# Workplace Violence and Corporate Policy for Health Care Settings

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*AUTHOR-ABSTRACT: * Nonfatal assaults occur nearly four times more often in health care than in all private sector industries combined.; * Compounded by performance pressure, the health care workplace has become a pressure cooker for leaders and staff alike.; * Ideally, the workplace is free of violence, in terms of threats or actions, either verbal or physical.; * A comprehensive organizational violence prevention program begins with a zero tolerance for violence policy and is supported by a data collection mechanism to monitor violence, ongoing prevention initiatives, and a post-event support plan.; * Workplace violence monitoring tools typically capture the type, mode, and severity of the incident and, like safety monitoring tools, support the identification of trends for ongoing intervention and education.; * In the event of a severely violent event, the organizational response should encompass a variety of group and individual efforts to support and stabilize the staff and work environment immediately, and in the many months to follow.*

TYPICALLY THOUGHT OF AS "safe" places, health care agencies are now facing a significant increase in multidirectional acts of aggression from personnel, clients, and visitors (National Institute of Occupational Safety and Health [NIOSH], 2003). Media coverage of workplace violence has heightened the underlying sense of insecurity about when, where, and how the next traumatic event will occur. Health care providers are now confronted with the idea that "it could happen here" and "it could happen to me."

In response, organizations are focusing on developing or enhancing workplace safety policy and adopting preventive measures, methods for early detection, psychological post-trauma interventions, and methods of maintaining corporate function after sentinel events resulting from workplace violence (Bendersky-Sacks, Clements, & Fay-Hillier, 2001; NIOSH, 2003; Occupational Safety and Health Administration [OSHA], 2004).

Most mainstream media cover sensational, dramatic, and rare types of violent assaults, such as those carried out by disgruntled employees. Concentrating only on the "gunman" type of assault can distract employees from focusing on other significant, but less dramatic risk factors that can be just as dangerous. For example, one of the most common types of workplace violence occurs when the language or behavior of another employee, a patient, or a visitor is perceived as

threatening. Other examples include (U.S. Department of Health and Human Services [USDHHS], 2002):

- Threats. Expressions of intent to cause harm, including verbal threats, threatening body language, and written threats.

- Physical assaults. Attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives.

- Muggings. Aggravated assaults, usually conducted by surprise and with intent to rob.

The overarching reality in the health care workplace is that many employers now find themselves dealing with workplace violence, including assault; property damage; racially, ethnically, or religiously motivated violence; sexual assault; employee suicide; or homicide. Regardless of a health care agency's size or mission, when unexpectedly confronted with workplace violence, staff members are typically overwhelmed with shock, followed by multiple questions surrounding how the event could have occurred in the safety of the workplace (DeRanieri, Clements, & Henry, 2002).

It is often impossible to separate the roles of the "professional" and the "person" in an attempt to cope with the occurrence of workplace violence (Clements et al., 2003). Therefore, when tragedy strikes a peaceful and productive workforce head-on, chaos and debilitation can ensue, necessitating immediate intervention and stabilization (Bendersky-Sacks, Clements, DeRanieri, KlinckKrentel, & Fay-Hillier, 2000; Bendersky-Sacks et al., 2001). The current health care environment often requires that employees maintain optimal performance even in the immediate chaotic aftermath of workplace violence. However, without time to examine how the traumatic event may be interpreted within their own personal, moral, ethical or cultural code, there may be a disruption in corporate function and provision of care (Clements & Bradley, 2005, Clements, DeRanieri, Fay-Hillier, & Henry, 2003).

Awareness of the dynamics and issues related to trauma, loss, and ongoing fear after workplace violence can guide policy and related interventions to promote stability and provide a platform for adapting to the potential devastation of such a traumatic event (Bendersky-Sacks et al., 2001; DeRanieri et al., 2002).

**Incidence of Violence in the Workplace**

Today more than 5 million U.S. hospital workers from many occupations perform a wide variety of duties. They are exposed to many safety and health hazards, including violence. Recent data indicate that hospital workers are at high risk for experiencing violence in the workplace. According to estimates of the Bureau of Labor Statistics, 2,637 nonfatal assaults on hospital workers occurred in 1999 (8.3 assaults per 10,000 workers). This rate is much higher than the rate of nonfatal assaults for all private-sector industries, which is 2 per 10,000 workers

In 2001, the American Nurses Association released its Bill of Rights for Registered Nurses, which set forth the tenet that nurses have the right to work in an environment that is safe for themselves and their patients. However, studies have shown that between 35% and 80% of hospital staff have been physically assaulted at least once and that nurses are at great risk for violence while on duty (Arnetz & Arnetz, 2001; Bruser, 1998: Kinross, 1992; Lanza, 1996;

Shepard, 1996; Whitehorn & Nowland, 1997; Williams & Robertson, 1997). Workplace violence in health care settings is not limited to physical assault. NIOSH (2003) has defined workplace violence as any physical assault, threatening behavior, or verbal abuse occurring in the workplace. The definition includes, but is not limited to, such events as beatings, shootings, rape, suicide or suicide attempts, and psychological traumas, such as threats to harm, obscene phone calls (also known as scatalogia), intimidation, or harassment, including being followed or sworn at.

