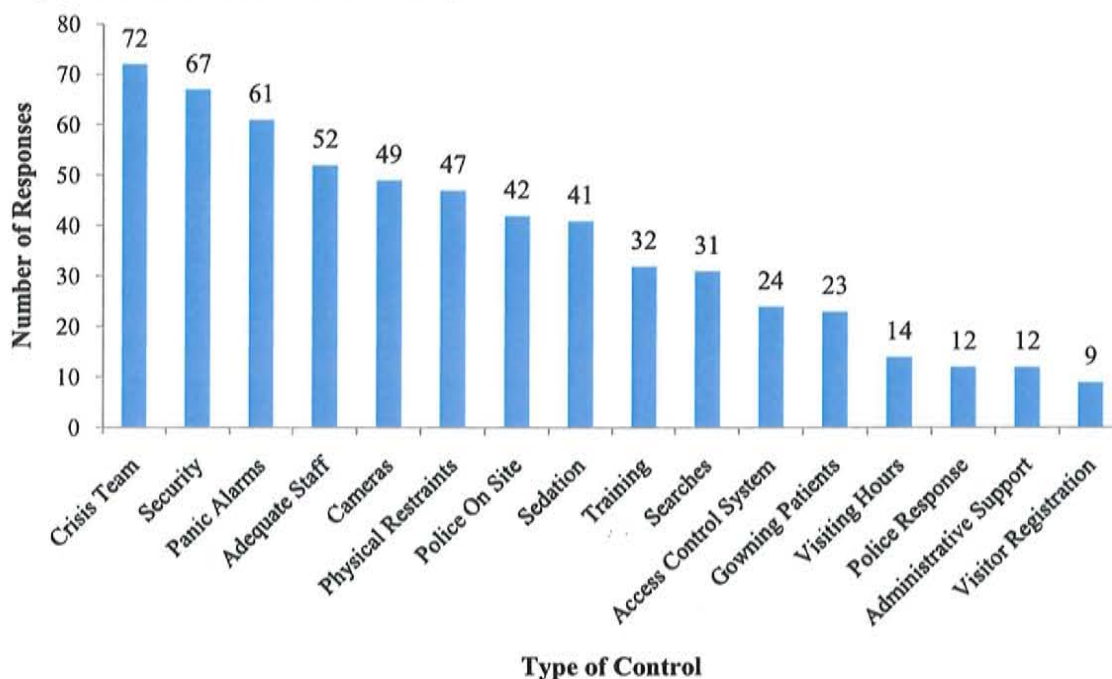
Visiting hours. Fourteen percent of victims believed that restricted visiting hours, thus limiting the time visitors may enter the work-environment, minimized the risk associated with workplace violence.

Police response. Twelve percent of victims believed that a short response-time of law enforcement to respond to an emergency call was a significant factor in minimizing the risk associated with workplace violence.

Administrative support. Twelve percent of victims identified that the support from their supervisors, executives, and administrators was significant to effectively address and manage workplace violence.

Visitor registration. Nine percent of victims identified that a process by which visitors are required to register, subject to screening, and announced was significant in minimizing workplace violence.

Figure 43. Victim's Identification of Available Controls & Measures for Protection Against Workplace Violence Incidents at Hospital XYZ



Needed controls. In addition to being prompted to identify available controls, each of the eighty-nine victims were also asked to identify controls and measures that were not in place and were needed to further protect them from workplace violence. As presented in *Figure 44*, victims surveyed identified the following controls and measures:

More effective visitor registration. Fifty-three percent of the eighty-nine victims interviewed identified that the current process for registering and screening visitors was inadequate to effectively minimize the risk of workplace violence within their work environment, and contended the process needed improvement.

Additional training. Forty-one percent of victims advocated that additional training was required for hospital workers to adequately prepare them for and protect them from workplace violence.

Staff consistency. Thirty-nine percent of victims identified that the inconsistency in staff practices in enforcing policies and following procedures led to inconsistencies, which tended to promote workplace violence incidents.

Availability of psychiatric facilities. Thirty-nine percent of victims identified the limited availability of facilities with safer and more controlled environments, and more appropriate to provide care to persons with behavioral issues and psychiatric problems resulted in many violent patients being contained in the environment for longer periods of time than necessary.

Physician consistency. Thirty-three percent of victims identified that inconsistency in physician assessment and treatment, particularly when issuing orders for restraint and medication, tended to promote workplace violence committed by patients.

Availability of detoxification facilities. Twenty-five percent of victims identified the limited availability of detoxification facilities with safer and more controlled environments, and more appropriate to manage the behavior of persons under the influence of alcohol and drugs resulted in many violent patients remaining in the environment for longer periods of time than necessary.

Additional staff. Twenty-one percent of victims identified that an inadequate number of staff resulted in some workers being unprotected and vulnerable to workplace violence.

Additional surveillance equipment. Twenty-one percent of victims identified that additional surveillance equipment would be beneficial to more consistently monitor and effectively detect workplace violence incidents occurring within the environment without directly exposing staff to the risks.

Additional security personnel. Nineteen percent of victims identified that additional security personnel within the environment was necessary to consistently monitor, detect, and manage workplace violence.

More effective debriefing process. Nineteen percent of victims believed that the current process of reviewing and evaluating violence in the workplace was ineffective in identifying root-causes and potential solutions to further minimize workplace violence.

Additional law enforcement presence. Eighteen percent of victims believed that employing licensed peace officers to provide service within the hospital was necessary to further reduce workplace violence.

More effective access control. Twelve percent of victims identified that restricting and controlling the access of into their work environment was necessary to effectively manage workplace violence.

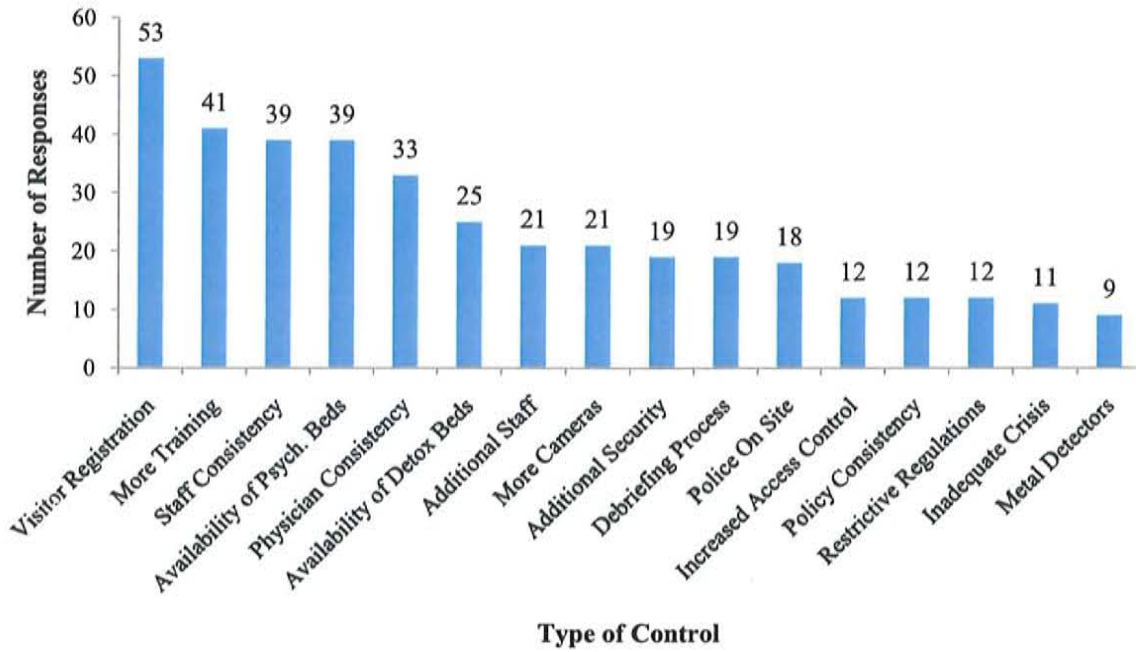
More consistency in policies. Twelve percent believed that the inconsistency of policies (e.g. patient care & guest service versus violence-free work environment) resulted in confusion of how workers were empowered to address inappropriate or violent behavior, thus resulted in a higher risk of workplace violence.

