

Workplace Violence

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Abstract

Workplace violence (WPV) is a serious and growing concern for many employees in the healthcare profession. Patients displaying aggressive and violent acts of physical and verbal abuse toward nurses are becoming more frequent, especially for those working in the emergency department setting. The potential for WPV can cause nurses to experience emotional stress while trying to provide care to patients, while actual acts of WPV can result in long term consequences that can have lasting effects on both the employee and the organization. Some states have laws that protect nurses against these types of occurrences and regard them as punishable crimes. Is there enough evidence to show the negative effects that WPV has on nurses, patients and organizations to encourage all states to legislate for stronger infractions against those that commit these acts of hostility and violence toward nursing staff?

Violence against healthcare workers is a growing concern in the United States. As of recently, the public tends to associate workplace violence (WPV) more often with hostility and aggression directed toward schools or common businesses where there are disgruntled employees that retaliate against their employer. The U.S. Bureau of Justice Statistics reports that approximately 1.7 million workers sustain an injury related to WPV annually. Although healthcare workers are less likely to be killed in the line of duty, in 2006 they accounted for 60% of all reported assaults with the majority being inflicted by a patient (Gates, Gillespie, & Succop, 2011). According to the National Crime Victimization Survey conducted between 1993 and 1999, nurses reported being victims of assault while on the job almost two times more per 1,000 workers compared to all other occupations (Gacki-Smith, Juarez, Boyett, Homeyer, Robinson & MacLean, 2009).

Workplace violence can be defined as when one person directs hostility or aggression toward another person that is at a place of work and actively on duty. Workplace violence is described as physical assault, verbal or emotional abuse or any behavior that can be threatening, harassing or intimidating toward someone (Gacki-Smith, et al., 2009). Most of the media that the public is exposed to related to WPV is associated to large mass shootings or violence that leads to significant loss of life or limb. However, the majority of healthcare related violence is in the form of physical aggression such as hitting and slapping, perceived or real verbal threats, property damage and racial or ethical insults (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005). A study conducted by the American Nurses Association (ANA) in 2001 showed that fewer than 20% of nurses felt safe in their work environment. These nurses were frequently concerned with their safety due to hostile patient behaviors and having inadequate safety measures in place. The nurses felt a lack of support from leadership within the organization because they had failed to fulfill commitments to improve security, and education and training for staff awareness for WPV (Gacki-Smith, et al., 2009). In this same year, the ANA “released its Bill of Rights for Registered Nurses, which set forth the tenet that nurses have the right to work in an

environment that is safe for themselves and their patients” (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005, p. 120).

Violence against healthcare workers in hospital settings occur more often in certain units including the emergency department, waiting rooms and geriatric and psychiatric units. In surveys conducted, up to 80% of hospital staff report that they have been victim to some type of physical assault at least once during their career (Gacki-Smith, et al., 2009). The Emergency Department (ED) ranks as one of the highest areas in a hospital where nurses report assaults. In one study conducted on WPV, 82% of nurses working in the ED reported experiencing physical assault within the current year (Gacki-Smith, et al., 2009). A study in 2002 reported that 100% of ED nurses surveyed had been verbally assaulted within the year. In 2006, the Emergency Nurses Association (ENA) conducted a survey that supported the previous studies results by concluding that 86% of ED nurses reported being the recipient of some type of violent act from either a patient or a family member. Forty percent of these same nurses reported feeling very little to no safety in their work environment (Stokowsk, 2007). Of all workplace violence directed toward healthcare workers, emergency department nurses experience higher rates of physical assaults than any other nurses and a study conducted at a Minnesota hospital reported that ED nurses reported violent encounters four times more than other nurses (Gates, et al, 2011). “A recent national study of 3,465 ED nurses found violence is highly prevalent and prevention is dependent on commitment from hospital administrators, ED managers, and hospital security” (Gates, et al., 2011, p. 50). Even with the significant results related to nurses that have experienced and reported some type of assault or aggressive behavior, many never report these incidents because they feel that it is part of their job. Emergency nurses work in an unpredictable environment. The ED is frequently dealing with overcrowding issues, caring for an increased number of patients presenting with substance abuse and psychiatric issues and may be working under staffed. These combinations can lead to increased frustrations that predispose nursing staff to potential violent risk behaviors from patients and

families (Kowalenko, Hauff, Morden & Smith, 2012). With government and healthcare budget cuts over the past several years, mental health care services and resources are limited resulting in more psychiatric and mental illness complaints and EDs are seeing more patients that do not have primary care providers, which in turns causes longer wait times and accessibility resulting in a more unstable and potentially hostile work climate (Greenlund, 2011).

