



presented by the  
**ASIS Healthcare Security Council**



# MANAGING DISRUPTIVE BEHAVIOR AND WORKPLACE VIOLENCE IN HEALTHCARE



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## Managing Disruptive Behavior and Workplace Violence in Healthcare

### Acknowledgement

The ASIS Healthcare Security Council provides resources and information on healthcare best security practices. The committee's mission is to provide credible and progressive sources of information, which include forums that foster the exchange of information and ideas, and leadership on issues affecting healthcare security. To achieve this mission, the Healthcare Security Council establishes and promotes excellence in the healthcare profession by developing and delivering the highest quality educational programs in security and related disciplines, which include: safety, emergency management, risk management, transportation, parking, and communications.

To this end the Healthcare Security Council has created the first in a series of white papers on topics that are significant to the healthcare security industry.

Because violence within the healthcare setting is increasing at an alarming rate, this white paper is being created to provide supporting documentation for healthcare security professionals to create and sustain a violence prevention program that will effectively reduce the potential for violence.

This document was developed and published by members of the ASIS Healthcare Security Council. Special thanks to the following council members who participated in the development of this document. These members volunteered their time and hard work to create a credible and progressive document.

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## INTRODUCTION

Recent events bring to attention a problem that connectively affects the healthcare sector. Multiple studies show healthcare workers are regularly subjected to minor as well as major verbal and physical abuse from patients, visitors, and other staff. Many incidents go unreported and the number of reported cases is on the rise. Compared to other working environments, hospitals and adult care facilities are dangerous places to work. The following examples illustrate the continual need to proactively address the concerns for administrators to consider the implementation of programs designed to protect medical and security staff, patients, visitors, and facilities.

- On an early February morning in 2010, a shooting took place inside the emergency department of Scotland Memorial Hospital in Laurinburg, North Carolina. Laurinburg Police reported that a gunman critically wounded a patient at the hospital as a result of a bar fight which occurred hours prior. When the attack was over, the patient had suffered multiple gunshot wounds to the chest, the alleged attacker was in police custody, the hospital was in lockdown, and a number of healthcare professionals and their patients, though not physically injured, were badly shaken.
- A month later a patient pulled out a gun and opened fire at Danbury Hospital in Connecticut. The eighty-five year old man pulled out a revolver and started shooting without warning, wounding a male nurse.
- Dr. David Golan's nose was shattered in February, 2009, at the University Medical Center in Las Vegas. The patient shouted, "I'm going to kill you!" as he threw punches to Dr. Golan's face. The doctor staggered but managed to get his attacker in a headlock as another doctor rushed to aid. With help from security, they tackled him to the bloody floor whereupon a nurse injected the man with a sedative.
- Registered nurse Stephanie Embrey has handled her share of screaming and pushy patients at the Beverly Hospital emergency room. However, when she was struck in the chest by an agitated woman in September, 2009, she was left shaken. It took four staff members to subdue the woman who also bit a security officer.

The problem of violence is so prevalent the Joint Commission (TJC) has issued two sentinel event alerts relating to violence. A sentinel event alert identifies specific events of concern determined through data collected by the Joint Commission. The alert describes common underlying causes and suggests steps to prevent future occurrences. Alerts are published to assist healthcare facilities in designing or reevaluating relevant processes to mitigate potential risks outlined within the alert. On July 9, 2008, the Joint Commission published issue 40 entitled "Behaviors that undermine a culture of safety." This alert relates to intimidating and disruptive behaviors that can cause an unsafe work environment (see Appendix F). On June 3, 2010, issue 45 was published. "Preventing violence in the health care setting" acknowledges that an increase in violence is occurring within the healthcare profession and provides recommendations to reduce the potential for violence (see Appendix G).

## STATISTICAL DOCUMENTATION OF THE PROBLEM

Workplace violence is a concern for healthcare professionals on an international and national level. A study of the 310 accident and emergency departments (A&E) within the United Kingdom and the Republic of Ireland determined that alcohol, waiting times, recreational drug use, and patients' unrealistic expectations were the primary causes of violence. Patients were reportedly the most common assailants and nurses were the most common victims. Within the surveyed population, staff sustained 10 fractures, 42 lacerations, and 505 soft tissue injuries. There were 298 arrests and 101 court appearances that resulted in 66 convictions. The study concluded (Jenkins et al., 1998):

The strong impression gleaned from this survey is that, for many A&E departments, verbal abuse and physical assaults on staff are a major problem. There is under-recording of these incidents and a sense that abuse of staff is not taken seriously enough by management. Serious injuries do occur and significant numbers of working days are lost. There are few arrests and even fewer prosecutions.

A Canadian study of 8,780 staff nurses from 210 hospitals from two provinces determined that 46% of the nursing staff experienced some form of violence during the last five shifts they worked. In the study, 18% reported experiencing a physical assault (identified as being spat upon, bit, hit, or pushed) during the last five shifts. Remarkably, 70% of those individuals did not report the incident (Hesketh et al., 2003).

Workplace violence is a serious occupational risk for the domestic and global workplace, accounting for approximately 900 deaths and 1.7 million incidents of nonfatal assaults each year in the U.S. In 2004, 14% of all work-related fatalities in the U.S. were due to workplace violence. Although these numbers are considerable, the incidence of workplace violence may be more prevalent than current statistics indicate. Lack of a universal definition of workplace violence, incident underreporting, and lack of mandated regulations for workplace violence prevention have made tracking the extent of the problem difficult.

