

Reporting Incidents of Workplace Violence

Effective Date: 2019

Overview

The rate of violence against health care workers has reached epidemic proportions. According to a 2012 report by the U.S. Government Accountability Office (GAO), health care workers in inpatient facilities experienced workplace violence-related injuries requiring days off from work at a rate at least five to 12 times higher than the rate of private-sector workers overall.ⁱ This type of violence includes incidences of violence against registered nurses (RNs) by patients, patients' family members and external individuals, and it includes physical, sexual and psychological assaults.

Workplace violence has a demonstrable negative impact on the nursing profession and the overall health care field.ⁱⁱ Multiple studies have shown that workplace violence – including other forms such as bullying and incivility as perpetrated by coworkers or supervisors – can adversely affect the quality of patient care and care outcomes,ⁱⁱⁱ contribute to the development of psychological conditions,^{iv} and reduce the RN's level of job satisfaction and organizational commitment.^{v, vi}

Moreover, the full scope of the problem is not fully known. As the GAO report noted, "Health care workers may not always report such incidents, and there is limited research on the issue, among other reasons." In fact, research has variously found that only 20 to 60 percent of nurses report incidents of violence.^{vii, viii, ix}

That being said, in order to address a problem, building on the ANA position statement on incivility, bullying and workplace violence (ANA, 2015), one must first understand its full scope. Therefore, in addressing workplace violence against health care workers, RNs in particular, the reasons for underreporting incidents of violence must be identified and addressed. Because workplace violence events are difficult to substantiate with physical evidence, a systematic reporting mechanism is warranted.

Barriers to Reporting

The literature identifies various barriers to reporting incidences of workplace violence. These barriers impact the ability not only of RNs but also of health care workers in general to report incidences of workplace violence and to address their root causes. They include the following:

- A health care culture that considers workplace violence part of the job.^x
- A perception that violent incidents are routine.^{xi}
- A lack of agreement on definitions of violence; e.g., does it include verbal harassment?^{xii}

- Fear of being accused of inadequate performance or of being blamed for the incident, and fear of retaliation by the offender and or employer.^{xiii}
- Lack of awareness of the reporting system.^{xiv}
- A belief that reporting will not change the current systems or decrease the potential for future incidents of violence.^{xv}
- A belief that the incident was not serious enough to report.^{xvi}
- A practice of not reporting unintentional violence, e.g., incidents involving Alzheimer’s patients.^{xvii}
- Lack of manager and employer support.^{xviii}
- Lack of training related to reporting and managing workplace violence.
- A fear of reporting supervisory workplace violence.^{xix}

These barriers together create significant disincentives for RNs to report incidents of workplace violence. Removing these barriers requires a multifront strategy and the buy-in of both RNs and their employers.

Creating a Culture That Supports Reporting

The ANA has long supported voluntary reporting of events, near misses and unsafe conditions through position statements like the one from 2010, “Just Culture.”^{xx} In 2016, the ANA called for a “culture of safety” as the National Nurses Week theme. In the 2016 press release for National Nurses Week, Pamela M. Cipriano, PhD, RN, NEA-BC, FAAN explicitly tied worker safety and a culture of safety together when she described a culture of safety as one in which “injuries to nurses and other health care professionals should not be tolerated as just ‘part of the job.’”^{xxi} Nurses are not alone in creating a culture of safety; leaders and managers from across the health care industry are called upon to take action in creating a culture of safety. In 2017, the American College of Healthcare Executives and the IHI/NPSF Lucian Leape Institute created a document, “Leading a Culture of Safety: A Blueprint for Success,” calling on health care executives to place safety as a “core value that is fully embedded throughout our organizations and our industry.”^{xxii}

The introduction states:

“By prioritizing, developing, and sustaining an organizational culture focused on safety, we can drive the future of healthcare to a place where patients and those who care for them are free from harm. It is not only one of many priorities, but is the overriding ethical imperative for all leaders.”^{xxiii}

It is important as we move forward that we view nurse safety as part of the broader work of creating a culture of safety and recognize that there is support from the highest levels to address the cultural barriers listed above.