Regulations too restrictive. Twelve percent of victims believed that current regulations and regulatory agencies were “too restrictive” in regulating the use of restraints to manage violent patients.

Inadequate crisis response. Eleven percent of victims believed that the response of Hospital XYZ’s crisis team was inadequate, ineffective, and unreliable.

Metal detectors. Nine percent of victims believed that the implementation of metal detectors at entrances would minimize the risk associated with workplace violence.

Figure 44. Victim's Identification of Needed Controls & Measures for Protection Against Workplace Violence Incidents at Hospital XYZ



Chapter V: Conclusions and Recommendations

Summary

An analysis of the results obtained from the observational study and targeted surveys at Hospital XYZ will be outlined in this chapter. A fundamental finding was that Hospital XYZ maintained no comprehensive plan to define, assess, and manage workplace violence. The following sections will identify factors which may be used to more effectively assess workplace violence incidents, evaluate the current perception of how hospital workers define workplace violence incidents, and identify current measures and controls available to address workplace violence. The following findings are aimed to provide Hospital XYZ a more effective platform to establish a management plan, assess their environment, evaluate current controls, and improve the performance of its current workplace violence initiatives.

Purpose of the Study

The purpose of this study is to further evaluate the problem of workplace violence in healthcare facilities. Through a qualitative analysis, this study will capture how the healthcare worker typically defines workplace violence. In addition, this study will identify potential factors used to assess and measure workplace violence as well as strategies, both formal and informal, that healthcare facilities use to manage workplace violence and protect healthcare workers in these environments. Finally, this study will evaluate these strategies and provide recommendations to increase the safety of the healthcare worker from the risks associated with workplace violence.

Goals of the Study

1. Identify factors to assess and evaluate workplace violence in the healthcare environment by conducting a post-incident analysis of workplace violence incidents occurring within a pre-identified acute-healthcare facility using a targeted survey.
2. Assess factors which influence how healthcare workers misperceive “workplace violence” within a pre-identified acute-healthcare facility using a targeted survey for healthcare workers.
3. Identify current strategies to protect healthcare workers from workplace violence associated with patient behavior using a targeted survey for healthcare workers within a pre-identified acute healthcare facility.
4. Identify fundamental elements that may be incorporated into a healthcare facility’s workplace violence safety program using a targeted survey for healthcare workers within a pre-identified acute healthcare facility.

General Findings

Workplace violence is still a problem. Fundamentally, the study revealed that workplace violence is of significant concern within Hospital XYZ. Over the past three years, using the data provided in *Table 7*, Hospital XYZ experienced an average of 668 incidents per year, which resulted in an average of thirteen recordable injuries per year. During the thirty-one day study period, Hospital XYZ reported 117 incidents involving workplace violence, eighty-nine of which were involved in this study. During the study period, two hospital workers sustained injuries which were classified as OSHA recordable injuries. However, one significant trend is that although the general OSHA recordable incident rate increased from 20.30 to 25.27 recordable injuries per one-hundred employees, the OSHA recordable incident rate for assaults

decreased from 4.10 to 1.47 recordable injuries per one-hundred employees. Thus, although twenty-percent of recordable injuries sustained by hospital workers three years ago were due to assaultive behavior, this proportion dropped to seven percent only two years later. However, as the worker injuries tended to decrease over the three year period, the number of patients within the work environment who were assaultive or threatening actually *increased* by eleven percent.

As trend of incidents remains steady, workers use of available controls significantly decreased. One may surmise that these trends may be attributable to some significant change in the environment to adopt new means of assessment, instituting alternative controls and measures, and providing a more comprehensive approach in managing the hazard of violence in the workplace. However, the study also revealed no measures specifically tailored to objectively define or evaluate workplace violence incidents, no means to evaluate the patterns and trends of incidents, no comprehensive management plan outlining the controls and measure in place to address the hazard of violence. In addition, although the number of patients observed who were assaultive or threatening slightly increased by eleven percent, the hospital worker's utilization security-precautions intended to manage this hazard decreased thirty-eight percent. Thus, as the tendency for the hazard increased, staff was less inclined to adopt the provided protective security measures.

Goal One

In order to more effectively evaluate, and thus manage, workplace violence incidents, it is important to assess whether various environmental factors influence the likelihood of a workplace violence incident occurring. Congruent with the data collected, the following sections will evaluate the factors that were considered in this study, which involved the time of day;

location; number of co-workers; role-relationship; severity of the incident; response of the victims; work-experience of the victims; genders and ages of both the victims and perpetrators.

Time of day appeared to be a factor. Although the study revealed that workplace violence incidents were likely to occur at any time of day, there appeared to be a tendency for workplace violence to occur during daytime hours. As depicted in *Figure 1*, seventy-five percent of incidents occurred between the hours of 10:00 am to 10:00 pm. Possible explanations for this tendency are number of patients, employees, and visitors is lower outside of these hours; work-environment maintains higher level of security and access control; patients are more likely to be sleeping and less likely to be active; and disruptions that occur become more apparent in a more tranquil environment are become more apparent. However, additional study is recommended to over additional periods of time assess the strength of time of day being identified as a factor.

Location appeared to be a factor. Although the study revealed that workplace violence were likely to occur at any location within Hospital XYZ, there was a strong tendency for most incidents to have occurred in Hospital XYZ's Emergency Department. As represented in *Figure 2*, Sixty percent of incidents occurred within the Emergency Department. Recognizing that this area involves circumstances that are critical and highly emotional. In addition, seventy-eight percent of incidents occurred in areas where acute behavioral and psychiatric treatment was rendered (e.g. Emergency department, in-patient and out-patient behavioral care unit, chemical dependency treatment unit), and where patients were likely to be characterized with the individual factors presented in *Table 6*.

Number of co-workers in the area may or may not be a factor. Although the study revealed that workplace violence incidents occurred without regard to the number of co-workers in the area of the victim, eighty-three percent of incidents occurred where the victim was

surrounded by six or more co-workers (see *Figure 3*). However, additional study is required to identify the proportion of employees who work alone or with fewer people versus employees who work with six or more.

Role-relationship between victim and perpetrator appeared to be a factor. Although the study demonstrated that Hospital XYZ employees were subjected to violence perpetrated by patients, visitors, and even other employees, the study also revealed that a great majority of incidents involved an employee-client (i.e. employee-patient) relationship. *Figure 4* illustrates that eighty-two percent of workplace violence incidents reported involved patients perpetrating violence upon Hospital XYZ employees, and fifteen percent of incidents involved visitors perpetrating violence upon employees.

Severity of workplace violence appeared to be a factor. Although the eighty-nine incidents evaluated in this study were comprised of varying levels of severity, the significant majority of incidents involved severity of lesser-degrees where the number of incidents decreased as the severity increased. As illustrated in *Figure 5*, sixty-three percent of workplace violence incidents were characterized as entirely verbal with no physical interaction between the victim and perpetrator, and eighty-one percent involved no physical aggression towards the victim by the perpetrator.

Response of victim may be a factor. As depicted in *Figure 6*, thirty percent of victims who first encountered the workplace violence incident took no action at all. Upon considering the factors presented in *Table 6* (i.e. unattended hostility, controlling and demanding presence, unusual frustration levels), it is possible that this failure to respond to or address violent behavior, regardless of severity, may serve to promote violence of increased severity. However,

additional study is required to assess the relationship between the victim's response to the perpetrator's behavior, and the perpetrator's counter-response

Work-experience may or may not be a factor. As presented in *Figure 7*, workplace violence incidents occurred regardless of the years of work-experience of the victim. However, twenty-seven percent of incidents involved victims with six to ten years of work experience, and sixty-four percent of victims had between three and fifteen years of work experience. However, an additional consideration is the demographics of Hospital XYZ's workforce with regard to years of experience. Although sixty-four percent of the victims maintained between three and fifteen years of experience, it is unknown whether sixty-four percent of Hospital XYZ's total workforce also maintains between three and fifteen years of experience, or whether that percentage is significantly higher or lower. Thus, additional study is needed to compare the demographics of the sample of Hospital XYZ victims to the demographics of the general population of Hospital XYZ employees.

