Workplace Violence Assessing Occupational Hazards and Identifying Strategies for Prevention, Part 1

This home study CE is part one of a two-part series and upon final completion, provides four contact hours (CEH). Look for the second installment and the CE quiz to appear in the next issue of National Nurse.

Description

This home study course examines conditions in the healthcare environment associated with workplace violence. Included is a review of key terms, relevant definitions, practices, standards, and regulatory policies so registered nurses (RNs) can more quickly identify threatening behaviors and situations where the potential for lateral, horizontal, and physical violence exists. It further examines the scope of the problem of workplace violence and how RNs can be proactive in their practice settings to promote workplace security and mitigate the potential for harm to themselves and their patients. RNs will learn strategies for taking action and, as circumstances require, changing administrative policies that encumber their ability to provide safe, therapeutic, and effective patient care. Selected highlights of publicly reported assaultive and violent incidents which resulted in harm or death to healthcare workers will help nurses formulate a corrective action plan for effectively dealing with the aftermath.

Objectives

Upon completion of this home study RNs will be able to:

- State the NIOSH definition of workplace violence
- Identify behaviors that undermine a culture of safety
- Describe the concept of horizontal hostility
- List OSHA workplace factors that create or potenti ate stress and emotional strain
- Identify signs and symptoms of potentially hostile or aggressive patients, clients, coworkers
- Describe steps or actions RNs can take to reduce the risk of violence in their workplace at the facility level and in the public policy arena

Background

Workplace violence is a major public health concern that has grown substantially over the past decade. Violence in healthcare settings is on the rise throughout the nation, and the risk of workplace violence is a serious occupational hazard for registered nurses (RNs) and other healthcare workers. Nurses are known to be at high risk as employees who provide direct care to people in distress. The incidence of workplace violence is now recognized as a major health priority by the World Health Organization, the International Council of Nurses, and Public Services International. What has been described as “an epidemic” of workplace violence in hospitals has gained national attention since the Journal of the American Medical Association (December, 2010) published a research paper on the increasing violence in U.S. hospitals.

The authors of the JAMA report include statistics from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, and the Bureau of Justice. Statistical data estimates 1.7 million injuries per year due to workplace assaults, accounting for 18 percent of all violent crime in the United States. The healthcare industry constitutes 45 percent of the incidents of workplace violence. The rate of workplace violence in healthcare settings is approximately four times the national average.

Violence against nurses is a complex and persistent occupational hazard facing the nursing profession. Paradoxically, the job sector with the mission to care for people appears to be at the highest risk of workplace violence. Nurses are among the most assaulted workers in the American workforce. Increasingly nurses are exposed to violence – primarily from patients, their families, and visitors. This violence can range from shouting and belligerence to stalking, beating, stabbing, and shootings. Nurses also perceive and experience on-the-job abuse from their supervisors and other healthcare workers; this includes acts of intimidation, coercion, harassment, bullying, undermining, retaliation, and other forms of assault.

Psychological consequences resulting from violence may include fear, frustration, and lack of trust in hospital administration, decreased job satisfaction, and burnout. Incidences of violence early in nurses’ careers are particularly problematic as nurses can become disillusioned with their profession. Violence not only affects nurses’ perspectives of the profession, but it also undermines recruitment and retention efforts which, in a time of a pervasive nursing shortage, threaten patient care.

In 2009, the Emergency Nurses Association released a survey that showed more than 50 percent of emergency room nurses had experienced violence by patients on the job (being spit on, hit, pushed or shoved, scratched, or kicked); and more than 25 percent had experienced 20 or more violent incidents in the past three years. In addition, 70 percent had experienced verbal abuse (being yelled or cursed at, intimidated, or harassed with sexual language or innuendo) in the previous year.
The research reveals that long wait times, a shortage of nurses, drug and alcohol use by patients, and treatment of psychiatric patients all contributed to violence in the ER. Of note, the rate of assault injuries to psychiatric nurses has been estimated at 16 per 100 employees per year, which exceeds the annual rate of all injuries found in many high-risk occupations. Patients and their relatives were the perpetrators of the abuse in nearly all incidents of physical violence (97.1 percent) and verbal abuse (91 percent).

According to the Bureau of Labor Statistics’ latest report of occupational fatalities in 2010, fatal assaults by a newly defined perpetrator, “the customer,” has shown an increase over previous years. In an article entitled “When Disgruntled Customers Kill,” author Alan Fox claims this trend is because “customer service has become customer disservice.” He reports that customers and clients are feeling increasingly frustrated and powerless as automated and scripted recordings have replaced direct communication. As nurses on the front lines every hour of everyday, interacting with patients and their families, we know this to be true.

