Workplace Violence in Healthcare

Understanding the Challenge

Workplace violence risk factors vary by healthcare setting, but common factors include the following:[1]

- Working with people who have a history of violence or who may be delirious or under the influence of drugs
- Lifting, moving, and transporting patients
- Working alone
- Poor environmental design that may block vision or escape routes
- Poor lighting in hallways or exterior areas
- Lack of means of emergency communication
- Presence of firearms
- Working in neighborhoods with high crime rates
- Lack of training and policies for staff
- Understaffing in general, and especially during meal times and visiting hours
- High worker turnover
- Inadequate security staff
- Long wait times and overcrowded waiting rooms
- Unrestricted public access
- Perception that violence is tolerated and reporting incidents will have no effect

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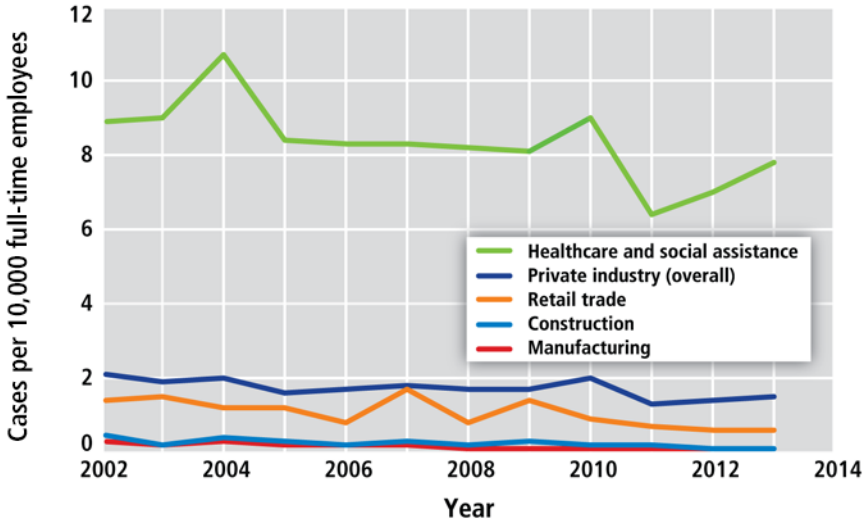
OSHA 3826 - 12/2015

Workplace violence is a serious problem. Different organizations have defined workplace violence in various ways. The National Institute for Occupational Safety and Health defines workplace violence as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty." Enforcement activities typically focus on physical assaults or threats that result or can result in serious physical harm. However, many people who study this issue and the workplace prevention programs highlighted here include verbal violence—threats, verbal abuse, hostility, harassment, and the like—which can cause significant psychological trauma and stress, even if no physical injury takes place. Verbal assaults can also escalate to physical violence.

In hospitals, nursing homes, and other healthcare settings, possible sources of violence include patients, visitors, intruders, and even coworkers. Examples include verbal threats or physical attacks by patients, a distraught family member who may be abusive or even become an active shooter, gang violence in the emergency department, a domestic dispute that spills over into the workplace, or coworker bullying.

Healthcare workers are at an increased risk for workplace violence. From 2002 to 2013, incidents of serious workplace violence (those requiring days off for the injured worker to recuperate) were four times more common in healthcare than in private industry on average. In 2013, the broad "healthcare and social assistance" sector had 7.8 cases of serious workplace violence per 10,000 full-time employees (see graph below). Other large sectors such as construction, manufacturing, and retail all had fewer than two cases per 10,000 full-time employees.

