

WORKPLACE VIOLENCE IN HEALTHCARE

Maryland’s Silent Crisis

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“IT ALL HAPPENED SO QUICKLY.”

Lauren*, who works as a Registered Nurse in the Emergency Department of a Baltimore-area hospital, was washing her hands when a patient came up from behind and struck her in the head. She fell to the floor. What followed was a savage assault. At some point, she lost consciousness. She awoke on a gurney, headed for a CT scan.

**Lauren’s last name is withheld to protect her anonymity.*



I. INTRODUCTION

Lauren’s story, while shocking, is far from an isolated incident. The healthcare industry is one of the most dangerous places to work in the United States. Healthcare and social assistance workers are the most assaulted workers in the nation, accounting for almost 60 percent of violent assaults in the workplace.¹

In Lauren’s story, we see the risks healthcare workers face on a daily basis. We also see the failure of our healthcare system to properly reduce the risk of workplace violence; and the failure to properly address incidents after they have occurred. Lauren’s employer did not report the incident to the police. Lauren, as she lay on a gurney, was the first person to call the police, a move that drew the ire of her supervisor. The incident was never addressed as a group with staff, though numerous staff members had been directly affected by it, and countless more were shaken by the news of it.

Lauren was offered two weeks off. She ultimately required more than a month to recover from her physical injuries before being able to return to work. She was offered a lengthy list of therapists and advised that she may want to seek counseling. She continues to have flashbacks of the incident. She now sleeps with the lights on in her home.

“Someone is going to end up dead if we don’t come out and talk about this.” This is how Lauren recently explained why she was speaking out on behalf of all healthcare workers in Maryland. Sadly, it’s a sentiment that was echoed in interviews with countless Maryland healthcare workers conducted in the course of researching this paper.

Traditionally, caregivers have been led to believe that welts and broken limbs are an unfortunate, but mostly unavoidable, part of their work. They deal with people in crisis situations and who are experiencing physical pain or distress that can lead to violent explosions. They minimize their own injuries; they see themselves as foremost advocates for their patients.

Healthcare workers are increasingly speaking out, however, breaking the silent and demanding solutions to this avoidable crisis that exacts far too high a toll on healthcare workers and our healthcare system. Citing numerous violent incidents in their own facilities and a lack of state-wide protections, healthcare workers in Maryland are joining what has become an important national movement of healthcare workers: *the call to end workplace violence*.

Obviously, workplace violence takes a significant physical, financial and emotional toll on its victims. What is less obvious is its impact on, and danger to, patients and healthcare institutions. Workplace violence can cause lasting harm to patients and nursing home residents. It can also lead to short-staffing and longer wait-times in emergency rooms; it contributes to workers' compensation claims and legal expenses. It also stifles efficiency, deteriorates morale and hinders employee retention. All of these hidden costs will hamper the massive state-wide effort to expand and improve healthcare as national healthcare reform is implemented.

The effects of workplace violence extend beyond the immediate victim of violence to his or her family. In 2011, the Occupational Safety and Health Administration (OSHA) wrote that workplace "injuries can end up destroying a family's emotional and financial security. While workplace injuries, illnesses and fatalities take an enormous toll on this nation's economy – the toll on injured workers and their families is intolerable."²

At least seventeen other states around the nation have taken measures to protect their workers and patients from violence in healthcare. Nine of those states have passed laws that mandate workplace violence prevention programs in the workplace.³ *Maryland has yet to do so.*

This paper addresses the importance of healthcare to Maryland's economy, the prevalence and broad impact of workplace violence in healthcare today, and solutions to this silent crisis.

