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Mitigating Workplace Violence in Hospital Medicine

Overview

The Occupational Safety and Health Administration (OSHA) defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assault and even homicide."[i] As such, it is important to note that there is a wide spectrum of behavior that is defined as violent.

The Centers for Disease Control and Prevention classifies workplace violence into Types 1-4: events with criminal intent, occurrences between the customer/client, worker-on-worker violence, and violence involving personal relationships. 'Type 2' workplace violence involving the 'customer/client' relationship is the most common in healthcare settings. In healthcare contexts, this includes patients, their family members, and visitors against healthcare workers. Violence in hospital settings has increased since the onset of the COVID-19 pandemic with the incidence of injuries resulting in days away from work nearly doubling between 2019 and 2020. Most of these events involve nursing assistants and occur most commonly in emergency and psychiatric treatment settings.[ii, iii] While these statistics are concerning, they are even more sobering when we consider that up to 88% of incidents may not be reported – leading to an underestimation of the scope of the problem.[iv]

In addition to physical harm, healthcare workers who experience violence feel less motivated, more dissatisfied with their jobs, and consider quitting following an event.[v] A recent study reports that the consequences of verbal abuse and threats can have longer lasting effects than physical assaults.[vi] Incidents, particularly unaddressed, against residents also risks normalizing workplace violence as "part of the job."

Risk factors for workplace violence include organizational determinants which span the domains of work stress, staff interactions, and safety climate (e.g., working in understaffed environments, long waits, poor environmental design, inadequate security, lack of staff training and policies to prevent and manage patient crises). These organizational factors may interact with other variables including patient access to firearms, working with patients who are under the influence of drugs, alcohol, or those with a history of violence or certain psychiatric diagnoses to culminate in workplace violence.[vii]

To provide actionable guidance applicable to hospital medicine and to complement The Joint Commission's Workplace Violence Prevention Compendium of Resources,[viii] the Society of Hospital Medicine (SHM) gathered insights from a range of stakeholders and experts. This included hospital medicine leaders and administrators who have worked on and implemented workplace violence policies in addition to hospitalists whose scholarly interests include violence and bias reduction. We present a compilation of steps that groups can take to mitigate violence in the workplace. We acknowledge an important limitation of recommendations on this topic in that high-quality experimental evidence is often lacking and complicated by the wide and variable spectrum of policies and enforcement across groups. **We additionally acknowledge *the underlying tension between the dual and critical needs of keeping hospital staff safe while providing compassionate, safe, and patient-centered care, particularly when biases can confound our best intentions.*** We encourage additional research on the subject so that continuous improvements can be made.

Strategies to Mitigate **Workplace Violence** In Healthcare

The materials are organized into strategies that address prevention, response, support, and monitoring and continuous improvement processes required to mitigate workplace violence in healthcare.

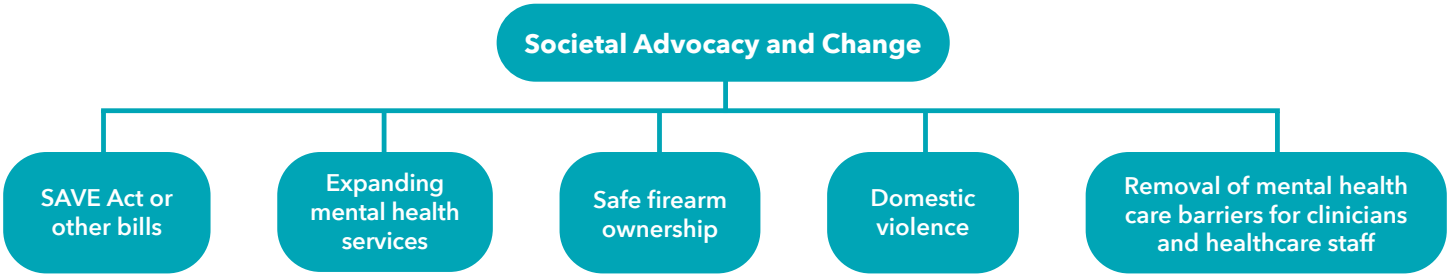
Prevention

As violence in healthcare settings may be the result of a complex interaction between psychosocial, physiological, and organizational determinants, prevention strategies are similarly diverse.

