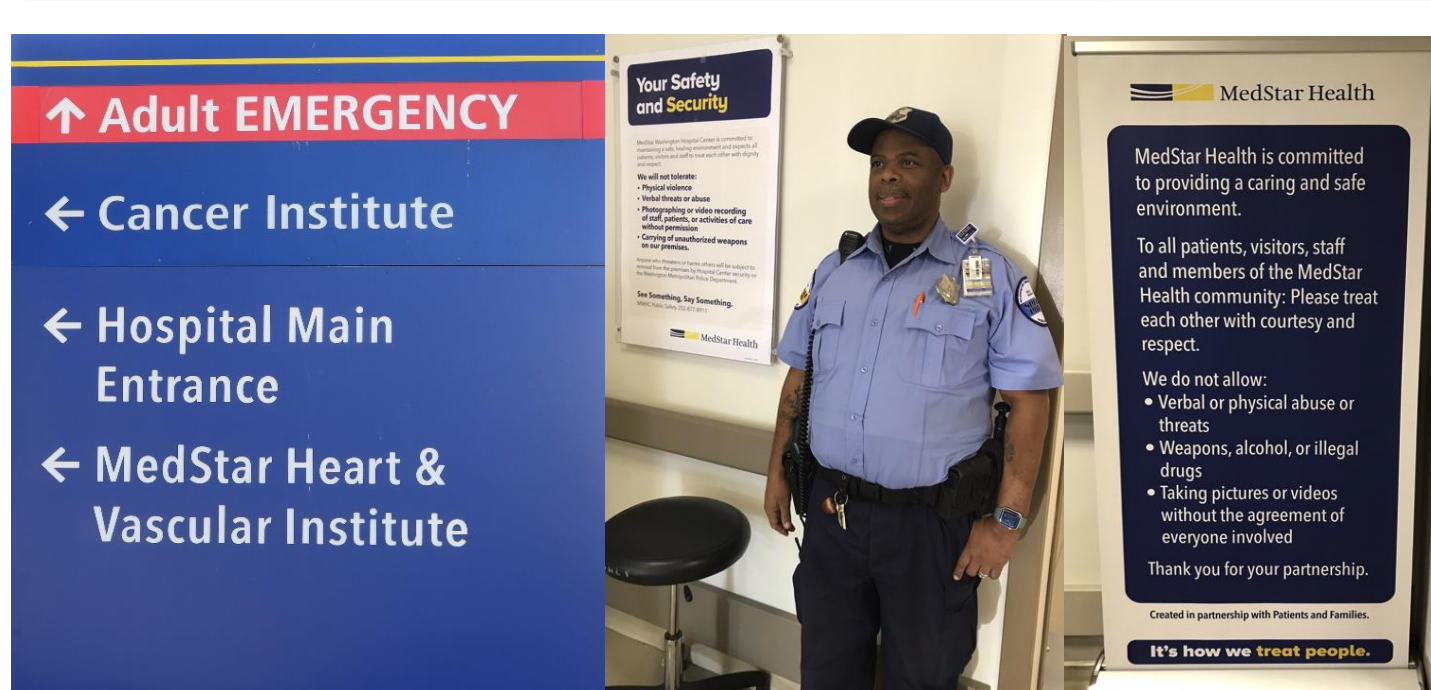


What is Workplace Violence (WPV)?

The National Institute for Occupational Safety and Health (NIOSH): "... any physical assault, threatening behavior, or verbal abuse occurring in the work setting" (1).

The World Health Organization (WHO) and the International Council of Nurses (ICN): "... incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health" (2).

Type of Violence Experienced in the Past Year	Nurses Reporting
Verbally threatened	67.8%
Physically threatened	38.7%
Pinched or scratched	37.5%
Slapped, punched, or kicked	36.2%
Objects thrown at you	34.6%
Verbally harassed based on your sex or appearance	33.3%
Spat on or exposed to other bodily fluids	29.9%
Groped or touched inappropriately	19.8%
I have not experienced WPV	18.4%



WPV takes its toll

Impacts of Workplace Violence	Nurses Reporting
Anxiety, fear, or increased vigilance	63.5%
Considered leaving the profession	37.2%
Physical injury or other physical symptoms (headaches, stomach aches, etc.)	33.4%
Difficulty working in environment that reminds me of past incident	27.4%
Took time off work or reduced work	22.9%
Changed or left job	19.2%
Psychological effects prevent me from working	9.7%
Applied for workers' compensation	5.0%
Physical injury prevents me from working	3.7%
Left profession	4.1%
No injury/no effect	18.5%

Healthcare can be Dangerous!

