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Understanding and Addressing Workplace Violence Against Hospital and Emergency Workers

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ABSTRACT

Introduction: Violence is a common hazard faced by healthcare workers. Healthcare workers report more workplace violence injuries than workers in any other industry and are significantly more likely than other workers to experience violence. Healthcare and social service workers are the largest group of workers at risk for violence. Workers singled out as particularly vulnerable to violence are those who work in emergency departments. Violence is such a serious problem in the healthcare industry that regulations specifically concerning violence against healthcare workers have been established.

Two major consequences of workplace violence are physical injuries and psychological trauma. Physical injuries, including lacerations and concussions, can sometimes prove to be fatal. Psychological trauma, which can result from even attempted violence, can have serious long-lasting effects. Workers who are severely physically and psychologically traumatized may be unable to work for long periods or may even leave healthcare work altogether. Staffing shortages in healthcare mean that there are not nearly enough nurses to fill severe shortages in the nursing workforce. In addition, injury and trauma in nurses tie up other healthcare workers, including physicians and other nurses, who are necessarily diverted from scheduled work to fill in for their absent colleagues. Finally, healthcare workers who were recently assaulted are more likely to be assaulted again. Therefore, physical and psychological trauma are not only important outcomes of workplace violence in hospitals and emergency rooms; they also help perpetuate that violence.

Methods : To explore the current status of workplace violence against hospital and emergency workers, we conducted a comprehensive review of recent research. To identify the surveys and studies about physical assaults, violence, and behaviors against healthcare workers, a systematic literature review was performed from publications in English in various databases. The database search returned 52 articles, from which we extracted the following information: study year, data collection period, country, type of study, sample size, objective, definition of workplace violence, rate of workplace violence, type of violence, and intervention.

Conclusion: The topic of workplace violence against health professionals represents a new field for policy-relevant research in the area of labor relations and the quality of healthcare. State and federal statutes have found it necessary to address hospital workplace violence using specific criminal punishment. Private labor arbitrators who have advantages of flexibility with striking judges enforce contractual provisions promoting safe workplaces. Intuitive attention permits the design of a modest policy to protect health professionals from violence by hospital patients. Furthermore, the management style of the physician affects the probability that the patient will be violent towards other workers. Given the availability of information, the policy solution commands broad-based support. Yet modest results may still prove difficult to achieve. The combination

of the adversarial interests makes success anything but certain. Clearly, more focused and better research is essential to addressing this ever-present danger.

Keywords: violence, workplace, literature, danger.

INTRODUCTION

Health care occupations continue to be among the most dangerous occupations in the United States. These workers continue to experience high rates of nonfatal occupational injuries. While recent emphasis has been placed on understanding and addressing back and other musculoskeletal injuries to nursing and other health care staff, many hospital and emergency workers continue to be exposed to the universal hazard of workplace violence. Hospital violence is a much less understood problem. Recent well-publicized incidents of workplace violence have resulted in workers' compensation claims, public concern, and legal action. In addition, violence can have social, financial, and physical sequelae for hospital staff. It can also interfere with the delivery of services and cause hospitals to incur additional expenses. The primary purpose of this paper is to help hospitals understand and begin to address the problem of workplace violence against their workers.

In a report on workplace violence, workers in the health care and social assistance sectors were identified as at relatively high risk for workplace violence. They compared the incidents of workplace violence per 1,000 employed persons overall to the high rates in state mental hospitals; in geriatric care facilities; in mental health centers; in substance abuse facilities; and in the wide variety of different facilities included in the general category of federal and state hospitals. These data suggest that health care and social assistance workers are significantly more likely to be personally affected by workplace violence, including physical and psychological injuries incurred as the result of a violent event. Furthermore, most of the violence associated with occupations in the health care and social sectors was estimated to be committed by persons in these caregiving and assistance-providing facilities.

1.1. Background and Scope of the Issue

The definition of workplace violence includes any physical assault, threatening behavior, or verbal abuse occurring in the work setting. It includes both direct and indirect acts carried out by coworkers, other persons, or the perpetrator(s) of violence. Nearly 2 million American workers are victims of violence in the workplace each year. In health care alone, health care and social assistance workers are more likely to be attacked than workers in any other sector. Health care workers are assaulted on the job more than workers in any other occupation. A recent study found that nearly 45 percent of all workplace assaults reported by American workers occurred in health care and social service settings and that a significant percentage of those reported assaults involved violent acts by patients.

