Workplace Violence – 21st Century Update

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“I have nothing to disclose”
Donna Gross

- 54 y.o. psychiatric technician at large California forensic psychiatry facility
- Strangled and killed while returning from dinner break to locked unit
What is workplace violence?

Any physical assault, threatening behavior, or verbal abuse occurring in the work setting

The four types of violence

• Type 1: Criminal intent
  – Robbery, shoplifting, trespassing, and terrorism
• Type II: Customer/client
  – Caregivers, police/correctional officers, flight attendants, teachers, social service workers
• Type III: Worker on worker
  – Verbal abuse, bullying (“Horizontal violence”)
• Type IV: Personal relationship
  – Domestic violence
WPV is a major problem

- nearly 2 million acts of nonfatal work-related violence occur annually
- third leading cause of occupational injury fatality in the United States and the second leading cause of death for women at work
- 63% of workers report a past incident of sexual threat, and 84% report a past incident of physical or sexual assault.

Health care workers are at high risk for WPV

- Injury rates second only to law enforcement (OSHA 2003)
- Nurses 3x more likely to be victims of violence than other professionals (Keely 2002)
- More than ¾ of nurses have experienced verbal or physical abuse in past year (Hader 2008)
Health care workers are at high risk for WPV (more)

- increased WPV rates in nursing home/long term care facilities, intensive care, psychiatric/behavioral or emergency departments, and with geriatric patients (Gerberich 2004)

Psychiatric nurses are at very high risk

- Almost every psychiatric nurse has been assaulted during career (Hatch-Mailette 2007)
- 1/3 of psychiatric inpatients in physical assaults during stay (Bjorkly 1999)
- Inpatient risk > outpatient risk (Gale 2002)
- Psychiatric nurses greatest risk on team (Trenowith 2003)
Most injuries do not get reported

• About half of all incidents do not get reported (Findorff 2005)
• More frequent and severe injuries tend to get reported
• Women report more often than men but incidence similar

Why don’t injuries get reported?

• “What’s the point?”
  – Organizational/safety culture and commitment
• “Fear factor”
  – job loss, blame, peer pressure
• “It’s just part of the job”
  – @#$% happens
  – the patient is the problem
Consequences of WPV

• Physical injuries are the “tip of the iceberg”
• Emotional and psychological affects
  – anxiety, depression, insomnia, loss of self-confidence (Findorff 2005, Gilioli 2006)
  – Burnout and exhaustion, low morale (Hutchinson 2008)
  – More sick leave and staff turnover (O’Connell 2000)
• Direct and indirect costs >$250,000 per serious incident (Murray 2008)

Predicting violence is difficult

• Older males with schizophrenia and substance abuse, or younger male/female patients with personality disorders and violence history (Flannery 2011)
• Precipitating factors
  – Acute psychotic disorganization
  – Organic impairment
  – Denial of service
  – Provocation by others
Predictive tools are not perfect

• Dynamic Appraisal of Situational Aggression (DASA) (Ogloff 2006)
• Attempted and Actual Assaults Scale (Bowers 2007)
• Historical, Clinical, Risk Management-20 (HCR-20) (Gray 2010)

Modest value in predicting WPV in forensic/state hospitals

• Most assaultive patients had a primary psychotic disorder, but the most common type of assault was impulsive (54%), rather than psychotic or organized (Quanback 2007)
• Classification of Violence Risk (COVR) (McDermott 2011)
  – 146 patients followed for 20 weeks
  – Modest correlation (.331)
Environmental factors important

• Avoid coercive behaviors and “power struggles”
• Enhance verbal and nonverbal communication, reduced stimulation, active listening, diversionary techniques, limit setting, and as-needed medication
• Promote culture of structure, calmness, negotiation, and collaboration rather than control

Staffing levels make a difference

• Staffing levels inversely proportional to incidence of violence (Bowers 2007)
• Improved quality indicators with greater nursing ratios (DeLacy 2005)
Training necessary but not sufficient

- De-escalation of violence important
- Late intervention – not primary prevention
- Does not predict or prevent all situations
- Training does not consistently decrease assault rates (Wassell 2009)

Post violence staff needs

- Common reactions of fear, anger, denial, secrecy and retaliation
- Positive outcomes with group sessions post-assault (Lanza 2005)
- Post assault support decreases emotional and social reactions (Lu 2007)
Prosecution for assaults

- Psychiatric patients often not charged
- Reluctance of staff to participate in legal case
- BUT - ignoring assaults undermines security and increases fear and cynicism
- No data on effectiveness of reporting requirements

Interventions *can* make a difference

- Decreased rates of WPV with cell phones and personal alarms (Gerberich 2005)
- Comprehensive WPV programs are feasible and have an impact (Lipscomb 2006)
- Security personnel can reduce workplace assaults (Trinkoff 2008)
- Decreased assault rates in ERs and psychiatric units after 1995 California Hospital Safety and Security Act (Peek-Asa 2009, Casteel 2009)
WPV prevention programs

- Management commitment and worker participation
- Education and training
- Incident reporting and followup
- Adequate staffing
- Environmental modifications
  - Crime Prevention Through Environmental Design (CPTED)

What went wrong?