Chavez (2003) reports that workplace violence continues because some employers simply fail to adequately address the problem. He posits: This has not been purposeful but instead rather to a lack of awareness of the problem coupled with everyday workplace and industry pressures. It is conceivable that workplace violence prevention has not been given the priority it rates. This has resulted in employers being oblivious to some of the most obvious organizational factors that have contributed to scenes of unimaginable horror across the country. Some of those factors include:

- A weak or nonexistent policy against all forms of violence within the organization:

- Inadequate employee acquisition, supervision, and retention practices;

- Inadequate training on violence prevention at all levels;

- No clearly defined rules of conduct;

- Failure to introduce employees to antiviolence policies and prevention strategies;

- Inability of managers and supervisors to adequately assess threats:

- A nonexistent or weak mechanism for reporting violent or threatening behavior;

- Failure to take immediate action against those who have threatened or committed acts of violence (p. 1).

The frequency and severity of aggressive incidents have not been well documented in the past. The stigma of victimization, such as shame, isolation, fear, or threat of further violence, has often deterred victims from reporting violent behavior (Hoff, 1992). Other variables, including underreporting of violent events, are correlated with lack of support from administration and management or the fear of reprisal, poor reporting mechanisms, excessive paperwork, and poor documentation and/or followup by hospitals (Arnetz & Arnetz, 2001; Kinross, 1992).

**Zero Tolerance for Violence in the Workplace**

National mandates now indicate that health care organizations have a duty to provide a safe environment for their employees (NIOSH, 2003; OSHA, 2004). By implementing a zero tolerance for violence policy, organizations can assist in minimizing the frequency of abuse and the potential harm to employees. A comprehensive organizational violence prevention program should include a reporting and documentation system for acts of violence and a workplace violence prevention policy that includes specific strategies that can be instituted system-wide in the event of a violent incident, as well as post-event support and adequate training of personnel for pre and post-event incident management (Bruser, 1998; Burgess et al., 1997; Williams & Robertson, 1997).

The identification and reporting of data related to violent incidents are required to assess the need for action and for the implementation of reasonable intervention strategies for the individual health care organizations (Burgess et al., 1997; Kohm, McNally, & Tiivel, 1996; Williams & Robertson, 1997). Workplace violence monitoring tools that encompass all types and severity levels of aggression can provide insight into identifying potential threats and can help to educate employees about any dangerous risk factors that might have contributed to the aggressive events. Such tools contribute towards an accurate assessment and identification of the type of aggression (physical and/or verbal), the mode of aggression (direct or indirect), and the impact and severity (physical, psychological, and/or emotional) on the victim and institution. Improved documentation will help in the development of intervention strategies that would be useful to the employees and the organization (Burgess et al., 1997).

Once a mechanism for reporting workplace violence has been established, the information obtained must be analyzed. A team should be established to assess the threat of violence and to determine how specific the threat is, whether the perpetrator has a means of carrying out the threat, and what would be necessary to prevent any further acts of aggression (NIOSH, 2003). This team should typically consist of interdisciplinary members, including human resource personnel, front-line employees, union members, security personnel, management, administration, possibly legal representation, public relations staff, and any individuals who can provide valuable insight into organizational safety. Zero tolerance would anticipate that the risk of aggression is not limited to external threats, but would also address any internal threats of violence between co-workers and explicitly address the management of its own personnel. The zero tolerance assessment team would be responsible for continuous review of reported workplace violence as well as any recommendation or revisions that would lead to the prevention of any further violent incidents within the workplace.

Recognition of risk factors for enhanced assessment and monitoring based on national reporting can raise employee awareness and development of policy and procedures to minimize violent events within health care agencies. The risk factors for violence vary among health care agencies depending on location, size, and type of care. Common risk factors for health care agency violence are listed in Table 1.

Of note, support to employees should not be provided only after a violent threat or event. A culture of safety within the workplace would demonstrate support by regularly providing aggression and violence training, as well as open forums for discussion. A zero tolerance policy should be implemented and subjected to annual review. The managerial and administrative role in violence prevention would clearly identify accountability, role, and procedure. The development of an identification system for potential violence, response to threats or violent events, and constructive support procedures after the event will contribute to zero tolerance of violence in the workplace.

