Violence in the Workplace
We Aren't OK

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"Code Gray!" The announcement over the public address system signaled an out of control, potentially dangerous person on a medical floor in our hospital. As part of a team of staff who are trained to respond to and manage assaultive or disruptive behavior, I arrived on the scene where four security officers were struggling to restrain a mentally ill patient. Amid the chaos, staff explained that the patient suddenly lunged at a staff member, dragging her across the room. Staff and visitors rushed to the sounds of the commotion and managed to free the victim, holding the patient at bay until more help arrived.

While never routine, regrettably, Code Gray is an all too common occurrence in the hospital setting. Approximately 19,000 workplace assaults occur in health care and social services settings annually.[1] Health care workers are at least four times more likely to be victimized by workplace violence than workers in private industry.[2] Health care workers are subject to serious physical assaults such as choking, punching, kicking, spitting and sexual assault. Less common circumstances may include gun violence and stabbing. Nearly every hospital health care provider has experienced verbal assaults, including profanity, name calling and threats of future violence or retribution. Particularly unnerving and frightening are threats that persist after the care relationship has ended. This type of threat is even more alarming because it is typically targeted at specific individuals or departments.

Increasingly, hospitals are called on to treat potentially violent individuals. Often, patients transported to the hospital accompanied by law enforcement are then released from custody and left in the care of hospital clinicians. Because violent offenders may exhibit medical and mental health symptoms, law enforcement agencies ensure an offender is medically stable before he or she can be jailed. Compounding this, law enforcement leaders cite a lack of financial and human resources that would enable officers to remain with patients throughout their emergency department visit or hospital stay; therefore, decisions to arrest are deferred until the patient's health care visit is complete. And the use of hospitals for the

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treatment of acutely disturbed individuals, who otherwise may be appropriate for police custody or jail, is cited as a major stressor in medical facilities.[3]

As the hospital supervisor and Code Gray response team leader, I confirmed with security and nursing staff that the patient was safely restrained and no longer presented an imminent threat to himself or to staff. Then I went in search of the health care worker who had been assaulted. I found her hunched against the wall in a remote corner of her department, struggling against tears, bravely trying to regain her composure. She sought to reassure me that she was "OK." She said that she was experienced and could handle what occurred.

Unlike other industries, health care workers often accept being victimized because many patients or patients' family members suffer from some form of altered mental status, usually associated with dementia, delirium, substance intoxication or decompensated mental illness.[4]

This may result in staff perceptions that abuse is an inevitable part of the job because persons in such altered mental states are not responsible for their behavior.[5]

Research shows that the majority of nurses who experience violence in the workplace do not even report the incident.[6] One reason for underreporting is the belief that coping with assault is part of the job. Other reasons for minimizing or underreporting violence include laborious reporting systems, perceptions that reporting will not benefit the employee, or that the assault may even be viewed as evidence of poor job performance.[7] No health care worker should accept or expect that becoming a victim of verbal or physical assault is part of the job, or that the victim is somehow to blame.

PRESERVING SAFETY, PROVIDING CARE

I often hear comments from health care workers suggesting violent or disruptive patients should simply be discharged and escorted off the premises. However, complex issues arise as organizations struggle to balance staff safety with the legal and ethical duty to provide care for all patients who need services. Many abusive patients are not mentally competent to be held accountable for their behavior. Others, while competent, may not be medically stable for a safe discharge. We are challenged to balance the duty to provide compassionate, dignified care for patients and the absolute requirement to provide a safe workplace for health care workers.

CHI has a long-standing commitment to violence prevention as an essential element of creating healthy communities, and it is a leadership priority. In 2018, CHI released an updated guide for workplace violence prevention and emphasized the elimination of workplace violence as a key element in reducing societal violence.[8] Despite complex and troubling circumstances, it is possible to achieve a safe work environment in hospitals and other health care settings. The creation of reliably safe workplaces can be accomplished only through rigorous and relentless focus on violence prevention strategies.