Reporting Process

It bears noting that there is no standardized process or regulatory requirement – except for a few states (n=9) that enacted workplace violence prevention and management legislation for health care workers to report incidents of violence in the U.S. – much less a central repository to report them to (as seen in national health systems, e.g., in the U.K.^{xxiv} and Australia^{xxv}). Therefore, a health care worker who experiences an incident of violence must follow the policies and procedures of his or her particular health care facility.

This leads to a fragmented system where incidents of violence are reported differently at each health care facility and are not reported to any outside entity, limiting the ability of researchers to properly understand the scope and nature of the problem.

The Joint Commission considers assault a “sentinel event.” However, sentinel event reports are voluntary on the part of health care facilities, and this particular sentinel event appears to be vastly underreported; only 256 incidents were reported from 1995 to 2010.^{xxvi} In comparison, the Department of Labor estimated in 2011 that there are 22,250 to 80,710 incidents of violence against health care workers each year.^{xxvii}

In 2016, the Occupational Safety and Health Administration (OSHA) requested information from health care stakeholders on issues that might be considered in developing a regulation addressing workplace violence in health care settings. ANA submitted a comment letter to OSHA noting its support for a unified OSHA standard for workplace violence prevention programs. To date, there has been no movement on comments submitted in response to the request for information. “A 2014 update to OSHA’s recordkeeping regulation requires all employers, including those in partially exempt industries, to report any work-related fatality to OSHA within eight hours of learning of the incident. The revised regulation also requires all employers to report work-related inpatient hospitalizations, amputations, and losses of an eye to OSHA within 24 hours of learning of the incident.” (OSHA, 2015, p.7) These events can be reported to OSHA in person, by phone or by using the reporting application on OSHA’s public website at <https://www.osha.gov/recordkeeping/>.^{xxviii}

ANA Zero Tolerance Policy on Workplace Violence

The 2015 ANA position statement “Incivility, Bullying, and Workplace Violence” professes a zero-tolerance policy on violence of any kind:

All RNs and employers in all settings, including practice, academia, and research, must collaborate to create a culture of respect that is free of incivility, bullying, and workplace violence. Evidenced-based best practices must be implemented to prevent and mitigate incivility, bullying, and workplace violence; to promote the health, safety, and wellness of RNs; and to ensure optimal outcomes across the healthcare continuum.

ANA also recognizes the contribution of other health care professions and notes that this position statement is relevant to other health care professionals and stakeholders who collaborate to create and sustain a safe and healthy interprofessional work environment.^{xxix}

In order to adequately address the issue of workplace violence, it is critical that nurses, other health care professionals and their employers shift the professional and workplace culture to adopt a mindset of zero tolerance toward workplace violence. Ambiguity on what constitutes workplace violence has proven to be a major impediment to reporting such incidents; a uniform zero-tolerance policy diminishes those barriers and ensures that employees report all incidents. Only by following such a paradigm shift can nurses and employers begin to make impactful and long-lasting steps to reduce and ultimately end these incidences of workplace violence.

Recommendations

ANA recommends a multifaceted strategy to combat the significant issue of workplace violence. The first component of this strategy is promoting and instilling a culture of zero tolerance toward workplace violence. This shift must be officially stated in all health care workplace policies and procedures. No workplace should tolerate any type of violence against health care workers, including RNs.

To this end, ANA recommends that OSHA establish a unified standard for employers in health care and social assistance settings to mitigate the frequency and severity of workplace violence; ANA in April 2017 submitted a comment letter to OSHA on just such a standard. Any OSHA standard to protect health care and social assistance employees from workplace violence requires an ongoing commitment on behalf of both RNs and employers to create a safe and trustworthy environment in order to promote and create a culture of health and safety.

