Workplace Violence

Recent violent occurrences in healthcare areas have pushed the issue of workplace violence to the forefront of the nursing community and other agencies taxed with ensuring staff and patient safety. Nurses care for their patients and envision making a difference in their patient’s health status, decision-making abilities, and health outcomes. Health care agencies, typically thought of as safe havens, now are facing a significant increase in multidirectional acts of aggression from patients and visitors. This course will discuss this important and growing issue, the incidence of workplace violence, its consequences, and some strategies to prevent and deal with occurrences of workplace violence.

**Purpose:** The purpose of this course is to enhance the learner’s awareness and understanding of workplace violence.

**Objectives:** Upon completion of this course, the learner will be able to:

- Define workplace violence
- Describe the consequences of workplace violence.
- Discuss some strategies to prevent and deal with workplace violence.
- Explain the phenomenon of horizontal violence.
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Introduction

Workplace violence, a complex and widespread issue, has received increased attention from the public, mental health experts, law enforcement, and healthcare professionals. According to a 2010 report from the Bureau of Labor Statistics, 48% of all nonfatal injuries from occupational assaults and violent acts occur in healthcare and social service settings. A recent increase in workplace violence has been noted, causing a heightened awareness of this issue among nurses.

What is Workplace Violence?

In September 2010, Baltimore city police and tactical team rushed to Johns Hopkins Medical Center to subdue a gunman on the eighth floor of the hospital. Patients, nurses, and other healthcare workers in the hospital and vicinity were immediately evacuated when the alert was sounded. The suspect became emotionally distraught after a surgeon updated him on the status of his mother’s grave condition. After hearing the news, the gunman allegedly fired a semiautomatic handgun and shot the doctor in the abdomen, seriously wounding him.

The case described above is tragic, but workplace violence is not a new phenomenon. Workplace violence against nurses has been documented historically since 1824 (McNamara, 2010). The wide range of acts that falls under the rubric of workplace violence include all violent behavior and threats of violence, as well as any conduct that can result in injury, damaged property, induce a sense of fear, and otherwise interfere with the normal course of work. Threats, harassment, intimidation, bullying, stalking, intimate partner violence, physical or sexual assaults, and homicides fall within this category.

The World Health Organization (WHO) defined violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (Punnett & Boyer, 2011). Workplace violence includes intimidation, verbal or physical threats, physical attack, property damage and sexual harassment. The major types of workplace violence are described in the table below.

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<tr>
<th>Type of Violence</th>
<th>Description</th>
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<td>Verbal</td>
<td>Outbursts of yelling and screaming; use of an exaggerated or angry tone of voice; cursing; use of derogatory, foul, condescending, or inappropriate language, or use of racial or ethnic slurs. It is not always what is said but how it is said or when and where a comment is made.</td>
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<td>Nonverbal</td>
<td>Includes eye rolling, raising eyebrows, making a face, turning away from a person, or physically excluding someone. Although these nonverbal behaviors are not spoken, they are seen and felt as abusive.</td>
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<td>Passive behaviors</td>
<td>The absence of an action rather than an overtly identifiable action that directly affects communication between caregivers and can include not answering pages or returning phone calls, not responding to or being impatient with questions, deliberately communicating incomplete information, and silence.</td>
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<td>Passive-Aggressive Behaviors</td>
<td>Behavior such as complaining about an individual to others; gossiping; badmouthing the organization, colleagues, or physicians to patients or others; discrediting leaders; fostering disregard of policies and procedures; and being unnecessarily sarcastic or negative. This type of behavior negatively affects the patient care culture by demoralizing staff members and destroying team support.</td>
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<td>Physical Abuse</td>
<td>Behavior such as fighting, hitting, spitting, pushing, shoving, pinching, kicking, and throwing objects is easy to identify and must be off-limits to everyone. This includes any unwanted or hostile physical contact, threatening body language or aggressive movements or gestures.</td>
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<tr>
<td>Sexual Harassment</td>
<td>Demonstrates a lack of respect for an individual through the use of overtly friendly or sexual behavior, inappropriate touching, unwelcome advances or invasion of personal space with intent to intimidate, or verbal conduct of a sexual nature (e.g., using vulgar or sexual language; telling off-color “dirty” jokes or stories; referring to an individual’s body; describing instruments or equipment in a sexual manner.)</td>
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<td>Employer/Manager Abuse</td>
<td>Issuing threats to report a person, making threats about the employee’s performance evaluation, berating staff members in public or private, or denying an employee’s physical or emotional response to an on the job injury. Employers and managers have a responsibility to provide a safe workplace. This involves being aware of and addressing the physical and emotional safety of employees.</td>
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Workplace violence has been divided into four categories or acts based on the relationship among victims, perpetrators and work settings (Romano, Levi-Minzi, Rugala & Van Hasselt, 2011). Type I incidents involve offenders who have no relationship with either the victim or the establishments. Type II events are those where the offenders currently receive services from the facilities when they commit an act of violence against them. Type III episodes involve those current or former employees acting out toward their present or former places of employment. In Type IV situations, domestic disputes between an employee and the perpetrator spill over into the workplace. Another type of workplace violence, horizontal violence, is the violence that occurs among and between workers and their colleagues and will be discussed later in this course (King-Jones, 2011).