II. MARYLAND'S HEALTHCARE INDUSTRY

Healthcare is a major driver of Maryland's economy. As of 2011, Maryland's healthcare and social assistance industry represented 8.1 percent (\$24.4 billion) of Maryland's Gross Domestic Product (GDP).⁴ According to a 2012 report by the Maryland Healthcare Commission, the average Marylander spends 15.7 percent of her income on healthcare--\$7,698--which is almost 9 percent higher than the national average.⁵

Led by large and prestigious medical systems like Johns Hopkins Health System and the University of Maryland Medical System, the healthcare industry in Maryland makes up 12 percent of Maryland's workforce.⁶ According to the Maryland Department of Labor, Licensing, and Regulation, Maryland's healthcare industry employs over 280,000 people in Maryland.⁷ Furthermore, by 2020, the healthcare industry is expected to employ over 400,000 people in the state.⁸

The expansion of Maryland's healthcare workforce is in anticipation of, and in response to, the ongoing implementation of healthcare reform in the state. Maryland's leaders have positioned the state among just a few states at the vanguard of the roll out of national healthcare reform. These reforms will substantially increase the number of Marylanders with access to covered services – either through expanded Medicaid eligibility or through private insurance purchased through the state's newly created healthcare exchange.

Clearly, an expanded patient base will put added strain on our state's healthcare system. At the same time, the philosophical and practical shift by policy makers under healthcare reform toward episodic and community-based care will change the way that healthcare is delivered for many Marylanders. An even greater focus on quality indicators in hospitals will also demand a higher level of integration across departments and will require new skills and systems.

Measured by resources allocated, services used, and employment, healthcare in Maryland represents a focal point for consumers and policymakers alike. Yet, despite the enormity of Maryland's healthcare industry, consecutive state budget shortfalls have left healthcare providers feeling squeezed. "Not surprisingly, system deficits that erode patient safety and the quality of care are often the same root deficits that result in unsafe working conditions."⁹

Marylanders individually and collectively invest considerable resources in healthcare. Maryland's residents and policy makers should, thus, expect a healthcare system that includes excellent care in a safe environment conducive to improving and maintaining personal health.

MARYLAND IN THE NEWS

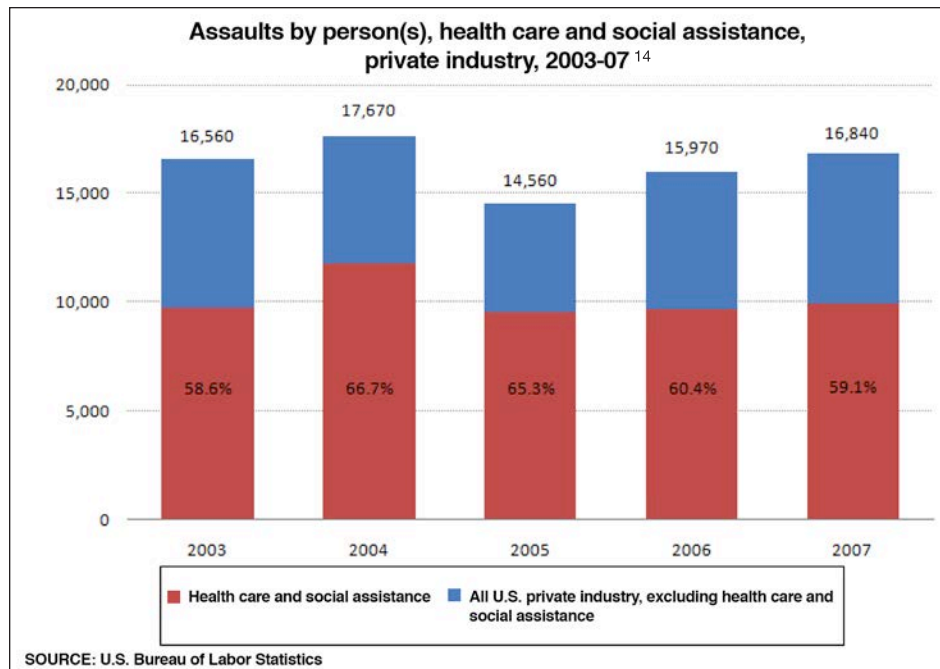
Over the past several years we've seen the growing problem of workplace violence play out in news coverage across the state. Listed below are a few of the most shocking incidents.

