

“Violence in the Health Care Sector Workplace:  
How Broken Windows Can Be Mended”

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## **1. Introduction**

Workplace violence has existed since the first merchant or doctor interacted with the first customer or patient. Dr. Nicogossian defines violence as “Verbal or physical threat or assault perpetrated against co-workers, family members, companions, or oneself” (Nicogossian 2005). Despite its historical existence, many believe it has grown to health-impacting proportions and should, on behalf of worker health and safety, be curtailed. The Broken Windows theory, discussed in a later section of this paper, borrowed from criminal justice philosophy, begins to apply prevention concepts to the ubiquitous workplace violence. This paper reviews the current body of literature on a certain population of victims at risk of workplace violence occurrence—health care workers—and proposes several key issues that are necessary to consider when creating a plan to prevent an increase in the incidence of workplace violence in the health care sector.

### **1.1 Violence: Part of Our Culture or Epidemic?**

Each year, over 1.6 million people die as a result of violence (Nicogossian 2005). Dr. Nicogossian attributes violence in part to disparities with respect to literacy, technology, health, social/economic/political status, infrastructure, and access to health, education, food, living conditions, etc as well as divides such as gender, race, age, sex, ethnicity, environment, social status, education, and occupation. He quotes Merck Medicus: “Interpersonal violence, as victim or as perpetrator, is now a more prevalent health risk than infectious disease, cancer, or congenital disorders for children,

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adolescents, and young adults.” Violence is clearly an epidemic of national importance in the United States.

### **1.2 Media as Promoter of Violence**

When images of the attack on the World Trade Center towers and Pentagon were repeatedly displayed after 9/11 in media such as television and newspapers, Americans were repeatedly exposed to an incredibly violent crime scene. In this way, the American media assisted the terrorists in exposing all Americans to the violence; not only were the direct victims affected by violence but all Americans were victimized. “Studies [of] real life disasters & bioevents have demonstrated that anyone even remotely connected with the event may suffer psychological trauma” (Weinstein 2005). In his presentation, Dr. Weinstein lists the results of a survey of adults showing symptoms of post traumatic stress disorder, depression and anxiety (6-8 weeks after 9/11) that shows remote victims to be more likely to be affected than proximal or direct victims due to the prolonged exposure to violence.

“Manhattan residents – 17.2%

WTC responders – 59%

All U.S. adults – 61%”

(Weinstein 2005).

The higher percentage of US adults remotely psychologically affected by the terrorist violence was said to be due in part to the outpouring of aid and sympathy across the country as well as to repeated and prolonged exposure; the media promoted a lack of closure.

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The media also is a promoter of violence in entertainment. Cinematic productions rarely exclude violent concepts even if they avoid the images of actions. Dr. Nicogossian points to the history of violent jousting, dueling, and other ‘sports’ in human culture as a predecessor to football, soccer, boxing, wrestling, hockey and basketball—all lucrative industries in the United States (Nicogossian 2005). Dr. Nicogossian further reports that 61% of surveyed television programming portrayed interpersonal violence with the highest proportion found in programming targeted toward children. Video and computer games are also prevalent sources of violence in entertainment. “Research has associated exposure to media violence with a variety of physical and mental health problems for children and adolescents, including aggressive behavior, desensitization to violence, fear, depression, nightmares, and sleep disturbances” (Nicogossian 2005). It is this exposure to and desensitization to violence that initiates violent behavior in the victim. “Bullying or being bullied was associated with each of four violent behaviors—carrying a weapon, carrying a weapon in school, frequent fighting, and being injured in a fight” (Nicogossian 2005). Thus, American media is a promoter and perpetuator of violence.

### **1.3 Violence in the Workplace**

Violence in the workplace is a health problem (Nicogossian 2004) and is the business of health, security and safety (Nicogossian 2005). Dr. Nicogossian states that workplace violence is not solely a criminal issue but affects individuals at work and home. It has social, political and economic implications that range from regional to global and consequences that are “economic, emotional, psychological, physical and societal.” It has a \$36 billion impact in the United States alone. The hostility of work environments range from low (with verbal or sexual harassment, shunning, bullying,

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profiling, and discriminating) and moderate (improper behavior, domestic violence, sexual assault, stalking, physical harassment, mobbing) to high (rape, assault and mobbing) and extreme (homicide and terrorism). If the violence is not remediated effectively, the hostile environment can become an established pattern at work (Nicogossian 2005). Dr. Nicogossian lists the occupations at higher risk to be health care workers, correctional and law enforcement officers, social services employees, teachers, municipal housing inspectors, public works employees, and retail employees.”