Workplace violence in healthcare can take many forms. Violence from relatives and friends of patients may occur as a result of frustration with a perceived lack of care or communication. Pain, anxiety, loss of control, powerlessness, and disorientation may result in aggressive incidents from patients to nurses. Violence in Emergency Departments (EDs) may result from the crowded and emotional situations that can occur with emergencies. In addition, ED patients could be involved with crimes, weapons and violent behaviors that could put the ED employee at an increased risk of workplace violence. Some healthcare organizations have implemented a “code” for violence that evokes a response like that of a rapid response team.

The U.S. Occupational Safety and Health Administration (OSHA) reports that two million American workers report having been victims of workplace violence each year. Although, many more cases go unreported. Workplace violence can strike anywhere, anytime, and no one is immune. Research has identified factors that may increase the risk of violence for some workers at certain worksites. Such factors include exchanging money with the public and working with volatile, unstable people. Working alone or in isolated areas may also contribute to the potential for violence. Providing services and care, and working where alcohol is served may also impact the likelihood of violence. Additionally, time of day and location of work, such as working late at night or in areas with high crime rates, are also risk factors that should be considered when addressing issues of workplace violence. OSHA has identified those with higher risk are workers who exchange money with the public, delivery drivers, healthcare professionals, public service workers, customer service agents, law enforcement personnel, and those who work alone or in small groups (Workplace Violence, 2012).

Healthcare workers, including nurses, are at particular increased risk for workplace violence due to the following factors:

- 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 (these patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others).
- 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 and 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, drug or alcohol abusers, trauma patients or distraught family members.
• Low staffing levels during times of increased activity such as mealtimes, visiting times and when staff members are transporting patients.
• Isolated work with clients during examinations or treatment.
• Solo work (where a health worker functions alone), 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).
• Lack of staff training in recognizing and managing escalating hostile and assaultive behavior.
• Poorly lit parking areas.

Incidence

Violence isn’t just a problem for organizations in urban settings or high-crime communities. Incidents occur at community hospitals, and in organizations in rural or medium-sized cities. According to a report by the U.S. Bureau of Justice Statistics (BLS), an estimated 1.7 million workers are injured each year due to assaults at work. In 2006, the BLS reported 60% of workplace assaults occurred in healthcare, and most of the assaults were committed by patients (Romano, Levi-Minzi, Rugala & Van Hasselt, 2011). Healthcare support occupations had an injury rate of 20.4 per 10,000 workers due to assaults, and healthcare practitioners had a rate of 6.1 per 10,000. Acute care hospitals account for almost one in 10 of all workplace assaults that lead to lost workdays. As significant as these numbers are, the actual number of incidents is much higher due to the gross underreporting that is related to the persistent perception that assaults are part of the job.

Many nurses do not report violent incidents for a variety of reasons: such as, believing that reporting does not make any difference since violence is expected and tolerated, that incidents are seen as a sign of their incompetence, or that they might encounter retaliation by management or administration. Key barriers to report a violent or aggressive act include intimidation and a belief that in such acts will be tolerated. Others fear that the other healthcare staff will view them as alarmists and inadequate to handle the stress and relationships supporting patient care. Many nurses don’t report incidents because they feel workplace violence is part of the job such as in ED or psychiatric units where violent patients are not uncommon. Other reasons assaults may not be reported include the reporting process is considered to be too time consuming, doubts about the benefits of reporting, and feeling sorry for the patients or residents. Lack of a consistent definition for violent behavior is also a contributing factor in underreporting. The interpretation of what behaviors or actions constitute a violent act can be subjective or situational in nature. A confused elderly patient who attacks a nurse may not be identified as violent but instead confused. Also, concerns that assaults may be viewed as a result of poor job performance or worker negligence may lead to fears about job security.
Among healthcare workers, nurses and patient care assistants (PCAs) experience the highest rates of violence. Nurses are three times more likely to be the victims of violence than other health care personnel and Emergency Department (ED) nurses experience physical assaults at the highest rate of all nurses. A 2006 study found that 67% of nurses, 63% of PCAs and 51% of physicians had been assaulted at least once in the previous six months by patients. A later study showed that in 2008, 2250 hospital workers had injuries from assaults that were serious enough to require days away from work or restricted days, according to the US Bureau of Labor Statistics, which represented a slight increase from 2006 and 2007 (Whelan, 2008).

Workplace violence is not only an issue in hospitals; it is also a significant problem in nursing homes and long-term care facilities. One study showed that the most assaulted worker in the US is the aide working in a nursing home. Based on self-reports, up to 70% of nursing home staff are assaulted at least once a month. Nursing home workers are frequently assaulted physically by the residents for whom they care, or by residents’ visitors or family members. Violence may partially explain the very high employee turnover rate in nursing homes (25% to 150% annually) (Gates, Gillespie, & Succup, 2011).