Target audiences for this guidance include hospital administrators, charge nurses, leaders, managers, supervisors, worker occupational safety and health professionals, and workplace violence prevention committee members. The scope of the guidance is intended to be broad in nature and includes all persons at the hospital, from all clinical and nonclinical care settings including but not limited to the Emergency Department, Intensive Care Unit, medical/surgical inpatient units, surgery, labor and delivery, newborn nursery, pediatrics, and psychiatric inpatient unit.

2. Types and Forms of Workplace Violence

Numerous definitions are currently employed when discussing workplace violence. They often focus on who commits the violence. They may limit the definition solely to outsiders to the organization who initiate violence directed toward employees. They may also include employees, patients, or visitors who commit these acts. Differences among the definitions have significant consequences for organizations in the development, promulgation, and enforcement of policy. Several researchers suggest that one definition that may move the research field to a state more similar to theory is creating a broad definition: that workplace violence involves threats, assaults, and other threatening behavior by an individual or individuals who may be employees, patients or clients, or acquaintances. Sometimes definitions of workplace violence are broadened to include institutional factors of violence related to the definition.

Workplace violence is categorized in several ways, often related to the setting in which the violence occurs. Typically, the literature groups violence into categories such as criminal, client-on-client, and client-on-staff violence. An alternative taxonomy includes terrorism in healthcare organizations. These definitions may overlap. For example, when a visitor physically attacks an employee when both share a workplace in the hospital, the attack is likely defined as workplace violence. However, if the target person in the same situation is a visitor to the hospital who had been in a car accident related to a drunk driver currently being evaluated and detained in the emergency department, the administrator may categorize the behavior as criminal violence. Understandably, hospital administrators have a vested interest in ensuring the second violent episode is defined

as criminal behavior within the hospital's jurisdiction, thereby affecting liability to the hospital and the liability of the employee who was the target of the violent act.

2.1. Physical Violence

Merriam and Webster define violence as the exertion of any physical force to injure or abuse. As many may realize, this can be the most overt type or form of violence experienced by workers, colleagues, and clients in the workplace. Many people are injured and often killed every week in this country while working. Some injuries and deaths are due to the intrinsic risks of a given occupation, with physical violence as a feared outcome of the job. It is well documented that increasing tensions in our society are increasingly being played out in conflict and violence at the junction with worker action. Physical violence tends to be the most overt and noticeable aspect of workplace violence. The physical violence tends to be limited to "fits of rage and misunderstanding" after touring a unit in these conditions. Physical violence covers a wide range, from pinching and biting to kicking and hitting, and murder. While physical violence covers the high end of the spectrum, the verbal abuse stated earlier has been described as violence in word only and tended to be discounted by staff as "overblown" when items related to violence were included in original analyses of an acknowledged violence incident.

2.2. Verbal Abuse and Threats

There exists clear and consistent evidence that verbal abuse of hospital workers is common. The nurses in my study related numerous on-the-job experiences of "being yelled at", "having things thrown at me", "being threatened with bodily harm", and "being manipulated by others to work longer hours." Anecdotal, clinical, and popular literature all confirm the accuracy of this research. A national survey of nurse practitioners found verbal abuse to be a widespread occupational stressor. In a recent study of health care workers, it was found that verbal abuse contributes significantly to work stress among health care workers. In telephone interviews, most of the participants stated that they are not prepared to deal effectively with this kind of abuse.

Verbal violence against hospital workers can lead to several deleterious effects. For example, nurses exposed to patient verbal violence report a belief in a decrease in personal control, a decrease in self-esteem, and a loss of self-confidence. Nurses also expressed an increase in anger and a sense of confusion. The findings from my study found that nurses exposed to this type of verbal violence resulted in increased frustration with a patient and a decrease in their quality of patient care. In sum, these various descriptions of verbal abuse present us with a grim picture of the potential consequences of such violence. With a clear picture of this workplace violence, it is obvious that we must examine this phenomenon further in order to better understand the magnitude of this workplace hazard. Such an endeavor will enable us to suggest ways that violent incidents can be reduced or restricted and enable workers to learn successful strategies to cope with this professional hazard.