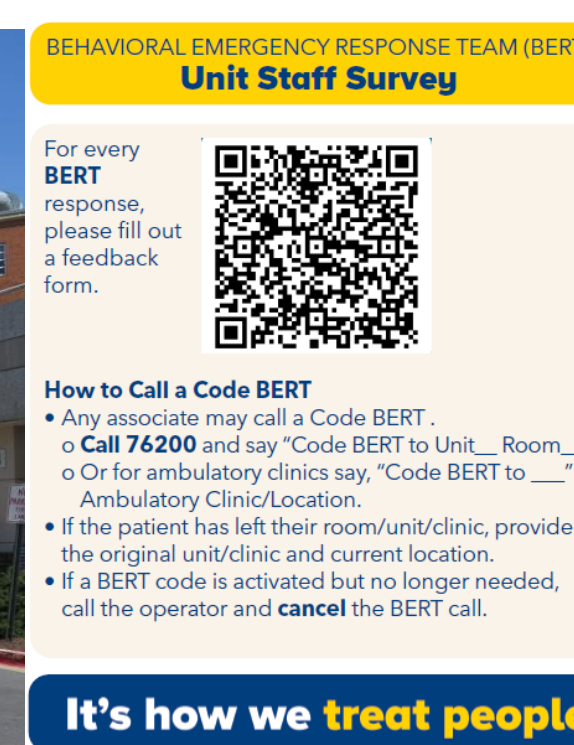
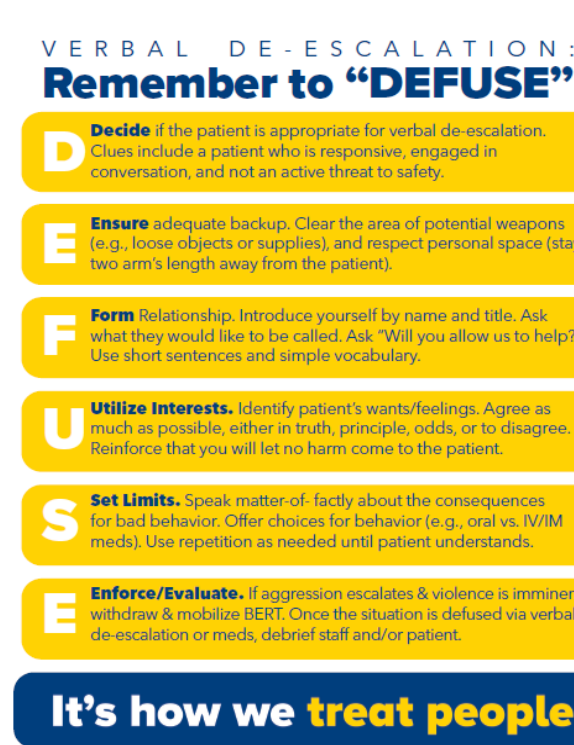
According to the Bureau of Labor Statistics, 20,050 workers in the private industry experienced trauma from nonfatal workplace violence in 2020. These incidents required days away from work.

- Of those victims who experienced trauma from workplace violence:
- 73% were female
 - 62% were aged 25 to 54
 - **76% worked in the healthcare and social assistance industry**
 - 22% required 31 or more days away from work to recover, and 22% involved 3 to 5 days away from work (3)

How can medical librarians assist with hospital workplace violence prevention efforts?

The dearth of evidence-based interventions in healthcare workplace violence prevention presents significant opportunities for medical librarians to facilitate data collection, tool creation, and program development. At MedStar Health, a non-profit healthcare organization with 10 hospitals and over 100 care sites serving the Baltimore-Washington area, medical librarians play a significant role in the system's workplace violence prevention program and on the system's multi-disciplinary workplace violence prevention committee.