**1.4 Statement of Purpose: Broken Windows in the Health Care Sector**

The health care industry has experienced especially high rates of violence. Data on nonfatal assaults that caused lost time from work, collected by the Bureau of Labor Statistics in 1997, revealed the following: “1. The assailant was a health care patient 45% of the time. 2. Fifty-four percent of the victims were women. 3. In 47% of the cases, the attack involved hitting, kicking, and beating. 4. Of nonfatal assaults, 27% occurred in nursing homes, 13% in social services settings, and 11% in hospitals” (Rosen 2001). I chose to focus on the health care environment as a significant setting of workplace violence. It is not the most common or fatal forms of violence that occurs in the health care sector workplace, but a more unobtrusive, ubiquitous, but insidious form of violence (like broken windows in a community). The negative impacts of workplace violence in health care are not only physical and financial but include psychological effects like “stress reactions; poorer general health, anxiety, depression, psychosomatic symptoms, isolation, loneliness, deterioration of relationships, concentration problems, impaired problem-solving capacity, reduced self-confidence, diminished work satisfaction, fear reactions, and post-traumatic stress” (Beech and Leather 2005).

## **2. Violence in Health Care**

The health care worker is exposed to many health risks. In the process of responding to and caring for victims of disease outbreaks, accidents, criminal activity, and natural disasters, health care workers expose themselves to infectious pathogens, hazardous materials, even the hot zone or disaster site itself—particularly applicable to first responders like emergency medical technicians. With so many potential physiology-altering items in a hospital (needles, medications, IVs, surgical equipment, etc), accidental injury is a significant risk. One hazard which ought to be the least of these is workplace violence. But workplace violence is a hazard, and its incidence is ever increasing. A “2000–2001 Department of Health national survey revealed 84,214 reported incidents of violence, an increase of 30% over 1998–1999” and a survey by the National Audit Office of the year 2001-2002 “showed a further 13% increase to 95,501 reported incidents and significant variation across regions of the country” (Beech and Leather 2005). With the rate of underreporting estimated to be 39%, it is still “generally accepted that the number of incidents of workplace violence, whether in health care or elsewhere, is increasing” (Beech and Leather 2005). According to a brochure produced by the Department of Health and Human Services (DHHS) Centers for Disease Control and Prevention (CDC) National Institute for Occupational Health and Safety (NIOSH), more than 5 million individuals performing various roles work at hospitals and are exposed to a variety of health and safety hazards.

“Recent data indicate that hospital workers are at high risk for experiencing violence in the workplace. According to estimates of the Bureau of Labor Statistics (BLS), 2,637 nonfatal assaults on hospital workers occurred in 1999—a

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rate of 8.3 assaults per 10,000 workers. This rate is much higher than the rate of nonfatal assaults for all private-sector industries, which is 2 per 10,000 workers” (NIOSH 2002).

Assaults can occur when access is denied, when authority figures attempt to set limits on behavior, and when patients are involuntarily admitted. Visiting hours, patient transportation, mealtimes, and patient intake are all times of high activity. During these times, health care workers need to be focused on their patients. Supervision of visiting family members and friends should not be a burden to health care workers. However, each individual that enters a hospital is a potential perpetrator and needs to be supervised for the safety of all individuals in the hospital. The most likely victims of hospital violence are nurses and aides as they have the most direct contact with patients, but NIOSH also lists the hospital workers at increased risk as “emergency response personnel, hospital safety officers, and all health care providers.” NIOSH defines workplace violence as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty” and lists examples such as:

“An elderly patient verbally abused a nurse and pulled her hair when she prevented him from leaving the hospital to go home in the middle of the night,” as well as “An agitated psychotic patient attacked a nurse, broke her arm, and scratched and bruised her,” and “A disturbed family member whose father had died in surgery at the community hospital walked into the emergency department and fired a small-caliber handgun, killing a nurse and an emergency medical technician and wounding the emergency physician.”

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NIOSH also brings up a very significant point in that the typical violence experienced by other occupations while at work is very different from that which health care workers experience. “In other workplaces such as convenience stores and taxicabs, violence most often relates to robbery. Violence in hospitals usually results from patients and occasionally from their family members who feel frustrated, vulnerable, and out of control” (NIOSH 2002).

### **3. Violence’s Rationale**

It is this feeling of the loss of control that I believe is the major factor in the epidemic of violence worldwide. The natural reaction of a biological life form to a lack of resources is to obtain those resources. A perceived inequality between oneself and others of one's species will provoke an attempt by the one without to obtain those resources. With the growing global population of humans, and a finite pool of natural resources, perceived disparities will only increase and attempts to obtain what one does not have (food, water, health, education, societal status, etc) will become more prevalent. This was seen among displaced persons fleeing from the disaster of Hurricane Katrina. When more humans were placed in a finite community with finite resources, the result was perceived disparities and loss of control, and violent attempts to obtain ‘more.’ Violence, in this way, is a result of a loss of control ‘perception’ whereby the violent individual desperately seeks to reacquire that control. In the setting of the hospital, the loss of control can be physical, mental, emotional, societal, financial, etc as this setting is often the site of many life-changing events—birth, death, sickness, and disability—for oneself or loved ones. The occupation itself has intrinsic features that create an environment for potential violence. “Among those intrinsic work features which put an occupational

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group 'at risk' is the need to interact with members of the public who are in pain, frustrated, receiving bad news that confirms their worst fears, or who may have poor impulse or anger control as part of their problem, or who are in hospital against their wishes" (Beech and Leather 2005).