Gender may or may not be a factor. *Figure 8* illustrates that sixty-four percent majority of victims were female, and *Figure 9* illustrates that fifty-three percent majority of perpetrators were male. Thus, it appears that the majority of incidents involved a male perpetrator and female victim. *Figure 10* confirms this presumption by identifying that thirty-five percent of incidents involved a male perpetrator and female victim. In addition, the second most common gender relationship encountered was where both the victim and perpetrator were female. However, this study does not conclusively establish that gender influences the likelihood of a workplace violence incident occurring. Similar to the factor involving work-experience, the demographics of Hospital XYZ's workforce and patient-population with regard to gender is needed to compare

the demographics of the sample of Hospital XYZ victims and perpetrators to the demographics of the general population of Hospital XYZ employees and patients.

Age may or may not be a factor. Fundamentally, the study demonstrated that workplace violence involves victims and perpetrators of all ages. However, *Figure 11* depicts that the forty-percent majority of victims were between twenty-six and thirty-five years of age, and that thirty-three percent of victims were between thirty-six and forty-five years of age. Similarly, *Figure 12* identifies that the thirty-five percent majority of perpetrators were between twenty-six and thirty-five years of age, and that twenty-six percent of perpetrators were between thirty-six and forty-five years of age. More significantly, as depicted in *Figure 13*, fifty-five percent of victims were either within the same age group or one age group older than their respective perpetrator, which would suggest that violence within the healthcare setting is likely to be perpetrated by someone who is of similar age to the victim. However, mirroring the concerns with both work-experience and gender, the demographics of Hospital XYZ's workforce and patient-population with regard to age must be compared to the sample of Hospital XYZ victims and perpetrators.

Subjective ratings of stress, anger, fear, and disruption not within scope of study to be regarded as a factor. Fundamentally, the victims' self-rating of the changes in their levels of stress, anger, fear and disruption were regarded as *responses* to the workplace violence incidents they encountered, and were intended to assess their impact on how the victim subsequently perceived and classified the incident they encountered. In addition, the levels assessed were not measured prior to their encounter with the incident, thus the measures cannot be regarded as factors which may or may not impact the likelihood of workplace violence incidents occurring. However, this is not to say that a victim's level of stress, anger, or fear cannot serve to influence the probability or severity of a workplace violence incident occurring.

Goal Two

As represented in *Figure 19*, fifty-two percent of victims who encountered their respective workplace violence incident misperceived their encounter. Although two victims actually identified violence where none was present, the vast majority (ninety-six percent) failed to identify violence where violence had occurred. Thus, if the researcher had not identified the violence, forty-four incidents would have gone unreported as workplace violence. Thus, one can conclude that other occurrences of workplace violence, both prior to and during the study period, have gone unreported. In addition, this disparity is symptomatic of inconsistency among Hospital XYZ's employees in defining and recognizing workplace violence. Most significantly, the misperception of workplace violence compromises the ability of staff to intervene in incidents of low-severity, thus allowing incidents to escalate in severity and pose higher risk to persons within the environment. The following sections will assess the relationship between the victims' misperception of the incident and the various factors involving the number of co-workers; severity of the incident; work-experience of the victims; genders and ages of both the victims and perpetrators; and the victims' subjective ratings of the changes in the levels of stress, anger, fear and disruption.

Number of co-workers in the area may be a factor influencing the accuracy of perception. In examining *Figure 21*, victims who were accompanied by six or more co-workers in their immediate work environment were more likely to misperceive a workplace violence incident than employees who were either alone or were with five or less co-workers. Thus, it may be concluded that workers who are accompanied by more co-workers are more likely to fail to identify violence. However, the disproportion between the number of victims surrounded by five

or less co-workers and victims accompanied by six or more yields that additional research is needed.

Severity of the incident may be a factor influencing the accuracy of perception. As depicted in *Figure 23*, twelve percent of victims misperceived violence within incidents where the alleged perpetrator was complaint and cooperative, and had not committed any violence. However when compared to victims who encountered incidents involving violence, victims were far less likely to misperceive violence where there was none than fail to perceive violence when it was present. In addition, where violence occurred within an incident, victims were more likely to fail to recognize violence of low-level severity. As can be observed in *Figure 23*, as the severity level of the violence increased, the rate of misperception decreased.

Work-experience of the victim may be a factor influencing the accuracy of perception. *Figure 25* appears to suggest the relationship that as the victim gains more work experience, the victim rate of misperception decreases. Where victims maintained between three and five years of work experience, the rate of misperception was sixty-five percent. Where victims had at least sixteen years of work experience, the rate of misperception decreased to forty-four percent. This rate decreased to thirty-three percent where victims had at least twenty-five years of work experience.

Gender may be a factor influencing the accuracy of perception. As discussed previously, *Figure 8* exemplifies that the sixty-four percent majority of the victims were female. However, although females appear to represent the majority, males were far more likely to misperceive a violent incident than females. As depicted in *Figure 27*, male victims misperceived fifty-nine percent of violent incidents being non-violent, whereas only forty-seven percent of females misperceived violent incidents as being non-violent. Thus, considering that

fifty-two percent of workplace violence incidents are misperceived, potentially resulting in a vast number of incidents going unreported, the study suggests that males are more likely than females not to perceive, thus not report, incidents of workplace violence.

Gender-relationship may be a factor influencing the accuracy of perception. In examining *Figure 27*, where the victim and perpetrator were of different genders, the rate of misperception was approximately fifty-seven percent, regardless of the gender associated with the various roles. Peculiarly, the rate of misperception was significantly lower or higher if the victim and perpetrator were of the same gender. The rate of misperception was lowest (i.e. thirty-five percent) where both the victim and perpetrator were female. Thus, the victim was most accurate in identifying violence where both the victim and perpetrator were female. In contrast, the rate of misperception was sixty-three percent where both the victim and perpetrator were male. Thus, it may be concluded that a predominantly female workforce providing services to a predominantly female client base would be least likely to misperceive violence, thus provide a higher level of accuracy with reporting.

Age-relationship may be a factor influencing the accuracy of perception. As depicted in *Figure 29*, where the victim was three years younger than the perpetrator, the victim was one hundred percent likely to misperceive the incident. In contrast, where the victim was four years older than the perpetrator, the victim was not likely to misperceive the incident at all. However, as each category encompassing these age relationships involved no more than two incidents, the relationship cannot be established with any statistical significance. Upon examining the age-relationships in between, the rate of misperception appears to be highest (i.e. seventy-one percent) where the victim and perpetrator were within the same age-group. As the victim and perpetrator were separated by one age-group, the rate of misperception decreased to fifty percent,

and again decreased to forty-two percent where the victim was two age-groups younger, and thirty-three percent where the victim was two age-groups older.

Victim's change in stress level may not be a factor influencing the accuracy of perception. As illustrated in *Table 31*, every victim in the study indicated some change in their stress level as result of their encounter. However, the groups of victims who rated their change as a one or two maintained a rate of misperception of fifty-five percent, and the group who rated their change as a three maintained a rate of forty-eight percent. As the difference between the rates of these three groups was relatively small, there appears to be little correlation between a change in stress level and rate of misperception.

Victim's change in anger level may or may not be a factor influencing the accuracy of perception. *Table 33* represents the victims' subjecting ratings of their change in anger level and rates of misperception for each group. The group of victims who indicated no change in their level of anger maintained a rate of misperception of fifty-four percent. The group of victims who indicated a nominal change in their anger maintained a rate of fifty-percent. Thus, this suggests a level of accuracy of perception that is slightly higher for victims who experienced some change in their anger. However, as ninety-seven percent of victims identified either no change in their anger level or a nominal change in their stress level, the data is not sufficiently representative of victims who experience a higher rating of change within their level of anger.

Victim's change in fear level may be a factor influencing the accuracy of perception. *Table 35* embodies the victims' subjective ratings of the change they experienced involving their level of fear and corresponding rates of misperception for each group. Where victims noted no change in their fear levels, their corresponding rate of misperception was at fifty percent. Where victims scored a one, their rate increased to sixty one percent. However, as victims who scored a

two maintained a rate of forty percent. Victims who scored a three maintained a rate of thirty-three percent. This, there is an indication that as victims noted a higher change in their fear level, their accuracy in perceiving the incident as violence increased.