- Unrestricted grounds pass
- Personal alarm didn’t work outside
- No escort or bus system
- No security personnel on grounds
Senate Bill 1299

- WPV prevention plan
- Definition of violence
- Hospitals document a written record of any violent incident
- Hospitals* must report violent incidents to DOSH
- DOSH must post report to website

*Does not apply to any hospital operated by State Hospitals, Development Services, or Corrections and Rehab
Combine Petitions with SB 1299

Source: Rebecca Jackson, MPH

Workplace Violence Claims among Healthcare workers, California 2010-2012

Source: Rebecca Jackson, MPH
### Demographics of Workplace Violence Claims, California 2010-2012

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>4,884</td>
<td>100%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3,393</td>
<td>69%</td>
</tr>
<tr>
<td>Male</td>
<td>1,466</td>
<td>30%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 – 19</td>
<td>22</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>20 – 24</td>
<td>573</td>
<td>12%</td>
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<tr>
<td>25 – 34</td>
<td>1,234</td>
<td>25%</td>
</tr>
<tr>
<td>35 – 44</td>
<td>1,024</td>
<td>21%</td>
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<tr>
<td>45 – 54</td>
<td>1,339</td>
<td>27%</td>
</tr>
<tr>
<td>55 – 64</td>
<td>583</td>
<td>12%</td>
</tr>
<tr>
<td>65 - 84</td>
<td>98</td>
<td>2%</td>
</tr>
</tbody>
</table>

*Source: Rebecca Jackson, MPH*

### Violence Typology, Health Care Workers, WCIS 2010-2012

- **Type 2**

*N = 4,884*

Workers Compensation Information System (WCIS). Data extracted March 28, 2014

*Source: Rebecca Jackson, MPH*
What Happens?

Employee was assaulted and robbed in the parking lot of a scenic location during lunch time.

Co-worker made multiple threats and threaten to kill the claimant causing stress.

Punch to right side of face/ cheek by hospice patient when LPN was trying to calm an agitated patient.

Employee tried assisting resident to the restroom when resident became aggressive hitting and pulling the employee hair, resulting in an unknown injury to the head.

Source: Rebecca Jackson, MPH

Workplace Violence Claims among Healthcare workers, California 2010-2012

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>1629</td>
<td>33%</td>
</tr>
<tr>
<td>Skilled Nursing and Intermediate Care Facilities</td>
<td>866</td>
<td>18%</td>
</tr>
<tr>
<td>Government</td>
<td>583</td>
<td>12%</td>
</tr>
<tr>
<td>Residential and Intellectual Disability Facilities</td>
<td>303</td>
<td>6%</td>
</tr>
<tr>
<td>Residential Care Facility - Elderly</td>
<td>276</td>
<td>6%</td>
</tr>
<tr>
<td>Psych and Substance abuse and Specialty Hospitals</td>
<td>200</td>
<td>4%</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>188</td>
<td>4%</td>
</tr>
<tr>
<td>Child and Youth Services</td>
<td>162</td>
<td>3%</td>
</tr>
<tr>
<td>Ambulance and Ambulatory Care Services</td>
<td>154</td>
<td>3%</td>
</tr>
<tr>
<td>Physician Offices</td>
<td>129</td>
<td>3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>183</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Rebecca Jackson, MPH
Section 3342 – WPV in healthcare

• Scope – very broad
• Workplace violence – Types 1, 2, 3 and 4
• WPV prevention plan – comprehensive
• Violent Incident Log
• Annual program review
• Training
• Special reporting for general acute care, acute psych and special hospitals
The most common type of workplace violence is:

A. Type 1: *Criminal intent*
B. Type II: *Customer/client*
C. Type III: *Worker on worker*
D. Type IV: *Personal relationship*

Which of the following is correct?

A. Most WPV incidents are reported
B. Nurses are less likely to be victims of violence than other professionals
C. WPV incidents are the second leading cause of death for women at work
D. Verbal abuse is generally not considered a form of WPV
All of the following interventions for WPV should be considered *except*:

A. Security staff
B. Alarm systems
C. Definitive patient screening tools
D. Adequate personnel