- **During program development:** provided regulatory literature from government agencies overseeing workplace safety.
- **In protocol implementation,** provided materials reflecting methods and implementation guidance.
- **Provided foundational literature and tools on physical assault risk in patients with mental illness.** Literature has served to provide structure for policy protocol implementation and the tools found are being incorporated into the electronic medical record.
- **Acquired books relevant to Workplace Violence prevention.**
- **Currently:** perform targeted literature searches on topics and programs of discussion and in planning.
- **Set up autoalerts to look for workplace violence-related Medline and Embase articles.**
- **Provided evidence-based tools for consideration and implementation.**
- **Discuss and disseminate literature and articles for review both at local and system workplace violence prevention committees.**
- **Facilitate data collection and publication of work and findings.**
- **Serve as "eyes and ears" in identifying trends and research in healthcare violence prevention.**



What is MedStar Health doing to prevent WPV?

MedStar Health is taking a multi-pronged approach to violence prevention. The approach involves **education, clinical risk assessment, risk stratification, data analysis, technology, awareness, and legal interventions.**

Our comprehensive **education** program encompasses several fronts and includes learning prevention strategies through recognition of risk factors and sound verbal de-escalation skills. We provide physical skills training based on risk of violence in individual workspaces (Emergency Departments, Behavioral Health Units, Home Health Care, etc.). Physical skills training incorporates the basics of verbal de-escalation and risk factor recognition as the foundation for training. Additionally, MedStar Health has online videos of escalating scenarios and both effective and ineffective responses so staff can see how inappropriate response can escalate into physicality.

We have incorporated **clinical risk assessment** tools into our electronic medical records. Admission and triage assessments identify current behaviors or past histories of violence or other risk factors that could lead to violence. MedStar Health's medical librarians identified evidenced based tools to assess patients admitted with mental illness. These tools and associated treatment protocols are automatically initiated on admission and are validated stratified predictors of physical assault in the coming 24 hours. Level of risk initiates various interventions. The tools have been an effective means to communicate risk across shifts and care settings. Our electronic medical record also allows chart alerts that identify patients with histories of violence. These alerts can be seen across care settings throughout our large system.

Our **awareness** campaign also incorporated a code of conduct that is run regularly on our internal TV screens and is front facing on our external websites. We have worked with local and state governments to make officials and the public aware of violence perpetrated in our facilities. And we have comprehensive and system-wide standardized signage on violence prevention.

Violence risk stratification has allowed the system to better drive resources based on identified need. The type of violence in emergency departments requires a robust security presence, hardened infrastructure, and planned emergent responses. Behavioral health units require comprehensive behavioral assessments that drive clinical protocols and both inpatient and outpatient resources to mitigate future admissions. Areas where visitor violence is greatest have been provided with improved signage/messaging, access controls, and upgraded videography.

Data analysis is predicated on reporting and includes reviews of victim self-report, occupational health reports of injuries that reflect lost or restricted workdays and OSHA reportable injuries. We use worker compensation claims dollars spent for victims of workplace violence injuries as an annual metric of the expense of violence on our system. Our safety event reporting system has allowed tracking of security interventions, police contacts, and types of patients who are committing various types of violence.

MedStar Health has upgraded **technology**, including videography capabilities, weapons detection, access controls, and visitor management over the past several years.

Lastly, we support **legal action** when our employees are victims of physical assaults. We provide legal assistance, court escorts, and coaching when completing witness statements. We work with government attorneys who prosecute assailants and encourage cases to be adjudicated appropriately. We ask prosecutors to advance cases where the assailant has a known behavioral health illness into behavioral health court. Cases involving assaults while on illicit drugs may be asked to be adjudicated in state drug courts. These alternate courts allow a safe disposition to violence that mandates treatment to prevent criminal convictions and have proven useful in mitigating "revolving doors" of violence.

(1) <https://www.cdc.gov/niosh/docs/96-100/>
 (2) https://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf
 (3) Reported in <https://www.cdc.gov/niosh/topics/violence/fastfacts.html>
 (4) https://www.n.cdc.gov/WPVHC/Nurses/Course/Slide/Unit1_8
 Information in tables used with permission of National Nurses United
 Photographs by Fred King. Thanks to Officer Kelley for giving permission to use his picture.

We don't know the extent of the problem.