Several major professional nursing organizations have issued position statements or directives outlining intolerance of workplace violence and highlighting their support for the creation of safer work environments including the American Nurses Association (ANA), Emergency Nurses Association (ENA), American Psychiatric Association (APA), and the Canadian Nurses Association (CNA).

Violence has become so prevalent globally that the International Labor Organization (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Professional Service Industries (PSI) have jointly issued guidelines to address workplace violence in the health care environment. According to this joint alliance, workplace violence, “be it physical or psychological, has become a global problem crossing borders, work settings and occupational groups” (Hardin, 2012). In addition, the Occupational Safety and Health Administration (OSHA) have issued violence prevention guidelines for health care workers. In 2003, the American Association of Occupational Health Nurses Inc. (AAOHN) signed an alliance with OSHA, renewed in 2005 and 2007, regarding workplace violence. AAOHN agreed to promote national dialogue on workplace safety and health and to provide outreach and communication regarding the problem (Gallant-Roman, 2008).

The American Association of Critical Care Nurses (AACN) position statement on workplace violence prevention includes a call to action for institutions and nurses. The AACN demands the provision of a safe workplace, including written policies, employee training, proper staffing, and investigation of any incidents. It also mandates the implementation of a comprehensive policy for preventing and managing workplace violence that establishes a clear expectation of employee behavior and a course of action for employees and managers to take when workplace violence occurs with full administrative support for these policies.
Consequences

Violence in the healthcare setting affects the employee, employer, and patients. In addition to physical injury and disability, chronic pain, and muscle tension, employees who experience violence suffer psychological problems such as loss of sleep, nightmares, and flashbacks. Healthcare workers who are assaulted experience short-term and long-term emotional reactions, including anger, sadness, frustration, anxiety, irritability, apathy, self-blame, and helplessness. One 2006 study found that assaulted nursing assistants in long-term care facilities were significantly more likely to suffer occupational strain, role stress, anger, job dissatisfaction, decreased feelings of safety, and fear of future assaults (Deaton & Bolyard, 2011). Symptoms occurred regardless of whether an injury was sustained from the assault. These effects are significant; as demonstrated in a 2004 study that found at-risk health care workers frequently suffer symptoms of post-traumatic stress disorder (PTSD) assaults (Deaton & Bolyard, 2011). The consequences of workplace violence continue after a violent event, affecting quality of life for years after the event.

There is a long list of physical symptoms and behaviors reported by the victims of workplace violence, some of which include anger, sadness, frustration, irritability, fear, self-blame, increased stress levels and stress-related illness, sleeplessness and loss of appetite, weight loss or gain, gastrointestinal disorders, fatigue, headache, increased smoking, drinking, or drug use, depression, posttraumatic stress syndrome and loss of relationships.

Male nurses report higher levels of physical and nonphysical violence than do female nurses. Younger age and having an associate degree education (vs. diploma or bachelor’s degree) are related to increased physical and nonphysical workplace violence. In addition, nurses who have poor interpersonal relationships with supervisors, management, colleagues, physicians and/or administration are at higher risk for experiencing workplace violence. Race and the number of years worked as a nurse or in a particular department appear to have little effect on the experience of violence in the workplace.

Further consequences of workplace violence include absenteeism, higher turnover and job dissatisfaction. A study completed by the American Nurses Association (ANA) in 2001 found that 54% of nurses would not recommend nursing as a profession (Miranda, Punnett, Gore, & Boyer, 2011). Fewer than 20% of the respondents felt safe at work, and almost 60% reported they were threatened or verbally abused during the past year. Overall 90% of nurse respondents cited health and safety concerns as influencing their decision to continue working in the nursing profession. Research reveals that nursing is a violent profession, second only to law enforcement in the violence that occurs at work.

Other consequences of workplace violence include changes in employee morale, job stress, employee turnover, reduced quality of life, and a change in the culture or overall working environment. Workplace violence and patient aggression can cause nurses to adopt non-productive strategies for coping with anxiety that are consequentially detrimental to the quality of care. One good example of this in the clinical setting is nurses employing ‘patient-avoiding behaviors’ or ‘social distancing’ (i.e. avoiding verbal interaction or talking and listening to patients less than other colleagues on non-violent units.) Negative staff attitudes and the use of such controlling or coercive behavior in managing patient aggression and violence can be
associated with higher levels of patient aggression that may consequently become a vicious cycle in the clinical setting.

Poor performance, lost productivity, and loss of self-confidence, concentration, and creative problem-solving capacity could put the nurse and patient in danger. Abusive work situations can lead health care professionals to make mistakes, the consequences of which patients must suffer. Patient safety is further compromised when communication flow is interrupted, collegial relationships are weakened, and team collaboration is disrupted. These consequences of workplace violence have been shown to increase the potential for medical errors or adverse events ("Workplace Violence", 2012). Other negative effects of violence on patient safety include disruption in distribution of pain medications resulting in unnecessary or prolonged pain for the patient, patients receiving other medications or antibiotics late, administration of incorrect medications, misdiagnosis, performance of wrong site surgeries and death. An important aspect of a culture of safety is creating a violence-free work environment of mutual respect, dignity, and fairness that nurtures teamwork and open communication.