At the societal level:

Hospital medicine groups and individual clinicians should consider advocacy outside the healthcare system on issues such as domestic violence, safe firearm ownership, expanding mental health services, and supporting passage of laws such as the Safety from Violence for Healthcare Employees Act or the "SAVE Act."

Additionally, individuals and health systems should advocate for the removal of barriers to mental health care for clinicians and healthcare staff, such as stigmatizing questions on licensing and credentialing applications, as they can impede an individual's ability to seek support.



At the organizational level:

Climate, culture, and work environments: Organizational determinants of violence in healthcare include factors that impact day-to-day work and the physical space.

Workplace violence is *NOT* "part of the job."

Interventions should aim at improving coworker relationships, work efficiency, and workloads.[ix]

Simultaneously, it is crucial that organizations develop a culture and climate of safety. Changing the culture and climate enables better reporting and increased confidence among staff that by reporting incidents, action will be taken. The organizational priorities may be signaled by the active involvement of group leaders and hospital administration and the dedication of resources in discussions and strategic planning surrounding violence in healthcare. Dedicated effort to lead hospital medicine workplace violence prevention programs and liaise with other teams, such as psychiatry, behavioral health nurses, geriatric nurses, behavioral emergency response teams, ethics, and hospital security should be considered. All staff and trainees should have protected time to receive any necessary training.

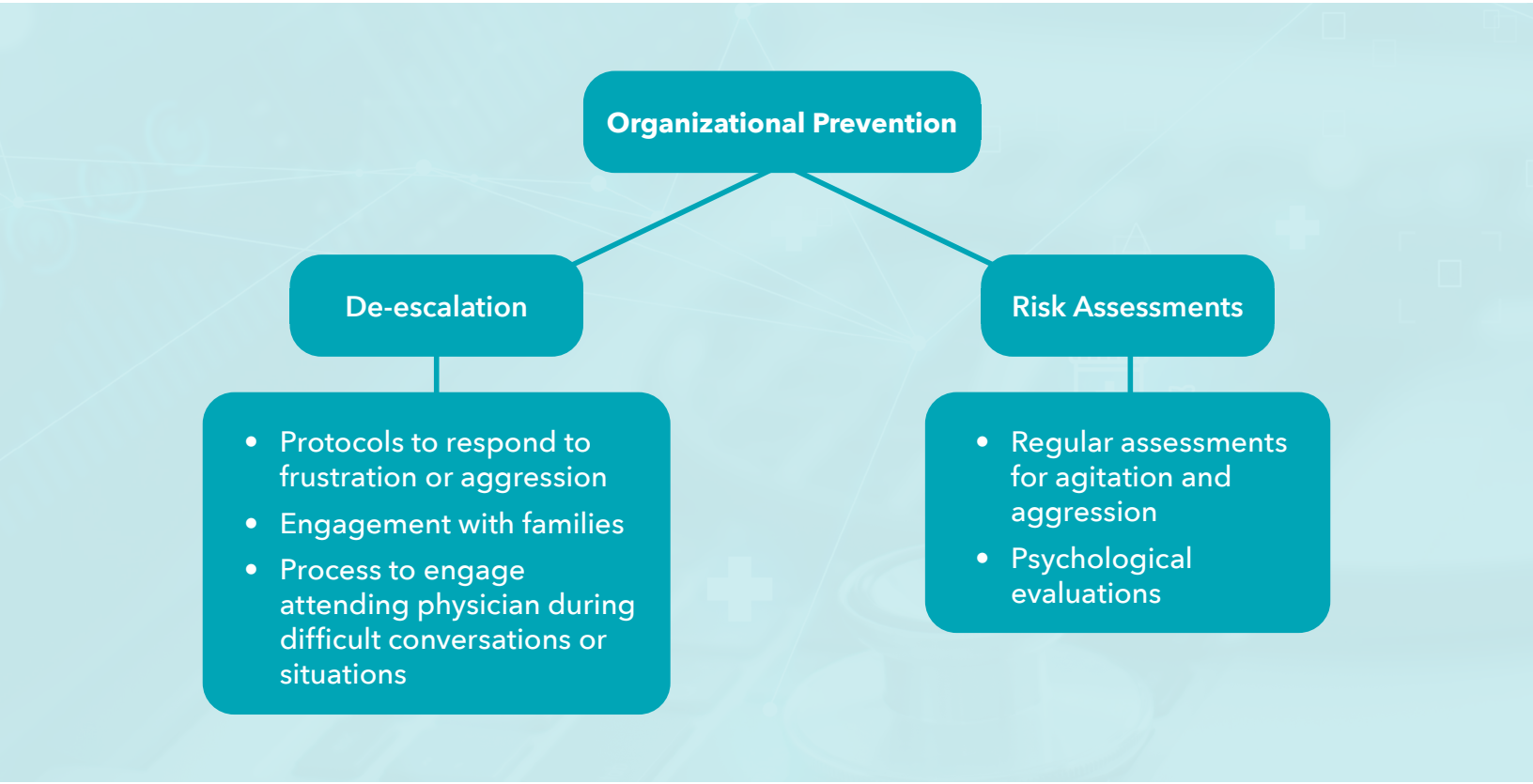
Other strategies may include creating definitions of workplace violence, so all staff members hold patients, visitors, and each other to the same standards. Behavioral aggression or violence should be de-normalized and not accepted as "part of the job."