Victim's change in perceived level of disruption may be a factor influencing the accuracy of perception. As represented in *Table 37*, victims who noted no disruption within the work environment maintained the highest level of accuracy (i.e. eighty-eight percent) in identifying workplace violence. However, as victims observed a minimal level of disruption (i.e. scored a one or two) within their environment, their rate of misperception gradually increased. Victims who scored a moderate level of disruption maintained the highest rate of misperception. However, as the rating of disruption became significant, victims rate of misperception again decreased. This trend appears to suggest that disruptions that are acknowledged, but either minimal or significant are more accurately identified than disruptions that are moderate.

Goal Three

Forecasting. Eighty percent of victims believed they could have accurately predicted their encounter using indicators available to them. The most common indicators identified, as depicted in *Figure 39*, were the verbal, non-verbal, and physical behavior of the patient; the medical report received from emergency medical and public safety personnel transporting the patient to the facility; and whether the perpetrator was under the influence of alcohol, drugs or some other substance. However, recognizing that half of the victims misperceived the incident as not being workplace violence indicates victims may have failed to deliberately recognize these factors and identify a potential workplace violence situation. Thus, Hospital XYZ should institute a formal process to allow hospital workers to assess a patient's propensity for committing violence upon the patient's initial assessment.

Prevention and protection. Sixty-four percent of victims in the study believed they could not have prevented the incident from occurring, although eighty percent of victims believed they could have accurately predicted their violent encounter. Thus, although the vast majority of hospital workers believe they can accurately assess whether a workplace violence incident is likely to occur, a significant majority also believe that there is nothing they can do to prevent the incident from befalling upon them. However, once the incident occurs, fifty-four percent of victims believed they were adequately prepared for their encounter, and fifty-three percent of victims believed they were adequately protected. This is a strong indication of a reactionary management process as opposed to one that is holistic and preventative in nature.

Controls. Victims who were interviewed in the study identified a number of measures that were either available or needed to effectively protect them from violence in their work environment. These controls are re-illustrated in *Figure 43* and *Figure 44* below.

Figure 43. Victim's Identification of Available Controls & Measures for Protection Against Workplace Violence Incidents at Hospital XYZ

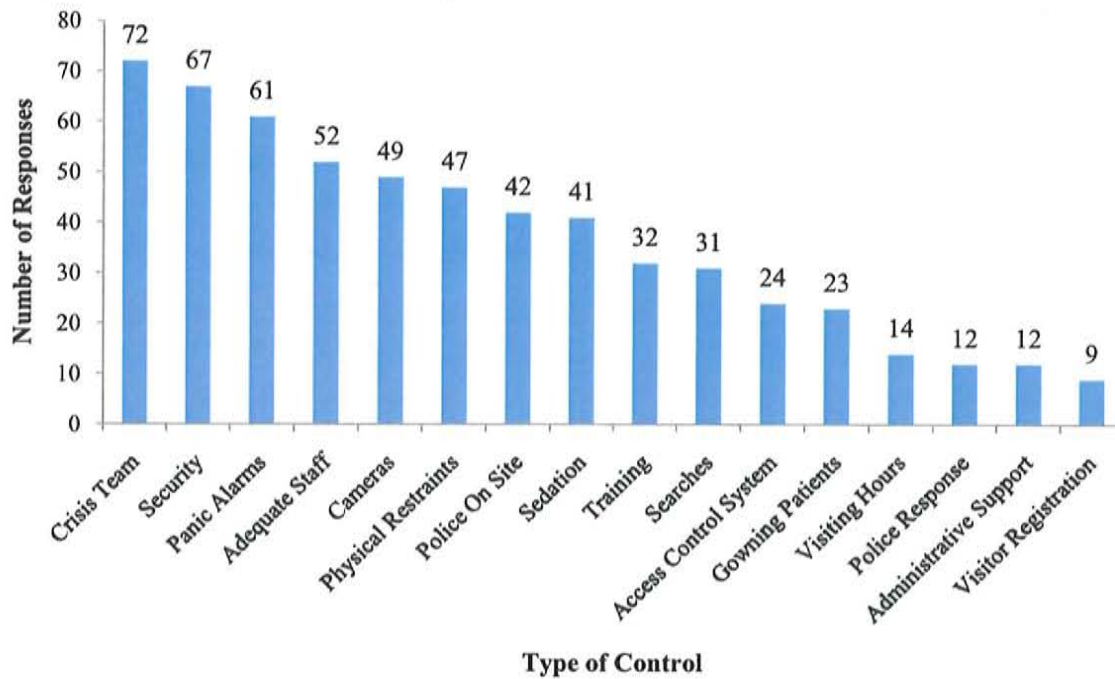
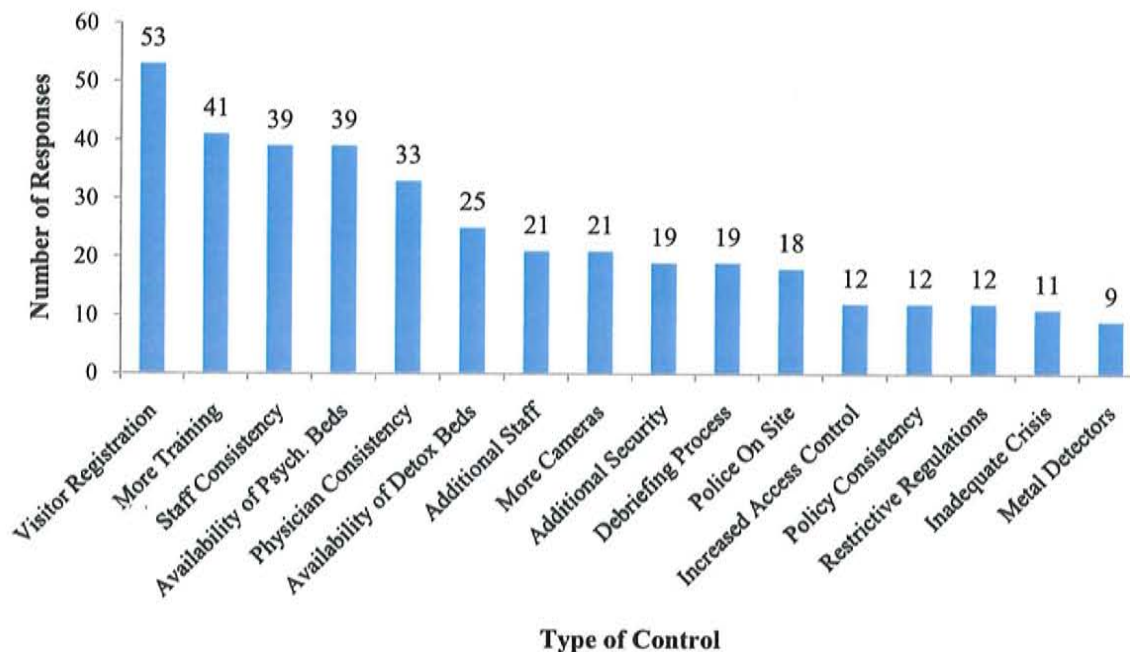


Figure 44. Victim's Identification of Needed Controls & Measures for Protection Against Workplace Violence Incidents at Hospital XYZ



The controls identified can be classified into eight broad categories: Administrative support, crisis response and management, staffing, therapeutic controls, security and law enforcement support, access control and surveillance, community resources, and training. Each of these elements will be addressed below.

Administrative support. Although thirteen percent of victims acknowledged support by Hospital XYZ's executive and administrative team, this number is relatively low to indicate a strong collective feeling of support by upper management. In addition, thirty-nine percent of staff expressed concern involving the lack of consistency in practices involving co-workers, and thirteen percent of staff also indicated a concern involving the consistent application of policies and procedures which may tend to undermine Hospital XYZ's efforts to manage workplace violence. These numbers suggest that a higher level of support and involvement by upper management to provide consistency in policy

development, implementation and enforcement in order to instill a higher level of employee confidence.