- In December 2012, a patient at St. Joseph's Medical Center grabbed an officer's gun after a struggle and fired once at the officer, grazing her in the leg.¹⁰
- In August of 2012, at Heritage Health and Rehabilitation Center in Annapolis, a patient tried to kill a nurse by slitting her throat.¹¹
- In October of 2011, a patient at a nursing facility in Rockville shot his wife to death and then turned the gun on himself.¹²
- In January of 2011, an employee at Suburban Hospital in Bethesda stabbed his boss more than 70 times in a hospital boiler room.
- In September of 2010, a man upset about his mother's worsening medical condition, shot a doctor at John's Hopkins Hospital, shot and killed his mother, then turned the gun on himself.¹³

While most of these incidents were egregious enough to garner media headlines, the vast majority of violent incidents fail to rise to the level of public or media attention, and news stories often fail to capture the broader story of industry-wide risk. Thus the silent crisis continues, and the need to address workplace violence in a systematic manner persists.

III. WORKPLACE VIOLENCE IN THE HEALTHCARE SETTING

Against the backdrop of rapid expansion and change within the state's healthcare industry, Maryland's healthcare workers and employers are quietly grappling with the growing problem of workplace violence. Violence directed at staff in healthcare settings is a problem that plagues healthcare facilities across the nation. The fact that 60 percent of assaults in the workplace occur in healthcare highlights the urgency of the problem, but it does not fully capture the depth of the issue.



OSHA DEFINITION

OSHA defines workplace violence as “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors.”¹⁵

OSHA’s mandate is derived from The Occupational Safety and Health Act of 1970, passed by Congress to make work environments safer. In addition to setting specific standards to reduce occupational illness and injury, the Act mandates that “all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.”¹⁶

LIKELIHOOD AND SEVERITY

National Workplace Violence Incident Rates

A 2011 BLS study of injuries that required days away from work found that for every 10,000 private sector healthcare and social assistance workers, 14.6 were the victims of a violent attack.¹⁷ That is double the total private, State and local government rate of 7.3.¹⁸ Meanwhile, state healthcare and social assistance workers accounted for an astonishing 132.9 of violent injuries per 10,000 workers.¹⁹

A 2002 study on workplace violence by the Federal Bureau of Investigation (FBI) found that, “employees experiencing the largest number of Type 2 assaults [assaults by customer/patient] are those in healthcare occupations—nurses in particular, as well as doctors, nurses and aides who deal with psychiatric patients; members of emergency medical response teams; and hospital employees working in admissions, emergency rooms, and crisis or acute care units.”²⁰

Maryland’s Workplace Violence Incident Rates²¹

In 2010, health care and social assistance workers made up just 16% of Maryland’s workforce but accounted for 62% of workplace violence incidents that resulted in at least one day away from work. Even more staggering, between 2008 and 2010, health care and social assistance workers in Maryland accounted for 74% of all workplace violence incidents that required at least one day away from work.

Severity

“Median days away from work is a key measure of the severity of an injury,”²² and demonstrates the brutality of the assaults that confront healthcare workers when they walk onto the job. The average healthcare and social assistance worker needed a median of six required days from work after an assault.²³

Recognizing the high incidence rate for healthcare workers in 2011, OSHA determined that “it is unacceptable that the workers who have dedicated their lives to caring for our loved ones when they are sick are the very same workers who face the highest risk of work-related injury and illness.”²⁴ That week, OSHA announced that it was launching “National Emphasis Program for Nursing and Residential Care Facilities,” in order to reduce workplace injuries caused by, amongst other things, workplace violence.²⁵

WOMEN: MOST ATTACKED

When there is a workplace assault in a healthcare institution, chances are the victim is a woman. Women account for almost 80 percent of workers in the healthcare and social assistance industries. As a result, women “generally account for about 80 percent of the reported injuries and illnesses involving lost work-time in this industry.” Meanwhile, women only account for roughly 39 percent of reported injuries and illnesses in all industries.²⁶

UNDERREPORTING: “JUST PART OF THE JOB”

Most workplace safety experts agree that workplace violence is underreported.²⁷ One cause for this has been labeled, the “warrior mentality,” by many in the field. This mentality represents the resignation that workplace violence is a burden that comes with working in healthcare.