Incidents of workplace violence go unreported for many reasons:

- Workplace violence is "part of the job"
- Poor or non-existent institutional policies, procedures, staff training or supports
- Overly complex reporting procedures create a disincentive for reporting
- Concern that violence happens so frequently that it's time-consuming to report every event, in addition to a lack of response when time is taken to report
- Fear that reporting will reflect poorly on the nurse (victim blaming);
- Belief that some patients cannot be held accountable for their violent actions. (4)

There are ways to prevent WPV, but many hospitals have not implemented them

Employer Prevention Measures	Nurses Reporting
Provides training on WPV	62.8%
Provides a clear way to report incidents	31.7%
Has staff available at all times to respond to violent incidents	29.5%
Uses a charting or room-flagging system to indicate patients with increased risk for violence	26.8%
Uses security cameras	24.8%
Places additional staff to reduce the risk of violence (e.g. sitters, additional nurses, additional techs, security staff)	17.0%
Limits visiting hours	15.4%
Includes nurses and other employees in violence risk in violence risk assessments	12.3%
Uses metal detectors	7.1%
I'm not sure	13.7%
None of these	10.8%

MedStar Health is doing all of these!

MedStar medical librarians are on the lookout for new information



MedStar Health has chosen the Dynamic Analysis of Situational Aggression as their framework. The library acquired the relevant publications



Daily autoalerts search for new WPV articles in Medline and Embase

[EXTERNAL] AutoAlert: VPV
 Total documents retrieved: 3
 Results Generated From:
 Ovid MEDLINE(R) ALL <1846 to March 20, 2024>
 Ovid MEDLINE(R) <December Week 4 2023 to March Week 3 2024> (updates since 2024-03-19)
 <1>
 Unique Identifier: 38437050
 Title: Workplace Violence Prevention Training for Home Care Workers.
 Digital Object Identifier: <https://dx.doi.org/10.1093/jama.2024.1140>
 Source: Home Healthcare Now. 42(2):120-121, 2024 Mar-Apr 01.
 Authors: Small TF
 Authors Full Name: Small, Tamara Felice.
 Publication Type: Journal Article.
 Publication Status: ppublish
 <2>
 Unique Identifier: 38386330
 Title: State Approaches to Stopping Violence Against Health Care Workers.
 Digital Object Identifier: <https://dx.doi.org/10.1093/jama.2024.1140>
 Source: JAMA. 331(10):825-826, 2024 Mar 12.
 Authors: Ninan RJ; Cohen IG; Adashi EY
 Authors Full Name: Ninan, Rebekah J; Cohen, I Glenn; Adashi, Eli Y.
 Publication Type: Journal Article.
 Publication Status: ppublish
 <3>
 Unique Identifier: 37781837
 Title: Evaluation of violence against primary care healthcare professionals through different dimensions.
 Digital Object Identifier: <https://dx.doi.org/10.3233/WOR-220619>
 Source: Work. 71(3):891-899, 2024.
 Authors: Colak M; Gokdemir O; Ozcaakar N
 Authors Full Name: Colak, Mutteber; Gokdemir, Ozden; Ozcaakar, Nilgun.
 Abstract:
 BACKGROUND: Violence is common in emergency departments and is also increasing in primary care settings. It is important to research the factors that cause violence to prevent incidents.
 OBJECTIVE: The aim of this study is to determine the frequency, causes, and effects of violence in the workplace of primary care physicians in a province in Turkey.
 METHODS: This cross-sectional study was conducted among 303 family physicians working in Family Health Centers. The subjects completed a questionnaire consisting of questions designed to elicit healthcare professionals' perspectives on violence. The analysis was performed using SPSS 15.0 software, with p < 0.05 considered significant.
 RESULTS: The participants' mean age was 48.05±6.11. The majority (82%) stated that they had been subjected to violence throughout their professional life. Although the rate of exposure to violence was 56.4% in the previous year, they did not report these incidents to the appropriate authorities. The main reason for failing to report violent acts was "not caring" (40.1%). Respondents who believed "violent incidents should be reported" were under 50 years old (p = 0.045). The impact of violence on their lives was expressed as "losing interest in their profession" (40.8%). The most commonly cited cause of violence was "educational problems" (74.9%).
 CONCLUSION: Violence is prevalent in primary healthcare settings. It is suggested that there can be numerous reasons for violence, primarily a lack of education, and its effects, such as professional disengagement, are notable. Measures should be implemented to provide physicians with safe working conditions and reduce the risk of violence.
 Publication Type: Journal Article.
 Publication Status: ppublish



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