The Other Epidemic: Violence Against Healthcare Workers

PATIENT AT HOLY SPIRIT HOSPITAL ACCUSED OF ASSAULTING 2 STAFF MEMBERS

Nurses Under Attack: Violence Is Getting Worse in Hospitals

ER Nurses File Workplace Safety Complaint Over Alleged Violence Against Staff

Escalating Workplace Violence Rocks Hospitals

Health Workers Once Saluted as Heroes Now Get Threats

Trends, Policies, and Protocols Related to Healthcare Workplace Violence

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The headlines speak volumes, and they all lead to the same conclusion: violence in healthcare facilities presents a significant challenge to patients, providers, support staff, and visitors. The Occupational Safety and Health Administration (OSHA) estimates that nearly 75% of about 25,000 workplace assaults reported annually happen in healthcare settings. In addition to violent incidents happening more often, victimized healthcare workers are increasingly more likely to report them, rather than dismissing maltreatment as "part of the job."

Security varies significantly in healthcare facilities—some do not have a formal force, some larger systems employ their own departments, others may contract the service out, and in some areas, local law enforcement departments may set up substations within the emergency department (ED).

This article provides an overview of workplace violence, highlights risk factors that contribute to healthcare workplace violence, and summarizes related legislation and policies. It also highlights strategies and guidance healthcare staff and security partners can incorporate into their coordinated healthcare workplace violence plans.

The Prevalence of Workplace Violence in Healthcare Facilities

Healthcare workplace violence is traditionally underreported (Stephens, 2019). Many feel as though it is "part of the job" and there is a culture of silence associated with this type of victimization. The U.S. Bureau of Labor Statistics (2020) reports:

> "In 2018, the private ownership all-worker incidence rate for nonfatal occupational injuries and illnesses involving days away from work resulting from intentional injury by other person in the private healthcare and social assistance industry was 10.4 per 10,000 full-time workers, compared to the all-worker incidence rate of 2.1. **The health care and social service industries experience the highest rates of injuries caused by workplace violence and are 5 times as likely to suffer a workplace violence injury than workers overall**" (emphasis added).

> *In 2020, staff from Cox Medical Center (Branson, MO) reported more than 120 assaults on staff, three times the number reported in 2019. Assaults leading to injuries also increased by 21% (Gerber, 2021).*

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Omar et. al (2018) compared the results of two surveys to determine how rates of violence against emergency physicians have changed between 2005 and 2018. Despite the relatively low response rate and small sample size, their findings were helpful and can contribute to an understanding of the problem:

- More than 80% said a patient had threatened to return and harm them or their emergency department staff
- 71% personally witnessed others being assaulted during their shifts
- Nearly 22% frequently felt afraid of becoming a victim of violence
- There was a significant increase in the number of respondents reporting that their hospitals had security personnel that performed rounds throughout the facility and armed security officers

A study of violent incidents tracked in 106 hospitals between 2012 and 2015 found that nursing assistants and nurses had the highest injury rate per 1,000 full-time equivalent employees. A review of home care aides who reported verbal abuse in the past year found that they were 11 times more likely to also report physical abuse (Gerberich, 2019). Violence committed against healthcare workers is not limited to hospitals; it occurs in outpatient clinics, during patient transport, and in pharmacies.

Workplace violence is expensive—in addition to treating physical injuries (e.g., concussions and lacerations), there are costs associated with the negative mental health effects survivors may experience (e.g., missing work, taking time off to seek behavioral health care). Incidents can also lead to staff turnover in a field that is already strapped for human resources; one study found 30% of healthcare workers who had experienced workplace violence had thoughts about leaving their job or career.

Patients and visitors often bring weapons to healthcare facilities, presenting another daily challenge. In an interview, Dr. Tom Mihaljevic, President and CEO of Cleveland Clinic, indicated that in 2018, the system—which has been using metal detectors since 2016—"confiscated a staggering 30,000 weapons from patients and visitors in its system in the Northeast Ohio region" (Coutré, 2019).

Active Shooter Incidents

The Federal Bureau of Investigation (FBI) reports that there were a total of 277 active shooter incidents in the U.S. between 2000 and 2018, resulting in 884 deaths and 1,546 wounded. Twelve of these incidents took place in healthcare facilities (two in 2018), resulting in 25 fatalities (including three law enforcement officers) and 30 wounded (including 8 officers).