In 2001, the Bureau of Justice Statistics released the findings of its National Crime Victimization Survey on Violence in the Workplace. This showed that significant costs are associated with workplace violence. These costs include medical expenditures, lost wages, legal fees, insurance administrative costs, lost fringe benefits, increased security measures and household production costs. The cost per case for assaults to registered nurses has been estimated at $31,643 and $17,585 for licensed practical nurses and up to $13.5 billion per year nationwide. This figure is difficult to determine, however as only 20% of private industry and 36% of government establishments track the cost of incidents related to violence (Gates, Gillespie & Succup, 2011).

**Strategies to Prevent Workplace Violence**

Foremost, violence should never be accepted and tolerated as part of the job. In addition, workplace policies and procedures are needed that focus on the security of the environment, reporting and surveillance, and education for all employees and managers on how to prevent and manage violence. When violence does occur, it is critical that formal or informal debriefing be offered to nurses and all staff members experiencing violence. Unfortunately, this level of support is not found in all organizations. Many nurses report that unless they are physically injured, they are often expected to return immediately to their work after being physically assaulted by a patient or visitor.

Staff should be encouraged to report violent encounters or behaviors in a confidential manner resulting in swift response by management. This can be supported through policies mandating documentation of certain types of nonconsensual, nonprofessional physical contact.

OSHA reports that one of the best protections employers can offer their workers is to establish a zero-tolerance policy toward workplace violence (Workplace Violence, 2012). This policy should cover all workers, patients, clients, visitors, contractors, and anyone else who may come in contact with company
personnel. OSHA also states that by assessing their worksites, employers can identify methods for reducing the likelihood of incidents occurring. OSHA believes that a well written and implemented Workplace Violence Prevention Program, combined with engineering controls, administrative controls and training can reduce the incidence of workplace violence in both the private sector and Federal workplaces. This can be a separate workplace violence prevention program or can be incorporated into an injury and illness prevention program, employee handbook, or manual of standard operating procedures. It is critical to ensure that all workers know the policy and understand that all claims of workplace violence will be investigated and remedied promptly. In addition, OSHA encourages employers to develop additional methods as necessary to protect employees in high-risk industries.

Studies conducted by OSHA show that employers who implement effective safety measures can reduce the incidence of workplace violence. These measures include training employees on workplace violence, encouraging employees to report assaults or threats, and conducting workplace violence hazard analysis. Other methods such as using entrance door detectors or buzzer systems for entry, and providing adequately trained staff, alarms and employee “safe rooms” for use during emergencies in healthcare settings can help minimize risk.

Many violent situations directed towards nurses could have been avoided by recognizing early signs of aggression. Findings from a study in a rural ED emphasized the importance of active listening, building rapport, presenting to the patient with a calm demeanor, and being supportive to de-escalate aggression. Despite professional knowledge regarding triggers for aggression, most nurses only address violent behaviors when the behavior has escalated. Table 2 describes common triggers and suggested actions by the nurse as responses to de-escalate the situation. Behaviors leading to aggression may be identified at any stage in the care process but should be assessed initially with a thorough admission history.

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<th>Common Triggers of Aggression &amp; Violent Behaviors</th>
<th>De-Escalation Techniques for Nurses</th>
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<tr>
<td>Poor communication and insensitive attitude by the nurse or other care provider</td>
<td>Set behavioral standards and hold staff accountable for customer service skills. Consider implementation of emphasis on caring in the practice model.</td>
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<tr>
<td>Recent patient history of stressful life events (divorce, unemployment, drug addiction, death of a loved one)</td>
<td>Perform a thorough and comprehensive admission history including social system and support network assessment. Address plans for support and interventions in multidisciplinary care plan and conferences if appropriate.</td>
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<td>Atypical or increased anxiety on the part of the patient or family.</td>
<td>Communicate clearly. Solicit support for patient/family from pastoral care, social services, medical staff and patient’s personal support system. Provide enough time to communicate appropriately.</td>
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Lack of availability of clinical information in understandable language.  

| Work with colleagues to increase patient trust through consistency in communication and terminology and language that the patient understands. |
|---|---|
| Confusion and delirium. | Use of supportive listening, allowing the patient to express concerns when possible. |

Certain individuals are more prone to violence, so thorough evaluation for specific diagnoses and behaviors is necessary. Violent behaviors may be found in individuals with psychiatric diagnoses such as affective disorders (bipolar or manic), paranoid delusions or psychosis, chemical abuse or dependency, dementia from any cause, impulse control disorders, and personality disorders. Additional factors that may indicate an increased risk of violence are a history of violence against people, pets, or property, court-ordered treatment for violence, and failure to take psychiatric medications. Beyond these red flags are general characteristics that can predict violence, including age younger than 40, single, residence in an urban area, substance misuses, homelessness, little or no social contact, and paranoia.