Crisis response and management. The vast majority (i.e. eighty-one percent) of victims identified the crisis response team and the most significant control available to them to protect them from workplace violence. Similarly, sixty-nine percent of victims expressed that panic alarm devices to immediately summon emergency assistance were also significant. Although these measures are significantly important, they are reactionary measures which provide little opportunity for preventing workplace violence. In addition, although the majority of victims identified the crisis response team, only nineteen percent acknowledged the importance of a post-incident debriefing and evaluation process as an opportunity to prepare for – and potentially prevent – future incidents. This may indicate that employees do not view other preventative measures with equal importance, and suggests training should be provided to address early indication signs, addressing anxiety and stress, and communication and de-escalation.

Staffing. Fifty-two percent of victims acknowledged the importance of maintaining an adequate number of employees within a work area to effectively protect them against workplace violence. Twenty-one percent expressed concern that additional staffing is necessary, which is consistent with the fact that seventeen percent of victims were accompanied by five or less co-workers at the time of their encounter. This suggests that employees should be accompanied by at least six co-workers in their environment in order for its employees to feel adequately protected.

Therapeutic controls. Fifty-three percent of victims identified therapeutic restraints were an effective tool to control violent behavior, while thirteen percent expressed concern that

applicable regulations were too restrictive by discouraging the use of restraints where the victim believed they were necessary. In addition, forty-six percent of victims noted that sedation was a necessary measure to minimize the risk of violent behavior. Thirty-five percent of victims noted that conducting searches of potentially violent patients was necessary to protect them from violence, and twenty-six percent of victims advocated for a process whereby potentially violent patients were required to wear a hospital gown and be separated from their clothes and personal belongings while in the environment.

Security and law enforcement. Only thirteen percent of victims identified a sufficient response time for local law enforcement that was adequate to provide assistance with workplace violence incidents. Seventy-five percent of victims identified security personnel as being a significant protection against workplace violence, and twenty-one percent of victims noted that additional security staff are needed to more effectively address workplace violence. In addition, forty-seven percent noted that employing licensed police officers within the environment is also a significant measure, and an additional twenty percent expressed the need for an additional law enforcement presence. These statistics suggest a high level of advocacy for personnel whose primary role is providing support with persons exhibiting deviant, defiant or criminal behavior.

Access control and surveillance. The implementation and use of access control and surveillance systems was of significance to many victims interviewed. Fifty-five percent of victims identified surveillance equipment as a means available to protect them from workplace violence, and twenty-four percent of victims advocated for additional surveillance cameras. Congruently, twenty-seven percent of victims recognized that access-control systems were essential for their protection, while thirteen percent

promoted the need for additional access control measures. In addition, while sixteen percent of victims recognized that limited visiting hours was a protective measure, and ten percent identified the registration and screening process for all persons entering the work environment a protective measure, sixty percent of victims advocated that additional measures are necessary to effectively register and screen visitors entering into the hospital.

Community resources. Although thirteen percent of victims acknowledged support of local law enforcement, victims expressed concern with the lack of resources within the local community to minimize the risk associated with workplace violence. Forty-four percent of staff identified that an insufficient number of psychiatric beds were available within the local healthcare community to provide short-term behavioral care to patients who could not be discharged back into the community. In addition, twenty-eight percent of victims noted that the availability of detoxification beds was insufficient to accommodate those patients who were too intoxicated to be released back into the community. The unavailability of these accommodations results in these patients having to be managed by healthcare workers, and remain within a healthcare environment that does not adequately safeguard the patient or workers from the behavior associated with the patient's condition. This necessitates community involvement to advocate for additional resources in order to effectively protect healthcare workers.

Training. Thirty-six percent of victims identified training with respect to crisis-management and workplace violence was significant in protecting them. However, upon reflecting that fifty-four percent of victims believed they were adequately prepared for a workplace violence incident, it is interesting to note that forty-six percent of victims

believed that additional training was required to effectively equip hospital staff to safely work around potentially violent behavior. It is unclear as to whether these two figures represent two distinct groups or if there is significant overlap. But it is apparent that training is recognized as an essential component to healthcare workers.

Goal Four

In completing this research, it is important to provide healthcare facilities with outcomes that may be adopted by any healthcare organization in their efforts to protect their healthcare workers from workplace violence management. As a conclusion, this study has identified many fundamental components which are essential to any healthcare organization's workplace violence management program. The following are recommended elements based on this study.

Administrative support. As proffered by many of the victims interviewed in this study, there must be unquestioned dedication on the part of executive-level leadership to instill confidence with all healthcare workers that their safety is valued. Although it was suggested by many victims that violence cannot be prevented, healthcare executives must persistently demonstrate their commitment by recognizing that change is needed, establishing and enforcing a pronounced policy, and investing time and resources into initiatives which more effectively protect their workers from violence.

Formal program. The study pointed out that workers will emphasize the reactionary controls and measures where there exists only a policy, and comprehensive program bringing all of the elements together is absent. Healthcare organizations must develop a plan that encompasses all of the elements which play a role in minimizing workplace violence within the work environment. In addition, it is likely that a crisis involving a violent patient would be handled much differently than one involving an illegitimate visitor. Thus, the workplace violence

management program should not attempt to develop a “one-size-fits-all” management and response process, but rather tailor a program specific to the varying role-relationships involved.

Definition of violence. Employers should ensure that the definition of violence adopted by their respective organization encompasses the entire *Workplace Violence Continuum* as presented in *Table 5*. Employees must be cognizant that workplace violence is not merely limited to the physical or significantly disruptive, but is also inclusive of those that are of low severity.

Workplace violence management committee. Every employer must establish a committee specifically designated to assess and manage the workplace violence management program. The committee should be comprised of employees within organization, be multi-disciplinary, and should consist of employees at varying levels of management including low-level non-supervisory employees.

Community collaboration. Employers must establish and maintain active partnerships with local agencies specializing in varying aspects of workplace violence. Strong partnerships should be established with local representatives within the fields of law enforcement, fire, hazardous materials, public health, human services, and emergency management.

Measures. At minimum, healthcare employers should adopt a means by which workplace violence incidents are reported and tracked. O.S.H.A. defined incident rates will provide a comparison based on the number of employee hours worked during the specified period. However, rates should also be developed to include number of patients, number of patient-days, and number of visitors. In addition, tabulating and tracking the demographics of both employees and patients may aid in assessing the rates of misperception as well as estimating the number of incidents that have been unreported.

Staffing. Employers should be very deliberate in providing every position or role with the company of a team of co-workers in the environment. Instances of “lone-workers” should be avoided whenever and wherever possible. In addition, security personnel should be staffed within the environment to ensure that there are persons assigned with the sole responsibility of monitoring the facility and keeping watch for persons, conditions or circumstances which create a propensity for workplace violence.

Nursing practice. Healthcare organizations must continue to engage in an evaluation of nursing practices to ensure that concerns and indicators are accurately documented. In addition, organizations must continue to find opportunities to improve communication between healthcare workers, physicians, and public safety professionals to convey concerns or indicators to ensure workers are kept apprised of any violent propensities.

Patient assessment. The victims of the study revealed that several measures exist to aid workers in forecasting workplace violence incidents. Hospitals must adopt a process by which care-givers conduct an objective assessment of patients upon arrival, thus evaluating the patient’s propensity for engaging in violent behavior. First and foremost, assessments should include workers being attentive to the verbal and physical demeanor of the patient in addition to the patient’s symptoms and expressed concerns. In addition, these assessments should include initial report from emergency medical and public safety professionals; statements from friends and family of the patient; previous medical history. Finally, the assessment should not only include the patient’s previous medical history, but any history maintained by the hospital’s security personnel involving prior encounters with the patient.

Access control. Healthcare organizations should ensure that access into their facilities is restricted and monitored. The use of access control and surveillance systems should be

encouraged to minimize the exposure of hospital workers and/or security personnel from a direct encounter with a perpetrator attempting to forcefully access the environment. Surveillance equipment should also be used to remotely detect potentially violent activity as well as allow for remote monitoring of a workplace violence incident. A process of access control should not only be implemented at the perimeter of the healthcare facility, but also be duplicated in areas where there is a high propensity for violence (e.g. emergency department, psychiatric units).