Violent Injuries Resulting in Days Away from Work, by Industry, 2002–2013

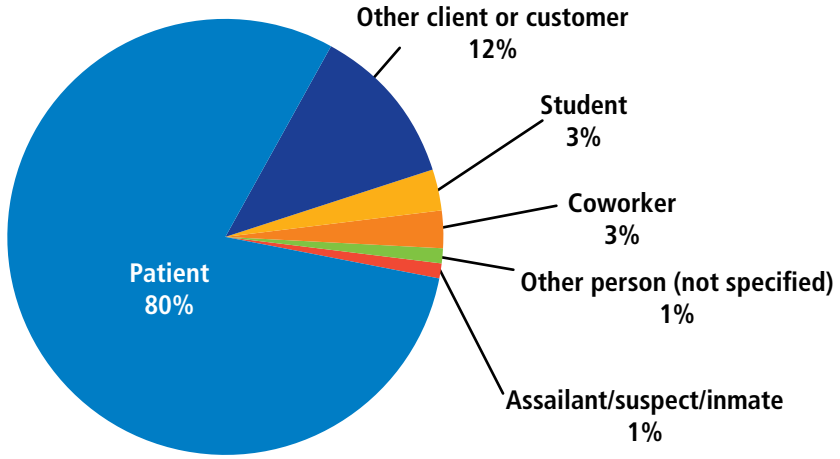


Data source: Bureau of Labor Statistics data for intentional injuries caused by humans, excluding self-inflicted injuries.

Violent incidents come from a variety of sources. Many are not reported.

Patients are the largest source of violence in healthcare settings, but they are not the only source. In 2013, 80 percent of serious violent incidents reported in healthcare settings were caused by interactions with patients (see graph). Other incidents were caused by visitors, coworkers, or other people.

Healthcare Worker Injuries Resulting in Days Away from Work, by Source



Data source: Bureau of Labor Statistics (BLS), 2013 data. These data cover three broad industry sectors: ambulatory healthcare services, hospitals, and nursing and residential care facilities. Source categories are defined by BLS.

Violence is vastly underreported. The numbers above only include incidents that led to time away from work. While some data are available for other violent incidents, surveys show that many incidents go unreported, even at facilities with formal incident reporting systems.[2] For example, a survey of 4,738 Minnesota nurses found that only 69 percent of physical assaults and 71 percent of non-physical assaults were reported to a manager,[3] while one medical center found that half of verbal and physical assaults by patients against nurses were never reported in writing.[4] Bullying and other forms of verbal abuse are particularly prone to underreporting. Reasons for underreporting include lack of a reporting policy, lack of faith in the reporting system, and fear of retaliation.

Unique challenges in healthcare

Healthcare has some unique cultural factors that may contribute to underreporting or acceptance of workplace violence. For example, caregivers feel a professional and ethical duty to "do no harm" to patients. Some will put their own safety and health at risk to help a patient, and many in healthcare professions consider violence to be "part of the job." Healthcare workers also recognize that many injuries caused by patients are unintentional, and are therefore likely to accept them as routine or unavoidable. Another consideration is unwillingness among healthcare workers to stigmatize the perpetrators due to their illness or impairment.

Healthcare is also evolving in ways that increase the challenge. For example, because of reduced funding for mental health services, severely ill patients with violent tendencies are increasingly using emergency departments rather than more specialized facilities for treatment.

Workplace violence is widespread in healthcare professions.