Fox urges companies and businesses to begin humanizing customer service by employing an adequate number of easily accessible “competent and concerned human beings” rather than relying on impersonal machines. For obvious reasons, hospitals, health maintenance organizations (HMOs), and other healthcare work settings would be wise to heed the message. A substantial body of research links enriched nurse-to-patient ratios with high patient satisfaction, improved patient outcomes, increased retention, and job satisfaction among RNs.

**Selected key terms and definitions**

**Assault:** The definition of assault used for the recording of healthcare assault data is “intentionally, knowingly, or recklessly causing physical injury.” This definition requires a subjective judgment of intent and may have led to variable reporting of assaults.

**Assault and Battery:** Although frequently used in a single phrase and often thought of as a single offense, the terms “assault” and “battery” refer to two separate torts. The two offenses are often committed almost concurrently, that is, an assault followed immediately by a battery. However, an assault does not include a battery because it is merely the apprehension of a contact that if made would constitute a battery. Although a battery is often a completed assault, a battery still may be committed without an accompanying assault, as in the case where the plaintiff was not aware that a battery was imminent.

A person may be criminally as well as civically liable for assault and battery. Various state penal codes commonly define assault as
an unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another. A similar definition is found in the legal treatises: Assault occurs when the defendant’s acts intentionally cause the victim’s reasonable apprehension of immediate harmful or offensive contact. A battery is any willful and unlawful use of force or violence on the person of another. Battery occurs when the defendant’s acts intentionally cause harmful or offensive contact with the victim’s person.

Bullying: Overt and/or covert acts of verbal and/or nonverbal aggression perpetrated by one in a higher level of authority. “Repeated, health-harming mistreatment, verbal abuse, or conduct which is threatening, humiliating, intimidating, or sabotage that interferes with work or some combination of the three” (Namie). “A person is bullied when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other persons, and he or she has difficulty defending himself or herself” (Olweus).

This definition includes three important components:
1. Bullying is aggressive behavior that involves unwanted, negative actions.
2. Bullying involves a pattern of behavior repeated over time.
3. Bullying involves an imbalance of power or strength.

In conflict theory, bullying signifies an unsolved social conflict that has reached a particularly high level of escalation with an increased disparity in the balance of power.

Coercion: The practice of compelling a person to involuntarily behave in a certain way (whether through action or inaction) by use of threats, intimidation, or some other form of pressure or force. (Social Psychology)

General Duty Clause: Section 5(a)(1) of the OSH Act, often referred to as the General Duty Clause, requires employers to “furnish to each of his (sic) employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.” Section 5(a)(2) requires employers to “comply with occupational safety and health standards promulgated under this Act.”

Horizontal Hostility: A consistent pattern of behavior designed to control, diminish, or devalue a peer (or group) that creates a risk to health and/or safety (Farrell 2005).

Lateral Violence: Also known as horizontal abuse or hostility, lateral violence is the disruptive, disrespectful, or antagonistic behavior of others on the same hierarchical level. Lateral violence occurs when people who are both victims of a situation of dominance turn on each other instead of confronting the system that oppresses them both. Lateral violence occurs when oppressed groups/individuals internalize feelings such as anger and rage, and manifest their feelings through behaviors such as gossip, jealousy, putdowns, and blaming.

Moral Distress: Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action. (Jameton, 1984)

NIOSH: The National Institute for Occupational Safety and Health conducts research and makes recommendations to prevent work-related illness and injury. NIOSH works with industries, labor organizations, and universities to understand and improve worker safety and health. NIOSH is a Centers for Disease Control and Prevention research agency in the U.S. Department of Health and Human Services.

OSHA: The Occupational Safety and Health Administration is a regulatory agency in the U.S. Department of Labor. With the Occupational Safety and Health Act of 1970, Congress created OSHA to assure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance. The act can be found at www.osha.gov/pls/oshaweb/owasrch_search_form?p_doc_type=OS HACT&p_toc_level=0&p_keyvalue=

Post-Traumatic Stress Disorder (PTSD): A disorder that affects a person who has 1) experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury or a threat to the physical integrity of self or others; and 2) the person’s response involved intense fear, helpless essence, or horror. (DSM-MD 4th Ed., Text Rev.)

Threat: A statement or expression of intention to hurt, destroy, punish, etc. as in retaliation or intimidation. (U.S. Department of Justice)

Work environment: Consists of the employer’s premises and other locations where employees are engaged in work-related activities or are present as a condition of their employment. The work environment includes not only physical locations, but also the equipment or materials used by the employee during the course of his or her work. (United States Department of Labor)

Workplace Violence: Violent acts (including physical assaults, threats of assaults, and verbal abuse) directed toward persons at work or on duty. (NIOSH)

Introduction
According to recent research commissioned by the National Institute of Occupational and Environmental Health (NIOSH), healthcare workers, especially those providing emergency and psychiatric care, have long been recognized as having a high risk of work-related assault, and nurses are at particularly high risk, with the highest rate of victimization among occupations in the healthcare industry.

