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NEW THINKING IN HEALTHCARE
VIOLENCE PREVENTION

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Overview

On Friday, August 11, nurses in St. Charles, Illinois rallied to stop the daily barrage of violence they face in all different types of health care settings. Their theme was #STAMP, an acronym for “Stop Assaults on Medical Providers.” The event was prompted by a horrific incident during which a gun taken from a security guard and used against nurses who were taken hostage, tortured at gunpoint, and raped in a Kane County community hospital. Prisoners transported for emergency care have contributed to Emergency Departments becoming possibly the most dangerous workplaces in America, but violence against healthcare workers in all settings is rampant.[i] Aside from law enforcement, the healthcare sector is statistically among the industries most subject to violence in the United States.[ii]

According to a study published in the New England Journal of Medicine in June 2016, *“Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored.”*[iii] According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHCO), healthcare settings that were once considered sanctuaries are now confronting *“steadily increasing rates of crime, including violent crimes such as assault, rape, and homicide.”*[iv] The highest number of assaults in U.S. workplaces each year is directed against health care workers.[v] Dramatic active shooter incidents in hospitals and healthcare facilities make for sensational headline news stories, but those incidents are not representative of the violence healthcare workers actually face every day. Active shooter incidents are the rarest, but most devastating form of workplace violence, and therefore due to their seriousness, must be included in a hospital or healthcare organization’s approach to violence prevention, but should not be the exclusive focus.

Violence in healthcare settings has risen steadily in recent years. That has taken a growing financial and human toll on the nation's 15 million healthcare workers and on its hospitals and other healthcare organizations. It is important for administrators, staff and others concerned with safety and security in healthcare environments to have an accurate

understanding of the problem in order to develop meaningful and effective countermeasures to this risk. Healthcare workers have the right to education and training in the recognition, management, and reduction of workplace violence. The mitigation of workplace violence requires a *"zero tolerance"* environment instituted and supported by hospital leadership.

- 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 become an active shooter
- gang violence in the emergency department
- a domestic dispute that spills over into the workplace
- or coworker bullying

As a starting place, it is important to have an inclusive understanding of workplace violence in general, and knowledge of how general workplace violence prevention principles require modification for the unique risks faced in healthcare. A comprehensive view of the problem must be inclusive of five different types or sources of violence. While some are more common in hospital and healthcare settings, no organization is immune from each of these types of violence.

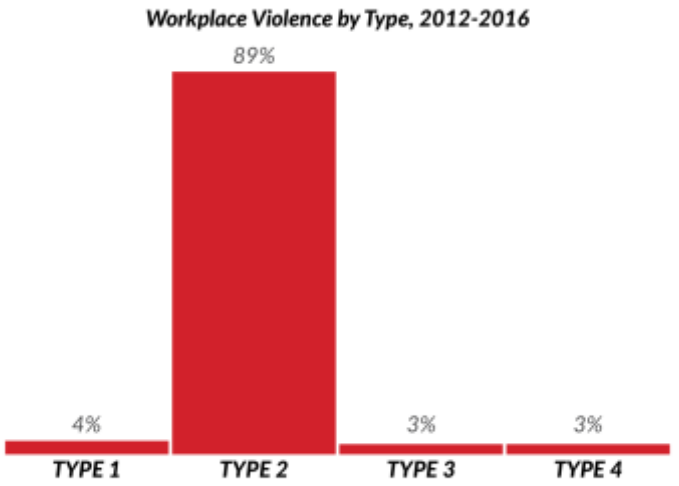
Type I Violence

Type I violence occurs during the commission of a property crime such as a robbery, theft or trespassing. In this scenario, there is no legitimate business relationship between the offender and the organization. The organization or victim is selected because of the perception that there is something of value to be taken, such as cash, medications or electronics.

Type I violence is most common in convenience stores, liquor stores, and gas stations, as well as taxis and limousines, where people may work late at night, alone, and have cash on hand. Hospitals and healthcare facilities, especially those with pharmacies, are at a heightened risk, as are home health workers who may be perceived by others as potentially carrying medications or cash. Hospitals are also 24-hour operations with large facilities where a worker may be alone in part of the building for extended periods of time. In general, Type I workplace violence is the most prevalent in the general U.S. workforce, and 85% of workplace homicides occur in this category, but this is not the most common source of violence in healthcare work.

Type II Violence

Type II violence is by far the most prevalent form of workplace violence in hospital and health care jobs. Healthcare and social service workers are four times more likely to be the victims of violence on the job than any other type of worker in the U.S.[vi] In instances of Type II violence the offender is known to the organization as a client, customer or patient, and the violence occurs during the routine delivery of services. In some settings, and especially in healthcare, the risk of assault or injury by patients represents a real and ongoing threat in everyday work.