In 2000, the U.S. Bureau of Labor Statistics reported injuries resulting from assaults and violent acts to healthcare workers were 9.3 incidents per 10,000 full-time workers. The rates for social service workers and for nursing were 15 and 25 per 10,000 respectively. These numbers are exceptionally high when compared to all other industries in the private sector, which had an injury rate of 2 incidents per 10,000 full-time workers (OSHA, 2004).

Many nurses deem physical assault as their top safety concern on the job. Sources estimate nurses and other healthcare workers are assaulted more frequently than any other worker group in the United States (Elliott, 1997; Lanza, 1992; Stultz, 1993). Data from the Bureau of Labor Statistics show 48% of all non-fatal injuries from occupational assaults and violent acts occurred in the healthcare setting. The majority occurring in hospitals, nursing and personal care facilities, and residential care services. The most victimized job professions were nurses, aides, orderlies, and attendants (OSHA, 2004).

The acts of violence are not isolated to doctors and nurses. Ambulance staff, physical and occupational therapists, medical technicians, X-ray technicians, in-home care workers, and pharmacists are also vulnerable. A poll conducted by the Institute for Safe Medication Practices in 2003 of more than 1,500 nurses, 350 pharmacists, and 175 other healthcare workers found almost 90% of the respondents had experienced some form of workplace intimidation during their prior year of employment (Schaffner, Stanley, & Hough, 2005).

A study conducted in 2005 surveyed 259 emergency physicians in the state of Michigan. 171 active physicians responded. 75% of the physicians reported verbal threats and 28% reported being physically assaulted within the year of the survey. The study indicated that 89% of the physical assaults came from the patient. Drugs and alcohol were considered a factor in 45% of violent acts. Because of violence, 16% of the emergency physicians in the study considered leaving their hospital (Butler, 2008).

The Emergency Nurse Association (ENA) initiated a landmark study of workplace violence in 2007. Nearly 3,500 emergency department nurses were surveyed. The results revealed that in the previous three years of employment, 86% of emergency department nurses experienced at least once a situation they would consider as an act of physical violence against their well-being. 27% experienced violence on more than twenty occasions during the same time period. Physical violence ranged from pushing and scratching to assault with a deadly weapon and sexual assault (Tavernero, 2009). Verbal abuse was encountered more frequently with 41% experiencing verbal abuse on a weekly basis and 27% experiencing verbal abuse during every shift.

Issued in June of 2010, the Joint Commission's sentinel event alert indicates that under the category of assault, rape, and homicide (combined) they have received 256 sentinel event reports since 1995. One hundred and ten (42.9%) of these occurred between 2007 and 2009. The assault, rape, and homicide category of sentinel events is consistently among the top 10 types of sentinel events reported (see Appendix G).

Verbal abuse is reportedly the most common form of violence experienced by nurses. Although patients have been identified as the main source of verbal abuse, other perpetrators were identified as physicians, patient's family members and friends, supervisors, and co-workers. Frequent emotional reactions to physician verbal abuse have been disgust, embarrassment, humiliation, sadness, and hurt. Emotional repercussions such as anger, low self-esteem, embarrassment, and fear may be as damaging as any physical attack for the individual. If incidents of verbal abuse are not dealt with adequately, the consequences can be devastating. Not only in terms of psychological trauma but also from a professional perspective: potential compromise to patient care. Lateral violence (staff-on-staff abuse) is caused by behaviors that humiliate, intimidate, degrade, or otherwise indicate a lack of respect for the dignity and worth of another individual. These behaviors include yelling, swearing, verbal insults, and threats of harm. The Joint Commission raised this concern when it issued its 40<sup>th</sup> sentinel event alert, "Behaviors that undermine a culture of safety" (see Appendix F).

Statistical data indicates that violence plays a significant role in the recruitment and retention of clinical staff. According to one study, lateral violence caused about 60% of new graduates to leave their first nursing position within their first six months of employment (Beecroft, Kunzman, & Krozek, 2001). 72% of nurses reported they did not feel safe on the job and 19% indicated they were leaving the emergency nursing profession because of violence (Tavernero, 2009).

Concerns about the rise of healthcare violence have reached many state legislators who have sponsored state statues providing stringent penalties for crimes against healthcare professionals. In Massachusetts, several bills are under consideration including one that would mandate violence prevention programs in healthcare institutions. In another bill, it would require the people who commit acts of violence against healthcare workers to be subject to fines and jail terms of up to 90 days. New York State has passed a law to control violence in public hospitals and nursing homes by increasing the penalties for assaulting healthcare professionals.



## WHAT CAUSES WORKPLACE VIOLENCE IN HEALTHCARE

Since the early 1990's, workplace violence within the healthcare sector has been a security concern on the rise. Organizations realize workplace violence is something that cannot be ignored. The violence that affects healthcare organizations has been described as one of the more complex and dangerous occupational hazards facing nursing today. Among several factors, the complexity stems from a culture that seems to resist the notion that healthcare providers are at risk from the people they are administering care towards. Consequently, violence against healthcare workers might not be treated seriously enough and professionals may feel that the violent incidents and disruptive behavior are acceptable job hazards. The bottom line is violence in the workplace can lead to increased stress for the victims and subsequently reduce morale, job satisfaction, job performance, increase staff turnover, and ultimately affect the quality of patient care.