The same research demonstrated that among hospitals, surveillance of workplace violence events is “uncordinated and inefficient,” employee training programs rarely included review of violence trends within their specific hospital, few hospitals had effective systems to communicate about the presence of violent patients, hospital security equipment systems were uncoordinated and insufficient to protect the unit, and security programs and training were often less complete in psychiatric units than in emergency departments.

Concerns over workplace violence reached a fever pitch in California near the end of October 2010, when an experienced RN working at a county correctional/detention facility was violently assaulted by an inmate while attempting to provide him care. Unable to recover from the injuries she sustained from the assault, she tragically died three days later. Just days before her death, a psychiatric technician was killed by a patient on the grounds of a state psychiatric facility that treats adults with serious mental illnesses; 90 percent of the inpatient population is forensic, referred through local governments or the court system (including those incompetent to stand trial; mentally disordered parolees; not guilty by reason of insanity; mentally disordered sex offenders; minors, Department of Juvenile Justice commitment). Their deaths sparked a public outcry over the safety of RNs and other healthcare workers, and called into question the efforts of healthcare employers to enact standards and policies that ensure the safety and security of their employees. The deaths of these healthcare workers, and the countless acts of assault, battery, and aggression that routinely take place in health-
care settings, demonstrate a frightening trend of increasing violence faced by healthcare workers throughout the country.

Nurses and other coworkers, together with the correctional facility RN’s relatives and friends, had gathered to remember her caring spirit and compassion. Although staff had proposed modifications to their work environment that would make it safer, the changes were not implemented by facility management until after the tragedy occurred. Upon learning of the circumstances surrounding her untimely death, her fellow nurses said, “Enough is enough!” and they strongly advocated for meaningful legislation to prevent such a senseless tragedy from occurring ever again.

An investigation of this tragic and violent incident conducted by Cal OSHA resulted in three “Citation and Notification of Penalty” violations being issued with fines imposed on the facility. Among the findings (excerpt):

Citation 1 (General): “At and prior to the time of the Cal OSHA inspection, the employer did not establish and implement effective training and instruction for health services employees, including but not limited to nurses and their supervisors. These employees worked with inmates and were exposed to physical assault hazards. The employees were not provided with effective training and instruction on the following subjects pertaining to physical assault hazards:

- Escalation signs; and,
- Verbal and non-verbal de-escalation techniques; and,
- Physical deflection and escape techniques; and,
- Control of relatively larger work objects that could be used as weapons, such as staplers, hole punchers, monitors, and lamps.

Citation 2 (Serious): The employer did not conduct effective inspections and evaluations of physical assault hazards in the intake area, including:

- Prior to and around the beginning of the Cal OSHA inspection, the hazards created by unsecured and relatively larger work objects that were kept within reach of inmates and that could be used as weapons, such as staplers, hole punchers, monitors, and lamps; as a result, on 10/25/10 an inmate used an unsecured and within-reach lamp as a weapon to fatally injure a nurse; and,
- Prior to the Cal OSHA inspection, the hazards created by the configuration of the rear nurse’s intake work station (the station adjacent to the multi-inmate female holding area); separation was not provided between the inmate and the nurse, where separation could have been used to minimize the assault hazard for certain tasks.

Citation 3 (Serious): T8 CCR 3203(A)(6) “Injury and Illness Prevention Program. Effective July 1, 1991, every employer shall establish, implement, and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum: Include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices, and work procedures in a timely manner based on the severity of the hazard:
- When observed or discovered; and,
- When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property, remove all exposed personnel from the area except those necessary to correct the existing condition. Employees necessary to correct the hazardous condition shall be provided the necessary safeguards.”

Findings: “The employer did not effectively implement corrective methods and/or procedures for unsafe conditions or work practices involving physical assault hazards.”

In addition to the citations issued by Cal/OSHA to the correctional medical detention facility mentioned above, the proposed penalties for violations of the General Duty Clause were as follows:

Citation 1 Item 1 Type of Violation: General $ 560
Citation 2 Item 1 Type of Violation: Serious $ 6,750
Citation 3 Item 1 Type of Violation: Serious $ 6,750
Total of Proposed Penalties: $14,060

After the death of the psychiatric technician, state regulators determined the hospital facility’s administration was aware that individuals with a history of escalating impulsive violent behavior toward staff could result in serious injury. Although the mission of the state hospital is “to provide hope to adults with a serious mental illness and support each individual to achieve personal recovery,” failure to properly monitor and provide appropriate care for predatory patients can make violence and intimidation a part of the daily work life according to published interviews with staff. Inadequate staffing and non-adherence with safety program guidelines and regulations not only increase the risk of violence, but serve as a barrier to the ability of healthcare professionals to provide therapeutic treatment.