A multidisciplinary behavioral emergency response team to prevent violence should also be developed and should comprise behavioral health experts, nursing staff, administrators, and security. Consider the development of a hospital Workplace Violence Committee with a multidisciplinary team of key stakeholders to implement, monitor, and improve processes and ensure the adequate training of staff. To mitigate race-based disparities in healthcare and in the activation of security protocols, organizations should continue to diversify the workforce to better reflect their communities.[x]

Policies should be developed that address patients and family rights and responsibilities and should include guidance on how to address requests for changing staff based on 'othering'. Such policies may suggest bioethics consultations in certain scenarios and should balance what the patient should expect (e.g., encourage asking questions) and the consequences of violent or aggressive behavior. These policies should be posted in public areas.

The physical layout and space should be considered, and sites may need to consider the installation of weapon and metal detectors.

Risk assessment and de-escalation: Organizations should implement regular agitation and aggression assessments of patients and implement de-escalation strategies when needed.



Example tools for screening for signs of agitation and/or aggression are listed below.

- Dynamic Appraisal of Situational Aggression - Inpatient Version (DASA-IV)
- Aggressive behavioral risk assessment tool for long-term care (ABRAT-L)
- The Brøset Violence Checklist

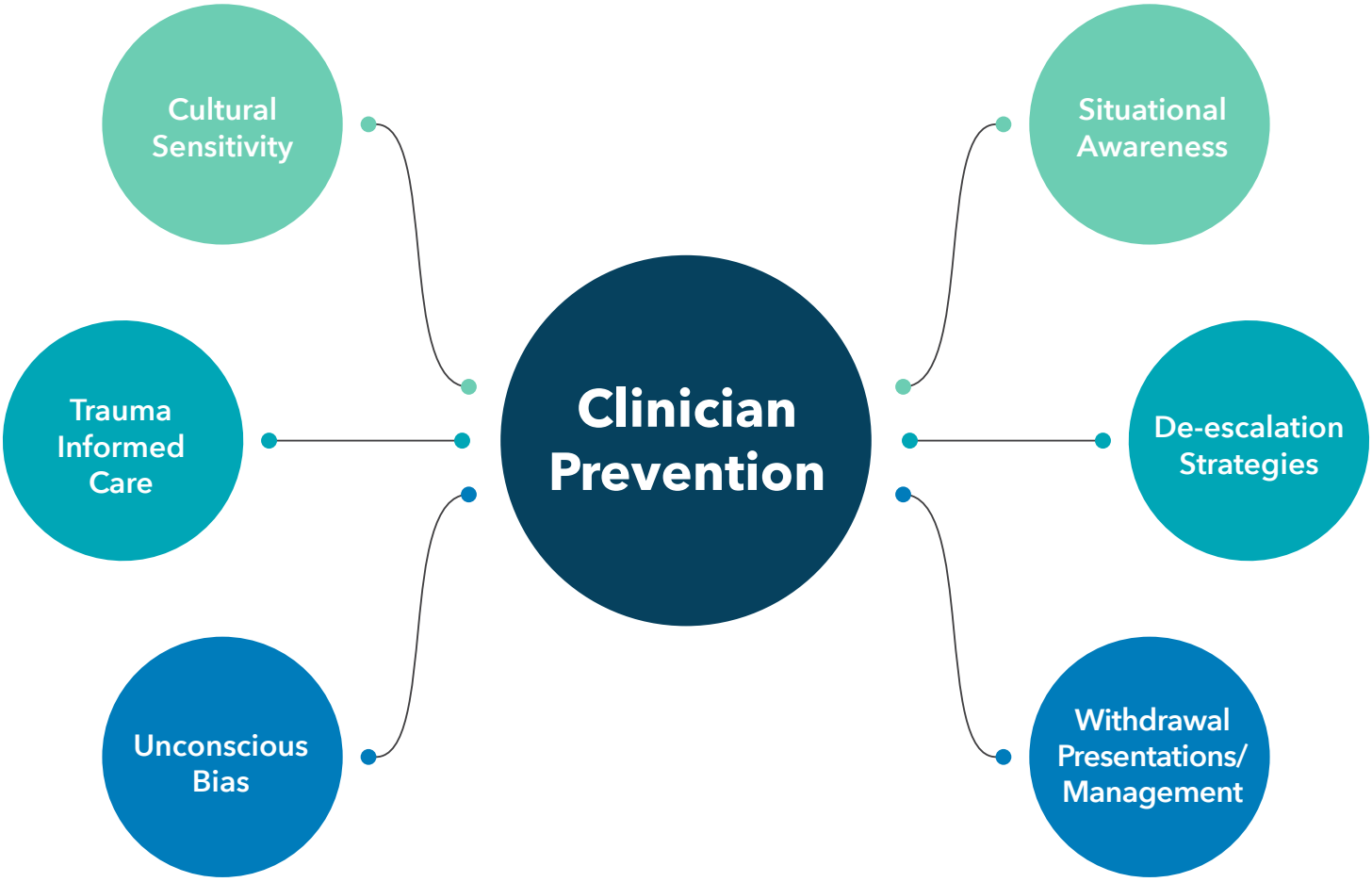
Results of assessments must be communicated to necessary staff and the next shift, and clear processes for responding if a patient displays frustration or agitation should exist.

If aggression or agitation is present, talking to the patient can be an effective management of an aggressive event, but often additional interventions are needed. The attending physician should be in the room to support nursing staff during difficult conversations with security personnel close by. The roles and responsibilities of each person should be specific and delineated. Family members should be engaged wherever possible to help develop a de-escalation plan as they may (specifically in chronic illnesses) have suggestions regarding the best management. De-escalation measures could include engaging psychological evaluations, creating patient behavioral agreements (for patients with decision-making capacity), and creating expedited safe discharge plans. Patients should be reassessed frequently to provide support and gauge the effectiveness of any de-escalation strategies that are deployed.

Behavioral agreements may be prone to bias and there are concerns about their effectiveness and conflicts with justice.[xi] As such, these agreements should be thoughtfully and carefully crafted and deployed only when necessary. Input should be sought from the hospital and/or group's C-suite and legal team in writing the agreement and should explicitly outline what behaviors will not be tolerated and possible consequences, including discharge, and police involvement.