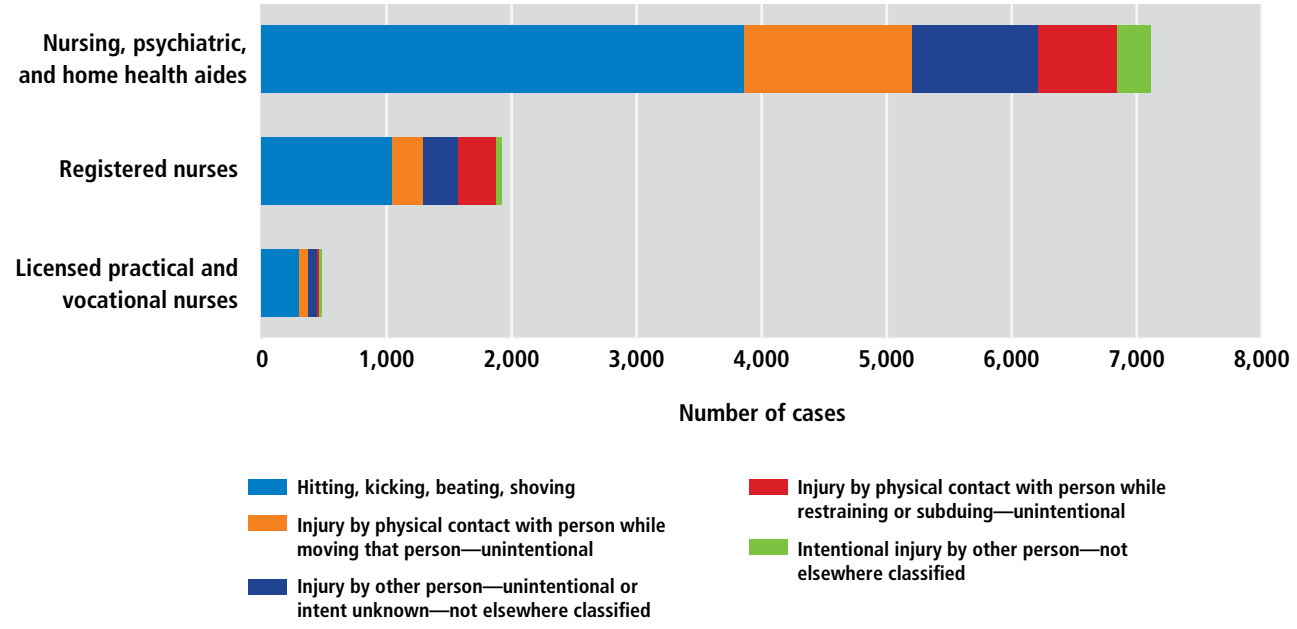
Surveys highlight the prevalence of workplace violence among healthcare occupations:

- **21 percent** of registered nurses and nursing students reported being physically assaulted—and **over 50 percent** verbally abused—in a 12-month period (2014 American Nurses Association's Health Risk Appraisal survey of 3,765 registered nurses and nursing students).[5]
- **12 percent** of emergency department nurses experienced physical violence—and **59 percent** experienced verbal abuse—during a seven-day period (2009–2011 Emergency Nurses Association survey of 7,169 nurses).[6]
- **13 percent** of employees in Veterans Health Administration hospitals reported being assaulted in a year (2002 survey of 72,349 workers at 142 facilities).[7]

Some professions and settings are more at risk than others. In 2013, according to the Bureau of Labor Statistics, psychiatric aides experienced the highest rate of violent injuries that resulted in days away from work, at approximately 590 injuries per 10,000 full-time employees. This rate is more than 10 times higher than the next group, nursing assistants, who experienced about 55 such injuries per 10,000 full-time employees. Registered nurses experienced about 14 violent injuries resulting in days away from work per 10,000 full-time employees, compared with a rate of 4.2 in U.S. private industry as a whole. Surveys show that high-risk areas include emergency departments, geriatrics, and behavioral health, among others.[6,7]

In 2013, the most common causes of violent injuries resulting in days away from work across several healthcare occupations were hitting, kicking, beating, and/or shoving (see graph).

Violent Injuries Resulting in Days Away from Work, by Cause



Data source: Bureau of Labor Statistics, 2013 data.

Workplace violence is costly—and preventable.

Workplace violence comes at a high cost. If an employee requires medical treatment or misses work because of a workplace injury, workers' compensation insurance will typically have to pay the cost. For example, one hospital system had 30 nurses who required treatment for violent injuries in a particular year, at a total cost of $94,156 ($78,924 for treatment and $15,232 for lost wages).[8] If your organization self-insures (as some large healthcare organizations do), it will bear the full cost. If your organization does not, its claim experience can still affect insurance premiums.