Stress and anger were reported as frequent responses to verbal abuse. The negative influence of violence and aggression on the well-being of people has been well documented. In extreme cases it can result in substance abuse or to a psychiatric disorder such as burnout. Literature on violence indicates that many victims feel emotional rage, anger, disappointment, helplessness, and anxiety following a violent incident.

There are several reasons why workplace violence within the healthcare setting is a growing problem. Among the reasons is an institutional culture that does not appear to recognize or acknowledge the risk of violence to healthcare workers. In those environments, even if there is a violence prevention program in place, it is likely not adequately developed and ineffective. Organizational challenges such as staffing shortages and increased patient acuity are contributing factors to healthcare violence. Dynamics related to the economy, job loss, and access to quality health insurance also contribute. In addition, aggressive drug-seeking behavior or patients with psychological disorders can add to the problem.

### **Lack of Mandated Standards**

The Occupational Safety and Health Administration (OSHA) published "Guidelines for preventing workplace violence for health care and social service workers" in 2002. This document includes policy recommendations and practical methods to help prevent and mitigate workplace violence. However, these guidelines are voluntary. In addition to OSHA, ASIS International as well as the International Association for Healthcare Security and Safety (IAHSS) have independently developed and published guidelines on workplace violence.

The Joint Commission's 45<sup>th</sup> sentinel event alert recommends that all healthcare facilities identify high risk areas and perpetrators of violence to patients, and then institute prevention strategies to reduce the level of violence. The alert recommends guidelines for the reduction of violence in the workplace as outlined within its requirements for a safe and secure healthcare environment. Again, falling short of mandating a definitive violence reduction program.

## Underreporting

Incidents of violence in the workplace are often not reported. In a study of emergency room, intensive care, and general floor nurses working at a regional medical center, the respondents confessed 50% of verbal and physical assault incidents perpetrated by patients against nurses were never reported in writing. Additionally, incidents of assault or abuse by patients' family members or visitors were never reported by approximately half of the surveyed nurses. The nurses indicated they viewed these behaviors as part of the job and felt reporting them would be ineffective due to lack of evidence of physical injury, empathy for the patients and their family members, fear of retaliation, inconvenience of reporting, or concern that doing so may affect customer service scores. Another reason why nurses do not report assaults in the workplace is a perception that the incident might be viewed by employers to be the result of negligence or poor job performance by the reporting nurse (Elliot, 1997).

The stigma of victimization, such as shame, isolation, fear, or threat of further violence, often deters staff from reporting violent behavior. Other non-reporting variables 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 follow-up by hospitals (Clements et al., 2005).

Several studies have addressed reporting of both physical violence and non-physical violence. In a survey of 4,738 Minnesota nurses, only 69% of violent events and 71% of non-violent events were reported to a supervisor or other management personnel. In another study, nurses and attendants employed in an accident and emergency department said that 63% of all violent incidents and 29% of assaults were not reported. Studies that have compared reporting violence through formal incident reports have also shown vast under-reporting (Findorff et al., 2005).

## Environment

The very nature of healthcare institutions may contribute to violence within the workplace. Many healthcare institutions operate 24 hours a day, seven days a week; contain a largely female workforce; and maintain reduced staffing levels during the off-hours.

Other environmental contributors include (OSHA, 2004):

- The prevalence of handguns and other weapons among patients, their families or friends
- The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals
- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care
- The availability of drugs or money at hospitals, clinics and pharmacies, making them likely robbery targets
- Factors such as the unrestricted movement of the public in clinics and hospitals as well as long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly

- The increasing presence of gang members, psychiatric patients, drug or alcohol abusers, trauma patients or distraught family members
- Isolated work with clients during times of examinations or treatment
- Solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems (this is particularly true in high-crime settings)
- Stressful work environment
- Failure to recognize and respond to warning signs such as behavioral changes, mental health issues, personal crises, drug or alcohol use, and disciplinary action or termination, can elevate the risk of a staff member becoming violent towards a patient
- Failure to report inappropriate, intimidating or bullying behavior that can evolve into threatening or violent incidents

### **Management's Failure to Address the Problem**

Larry Chavez, who created a workshop called Workplace Violence 101 to educate employers and employees on preventing and dealing with violence in the workplace, reported that workplace violence continues because some employers fail to adequately address the problem (Clement et al., 2005):

This has not been purposeful but rather to a lack 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.

A sense of administrative abandonment may result from:

- inadequate staffing levels,
- unfulfilled promises to improve environmental safety,
- ignored concerns,
- insufficient education and training, and
- lack of support from peers, physicians, and administrators in the aftermath of an incident.

The Human Resource department plays a critical role in preventing workplace violence, but often does not see the importance in developing and following through on hiring, firing and disciplinary practices, and in performing thorough criminal background checks on all new hires. Although criminal background checks are costly, at a minimum, organizations should conduct criminal background checks on job candidates who are to be placed in high risk areas such as the emergency department, obstetrics, pediatrics, nursery, home care, and senior care settings (TJC, 2010).

## **Cultural Differences**

Patients and visitors have values, beliefs, and attitudes that differ from those of caregivers due to culture, ethnicity, age, gender, and the effects of illness. Respect for and sensitivity to this fact is critical when dealing with those that become hostile (Tuthill, 2003).