Understanding the three levels of prevention helps us focus on specific standards and competencies needed to be instituted to prevent workplace violence.^{xxx} The standard could focus on the following:

- I) **Primary Prevention: Stopping violence before it occurs.^{xxxi} Develop education and other strategies to identify risks, increase buffers and reduce vulnerabilities in order to prevent workplace violence:**
 - a. *Employee Strategies:* Active participation in the development of the workplace violence prevention program; active participation in the education of organizational workplace violence prevention policies; a general emphasis on using situational awareness in order to anticipate, prevent and respond in crisis situations; awareness and knowledge of environmental controls; incorporation of health and wellness strategies; and openness to constructive feedback.
 - b. *Employer Strategies:* Ongoing leadership commitment, a supportive and nonpunitive work environment, the development of a comprehensive workplace violence prevention program aligned with OSHA's 2015 guidelines, the use of thorough background checks on potential employees, and optimal staffing levels.
- II) **Secondary Prevention: Immediate and effective response to violence, including emergency care. Intervention intended to address emergent short-term consequences and reduce the negative impact of workplace violence^{xxxii}:**
 - a. *Employee Strategies:* Participation in the implementation of a comprehensive workplace violence program, the use of crisis intervention and management strategies, the use of existing administrative and environmental controls and of an approved reporting system, and the reporting of any concerns regarding weaknesses in the system.
 - b. *Employer Strategies:* Continual data collection and analysis for use in quality management, sustained conformance to areas of improvement, the identification of strengths and weaknesses in the program, serious treatment and investigation of all reported cases of workplace violence, and the review by an interprofessional team of each reported episode.
- III) **Tertiary Prevention: Long-term responses to violence. Intervention intended to reduce the long-term negative and rehabilitation consequences of workplace violence^{xxxiii}:**
 - a. *Employee Strategies:* Engagement in evaluation and improvement of the workplace violence prevention program, participation in post-incident meetings and debriefing, the use of

counseling programs and EAP resources after a workplace violence incident, referral of others to grief counseling or other health services when appropriate, and the expression of sympathy and support following an incident.

- b. *Employer Strategies:* Evaluation and improvement of the program, acknowledgment of injury or loss following an incident, arrangement of immediate coverage if an RN needs to leave work following an incident, provision of ongoing support to facilitate the return to work for employees involved in an incident, provision of grief and bereavement counseling to others when appropriate, and the conduction of a root cause analysis following an incident.

ANA strongly recommends that in addition to a standard to prevent workplace violence, OSHA and other stakeholders – including accrediting bodies, federal and state regulatory agencies, and trade associations – work toward creating an electronic database through which employees can anonymously report incidents of workplace violence as well as processes and guidelines by which employees might disclose these events. Lack of reporting is one of the biggest barriers to making progress toward reducing incidents of workplace violence and capturing actual incidences. Empowering RNs to report these incidents in a streamlined electronic database would represent a major step toward achieving the goal of eliminating workplace violence. Also, nursing prelicensure programs should prepare student nurses to identify and manage workplace violence exposure.

It is abundantly clear that workplace violence in health care and social assistance settings is a problem in search of a solution. Fortunately, as laid out in this issue brief, solutions are lying in plain sight. RNs and their employers together must first drive toward achieving a paradigm shift in the way that health care workers view workplace violence; rather than thinking of workplace violence as a fait accompli, they must adopt a zero-tolerance policy toward it and take steps to prevent it.

Federal and state lawmakers and officials must also develop – with RN input – a unified standard for workplace violence prevention programs with an emphasis on full buy-in from employees and employers. Finally, federal and state stakeholders must work to create a unified, electronic reporting database in order to encourage RNs and other health care workers to report incidents of workplace violence without fear of reprisal. How about state-level workplace prevention and management laws?

It is critical that RNs, other health care workers and their employers be engaged in the development, implementation and improvement of workplace violence prevention programs and appropriately respond to its aftermath. The level of engagement by both employee and employer is critical to the success of any workplace violence prevention program. Only by following these steps can RNs finally begin to tackle the issue of workplace violence.

