Workplace Violence Toolkit – Section 1

Contents

Understanding Work Place Violence (WPV)

What is Workplace Violence (WPV)?

The Occupational Health and Safety Agency (OSHA) defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior, that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide, and can involve employees, clients, customers and visitors. (OSHA, 2015).

Terms and definitions used to define WPV in occupational safety and violence literature can vary for example, violence that occur between coworkers may be defined as bullying, lateral or horizontal violence or incivility. The definition of assault as related to criminal law also varies by state and federal judicial systems.

Workplace violence in health care can also be defined as intentional e.g., where there is intent by a patient to cause physiological, emotional and bodily harm to an employee, or 'non -

Definitions of Violence

Harassment – any behavior (*verbal or physical*) that demeans, embarrasses, humiliates, annoys, alarms, or verbally abuses a person, and that is known or would be expected to be unwelcome. This includes use of offensive language, sexual innuendos, name calling, swearing, insults, use of condescending language etc., arguments, gestures, pranks, rumors, intimidation, bullying, or other inappropriate activities.

Verbal or written threats – any expression of an intent to inflict personal pain, harm, damage, and/or psychological harm, either through spoken word or in writing.

Threatening behavior – such as shaking fists, intentionally slamming doors, punching walls, destroying property, vandalism, sabotage, theft, or throwing objects.

Physical attacks or assaults – hitting, shoving, biting, pushing or kicking. Extremes include rape, arson, and murder. Note: ORS 654.412 to 654.423 defines assault as *'intentionally, knowingly or recklessly causing physical injury'*.

Aggravated Assault - An unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. This type of assault usually is accompanied by the use of a weapon or by means likely to produce death or great bodily harm.

Source: IAHHS 2016, Boyle, 2016, OSHA 2015, EEOC 2016, Fell-Carlson, 2008

intentional' e.g., violence by individuals with cognitive impairment associated with dementia, brain injury, or a physiological reaction to anesthesia or medication. The perception of a patient's intent to cause harm and how 'intent' is defined greatly influences reporting of violence by health care workers, as discussed later in this section.

WPV incidents generally fall into four categories:

▶ Type I (Criminal Intent): Results while a criminal activity (e.g., robbery) is being committed and the perpetrator has no legitimate relationship to the workplace.

▶ Type II (Customer/client): The perpetrator is a customer or client at the workplace (e.g., health care patient) and becomes violent while being served by the worker.

▶ Type III (Worker-on-Worker): Employees or past employees of the workplace are the perpetrators.

▶ Type IV (Personal Relationship): The perpetrator usually has a personal relationship with an employee (e.g., domestic violence in the workplace).

(OSHA, 2015)

The focus of this toolkit is prevention and control of Type II (customer/client) violence, where violence is perpetrated by patients and visitors toward employees, contract personnel, and volunteers, who work within a hospital and/or clinic setting. However, any WPV prevention programs should also incorporate policies and procedures to address risk of violence of any type and cause such as, bullying, domestic, and criminal activity, that could in any work setting within a health care organization.

Occurrence of WPV in Health Care

In the US, workers in health care experience substantially higher estimated rates of nonfatal injury due to workplace violence compared to workers in all other industries. Health care and social assistance workers are nearly <u>four times</u> more likely to be injured and require time away from work as a result of WPV (OSHA, 2015).

Within health care settings, approximately 24,000 workplace assaults occurred between 2010 and 2013, with most threats and assaults occurring between noon and midnight (Wyatt et. al, 2016).

The Bureau of Labor Statistics reports that while less than 20% of workplace injuries involve health care workers, 50% of work place related assaults involve health care workers.

Type II violence is the most common in health care settings that is, verbal or physical abuse and assaults perpetrated by patients, their family members, and visitors, toward health care workers. Examples include, intentional and non-intentional verbal threats or physical attacks by patients, a distraught family member who may be abusive or even become an active shooter, or gang violence in the emergency department.

- In two studies of Emergency Department nurses 50-100% of respondents reported experiencing verbal or physical violence at work (ENA 2011, Phillips, 2016).

- In another study, of 762 nurses in one large hospital system, 76.0% reported experiencing verbal violence and 54.2% reported experiencing physical violence. (Speroni et al., 2014)

- In a Health Risk Appraisal survey of 3,765 registered nurses and nursing students conducted by the American Nurses Association in 2014, *21 percent* of registered nurses and nursing students reported being physically assaulted, and *over 50 percent* reported being verbally abused in a 12-month period (OSHA, 2015).

In one 2014 survey on hospital crime, Type II violence accounted for 75% of aggravated assaults and 93% of all assaults against employees (Phillips, 2016).