One study suggests violence has become a part of society's culture and the media has become a promoter of violence. The zero tolerance of violent behavior needs to start with the precursors—less obvious manifestations of violent tendencies. According to Hesketh, when emotional abuse or sexual harassment is no longer tolerated and an atmosphere of courtesy and respect has been installed, potential perpetrators of violence will not perceive an environment fostering violence (Hesketh et al., 2003).

## **Lack of Training**

Training is the essential element of successful workplace violence reduction programs. Many healthcare institutions, however, provide no training or train only limited staff in the art of violence prevention. All staff working within the healthcare field should be required to successfully complete a violence prevention training program. Training should not be limited to only clinical staff. All administrative and support service staff should be trained as well. Training should be conducted as soon as employment starts, and then made available annually so that employees can maintain their violence prevention skills.

## WHAT CAN BE DONE TO REDUCE VIOLENCE

Research indicates a significant proportion of workplace aggression is preventable. In order to develop effective violence prevention programs, clear policies that outline institutional goals to prevent, predict, manage, and measure violent events need to be created. Hospitals should adopt a “zero tolerance” policy for workplace violence, which is supported and enforced by senior-level administrators and medical staff. Healthcare institutions should implement an interdisciplinary approach to the creation and maintenance of a workplace violence prevention program. Nurses should play an integral role in all aspects of violence prevention planning and monitoring including risk assessments, development of workplace safety policies and procedures, implementation of security measures within the emergency department, and nurse safety education and training (ENA, n.d.).

The five main components of an effective workplace violence prevention program include (IAHSS, 2009):

- Management commitment and employee involvement
- Worksite analysis
- Hazard reduction and response
- Training
- Record keeping and program evaluation

### **Creating Industry-Wide Standards**

Probably one of the most important undertakings to change the reduction of workplace violence is the creation of a standard, universal definition of what constitutes a physical or verbal threat, assault, or act of workplace violence. The lack of standards creates a number of problems, which contribute to the high number of violent acts. These include underreporting events and a lack of mandated regulations for workplace violence.

### **Assessment**

Every healthcare institution should establish a process to ensure organizational assessments regarding safety of team members, patients, and visitors. The process should effectively and accurately assess the program on a continuing basis. Workplace violence should be considered a “systems” problem rather than one that is limited to a single event, perpetrator, or even victim responsibility. All employers have a regulatory responsibility to provide their employees with a workplace free from hazards that could cause death or serious physical harm. Employers also have an ethical responsibility to provide a safe, nonviolent work environment free from intimidation and bullying behaviors.

Evaluation should consider all three types of potential workplace violence:

- Criminal intent
- Customer/client
- Worker-on-worker violence

The assessment must include the evaluation of physical environment (layouts and security systems) and policies, procedures, and their effectiveness as measured by empirical data. It is also essential that not only is the assessment multidisciplinary and inclusive, but it should be done without assessing fault for deficiencies that may be found. The process should be considered as an opportunity to improve the environment (Hader, 2008).

## Identification

According to a study conducted by the American Association of Occupational Health Nurses (AAOHN), many hospital staff do not effectively recognize the warning signs of workplace violence. Hospital staff must know how to identify the early signs of violence, intimidation, and bullying. Early intervention is the key to successfully reducing workplace violence within hospitals. Identification of escalation toward violence or key factors that contribute to violence is paramount to violence reduction. Most violent behavior within healthcare is the result of chronically ill people or family members involved with their care. Clinical reasons such as terminal illness, mental illness or injury which may result in death are prime examples of why persons may exhibit violent behavior (ENA, 2008).

## Program

Clement et al. (2005):

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). ...

Procedures and responsibilities of personnel should be spelled out within the workplace violence policy.

... 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, [clinical staff], 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, [the effectiveness of] organizational response will play a significant role in the recovery process. When an organization is perceived as “protecting” itself and failing to understand or 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).

In other words, critical incident debriefing should be a standard and safe process following any significant incident. Staff not participating in this effort should still be supported by the organization by receiving meaningful information and an open door for addressing ongoing trauma-related needs.

## **Training**

Education and training on workplace violence prevention, response, and recovery is a necessity. Violence prevention educational programs must be mandated for all leaders, staff members, and physicians. Teaching staff how to manage and prevent workplace violence is essential to staff morale and success in the job. An education and training plan should be mandatory and should include all hospital workers, nurses, physicians, ancillary staff, managers, supervisors, and security personnel. Training should be specific to the role and responsibilities of staff members.

Workplace violence training should be conducted with the personal safety of the staff as a priority. Healthcare organizations have to come to the realization that a serious role conflict exists between personal safety and patient focused care. It is imperative that training programs focus on staff safety first. Personal safety first is a healthy component of patient focused care. The main component of training should be verbal de-escalation. The ability to stop the cycle of escalating violence is paramount to reducing violence within the healthcare setting.

Training needs to be ongoing. It should be conducted as part of new employee orientation and conducted annually thereafter. Briefings and seminars should be conducted on a regular basis. Drills should be conducted as well that include both tabletop and functional exercises. The use of full-scale exercises (as done for emergency preparedness) should be considered as well (Hader, 2008).