Generally, people with mental illness aren’t especially dangerous; many are vulnerable and at risk of being abused or assaulted themselves. They should be provided with a safe, effective, and therapeutic environment of care. Mental health professionals, law enforcement officials, and regulators should work together to protect workers and provide violent psychiatric patients with the treatment nurses and doctors know they need without punishing people for being sick.

In May 2011, Cal/OSHA fined the state hospital more than $100,000 for a series of serious and willful violations in the death of the psychiatric technician. The employer’s Injury and Illness Prevention Program was cited for being ineffective.

Citation 1, Item 1 (excerpt): “Program Directors/Department Heads have authority and total responsibility for maintaining safe and healthful working conditions for employees within their jurisdiction.”

Citation 1, Item 2 (excerpt): “Injury and Illness Prevention Program was not effectively implemented in that employer does not ensure that employees who escort individuals comply with safety procedures and policies.”

Citation 1, Item 3 (excerpt): “Injury and Illness Prevention Program was ineffective in that the employer’s procedure to investigate occupational injury and illness was not implemented and maintained. Many of employer’s Supervisor’s Report of Occupational Injury or Illness’ forms pertaining to assaults showed that investigations lacked analysis of the cause and thus were ineffective in preventing further occurrences.”

Citation 1, Item 4 (excerpt): “The employer’s Injury and Illness Prevention Program was ineffective with respect to employee training and instruction in that:

TSI training given to employees was not applicable to the type of assaultive situations that an employee’s experience from unsupervised individuals on the grounds in the Secure Treatment Area.

The employer’s program did not train employees in how to recognize stalking behavior by individuals on the grounds of the Secure Treatment Area, nor how employees were to be protected from this behavior.”
Citation 2, Item 1 (excerpt): “The employer’s Injury and Illness Prevention Program was ineffective with respect to the employer’s communication system on health & safety matters in that:

Employer required all employees to confront unsupervised individuals engaged in prohibited behavior. Employer’s procedures did not provide for communication to the employees the history and behavioral triggers of the hundreds of unsupervised individuals that they expected to confront.

Employees had no effective, available means of communicating threatening behavior by individuals to the employer.

Employer’s communication system used during assaults introduces delay or the potential for failed communications.”

Citation 3, Item 1 (excerpt): “The employer’s procedures for identifying and evaluating hazards were ineffective in that, as the employer’s forensic individual population increased, the employer failed to identify the hazards posed to employees by increasingly threatening and felonious assaultive behavior by individuals.” As a result, an employee suffered a fatal injury by an individual.

Citation 4, Item 1 (excerpt): “The employer had not established procedures for sounding emergency alarms outside of the units for employees engaged in traversing the grounds to and from work, or when escorting individuals. As a result, an employee who had no means of sounding an emergency alarm was fatally injured by an unsupervised individual who was out on grounds at the same time as the employee.”

Citation 5, Item 1 (excerpt): “The employee alarm system established by the employer did not allow for sufficient reaction time for

References


safe escape of employees when assaulted by individuals in that police/emergency responders were delayed by existing procedures.”

Citation 6, Item 1 (excerpt): “Employer’s Program was not effective with respect to correction of hazards, in that the methods and procedures for correcting the hazards posed by violent individuals to employees were not implemented:

Employer through its Safety & Security Committee meetings, was made aware of the felonious and threatening behavior exhibited by individuals allowed outside on the grounds of the Secure Treatment Area. However, it failed to address the hazard, as it did not implement the requirements of its own policy in restricting and/or issuing grounds passes to individuals, based on their previous behavior and history of violations of the rules.

Employer was aware of the hazard posed by one of these individuals because of his recent history of aggressive behavior, illegal drug usage, and stalking, and made no reasonable effort to protect the employees against the hazard by allowing this individual to maintain his grounds pass without restriction, with no supervision, in a totally unstructured environment. As a result, an employee was killed by this individual out on the grounds.”

While there is no amount of money that can compensate a bereaved family for the unjust loss of a precious life, substantial fines may serve as an effective deterrent and tool that compels employer compliance with existing health and safety laws. However, when the proposed fine for violations is a less expensive alternative to implementing and following the law (e.g., safe staffing and an environmentally safe work site), it


State of California, Division of Occupational Safety and Health (2011). Citation and Notification of Penalty. Inspection Number 314325325; Inspection Dates: 11/02/2010-03/21/2011; Issuance Date: 03/21/2011, pp. 5-7.


becomes a travesty of justice. Puny fines are an insult to the sensibilities of the working people the laws are designed to protect.