The most common causes of violent injuries resulting in days away from work across several health care occupations were hitting, kicking, beating, and/or shoving (GAO, 2016).

The highest rates of violence occur in emergency rooms and inpatient psychiatric or behavioral health departments or facilities, geriatric long-term care settings, and residential and day social services (OSHA, 2015).

Some health care professions are more at risk for exposure to WPV than others. In 2013, Psychiatric Aides experienced more than 10 times the rate of violent injuries that resulted in days away from work than Nursing Assistants (NAs). NAs experienced more than 3 times the rate of violence than Registered Nurses (RNs) (OSHA, 2015).

However, there is little data to indicate occurrence of violence in other health care units such as intensive care; and in other health care settings such as, outpatient clinics or within many job categories such as emergency medical service workers or diagnostic technologists.

Data collected by the National Institute for Occupational Safety and Health (NIOSH) for 2012 through 2014, shows that injuries resulting from workplace violence appears to be *increasing* among all health care personnel and particularly among nursing assistants and nurses. The majority of these injuries result from physical assaults on nursing staff (NIOSH, 2016).

Injury and staff survey data collected during the WSI indicated that:

- A majority of violence is perpetrated by patients.

- Employees reported that verbal abuse is the most common type of violence that they had experienced in the last year.

- Incidence of violence mostly occurred in the ED, Behavioral health, Intensive Care units, and Medical/Surgical units. In one hospital, violence was reported as increased in family birth and in home health units, and 2 hospitals reported an increase in violence in outpatient clinics.

The WPV related event that occurs in health care and receives the greatest media and public attention involves *active shootings* however, these events are *uncommon*. The Federal Bureau of Investigation (FBI) recognizes that between 2000 and 2013, there were 160 reported shootings with injury either inside a hospital or on the grounds. Reported motivation for these events include revenge, suicide and mercy killing. In nearly 20% of the incidents, the perpetrators did not bring their own firearm to the hospital, and in 8% of all events the perpetrator took the gun from a police or security officer. In 28% of events involving firearms, a law enforcement officer shot a perpetrator in the hospital (Phillips, 2016, Aumack, 2017).

FBI Investigations indicate an increasing trend in workplace active shooter incidents for all industries including health care, from an average of 6.4 incidents per year between 2000 and 2006, to 16.4 incidents per year between 2007 and 2013.

In terms of *fatal* workplace violence, the Centers for Disease Control (CDC) report a *decreasing* trend over the past ten years in all non-health care industries, while the numbers of homicides in health care have remained relatively stable (NIOSH, 2015).

WPV in Oregon

Between 2013-2015 there were a total of 1646 work related accepted disabling claims (ADCs) from assault in Oregon. However, in 2015 alone, *only 3.1%* of all ADCs in Oregon were attributed to assault in all industries which likely supports the premise that WPV incidents are vastly underreported.

Health Care and Social Assistance in both the private and public sector accounted for 49% of these claims, which is more than any other industry. A majority of ADCs in the private sector occurred in nursing and residential care facilities. 84% of these injuries occurred as a result of health care workers being hit, kicked, bitten, or shoved. One WPV related homicide occurred between 2012-2016 in Oregon in a nursing and residential care facility. (Oregon OSHA; DCBS 2016).

Why is WPV Underreported in Health Care?

Studies indicate that violence in health care is hugely underreported. In one report, only 30% of nurses and 26% of physicians reported incidents (Philips, 2016).

Bullying and other forms of verbal abuse are more frequently underreported. In these cases, reasons for underreporting include lack of a reporting policy, lack of faith in the reporting system, and fear of retaliation (Blando, 2013).

Table 1.1 lists the factors that influence whether staff report a WPV episode or event in health care.

Employees at hospitals participating in the WSI project reported similar factors or barriers to reporting WPV incidents.

In addition to underreporting of WPV, inconsistencies in data collection and definitions of violence contributes to a lack of knowledge about the frequency and severity of WPV in health care.

Without accurate incident data, development and implementation of effective violence prevention programs and control strategies can be challenging.