#### **4. Violence is Not Limited to US Hospitals**

Violence in the health care sector is a problem worldwide. The rise in rates of workplace violence has been associated internationally with "crises in recruitment and retention of nursing staff" (Beech and Leather 2005). "In studies conducted in Turkey and other countries, 16.8% and 28.0% of Emergency Staff, respectively, had experienced a physical attack" (Ayranci 2005). A study reporting violence experienced by mental health nurses of the UK shows a greater risk to nurses working in isolation than in institutional settings (Nolan, Soares et al. 2001). A survey of nurses in Australia reports that nurses perceive violence as a 'part of the job:'

"National and international studies bring attention to the severity of the problem for nurses with a particular focus on Emergency nurses. Some of the issues identified and discussed include: increased waiting times and frustration; increasing use of weapons; inadequate systems of security; culture of silence; inadequate support for emergent mental health needs; lack of reporting; lack of institutional concern and systems of support; and demands of triage nursing" (Jones and Lyneham 2001).

A report on the nursing industries in British Columbia and Alberta indicates that violence is not limited to traditionally 'high risk' areas like emergency and psychiatry, but is also occurring "with disturbing frequency on other types of units, especially medical–

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surgical” (Hesketh, Duncan et al. 2003). This article also reports that violence from co-workers is the second most prevalent and is also often underreported—potentially because of the taboo of breaking up the nursing teamwork culture, burdensome paperwork, and disbelief from administration, coworkers and law enforcement. Also, the emotional abuse prevalence in British Columbia and Alberta hospitals, though it does not affect workers as obviously as other forms, has a distinct correlation with lower job satisfaction. Nurses and physicians both contribute equally to the emotional abuse that nurses experienced. Sexual harassment is insidious and underreported. The Canadian Supreme Court recently acknowledged that the “sexual harassment, experienced by nearly one-quarter of all Canadian women, creates an ‘intimidating, hostile or offensive work environment.’” Although many Canadian organizations have publicized anti-violence policy promotions, Hesketh et. al. state that “it is regional health authorities and institutional decision-makers who are positioned to implement the most effective changes and to support organizational solutions.”

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	Med/Surg	Critical care	Emergency	Psychiatry	Other units	Multiple units
<i>Physical assault</i>	(N=587)	(N=168)	(N=145)	(N=55)	(N=508)	(N=146)
Patient	99.3%	96.4%	95.9%	100.0%	98.7%	98.6%
Family/Visitor <sup>a</sup>	0.2%	1.8%	2.1%	0.0%	0.3%	0.7%
Physician	0.2%	1.2%	0.0%	0.0%	0.3%	0.7%
Nursing co-worker	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%
Other	0.3%	0.0%	1.4%	0.0%	0.0%	0.0%
Multiple sources	0.0%	0.6%	0.7%	0.0%	0.3%	0.0%
<i>Threat of assault</i>	(N=538)	(N=122)	(N=269)	(N=127)	(N=263)	(N=148)
Patient	90.0%	84.4%	70.3%	92.1%	81.7%	83.1%
Family/Visitor <sup>a</sup>	4.8%	9.8%	11.2%	1.6%	12.9%	10.1%
Physician	0.6%	1.6%	0.0%	0.0%	1.1%	2.0%
Nursing co-worker	0.2%	1.6%	0.0%	0.0%	0.4%	0.0%
Other	3.5%	2.5%	17.8%	5.5%	3.8%	4.7%
Multiple sources	0.9%	0.0%	0.7%	0.8%	0.0%	0.0%
<i>Emotional abuse</i>	(N=1037)	(N=420)	(N=445)	(N=168)	(N=651)	(N=311)
Patient	47.2%	15.2%	31.2%	67.9%	27.3%	32.8%
Family/Visitor <sup>a</sup>	10.7%	8.3%	15.3%	2.4%	14.4%	12.5%
Physician	8.1%	31.2%	5.4%	3.0%	18.7%	17.4%
Nursing co-worker	10.5%	25.5%	8.1%	7.7%	13.4%	19.8%
Other	8.3%	5.2%	21.6%	4.8%	8.1%	6.8%
Multiple sources	15.2%	14.5%	18.4%	14.3%	18.0%	16.7%
<i>Verbal sexual harassment</i>	(N=194)	(N=71)	(N=77)	(N=52)	(N=106)	(N=49)
Patient	75.3%	35.2%	72.7%	92.3%	73.6%	65.3%
Family/Visitor <sup>a</sup>	3.2%	5.0%	1.3%	1.9%	6.0%	0.0%
Physician	6.2%	43.7%	7.8%	0.0%	11.3%	24.5%
Nursing co-worker	6.7%	9.9%	1.3%	1.9%	2.8%	2.0%
Other	3.6%	1.4%	9.1%	1.9%	1.9%	6.1%
Multiple sources	3.1%	4.2%	7.8%	1.9%	3.8%	2.0%