2.3. Bullying and Harassment

In considering what is known about the impact of violence on emergency workers, it is important to differentiate bullying and harassment, which can also shape social norms and distress. The data shows that 11% of European hospital workers have experienced violence, but 19% of all hospital workers report having experienced harassment, with 20% of women and 17.3% of men reporting having experienced bullying. The data also identify professional groups with over a quarter of psychological job demands as episodes of bullying. For women, it is nurses (29.6% experiencing bullying) and 29% of obstetricians experiencing bullying. For men, 28% of pathologists and 26% of administrative staff experience bullying.

Occupational psychiatry recognizes that workplace violence is an important independent variable. Although bullying and harassment questions are excluded from the survey assessment of the causes of mental ill health, the labor and public management literature provides an evidence base as to why management style and worker-manager relations might cause mental ill health and the association between bullying and harassment and degraded work conditions. One key finding is gender parity, with levels of mental ill health higher in environments where bullying and harassment were reported for men and women. Another finding is that gender significantly modifies the relationship between harassment and well-being. With men, those employed in a sector with a high proportion of females are at decreased risk, while for women, the opposite is the case, and the opportunity for chronic disease evidence is mainly sourced from the labor literature.

3. Factors Contributing to Workplace Violence

Individual approaches to understanding and addressing workplace violence emphasize its dimensions, such as the form it takes, who the victims and perpetrators are, and factoring acute situational changes or organizational environments that contribute to violence. Research has used both real-life violence and job stress as the bases for understanding workplace violence in the healthcare sector. In examining contributors to the violence of inpatient psychiatric patients, researchers have looked at sociodemographic, clinical, and behavioral data,

including factors such as age, sex, psychosis, cognitive deficits, functioning limitations, pain distress, suicidal ideation, and assaultive behaviors. (Copeland & Arnold, 2021)(Park and Choi2023)(Howell, 2024)
A number of exogenous work characteristics of healthcare organizations and employees are also potential sources of workplace violence. These can be characterized as patient behavioral factors, staff perception factors, and staff impact factors. Patient behavioral factors represent types and courses of patient aggression, while staff perception and staff impact factors encompass staff beliefs, cognitions, emotions, coping strategies, and impacts or consequences of the aggressive interactions. These factors suggest that the actual behavior of the patient is negotiated or mediated by the perceptions, emotional reactions, and coping style of the employee. Moreover, differences in how staff perceive and respond to patient aggression are likely to be based on contextual as well as endogenous factors, such as individualized perceptions of the workplace and community of which it is a part.

3.1. Environmental Factors

Workplace violence against hospital employees is not evenly distributed across different service areas within hospitals. Nurses working in emergency departments report the highest prevalence rates of physical and non-physical workplace violence. Workplace violence may be more common and severe among emergency department employees because of environmental factors increasing the risk for violence. Emergency department environments may become physically and visually congested, particularly due to medical and surgical supplies, pharmacy carts, charting cabinets, and laboratory services. Bright lighting is necessary, but potentially harmful, to the development and/or worsening of agitated and disoriented patient behaviors. Hospital-wide design recommendations to limit such overcrowding and workers' proximity to confused and vulnerable patients include organizing efficient traffic flow patterns for both people and supplies, storing equipment in a consistent and efficient manner, and limiting the overall volume of equipment and staff. A significant component contributing to the high rate of emergent agitation and aggression is the increasing number of emergency psychiatric patients seeking treatment or evaluation in the emergency department. This literature suggests that security measures do not just reduce incidents of post-traumatic stress disorder and other occupational stresses of emergency department workers, but may serve to prevent emergent violence against them.

3.2. Individual Factors

Occupational violence can have an impact on those who experience it in multiple ways. These impacts range from emotional distress to long-term severe mental or physical issues. Feelings of psychological and emotional distress will be addressed first. Emotional distress related to violence includes feelings of helplessness, humiliation, intimidation, being verbally abused, experiencing a lack of control, feelings of vulnerability, fear, and feeling unsafe at work. Hospital workers who experience verbal and threatening violence have self-defeating thoughts that negatively affect their coping and ability to provide quality care. These self-defeating thoughts can lead to feelings of powerlessness.
Employees are more willing to report occupational violence when they have feelings of job control, supervisor support, and empowerment. Job control is the degree to which an individual can use their skills at work, or the discretion they feel they have to control a situation, and their level of input into decision-making. Finally, workers feel empowered when they have feelings of control and are able to use skills and knowledge to make meaningful decisions. When employees have feelings of job control, supervisor support, and empowerment, the likelihood of reporting violence increases. However, supervisor characteristics like lack of experience, poor attitudes, and inadequate responses were found to be contributing factors to occupational violence. Medical support staff report that poorer supervisor support is negatively related to the intention to remain in their job.