One of the consequences of underreporting is the considerable amount of unfiled workers’ compensation claims. While this clearly represents a forfeiture of benefits for workers, it also leads to an underestimation of the severity and scope of workplace violence. According to a survey completed by mental health workers in Washington State, only 43 percent of those reporting moderate, severe, or disabling injury filed for workers’ compensation.²⁸ The same study found that health services was the second highest risk industry (after social services) based on workers’ compensation data.²⁹

RISK FACTORS

The National Institute for Occupational Safety and Health (NIOSH) identifies the following risk factors for workplace violence:³⁰

Working directly with volatile people, especially if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses	Lack of policies for preventing and managing crises with potentially volatile patients
Working when understaffed—especially during meal times and visiting hours	Poor environmental design
Working alone	Lack of staff training
Long waits for service	Inadequate security
Overcrowded, uncomfortable waiting rooms	Drug and alcohol abuse
Transporting patients	Access to firearms
Poorly lit corridors, rooms, parking lots, and other areas	Unrestricted movement of the public

IV. THE HIGH COSTS OF WORKPLACE VIOLENCE IN HEALTHCARE

According to a 2011 report by the Maryland Health Care Commission, Maryland can expect approximately 350,000 people to gain insurance as a result of health care reform.³¹ The Affordable Care Act enacts two important reforms that bring both the cost of healthcare and workplace violence into focus: First, healthcare institutions are anticipating a record number of patients to walk through their doors once all of healthcare reform goes into effect. Second, the shift towards episodic care includes the tying of reimbursements to patient satisfaction. The former increases the chances of workplace violence and the latter may lead to lower reimbursement rates if workplace violence does occur.

According to the Maryland Workers’ Compensation Commission FY2012 annual report, hospitals alone represented the fifth highest number of workers’ compensation claims in Maryland. This does not account for nursing facilities or other medical facilities.

A 2002 study of workplace homicides in all industries in the U.S. estimated an annual cost of \$970 million.³²

A 2005 report commissioned by the International Labor Organization (ILO) on the costs of workplace violence, estimates that losses from stress and violence at work represent from 1.0 to 3.5% of GDP over a range of countries.³³

A 2002 report on workplace violence in all industries by the Federal Bureau of Investigation states that “estimates of the costs, from lost work time and wages, reduced productivity, medical costs, workers’ compensation payments, and legal and security expenses, are even less exact, but clearly run into many billions of dollars.”³⁴

It is clear that workplace violence does not solely affect worker’s lives. It costs our health care system money at a time when health care reform is attempting to root our inefficiencies.

IMPACT ON PATIENT CARE

The consequences of workplace violence have real ramifications for healthcare delivery. “Staff safety and the quality/safety of client care are inextricably linked...researchers have found that violence experienced by healthcare staff is associated with lower patient ratings of the quality of care.”³⁵

According to a 2001 study on the effects of workplace violence on quality of care in health care institutions, “work efficiency ratings were lower amongst staff who had experienced patient violence.”³⁶ The study concluded: “there is an association between violence experienced by health care staff and patient-rated quality of care.”³⁷

Patients feel the effects of workplace violence, both directly and indirectly. Now that hospital reimbursements are more severely related to patient experience, health care employers’ bottom-lines will also feel the effects of workplace violence.