Kelen et al. (2012) identified 154 hospital-related (i.e., inside the hospital and on the grounds) shootings between 2000-2011. Reasons for the shooting ranged from settling a "grudge" (27%), attempting suicide (21%), "euthanizing an ill relative" (14%), and prisoner escape (11%). Almost one third of these shootings took place in the ED area, followed by the parking lot and patient rooms. A subsequent study (Gao and Adashi, 2015) highlighted a generally consistent rise in active shooter incidents and emphasized the need for more research.

Workplace Violence: Definitions

The Joint Commission (2021), which evaluates and accredits healthcare organizations and programs in the U.S., defines workplace violence as "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."

OHSA 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 assaults and even homicide. It can affect and involve employees, clients, customers and visitors." OSHA defines "serious workplace violence" as an incident in which the victim needs time off to recover.

Related ASPR TRACIE Resources

Workplace Violence Topic Collection

Active Shooter and Explosives Topic Collection

Workplace Violence and Active Shooter Technical Assistance Responses

The FBI defines an active shooter as one or more individuals actively engaged in killing or attempting to kill people in a populated area.

COVID-19 and Violence Against Healthcare Workers

The vast majority of people appreciate and support healthcare workers, particularly since the COVID-19 pandemic began. More recently, however, healthcare workers have been targeted in person and online for a variety of reasons, including:

- Frustration with visitation policies that keep people from their sick loved ones

- Longer wait times contributing to irritated, ill patients

- Disbelief in the virus, vaccination, and treatment protocols

- Frustration with/refusal to comply with isolation protocols

- Anger at having alternate care/treatment/vaccination sites set up in communities

- The belief that healthcare workers are somehow spreading the virus

- Being perceived as pro-mask and pro-vaccine by those who do not support either strategy

Bullying (e.g., physical aggression, making offensive comments, and spreading rumors) is also considered a form of workplace violence (Kumari et al. 2020); risk is heightened in a competitive work environment with a relatively unsupportive administration.

Since 2020, healthcare workers have been under an inordinate amount of stress. In some circumstances, colleagues may face off at work; what may have been a simple disagreement before COVID-19 may now devolve into a physical altercation. Or, for some who work in healthcare, simply attending a school board meeting on mask mandates—as a parent, not an employee—can lead to a high-stress encounter, or worse. While the data accumulates, videos, social media, and anecdotal evidence demonstrate that "pandemic fatigue" is taking its toll on this country, and healthcare workers are often treated as scapegoats.

Risk Factors Associated with Violence

What risk factors are associated with violent encounters in a healthcare setting? In a recent Joint Commission "Sentinel Event Alert" on physical and verbal violence against healthcare workers, the authors reviewed the literature and lessons learned from past incidents, creating this list of risk factors:

- Patients with altered mental status associated with dementia, delirium, substance intoxication, or various forms of mental illness

- Patients in police custody (they cited a study that found these patients were involved in 29 % of ED shootings; 11 % occurred during escape attempts).

- Stressful conditions (e.g., long wait times, crowding, being given bad health-related news)

- Lack of policies and training related to de-escalation

- Gang activity

- Domestic disputes among patients or visitors

- The presence of weapons

- Inadequate on-site security and/or mental health personnel

- Understaffing (in general and during visiting hours)

- Staff working in isolation or in physical locations that do not have an escape route

- Poor environmental design (e.g., lighting and factors that affect visibility in hallways, rooms, parking lots and other areas)

Risk factors may vary by location. One study that examined violence against healthcare workers in the ED found that risk increased when there were no areas where people could go to de-escalate, no alarm systems, no workplace violence task forces, and when staff worked alone. Risk factors reported by home care aides include working with clients with dementia and working in homes with limited physical space. In skilled nursing facilities, patients with cognitive challenges and residents' "emotionally charged" visitors were more likely to be involved in incidents.

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- No access to emergency communication, such as a cell phone or call bell
- Unrestricted public access to hospital rooms and clinics
- Lack of access to community mental health care

Kumari et al ([2020](#)) added several factors to this list, categorizing them as:

- Patient related factors (e.g., unexpected/high cost of services, poor previous experience, and complex family relationship)
- Doctor related factors (e.g., being female, having less experience, being unable to deescalate)
- Organizational factors (e.g., psychiatric and ED, lack of security, lack of guidelines and protocol, discouragement in reporting)
- Societal factors (language/cultural barriers, lack of respect for authority, patient distrust, negative media image, and lack of policies).