The most important and foundational violence prevention strategy is to establish and communicate a strong commitment from system and hospital administration. CHI leaders are directed to establish interdisciplinary workplace violence prevention teams with staff representation from across the organization. The Joint Commission urges health care leaders to establish a goal of zero violence-related harm.[9] It is not enough to develop policies that assert "zero tolerance for violence." The actual goal must be zero harm to health care workers.

Evidence shows that higher commitment to violence prevention from hospital administration is associated with lower odds of physical violence and verbal abuse.[10] This is especially true in organizations with a culture of rigorous reporting expectations.[11] Leaders must encourage, support and insist upon reporting of incidents of verbal and physical violence. This culture can be fostered by asking each day in team huddles (short daily staff meetings at the beginning and/or end of each shift) if team members have experienced violence. Clinical and ancillary department leaders should ensure staff understand how to routinely evaluate and identify patient and family risk factors which may signal the potential for violence. Each opportunity to proactively review a potential or near miss situation is an opportunity to prevent violence and harm.

Each episode of actual violence should be followed by an immediate team debriefing and, if indicated, a scheduled in-depth review. All immediate and follow up reviews must include members of the team involved in the incident and provide a supportive environment to explore

how a similar event can be avoided in the future. Debriefings should seek to identify root causes for the incident, but not stop there. The Occupational Safety and Health Administration (OSHA) cautions against stopping at identifying "worker error" and "unpredictable event" as root causes of workplace violence harm.[12] More questions need to be asked. For example, "How can we better support and prepare each worker for future situations?" and "What signs might have predicted the violent behavior?"

To reach a goal of zero harm, organizations must create simple data reporting systems, identify who is responsible for gathering and analyzing data, and routinely evaluate the findings. The data collected and analysis of trends for potential and actual incidents of violence should be shared in a transparent manner with staff, executives, board members and labor unions.

Leadership and front-line health care workers need to work together, using their own organization-specific risk assessment data, to identify changes to the physical environment that can improve staff safety. This could include video surveillance systems, mobile panic buttons, access control systems (such as touchpad or key card restricted entrances), enclosed staff work areas, and patient care spaces where potentially violent patients can be quickly and safely isolated until a threat can be mitigated.

The presence and location of security personnel should be routinely evaluated by security and clinical leadership. Visible security presence in high-risk areas, such as the emergency department and its waiting room, can deter violence and ensure timely responses when incidents occur.

Time and resources need to be allocated to routine and ongoing staff training. Comprehensive training will include recognizing and de-escalating potential threats, self-defense, response to emergency codes and the opportunity to practice in drills.

Leaders in health care, mental health and community law enforcement, along with front- line staff in each profession, should meet regularly to learn about and understand the problems that impact their shared populations, outside and within the walls of the hospital. Improved communication and understanding each agency's challenges and limitations can result in collaborative problem solving and better utilization of resources.

Within just a few days of the Code Gray incident, I responded to another Code Gray, and days later another and another. Nearly every day, I am called upon to assist with a patient or visitor who is verbally threatening or abusive. The expectation of a safe workplace is foundational to achieving the mission and core values of CHI.[13] Only when health care workers can confidently expect a violence-free workplace will they become empowered to achieve CHI core purposes to heal body, mind and spirit.

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NOTES

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4. The Joint Commission, "Sentinel Event Alert" no. 59, (April 17, 2018). www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf.
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7. Emergency Nurses Association, *Emergency Department Violence Surveillance Study*, (Des Plaines, Ill., Institute for Emergency Nursing Research, November 2011), 10.
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10. Emergency Nurses Association, *Violence Surveillance Study*, 9.
11. Emergency Nurses Association, *Violence Surveillance Study*, 9.
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13. Catholic Health Initiatives, *Violence Prevention Resource Guide* (Englewood, Colo.: Catholic Health Initiatives, August 2018). www.catholichealthinitiatives.org/content/dam/chi-national/website/documents/CHI%20Violence%20Handbook%207-16a.pdf.

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