Certain behaviors can signal escalation toward violence including rapid, loud or profane speech, increased confusion or disorientation, clenched fists, gritted teeth, reddened eyes, flaring nostrils, rapid breathing, agitation evidenced by pacing, fear, or inability to remain still, hallucinations, and sudden change in or extremes of affect. These behaviors are all clear warning signs those individuals should be approached carefully and quickly. Other warning signs that people may be near the breaking point include veiled threats, vindictiveness, a resentful attitude, anger issues, depression, co-worker complaints, obsessive-compulsive controlling behavior; and an inability to get along with others.

Research by the Emergency Nurses Association (ENA) revealed that nearly 56% of patients who physically assaulted nurses were under the influence of alcohol, 47% were under the influence of illicit or prescription drugs and 45% were mentally ill (Taylor & Rew, 2010). Nearly all perpetrators in this study were patients. ENA research also shows there are lower rates of abuse when panic buttons, locked entries, enclosed nurses’ stations, call code pseudonyms, security signs and well lit areas are used in the Emergency Department (ED). But the most effective approach is a violence mitigation program that includes facilities management that listens to staff to understand what they need to keep themselves and their patients’ safe.

Safety risks such as poorly lit hallways, parking areas, walkways and a poor design for traffic and workflow may be inherent in the environment and can contribute to workplace violence. Unrestricted access to entrances, inadequate security; overcrowded waiting rooms; access to weapons, drugs or alcohol; and the presence of addicted or psychiatric patients or visitors with a history of violence all enhance the risk of violence. Working in an understaffed unit or working alone also increases risk. Other organizational risk factors include managers with poor skills, inadequate policies or failure to enforce existing policies, lack of managerial or staff member conflict resolution skills, lack of a reporting system, and lack of consequences for offenders.
Organizational risk factors include uncertainty regarding patient treatment, poor quality teamwork, time pressures, role conflict and ambiguity, high levels of physical strain at work, frequent interruptions, irregular hours, staffing shortages, dissatisfaction of work schedules, managers with poor skills, inadequate policies or failure to enforce existing policies, lack of managerial or staff member conflict resolution skills, lack of a reporting system, and lack of consequences for offenders. One expert states that a respectful workplace is the best defense against violence on the job:

“Create a culture in which violence is less likely to occur by treating adults in a respectful manner and building respect into the company’s policies and training. It’s also important to train staffers for interpersonal skills and conflict resolution so that they can solve problems in an appropriate way” (Gallant-Roman, 2008).

OHSA provides a workbook entitled “Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers” (2012) and the Joint Programme on Workplace Violence in the Health Sector has issued “Framework Guidelines for Addressing Workplace Violence in the Health Sector (2012.) Highlights of these documents include:

1. **Evaluate the Workplace.** Each workplace is unique and should be analyzed for its vulnerability to violence. A plan can then be developed that will prevent and control these hazards. Safety and health training can occur and policies can be disseminated. This analysis should be an ongoing process, evaluating the effectiveness of the program so changes can be made.

2. **Use a Top-Down Approach.** Workplace violence must be addressed starting at the top and working down. It is the employer’s duty to provide a safe working environment. No prevention program has a chance of success without the support of management.

3. **Institute Zero Tolerance.** At the heart of OSHA’s guidelines for preventing workplace violence in health care is zero tolerance, considered the minimum requirement for a workplace violence prevention program. According to OSHA, zero tolerance for workplace violence and verbal and nonverbal threats and related action policies should be created and disseminated among all managers, supervisors, workers, patients and visitors.

4. **Empower Nurses.** Nursing is a complex environment. More patients with higher acuity and more complex needs can result in nurses feeling overwhelmed. Nurses must be empowered to report incidents when they occur.

5. **Predict High-Risk Events.** Violence has been described as a process with three behavioral phases; baseline, a calm phase of normal demeanor prior to disturbance; preassault, when an individual becomes disturbed and displays verbal and nonverbal behaviors that indicate the threat of violence; and assault, or the acute excitement phase, when the individual displays out of control verbal and physical behavior. The goal is to recognize when an incident has reached the preassault phase and intercede, leaving the spiral of violence.

6. **Provide Education.** A successful educational program geared toward preventing workplace violence must be fluid and change with the needs of the organization in an effort to identify and reduce the risks involved. Education should be provided to all employees, but initially to supervisors, whose support is crucial to the success of the program. Annual retraining is imperative, and workplace violence prevention training should begin in nursing schools.
In a Sentinel Event Alert, the Joint Commission accrediting body reminds hospitals of the requirement to maintain a written security plan, conduct risk assessments, develop prevention strategies, and maintain a response plan that would be implemented if there is a violent incident. The Joint Commission offered the following recommendations for reducing the risk of violence in healthcare organizations:

1. Work with the security department to audit your facility’s risk of violence.
2. Make improvements to the facility’s violence prevention program.
3. Take extra security precautions in the ED, especially if the facility is in an area with a high crime rate or gang activity.
4. Work with Human Resources (HR) to make sure it thoroughly prescreens job applicants and establishes/follows procedures for conducting background checks of prospective employees and staff.
5. Confirm that HR has procedures in place for disciplining and firing employees as a way of avoiding violent reactions.
6. Require key staff to undergo training in responding to patients’ family members who are agitated and potentially violent.
7. Encourage employees to report incidents of violent activity.
8. Educate supervisors that all reports of suspicious behavior or threats by another employee must be treated seriously.
9. Ensure that counseling programs for employees who become victims of workplace crime or violence are in place.