According to the Emergency Nurses Association (2013), North Carolina General Statute § 14-34.6, a person can be charged with a Class A1 misdemeanor if they display physical harm to emergency medical personnel, which includes and emergency department nurse (ENA). If charged with a Class A1 misdemeanor, the accused can serve from 1 to 150 days either in jail or prison or complete community service, dependent upon previous infractions and the judge's discretions. In North Carolina in 2010-2011, there were 150,810 misdemeanor convictions, with 71% receiving community service time (The North Carolina Sentencing and Policy Advisory Commission, 2012).

On August 6, 2009, the ENA reported that North Carolina had pending legislation on Senate bill 1036. This bill sought to increase the punishment for simple assault to an emergency worker, including an ED nurse, a felony instead of a misdemeanor. Senate bill 1036 is titled Assault on Law Enforcement & EM Worker/Felony. This bill was introduced into the North Carolina General Assembly and the Senate filed an action on March 26, 2009. The bills primary sponsor was Senator Andrew C. Brock. Additional sponsors included Tom Apodaca, Philip Berger, Harry Brown, Neal Hunt, Jim Jacumin, Jean Preston and Jerry Tillman. The last and only other action on this bill was a referral to Judiciary I on March 31, 2009 (NCGA, 2009-10). Upon further research of this law, Senate bill 1190 was introduced and filed by the Senate on May 19, 2004 and was referred to the Committee on Judiciary I on May 20, 2004. This bills primary sponsor was R. C. Soles Jr. and co-sponsors included Andrew C. Brock, Virginia Foxx and R. B.

Sloan, Jr. (NCGA, 2003-04). This earlier bill also requested making this act of assault a felony however; no additional information was discovered on either bill after referral to Judiciary Committee.

Violence and assault toward nurses impacts both the organization and the nurse. Nurses that become victims of physical assault, verbal abuse, threats or intimidation, can experience signs and symptoms of physical illness and injury, chronic pain, emotional stress, and short or long term feelings of fear, anger or anxiety. Whether occurring only once or frequently, acts of WPV can decrease job satisfaction which can ultimately lead to nurse turnover. Studies have shown that WPV can lead to Post Traumatic Stress Disorder (PTSD) and 12% of ED workers in a study met full criteria for diagnosis of this disorder after an assault (Gates et al., 2011). The American Nurses Association (ANA) reports that in 2009, there were 2,050 reported violent acts toward registered nurses. Injuries and emotional distress sustained from these attacks lead to an average of four days of missed work. One thousand eight hundred and thirty of the assaults on staff were inflicted by patients (ANA, nd). Injuries, missed worked and nurse turnover can all lead to economic loss for both the nurse and the hospital. The extent of some injuries may lead to long term or permanent disability, increasing the cost of worker's compensation for an organization (Greenlund, 2011). Organizations in Minnesota paid out over \$5 million for 344 non-fatal assaults on healthcare workers. These costs were related to medical bills, lost wages and legal and administrative costs related to injuries. Registered nurses that were injured received an average of \$31,643 per case (Gates et al., 2011).

Patient care can also be affected because the potential for WPV can give nurses a sense of insecurity in their work environment. In the study conducted by Gates, Gillespie & Succop (2011), emergency nurses that were involved with violent acts of aggression reported that they could continue to work at a productive pace even after a WPV event occurred, however, the study showed a significant decrease in productivity and ability of the nurse to maintain emotional and mental focus. The inability

of the nurse to be able to connect and focus on patient care could lead to decreased interaction and communication with patients, increased errors related to medication administration or documentation and an overall disconnect with both patients and co-workers (Gates et al., 2011).