A fine alone is not going to prevent a malicious and villainous act that proceeds from an evil heart or purpose. But every event has a preventable component. A substantial fine doesn’t always serve as a deterrent, nor does it mitigate the egregious violation of employer responsibility to provide a safe work place. Puny fines give the impression that the value of a human life is dirt cheap compared to the crime committed against innocent victims due to their employer’s lack of diligence and accountability.

The facts speak for themselves. The fact that the nursing and healthcare staff had proposed changes to their work environment that could’ve prevented these tragedies is heartbreaking. It’s unconscionable that the changes weren’t made until after healthcare workers died. Had management implemented the changes recommended by staff, and exercised due diligence as employers rather than cutting corners, loss of life could have been averted. Some cuts don’t heal.

California Nurses Association/National Nurses United (NNU) sponsored emergency legislation to bring uniform standards, stricter guidelines, and enforcement penalties to help ensure facility compliance with regulatory and professional workplace safety initiatives.

Promoting a Socially Just Culture
According to the Institute of Medicine, lapses and mistakes are all serious and can potentially harm patients and jeopardize careers. Current responses to errors in healthcare settings tend to focus on active errors by punishing individuals. Although a punitive response may be appropriate in some cases (e.g. deliberate malfeasance, gross negligence), it is not an effective way to prevent recurrence. Preventing harm and improving safety for patients and staff requires a systems approach in order to modify the conditions that increase the risk of harmful consequences.

Latent errors pose the greatest threat to safety in a complex system because they are often unrecognized; they can include such things as poorly structured organizations and bad management decisions. Latent “errors” can be difficult for people working in the system to notice since they may be hidden in the design of routine policies, processes in computer programs, or in the structure or management of the organization. People can become accustomed to such defects and often work around them, so they are often unrecognized. The “normalization of deviance” occurs when small changes in behavior become acceptable; the potential for harm reoccurs because important processes and standards are overlooked. Direct-care RNs are important advocates who are uniquely qualified and well positioned to identify, evaluate, and intercept a majority of potentially harmful errors and “near-misses” in their employment settings.

Nature versus Nurture: Is the System to Blame?
As the great Canadian physician Sir William Osler once said, “Variability is the law of life; and as no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease.” Nurses understand this and are educated to observe and care for patients holistically. Patients may have extremely emotional, stressful, and personal circumstances related to age, dependency, disability, gender, sexual orientation, ethnicity, bereavement, or socio-economic status that affects their ability to cope and adjust to their illness, injury, medications, treatment interventions, and/or a life-changing condition. Hospitals are known as caring places, but they are not immune to workplace violence for many reasons.

The U.S. Department of Labor’s Occupational Safety and Health Administration website describes potential psychological hazards found in hospitals as “factors and situations encountered or associated with one’s job or work environment that create or potentiate stress, emotional strain, and/or other interpersonal problems.” According to NIOSH, stressors common in healthcare workplace settings include: inadequate staffing levels, job and task demands/work overload, poor organizational climate, unfair management practices, financial and economic factors, shift work, and long work hours.

We’ve come a long way? Lateral Violence, Gender, and Oppressed Group Theory
LATERAL VIOLENCE, horizontal violence, and bullying are all terms that have been used to describe non-physical violence between members of groups. Lateral violence is common among nurses and other healthcare workers, and it occurs when individuals internalize feelings of anger, frustration, fear, and rage, subsequently manifesting those feelings through behaviors such as gossip, putdowns, jealousy, “backstabbing,” withholding information, blaming, and undermining.

Compared with physical assaults, non-physical violence is even less well documented, although it has been reported that in many situations, verbal abuse can produce the same degree of psychological distress as physical abuse. Researchers Magnavita and Hepoinemi (2011) report that a systematic review of studies on aggression showed that despite differing countries, cultures, research designs, and settings, nurses’ responses to aggression are similar and include anger, fear or anxiety, post-traumatic stress disorder symptoms, feelings of guilt, self-blame, and shame. These psychological effects can persist for months or years after the original event.

The gender theory of lateral violence states that since professions associated with a predominantly female workforce have been traditionally undervalued and unappreciated, women engaged in such professions often lash out at one another, rather than collectively confront the hierarchy that oppresses them. Many women have not been socialized to appreciate themselves or the importance of their role in society, a role that acknowledges their interdependence, the dignity of their work, and their worth as human beings. “The woman question” is a phrase often used in connection with social change in the latter half of the nineteenth century, which questioned the fundamental roles of women and their right to be in control of their own person, children, property, legal, medical, financial and other civil rights that we now tend to take for granted.