**Organizational Response to Immediate Workplace Violence**

In the event of a violent incident within the workplace, procedures and responsibilities of personnel should be explicit in the zero tolerance for violence policy. The policy should address

immediate response to acts of violence. This includes designating personnel who have completed specialized training, for example, a code team to assist in intervention. The immediate responders might include security staff, mental health professionals, law enforcement personnel, or management staff, as well as any of those who have been trained in the handling of violent situations. If an immediate threat of violence has occurred, whether specific or broad, the threat should not be ignored but, again, allocated to the appropriate personnel, whether they be legal, personnel, human resources staff, or any of the previously mentioned individuals trained in violence management (Burgess et al., 1997; Kohm et al., 1996; Williams & Robertson, 1997).

Once a traumatic event has occurred, organizational response will play a significant role in the recovery process. When an organization is perceived as "protecting" itself and failing to understand and respond to the needs of the employees who may have been "victimized," it may inflict further trauma (Bendersky-Sacks et al., 2000, 2001; Bowie, 1996; DeRanieri et al., 2002). To meet the needs of the victim, the organization should provide immediate comfort and peer support, such as a community meeting, expression of understanding by management, specific debriefing, and a referral to the appropriate resources (Clements et al., 2003; DeRanieri et al., 2002).

The debriefing or review procedure should be routine and constructive, and should occur within 24 to 72 hours after the event. The atmosphere should be considered safe, and blame should not be discussed. Once therapeutic safety has been assured, the debriefing procedure can begin. The individual conducting the debriefing must provide support while ascertaining information relevant to the event. A manager may be the initial individual who provides this support while initiating the investigation; however, if any issue of accountability emerges, it is best to defer the process to another individual within the management system. The debriefing procedure should be voluntary; however, if employees decline debriefing, the agency can insist that they provide at least relevant psychoeducational information (usually in printed form, such as a brochure) pertinent to the adaptive and maladaptive response patterns for individuals after exposure to a traumatic event (Bendersky-Sacks et al., 2000, 2001; Clements et al., 2003).

**Organizational Therapeutic Management and Education**

When providing support and education after workplace violence, employees should be encouraged to discuss the traumatic event. Employers and clinicians should treat the subject in a supportive and matter-of-fact manner and take the lead in asking questions, while allowing the employees to lead the meeting as they feel comfortable (Clements et al., 2003; Clements & Henry, 2001; DeRanieri et al., 2002).

Employees should be encouraged to explore what they know or what they have been told. They should be asked to describe what the "hardest part" is for them. This is beneficial, even if the details are horrific (or conversely, seemingly benign) because employees will seek validation of their experience and related feelings, including disturbing descriptions or memories. Often this validation will be sought from management, and will subsequently be discussed and examined among peers as an indication of the level of support that management and administration provide to the agency employees.

Employees should be assured that the violent event was not their fault, as it is not uncommon for them to blame themselves for "not preventing" the event from happening, even when they had no control or ability to intervene. It is important for management to be proactive rather than reactive. Even in cases of extreme outrage about how such an event could occur in the safety of the workplace, a therapeutic stance of support and encouragement toward normalcy must be made. Initial resistance or projection of anger, fear, or anxiety by employees should not lead to therapeutic disengagement, but rather to assistance in redirecting the anger, fear, or anxiety to the true source of these feelings.

Management can facilitate healthy recovery by guiding and supporting employees along the continuum of tasks and challenges during the initial months after the event, which may include ongoing reminders of the event, such as legal inquiry, media coverage, and other changes in the institution's operating procedures. Reassuring employees that frustration and anxiety relative to these activities are not unusual in aftermath of a traumatic workplace event can be beneficial in reducing anxiety levels and other disturbing thoughts and feelings (Clements et al., 2003; DeRanieri et al., 2002; Maxey, 2003).

During the first weeks after the violent event, it is typically difficult for employees to concentrate on and to process large amounts of information, regardless of its importance. Information should be given in a clear and succinct format. "Check-ins," or followup reflection of employee feelings and concerns, from time to time, can help avoid possible misinterpretations and indicate that the management is "listening." It also provides insight into how well the information is being understood and integrated as the employees move forward in adaptive coping and return to agency routine. Additionally, when discussing important therapeutic issues, providing an environment with decreased stimuli and distractions that can decrease unanticipated sources of stress and tension is important. Affective disturbances are normal and should be expected. Typically, most employees will internalize (depression, avoidance, withdrawal) or externalize (anger, outbursts, labile mood) emotional and behavioral responses. It is important for management to be able to tolerate silence when the employee needs quiet time; conversely, it is just as important to tolerate apparently unmotivated outbursts of anger and hostility (Clements et al., 2003; Clements & Henry, 2001; DeRanieri et al., 2002).