At the clinician level:

Clinician preparedness is key to both mitigate and respond to workplace violence events.



Staff should be trained in trauma informed care approaches and cultural sensitivity to ensure all patients feel respected. For patients with substance use disorders, withdrawal should be anticipated and addressed, and clinicians should be familiar with the different presentations and medical management. As there are race-based disparities in the activation of security protocols in hospitals, staff training to recognize and mitigate unconscious bias should be offered regularly.[xii] For example, there may be different interpretations of behavior, even using assessments, so training and monitoring of data is necessary.

Structured in-person de-escalation training may provide the sustained ability for hospitalists to cope with workplace violence and staff should receive regular training in de-escalation techniques and in situational awareness.[xiii]

Example tools for de-escalation:

- Mandt System®
- Nonviolent Crisis Intervention® Training
- Pro-ACT (Professional Assault Crisis Training)®
- Therapeutic Options™
- AVADE (Awareness-Vigilance-Avoidance-Defense-Escape)®

Response

An effective response requires adequate training in both active and post-event protocols.

Clinician Training

- Active shooter protocols
- Workplace violence protocols

Active Response

- Personal protective equipment
  - → Panic buttons
- Monitoring systems
  - → Paging systems
- Multidisciplinary response team

Post-Event

- Surveillance
  - → Patient flagging system with expiration
- Communication between teams
- Protocols for safe travel

Clinician Training

In a recent study of healthcare workers, only 20% of respondents felt prepared to handle an aggressive situation.[xiv] To mitigate harm from violence, hospital medicine groups should check with the hospital to see what the active shooter protocol is. If there is none, one should be developed. Staff should be trained in workplace violence and active shooter protocols at the time of hire and at least annually. The most effective frequency of such training (training that leads to increases in staff confidence and knowledge in dealing with violence) may be site specific.

Active Response

Active response measures also include the availability of panic buttons that are easily accessible to staff in the event of an emergency, the provision of adequate personal protective equipment (ex. spit guards) and monitoring system (cameras), and the development of paging systems to differentiate between situations so the response can be appropriate (e.g., agitated patient vs. active shooter).

The team responding to an act of aggression should comprise representatives from multiple disciplines including behavioral nursing staff, administrators, and security. De-escalation techniques should be used before other methods are employed. If restraining techniques or medication are used, teams must have been trained on the appropriate and safe use of those measures. If local police are involved in security, organizations should ensure that there is a delineation between the promotion of safety and law enforcement.

Post-Event

When available, electronic surveillance (e.g., video monitoring) instead of in-person monitoring of the patient should be considered. Earlier discharge may be considered if it can be safely achieved. A system to communicate between teams and other settings (e.g., hospital at home and primary care) as patients move through the different settings of the healthcare system should be considered to convey accurate and appropriate information necessary to balance patient care and staff safety. While electronic health record 'flags' for patients at risk for violence may be helpful in alerting healthcare workers of possible risks, such alerts have been found to be deployed more frequently for Black patients.[xv] Therefore, there should be clear criteria for flagging patients and for sunsetting the alert as these alerts may impede care and exacerbate race-based healthcare disparities.

If threats are made to hospital staff and/or their family, hospital medicine groups should engage with security personnel and/or law enforcement and consider protocols to ensure that staff can safely travel to and from the hospital.

Support

Communication and planning in the immediate aftermath of an event occurs under enormous stress and there should be clear and formal demarcations between the responsibilities of the physicians who should focus on the therapeutic plan and that of security personnel who should assume responsibility for maintaining physical safety of the environment.

In the event a workplace violence event occurs, it is important to offer immediate and continual support to victims and witnesses.