Figure 1: Sources of Hospital Violence in Canada Categorized by Specialty (Hesketh, Duncan et al. 2003)

Violence is prevalent, not just in emergency departments and psychiatric wards, but also in geriatric wards and all other settings of health care (NIOSH 2002). Victims of violence in the health care sector also include emergency responders and workers at out-patient clinics, doctors' offices and medical education institutions. A study of pre-hospital staff (emergency responders) reports encounters with violent and abusive situations while on the job. "Violence-related policies, associated training, and reporting systems were not in place for the Albuquerque Fire Department in 1995. With a 90% exposure to violence, combined with the lack of training or policies about violence, the potential for work-related injuries and liabilities is evident" (Pozzi 1998). Nurses working

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in an in-home environment are likely to be victims of violence as well as their institutional counterparts (Nolan, Soares et al. 2001) and (Barling, Rogers et al. 2001).

### **5. Violence Against Emergency Department Nurses**

In a study reported in 2003, nurses had the second highest risk of being physically assaulted, (four times the national average), while their exposure to verbal threat and intimidation was twice the national average (Beech and Leather 2005). Violence, although not limited to emergency staff as we have seen, appears to be a most significant problem for emergency department nurses. One study reports a rate of violence of “0.2% or two episodes of violence for every 1000 patients who presented and approximately 5 violent incidents per week” (Crilly, Chaboyer et al. 2004). The most common forms of verbal violence were swearing, yelling, threatening and intimidating, while the most common physical violence forms were pushing, slapping, kicking, or hitting (Crilly, Chaboyer et al. 2004). The more violent forms occurred more often at night and most often in the triage area (Crilly, Chaboyer et al. 2004). Many of the violent individuals displayed behavior associated with mental illness and/or were under the influence of alcohol or drugs (Crilly, Chaboyer et al. 2004). The underreporting noted by many articles could be caused by the emotional trauma associated with the incidents as well as the fear of reprimand or labeling as not coping. The emotional abuse aftermath, like a broken window, is easy to overlook. Prolonged waiting—a characteristic loss of control—was noted as being one of the precipitating factors of hospital violence. “Over half of all types of violence involved patients who had prolonged waiting times” (Crilly, Chaboyer et al. 2004), a condition which could be quite prevalent in times of mass trauma such as the aftermath of a terrorist event.

## **6. Perceptions of Emergency Department Nurses**

A study by Catlette in 2005 reports that emergency department registered nurses perceive inadequate safety measures and vulnerabilities to be ubiquitous in their environment. One issue brought up was the easy access to the hospital of outside individuals and how the burden of surveillance was placed on already-busy nurses (Catlette 2005). Participants in this study also recall

“several [patients who were carrying weapons] in the trauma room when we've cut their clothes off of them.” “Patients that come by ambulance... are not going through the metal detector. So there is potential.” “They could grab a needle from the IV bucket sitting right there, if we turned our backs. A needle, to me, is a weapon, especially a bloody needle; it might as well be a loaded gun” (Catlette 2005).

These nurses feel that the security officials present at the emergency department portals are a presence, not a force. The nurses don't know the policies regarding what the officials can do to help them in violent situations. They also feel that safety policies in existence are not enforceable and that their education did not prepare them to interact in a setting with so much potential for violence. One nurse noted “It was never talked about that ... if you have a patient that presents with this, you might want to be aware that they are a victim of domestic violence and that their husband might come in...but it was never taught” (Catlette 2005). Some feel that what education they have received is not helpful in such an uncontrolled environment. Another nurse describes how the potential for violence is overlooked “until something happens and it brings it close to home. They don't realize the type of people we bring into the emergency room” (Catlette 2005).

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Further vulnerability stems from the fact that the emergency department is chaotic and busy. “We make a lot of people mad, not only employees and hospital people, but patients too” (Catlette 2005). Nurses expressed vulnerability with regard to specific characterizations of patients which were in line with other articles’ results: impatience, psychiatric disorders, and drug or alcohol abuse topped their lists.