A major characteristic of oppressed group behavior stems from the ability of the dominant group to set the frame for social norms. The dominant group’s use of patriarchal and coercive power, (control exercised through fear, threat, or force to discipline, punish, terminate, or even inflict harm), often includes forms of socio-cultural ostracism to enforce their values. This elicits negative behaviors in the oppressed group which leads to poor self-esteem and a paradigm of learned helplessness. Individual members of the oppressed group begin to believe they are powerless and, sadly, their behavior is often congruent with that belief. In a real sense, the members of the oppressed group become accomplices in their own subordination, thereby preserving and even defending the status quo.
However, since the inception of modern nursing and state licensing of professionals, direct-care nurses fought for the right to control their practice and their profession to advance the interests of the public. Early nurse leaders such as Lavinia Dock and Lillian Wald advocated union membership for nurses as a profession. Nurses’ moral authority and authentic power is derived from a higher level of integrity based on human needs and ethical values of caring and compassion. Their professional values included treating everyone equally with dignity, respect, fairness, honesty, and a single standard of excellence in the provision of care. Over the years they helped lead the paradigm shift in the conceptualization of the role of the nurse from loyal subordinate to autonomous advocate.

They recognized that belonging to a nurses’ union was essential to helping nurses fulfill their obligation to effectively influence and implement safe, therapeutic, and effective standards of care within the employment setting. Union membership and collective patient advocacy effectively shifts the balance of power away from an oppressive hierarchy to ensure humane working conditions and the right to fair compensation that promotes delivery of the highest quality of nursing care.

Dock and Wald understood that the profession needed to exert collective advocacy power in unity, to change the status quo. They recognized the barriers to autonomy and fought to prevent encumbrance of their professional practice by the male/physician-dominated hierarchy and their matron enablers existing in hospitals.

As a result, from the first decade of the century onward, physicians and hospital administrators have remained in positions of dominance and control over nursing and healthcare. It wasn’t so long ago that Lavinia Dock wrote of her “abounding discouragement” with regards to the American Nurses Association, because they “actually voted in opposition to the equality amendment on which women of all nations are pinning their hopes.”

Lavinia Dock and Lillian Wald have provided us with a respected legacy and a challenge to carry this mission forward on behalf of our patients and our practice. We cannot ignore our duty, or refuse to accept it. As Lillian Wald said, “We commit ourselves to any wrong, or degradation, or injury when we do not protest against it.”

Furthermore, Lavinia Dock warned the nursing leaders that male dominance in the healthcare field was a major problem in the nursing profession. Her warnings went unheeded and nurses became accomplices of their own subordination. Nurse leaders ignored all her warnings and in the second decade of the century actually became nonvoting members of the American Hospital Association. They worked with physicians and administrators on joint committees, expecting their oppressors to help them solve nursing problems. They sought approval from men, not liberation.

Nurses have a compelling obligation, inherent in the profession’s broad social responsibility, to apply their skills to identify the preventable components and work to change the course of potentially harmful situations by being sensitive to risk factors and early indicators of all forms of violence. Nurses know that an ounce of prevention is worth a pound of cure, whether it’s at the bedside or in the community at large.

“CHILDREN’S HOSPITAL...FINED”
State investigators fined a California hospital for failing to provide adequate controls and policies in the wake of violent and potentially unsafe situations at the hospital. The state’s Division of Occupational Safety and Health, known as Cal/OSHA, issued the safety violations in connection with two incidents, one of which happened when a homeless man armed with a gun burst into the emergency room and briefly took an employee hostage before surrendering. In the second incident, a gunshot victim was dropped off in the front of the hospital instead of at the emergency room entrance. Nurses reported feeling unsafe while tending to the patient outside the hospital before additional help arrived.

“COPS: MAN SHOOTS DOCTOR, THEN KILLS MOM, SELF AT HOSPITAL”
Baltimore - A man who became distraught as he was being briefed on his mother’s condition pulled a semi-automatic gun from his waistband and shot the doctor, then killed his mother and himself in her room.

“COURT AWARDS $1.4M TO VICTIM’S FAMILY IN PHARMACIST’S SLAYING”
A court found a Jacksonville hospital and its security company negligent for the death of a hospital employee, as a result of inadequate security and for overlooking the killer’s history of violence.

“HOSPITAL VIOLENCE IS ON THE RISE, HEALTH AGENCY WARNS”
Once considered safe havens, healthcare institutions today are confronting steadily increasing violent crime, said an alert issued by the Joint Commission, a national accrediting agency. Assault, rape, and murder pose a growing threat to medical caregivers.

“LONG BEACH HOSPITAL SHOOTINGS MAKE NO SENSE”
Hours before he walked into his workplace with two handguns to fatally shoot his supervisors and then himself, he gave his children breakfast, took them to school, and returned home to get ready for his job as a technician at the hospital’s pharmacy. Many of his colleagues speculated that he had turned to violence because he feared being laid off. Officials with the police department noted that the incident may be part of a national trend of workplace related shootings by people distraught over the economic downturn.