Immediate Support

- Debriefing
- Documentation
- Shift of clinical and administrative burden

Continual Support

- Confidential peer support groups
- Therapy and mental health care
- Support in pursuing charges, if applicable

Organizational Support

- Model self-care
- Solicit and welcome feedback

Immediate Support

Debriefing opportunities should be created in the immediate aftermath of the event to allow reflection and support. However, the administrative and documentation burden should be shifted to a supervisor and if the victim wants/needs to leave work, the supervisor should be responsible for making the appropriate arrangements.

Documentation of the event is critical so that groups can justify the need for resources and to monitor the effectiveness of interventions. In addition to the incident, it is important to track the severity and level of exposure to the incident. Event counters and logs can assist in this data collection.[xvi]

Continual Support

The most common consequence of an aggressive event was found to be feelings of anxiousness.[xvii] Confidential peer support groups may be helpful, and support should be extended beyond the immediate period as stress reactions may not occur until hours or days after an event.

When needed, therapy and mental health care should be encouraged. Systems should adopt policies that allow for and encourage employees to access care. Stigmatizing questions on credentialing, if they are present, should be removed. Coverage models should be developed for employees to attend appointments when working, not only outside of work.

Victims should be supported if they choose to pursue charges against patients with decisional capacity.

Organizational Support

A general culture of support should also be developed by modeling self-care, welcoming feedback, listening reflectively, and normalizing being human by sharing both stressors and things that are going well. Periodic listening sessions may be helpful and transparent, clear, and frequent communications may also foster connections within the team.

Monitoring & Improvement

Workplace violence should be addressed similar to other harm events in the hospital such as 'code blues' and the principles of continuous learning and improvement should be applied.

MONITORING

- Efficacy of Staff Trainings
  - → Patient outcomes
  - → Staff outcomes
- Number and types of events
  - → Clinical scenarios
- Demographics of involved parties
- Interventions deployed

IMPROVEMENT

- Outcomes
- Assessment for bias

TRANSPARENCY

- Share data
- Staff listening sessions

Monitoring:

Institutions should develop a process to monitor all aspects of workplace violence, including the efficacy of staff training, data from debriefings, the number, types, and severity of events, the demographics of those involved, the clinical scenario, interventions deployed, and patient and staff outcomes including metrics to measure well-being. Figure 1.0 includes a list of suggested metrics for each strategy and stage of the violent event.

Figure 1.0 Suggested metrics for monitoring and ongoing improvement

PREVENTION

- Safe staffing metrics
- Culture and climate survey
- Diversity of workforce
- Proportion of staff with dedicated time to attend training
- Proportion of clinicians who have completed appropriate training (e.g., trauma informed care, bias reduction, de-escalation techniques)
- Self-reported efficacy of training

RESPONSE

- Presence of support mechanisms
- Utilization of support mechanisms (respecting need and desire for privacy)

CONTINUOUS IMPROVEMENT

- Numbers and locations of events
- Demographic data of those involved in events (race, ethnicity, age, gender, language proficiency)
- Monitoring interventions deployed and periodically stratify and examine by demographics
- Monitoring electronic medical record alerts: demographics of those on whom activated, sunsetting
- Monitoring for unintended consequences (e.g., missed care, or diagnosis)
- Developing data sharing and research agenda

Improvement:

Metrics should be analyzed regularly to assess efficacy and for the presence of overt or unconscious bias, and to identify areas of improvement. Data should be shared and be transparently available. Groups should assess their readiness and response to workplace violence events using the checklist on the following page and fill gaps accordingly.

Transparency:

Data on workplace violence events, including the efficacy of interventions and training, should be shared as much as possible with staff. Listening sessions and other venues for staff feedback and suggestions can help identify areas for improvement, solicit additional details on events and circumstances, and may increase buy-in.

Violence in healthcare settings may create a tension between providing patient care and keeping staff safe. Emerging data from research should be monitored continuously to improve the ways we do both and institutions should consider supporting data sharing and research that allows us to improve practices collaboratively and effectively.