### **7. Legislation Mandates Awareness and Consideration**

Legislation in regions of the US and Canada has required the health care industry to take note. “By the early 1990s, policymakers concerned with occupational safety and health explicitly recognized assaults as an important cause of morbidity and mortality in the workplace” (Barish 2001). This prompted agencies such as the Occupational Safety and Health Administration (OSHA) to develop guidelines. Although the 1996 OSHA guidelines for protecting the health care workplace are not mandatory, a failure to practice a ‘zero-tolerance’ policy with regard to any type of violence can lead to financial penalization (Catlette 2005). California began the effort in 1993 with legislation mandating that licensed state hospitals perform an assessment of safety and security, and “based on that assessment, develop a plan to protect personnel, patients, and visitors from aggressive and violent behavior” (Barish 2001). The legislation also required training of emergency room personnel (Barish 2001). The second state, Washington, followed California’s effort six years later with legislation mandating the development and implementation by health care settings of “detailed plans to prevent and protect employees from violence” (Barish 2001). The following year brought legislation to add two psychiatric wards to the state coverage (Barish 2001). These health care settings now must assess security and safety for existing and potential workplace violence hazards.

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They have been tasked with identifying their own ‘appropriate preventative measures.’

“Based on the hazards identified in the security and safety assessment, the violence-prevention plans must address security considerations related to the following:

1. The physical attributes of the health care setting,
2. Staffing—including security staffing,
3. Personnel policies,
4. First aid and emergency procedures,
5. Reporting of violent acts [against employees, patients and visitors], and
6. Employee education and training”

(Barish 2001).

A greater awareness of the hazard of workplace violence helped to further the effort to reduce or eliminate the risk. (Barish 2001). Although it is a step in the right direction, this legislation does not cover every worker and it makes no attempt to recommend or regulate specific intervention measures, but instead leaves it up to the employer.

### **8. Many Recommendations with Little Proof**

Many nurses, organizations, and review articles have made recommendations. A review of training procedures recommends an integrated approach consisting of “preventing incidents, empowering staff to better handle them, and supporting victims post-incident” (Beech and Leather 2005). Catlette (2005) promotes a comprehensive plan for preventing workplace violence in emergency departments with adherence to the OSHA guidelines and inclusion of “examination of existing policies as well as monitoring their enforcement.” Rosen (2001) lists three components of an effective intervention plan as a true commitment from management, worker involvement, and an

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implementation of recommendations involving hazard control. Many articles including (Schat and Kelloway 2003) agree that organizational support is beneficial to employees at risk but is not a replacement for policy revision.

A review of policies and resources is necessary. Policy issues include access to hospitals, efficiency of security personnel and equipment, staffing of surveillance personnel to decrease the burden on nurses, educational training for prevention of workplace violence for all hospital personnel, employment orientation on the types of patient situations in which nurses are at risk for violence and the measures to take to decrease risk of occurrence. Resources include counseling services and training, and can come from the hospital or community; if they are not available, they should be developed (Catlette 2005).

Crilly et. al. make specific recommendations for improving the emergency department setting. Organizations should develop a continuing professional training program for “de-escalation and aggression management, skill acquisition, peer mentoring and support,” create or revise policies and procedures to manage occurrences of violent situations and appropriately staff triage areas, and establish an entity (‘Violence Management Team,’) to ensure effective patient management and protect the health and safety of staff (Crilly, Chaboyer et al. 2004).

A review of nine articles which evaluated administrative and behavioral measures to prevent workplace violence in health care suggests processes to determine the best intervention measures. Organizational rather than individual risk factors as the focus of intervention measures will likely yield greater success. (Runyan, Zakocs et al. 2000).

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Measures need not only to be proposed but also to be carefully evaluated in an experimental method, concerning three types of evaluation: “process, impact, and outcome.” A determination of the effectiveness of policy measures is crucial (Runyan, Zakocs et al. 2000). This review laments the then-current condition of research into the effectiveness of interventions, and believes that a “a mix of environmental and behavioral approaches” is helpful in obtaining optimal effectiveness, provided the strategies are “carefully developed using theoretical and conceptual frameworks and appropriate evaluations, and are applied judiciously” (Runyan, Zakocs et al. 2000). Another report recommends a “simultaneous focus on everything from security measures, through individual, team and organizational work practices, to organizational policies, codes of practice and arrangements for everything from job and work design to post incidence support and counseling” (Beech and Leather 2005).

### **9. Training as Intervention**

Catlette (2005) believes that it is the responsibility of nursing education institutions as well as health care institutions to “provide meaningful instruction on the prevention of workplace violence specific to the practice environment.” Beech and Leather (2005) note that recent analyses of workplace violence suggest a more integrated rationale behind violence in health care. For instance, environmental factors (e.g. overcrowding and noise) might be combined with organizational/structural factors (e.g. limiting of the patient’s movements about the hospital) as well as individual factors (e.g. tendency of a patient to be irritated and impatient) to yield a situation of potential violence. The acceptance of the multifactor model enables consideration of a greater variety of possibilities for intervention (Beech and Leather 2005). Though no single

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method of intervention is effective alone, articles generally agree that training of staff is very effective if done correctly (performed and evaluated). In the health care sector, Type II violence (victimization of a service-provider by clients, patients, customers, etc.) is most prevalent. In this context, at least in theory, training can help health care workers better manage situations and relationships (Beech and Leather 2005).