## **Legislation**

Clement et al. (2005):

National mandates now indicate that healthcare 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.

Several states including New York, California, and Ohio have either passed or awaiting passage of legislation requiring hospitals to develop programs to reduce the level of violent incidents. Numerous nursing, other healthcare professional organizations, and unions are advocating for federal regulations that require healthcare institutions to provide improved environmental safety.

## CONCLUSION

Workplace violence in healthcare settings is a growing, significant, and complicated issue. Although no single set of preventative, reactive, and responsive activities will address all the needs of the entire sector, specific actions are recommended. Organizations that are best prepared to prevent, respond to, and recover from incidents of workplace violence exhibit a number of commonalities. These include:

- Well-written organizational policies, procedures, and processes
- Effective preemployment screening and threat assessment practices
- Mandatory employee orientation, which includes information on workplace violence
- Mechanisms that support and require reporting of workplace violence concerns
- Threat assessment teams or programs charged with evaluating risk and mapping safe workplace strategies
- Reasonable, logical, and appropriate zero tolerance programs designed to protect staff, patients, visitors, and facilities
- Programs that support line supervisors and managers in addressing potential workplace violence concerns
- Process of self-evaluation and continuous improvement when threats or incidents of workplace violence occur
- Effective workplace violence management teams that include security, first responders, human resources, nursing, legal, risk management, administration, clinical staff, and other key stakeholders appropriate for the size and capacities of the organization
- Recognition that sometimes bad things happen in good places. Commitment to be prepared to respond to and recover from incidents should they occur

Preventative and response activities will not negate all incidents of workplace violence. It is, however, incumbent upon organizations to reduce the potential for these incidents and ensure an effective response and recovery effort through the implementation of reasonable, responsible, and appropriate activities and policies.



## RESOURCES WHICH SUPPORT THE DEVELOPMENT OF A WORKPLACE VIOLENCE REDUCTION PROGRAM

### List of Supporting Documents

1. *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers* (OSHA 3148-01R 2004). United States Department of Labor & Occupational Safety and Health Administration.
2. American Nurses Association. *Model "State" Bill: The Violence Prevention in Health Care Facilities Act*. Requires healthcare entities to establish programs to protect healthcare workers from acts of violence.
3. ASIS International. *Workplace Violence and Prevention Response Guidelines*. [www.asisonline.com](http://www.asisonline.com).
4. IAHSS. *Healthcare Security: Basic industry guidelines*. [www.iahss.org](http://www.iahss.org).
5. ASIS Foundation. *CRISP Report: Preventing Gun Violence in the Workplace*.
6. California Division of Occupational Safety and Health. *Cal/OSHA Guidelines for Workplace Security* [http://www.dir.ca.gov/dosh/dosh\\_publications/worksecurity.html](http://www.dir.ca.gov/dosh/dosh_publications/worksecurity.html).
7. California Division of Occupational Safety and Health. *Guidelines for Security and Safety of Health Care and Community Service Workers*. [http://www.dir.ca.gov/dosh/dosh\\_publications/hcworker.html](http://www.dir.ca.gov/dosh/dosh_publications/hcworker.html).
8. New Jersey Public Employee Occupational Safety and Health. *Guidelines on Measures and Safeguards in Dealing with Violent or Aggressive Behavior in Public Sector Health Care Facilities*.
9. Washington State Department of Labor & Industries. *Violence in Washington Workplaces*.
10. Washington State Department of Labor & Industries. *Study of Assaults in Staff in Washington State Psychiatric Hospitals*.
11. The Joint Commission. Comprehensive accreditation manuals for hospitals.
12. The Metropolitan Chicago Healthcare Council. *Guidelines for Dealing with Violence in Health Care*.
13. American Nurses Association. *Promoting Safe Work Environments for Nurses*.
14. Emergency Nurses Association. *Violence within the Emergency Department*.
15. Emergency Care Research Institute (ECRI), an independent nonprofit organization. "Violence in Healthcare Facilities."

## THREAT ASSESSMENT CHECKLIST

Case# \_\_\_\_\_ Date \_\_\_\_\_

Complainant \_\_\_\_\_

Department \_\_\_\_\_ Phone \_\_\_\_\_ Shift \_\_\_\_\_

### Vehicle Information:

Make/Model/Color/License/Assigned Parking Location \_\_\_\_\_

\_\_\_\_\_

---

### Suspect Information:

Name \_\_\_\_\_

Description \_\_\_\_\_

Employed (where/shift) \_\_\_\_\_

Known abuser of drugs/alcohol? \_\_\_\_\_

Picture available? If yes, where is it located? \_\_\_\_\_

Suspect vehicle information \_\_\_\_\_

Weapons \_\_\_\_\_

Criminal record \_\_\_\_\_

(Source) \_\_\_\_\_

Restraining order? If yes, is copy available and where is it located? \_\_\_\_\_

Post Traumatic Stress Disorder (PTSD) \_\_\_\_\_

(Source) \_\_\_\_\_

### Law Enforcement Agency:

Notified \_\_\_\_\_

### Actions Taken, Including Threat Assessment Team (TAT) Member Involvement:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# SAMPLE WORKPLACE VIOLENCE POLICY

## I. Policy

[organization/hospital name] recognizes that violence in general and violence in the workplace as inappropriate methods for dealing with conflict and significant public health care issues. This policy outlines some of the behaviors that are inappropriate. It also provides a mechanism to identify acts or potential acts of violence and establishes a protocol to respond to either.