Factors that influence reporting of WPV incidents

Incident type and patient condition

- The severity of the incident i.e. whether the employee suffered physical injury requiring medical treatment

- The condition of the patient – for example when violence is perceived as unintentional due to the patient's clinical condition or diagnosis e.g. dementia

- Perception of what is 'violence' by employees

Organizational Culture

- Concerns that assaults by patients and visitors may be viewed as a result of poor performance or negligence of the employee

- The intense focus on customer service in health care where the "the customer is always" right or the impact of money and profit driven management models

  Normalizing of WPV – 'it's just part of the job'

Reporting process

- Whether someone else reported the incident

- No clear reporting policy

- Complicated reporting process e.g. forms take too long to complete

Response to Reporting

- Fear of retaliation e.g., from patient and/or their family in smaller communities where everyone knows each other, stigmatization or bullying from co-workers for reporting

- Lack of action resulting from reporting e.g. informal report to a supervisor goes no further or there is no response to a formal report or preventative action is not taken

- The complexity of the legal system and response from law enforcement when reporting and/or pressing charges

Source: ENA 2011, Blando 2013, Arnetz, 2015, OSHA 2015, Philips 2016

Table 1.1

Causes of WPV in Health Care

The cause of WPV in health care is often multifactorial and can be summarized in four broad categories.

1. **Clinical** related risk factors are the most common cause or contributor of violence e.g., patients with poorly managed mental illness, dementia, delirium, developmental impairment, and drug and alcohol intoxication and abuse.

2. **Social and economic** risk factors that contribute to violence include financial stress, domestic violence that extends into the workplace, ethnic conflict, access to weapons; neighborhoods with high crime rates and the increasing presence of gang members. The availability of drugs or money at hospitals, clinics, and pharmacies, makes them likely

robbery targets. The increasing use of prescription opioids and related addiction in the general population is a newer concern for clinics and physician offices.

3. **Environmental** related risk factors include noise, crowded waiting areas, open access of the public in clinics and hospitals; poorly lit spaces.

4. **Organizational** factors include design of financial/billing services, long wait times, dehumanizing, and inhospitable environments, poor communications, staff shortages, lack of or inadequate training, lack of or inconsistent process to identify and respond to undesirable behavior, working alone, working with cash and/or narcotics, use of seclusion/restraints, lack of situational awareness, and inadequate presence of security and mental health personnel on site.

(ENA, 2010, Design Council, 2011, NIOSH 2013, OSHA 2015, Philips 2016)

There is also a vicious cycle or "Revolving Door" Syndrome that sometimes links workplace violence, psychiatric treatment, and the "revolving door" (NIOSH, 2013). This occurs when patients with mental health or substance abuse issues are treated in an emergency room (ER) and released back into the community without follow-up care, so they return to the ER when another mental health or substance abuse crisis occurs.

Community based mental health care is often not available due to lack of funding. This issue also contributes to the increasing use of hospitals by police and the criminal justice system, for criminal holds and the care of acutely disturbed, violent individuals.

The Joint Commission analyzed 33 homicides, 38 assaults and 74 rapes in health care workplaces from 2013 to 2015, and reported that the most common "root causes of these events were:

- Failures in communication

- Inadequate patient observation

- Lack of or noncompliance with policies addressing workplace violence prevention

- Lack of or inadequate behavioral health assessment to identify aggressive tendencies in patients

Source: Wyatt, 2016

The Cost of WPV to Health Care Organizations and Workers

Direct costs of workplace violence injuries include cost of medical treatment for physical injuries sustained and time loss from work.

Speroni, K.G., et al., report that in one study the annual workplace violence costs for the 2.1% of nurses who reported injuries were $94,156 ($78,924 for treatment and $15,232 for indemnity).

There can be a short and/or long-term psychological impact to employees who are the victims of WPV. Some employees may develop post-traumatic stress disorder (PTSD). The psychological impact of WPV is sometimes harder to quantify in terms of cost to the organization and to the affected employees.

Studies have shown that there is an *increase* in the rate of missed workdays, burnout, and job dissatisfaction, along with decreased productivity, and deterioration in staff health by employees involved in episodes of WPV (Philips, 2016, Pestka et. al, 2012).

Workplace injuries and stress are common factors that contribute to employee turnover which can be costly for a health care organization. For example, the estimated cost of replacing a nurse is $27,000 to $103,000.

Other organizational costs include increased security needs in terms of equipment and personnel, litigation, increased insurance costs, and property damage.

There is also an indirect relationship between WPV and patient safety. Caregiver fatigue, presenteeism, injury, and stress, are tied to a higher risk of medication errors and patient infections. In hospitals where *fewer* nurses are dissatisfied or burned out, there is *higher levels of patient satisfaction* (OSHA, 2015).

The relationship of worker safety and morale to safe delivery of care and achievement of organizational goals cannot be overstated.

In 2014, the National Patient Safety Foundation published the white paper **"Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care"**, which highlights the importance of creating a culture in health care organizations that embraces worker and patient safety as equally important. The paper and subsequent related publications highlight the importance of creating a work environment where there is a goal of zero harm (physical and psychological) to the workforce; where there is a commitment to respect and safe behaviors; an effective system to measure, and a multidisciplinary, reliable process for responding to physical and psychological harm (NPSF, 2013, 2014).