Violence can also lead to other less obvious costs. For example:

- Caregiver fatigue, injury, and stress are tied to a higher risk of medication errors and patient infections.[9]
- Studies have found higher patient satisfaction levels in hospitals where fewer nurses are dissatisfied or burned out.[10]
- Injuries and stress are common factors that drive some caregivers to leave the profession. The estimated cost of replacing a nurse is $27,000 to $103,000.[11] This cost includes separation, recruiting, hiring, orientation, and training. Some estimates also account for lost productivity while a replacement is hired and trained.

Healthcare facilities can reduce workplace violence by following a comprehensive workplace violence prevention program. An effective program includes five key components:

- Management commitment and worker participation
- Worksite analysis and hazard identification
- Hazard prevention and control
- Safety and health training
- Recordkeeping and program evaluation

A workplace violence prevention program can also fit effectively into a broader safety and health management system, and it can help your facility enhance employee and patient safety, improve the quality of patient care, and promote constructive labor-management relations.

Workplace Violence Prevention Resources

- OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* describe the five components of an effective workplace violence prevention program, with extensive examples. See www.osha.gov/Publications/osha3148.pdf.
- *Preventing Workplace Violence: A Road Map for Healthcare Facilities* expands on OSHA's guidelines by presenting case studies and successful strategies from a variety of healthcare facilities. See www.osha.gov/Publications/OSHA3827.pdf.
- *Workplace Violence Prevention and Related Goals: The Big Picture* explains how you can achieve synergies between workplace violence prevention, broader safety and health objectives, accreditation, and a "culture of safety." See www.osha.gov/Publications/OSHA3828.pdf.

[1] Occupational Safety and Health Administration (OSHA). 2015. Guidelines for preventing workplace violence for healthcare and social service workers. No. 3148-04R.

[2] Findorff, M.J., McGovern, P.M., Wall, M.M., and Gerberich, S.G. 2005. Reporting violence to a health care employer: A cross-sectional study. *AAOHN Journal*. 53(9): 399–406.

[3] Gerberich, S.G., Church, T.R., McGovern, P.M., Hansen, H.E., Nachreiner, N.M., Geisser, M.S., Ryan, A.D., Mongin, S.J., and Watt, G.D. 2004. An epidemiological study of the magnitude and consequence of work related violence: The Minnesota Nurses' Study. *Occupational and Environmental Medicine*. 61(6):495–503.

[4] ASIS International. 2011. *Managing Disruptive Behavior and Workplace Violence in Healthcare*.

[5] American Nurses Association. 2014. *American Nurses Association Health Risk Appraisal (HRA): Preliminary Findings October 2013–October 2014*.

[6] Emergency Nurses Association and Institute for Emergency Nursing Research. 2010. *Emergency Department Violence Surveillance Study*.

[7] Hodgson, M.J., Reed, R., Craig, T., Murphy, F., Lehmann, L., Belton, L., and Warren, N. 2004. Violence in healthcare facilities: Lessons from the Veterans Health Administration. *Journal of Occupational and Environmental Medicine.* 46(11): 1158–1165.

[8] Speroni, K.G., Fitch, T., Dawson, E., Dugan, L., and Atherton, M. 2014. Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *Journal of Emergency Nursing*. 40(3): 218–228.

[9] Rogers, A.E., Hwang, W.T., and Scott, L.D. 2004. The effects of work breaks on staff nurse performance. *Journal of Nursing Administration*. 34(11): 512–519.

[10] McHugh, M.D., Kutney-Lee, A., Cimiotti, J.P., Sloane, D.M., and Aiken, L.H. 2011. Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs*. 30(2): 202–210.

[11] Li, Y., and Jones, C.B. 2012. A literature review of nursing turnover costs. *Journal of Nursing Management*. 21(3): 405–418. (Dollar amounts presented here are adjusted to 2013 prices.)