## II. Definition

For the purposes of this policy, violence is broadly defined as including, but not necessarily limited to, behavior involving employees, visitors, physicians, or patients, which cause or threatens to cause harm to anyone. Threats, verbal harassment or sexual harassment, in addition to actual physical harm, are considered acts of violence.

Persons engaging in violent behaviors as defined above are subject to disciplinary action as prescribed in the disciplinary policy and/or civil and criminal action as specified by local, state, or federal ordinances and statutes.

## III. Procedure

A Threat Assessment Team will be established at each designated facility to provide the necessary proactive and reactive resources to reduce and respond to actual occurrences. The team will be composed of representatives or their delegates from the following departments: Human Resources, Employee Assistance, Loss Prevention Services, and management representatives of the affected department(s). Additional ad hoc members such as Legal, Risk Management, Physicians, Behavioral Health Services, or Social Work may be included as needed.

Any employee may report threatening behaviors or situations involving employees, visitors, physicians, or patients/residents/clients, which they believe to be threatening, to their supervisor, Human Resources, or any member of the Threat Assessment Team. All supervisory and management personnel will be trained in recognizing behaviors and symptoms or actual or potential violence.

Any threat assessment team member who receives information regarding an actual or threatened occurrence will be responsible for contacting Threat Assessment Team members from other disciplines as deemed appropriate. Each discipline will be responsible for utilizing a checklist to ensure that routine and standard issues to threat department's area of concern are addressed. The team will meet or otherwise communicate as needed until such time that the situation is under control. While the team will be collaborative in nature, it will be chaired by the most senior member of Human Resources that is available.

The general areas of responsibilities for the members of the Threat Assessment Team are:

1. **Human Resources.** Coordination of issues related to discipline and employment including, but not limited to, suspension, transfer, or termination.
2. **Employee Assistance.** Management and dissemination of resources available that can reduce or eliminate factors that accompany threats or actual episodes of violence. EAP also offers problem assessment, appropriate reading materials and critical incident stress debriefing services as needed.
3. **Loss Prevention Services.** Coordination of protection and physical security needed to ensure the safety of persons. Also responsible for liaison with law enforcement agencies as needed.
4. **Department Management.** Provide information regarding the factors that have contributed to the problem and facilitate changes that have been identified as useful to reducing the potential for future violence. Suggest additional team members, especially when a patient is an involved party.

## **A SIX-STEP PROCESS FOR DEALING WITH VIOLENCE IN THE WORKPLACE**

- 1. Know the resources available to you within your facility/organization**
- 2. Identify the inappropriate behavior**
- 3. Address the situation**
- 4. Take Action: Refer the individual for help and/or consult with a member of the Threat Assessment Team (TAT)**
- 5. Address the needs of the effected department and implement a plan**
- 6. Follow-up**

## COMMON WARNING SIGNS

- **Verbal perception of reality others do not share**
- **Direct or veiled verbal threats of harm**
- **Carrying a concealed weapon**
- **Paranoid behavior**
- **Moral righteousness**
- **Unable to take criticism, holds grudges**
- **Desperation over recent family or personal problems**
- **History of violent behavior**
- **Inability to accept personal responsibility**
- **Shows excessive belligerence**
- **Spreads harmful rumors**
- **Plays mean pranks**

# PREVENTION OF WORKPLACE VIOLENCE ASSESSMENT

## Problem Identification and Selling Administration

### A. Assessing the Vulnerability

- **Community Experiences**
- **Industry Experiences**
- **Internal Data Gathering**

### B. Policy Development

- **Why**
  - **Organization's Values**
  - **Compatibility to Current Policies**
  - **Public Health Care Issues**
- **What**
  - **Define the Terms**
  - **Who Is Included**
  - **Identify Organizational Resources**
  - **Create the Team**
  - **Define the Roles**
- **Procedural Elements**
  - **Accessing the Policy**
  - **Training Program**
  - **Educational Opportunities**

# SENTINEL EVENT ALERT ISSUE 40

## Behaviors that undermine a culture of safety

Issue 40: Behaviors that undermine a culture of safety | Joint Commission



### Sentinel Event Alert

July 09, 2008

Issue 40, July 9, 2008

#### Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.(2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.(7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors.(1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.(13,14,15) "Any behavior which impairs the health care team's ability to function well creates risk," says Gerald Hickson, M.D., associate dean for Clinical Affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. "If health care organizations encourage patients and families to speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk."

#### Root causes and contributing factors

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care.(10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors.(4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.(8,11) They can lack interpersonal, coping or conflict management skills.

Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members.

Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with "blowing the whistle" on a colleague, as well as a general reluctance to confront an intimidator all contribute to underreporting of intimidating and/or disruptive behavior.(2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are "let off the hook" for inappropriate behavior due to the perceived consequences of confronting them.(8, 10, 12, 17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue."(17)

#### Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)\* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

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## Issue 40: Behaviors that undermine a culture of safety | Joint Commission

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

**Other Joint Commission suggested actions**

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.(10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.(2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
  - “Zero tolerance” for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
  - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
  - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.(10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
  - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.(11)
  - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.(4,10,18)
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.(4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.(10,17,18)
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services(20) and patient advocates,(2,11) both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods.(10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal “cup of coffee” conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety.(4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed.(4,7,14)
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.(1,2,4,10)
11. Document all attempts to address intimidating and disruptive behaviors.(18)

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\* The 2009 standards have been renumbered as part of the Standards Improvement Initiative. During development, this standard was number LD.3.10.