**Handling Workplace Violence**

Of course, even the most skilled nurses can prevent all instances of violence. An initial reaction to impending aggression may be a physical restraint or a reaction supporting physical restraint. The use of restraints should be minimized to promote patient safety. This is especially true with staff members that are not trained appropriately to implement and monitor restraints and restraint use. Inappropriately applied restraints can result in death, physical injury, emotional stress and extra work for the staff to monitor accordingly.

Some of OSHA’s key recommendations for healthcare administrative and work practice controls include the following (“Workplace Violence”, 2012):

- State clearly to patients, clients and employees that violence is not permitted or tolerated.
- Ensure that adequate and properly trained staff is available to restrain patients or clients, if necessary.
- Provide sensitive and timely information to people waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
• Ensure that adequate and qualified staff is available at all times. The times of greatest risk occur during patient transfers, emergency responses, mealtimes and at night. Areas with the greatest risk include admission units and crisis or acute care units.
• Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
• Establish a list of “restricted visitors’ for patients with a history of violence or gang activity. Make copies available at security checkpoints, nurses’ stations and visitor sign-in areas.
• Review and revise visitor check systems, when necessary. Limit information given to outsiders about hospitalized victims of violence.
• Supervise the movement of psychiatric clients and patients throughout the facility.
• Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
• Determine the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors.
• Establish a system – such as chart tags, log books or verbal census reports – to identify patients and clients with assaultive behavior problems. Keep in mind patient confidentiality and worker safety issues. Update as needed. Review any workplace violence incidents from the previous shift during change in-shift meetings.
• Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (such as rooms with removable partitions.)
• Use case management conferences with coworkers and supervisors to discuss ways to effectively treat potentially violent patients.
• Prepare contingency plans to treat clients who are “acting out” or making verbal or physical attacks or threats. Consider using certified employee assistance professionals or in-house social service or occupational health service staff to help diffuse patient or client anger.
• Transfer assaultive clients to acute care units, criminal units or other more restrictive settings.
• Ensure that nurses, physicians and other clinicians are not alone when performing intimate physical examinations of patients.
• Discourage employees from wearing necklaces or chains to help prevent possible strangulation in confrontational situations. Urge community workers to carry only required identification and money.
• Survey the facility periodically to remove tools or possessions left by visitors or maintenance staff that could be used inappropriately by patients.
• Provide staff with identification badges, preferably without last names, to readily verify employment.
• Discourage employees from carrying keys, pens or other items that could be used as weapons.
• Provide staff members with security escorts to parking areas in evening or late hours. Ensure that parking areas are highly visible, well lit and safely accessible to the building.
• Use the “buddy system” especially when personal safety may be threatened. Encourage home healthcare providers, social service workers and others to avoid threatening situations.
• Advise staff to exercise extra care in elevators, stairwells and unfamiliar residences, leave the premises immediately if there is a hazardous situation; or request police escort, if needed.
Nurses should not accept violence as a part of the job. If nurses are to continue practicing, a plan must be formulated that sends a clear and powerful message that workplace violence will not be tolerated. Nurses must be taught to recognize incivility and exit the spiral before situations result in violence.

If a violent incident cannot be predicted or prevented, the employer has a duty to provide immediate and appropriate treatment to the victimized employees. Immediate comfort and peer support, such as a community meeting, expression of understanding by management, specific debriefing, and a referral to the Employee Assistance Program should be initiated. Debriefing or review of procedures should occur routinely within 24-72 hours of the event, and this process should be safe, with no attempt to place blame. Information regarding typical adaptive and maladaptive response patterns following a traumatic event, along with a list of resources, should also be given to the traumatized employees.

**Horizontal Violence**

Constructive relationships among nursing colleagues are critical for quality patient care and nurse retention; however, another important type of workplace violence is horizontal or lateral violence. This is defined as overt and covert nonphysical hostility, such as criticism, sabotaging, undermining, infighting, scapegoat, and bickering. Horizontal violence refers to the harsh reality experienced by some nurses beginning their careers in nursing. Nursing researchers describe it as *eating our young*. Horizontal violence includes forms of nonphysical intergroup conflicts that are manifested in overt and covert behaviors of hostility. Acts of horizontal violence can range from intimidating body language to sarcastic comments and abusive language. Horizontal violence includes all acts of unkindness, discourtesy, divisiveness, and lack of cohesiveness. Examples include belittling gestures, verbal abuse, gossiping, sarcastic comments, faultfinding, devaluing comments, disinterest and discouragement, and controlling behaviors. Horizontal violence is psychologically, emotionally, and spiritually damaging behavior and can have devastating long-term effects on its recipients. Horizontal violence includes a wide range and variable degrees of antagonism including innuendo, intimidation, passive aggression, withholding information, insubordination and verbal and physical aggression. This is not a new phenomenon, as the effects of horizontal violence have been reported in the literature for almost 30 years.