Many authorities endorse staff training not as a ‘stand alone solution’ but as part of a integrated intervention plan. However several studies reported that only 12 to 51% of respondents had received training in managing workplace violence, and the level of training varied from breakaway, restraint, self defense and self-awareness to familiarization of policies and practices (Beech and Leather 2005).

Also, many forms of training focus on reacting to violence rather than preventing it through risk assessment and patient care training. Health care workers should understand forms of patient aggression, cues which predict its occurrence, proper adherence to policies, and methods of interacting with emotional patients (Beech and Leather 2005). Training that is “up-to-date, relevant, and purposeful, backed by evidence, given by experts... [open to] feedback, and attended by managers” is the sort of training that has been shown to be most effective (Beech and Leather 2005). With all of these guidelines on training, how is a manager supposed to know what form of training is appropriate and whom should lead the training? “Training is evaluated too infrequently, and when it occurs, it tends to be confined to measuring trainee reactions” (Beech and Leather 2005).

Beech and Leather (2005) review three models of training evaluation. The oldest model evaluates four levels: reaction, learning, behavior, and results. This model, while

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experimentally sound, does not recommend what goals to evaluate or how to measure them. The 'CIRO' model evaluates training on four levels: context, input, reaction and outcome. Beech and Leather believe both of these models identify the last level of evaluation as "the most difficult, the least often done and the most valuable" and that the reactions of participants (the most immediate evaluation method) is "the easiest, the least useful and the most frequently used." The third model reviewed is based on a psychological-methods-of-learning approach, dividing the goal (learning) into three categories: cognitive (fact recall and knowledge/understanding), skills-based (effective, error-free, smooth, rapid performance, automaticity, and multi-tasking), and affective (self-knowledge, attitude, and motivation) (Beech and Leather 2005). This model identifies goal outcomes (specifically when the categories are subdivided) and offers methods for measurement of the outcomes. Beech and Leather feel that this third model's "emphasis on learning outcomes has helped in refocusing the attention of course managers and trainers on to learning outcomes at every stage of the course design process." However, this model does not include such aspects as cost effectiveness or availability of resources. Beech and Leather propose combining the strengths of the three models and propose a new framework, seen in Table 2 at the end of this paper.

### **10. Other Comprehensive Plans**

Dr. Nicogossian presents a list of items which should be included in the comprehensive plan to reduce violence in the workplace.

-Risk identification, categorization and prioritization

-Surveillance of the environment

-Employee education (awareness, safety and crime prevention)

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-Prevention and control strategies

-Continuous evaluation and communication with employees & interested groups”

(Nicogossian 2005).

The Haden matrix is a generalized policy-addressing figure for measures of prevention. Dr. Nicogossian’s matrix adapted for workplace violence is seen in Figure 2 (2005). (A Haden matrix further adapted for workplace violence in the health care sector is displayed in Table 1 at the end of this paper.) The primary, secondary, and tertiary measures are to be put in place before an incident occurs. Primary measures are to prevent occurrence, secondary measures are to mitigate the effects of an incident in progress and tertiary measures are to mitigate prolonged aftermath. Dr. Nicogossian also lists several pitfalls to be avoided in the implementation of a comprehensive plan such as profiling and unfair or inconsistent enforcement of policies, poor record keeping and legal issues of privacy and discrimination. Many also feel that the organizational level is left out of many prevention plans.

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<b>Phases</b>	<b>Employee &amp;/or Victim</b>	<b>Perpetrator</b>	<b>Physical Environment</b>	<b>Social Environment</b>
<b>Primary</b>	Training	Policy enforcement Reporting concerns and expressing issues	Control and safety measures	Good management and workforce relationship and care
<b>Secondary</b>	De-escalation techniques Practice on violent-event response plan	Weapon prohibition Use of restraint	Good security force Exit avenues Alarm systems	Response plan available and understood
<b>Tertiary</b>	Crisis intervention and EAP	Awareness for apprehension and prosecution	Surveillance systems (cameras, visits etc.)	Cohesive and mutually supportive workforce

Figure 2: Haden Matrix presented by Dr. Nicogossian 2005

NIOSH (2002) also lists a comprehensive plan for hospitals and a list of safety tips for health workers. These are presented in Figure 3.