According to the NIOSH, “[workplace] violence may also have negative organizational outcomes such as low worker morale, increased job stress, increased worker turnover, reduced trust of management and coworkers, and a hostile working environment.”³⁸

Assaults may lead to short staffing and turnover and ultimately a drop in quality of delivery as healthcare administrators scramble for replacements for injured workers. When a worker goes on leave because of a workplace injury, healthcare employers must find a replacement and adjust their staffing grid with little to no notice. This may lead to short-staffing which is an indicator of workplace violence. As NIOSH states in a 2006 study, “low responsiveness and quality of service, which can result from inadequate staffing and skills of personnel, can produce frustration and agitation in clients or patients.”³⁹

PSYCHOLOGICAL TRAUMA

There are also psychological consequences to workplace assault. According to a 2005 study on the relationship between workplace violence and psychological trauma, “workplace violence is typically a traumatic event for those exposed to it, and many victims develop psychological disabilities as a consequence. The most common syndrome is *posttraumatic stress disorder (PTSD)*.”⁴⁰ Accordingly, OSHA recommends that every healthcare facility include psychological counseling services as part of their post-incident response system.⁴¹

The less obvious and more insidious psychological effects include long-term stress related to feeling unsafe and unsupported in one’s workplace. Interviews with numerous healthcare workers indicated that even those not involved in a “serious” incident, felt unsafe going to work at a facility where: 1) a violent incident had not been adequately dealt with after the fact, 2) threats of violence and physical confrontations were tolerated and thus became the norm (in the case of urban emergency rooms), or 3) repeated violent outbursts from a resident (in the case of nursing homes) were not addressed in a timely manner.

“I am constantly looking over my shoulder. Sometimes I have to stop my work and back away from my desk because I don’t know how patients are going to react,” explained Bill, who has witnessed numerous violent outbursts by patients and visitors in the Emergency Department of the Maryland hospital where he works as a clerical associate.

He goes on to say that “there are mornings when I hate to go to work.” The same sentiment was echoed in a separate interview with an RN in Bill’s department, who said, “It seems like every day I work lately, I leave with a migraine.”

Such long-term stress and its physical consequences reduce morale, increase turnover, and reduce productivity.

V. CURRENT LAW & ITS INADEQUACIES

NATIONAL REPORTING REQUIREMENTS

Currently, Federal law (OSHA) requires employers to file a report of an injury or illness in cases of:

- Death
- Loss of consciousness
- Days away from work
- Restricted work activity or job transfer
- Medical treatment beyond first aid

MARYLAND STATE REGULATIONS

In Maryland, employers only have to report violent incidents directly to the Maryland Occupational Safety and Health (MOSH) in cases of:

- Death
- At least three people are hospitalized at once.

In addition to the inherent underreporting of acts of violence in the healthcare industry, Maryland’s regulations currently do not require the proper documentation of violence in the workplace nor is there a requirement for facility-wide workplace violence policies.

VI. SOLUTION: THE SAFE CARE ACT

As outlined above, workplace violence has ruinous effects on staff morale, healthcare delivery, and bottom lines.

Fortunately, there are solutions supported by policy makers and academics alike.⁴² Those solutions give employers and front-line workers the flexibility to create a workplace violence prevention program that addresses their unique risks. In practice, an “effective management of safety and health protection improves employee morale and productivity, as well as significantly reducing workers’ compensation costs and other less obvious costs of work-related injuries and illnesses.”⁴³

In 2004, in an effort to provide a template for healthcare institutions, OSHA put forth guidelines for a comprehensive workplace violence prevention program. Those guidelines were designed “to eliminate or reduce worker exposure to conditions that lead to death or injury from violence.”

⁴⁴As mentioned above, at least nine other states have recognized the need for workplace violence prevention and have passed laws that mandate workplace violence programs.

As defined by OSHA, an effective workplace violence prevention program includes:⁴⁵

- Management commitment and employee involvement;
- Worksite analysis;

- Hazard prevention and control;
- Safety and health training; and
- Recordkeeping and program evaluation

THE SAFE CARE ACT

Each of these program elements is included in the Safe Care Act. The Safe Care Act presents preventative, employer-based solutions to workplace violence. There are four core pillars to the bill (all of which have been promoted by OSHA as solutions to workplace violence):

- An annual comprehensive violence risk assessment and recordkeeping
- Workplace violence prevention committees
- Annual violence prevention training and education
- A post-incident response system

Reporting and the Annual Risk Assessment

“Sadly, failures to report verbal or physical abuse represent lost opportunities for prevention. Lack of reporting is also a fundamental barrier to effective surveillance, a critical component of WPV prevention at all levels, from company-level to national-level prevention.”⁴⁶

Research shows that an ongoing worksite analysis is necessary for employers to adequately account for the multitude of variables that lead to workplace violence.⁴⁷ Accordingly, the Safe Care Act directs healthcare facilities to record incidents and complete an annual risk assessment of their facility. All incidents should be documented and all employees should be encouraged to report violent incidents.