Unfortunately, because WPV is vastly underreported in health care the full extent of the problem and its associated costs are unknown.

Solutions to Prevent and Manage WPV

When developing and implementing a WPV program, it's important to note that individual health care organizations have no or little 'control' of the social and economic factors that contribute to WPV. Nor can they prevent all the clinical factors that contribute to WPV. The goal of a comprehensive WPV program should be to minimize and eliminate where possible the organizational and environmental factors that contribute to WPV and to expedite early and accurate identification and management of clinically related and external risk factors.

Through collaboration with community stakeholders such as public health departments, law enforcement agencies, schools and social service organizations, hospitals may be able to assist in developing healthier social and safer physical environments that contribute to preventing violence in their communities (AHA, 2015).

WPV Legislation and Compliance

Oregon is one of several states that have passed legislation and has program requirements that address workplace violence.

The Oregon WPV law ORS 654.412 to 654.423, "Safety of Health Care Employees" and related (OAR) 437-001-0706, "Recordkeeping for Health Care Assaults" is only applicable to hospitals, ambulatory surgical centers, and home health care services operated by hospitals, and is aimed at preventing violence to employees from _intentional_ assault.

The Oregon WPV law requires specific program components to be implemented.

ORS 654.412 to 654.423, "Safety of Health Care Employees" – Summary of Requirements

- Conduct periodic security and safety assessments to identify existing or potential hazards for assaults committed against employees.

- Develop and implement an assault prevention and protection program for employees based on the assessments.

- Provide assault prevention and protection training on a regular and ongoing basis for employees.

- Maintain a record of assaults committed against employees.

The program components required in the Oregon law are incorporated into the recommendations for a comprehensive WPV program that addresses intentional and non-intentional Type II violence as described in this toolkit.

Federal OSHA is currently considering a standard to protect health care and social assistance workers from violence. Until such a standard is enacted the General Duty Clause of *Occupational Safety and Health Act of 1970* (OSH Act or Act) applies as related to protection of workers against violence in the workplace. The General Duty clause *also* applies to WPV circumstances where the OR WPV law may not be applicable e.g., in cases of non-intentional assault by patients or in cases of lateral violence or bullying.

The General Duty Clause requires employers to provide their workers with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm; and broadly states that employees cannot be discriminated against if they file a complaint related to work safety or reporting a work-related fatality, injury or illness.

Employers also have an *ethical* responsibility to promote a non-violent work environment that fosters a climate of trust and respect.

Lastly, some 33 states have enacted laws that make it a felony to assault a health care worker (or a specific health care discipline such as nurses). At this time, no such law exists in Oregon.

The Joint Commission's Sentinel Event Alert, *Issue 45* requires health care facilities to comply with certain criteria for the security of patients, staff and visitors (The JC, 2010). For example, accredited hospitals must assess their risk of violence, develop written plans, and implement security measures.

These criteria have also been incorporated into this toolkit. In addition, there are several Joint Commission 'Leadership, Environment of Care, Emergency Management and Rights and Responsibilities of the Individual' standards that directly and indirectly apply related to how a hospital should manage and control violence (OSHA, 2015).

Links to Oregon laws related to WPV and other compliance related considerations can be found in the Toolkit *'Introduction'*.

Other professional organizations such as the American Nurses Association (ANA) and the American Association for Occupational Health Professionals in Health Care (AOHP), have published position statements that state that there should be a Zero Tolerance for incivility, bullying and violence in the workplace (ANA, 2015, AOHP, 2017).

WPV Program Components

The box on the right lists the components of a comprehensive WPV program that provide the foundation to prevent (where feasible), reduce, and control the risk of violence in the workplace.

These program components are explored further in other sections of this toolkit as they relate to prevention of Type II violence. Program recommendations are incorporated from Oregon OSHA, Federal OSHA, The Joint Commission, and other professional associations, in addition to the lessons learned from partner hospitals in the WSI project.

Studies show that occupational injury prevention programs more effective and sustainable when they are multifaceted in nature, incorporated into an organization's overall safety and health program, and into the organization's culture, and assist to meet service delivery goals.

WPV Program Components

A. Management Leadership

B. Employee Participation

C. Written Violence Prevention Policy

D. Program Management Organization

E. Communications Structure

F. Hazard Identification & Assessment

G. Hazard Control and Prevention

H. Education & Training

I. Ongoing Program Evaluation and Improvement

However, there is little supporting evidence to indicate which WPV prevention program elements, or combination of program elements are more effective in preventing and managing violence in health care. This is likely because workplace violence in health care is a relatively 'new' topic which has been openly discussed for the past few years, as compared to other occupational hazards such as needlestick exposure or manual patient handling. In addition, designing experiments to test interventions is challenging in a clinical setting and risk factors for violence can vary from facility to facility.