Crisis management. Healthcare employers should develop a process to respond to and manage crisis situations involving violent persons. Workers should have an efficient and inconspicuous means of alerting hospital personnel of an impending situation and summon the appropriate assistance based on the circumstances of the situation. The crisis management team should be multi-disciplined, and comprised of personnel who have demonstrated their competency and confidence in managing potentially violent situations.

Debriefing. Healthcare employers must develop a process by which employees who have encountered a workplace violence situation are able to debrief. As indicated by the victims of this study, it is common for victims to experience stress and some level of fear as a result of workplace violence situations regardless of the severity. Exposed workers must have the opportunity to convey their concerns and recommendations involving the situation, and leadership must use these sessions as opportunities to identify additional means of improving the workplace violence management program.

Post-assessment. Exposed workers should be surveyed to identify the various characteristics set forth in this study which may be associated with the workplace violence incident. Information should be provided on the time and location of the incident; demographics

of the victim(s) and perpetrator(s); subjective ratings of the victim's change in stress, anger, and fear levels; and controls that were available or needed that may have provided a better outcome.

Trending. Employers must develop a means to monitor patterns and trends within the work environment as well as the healthcare industry. Measures adopted should bear some relationship to evaluate the effectiveness of controls implement or performance improvement initiatives adopted. Controls utilized whose effectiveness is not supported by objective measures should be questioned.

Training. Employers must adopt a formal training program encompassing the various aspects of workplace violence as well as the management program. As every employee bears a risk to being exposed to workplace violence, every employee should be required to participate in the training. The training should include means of identifying and forecasting violence, communication and de-escalation, control and restraint, personal safety, and crisis management. In addition, as stress is commonly associated with workplace violence incidents, training sessions should be dynamic and incorporate exercises which are likely similar to those found within the work environment.

Exercises. Employers must conduct regular drills which require the implementation of the workplace violence management plan and crisis response process. Exercises should be conducted to reflect the conditions and circumstances associated with an actual workplace violence event. Responders should be expected to play an active role in the response, management, recovery and evaluation process.

Surveys. Employers should adopt a means by which feedback and recommendations are solicited from the healthcare employees working in the environment. Surveys should incorporate means to assess the employees' levels of knowledge of, awareness of and confidence in the

various elements of the workplace violence program. In addition, the feedback of employees should also entail the employees' evaluation of current controls as well as recommendations for additional controls.

References

- Antonetti-Zequeira, Esq. (2002, September 17). Workplace violence: Its legal perspective and its socio-economic impact. *The Bulletin Newsletter*, 2, 7-11.
- Bureau of Labor Statistics (2009). *Injuries, illnesses, and fatalities*. Retrieved from http://www.bls.gov/iif/osh_nwrl.htm#cfoi
- Colling, Russell L. (2001). *Hospital and healthcare security* (4th ed.). Woburn, MA: Butterworth – Heinemann.
- Houghton Mifflin Company (2007). *The American heritage® dictionary of the english language*. Boston, MA: Houghton Mifflin Company.
- Goetsch, David L. (2002). *Occupational safety and health for technologists, engineers, and managers* (4th ed.). Upper Saddle River, NJ: Prentice Hall.
- The Gale Group, Inc. (1998). *West's encyclopedia of american law*. Farmington Hills, MI: Thomson Gale.
- Gray, Carrie L. (1998). Reducing the risk of workplace violence. *Foundry Management and Technology*, 126(9), 1-7.
- Hammer, Willie and Dennis Price (2001). *Occupational safety management and engineering* (5th ed.). Upper Saddle River, NJ: Prentice Hall.
- House, J.S. (1981). *Work stress and support*. Reading, MA: Addison-Wesley.
- International Collaborative on Nursing Statistics. (2005, December). *Nurses, nursing education, and nursing workforce: definitions*. Retrieved September 1, 2009 from <http://www.iconsdata.org/definitions.htm>
- Occupational Safety and Health Administration (2008). 29 C.F.R. 1904.7. *Recording and reporting occupational injuries and illness*. Retrieved August 9, 2009 from http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9638
- Occupational Safety and Health Administration (2002, February). *Healthcare wide hazards: Workplace violence*. Retrieved August 9, 2009 from <http://www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/viol.html>

- Reilly, D. Michael. (1999). *Workplace violence, tort exposure and employer prevention and mitigation in washington*. Retrieved October 6, 2004 from <http://www.lanepowell.com/1929/workplace-violence/>
- Schat, Aaron C.H., & Kalloway, E. Kevin. (2003). Reducing the adverse consequences of workplace aggression and violence: The buffering effects of organizational support. *Journal of Occupational Psychology*, 8(2), 110-122.
- Schat, Aaron C.H., & Kalloway, E. Kevin. (2000). The effects of perceived control on the outcomes of workplace aggression and violence. *Journal of Occupational Psychology*, 4(1), 386-402.
- State of Minnesota , Office of the Revisor of Statutes. (2008). Chapter 253B. *Minnesota commitment and treatment act*. Retrieved August 9, 2009 from <https://www.revisor.mn.gov/statutes/?id=253B>
- Tweedy, James T. (1997). *Healthcare hazard control and safety management*. Boca Raton, FL: Lewis Publishers (CRC Press LLC).
- Williams Jr., C. Arthur; Michael L. Smith; Peter C. Young (1998). *Risk management and insurance* (8th ed.). Boston, MA: Irwin/McGraw-Hill.

Appendix A:

Occupational Safety and Health Administration's
Workplace Violence Guidelines
for Healthcare Facilities
(Summation)

**Summation of the
 “Hospital eTool – Healthcare Wide Hazards Module: Workplace Violence.”
 Provided by the Occupational Safety and Health Administration:
 United States Department of Labor**

Written procedures:

- a) Creates and disseminates a clear policy that violence, verbal and nonverbal threats, and related actions, will not be tolerated.
- b) Ensures that no reprisals are taken against employees who report or experience workplace violence.
- c) Encourages prompt reporting of all violent incidents and recordkeeping of incidents to assess risk and measure progress.
- d) Establishes a plan for maintaining security in the workplace which includes law enforcement officials and other security specialists.

Work-site Analysis: Potential Hazard = Exposure to workplace violence because a worksite analysis was not performed.

- a) Plans which distinguish between the various workplace-violence relationships:
 - Employee-Employee
 - Employee-Patient AND Patient-Employee
 - Employee-Visitor AND Visitor-Employee
 - Patient-Visitor AND Visitor-Patient
 - Visitor-Organization
 - Patient-Organization
 - Third Party-Organization
- b) Availability of drugs/money which may yield the potential for robbery
- c) Personnel working evening/night hours in high-crime areas
- d) Prevalence of firearms
- e) Low staffing; high turnover rates; and stress
- f) Exposure to violent, confused, or mentally unstable patients
- g) Dealing with combative, disoriented, uncooperative patients
- h) Mentally unstable patients
- i) Exposure to workplace violence in rooms not prepared for violent patients

Hazard Prevention/Control: Potential Hazard = Exposure to workplace violence because potential hazards in the workplace were not identified and addressed.

- a) Provide better visibility and good lighting
- b) Measures to deter firearms inside the facility
- c) Bullet-proof glass at Pharmacy
- d) Security devices (e.g. panic buttons, beepers, surveillance equipment, alarm systems, two-way mirrors, card-access, and security staff).
- e) Curved mirrors at hallway intersections or concealed areas
- f) Access control in work areas
- g) Staff training for recognizing/managing hostile behavior
- h) Adequate staffing during night shifts
- i) “Safe Room” procedures for violent patients

Training/Education : Potential Hazard = Increased risk of violence because of ineffective training of staff to deal with or identify potential violence problems

- a) Understanding of workplace violence policy and program
- b) Encouragement and support to report incidents
- c) Ways of preventing or diffusing volatile situations or aggressive behavior
- d) The dynamics of violence
- e) How to recognize and deal with hostile aggressive persons (non-violent responses)
- f) Managing anger
- g) Techniques and skills to resolve conflicts
- h) Stress Management (e.g. relaxation techniques)
- i) Security procedures
- j) Personal security measures (e.g. self defense)
- k) Techniques for victim support

Post-Incident Response: Potential Hazard = Healthcare workers, given inadequate support following a violent incident, may quit or be fearful to go back to work.