Federal and State Legislation to Help Prevent and Respond to Workplace Violence

As of 2021, there were no OSHA standards specific to workplace violence. OSHA does highlight, however, the General Duty Clause of the Occupational Safety and Health Act of 1970 that requires employers to provide staff "a place of employment that is 'free from recognized hazards that are causing or are likely to cause death or serious physical harm'" ([OSHA, n.d.](#)).

The [Workplace Violence Prevention for Health Care and Social Service Workers Act](#) (H.R. 1195, 117th Congress) was passed by the House of Representatives in April 2021 and referred to the Senate Committee on Health, Education, Labor, and Pensions, where it awaits additional action. This bill was originally introduced in 2019 as [H.R. 1309](#) but failed to become law before the last congressional term ended.

If enacted, H.R. 1195 will require the U.S. Department of Labor to promulgate an occupational safety and health standard that requires covered entities to "develop and implement a comprehensive workplace violence prevention plan and carry out other activities or requirements… to protect health care workers, social service workers, and other personnel from workplace violence." An interim final standard would need to be issued "not later than 1 year" after enactment and be based on the [2015 OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers](#), at minimum. The final standard must be issued "not later than 42 months" after enactment and provide enforceable protections that are "no less" than any State workplace violence prevention standards. Covered entities would be required "to develop, implement, and maintain" a workplace violence prevention plan "not later than 6 months after the promulgation of the interim final rule." Annual employee training and reporting to the Secretary of Labor would also be mandated. The list of covered entities/services in H.R. 1195 is broad and includes:

- Any hospital, including any specialty hospital, in-patient or outpatient setting, or clinic operating within a hospital license, or any setting that provides outpatient services.
- Any residential treatment facility, including any nursing home, skilled nursing facility, hospice facility, and long-term care facility.
- Any non-residential treatment or service setting (e.g., home health care, home-based hospice, and home-based social work).

Related Legal Resources

American Nurses Association (2021). Workplace Violence.

Gonzalez, G. and Childers, A. (2019). States Lead the Way on Mitigating Workplace Violence in Health Care Settings. Business Insurance.

U.S. Congress. (2021.) H.R.1195 Workplace Violence Prevention for Health Care and Social Service Workers Act.

U.S. Congress. (2019). H.R. 1309 Workplace Violence Prevention for Health Care and Social Service Workers Act.

U.S. Department of Labor, Occupational Safety and Health Agency. (2015). Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.

U.S. Department of Labor, Occupational Safety and Health Agency. (n.d.). OSH Act of 1970.

U.S. Department of Labor, Occupational Safety and Health Agency. (2015). Workplace Violence Prevention and Related Goals.

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- Any medical treatment or social service setting or clinic at a correctional or detention facility.

- Any community care setting, including a community-based residential facility, group home, and mental health clinic.

- Any psychiatric treatment facility.

- Any drug abuse or substance use disorder treatment center.

- Any independent freestanding emergency centers.

- Any emergency services and transport, including such services provided by firefighters and emergency responders.

According to an analysis by the American Nurses Association, many states have established penalties for assaulting healthcare workers, though some only apply to certain settings or types of healthcare workers. As of 2021, only a small subset of states (n=9) across the U.S. have enacted legislation requiring employers to develop formal programs to prevent and/or report workplace violence in healthcare facilities. Eight of 9 states require the program to be based on a risk assessment, and for staff to receive training on the Workplace Violence Prevention plan/program. State requirements vary widely, and the laws do not include the same level of specificity and detail against which compliance may be assessed. Where specific standards for workplace hazards are lacking, the Occupational Safety and Health Act's General Duty Clause is often used to cite employers for violations (Gonzalez and Childers, 2019). Although only a few states have legislation requiring Workplace Violence Prevention plans/programs, 26 states, Puerto Rico, and the U.S. Virgin Islands had OSHA-approved State Plans as of 2015. Such plans must be "at least as effective" as Section 18(c) of the OSH Act of 1970.

Policies and Protocols to Help Prevent and Respond to Workplace Violence

The Joint Commission

The Joint Commission is updating and adding new workplace violence requirements (which all accredited hospitals and critical access hospitals must comply with) in January 2022. They recently published the Workplace Violence Prevention Compendium, which includes links to resources (authored by federal agencies and medical organizations) designed to help healthcare organizations create/update related policies and programs to ensure they are in compliance with these requirements.

This Joint Commission webpage shares how five healthcare organizations address workplace violence.

Select Policies and Protocols

In the 2019 article 6 Steps to Manage Violence Against Hospital Healthcare Workers, the author described strategies for protecting staff and patients and encouraging the reporting of violent incidents:

1. Know your jurisdiction/applicable laws in the state; many have specific laws that call for enhanced criminal penalties when a healthcare worker is assaulted (similar to assaults on first responders).