Checklist Summary for
Hospital Medicine Groups

- ☑ Are hospitalists in your group aware of opportunities and issues for advocacy that have the potential to reduce violence in healthcare?
- ☑ Are there strategically placed metal detectors at your institution?
- ☑ Does your institution signal commitment to healthcare violence reduction?
  - ☑ Has your institution/ group created and shared definitions of violence?
  - ☑ Does your institution/ group conduct surveillance of the safety culture?
  - ☑ Is there a multidisciplinary team/ committee responsible for violence reduction?
  - ☑ Is your institution/group engaged in strategies that diversify the workforce to match the communities served?
- ☑ Does your institution/ group use risk assessments to prevent behavioral escalations?
- ☑ Does your group/institution regularly offer de-escalation training?
- ☑ Does your group/institution have a written active shooter protocol?
- ☑ Does your group/institution regularly offer active shooter training?
- ☑ Are there protocols that help direct and delineate responsibilities of the clinical and security teams?
- ☑ Does your group/institution offer post-event support?
- ☑ Is there an infrastructure in place that allows continuous monitoring and improvement?
- ☑ Is your staffing considered safe?

Compendium of Resources

SHM Practice Management Webinar Series

- → Mitigating Workplace Violence by Implementing a Patient Behavior Agreements Program (recorded December 2023)
- → An Integrated Approach to Workplace Violence in Hospitals (recorded January 2024)

Violence in Healthcare Presentation by Che' Matthew Harris, MD and Ishaan Gupta, MBBS

Policies Collected

- → CHI Franciscan Health Management of Disruptive Patient Policy
- → CHI Franciscan Health Workplace Violence Prevention Plan
- → Mass General Brigham Patient Code of Conduct
- → OSUMC Patient Rights and Responsibilities
- → University of New Mexico Hospitals Guidelines Regarding Discriminatory Requests from Patients or Families
- → University of New Mexico Hospitals Policy Regarding Workplace Violence
- → University of New Mexico Hospitals Procedure Regarding Patient and Clinical Visitors

The Joint Commission's Workplace Violence Prevention Resources

Scopes & Shields

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References

[i]Occupational Safety and Health Administration. (May 2024) *Workplace Violence*. U.S. Department of Labor. https://www.osha.gov/workplace-violence

[ii]*Types of Workplace Violence*. (May 2024). The Centers for Disease Control and Prevention. Retrieved June 6, 2024 from https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit1_5

[iii]*Employer-Reported Workplace Injuries and Illness (Annual) News Release*. (November 2021). U.S. Bureau of Labor Statistics. Retrieved June 6, 2024. From https://www.bls.gov/news.release/archives/osh_11032021.html

[iv]Arnetz JE, Hamblin L, Ager J, Luborsky M, Upfal MJ, Russell J, Essenmacher L. Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents. *Workplace Health Saf.* 2015 May;63(5):200-10. doi: 10.1177/2165079915574684. Epub 2015 May 22. PMID: 26002854; PMCID: PMC5006066.

[v]Banga A, Mautong H, Alamoudi R, Faisal UH, Bhatt G, Amal T, Mendiratta A, Bollu B, Kutikuppala LVS, Lee J, Simadibrata DM, Huespe I, Khalid A, Rais MA, Adhikari R, Lakhani A, Garg P, Pattnaik H, Gandhi R, Pandit R, Ahmad F, Camacho-Leon G, Ciza N P, Barrios N, Meza K, Okonkwo S, Dhabuliwo A, Hamza H, Nemat A, Essar MY, Kampa A, Qasba RK, Sharma P, Dutt T, Vekaria P, Bansal V, Nawaz FA, Surani S, Kashyap R; For GRRSP-ViSHWaS Study Group. ViSHWaS: Violence Study of Healthcare Workers and Systems-a global survey. *BMJ Glob Health.* 2023 Sep;8(9):e013101. doi: 10.1136/bmjgh-2023-013101. PMID: 37696546; PMCID: PMC10496720