3.3. Organizational Factors

In addition to attending to pertinent policy and regulatory requirements, health sector organizations need to address organization-specific and worker safety-related issues, including staff working conditions, treatment team stress and workload management, recognition and support of staff, protocols and guidelines, as well as having the necessary organizational infrastructure in place. Strategies for effectively addressing violence in the treatment setting need to be based upon the principles of good management and effective safety management, rather than simply punishment and discipline. The overall cultural tone of the organization and the perceived commitment to worker safety from those in leadership roles must be of prime concern. Moving toward a safety culture involves organizational self-assessment leading to the recognition of areas in need of improvement and the prioritization of necessary actions and activities. The goal of these evaluations is the development and implementation of a comprehensive employer violence prevention and safety management system aimed at reducing injury and illness among workers. The development, implementation, and evaluation of prevention strategies, policies, guidelines, training, and other support programs always need to be considered in relation to other policies and procedures so that potential interactions can be recognized and addressed as necessary.

4. Impacts of Workplace Violence

Violence at work impacts the personal, social, financial, physical, and psychological well-being of workers. These experienced and anticipated impacts can be long-lasting and contribute to a variety of psychological and physiological outcomes such as post-traumatic stress disorder, anxiety, depression, and burnout. These consequences can affect the individual, the workplace, and their families. On the individual level, they can negatively impact the physical and mental health of one or more family members. On the organizational level, they can lead to increased workers' compensation claims and medical treatments, legal actions, decreased productivity, and morale. Intentional workplace injury and related medical and other costs totaled a significant amount in 2016. A study in the healthcare sector specifically estimated the cost to be substantial for a single violent event, with the cost increasing if the victim was critically injured and could not return to work. (Sauber & O'Brien, 2020)(Zhou et al., 2020)(Khamis, 2020)(Pressman et al., 2020)

Furthermore, it is observed that healthcare workers are in a stressful work environment because of staff shortages, increased workloads, and an increased demand for healthcare services due to the aging population. These work-related stresses have been associated with abuse and violence in healthcare settings. Thus, workplace violence at hospitals and other healthcare facilities has a "camouflage" effect because it can conceal the symptoms of work-related mental health difficulties. Consequently, healthcare professionals might experience a high level of emotional demands, moral distress, and emotional burnout that can have a negative connection with their work and the patients' institution. It can also cause medical errors and negatively affect the quality of care since it is already suggested that safety and quality of care are positively associated with the level of communication, vigilance, and teamwork.

4.1. Physical and Psychological Effects

Some forms of workplace violence result in obvious physical injuries, which can have severe effects including fatalities. In the case of long-term psychological effects, associated injuries may be less obvious. The existence of mass casualties, whether they are killed, wounded, or captured, increases the likelihood of psychological injury, and mechanisms that lead to these effects are frequently classed as 'wounding mechanisms.' Also, some researchers argue that injury severity thresholds, which may not be passed in many violent encounters in hospitals, reduce anxiety and stress and therefore increase the scope for improving mental health. If we accept that workplace violence incidents are 'wounding' in the sense discussed, the short-term and long-term effects of growing violence will not be pleasant.

Workplace violence very likely contributes to other hospital and emergency service work-related problems. Professions in the police, but not hospitals, have high rates of suicide, and the higher relative levels of alcoholism, drug addiction, and threat-induced post-traumatic stress-related medical problems in the police are possibly related to their greater average exposure to violence. Stress is an important workplace problem in day-to-day hospital work, and anecdotal accounts suggest at least two ways that workplace violence could be a factor in the stress encountered by hospital staff. The more general research suggests that the consequences of stress in the workplace can be severe, ranging from absenteeism, reduced performance, and negative impacts on organizational efficiency to more severe effects on mental health.