2. Set policies and protocols—make them consistent and include policy for investigating incidents. Focus on de-escalation. Disseminate widely.

3. Require employees to report workplace violence and assure them that they will not face retaliation for doing so.

4. Investigate violent incidents. Create emergency response teams (which would include representatives from human resources, legal, and security) to respond to these types of issues and decide next steps (e.g., press charges).

5. Enforce your policies.

6. Press charges. Sarah Swank of the American Health Lawyers Association was quoted in the article as saying, "A hospital can support its employees. For example, if there has been an assault and an employee has pressed charges, the hospital can provide information as part of the charges, or the employee can be given time off from work to testify in the criminal case."

In 2020, the Healthcare in Danger team from the International Committee of the Red Cross published a checklist that aligns these steps with a hospital's COVID-19 response. Their specific recommendations include:

- Support healthcare workers with high exposure to stress and violence.

- Assess the risks and implement preparedness measures.

- Understand and promote the rights and responsibilities of staff to provide respectful and ethical care.

- Engage, listen, and communicate with the public.

- Coordinate with security forces and other services.

- Document and monitor violent incidents.

Threat Assessment Teams and Protocols

Threat assessment teams (comprised of healthcare security, hospitalists, social workers, risk management, and nursing administration) can meet regularly to create/update "threat assessment protocols" (TAPs). These forms (e.g., the Violence Reduction Protocol Treatment Plan and the Brøset Violence Checklist) allow healthcare and security staff to track patients who may become violent, potentially "scoring" them based on variables such as negative behavior observed by staff, criminal background, medical history, and previous history with the healthcare facility.

Strategies for Reducing Risk

While preventing workplace violence incidents is ideal, a supportive leadership team and respectful environment combined with training staff how to recognize threats and respond appropriately is equally important. Healthcare facilities have implemented several strategies to minimize the threat, including remote access control technology (allowing staff to remotely activate locks, alarms, and sensors); panic buttons close to where ED staff conduct initial check in; badge access for staff; limiting visitor hours; using metal detectors/ wands on patients and visitors; placing security cameras in key areas; and offering training in de-escalation, self-defense, and other related topics.

> *Social media has increasingly been used as a platform for personal attacks on healthcare workers. The IMPACT social media harassment toolkit was created by a health advocacy group and includes links to related resources on recognizing, preventing, and reacting to online abuse.*

Apps and Panic Buttons

Coutré (2019) describes an app created with support of leadership at University Hospitals (Ohio)—it includes a mobile panic button; a system for reporting suspicious behavior; and a feature that allows users to set a timer that measures the time it takes to walk to the car (or home or next mode of transportation)—if the user does not enter a PIN into the app within that set time, the app will ask the user for confirmation and if none is received, the app will alert a designated person/security. One hospital is planning to issue staff personal panic buttons after assaults by patients increased by 21% in 2020.

De-escalation and Self-Defense Training

De-escalation training is also gaining in popularity, as ED staff find themselves having to manage patients and visitors who may be aggressive, violent, and/or experiencing severe stress. In this short video, Dr. Scott Zeller demonstrates how to speak with an agitated patient to reassure and comfort him. He also compares the level of time and other resources needed to de-escalate versus restrain (and sedate) a patient, highlighting that many assaults could be avoided by using de-escalation techniques. The Joint Commission (2021) encourages leadership to ensure that all staff be trained in escalation and self-defense, citing OSHA's 2015 guidance that training include a hands-on component.

Crime Prevention through Environmental Design

Another strategy being implemented in hospitals around the country is rethinking the design of EDs and reception areas. Jon Huddy, an architect who has helped design EDs for years lists the following considerations for "walk-in/public areas, [emergency medical systems] EMS entry points, forensic patients, general emergency department care areas, and behavioral health patients" (Huddy, 2016):

> *Check out the ASPR TRACIE 2021 article based on an interview with John Huddy for more information.*

- Ensure security staff are both visible and active.

- Use metal detectors (x-ray machines or wands, which are smaller and efficient), and make room for related equipment and more in-depth searches. Try to reduce lines/improve visibility.

- Harden reception desks or build new ones with increased security features (e.g., slope them so they are difficult to climb over, place staggered glass panes between visitors and staff that are impossible to climb between). No "islands" in this area—no one should be able to walk behind desk.

- Add security to EMS entrance as volume dictates. Consider having a substation in the ED.