Fortunately, there is a growing body of published case studies related to best practices for WPV prevention, and an increasing number of research activities are examining the effectiveness of WPV prevention programs.

WPV Hazard Control and Prevention

The approach taken to prevent hazards in many occupational safety, health and ergonomics programs is to first try to eliminate or substitute or replace the hazard before turning to engineering controls that are designed to isolate or protect workers from the hazard. However, in the case of preventing workplace violence, elimination and substitution, while most effective at reducing hazards are extremely challenging. Therefore, a

Source: NIOSH

combination of engineering and administrative controls is primarily used within a WPV program to prevent and manage the risk of violence. An example of personal protective equipment (PPE) is the use of gowns, gloves and face masks and shields to protect employees from blood and body fluid exposure that can occur when a patient is physically violent.
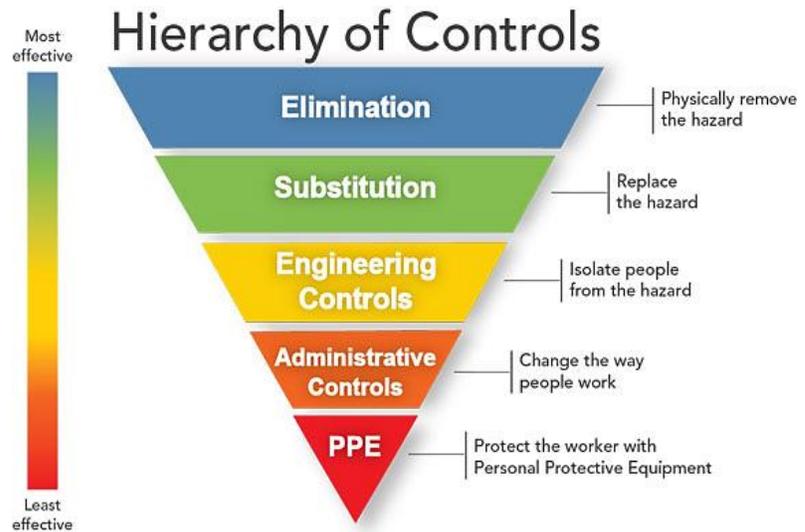
Engineering controls that are designed to isolate the worker from the hazard include:

- Improved worksite lighting

- Physical barriers at admitting/reception area

- Controlled access to buildings and units and monitored surveillance systems

- Panic alarms

- Design of waiting area to mitigate noise and overcrowding

Administrative controls which require the worker to change the way they work include:

- Procedures to:

  – Identify, assess and communicate patients/visitors at high risk for violence

  – Respond to incidents of violence and support systems for employees involved in violence

- Facilitate employee reporting of incidents and processes for effective response management

- Investigate incidents and correct hazards or work processes to prevent reoccurrence of a similar incident

- Security systems e.g. use of security personnel and surveillance systems

- Processes to track employees who work alone or with patients at high risk of violence

- Education & Training of all employees that is customized to their job responsibilities and role within the WPV program

- Recordkeeping and documentation

Engineering controls are preferred over administrative and PPE because they are designed to remove the hazard at the source.

Administrative controls and PPE programs may be less expensive to implement than engineering controls but over the long term, can be costly to sustain and require constant monitoring or 'supervision' to ensure desired changes to work practices and processes are maintained.

A more recent approach to worker safety and health that is starting to be embraced within health care is Total Worker Health®(TWH). TWH not only incorporates traditional safety principles to prevent and reduce risk of occupational injury or illness to workers through design and organization of work, tasks performed and organizational culture, but also considers the overall well-being of the worker. TWH considers other factors such as, the impact of shift work, wages, access to benefits, interactions with coworkers, nutrition and fitness. (NIOSH, 2016).

The TWH approach to both protect workers and advance their health and wellbeing should be considered when addressing workplace violence concerns.

References

Guidelines for preventing workplace violence for healthcare and social service workers (2015). Occupational Safety and Health Administration (OSHA). Retrieved from https://www.osha.gov/Publications/osha3148.pdf

Types of Discrimination - Harassment. U.S. Equal Employment Opportunity Commission (EEOC) Retrieved from https://www.eeoc.gov/eeoc/commission.cfm

Working safely in health care: a practical guide (2007). Fell-Carlson, D. Cengage Learning.