The annual risk assessment will detail the violent incidents that occurred at the facility since the last assessment. The assessment should include the perspective and input of various workers at the facility and must be kept on file at the facility at all times.

Workplace Violence Prevention Committees

“Without both management commitment and employee involvement, it is unlikely that an effective program will be developed.”⁴⁸

It is essential for those who are experiencing workplace violence first hand to have input in the policies of the facility. The Safe Care Act directs healthcare institutions to form workplace violence prevention committees whose membership will be comprised of an equal number of healthcare workers to management. The committee will help execute and inform the annual risk assessment and provide ongoing input and guidance to the facility with regard to workplace violence.

Training

Workplace violence can only be prevented with the active engagement of frontline staff who can both identify potentially violent situations and help defuse those situations when possible. The Safe Care Act directs healthcare institutions to provide an annual workplace violence training. That training should include:

- Overview and definition of workplace violence
- The healthcare facility’s commitment to providing a safe workplace and the process that will be used to involve the authorized employee representative and direct care staff
- The importance of reporting all incidents, including threatening behavior and verbal abuse, how to report such incidents, and the healthcare facility’s procedures for responding to such incidents

- The contents of the site-specific risk assessment, including all identified risk factors.
- Techniques on how to recognize and avoid workplace violence, including verbal and non-verbal de-escalation techniques and other specific agency and worksite policies, procedures, and protective measures
- Emergency response procedures and resources to assist healthcare workers who are injured or traumatized, such as workers' compensation and critical incident response.
- How to obtain a copy of the healthcare facility's written program and other written materials

A Post-Incident Response System

After a violent incident occurs, we now know that the workplace is disrupted in numerous ways. Victims need particular attention and support to recover from the physical and emotional effects of an attack. Witnesses and others can be affected as well. All involved need to know that concrete action will be taken to ensure their future safety.

The Safe Care Act mandates that facilities create a process and a mechanism for responding to incidences of workplace violence. This mechanism should be the workplace violence prevention committee. Although it is not mandated, the facility should provide post-incident counseling for the victim and coworkers who witnessed the incident.

Enforcer

The natural enforcer of the Safe Care Act is the Maryland Occupational Safety and Health Division (MOSH) of the Maryland Department of Labor, Licensing, and Regulation. MOSH's current charge is to "improve the safety and health of Maryland's working men and women by setting and enforcing standards; providing training, outreach, and education; establishing partnerships; and encouraging continual process improvement in workplace safety and health."⁴⁹

Aware of existing budget and staffing constraints, the Safe Care Act was crafted to have a minimal fiscal impact. The bill thus does not require MOSH to collect data on workplace violence on its own, but rather to inspect each healthcare facility's records and annual risk assessment when conducting its annual safety review. MOSH will determine appropriate penalties for violators during the process of writing regulations that govern the laws implementation.

VII. CONCLUSION

Workplace violence represents a significant threat to the wellbeing of healthcare workers, patient care and institutional productivity. It also threatens to diminish the overall strength of Maryland's healthcare system at a time of rapid expansion and change – a time when trained, empowered healthcare professionals are more important than ever.

Outlined above is a clear path forward to address the problem of workplace violence in healthcare settings in Maryland. We urge lawmakers in Maryland to take up the Safe Care Act, legislation that is founded in the research and recommendations of OSHA experts, that makes best use of existing state resources, and that engages frontline healthcare workers in creating a culture of safety in their workplace.



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