- a) Set up of trained response teams
- b) Post-incident response assistance (e.g. medical treatment, psychological evaluation, counseling, support groups, stress debriefing, crisis counseling, employee assistance program).

Record-keeping and Program Evaluation: Potential Hazard = Overall effectiveness of the program is reduced because of inability to identify and correct problems

- a) Medical reports of work injury
- b) Incidents of abuse (e.g. verbal abuse, aggression)

Employee Involvement: Potential Hazard = Exposure to workplace violence because of lack of employee involvement.

- a) Understand, support, and comply with established program
- b) Participate in employee suggestion/complaint process
- c) Provide prompt/accurate reporting of workplace violence incidents
- d) No fear of employer reprisals

Management Commitment: Potential Hazard = Exposure to workplace violence because of lack of management commitment. Provides the motivation and resources to deal effectively with workplace violence, and should include:

- a) Policy that violence, threats, harassment, intimidation, or other disruptive behavior will not be tolerated.
- b) Commitment to emotional and physical health of the employee
- c) Appropriate allocation of authority and resources to responsible parties
- d) Equal commitment to worker safety and health and patient/client safety/welfare
- e) System of accountability for managers and employees
- f) Program for medical and psychological counseling for employees experiencing or witnessing violent incidents
- g) No employee reprisals for reporting incidents

Appendix B:

Medicare/Medicaid Regulations for Hospitals:

Privacy and Safety

United States Code of Federal Regulations
42CFR482 Subchapter G - Part 482
Conditions of Participation for Hospitals

§482.13(c) Standard: Privacy and Safety

A-0056

§482.13(c)(1) The patient has the right to personal privacy.

Interpretive Guidelines §482.13(c)(1)

The underlying principle of this requirement is the patient's basic right to respect, dignity, and comfort. "The right to personal privacy" includes at a minimum, that patients have privacy during personal hygiene activities (e.g., toileting, bathing, dressing), during medical/nursing treatments, and when requested as appropriate. The right to personal privacy would also include limiting the release or disclosure of patient information such as the patient's presence in the facility or location in the hospital, or personal information such as name, age, address, income, health information without prior consent from the patient, as required by the Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule). However, patients that are admitted due to emergency circumstances may not wish that family members or significant others be uninformed as to their presence or status. The hospital should have procedures in place, in accordance with State law, to provide appropriate information to patient families or significant others in those situations where the patient is unable to make their wishes known.

People not involved in the care of the patient should not be present without his/her consent while he/she is being examined or treated, nor should video or other electronic monitoring/recording methods be used while he/she is being examined without his/her consent. If an individual requires assistance during toileting, bathing, and other personal hygiene activities, staff should assist, giving utmost attention to the individual's need for privacy. Privacy should be afforded when the MD/DO or other staff visits the patient to discuss clinical care issues or conduct any examination.

Additionally, audio/video monitoring (does not include recording) patients in medical-surgical intensive-care type units would not be considered violating the patient's privacy as long as patients/patient representatives are aware of the monitoring and the monitors or speakers are located so that the monitor screens are not visible or where speakers are not audible to visitors or the public. Staff must take appropriate precautions to provide patient privacy while patients are toileting, bathing, or being examined.

A patient's right to privacy may be limited in situations where a person must be continuously observed, such as when restrained or in seclusion when immediate and serious risk to harm self (such as when the patient is under suicide precautions or special observation status) or others exists. In most situations, security cameras in non-patient care areas such as stairwells, public waiting areas, outdoor areas, entrances, etc., are not generally affected by this requirements.

Survey Procedures §482.13(c)(1)

- Conduct observations to determine if patients are provided privacy during examinations, procedures, treatments, surgery, personal hygiene activities and discussions about their health status/care and other appropriate situations?

- Are patient names posted in public view?
- Is patient information posted in public view? Is the hospital promoting and protecting each patient's right to privacy?

A-0057**§482.13(c)(2) The patient has the right to receive care in a safe setting.****Interpretive Guidelines §482.13(c)(2)**

The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, including newborns and children. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would be components of an emotionally safe environment.

Survey Procedures §482.13(c)(2)

- Review and analyze patient and staff incident and accident reports to identify any incidents or patterns of incidents concerning a safe environment. Expand your review if you suspect a problem with safe environment in the hospitals.
- Review QAPI, safety, infection control and security (or the committee that deals with security issues) committee minutes and reports to determine if the hospital is identifying problems, evaluating those problems and taking steps to ensure a safe patient environment.
- Observe the environment where care and treatment are provided.
- Observe and interview staff at units where infants and children are inpatients. Are appropriate security protections (such as alarms, arm banding systems, etc.) in place? Are they functioning?
- Review policy and procedures on what the facility does to curtail unwanted visitors or contaminated materials.
- Access the hospital's security efforts to protect vulnerable patients including newborns and children. Is the hospital providing appropriate security to protect patients? Are appropriate security mechanisms in place and being followed to protect patients?

A-0058**§482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment.****Interpretive Guidelines §482.13(c)(3)**

The intent of this requirement is to prohibit all forms of abuse, neglect (as a form of abuse) and harassment whether from staff, other patients or visitors. The hospital must ensure that patients are free from all forms of abuse, neglect, or harassment. The hospital must have mechanisms/methods in place that ensure patients are free of all forms of abuse, neglect, or harassment.

Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect, for the purpose of this requirement, is considered a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

The following components are suggested as necessary for effective abuse protection:

- **Prevent.** A critical part of this system is that there are adequate staff on duty, especially during the evening, nighttime, weekends and holiday shifts, to take care of the individual needs of all patients. (See information regarding meaning of adequate at those requirements that require the hospital to have adequate staff. Adequate staff would include that the hospital ensures that there are the number and types of qualified, trained, and experienced staff at the hospital and available to meet the care needs of every patient.)
- **Screen.** Persons with a record of abuse or neglect should not be hired or retained as employees.
- **Identify.** The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.
- **Train.** The hospital, during its orientation program, and through an ongoing training program, provides all employees with information regarding abuse and neglect, and related reporting requirements, including prevention, intervention, and detection.
- **Protect.** The hospital must protect patients from abuse during investigation of any allegations of abuse or neglect or harassment.
- **Investigate.** The hospital ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment.
- **Report/Respond.** The hospital must assure that any incidents of abuse, neglect or harassment are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law.

As a result of the implementation of this system, changes to the hospital's policies and procedures should be made accordingly.

Survey Procedures §482.13(c)(3)

- Examine the extent to which the hospital has a system in place to protect patients from abuse, neglect and harassment of all forms, whether from staff, other patients, visitors or other persons. In particular, determine the extent to which the hospital addresses the following issues.
- Are staffing levels across all shifts sufficient to care for individual patient's needs?
- Does the hospital have a written procedure for investigating allegations of abuse and neglect including methods to protect patients from abuse during investigations of allegations?
- How does the hospital substantiate allegations of abuse and neglect?
- Do incidents of substantiated abuse and neglect result in appropriate action?
- Has the hospital implemented an abuse protection program? Does it comply with Federal, State and local laws and regulations? Is it effective?
- Are appropriate agencies notified in accordance with State and Federal laws regarding incidents of substantiated abuse and neglect?
- Can staff identify various forms of abuse or neglect?
- Do staff members know what to do if they witness abuse and neglect?
- What evidence is there that allegations of abuse and neglect are thoroughly investigated?
- Does the hospital conduct criminal background checks as allowed by State law for all potential new hires?
- Is there evidence the hospital employs people with a history of abuse, neglect or harassment

§482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

Interpretive Guidelines §482.41

This CoP applies to all locations of the hospital, all campuses, all satellites, all provider-based activities, and all inpatient and outpatient locations.

The hospital's Facility Maintenance and hospital departments or services responsible for the hospital's buildings and equipment (both facility equipment and patient care equipment) must be incorporated into the hospital's QAPI program and be in compliance with the QAPI requirements.

Survey Procedures §482.41

Survey of the Physical Environment CoP should be conducted by one surveyor. However, each surveyor as he/she conducts his/her survey assignments should assess the hospital's compliance with the Physical Environment CoP. The Life Safety Code survey may be conducted separately by a specialty surveyor.