Covert behaviors include failure to cooperate, failing to respect privacy, making untoward facial expressions, discouraging new staff, undermining staff abilities, providing minimal guidance during orientation and gossiping. The easiest targets for these behaviors are novice nurses. Novice nurses are more susceptible to horizontal violence than seasoned nurses due to their lack of experience. New-to-practice nurses rely on the more experienced nurses to assist them in their professional growth. Ineffective relationships between nurses contribute to instances of horizontal violence, making it imperative that nurses recognize and deal with the issue.

One author describes horizontal violence as having three categories of behaviors including harassment, discrimination and bullying (Pontus & Scherrer, 2011). Harassment is any form of unwanted behavior that may range from unpleasant remarks to physical violence. Sexual harassment is linked to gender or sexual
orientation. Racial harassment is typified by behaviors that are linked to a person’s skin color, cultural background, race or ethnicity. Harassment tends to have a strong physical component in manifested behaviors. Behaviors that include regular following and watching are termed stalking.

Discrimination involves a person being treated differently, and in particular, less favorably because of gender, race, sexual orientation or ability.

Workplace bullying is characterized by many incidents of unjustifiable actions of an individual or group toward a person or group over a long period. Bullying behaviors are persistent, offensive, abusive, threatening, and malicious in nature with the intent to do harm. The person who bullies may be in a position of power (actual or perceived.) Bullying involves intentionally targeting a colleague or employee and systematically creating a negative work environment for them through degradation, social exclusion and other negative acts aims at tormenting or frustrating the victim. One 2001 study outlines three forms of workplace bullying: (1) work-related bullying, such as, withholding information or imposing unreasonable deadlines; (2) personal bullying, such as, gossiping or spreading rumors; and (3) physical bullying, such as being shouted at or threatened with physical abuse (Pontus, & Scherrer, 2011). This study describes that, to be considered bullying the behavior must occur a minimum of once a week over a period of approximately six months, and the instigating party must have power over the intended target. Another study, conducted in 2009, found a bullying prevalence of 27% which is significant as nurses labeled as bullied were twice as likely to want to leave their current position, and three times more likely to want to leave the nursing profession (Griffin, 2011).

Work-life factors common in nursing environments such as role conflict, role ambiguity, role overload, work constraints and autonomy, have all been found to be antecedents of horizontal violence. In one 1997 study, that attempted to clarify what nurses report as aggression in their workplace and the extent and importance attached to aggression from colleagues, all 29 respondents reported that inter-staff aggression was more upsetting and problematic to deal with than aggression from patients or other disciplines. One of the researcher’s conclusions was that “it is paradoxical that within a discipline that has ‘caring’ for others as its main focus employee relationships are so poor” (King-Jones, 2011).

As with other types of workplace violence, the actual incidence is difficult to determine. One 1999 study revealed that, of the 270 nurses surveyed, 30% indicated that they dealt with aggression daily whereas 25% indicated that colleague aggression was a major stressor in the work environment (King-Jones, 2011). Another study in 2003 concluded that sabotage or undermining and destroying of integrity is prevalent. Of the 145 respondents, 87% reported they were expected to do the work of others and 73% reported they were not acknowledged for the work they completed. This researcher also reported that 79% of respondents reported being reprimanded in front of others (Pontus & Scherrer, 2011).

This is such a significant issue, for novice and seasoned nurses alike, that organizations such as The Joint Commission and the American Association of Critical Care Nurses (AACN), are taking an active role in addressing the issue of horizontal violence by advocating for healthy work environments. The Joint Commission issued Sentinel Event Alerts in 2009, 2010 and 2011 that address violence and incivility in
health care and recommend that the health care organizations take steps to end intimidating and disruptive behavior. The Joint Commission mandates that organizations develop and implement processes to offset horizontal violence that enforce a code of conduct, teach employees effective communication skills, and support staff members affected by bullying. The AACN identified six essential standards, one of which is skilled communication, to offset behavior that leads to horizontal violence (Griffin, 2011). The AACN further advocates that nurses’ communication skills should be as proficient as their clinical skills.

Consequences of Horizontal Violence

The consequences of this unprofessional behavior yield lessened job performance, satisfaction, and morale; and greater turnover and absenteeism. Ultimately, the effects of the continual stress from horizontal violence may culminate in health problems such as hypertension, diabetes, coronary artery disease, depression, panic disorders, and post-traumatic stress disorder.