[vi]DeSanto Iennaco J, Molle E, Allegra M, Depukat D, Parkosewich J. (2023) The Aggressive Incidents in Medical Settings (AIMS) Study: Advancing Measurement to Promote Prevention of Workplace Violence. *Jt Comm J Qual Patient Saf.* 2024;50(3):166-176, ISSN 1553-7250, https://doi.org/10.1016/j.jcjq.2023.11.005

[vii]Arnetz J, Hamblin LE, Sudan S, Arnetz B. Organizational Determinants of Workplace Violence Against Hospital Workers. *Journal of Occupational and Environmental Medicine.* 2018 Aug;60(8):693-699 | doi: 10.1097/JOM.0000000000001345

[viii]The Joint Commission. (2022) Workplace Violence Prevention Compendium of Resources to Support Joint Commission Accredited Hospitals in Implementation of New and Revised Standards. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/work-place-violence-prevention/compendium_final_1.pdf

[ix]Arnetz J, Hamblin LE, Sudan S, Arnetz B. Organizational Determinants of Workplace Violence Against Hospital Workers. *Journal of Occupational and Environmental Medicine*. 2018 Aug;60(8):693-699 | doi: 10.1097/JOM.0000000000001345

[x]Green CR, McCullough WR, Hawley JD. Visiting black patients: racial disparities in security standby requests. *Journal of the National Medical Association* 2018 Feb;110(1):37-43.

[xi]Fabi R, Johnson LSM. Responding Effectively to Disruptive Patient Behaviors: Beyond Behavior Contracts. *JAMA*. 2024;331(10):823–824. doi:10.1001/jama.2024.0216

[xii]Green CR, McCullough WR, Hawley JD. Visiting black patients: racial disparities in security standby requests. *Journal of the National Medical Association*. 2018 Feb;110(1):37-43.

[xiii]Gupta, Ishaan, et al. Prevalence of workplace violence and effects of de-escalation training among hospitalists: a pilot study. *Journal of Community Hospital Internal Medicine Perspectives.* 2023;13(3):1.

[xiv]Banga A, Mautong H, Alamoudi R, Faisal UH, Bhatt G, Amal T, Mendiratta A, Bollu B, Kutikuppala LVS, Lee J, Simadibrata DM, Huespe I, Khalid A, Rais MA, Adhikari R, Lakhani A, Garg P, Pattnaik H, Gandhi R, Pandit R, Ahmad F, Camacho-Leon G, Ciza N P, Barrios N, Meza K, Okonkwo S, Dhabuliwo A, Hamza H, Nemat A, Essar MY, Kampa A, Qasba RK, Sharma P, Dutt T, Vekaria P, Bansal V, Nawaz FA, Surani S, Kashyap R; For GRRSP-ViSHWaS Study Group. ViSHWaS: Violence Study of Healthcare Workers and Systems-a global survey. *BMJ Glob Health*. 2023 Sep;8(9):e013101. doi: 10.1136/bmjgh-2023-013101. PMID: 37696546; PMCID: PMC10496720

[xv]Agarwal AK, Seeburger E, O'Neill G, et al. Prevalence of Behavioral Flags in the Electronic Health Record Among Black and White Patients Visiting the Emergency Department. *JAMA Netw Open*. 2023;6(1):e2251734. doi:10.1001/jamanetworkopen.2022.51734

[xvi]DeSanto Iennaco J, Molle E, Allegra M, Depukat D, Parkosewich J. (2023) The Aggressive Incidents in Medical Settings (AIMS) Study: Advancing Measurement to Promote Prevention of Workplace Violence. *Jt Comm J Qual Patient Saf.* 2024;50(3):166-176, ISSN 1553-7250, https://doi.org/10.1016/j.jcjq.2023.11.005

[xvii]DeSanto Iennaco J, Molle E, Allegra M, Depukat D, Parkosewich J. (2023) The Aggressive Incidents in Medical Settings (AIMS) Study: Advancing Measurement to Promote Prevention of Workplace Violence. *Jt Comm J Qual Patient Saf.* 2024;50(3):166-176, ISSN 1553-7250, https://doi.org/10.1016/j.jcjq.2023.11.005

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