4.2. Workplace Culture and Morale

There is much evidence suggesting that these events can be much more than mere inconveniences or brief experiences of anger or fear because they have an influence on everyday, ongoing, and previously established relationships. Detailed and representative data are starting to emerge about levels of one potentially key component of that broader context, namely workplace violence. Thus, we now know that violence against health care workers occurs at alarming rates. There is similar evidence in several other countries too.

Current risks to many health care professions include an increasing presence of denigrated classes of both patients and workers in many service positions. This increasing juxtaposition of influences, tight money settings, and direct contact interpersonal relationships is a combination that has potential for conflict. Furthermore, institutional policies can potentially have a significant influence on both the occurrence and consequences of these ways of relating. For example, new institutional acts have recently encouraged public discussion about the desirability of increasing patient demands in the face of poorer working conditions and lower recognition and access to important and life-saving services. Collectively, these changes have affected what has been termed "moral experience"; workers report being caught in new institutional influences, both complex and contradictory, including the elaboration of a range of law-like forms of procedural and empirical evidence that are based on very simplified conceptions and which have consequences that seemingly run counter to the implicit values underlying health care work.

5. Preventative Measures and Interventions

The extension of compassion-centric DCM principles to the larger hospital or associated clinics and to medical or administrative staff and visitors requires a more complex approach. For healthcare workers to safely provide

assistance to those influenced by violence, safer working environments and sufficient levels of staffing and support are required.

Program and policy-related interventions are the most successful, effectively used alone or in conjunction. These encompass multiple methods and levels of involvement, from the hospital to the police, society, and state and national control. Such actions can be either permanent or have a transient impact. One specialized set of interventions, Critical Incident Stress Management, yields special interest because it promotes post-incident stress control, as such incidents appear to occur seldom and possess risk levels, particularly psychological ones, that rise far above more common healthcare provider stressors. However, such approaches will not have a lasting effect on violence prevalence or importance, minimizing their significance to health management or the healthcare system.

5.1. Training and Education Programs

Training and education programs are among the most effective means for reducing reactions such as fear of violence and for empowering workers to create a personal safety and security culture. These programs help to develop an internal worker locus of control, which is the belief that by using the appropriate blend of customer service, employee rights, and security strategies proposed by the employer who is willing to enforce rules, workers will be safe from the effects of workplace violence. Training and educational programs help staff to identify hostile or aggressive behavior patterns, which focus on the primary technique for preventing workplace violence. It is important to provide educational information in a variety of media including video training materials, computer-based training, and more traditional means. While training and education efforts are necessary complements to other site-specific prevention strategies, such as appropriate staffing levels and the presence, or the potential for the presence, of mental health treatment staff, they are insufficient as stand-alone interventions. Researchers who focus only on individual-level prevention strategies frequently criticize organizations and policymakers equipped with the responsibility for engineering or site-level strategies that are actually effective in preventing or interrupting workplace violence. But individual-level training and educational efforts are not without their benefits. Effective respect and fairness training provides a foundation upon which to develop and implement site-specific prevention strategies.

5.2. Security Measures and Protocols

Anecdotal reports suggest that the level 1 trauma centers and large medical centers have the greatest number of security staff. These security staff direct access and escort observers to typical problem behaviors. When hospitals are visited by a friend or family member of a patient who has a serious injury or acute medical emergency, asking security personnel for guidance may well be the best course of action. In small community hospitals and freestanding emergency departments, whether to hire uniformed security or obtain training in detainment and physical control of combative individuals by the fewest possible licensed law enforcement officers is a difficult issue when budgets are limited, local criminal disturbances are minimal, and sheriff departments do not staff deputies in hospitals and fire departments.

To be prepared for occasional disruptive or combative situations, especially when released patients have to come back to emergency rooms unarmed, unescorted, and away from security personnel, a given percentage of licensed law enforcement officers from regional public or private departments and hospitals will have to regularly attend shared training courses. Jointly sponsored regional restraints as well as handcuffing policies should be adopted by mutual agreement long before any of the involved members would have to act. Defusing room crises by trained law enforcement personnel is always best handled away from the medical malpractice and tort liability of the health care professionals and never involves outreach and communication, except to request specific protocols for frequent hazardous persons who never admit for completion of an evaluation. Prior notice to hospital administration when frequent hazardous persons are involved is essential when the legal responsibility for asking petty officers of the wardroom staff to secure travel orders is undefined.

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