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ⁱ U.S. Government Accountability Office. *Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence*. 10. Web: <http://www.gao.gov/assets/680/675858.pdf>.

ⁱⁱ Spector, P. E., Zhou, Z. E., & Che, X. X. (2013). *Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review*. *International Journal of Nursing Studies*, 51(1): 72-84. doi: 10.1016/j.ijnurstu.2013.01.010.

ⁱⁱⁱ Roche, M., Diers, D., Duffield, C., & Catling-Paull, C. (2010). *Violence toward nurses, the work environment, and patient outcomes*. *Journal of Nursing Scholarship*, 42(1): 13-22. doi: 10.1111/j.1547-5069.2009.01321.x.

^{iv} Demir, D., & Rodwell, J. (2012). *Psychosocial antecedents and consequences of workplace aggression for hospital nurses*. *Journal of Nursing Scholarship*, 44(4): 376-384. doi: 10.1111/j.1547-5069.2012.01472.x.

^v Rodwell, J., Brunetto, Y., Demir, D., Shacklock, K., & Farr-Wharton, R. (2014). *Abusive supervision and links to nurse intentions to quit*. *Journal of Nursing Scholarship*, 46(5): 357-365. doi: 10.1111/jnu.12089.

^{vi} Smith, L. M., Andrusyszyn, M. A., & Spence Laschinger, H. K. (2010). *Effects of workplace incivility and empowerment on newly graduated nurses' organizational commitment*. *Journal of Nursing Management*, 18(8): 1004-1015. doi: 10.1111/j.1365-2834.2010.01165.x.

^{vii} Phillips, J.P. *Workplace Violence against Health Care Workers in the United States*. *New England Journal of Medicine*, 374(17), 1661-1669. doi: 10.1056/NEJMr1501998.

^{viii} Chojnacka, I. and Ferns, T. *Reporting incidents of violence and aggression towards NHS staff*. *Nursing Standard*, 19(38), 51-56. doi: 10.7748/ns2005.06.19.38.51.c3881.

^{ix} Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H., Nachreiner, N. M., Geisser, M. S., ... & Jurek, A. (2005). *Risk factors for work-related assaults on nurses*. *Epidemiology*, 16(5), 704-709. doi:10.1097/01.ede.0000164556.14509.a3.

^x McPhaul, K., Lipscomb, J. (2004). *Workplace violence in health care: Recognized but not regulated*. *Online Journal of Issues in Nursing*, 9(3): Manuscript 6. Web: <http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No3Sept04/ViolenceinHealthCare.aspx>

^{xi} Cembrowitz, S.P. and Shepherd, J.P. *Violence in the Accident and Emergency Department*. *Medicine, Science, and the Law*, 32(2): 118-122. doi: 10.1177/106002809203200205.

^{xii} Kozłowska, K., Nunn, K., & Cousens, P. (1998). *Adverse experiences in psychiatric training. Part 2*. *Occupational Health and Industrial Medicine*, 3(38), 124.

^{xiii} Beale, D., Leather, P., Cox, T., & Fletcher, B. (1999). *Managing violence and aggression towards NHS staff working in the community*. *Journal of Research in Nursing*, 4(2), 87-100. doi: 10.1177/136140969900400203.

^{xiv} Findorff, M., McGovern, P., Wall, M., & Gerberich, S. *Reporting violence to a health care employer: A cross-sectional study*. *AAOHN Journal*, 53(9), 399-406. doi: 10.1177/216507990505300906.

^{xv} Gournay, K. (2001). *Mental Health Nursing in 2001: What happens next?* *Journal of Psychiatric and Mental Health Nursing*, 8(6): 473-476. doi: 10.1046/j.1351-0126.2001.00460.x.