Violence in hospitals and healthcare settings by type.

In hospitals and healthcare facilities there are many factors contributing to the risk of violence that simply do not exist in other types of employment. While the risk factors vary by healthcare setting, they typically include the following:

- 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
- Lack of means of emergency communication
- Presence of firearms (including those carried by law enforcement and security officers)
- Working in neighborhoods with high crime rates
- Lack of training and policies addressing violence
- Understaffing
- High worker turnover
- Long wait times and overcrowded waiting rooms
- Unrestricted public access
- Perception that violence is tolerated and reporting incidents will have no effect

Type II continues to dominate all other types of workplace violence and is increasing. Attacks by patients accounted for 85% of all aggravated assaults and 91% of all assaults in U.S. hospitals.

Type III Violence

When people think about workplace violence, the sort of violence most likely to come to mind is Type III; co-worker-to-co-worker violence. A hospital in New York City recently experienced an instance of extreme violence when a former physician returned looking for a colleague he blamed for forcing his resignation. The situation ended with another doctor being killed, and six others employees seriously injured, before the attacker took his own life.

Type III violence can involve both current and former employees. There are many instances in which the violence involves worker-to-supervisor, and in some cases supervisor-to-worker attacks. The motivating factor is often one of a series of interpersonal or work-related conflicts, losses or traumas, and may involve a sense of injustice or unfairness. Type III violence accounts for about 7% of all workplace homicides, and managers and supervisors are often at the greatest risk of being victimized. It is important to remember that even workers who have separated from the organization may still represent a risk of violence in some situations.

Type IV Violence

When violence and abuse follow a worker from home to work, it is considered Type IV or *"Intimate Partner Violence."* It is important for employers to recognize violence and abuse at home are not just personal problems; they can and do intrude into the workplace, sometimes violently with tragic consequences. There are many cases each year, often involving multiple victims, when a former spouse or partner brings violence or aggression to their partner's workplace. The perpetrator may know their partner's work hours, parking location or other information that may make them vulnerable. The risk of violence increases significantly when one party attempts to separate from the other.

Type IV violence is typically a spillover of domestic violence into the workplace and refers to perpetrators who are not employees or former employees of the affected organization. Women are more often the targets. Healthcare environments may be particularly vulnerable to Type IV violence since the workforce is often predominantly female. It is important to note a significant percentage of violent attacks to hospital workers occur in parking areas, a place where a potential target of Type IV violence may be especially vulnerable when transitioning from their vehicle to buildings.

Type V Violence

The intersection of workplace and terrorism is referred to as Type V violence. In these situations, the violent actor is an extremist of some sort who believes violence is necessary, justified or deserved in their radical views. Their violence is directed at an organization, its people and/or property for ideological, religious or political reasons. In Type V violence, target selection is not based on sense of personal or professional injustice in the workplace, but rather rage against what the targeted organization does or represents. The shooting at the Planned Parenthood clinic in Colorado Springs in November 2015 is an example of extreme ideology driving an active shooter event. Hate crimes and terrorism are examples of Type V violence especially when they are directed against an organization and its employees. Hospitals and healthcare organizations, especially those that may be affiliated with universities, may be at greater risk if they are involved in any type of controversial research or medical procedures.

Political pundits and the media often argue if such events are workplace violence or terrorism; Type V violence is the place where terrorism and workplace violence intersect. Terrorists can and have targeted hospitals. Approximately 100 terrorist attacks have been perpetrated at hospitals worldwide, in 43 countries on every continent, killing 775 people and wounding 1,217 others.[vii] Hospitals are attractive primary or secondary targets. An attack on a hospital can distract police and EMS from the primary target of attack, and also confound the removal and treatment of the wounded from the site of the primary attack.

In a recent study addressing the risk of active shooter situations in hospitals and healthcare setting, the authors pointed out, *"Although the risk of such events might be low, hospitals can be attractive targets because of the presence of pharmaceuticals, narcotics, radioactive materials, sensitive information and controversial research activities*."[viii]

The Active Shooter Risk in Healthcare Settings

Most episodes of workplace violence, regardless of the setting, do not involve weapons and do not result in fatalities. Of course, some do, and those cases of extreme violence, such as active shooter situations, receive a great deal of media coverage. As such, it is easy to understand why many people conflate workplace violence with gun violence, and furthermore, shooting incidents with active shooter situations. Administrators and planners should note active shooter situations in hospitals are different from those in other environments in several critical ways. In other settings, active shooters typically select target rich environments that offer the potential for high casualty counts, and in most instances, target selection is random with no prior relationship between the shooter (96% male) and his victims.[ix]

Despite media portrayals of hospital violence, the likelihood of being shot in a hospital is less than the chance of getting struck by lightning. Hospital shooting incidents tend to be acts of targeted violence and do not typically involve random victim selection. In hospital shootings, the shooter (91% male) more likely has specific targets in mind, usually individuals with whom he has a grudge.[x] Such instances usually arise from smoldering hostility, as opposed to sudden, impulsive, angry reactions. Many involved former staff or patients who have been off the hospital's radar for some time. The most common scenarios in hospitals stem from a beef with current or former caregivers or coworkers whom the perpetrator believes have wronged him or his loved ones in some way.