**Employee Reactions after Violence**

In the flurry of the investigative activity following the chaos of workplace violence, employees are typically confronted with disbelief, shock, and numbness. These are very normal reactions (American Psychiatric Association, 2000; Bendersky-Sacks et al., 2000; DeRanieri et al., 2002). Listening to the thoughts, feelings, and the reactions from the continuum of frontline employees, management, and administrators, all of whom have been confronted with the event, can be very helpful. It is important to acknowledge that each person will respond differently and that this is completely normal (Clements et al., 2003; Clements et al., 2005). It is important that employees not allow others to define the meaning of the event for them. Additionally, employees should be given permission to feel anger, a sense of betrayal, fear, confusion, or physical manifestations; these symptoms can be reflective of normal recovery. Employees may not necessarily be feeling better and "over it" in a month or 2. However, extreme trauma-related symptoms that contribute

to emotional or physical incapacitation and disrupt daily functioning require medical or mental health referral (Clements & Henry, 2001).

**Suggestions for Promoting Employee Mental Health**

Some employees are surprised to find that they repeat the story of the event to others over and over again. This repetitious sharing can actually be helpful in accepting the reality of what has happened and promote exploration of what the event really means to them and the facility.

Table 2 includes suggestions that may be shared in agency meetings to facilitate adaptive coping for all employees after a violent or traumatic event in the workplace.

**Employer/Employee Integration of Traumatic Events**

As employees progress through the process of integrating the trauma, some adaptive changes may be visible in the workplace. Employees may find that they are able to talk about the event without extreme affective responses. Energy levels typically improve, and workplace activities become more organized. Employees may, after a while, find that they can discuss the event in a matter-of-fact manner and there may be evidence of a returning sense of humor.

It is important for managers and administrators to recognize that a followup agency meeting and subsequent evaluation of the workplace as a whole is critical. Because individual employees will adjust at different rates and in different ways, it is important to assess the emotional trauma barometer of the unit several weeks after the event. Allowing employees to vent about how the traumatic event has affected their concentration at work and personally as an individual will promote a sense of caring and support by the institution (Clements et al., 2003; DeRanieri et al., 2002).

There will inevitably be situations, objects, and other things that will serve as reminders of the traumatic event; however, it is important to remind employees that inner healing occurs over a period of time. Employees should not be alarmed or surprised to find that they are emotionally charged by certain events or even the 1-year anniversary date. These are typical times for thoughts to be drawn to the memory of the event and the associated fears and losses (Clements & Henry, 2001).

**Summary**

Workplace violence is of significant concern to health care employers and employees. The identification and reporting of data related to violent incidents are required to assess the need for action and for implementing reasonable intervention strategies for the individual health care organizations. Additionally, awareness of the dynamics and issues related to trauma, grief, and bereavement after workplace violence can guide interventions to promote stability and provide a platform for adapting to the devastation of such a traumatic event.

**Table 1.**

*Common Risk Factors for Health Care Agency Violence*

- Working directly with volatile people, especially if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses.

- Working when understaffed, especially during meal times and visiting hours.

- Transporting patients.

- Long waits for service.

- Overcrowded, uncomfortable waiting rooms.

- Working alone.

- Poor environmental design.

- Inadequate security.

- Lack of staff training and policies for preventing and managing crises with potentially volatile patients.

- Drug and alcohol abuse.

- Access to firearms.

- Unrestricted movement of the public.

- Poorly lit corridors, rooms, parking lots, and other areas.

Source: USDHHS, 2002

**Table 2.**

*Suggestions for Facilitating Adaptive Coping After a Violent or Traumatic Event*

- Accept the fact that what you are feeling is real and may be painful.

- Remember that fear of the event or subsequent events might manifest in many different ways (physically, emotionally, or spiritually).

- Do not allow yourself to go into a state of isolation by avoiding those who care about you or who are attempting to be supportive.

- Do not allow guilt or fear to set you back. We often feel that we could have or should have done something to prevent the event from happening and may begin to worry about future losses.

- Experience your thoughts and feelings 1 day at a time.

- If you feel that you need help and are worried about your well-being or safety, contact your human resources department, a grief counselor, or other health care provider who will help to validate your feelings and plan strategies for appropriate assistance.

Sources: Clements et al., 2003; Clements & Henry, 2001

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