<b><u>Plan Components For Hospitals</u></b>	
Environmental Design	
	Develop emergency signaling, alarms, and monitoring systems.
	Install security devices such as metal detectors to prevent armed persons from entering the hospital.
	Develop emergency signaling, alarms, and monitoring systems.
	Install security devices such as metal detectors to prevent armed persons from entering the hospital.
	Install other security devices such as cameras and good lighting in hallways.
	Provide security escorts to the parking lots at night.
	Design waiting areas to accommodate and assist visitors and patients who may have a delay in service.
	Design the triage area and other public areas to minimize the risk of assault:
	Provide staff restrooms and emergency exits.
	Install enclosed nurses' stations.
	Install deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas.
	Arrange furniture and other objects to minimize their use as weapons.

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<b>Administrative Controls</b>	
	Design staffing patterns to prevent personnel from working alone and to minimize patient waiting time.
	Restrict the movement of the public in hospitals by card-controlled access.
	Develop a system for alerting security personnel when violence is threatened.
<b>Behavior Modifications</b>	
	Provide all workers with training in recognizing and managing assaults, resolving conflicts, and maintaining hazard awareness.
<b><u>Safety Tips for the Hospital Worker</u></b>	
Watch for signals that may be associated with impending violence	
	Verbally expressed anger and frustration
	Body language such as threatening gestures
	Signs of drug or alcohol use
	Presence of a weapon
Maintain behavior that helps diffuse anger:	
	Maintain behavior that helps diffuse anger:
	Present a calm caring attitude.
	Don't match the threats.
	Don't give orders.
	Acknowledge the person's feelings (for example, "I know you are frustrated").
	Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly).
Be Alert:	
	Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
	Be vigilant throughout the encounter.
	Don't isolate yourself with a potentially violent person.
	Always keep an open path for exiting-don't let the potentially violent person stand between you and the door.
Take these steps if you can't defuse the situation quickly:	
	Remove yourself from the situation.
	Call security for help.
	Report any violent incidents to your management.

**Figure 3: NIOSH Recommendations for Hospitals and Hospital Workers**

**11. How to Mend the Broken Windows in Health Care**

The broken windows theory (Hesketh, Duncan et al. 2003) describes how law enforcement/criminal justice views an escalating problem with violence and how to begin solving the issue. To inadequately summarize this theory, when a community allows

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broken windows to go un-mended, criminals perceive apathy in the community's criminal justice and will be more likely to commit other forms of crimes of increasing violence, like robbery and assault. Hesketh et. al. associate the health care emotional abuse with law enforcement's broken windows. Once the prevalence of broken windows or emotional abuse in hospitals is brought down, other violent acts will be less frequent. The zero-tolerance of violent behavior needs to start with the precursors—less obvious manifestations of violent tendencies. When emotional abuse or sexual harassment is no longer tolerated and an atmosphere of courtesy and respect has been installed, potential perpetrators of violence will not perceive an environment fostering violence.

## **12. Conclusion**

Violence in the health care sector workplace is a health problem in the hospital, in all health care environments, and in many non-health care environments. A global, comprehensive, continuing, effective, and integrated reaction to this problem is necessary to prevent the epidemic from growing even more. Research is necessary to evaluate what measures have been taken already and what measures will have been taken. A 'hot wash' is critical to the efficacy of any exercise and the process of growth and revision of the plan needs to be ever-continuing. It is the nurses and other victims who need to be educated as to how to prevent and handle violence; but the researchers, instructors, and policy makers also need to continue to learn how to understand this phenomenon. Orientations, briefings, drills, seminars, tabletop exercises, functional exercises, and full-scale exercises (as are done for emergency preparedness) would all be beneficial as this truly is a pandemic, affecting not just the direct victims but the entire community. The process of revision and rewriting of this 'plan,' like the 'National Response Plan' needs

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to involve many agencies, organizations, and individuals locally, regionally, nationally and even internationally. Violence is self-perpetuating and victims themselves are often more prone to violence. It is a contagious and insidious problem that will not just “go away” if enough time passes. In the interest of all entities, we must work toward a cure.

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**13. Tables and Works Cited**

Table 1. Haddon Matrix of administrative and behavioral interventions to prevent workplace violence<sup>a</sup>