Motives for hospital shooting incidents:

- Grudge/Revenge (27%)
- Suicide (21%)
- Ending life of ill relative (14%)
- Escape attempt by prisoner (11%)
- Societal violence (9%)
- Mentally unstable patient (4%)

Many clinical staff members will be familiar with the phrase used to train interns in making accurate diagnoses: *"When you hear hoofbeats, think horses, not zebras."* Those concerned with hospital and healthcare safety must be prepared for the exotic and statistically rare active shooter event, but must be as or more concerned with the constant risk of Type II: Patient-to-Staff violence that involves physical assaults without firearms.

Violence Risks in Home and Community-based Healthcare

A 2015 study by the U.S. Bureau of Labor Statistics (BLS) stated home healthcare is anticipated to experience the fastest job growth across all healthcare settings, with projected growth of 60% (adding more than 760,000 new jobs between 2014 and 2024). Employment of home health aides is projected to grow 38 percent during that same time, much faster than the average for all occupations.[xi] As the baby-boom population ages and the elderly population grows, demand for the services of home health workers will continue to increase.[xii]

Those workers away from traditional healthcare facilities may be especially vulnerable to safety and security risks. Violence risks in the field cannot be resolved in the same way as within a hospital, clinic or nursing home setting where employees have access to employment assistance programs, human resources or security personnel. In many instances, workplace violence policies and programs due not sufficiently address violence perpetrated by patients or others in the home against homecare workers.[xiii] All employers have a Duty of Care to each individual employee, regardless of where they work. Omitting mobile

workers from the organization's overall safety and security practices or programs creates a double standard and undermines both the employer's and employee's position. Safety and security for mobile workers is best addressed as an integrated part of an organization's overarching approach to hazard prevention, not as a standalone feature. The safety and security for mobile workers cannot be perceived to be a secondary concern. When it comes to safety and security, just because mobile workers are out of sight, does not mean they can be out of mind. The prevention of violence and injuries to homecare staff is critical. Such workers are often on their own, dependent only on their own knowledge and skills to handle high-risk situations. The right training and tools to handle crisis situations is essential to their safety and success.

The risk of violence to home health workers comes from several potential sources, including the five types of workplace violence previously discussed. In addition to violence from the designated patient, family members and others in the home may pose a risk; others on the streets around the patient's residence who believe that worker is carrying valuable medications or supplies; and hostile individuals who may be encountered during travel to and from the patient's home. The dangers include verbal abuse, weapons, illegal drugs, and other forms of violence in the home or community. Home healthcare workers may work any hour of the day or night; they find themselves in unsafe neighborhoods; and they might have to face alcohol or drug abusers, family arguments, and even aggressive dogs. The violence faced by these workers is unique to the home healthcare field, and special efforts must be made to identify and mitigate these risks.

Home healthcare workers must be trained to identify a potentially dangerous situation, and how to manage hostile and violent scenarios. Such training may include recognizing the indicators of drug use, threatening body language, and techniques to help defuse situations. Programs introducing basic *"street smarts"* can help workers safely manage encounters with potentially hostile strangers while coming and going from their assignments. It is also critical that workers in field settings have access to communications technologies to quickly and covertly let supervisors and co-workers know they are in trouble. Time and circumstances may not allow them to make a mobile phone call to the office or to the police. Panic buttons and other mechanisms should supplement safety and violence reduction practices such as informing their office of their intended itinerary and having a system in place to check on the whereabouts and welfare of field workers throughout their shift.

OSHA's Increased Focus on Healthcare Violence

Over the past year, the protection of healthcare and social service workers from violence has gained traction. In December 2016, OSHA issued a Request for Information when considering the possibility of developing a specific standard aimed at preventing workplace violence in healthcare and social services, noting the rates of workplace violence in those industries were *"substantially higher"* than in private industry. OSHA has published voluntary guidelines for healthcare and social service workers since 1996, but workplace violence in all industries typically falls under the *"General Duty Clause"* with no specific attention to high-risk occupations. Those guidelines were updated in 2015 to be more prescriptive, stating that a written program for workplace violence prevention, incorporated into an organization's overall safety and health program, offers the best approach to reducing the risk of violence.