Working towards a definition for workplace violence actions in the health sector (2016). Boyle, M. J., & Wallis, J. Safety in health, 2(1), 4.

Workplace violence against health care workers in the United States (2016). Phillips, J. P. New England journal of medicine, 374(17), 1661-1669.

Workplace Violence Toolkit (2010). Emergency Nurses Association. Retrieved from https://www.ena.org/docs/default-source/resource-library/practice-resources/toolkits/workplaceviolencetoolkit.pdf?sfvrsn=6785bc04_16

Underreporting of workplace violence: Comparison of self-report and actual documentation of hospital incidents (2015). Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. Workplace health & safety, 63(5), 200-210.

Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors (2014). Speroni, K. G., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. Journal of Emergency Nursing, Vol. 40, Issue 3, p218–228.

Preventing Workplace Violence in Healthcare. Understanding the Challenge (2015). Occupational Safety and Health Administration (OSHA). Retrieved from https://www.osha.gov/dsg/hospitals/workplace_violence.html

Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. GAO-16-11: Published: Mar 17, 2016. Publicly Released: Apr 14, 2016. Retrieved from http://www.gao.gov/products/GAO-16-11

Firearm discharges in hospitals: an examination of data from 2006-2016 (2017). Aumack, T et. al. Journal of Healthcare Protection Management. 33:1, 1-8.

Injury Trends from healthcare facilities throughout the US. NIOSH Occupational health safety network (OHSN). Retrieved from https://www.cdc.gov/niosh/topics/ohsn/default.html

NIOSH science blog - Violence in Healthcare 2015. Retrieved from https://blogs.cdc.gov/niosh-science-blog/2015/03/27/violence-in-healthcare/

Workplace violence Can it happen where you work? (2016) Oregon OSHA. Retrieved from http://osha.oregon.gov/OSHAPubs/2857.pdf

Workers' Compensation Claims Characteristics Calendar Year 2015. Oregon Department of Consumer and Business Services. Retrieved from http://www.cbs.state.or.us/external/imd/rasums/2055/15web/15_2055.html

Barriers to effective implementation of programs for the prevention of workplace violence in hospitals (2015). Blando, J., Ridenour, M., Hartley, D., & Casteel, C. Online journal of issues in nursing, 20(1).

Workplace violence in health care: A critical issue with a promising solution (2016). Wyatt, R., Anderson-Drevs, K., & Van Male, L. M. Jama, 316(10), 1037-1038.

Workplace Violence Prevention for Nurses Workplace Violence Prevention for Nurses CDC Course No. WB2908 – NIOSH Pub. No. 2013-155. Retrieved from http://www.cdc.gov/niosh/topics/healthcare/default.html

Reducing Violence and Aggression in A&E: Through a Better Experience (2011). Council, D. Design Council. Retrieved from https://static1.squarespace.com/static/50730747e4b00907bc1cdda3/t/529494fbe4b006d906127e20/1385469179391/DESIGN+COUNCIL_EVALUATION+SUMMARY.pdf

Enhancing safety in behavioral emergency situations (2012). Pestka, E. L., Hatteberg, D. A., Larson, L. A., Zwygart, A. M., Cox, D. L., & Borgen Jr, E. E. Medsurg nursing, 21(6), 335.

Through the eyes of the workforce: Creating joy, meaning, and safer health care (2013), and Getting Started on Workforce Safety (2014). Lucian Leape Institute at the National Patient Safety Foundation. Retrieved from http://www.npsf.org/?page=throughtheeyes

Health Research & Educational Trust. Hospital Approaches to Interrupt the Cycle of Violence (2015, March). American Hospital Association. Chicago, IL. Retrieved from www.hpoe.org

ORS 654.412 to 654.423, 'Safety of Health Care Employees' Retrieved from https://www.oregonlaws.org/ors/654.412

OAR 437-001-0706, 'Recordkeeping for Health Care Assaults'. Retrieved from http://osha.oregon.gov/Pages/re/healthcare-assault-log.aspx

Sentinel Event Issue 45: Preventing Violence in the Healthcare Setting (2010). The Joint Commission. Retrieved from
https://www.jointcommission.org/sentinel_event_alert_issue_45_preventing_violence_in_the_health_care_setting_/

Workplace Violence Prevention and Related Goals. The Big Picture (2015). Occupational Safety and Health Administration (OSHA). Retrieved from
https://www.osha.gov/dsg/hospitals/workplace_violence.html

Position statement incivility, bullying, and workplace violence (2015). American Nurses Association (ANA): Workplace Violence. Nursing World. Retrieved from
http://www.nursingworld.org/workplaceviolence

Position Statement Workplace Violence (2017). Association of Occupational Health Professionals in Healthcare. Retrieved from www.aohp.org

Fundamentals of Total Worker Health® Approaches Essential Elements for Advancing Worker Safety, Health, and Well-Being (2016). National Institute for Occupational Safety and Health NIOSH. Retrieved from https://www.cdc.gov/niosh/docs/2017-112/pdfs/2017_112.pdf

Resources Related to this Section – Articles

A national description of violence toward emergency medical services personnel (2016). Gormley, M. A., Crowe, R. P., Bentley, M. A., & Levine, R. Prehospital Emergency Care, 20, 4, 439.