-Top-

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# SENTINEL EVENT ALERT ISSUE 45

## Preventing violence in the health care setting

Issue 45: Preventing violence in the health care setting | Joint Commission



### Sentinel Event Alert

June 03, 2010

Issue 45, June 3, 2010

#### Preventing violence in the health care setting

Once considered safe havens, health care institutions today are confronting steadily increasing rates of crime, including violent crimes such as assault, rape and homicide. As criminal activity spills over from the streets onto the campuses and through the doors, providing for the safety and security of all patients, visitors and staff within the walls of a health care institution, as well as on the grounds, requires increasing vigilant attention and action by safety and security personnel as well as all health care staff and providers.

While there are many different types of crimes and instances of violence that take place in the health care setting, this *Sentinel Event Alert* specifically addresses assault, rape or homicide of patients and visitors perpetrated by staff, visitors, other patients, and intruders to the institution. The Joint Commission's Sentinel Event Database includes a category of assault, rape and homicide (combined) with 256 reports since 1995 – numbers that are believed to be significantly below the actual number of incidents due to the belief that there is significant under-reporting of violent crimes in health care institutions. While not an accurate measure of incidence, it is noteworthy that the assault, rape and homicide category of sentinel events is consistently among the top 10 types of sentinel events reported to The Joint Commission. Since 2004, the Sentinel Event Database indicates significant increases in reports of assault, rape and homicide, with the greatest number of reports in the last three years: 36 incidents in 2007, 41 in 2008 and 33 in 2009.

Of the information in the Sentinel Event Database regarding criminal events, the following contributing causal factors were identified most frequently over the last five years:

- Leadership, noted in 62 percent of the events, most notably problems in the areas of policy and procedure development and implementation.
- Human resources-related factors, noted in 60 percent of the events, such as the increased need for staff education and competency assessment processes.
- Assessment, noted in 58 percent of the events, particularly in the areas of flawed patient observation protocols, inadequate assessment tools, and lack of psychiatric assessment.
- Communication failures, noted in 53 percent of the events, both among staff and with patients and family.
- Physical environment, noted in 36 percent of the events, in terms of deficiencies in general safety of the environment and security procedures and practices.
- Problems in care planning, information management and patient education were other causal factors identified less frequently.

#### Identifying high risk areas

Because hospitals are open to the public around the clock every day of the year, securing the building and grounds presents specific challenges since it would be difficult to thoroughly screen every person entering the facility. For many reasons – in particular, high-traffic areas coupled with high-stress levels – the Emergency Department is typically the hardest area to secure, followed by general medical/surgical patient rooms. "A key to providing protection to patients is controlling access," explains Russell L. Colling, M.S., CHPA, a health care security consultant based in Salida, Colo., and the founding president of the International Association for Healthcare Security and Safety. "Facilities must institute layered levels of control which includes securing the perimeter of the property through lighting, barriers, fencing; controlling access through entrances, exits, and stairwells; and positioning nurses stations, to name a few of the steps that organizations need to take."

#### Perpetrators of violence to patients

While controlling access to the facility is imperative and ongoing surveillance of the grounds is a necessity, administrators must be alert to the potential for violence to patients by health care staff members. The stressful environment together with failure to recognize and respond to warning signs such as behavioral changes, mental health issues, personal crises, drug or alcohol use, and disciplinary action or termination, can elevate the risk of a staff member becoming violent towards a patient. Though it is a less common scenario, health care workers who deliberately harm patients by either assaulting them or administering unprescribed medications or treatments, present a considerable threat to institutions, even when the patient is unable to identify the responsible person. These situations point directly to the critical role human resources departments have in developing and following through on hiring, firing and disciplinary practices (which should be supported by management), and in performing thorough criminal background checks on all new hires. Since criminal background checks are costly, at a minimum, organizations may want to conduct criminal background checks on job candidates who are to be placed in high risk areas, such as the ED, obstetrics, pediatrics, nursery, home care and senior care settings.

#### Prevention strategies

There are many steps that organizations can take to reduce the risk of violence and prevent situations from escalating. "Each

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## Issue 45: Preventing violence in the health care setting | Joint Commission

hospital or institution must determine for itself how to protect the environment, and that is accomplished by doing a risk assessment and identifying all the things that can go wrong and how to address them with the least inconvenience and resources," Russell Colling says. "The most important factor in protecting patients from harm is the caregiver – security is a people action and requires staff taking responsibility, asking questions, and reporting any and all threats or suspicious events." Colling recommends that organizations adopt a zero tolerance policy and establish strong policies mandating staff to report any real or perceived threats. "The roots of violence need to be investigated and evaluated beginning at the unit level. Nurses and other health care staff should question the presence of all visitors in patient rooms and not assume that someone is a family member or friend," says Colling.