“SUSPECT IN FATAL SHOOTING AT CHICAGO HOSPITAL ARRESTED”
A housekeeping employee suspected in the fatal shooting of a coworker inside a hospital parking garage, which prompted an hours-long lockdown, was arrested during a traffic stop, police said. University police said the suspect also was a hospital housekeeper and characterized the killing as an “apparent domestic-related shooting” in a campus alert.
“SURVEY FINDS NO LETUP IN VIOLENCE AGAINST ED NURSES”
According to the report, more than a third (36.7 percent) of emergency nurses have considered leaving their current jobs because of workplace violence. We need hospitals and hospital administrators to take steps now to increase the safety of their emergency departments so that patients can receive the care they need.

“TWO DEAD IN TENNESSEE HOSPITAL SHOOTING”
A gunman fatally shot a woman and injured two others before killing himself outside a hospital in Knoxville. The attack happened at about 4:30 p.m. near the patient discharge area. According to published reports, all three victims were current or former employees of the hospital.

“VIOLENT ASSAULTS ON ER NURSES RISE AS PROGRAMS CUT”
Columbus - An emergency room nurse suffered bruises, scratches, and a chipped tooth from trying to pull the clamped jaws of a psychotic patient off the hand of a doctor. Nurses and experts in mental health and addiction say the problem has only been getting worse because of the downturn in the economy, as cash-strapped states close state hospitals, cut mental health jobs, and eliminate addiction programs. After her second attack in one year, she began pushing her hospital to put uniformed police on duty.

Barriers to Workplace Violence Prevention
Recently the U.S. Department of Justice, Federal Bureau of Investigation has expressed concern that there is a likely under-reporting of violence and a persistent perception within the healthcare industry that tolerating assaults are just part of the job. According to the researchers, under-reporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them, or employee fears that employers may deem assaults the result of employee negligence and/or poor job performance.

Fear of retaliation and the stigma of blowing the whistle on colleagues are pervasive. Within certain institutions, staff often perceives that powerful “revenue generating” physicians will be let off the hook for inappropriate behavior because of the implied consequences of confronting them. Financial considerations are controlling hospital administration responses to physicians who harass and bully coworkers and subordinates.

Many employers deny violence is a problem in their facilities and this denial often leads to violence prevention being a low priority. Subsequent lack of budgeted resources is now viewed as “penny wise and pound foolish” because the costs of workplace violence can be very high financially. The Institute for the Prevention of Workplace Violence estimates that one incident of violence can cost an employer $250,000 to $1,000,000 in workers’ compensation, disability, and medical costs, as well as legal fees.

NIOSH estimates the economic cost of workplace violence nation-wide at around $121 billion. In addition, the hidden costs of workplace violence include decreased productivity and morale, lost work time, legal fees, and personnel turnover. Non-fatal workplace assaults alone result in more than 876,000 lost work days (average of 3.5 per incident by those directly impacted), and $16 million in lost wages. The average award in a workplace violence lawsuit exceeds $1 million per case.

Nurses often fear that reporting abuse and violence will prompt hospital administrators to retaliate against them, and some who hesitate may have a point. Despite the initiatives to create a “blame free” environment, nurses are often asked, “What did you do to provoke this attack?” or, “What will you do to prevent this from occurring again?” The implication is not only that the abuse is the fault of the victimized nurse but that he or she could’ve easily prevented it. Nurses have been reprimanded or fired if they try to defend themselves against violence. Management may fear that reporting violence will affect their patient satisfaction scores and this may be an indication that hospitals are taking customer care and customer service schemes too far!

Most nurses who are injured don’t seek treatment for their injuries, which is indicative of a certain degree of resignation on the part of victimized nurses. Of the nurses who reported experiencing physical violence, 15 percent said they sustained a permanent injury as a result; and, in nearly half the cases, no action was taken against the perpetrator. Blaming the victim is a way some hospitals may avoid taking responsibility for and solving the problem. More security, better training, and improved staffing are solutions that cost money, yet they’re solutions that nurses should collectively demand for the benefit of their profession and their practice. In addition, they are effective “neighborhood watch” measures that increase awareness and safety.

NIOSH Responds
On September 8, 2011, the Occupational Safety and Health Administration (OSHA) issued its first directive on workplace violence detailing procedures for its inspectors. The directive puts employers on notice with regard to enforcement on this potential hazard. OSHA has no specific standard on the issue of workplace violence, but instead it cites employers for workplace violence hazards under its General Duty Clause.