North Carolina General Statute § 14-34.6 is a very important law. Several but not all states, have laws that consider assault or violent acts toward an emergency nurse a punishable crime, there are no federal laws that “protect nurses from violence in the workplace, impose penalties on the offenders, or mandate violence prevention programs” (Stokowski, 2010. p.na). Several states, as previously in North Carolina, have laws that protect emergency medical personnel, police officers and fire fighters, but still lack including emergency nurses in their statutes (Stokowski, 2010).

There are many organizations that support legislation related to WPV due to the increasing awareness of concerns related to the rising number of assaults on nurses. The US Department of Labor and OSHA have made recommendations to support the decrease in and reporting of WPV which includes having written WPV prevention plans, communicating to patients and visitors that WPV will not be tolerated, have a trained group of employees that respond to emergent, violent situations, encourage and support prompt reporting of attacks, have escape plans and panic buttons in place, install controlled access to the department and utilize the presence of police officers as much as possible. The Joint Commission also recommends for hospitals to perform a risk assessment, provide safety measures in emergency departments and ensure staff training and education on violence prevention (Stokowski, 2010). The American Nurses Association as well as the Emergency Nurses Association (ENA) supports legislation in all states as well as stricter punishment against those convicted of committing violent acts. The ENA’s position statement regarding workplace violence states that WPV is a significant threat facing emergency nurses and healthcare organizations have the responsibility of providing these nurses with a safe working environment. The ENA also believes that hospitals should

have a zero tolerance policy and train staff to recognize and resolve potential occurrences of WPV. The ENA also supports stronger legislation and tougher penalties against those who assault or commit violent acts against an emergency nurse (ENA, 2010). The American College of Emergency Physicians (ACEP) supports all states to enact the fullest degree of penalties against those that commit violent acts toward emergency department staff. Their goal is to protect all staff and patients from harm while delivering care (ACEP, 2013). According to Nixon (2004) in, "The Financial Impact of Workplace Violence," the cost of reacting after a serious incident has occurred is 100 times more costly than taking preventive actions" (Papa, & Venella, 2013).

As a nurse that has worked in the emergency department setting for nearly eighteen years, I do support the current law advocate for more stringent laws, with tougher punishments for offenders to be enforced in all fifty states. My emergency department setting has changed drastically over the past ten years, but more so over the last five. Although ED census has remained relevantly steady over the past few years, there has been a drastic increase in the acuity of patients and the types of patients that we are now seeing and treating. Increased acuities may be related to the patient's inability to afford insurance and have a family physician. This sometimes results in patients delaying treatment and seeking emergency care only when absolutely necessary. There is also a drastic increase in psychiatric and drug and alcohol abuse patients that present for treatment or are brought in by police officers. These patients often complain of suicidal and homicidal ideations which places them one on one with an ED staff member often for days or weeks until placement can be found. These patients frequently contribute to the physical and verbal attacks that our nurses experience. It is extremely stressful for the nurse to ensure that the needs of critical patients are met while experiencing derogatory and threatening comments from the psychiatric patient in the hallway. Our emergency department has annual education on violence in the ED. We have outside resources from the NC Justice Academy that come in annually and demonstrate real live scenarios of patient violence and

interventions to assist and teach staff safety techniques. They also conduct a risk assessment of our patient rooms and show staff even the smallest of items that patients could use to harm them, including the items they have on or in their pockets such as pens, stethoscopes and scissors. Our hospital also has a Code Gray team. Any staff member throughout the hospital that is willing to fulfill the training required to be on the team can join. When a patient becomes violent, this code is called and everyone that is on campus responds. The response of the team alone normally deescalates the situation due to the show of power in the number of people. We have experience emergency room nurses injuries and as the research states, this is a financial burden to the organization and takes an emotional toll on staff involved as well as those not involved. The potential of the frequent occurrences of outbursts and anger that we experience every shift from patients can make nurse uncomfortable and afraid. We have armed police officers at our hospital, but they are not always readily available in the emergency department. I believe that this is an area where our organization could improve by ensuring police presence around the clock in the emergency department, purchasing of metal detectors and bullet proof glass surrounding triage. I do believe that it is highly likely that my department will experience a more violent occurrence and unfortunately, this is what it usually takes for an organization to make drastic changes.

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