A-0318

§482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well being of patients are assured.

Interpretive Guidelines §482.41(a)

The hospital must ensure that the condition of the physical plant and overall hospital environment is developed and maintained in a manner to ensure the safety and well being of patients. This includes ensuring that routine and preventive maintenance and testing activities are performed as necessary, in accordance with Federal and State laws, regulations, and guidelines and manufacturer's recommendations, by establishing maintenance schedules and conducting ongoing maintenance inspections to identify areas or equipment in need of repair. The routine and preventive maintenance and testing activities should be incorporated into the hospital's QAPI plan.

Assuring the safety and well being of patients would include developing and implementing appropriate emergency preparedness plans and capabilities. The hospital must develop and implement a comprehensive plan to ensure that the safety and well being of patients are assured during emergency situations. The hospital must coordinate with Federal, State, and local emergency preparedness and health authorities to identify likely risks for their area (e.g., natural disasters, bioterrorism threats, disruption of utilities such as water, sewer, electrical communications, fuel; nuclear accidents, industrial accidents, and other likely mass casualties, etc.) and to develop appropriate responses that will assure the safety and well being of patients. The following issues should be considered when developing the comprehensive emergency plans(s):

- The differing needs of each location where the certified hospital operates;
- The special needs of patient populations treated at the hospital (e.g., patients with psychiatric diagnosis, patients on special diets, newborns, etc.);
- Security of patients and walk-in patients;
- Security of supplies from misappropriation;

- Pharmaceuticals, food, other supplies and equipment that may be needed during emergency/disaster situations;
- Communication to external entities if telephones and computers are not operating or become overloaded (e.g., ham radio operators, community officials, other healthcare facilities if transfer of patients is necessary, etc.);
- Communication among staff within the hospital itself;
- Qualifications and training needed by personnel, including healthcare staff, security staff, and maintenance staff, to implement and carry out emergency procedures;
- Identification, availability and notification of personnel that are needed to implement and carry out the hospital's emergency plans; • Identification of community resources, including lines of communication and names and contact information for community emergency preparedness coordinators and responders; • Transfer or discharge of patients to home, other healthcare settings, or other hospitals; • Transfer of patients with hospital equipment to another hospital or healthcare setting; and • Methods to evaluate repairs needed and to secure various likely materials and supplies to effectuate repairs.
- Provisions if gas, water, electricity supply is shut off to the community;

Survey Procedures §482.41(a)

- Verify that the condition of the hospital is maintained in a manner to assure the safety and well being of patients (e.g., condition of ceilings, walls, and floors, presence of patient hazards, etc.).
- Review the hospital's routine and preventive maintenance schedules to determine that ongoing maintenance inspections are performed and that necessary repairs are completed.
- Verify that the hospital has developed and implemented a comprehensive plan to ensure that the safety and well being of patients are assured during emergency situations.

A-0329

§482.41(c) Standard: Facilities

The hospital must maintain adequate facilities for its services.

Interpretive Guidelines §482.41(c)

Adequate facilities means the hospital has facilities that are:

- Designed and maintained in accordance with Federal, State and local laws, regulations and guidelines; and
- Designed and maintained to reflect the scope and complexity of the services it offers in accordance with accepted standards of practice.

Survey Procedures §482.41(c)

- Observe the facility layout and determine if the patient's needs are met. Toilets, sinks, specialized equipment, etc. should be accessible.
- Review the facility's water supply and distribution system to ensure that the water quality is acceptable for its intended use (drinking water, irrigation water, lab water, etc.). Review the facility water quality monitoring and, as appropriate, treatment system.

A-0331

§482.41(c)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

Interpretive Guidelines §482.41(c)(2)

Facilities must be maintained to ensure an acceptable level of safety and quality.

Supplies must be maintained to ensure an acceptable level of safety and quality.

This would include that supplies are stored in such a manner to ensure the safety of the stored supplies (protection against theft or damage, contamination, or deterioration), as well as, that the storage practices do not violate fire codes or otherwise endanger patients (storage of flammables, blocking passageways, storage of contaminated or dangerous materials, safe storage practices for poisons, etc.).

Additionally, “supplies must be maintained to ensure an acceptable level of safety” would include that the hospital identifies the supplies it needs to meet its patients’ needs for both day-to-day operations and those supplies that are likely to be needed in likely emergency situations such as mass casualty events resulting from natural disasters, mass trauma, disease outbreaks, etc.; and that the hospital makes adequate provisions to ensure the availability of those supplies when needed.

Equipment must be maintained to ensure an acceptable level of safety and quality.

Equipment includes both facility equipment (e.g., elevators, generators, air handlers, medical gas systems, air compressors and vacuum systems, etc.) and medical equipment (e.g., biomedical equipment, radiological equipment, patient beds, stretchers, IV infusion equipment, ventilators, laboratory equipment, etc.).

There must be a regular periodical maintenance and testing program for medical devices and equipment. A qualified individual such as a clinical or biomedical engineer, or other qualified maintenance person must monitor, test, calibrate and maintain the equipment periodically in accordance with the manufacturer’s recommendations and Federal and State laws and regulations. Equipment maintenance may be conducted using hospital staff, contracts, or through a combination of hospital staff and contracted services.

“Equipment must be maintained to ensure an acceptable level of safety” would include that the hospital identifies the equipment it needs to meet its patients’ needs for both day-to-day operations and equipment that is likely to be needed in likely emergency/disaster situations such as mass casualty events resulting from natural disasters, mass trauma, disease outbreaks, internal disasters, etc.; and that the hospital makes adequate provisions to ensure the availability of that equipment when needed.

Survey Procedures §482.41(c)(2)

- Interview the person in charge of medical equipment and determine if there is an adequate repair/periodical maintenance program.
- Verify that all medical devices and equipments are routinely checked by a clinical or biomedical engineer.
- Review maintenance logs for significant medical equipment (e.g., cardiac monitors, IV infusion pumps, ventilators, etc.).
- Are supplies maintained in such a manner as to ensure that safety?
- Are supplies stored as recommended by the manufacturer?
- Are supplies stored in such a manner as to endanger patient safety?
- Has the hospital identified supplies and equipment that are likely to be needed in emergency situations?
- Has the hospital made adequate provisions to ensure the availability of those supplies and equipment when needed

Appendix C:

Observational Participant Survey Tool

**“Workplace Violence in the Emergency Healthcare Setting:
Balancing the Needs of Behavioral Patients-In-Crisis with
the Personal Safety of Hospital Staff”
*Observational-Participant Survey***

Incident Information:

Incident Number: _____

Incident Description: _____

Time of Incident (Circle One):

0200-0559	0600-0959	1000-1359	1400-1759	1800-2159	2200-0159
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Location of Incident: _____

Demographics of Victim:

Gender: Male Female

Age Range: < 18 18-21 22-25 26-35 36-45 46-55 55>

Years of Healthcare Work Experience: <1 1-2 2-5 5-10 10-15 15-20 20-25 25<

of co-workers in area? 0 1-2 3-5 6-10 11-15 15+

Demographics of Perpetrator:

Gender: Male Female

Age Range: < 18 18-21 22-25 26-35 36-45 46-55 55>

Category (Colling): Patient/Customer Employee Legitimate Visitor Illegitimate Visitor

Demographics of Relationship between Victim and Perpetrator:

Role-Relationship (Colling): Type I (No Relationship) Type II (Customer) Type III (Personal)

- _____ Employee – Employee
- _____ Manager – Employee
- _____ Patient – Employee
- _____ Legitimate Visitor – Employee
- _____ Illegitimate Visitor – Employee
- _____ Vendor – Employee
- _____ Personal – Employee
- _____ Other: _____

Type (Continuum):

- _____ Vicarious
- _____ Compliant/Cooperative
- _____ Inappropriate Comments/Behavior
- _____ Threatening Gestures/Expressions
- _____ Verbal Threats/Intimidation
- _____ Physical - Passive Resistance
- _____ Physical - Active Resistance
- _____ Physical - Simple Assault
- _____ Physical - Aggravated Assault (Weapon Involved)
- _____ Physical – Injury/Death