To establish a violation of the General Duty Clause, OSHA must show: (1) a workplace hazard exists; (2) either the employer or the employer’s industry recognized the hazard; (3) the hazard is likely to cause serious injury or death; and (4) there is a feasible and useful way for the employer to abate the hazard. The directive explicitly states a citation will be issued if discovery of an existing hazard of workplace violence, likely to cause physical harm or death, is made during inspection, if the employer has failed to take reasonable steps to mitigate or eliminate the hazard.

The two scenarios that most likely will trigger an inspection: (1) there has been a complaint, referral, fatality, or catastrophic event relating to workplace violence; or (2) there is a planned programmed inspection at a worksite that is in an industry with a high incidence of workplace violence. OSHA has identified healthcare and social service settings, such as psychiatric facilities, hospital emergency departments, pharmacies, and drug abuse treatment clinics, as well as late-night retail businesses, as high-risk settings.

Bullying: Work Shouldn’t Hurt!
Workplace Violence May Grab the daily headlines, according to Drs. Gary and Ruth Namie, co-authors of The Bully at Work, but outside the spotlight, the pain and degradation of corporate bullying shatters lives nationwide. Incivility and bullying flourish in unsupportive work groups that normalize competitive and abusive behav-
Bullying and violent assaults often come from patients’ family members who are frustrated by the lack of attention they’re getting from providers. Because incidents and hazards associated with actual or potential violence and abuse differ from one facility to another, each employer must develop a defined plan for responding to any incident of violence. Collectively, nurses and other healthcare workers should become familiar with their employer’s guidelines, policies, reporting procedures, and methods to help prevent and reduce workplace violence and abuse.

**Where Do We Go From Here?**

As with most other risks, prevention of workplace violence begins with planning. Any organization will be far better able to spot potential dangers and defuse them before violence develops and will be able to manage a crisis better if one does occur. If executives and decision-makers have considered the issues beforehand and have prepared appropriate policies, practices, and structures. Unfortunately it is easier to persuade management to focus on the problem after a violent act has taken place than it is to get them to act before anything happens. Patients and the public have the right to expect that their healthcare needs will be competently provided for in a safe setting.

A plan should be proactive, not reactive. Employees have the right to expect a work environment that promotes safety from violence, threats, and harassment. If there are elements in the workplace culture that appear to foster a toxic climate, such as tolerance of bullying or intimidation; lack of trust between workers and management; high levels of stress, frustration, and anger; poor communication; inconsistent discipline; and erratic enforcement of company policies, these should be called to the attention of management for remedial action. NNU nurses should be familiar with OSHA recommendations for reducing workplace violence and hold their employers accountable by working proactively to implement effective practices.

Nurses belonging to collective bargaining units are strongly encouraged to address workplace violence and abuse prevention in their contract language and through their professional practice committee (PPC) by proposing and demanding safe staffing; secure and ergonomically designed work stations; and trained security personnel present and available should the need arise. Nurses have the duty and the right to advocate for their profession and on behalf of their patients. Nurses must act to change, as circumstances require, working conditions that are against the health, safety, and well-being of themselves and others.

**OSHA recommendations for reducing violence include:**

- Adopting a written violence-prevention program, communicating it to all employees, and designating a “Patient Assault Team,” task force, or coordinator to implement it.
- Advising all patients and visitors that violence, verbal, and nonverbal threats, and related behavior will not be tolerated.
- Setting up a trained response team to respond to emergencies.
- Encouraging employees to promptly report incidents and to suggest ways to reduce or eliminate risks.
- Reviewing workplace layout to find existing or potential hazards; installing and maintaining alarm systems and other security devices such as panic buttons, handheld alarms, or noise devices, cellular phones, and private channel radios where risk is apparent or may be anticipated; and arranging for a reliable response system when an alarm is triggered.
- Using metal detectors to screen patients and visitors for guns, knives, or other weapons.
- Establishing liaison with local police and state prosecutors, reporting all incidents of violence and providing police with floor plans of facilities to expedite emergency response or investigations.
- Ensuring adequate staffing at all times.
- Setting up a system to use chart tags, logbooks, or other means to identify patients and clients with assaultive behavior problems.
- Instituting a sign-in procedure with passes for visitors and compiling a list of “restricted visitors” for patients with a history of violence.
- Controlling access to facilities other than waiting rooms, particularly drug-storage or pharmacy areas.
- Providing medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents.

When necessary, nurses should request assistance verbally and in writing from outside resources, including threat-assessment psychologists, psychiatrists and other professionals, social service agencies, accrediting, licensing, and regulatory agencies, and law enforcement. NNU regards workplace safety, including safety from violence, as an employee’s right, just as worthy of union defense as wages or any other contractual right such as defending workers’ rights to due process. Training in violence prevention, threat detection, threat assessment, and threat management should become part of the workplace culture. **End of Part 1**