Other effects of horizontal violence include:

- Clinical errors
- Decreased productivity
- Marginalization of the competencies, intelligence and integrity of others
- Reduced self esteem
- Disconnection
- Apathy and low morale
- Depression, anxiety and sleep disorders
- Difficulty with motivation
- Difficulty with emotional control (bursting into tears)
- Impaired personal relationships (trust is destroyed, further eroding relationships in the workplace and creating a major obstacle to team building)
- Post-traumatic stress disorder
- Negative somatic symptoms
- Emotional exhaustion
- Fatigue and sickness
- Decreased mental health and emotional well being

Traumatic symptomatology includes:

- Loss of ability to manage everyday situations
- Over-reactive response, such as dissociation and psychic numbing
- Memory dysfunctions
- Activation of the brain’s circuit breakers
There are many forms of dissociative responses including forgetfulness, spacing, speechlessness, depersonalization and derealization, and fugue or amnesic state due to severe stress. This puts the nurse at great risk of omissions and errors in patient care.

Horizontal violence in the workplace creates an unsafe and unhealthy environment where everyone is negatively affected. Co-workers may feel very sorry for the nurse being targeted but are fearful of taking action as they worry that they will become the next target. Some may even side with the bully and blame the victim.

Covert behaviors of horizontal violence are just a detrimental as overt behaviors. Many nurses may unwittingly not be aware they are exhibiting horizontal violence. Regardless, these behaviors are destructive. It is imperative that nurses become aware of their behaviors and make a conscious decision not to perpetrate horizontal violence toward staff. Becoming a skilled communicator is essential to developing good interpersonal relationships. It is helpful that organizations are taking a stand to eradicate horizontal violence, but nurses must take responsibility and accountability for caring for self and others by confronting staff members who are causing the problem. By not speaking up, nurses risk the chance of devaluing themselves. Skilled communication is the common thread that weaves relationships together, lending itself to the prevention of horizontal violence.

**Strategies to Combat Horizontal Violence**

In some workplaces, an interdisciplinary team consisting of leadership from management, administration, as well as the occupational and safety nurse and other experts initiate the process of creating a culture of civil behavior. The aim is to rebuild social relationships focus on prevention and repair the harm from horizontal violence. This process is also sensitive to acknowledging that changing culture takes time, requiring wisdom, compassion, diligence and patience.

Naming the actions and behaviors that are unacceptable is a step toward controlling inappropriate behavior and moving toward a culture of patient safety. Three creative strategies to do so described in the literature include a code pink, code purple and CUSS words (King-Jones, 2011).

**Code Pink**
A code pink situation occurs when everyone in earshot of a disruptive behavior comes together and surrounds both participants, standing silently with arms crossed to provide support for the victim. The perpetrator usually realized his or her poor behavior and the silent disapproval of it, and the poor behavior often ceases. If it does not, management personnel may have to become involved.

**Code PURPLE**
The acronym PURPLE stands for Please Use Respectful Professional Language Every time. Nursing staff members can educate others by hanging posters about the concept around the unit and then verbally calling out a “code PURPLE” when someone acts inappropriately.
CUSS Words
The third strategy is for staff members to use the words “concerned”, “uncomfortable”, “scared”, or “stop” (i.e. CUSS words) proceeded by an “I am” or “I want” statement. (e.g., “I am uncomfortable with your behavior.” “I want you to stop yelling at me.”) When one of these CUSS words is used, it should signal the team to stop and take an account off what is happening. It is a way to empower every level of practitioner to safely call attention to an environment that could potentially cause a serious error.

Resources
Some online resources that may be helpful in regards to workplace violence include:

- [http://www.cdc.gov/niosh/docs/2012-118/pdfs/2012-118.pdf](http://www.cdc.gov/niosh/docs/2012-118/pdfs/2012-118.pdf)
- [http://www.cdc.gov/niosh/docs/video/violence.html](http://www.cdc.gov/niosh/docs/video/violence.html)
- [www.ena.org/IENR/ViolenceToolKit/Documents/toolkitpg1.htm](http://www.ena.org/IENR/ViolenceToolKit/Documents/toolkitpg1.htm)

Conclusion
Workplace violence is a significant issue that crosses all nursing work environments and has far reaching consequences. Patient, family and visitor aggression and violence towards nurses is a common phenomenon seen for nurses working in a variety of care environments. The aftermath effects are found to be associated with negative psychological and emotional responses and job dissatisfaction that can reciprocally lead to inadequate quality of care and a vicious cycle of patient’s aggression and violence towards nurses. This is a significant issue as the Bureau of Labor Statistics found that nurses were victims of nonfatal assaults more than twice as often as any other medical field workers.

Workplace violence can take many forms and be either overt and obvious, or covert and hidden. Any type of workplace violence can have serious consequences for all involved and should not be tolerated by the staff or management/administration of the organization. This course has described the different types of workplace violence, discussed the incidence of workplace violence, its consequences, and some strategies to prevent and deal with occurrences of workplace violence as well as some online resources that may be helpful in the further study of workplace violence.
References