ECRI Institute, an independent nonprofit organization that researches best practices to improve patient care, publishes a journal for health care risk managers called *Healthcare Risk Control (HRC)* (1). The September 2005 issue has a focus on "Violence in Healthcare Facilities" that discusses strategies for: preventing violent incidents; managing situations to prevent escalation; and enhancing the physical security of institutions through traditional measures (e.g., fences, locks, key inventory, strengthened windows and doors) and electronic measures (e.g., metal detectors, handheld security wands, video surveillance, alarms, access controls systems that require codes or cards). The publication also outlines:

- Techniques for identifying potentially violent individuals
- Violence de-escalation tools that health care workers can employ
- Violence management training
- Conducting a violence audit
- Conducting a violence assessment walk-through
- Responding in the wake of a violent event

In addition, the Occupational Safety and Health Administration offers advisory guidelines for preventing patient-to-staff workplace violence in the health care setting. (2) In January 2007, the International Association for Healthcare Security and Safety issued its first set of *Healthcare Security: Basic Industry Guidelines*, a resource for health care institutions in developing and managing a security management plan, addressing security training, conducting investigations, identifying areas of high risk, and more. (3)

**Existing Joint Commission requirements**

The Joint Commission's Environment of Care standards require health care facilities to address and maintain a written plan describing how an institution provides for the security of patients, staff and visitors. Institutions are also required to conduct risk assessments to determine the potential for violence, provide strategies for preventing instances of violence, and establish a response plan that is enacted when an incident occurs. The Rights and Responsibilities of the Individual standard RI.01.06.03 provides for the patient's right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

**Joint Commission suggested actions**

The following are suggested actions that health care organizations can take to prevent assault, rape and homicide in the health care setting. Some of these recommendations are detailed in the *HRC* issue on "Violence in Healthcare Facilities."

1. Work with the security department to audit your facility's risk of violence. Evaluate environmental and administrative controls throughout the campus, review records and statistics of crime rates in the area surrounding the health care facility, and survey employees on their perceptions of risk.
2. Identify strengths and weaknesses and make improvements to the facility's violence-prevention program. (The *HRC* issue on "Violence in Healthcare Facilities" includes a self-assessment questionnaire that can help with this.)
3. Take extra security precautions in the Emergency Department, especially if the facility is in an area with a high crime rate or gang activity. These precautions can include posting uniformed security officers, and limiting or screening visitors (for example, wand for weapons or conducting bag checks).
4. Work with the HR department to make sure it thoroughly prescreens job applicants, and establishes and follows procedures for conducting background checks of prospective employees and staff. For clinical staff, the HR department also verifies the clinician's record with appropriate boards of registration. If an organization has access to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank, check the clinician's information, which includes professional competence and conduct.
5. Confirm that the HR department ensures that procedures for disciplining and firing employees minimize the chance of provoking a violent reaction.
6. Require appropriate staff members to undergo training in responding to patients' family members who are agitated and potentially violent. Include education on procedures for notifying supervisors and security staff. (4)
7. Ensure that procedures for responding to incidents of workplace violence (e.g., notifying department managers or security, activating codes) are in place and that employees receive instruction on these procedures.
8. Encourage employees and other staff to report incidents of violent activity and any perceived threats of violence.
9. Educate supervisors that all reports of suspicious behavior or threats by another employee must be treated seriously and thoroughly investigated. Train supervisors to recognize when an employee or patient may be experiencing behaviors related to domestic violence issues.
10. Ensure that counseling programs for employees who become victims of workplace crime or violence are in place.

Should an act of violence occur at your facility – whether assault, rape, homicide or a lesser offense – follow-up with appropriate response that includes:

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## Issue 45: Preventing violence in the health care setting | Joint Commission

11. Reporting the crime to appropriate law enforcement officers.
12. Recommending counseling and other support to patients and visitors to your facility who were affected by the violent act.
13. Reviewing the event and making changes to prevent future occurrences.

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**Patient Safety Advisory Group**

The Patient Safety Advisory Group informs The Joint Commission on patient safety issues and, with other sources, advises on topics and content for *Sentinel Event Alert*. Members: James P. Bagian, M.D., P.E. (chair); Michael Cohen, R.Ph., M.S., Sc.D. (vice chair); Jane H. Barnsteiner, R.N., Ph.D., FAAN; Jim B. Battles, Ph.D.; William H. Beeson, M.D.; Patrick J. Brennan, M.D.; Martin H. Diamond, FACHE; Cindy Dougherty, R.N., CPHQ; Frank Federico, B.S., R.Ph.; Steven S. Fountain, M.D.; Suzanne Graham, R.N., Ph.D.; Jerri W. Green, M.D.; Ezra E.H. Griffith, M.D.; Peter Gross, M.D.; Carol Haraden, Ph.D.; Martin J. Hatlie, Esq.; Jennifer Jackson, B.S.N., J.D.; Henri R. Manasse, Jr., Ph.D., Sc.D.; Jane McCaffrey, MHSA, DFASHRM; David Mechtenberg; Mark W. Milner, R.N., MBA, MHS; Jeanine Arden Ornt, J.D.; Grena Porto, R.N., M.S., ARM, CPHRM; Matthew Scanlon, M.D.; Carl A. Sirio, M.D.; Ronni P. Solomon, J.D.; Dana Swenson, P.E., MBA; Susan M. West, R.N.

[http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea\\_45.htm?print=yes\[9/20/2010 11:47:11 AM\]](http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_45.htm?print=yes[9/20/2010 11:47:11 AM])

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