Many have called for OSHA to create an industry-standard to keep healthcare workers safe from violence. On his final day in office, the Assistant Secretary of Labor David Michaels announced OSHA will grant a petition by the National Nurses Union (NNU) for a standard to prevent workplace violence in healthcare settings. In January, OSHA began gathering input from the public and stakeholders, one of the early stages of a process that can take five to seven years before the implementation of a regulation.

In the absence of federal rules on violence in the healthcare industry, several states have legislated that healthcare employers put in place violence prevention programs, and more than half of all states now have enacted additional criminal penalties for assaults on staff. The American Nurses Association (ANA) has developed a template for a model state bill, titled the *"The Violence Prevention in Health Care Facilities Act"* to help law makers jump start the process.[xiv]

Mitigating the Risk of Violence in Healthcare

There is universal acceptance of the idea that violence against healthcare workers, in both fixed locations and field settings, is a real and pressing problem. Even so, there is

little agreement about how to reduce risk. Completely eliminating the risk of violence in healthcare may not be possible, but the current levels of violence are unsustainable. The associated costs, both human and fiscal, will continue to create pressures on the industry until viable countermeasures are developed. Violence in hospital and healthcare settings is a multifaceted problem that requires and multidimensional model using an integrative approach blending legistlative, legal-justice, administrative, physical security, personal technologies and personal safety practices across the entire healthcare workforce.

OSHA's *"Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers"* provides one of the more useful templates for developing an effective violence reduction program.[xv] One of the strengths of this guidance is that it is inclusive of violence prevention action-steps for both fixed locations and field workers in a range of healthcare occupations, including behavioral healthcare. There is a strong theme throughout the document reminding readers that safety and security are shared obligations between the employer and employee; both must do their part. Therefore, suggestions for management commitment and employee participation are prominent features in OSHA's recommendations. The various checklists provide a structured approach to what can seem like a large and amorphous problem. Leaders and planners must keep in mind there cannot be half-measures in violence prevention; everyone must be all in. To begin the process it is necessary to acknowledge the risk is real; failure to complete the project or develop a meaningful violence prevention program can create new risks unto themselves.

Conclusion

Working in healthcare, with real patients and real problems, invites certain risks. This is not to suggest in any way that violence is acceptable; it is not, ever. But it is unlikely, given the human condition, violence in healthcare will ever completely be eliminated. Mitigation is by definition those steps taken to reduce the likelihood of a problem or the seriousness of that problem if it occurs. The risk of violence comes at healthcare workers from many angles. Efforts to mitigate the risk of violence to all healthcare workers in all healthcare settings must also come from multiple angles. Training in techniques to recognize and effectively respond to violence; technologies that allow workers to quickly and covertly notify others of a need for assistance; the unconditional support of leaders in healthcare organizations and government; combined with changes in organizational culture that refuse to tolerate violence to healthcare workers, are all necessary elements of a viable violence reduction strategy that encompasses all five types of workplace violence, wherever a healthcare provider may be on the job.

About Everbridge

Everbridge, Inc. (NASDAQ: EVBG) is a global software company that provides critical event management and enterprise safety applications that enable customers to automate and accelerate the process of keeping people safe and businesses running during critical events. During public safety threats such as active shooter situations, terrorist attacks or severe weather conditions, as well as critical business events such as IT outages or cyber incidents, over 3,000 global customers rely on the company's SaaS-based platform to quickly and reliably construct and deliver contextual notifications to millions of people at one time. The company's platform sent over 1.5 billion messages in 2016, and offers the ability to reach more than 200 countries and territories with secure delivery to over 100 different communication devices. The company's critical communications and enterprise safety applications, which include Mass Notification, Incident Management, IT Alerting, Safety Connection™, Community Engagement™, Secure Messaging and Internet of Things, are easy-to-use and deploy, secure, highly scalable and reliable. Everbridge serves 8 of the 10 largest U.S. cities, 8 of the 10 largest U.S.-based investment banks, all four of the largest global accounting firms, 24 of the 25 busiest North American airports and 6 of the 10 largest global automakers. Everbridge is based in Boston and Los Angeles with additional offices in San Francisco, Lansing, Beijing, London and Stockholm.

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About the Author

Steven M. Crimando is a subject matter expert and trainer specialized in human factors/behavioral sciences in homeland and corporate security, violence prevention and intervention, emergency and disaster management. Steve is a Board Certified Expert in Traumatic Stress (BCETS) and Certified Trauma Specialist (CTS). He holds Diplomat status with the American Academy of Experts in Traumatic Stress and the National Center for Crisis Management. He has been awarded Level V Certification in Homeland Security. He is recognized as an expert in the behavioral response to CBRN emergencies, crowd behavior, and mass violence. Steve is the principal of Behavioral Science Applications and serves as a consultant and trainer for the federal, state and local law enforcement and emergency management agencies, as well as multinational corporations and NGO's worldwide.