A survey of workplace violence across 65 US emergency departments (2008). Kansagra, S. M., Rao, S. R., Sullivan, A. F., et al. Emergency Medicine. 15 (12):1268–1274.
http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2008.00282.x/epdf

Clinically assessed consequences of workplace physical violence (2015). De Puy, J., Romain-Glassey, N., Gut, M., Pascal, W., Mangin, P., & Danuser, B. International Archives of Occupational and Environmental Health, 88, 2, 213.

Healthcare managers' perceptions of patient perpetrated aggression and prevention strategies: A cross sectional survey (2016). Baby, M., Swain, N., & Gale, C. Issues in Mental Health Nursing, 37, 7, 507

Hospital-based shootings in the United States: 2000 to 2011 (2012). Kelen, G.D., Catlett, C.L., Kubit, J.G., and Hsieh, Y.H. Annals of Emergency Medicine. 60(6):790-798.

Improving patient and worker safety: opportunities for synergy, collaboration and innovation (2012). Joint Commission, & Joint Commission. Oakbrook Terrace, IL: The Joint Commission, 171. http://www.jointcommission. org/assets/1/18/TJC-ImprovingPatientAnd WorkerSafety-Monograph.pdf

Incidence and risk factors of workplace violence on psychiatric staff (2015). Ridenour, M., Lanza, M., Hendricks, S., Hartley, D., Rierdan, J., Zeiss, R., & Amandus, H. *Work*, *51*(1), 19-28.

New pool finds alarming rates of violence against nurses. (November 2017) Campus Safety. https://www.campussafetymagazine.com/hospital/new-poll-violence-against-nurses/

Nothing changes, nobody cares: Understanding the experience of emergency nurses physically or verbally assaulted while providing care (2014). Wolf, L. A., Delao, A. M., & Perhats, C. Journal of Emergency Nursing, *40*(4), 305-310.

Nursing and aggression in the workplace: a systematic review. Edward K.L. et al. Br J Nurs. 2014 23(12):653-4, 656-9.

Occupational injury among hospital patient-care workers: What is the association with workplace verbal abuse? (2014). Sabbath, E. L., Hurtado, D. A., Okechukwu, C. A., Tamers, S. L., Nelson, C., Kim, S. S., Wagner, G. & Sorenson, G. American Journal of Industrial Medicine, 2014, 57, 2, 222.

Occupational traumatic injuries among workers in health care facilities—United States, 2012–2014 (2014). Gomaa, A. E., Tapp, L. C., Luckhaupt, S. E., Vanoli, K., Sarmiento, R. F., Raudabaugh, W. M., & Sprigg, S. M. Health Care, 2012.

Overview and summary: Patient and visitor violence: What do we know? What can we do? (2013). Rosen, J. Online J Issues Nurs. Jan 31;18(1):1. http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Overview-and-Summary-Patient-and-Visitor-Violence.html

Reducing violence in healthcare facilities (2013). Vellani, K. H. Journal of healthcare protection management: publication of the International Association for Hospital Security, 30(1), 21-29.

Patient safety and quality: An evidence-based handbook for nurses (Vol. 3) 2008. Hughes, R. (Ed.). Rockville, MD: Agency for Healthcare Research and Quality. https://archive.ahrq.gov/professionals/clinicians-providers/resources/nursing/resources/nurseshdbk/nurseshdbk.pdf

Physical assault, physical threat, and verbal abuse perpetrated against hospital workers by patients or visitors in six US hospitals (2015). Pompeii, L. A., Schoenfisch, A. L., Lipscomb, H. J., Dement, J. M., Smith, C. D., & Upadhyaya, M. (2015). American journal of industrial medicine, 58(11), 1194-1204.

Safeguarding health care workers (2014). Benton, D. The American Journal of Nursing, Vol.114(12), p.61.

Stressful incidents of physical violence against emergency nurses (2013). Gillespie, G.L. et. al. Online J Issues Nurs. Jan 31;18(1):3.
http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Stressful-Incidents-of-Physical-Violence-against-Emergency-Nurses.html

Underreporting of workplace violence: Comparison of self-report and actual documentation of hospital incidents (2015). Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. Workplace health & safety, 63(5), 200-210.

Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports (2015). Arnetz, J. E., Hamblin, L., Essenmacher, L., Upfal, M. J., Ager, J., & Luborsky, M. Journal of Advanced Nursing 71(2), 338–348.

Violence against new graduated nurses in clinical settings: A qualitative study (2016). Ebrahimi, H., Hassankhani, H., Negarandeh, R., Jeffrey, C., & Azizi, A. *Nursing ethics*, 0969733015624486.

Violence against nurses and its impact on stress and productivity (2011). Gates, D. M., Gillespie, G. L., & Succop, P. Nursing Economics. The Journal for Health Care Leaders. 29(2), 59-66.

Violence toward nurses, the work environment, and patient outcomes (2010). Roche, M., Diers, D., Duffield, C., & Catling-Paull, C 42(1):13-22. Journal of Nursing Scholarship, *42*(1), 13-22.

Violence against nurses: An assessment of the causes and impacts of violence in nursing education and practice (5th Report 2007). National Advisory Council on Nurse Education and Practice (NACNEP).
http://www.hrsa.gov/advisorycommittees/bhpradvisory/nacnep/reports/fifthreport.pdf

Violence in healthcare facilities - updated 2017. ECRI Institute.
https://www.ecri.org/components/HRC/Pages/SafSec3.aspx?tab=1

Workplace assessment of violence risk: Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports (2015). Arnetz, J. E., Hamblin, L., Essenmacher, L., Upfal, M. J., Ager, J., & Luborsky, M. J Adv Nurs Feb; 71(2):338-348.

Workplace violence against health care workers in the United States (2016). Phillips, J. P. New England Journal of Medicine, 374(17), 1661-1669.

Workplace violence in healthcare settings: risk factors and protective strategies (2010). Gillespie, G.L., et al. Rehabil Nurs. 2010 Sep-Oct;35(5):177-84

Workplace violence and occupational stress in healthcare workers: A chicken-and-egg situation—Results of a 6-Year follow-up study (2014). Magnavita, N. Journal of Nursing Scholarship, 46:5, 366–376

Workplace violence prevention: Improving front-line health-care worker and patient safety (2013). Lipscomb JA & El Ghaziri M. New Solut. 23(2):297-313.

Workplace violence prevention programs in hospital emergency departments (2007). Journal of Occupational & Environmental Medicine, 49(7):756-763, Peek-Asa et al.

Books

(Re)Thinking Violence in Health Care Settings Hardcover (2012). Holmes, D., Rudge, T., & Perron, A. Ashgate January 1, 2012.

Workplace Violence in Mental and General Health Settings (2011). Privitera, M.R., Jones & Bartlett Learning 2011.

Resources Related to this Section – Other

Cost of Community Violence to Hospitals and Health Systems. Report for the American Hospital Association July 26, 2017. Van Den Bos, J, et. al. Milliman Research Report. http://www.aha.org/content/17/community-violence-report.pdf

Centers for Disease Control and Prevention (CDC)

- **Occupational Violence** http://www.cdc.gov/niosh/topics/violence/

- **Occupational Violence: Research on Occupational Violence and Homicide** http://www.cdc.gov/niosh/topics/violence/traumaviol_research.html

IHI Framework for Improving Joy in Work (2017). IHI White Paper. Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. www.ihi.org

Occupational Safety and Health Administration (OSHA)

- **Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (2015)** https://www.osha.gov/Publications/osha3148.pdf

- **Preventing Workplace Violence in Healthcare. Understanding the Challenge (2015)** https://www.osha.gov/dsg/hospitals/workplace_violence.html

- **Workplace Violence Prevention and Related Goals. The Big Picture (2015)** https://www.osha.gov/dsg/hospitals/workplace_violence.html

- **Facts About Hospital Worker Safety (September 2013). OSHA** https://www.osha.gov/dsg/hospitals/documents/1.2_Factbook_508.pdf

- **Workplace Violence – Website** https://www.osha.gov/SLTC/workplaceviolence/

The Joint Commission

- **Questions & Answers: Hospital Accreditation Standards & Workplace Violence** November 17, 2017. https://www.jointcommission.org/questions_answers_hospital_accreditation_standards_workplace_violence/

- **Work Place Violence Resources** https://www.jointcommission.org/workplace_violence.aspx

- **Workplace Violence Update.** Presentation on recent incidents in workplace violence. The 23rd State Hospital Association Forum 2016 https://www.jointcommission.org/assets/1/6/illinois_hospital_assoc_wpv_slides.pdf