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- ^{xvi} Lynch, J., Appelboam, R., & McQuillan, P. J. (2003). Survey of abuse and violence by patients and relatives towards intensive care staff. *Journal of the Association of Anesthetists of Great Britain and Ireland*, 58(9), 893-899. doi: 10.1046/j.1365-2044.2003.03338.x.
- ^{xvii} Pulsford, D. and Duxbury, J. Aggressive behavior by people with dementia in residential care settings: A review. *Journal of Psychiatric and Mental Health Nursing*, 13(5), 611-618. doi: 10.1111/j.1365-2850.2006.00964.x.
- ^{xviii} Privitera, M., Weisman, R., Cerulli, C., Tu X., Groman A. Violence toward mental health staff and safety in the work environment. *Occupational Medicine*, 55(6), 480-6. doi: 10.1093/occmed/kqi110
- ^{xix} Tepper, B. J. (2007). Abusive supervision in work organizations: Review, synthesis, and research agenda. *Journal of Management*, 33(3), 261-289. doi.org/10.1177/0149206307300812
- ^{xx} American Nurses Association. (2010). *Just culture* [position statement]. Retrieved from https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf
- ^{xxi} American Nurses Association. (2016). *American Nurses Association calls for a culture of safety in all health care settings* [Press release]. Retrieved from <https://www.nursingworld.org/news/news-releases/2016/american-nurses-association-calls-for-a-culture-of-safety-in-all-health-care-settings/>
- ^{xxii} American College of Healthcare Executives and NPSF Lucian Leape Institute. (2017). *Leading a culture of safety: A blueprint for success*. Chicago, IL: American College of Healthcare Executives. Retrieved from https://www.osha.gov/shpguidelines/docs/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf
- ^{xxiii} American College of Healthcare Executives and NPSF Lucian Leape Institute. (2017). *Leading a culture of safety: A blueprint for success*. Chicago, IL: American College of Healthcare Executives. Retrieved from https://www.osha.gov/shpguidelines/docs/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf
- ^{xxiv} Roche, M., Diers, D., Duffield, C., & Catling-Paull, C. (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), 13-22.
- ^{xxv} Hughes, Zoe. *Nurses and Violence in the Workplace*. Ausmed: August 2017. Retrieved from <https://www.ausmed.com/articles/nurses-and-violence-in-the-workplace/>
- ^{xxvi} The Joint Commission. (2010). *Preventing violence in the health care setting*. Sentinel Event Alert, Issue 45. Web: https://www.jointcommission.org/assets/1/18/SEA_45.PDF
- ^{xxvii} U.S. Government Accountability Office. (2016). *Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence*. Retrieved from <https://www.gao.gov/products/GAO-16-11>
- ^{xxviii} Occupational Safety and Health Administration (OSHA). 2015. Retrieved from <https://www.osha.gov/Publications/OSHA3827.pdf>
- ^{xxix} American Nurses Association. *Position Statement on Incivility, Bullying, and Workplace Violence*. 2015. Web: <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-WorkplaceViolence/Incivility-Bullying-and-Workplace-Violence.html>.
- ^{xxx} Centers for Disease Control and Prevention (CDC) (2017). Preventing intimate partner violence across the lifespan. Atlanta, GA: Retrieved from <https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf>
- ^{xxxi} Constantino, R.E. & Privitera, MR (2011). Prevention terminology: Primary, secondary, tertiary, and an evolution of terms. In MR Privitera, *Workplace Violence in Mental Health and General Healthcare Settings*. Boston: Jones and Bartlett Publishers.
- ^{xxxii} Constantino, R.E. & Privitera, MR (2011). Prevention terminology: Primary, secondary, tertiary, and an evolution of terms. In MR Privitera, *Workplace Violence in Mental Health and General Healthcare Settings*. Boston: Jones and Bartlett Publishers.
- ^{xxxiii} Privitera, M.R. & Arnetz, J (2011). Effect of workplace violence on staff, Institution, and quality of patient care. In MR Privitera, *Workplace Violence in Mental Health and General Healthcare Settings*. Boston: Jones and Bartlett Publishers.