Phases	Victim (host) <sup>c</sup>	Assailant/weapon (vector/vehicle)	Targets of change	
			Physical environment	Social environment
Pre-assault event	Train employees in conflict resolution and effective communication strategies (II) <sup>b</sup>	Inform patients about workplace anti-violence policies (health/social service settings) (II)	<i>Maintain adequate lighting in late-night retail establishments<sup>d</sup></i>	Ban working alone, especially during high-risk hours (I)
			<i>Place safe in visible location</i>	Close establishments during high-risk hours (I)
	Train managers in human relation skills (e.g., communication, team building, problem solving, diversity and conflict management) (III)	Educate clients/patients in anger control management (health/social service settings) (II)		Request police officers to check on workplace regularly, especially during high-risk hours (I)
				Hire security guards (I)
Train managers in how to identify/profile violent-prone employees (III)	<i>Modify guns so they are less easily concealed</i>		Provide escorts for employees when walking to parking lot or other external areas (I)	
			Create visitor identification system (health settings) (I)	
Regularly evaluate employees' work performances and allow opportunities to discuss grievances (III)				Ensure adequate and qualified staff coverage at all times (II)
				Adopt measures to decrease waiting time (II)
				Create system for assessing high-risk patients (health/social service areas) (II)
				Restrict or limit access of clients/patients (II)
				Conduct pre-employment screenings and background checks to detect violence-prone employees (III)
				Routinely test for alcohol and drug use (III)
				Provide employee assistance program (EAP) services (e.g., substance abuse treatment, domestic violence counseling) (III)
				Offer stress management workshops (III)
				Establish clear and "humane" termination policies (e.g., train managers, conduct exit interviews, adequately prepare for layoffs, offer outplacement services) (III)
				Develop and adhere to fair and consistent personnel and discipline procedures (III)
During assault event	Train employees in violence prevention strategies and/or how to respond during violent events (I)	<i>Restrict sale of "dum dum" or expanding bullets</i>	Reduce isolation of work spaces	Plan escape routes (I)
			Install alarm systems to access security	Develop an emergency/crisis plan for dealing with violent events (I)
	Train employees how to handle violent patients/clients (II), (III)			Create a system and establish a response team for investigating violent threats and acts (e.g., 24-hour hotline) (I)
				Develop an emergency/crisis plan for dealing with violent events (II), (III)
Train employees in self-protection strategies (e.g., control and restraint) (II), (III)			Create a system and establish a response team for investigating violent threats and acts (e.g., 24-hour hotline) (II), (III)	
Post-assault event	Develop and offer a crisis intervention counseling and services program to employee victims of violence (I), (II), (III)	<i>Make guns more easily traced</i>	Install surveillance cameras to facilitate capture of assailants	<i>Ensure easy accessibility of emergency care</i>
			Direct telephone line to EMS	<i>Develop strategies for physical rehabilitation and job retention for injured workers</i>
	<i>Train all workers in first aid</i>			

<sup>a</sup>Citations appear in the appendix.  
<sup>b</sup>Numbers in parentheses (I, II, III) refer to type of event.  
<sup>c</sup>Additional examples provided by the authors are indicated.

Table 1: Haden Matrix adapted for Health Care Violence Prevention, taken from Runyan et al 2001

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<ul style="list-style-type: none"> <li>• Reaction</li> </ul>	<p>Subjective satisfaction sheets (enjoyable, relevant, interesting)</p>
<ul style="list-style-type: none"> <li>• Learning(immediate)           <ul style="list-style-type: none"> <li>– Knowledge               <ul style="list-style-type: none"> <li>• Verbal, Organisation,</li> </ul> </li> <li>– Skills               <ul style="list-style-type: none"> <li>• Compilation</li> </ul> </li> <li>– Affective               <ul style="list-style-type: none"> <li>• Attitude,Motivation,</li> <li>• Confidence,</li> <li>• Self-efficacy</li> </ul> </li> </ul> </li> </ul>	<p>Knowledge tests, vignettes, scenarios (risk factors, statistics, interventions)            Problem solving (interventions, team approaches, management strategies, rationale, philosophy)</p> <p>Role play exercises and individual skills demonstration (de-escalation skills, breakaways, violence management and restraint), Self-assessed competence relative to an earlier time            External assessors?</p> <p>Attitude scales            Self assessment (confidence in managing escalating aggression, self and team morale, job satisfaction)</p>
<ul style="list-style-type: none"> <li>• Behaviour (intermediate)           <ul style="list-style-type: none"> <li>– Knowledge               <ul style="list-style-type: none"> <li>• Organisation,</li> <li>• Cognitive Strategies</li> </ul> </li> <li>– Skills               <ul style="list-style-type: none"> <li>• Automaticity</li> </ul> </li> <li>– Affective               <ul style="list-style-type: none"> <li>• Attitude, Motivation,</li> <li>• Confidence,</li> <li>• Self-efficacy</li> </ul> </li> </ul> </li> </ul>	<p>Manager review (annual individual performance review)</p> <p>Performance during incidents (feedback in post-incident de-briefing sessions and clinical reflection sessions)</p> <p>Manager review (annual individual performance review)            Customer satisfaction (user group feedback, complaints)            Team morale, Staff recruitment and retention figures, Team work</p>
<ul style="list-style-type: none"> <li>• Results (ultimate)</li> </ul>	<p>Work atmosphere assessment,            Reported incident figures –number, type &amp; seriousness,            Customer satisfaction (user group feedback, complaints)</p>
<ul style="list-style-type: none"> <li>• (Finance)</li> </ul>	<p>Complaints and inquiries, Sickness and injury claims, First aid consumables            Compensation claims</p>

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**Table 2: Evaluations of Training: Subcategories and Goals (Beech and Leather 2005)**

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