- Consider separate, secure entrance for "forensic patients" (defined as "prisoners and jail inmates who are brought to the emergency department for evidence collection") and those in custody requiring care.

- Ensure multiple ingress and egress options and staff awareness of options.

- Considerations for patients with behavioral health issues/areas where they are treated: if doors that lead to patient rooms swing, make sure they swing in both directions. Consider placing a de-escalation room near entrances. Ensure related equipment is available and visual supervision is possible.

Active Shooter Challenges and Strategies Specific to Healthcare Facilities

In 2017, the International Association of Emergency Medical Services Chiefs published the report Active Shooter Planning and Response in a Healthcare Setting. In this report, they list specific challenges active shooter incidents pose in a healthcare setting:

- A possibly large, vulnerable patient population that may be unable to flee

- The presence of hazardous materials (e.g., patients with infectious disease, heavy/sharp instruments

- Powerful magnets used in magnetic resonance imaging machines, which could remove firearms from the hands of law enforcement

Though healthcare providers are encouraged to follow the "Run, Hide, Fight" directive whenever possible, Inaba et al. presented the "Secure, Preserve, Fight" strategy in their 2018 article, taking into account the need for facilities to continue providing care for those patients who cannot be moved or for whom discontinuing care could have dire health effects.

As part of this strategy, the authors emphasize the need for a hospital-based active shooter plan that identifies and secures "essential patient care areas where lifesaving treatment is provided." They also describe methods for securing doors that lead into these areas and the need to stock the areas with "kits containing essential supplies for hemorrhage control." Inaba et al. refer to bleeding control as a "high-yield target for educational initiatives," and encourage healthcare facilities to train medical and support staff. The three steps are:

- **Secure.** Immediately safeguard the aforementioned areas and barricade entrances. Dim or switch off nonessential lights and silence communication devices.

- **Preserve** (the life of the patient and the provider). In this instance, the focus is on preserving patient lives, to include moving them to a sheltered area while continuing to provide just the most essential care. Healthcare workers should also preserve their own safety by fleeing or hiding when they are under immediate threat.

- **Fight** (last resort, only if necessary).

The authors also discuss the importance of having communication signals (that announce the threat and when it has been neutralized); a method for notifying patients' loved ones of their status; and a plan for "attending to the psychological first aid needs of the patients, family, visitors, and health care workers that were present."

Collaborating with Security to Prevent Workplace Violence

Whether security is provided by a private firm or local law enforcement, having a collaborative relationship is key to preventing, and identifying, responding, and recovering from workplace violence incidents. The Minnesota Hospital Association, Department of Health, and Sheriff's Association developed the Health Care and Law Enforcement Collaboration Roadmap that stresses the benefit of interdisciplinary safety teams and communications and security plans. Laid out like a checklist, this resource includes links to related resources that can help healthcare facilities create and follow their own maps.

As previously mentioned, creating a multidisciplinary threat assessment team can ensure a more coordinated approach. Staff who specialize in behavioral health, facility security personnel, front-line supervisors, and legal and labor union representatives can work "to create a culture of reporting in order to best detect threats" (Henkel, 2020). Together, they

can assess the threat and determine next steps (management and mitigation), done by level of threat (low, moderate, and high), concluding with ongoing case management (ibid).

The response to active shooter incidents changed after the Columbine High School shooting in 1999 and rescue task forces—where law enforcement immediately pursue and establish contact with and neutralize the shooter instead of waiting for a special weapons and tactics team to arrive—has become the preferred response strategy for many (Iselin, 2009).

Hospitals must have a plan for an active shooter incident that addresses expectations of on-site security (engage vs. track/confine) based upon their capabilities. The plan must also address questions related to the role of responding law enforcement, such as, would on-site security escort the teams and help them navigate to the affected area? How would law enforcement gain access to camera feeds? Maps can help, but in the moment, responding officers will likely need an escort to help them navigate as they are unlikely to know the facility layout very well. Planning and exercising together may help address these and other issues in advance.

Patient care units should have their own response plans that address actions to take to protect the unit, patients, and staff. "Safe" rooms should have a visual (but nonspecific) indicator on the door to assist staff in finding a lockable room. Exit routes should be easily recognized and staff should know the next closest unit that has controlled access.

The threat of workplace violence in its many forms is all too real. There are many mitigation and preparedness strategies that can reduce the chances of an incident and its impact. The information, education, and infrastructure/systems for notification and staff protection strategies highlighted in this article can help staff be safer at work.