WORKPLACE VIOLENCE IN HEALTHCARE:

Issues, Consequences and Best Practices for Prevention and Mitigation

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OVERVIEW

This paper is intended as a broad-based resource for those wanting to reduce Workplace Violence (WPV) in healthcare facilities. Following are notes to help readers make use of it.

Sections

The paper is divided into the following sections:

1. Workplace Violence, its updated definition, and consequences of WPV.
2. Causes of Workplace Violence, overt and underlying.
3. Challenges in preventing and mitigating Workplace Violence.
4. Current and Emerging Best Practices in:
    a. Creating a WPV Prevention Plan.
    b. WPV Prevention Strategies and Tactics.
    c. Leadership Involvement and their needs in approving WPV projects.
    d. Notes on proposing projects to leadership.
5. Getting WPV Prevention projects approved - Understanding and addressing the needs of leadership in making WPV strategy and investment decisions.

Stand-alone sections

Readers can take each section of this paper as stand-alone sections. Those wanting background information on WPV new to the problem may wish to start at the beginning, while those wanting to focus on challenges or solutions are welcome to do so.

Sources

The paper combines information from six Sam Houston State University, Institute for Homeland Security-sponsored papers, plus supplementary information added to further clarify the issues discussed. The authors of the selected papers are both academic and industry professionals, with a wealth of experience in multiple sectors.

Reading this paper

To make the paper easily readable and actionable, it is written in a non-academic format. Endnotes replaced footnotes to minimize disruptions in reading. *Note: If you are reading this document in a Word digital format, double-clicking the reference number either in the text or in the end notes section should allow you to move between them.*

We trust that this paper will be helpful to those in the healthcare community responsible for:

1. Staff safety, retention, and job satisfaction.
2. Patient safety, management, and healing.

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INTRODUCTION

Texas is no stranger to violence in healthcare.

- In October 2022, a parolee killed healthcare workers Jackie Pokuaa and Katie Flowers and assaulted his girlfriend and mother of their newborn child.1
- On July 25, 2023, a physician was shot and injured by a gunman at the Cedar Hill Methodist Family Health Center. The gunman appeared to have planned the attack as his ex-girlfriend worked at the clinic and was there at the time of the shooting.2
- On October 9, 2023, a woman at a San Antonio Be Well clinic, told staff her husband beat her. The husband ran from the clinic, followed by University of Texas Health policemen. When the husband reached for a gun, police shot at him, he surrendered.[3]

Workplace Violence (WPV) strikes healthcare workers more frequently than any other industry. The problem is growing and expected to get worse.

Commissioned by the Institute for Homeland Security at Sam Houston State University, this paper combines information from six SHSU-sponsored papers. The author used outside resources to fill in additional information to "pull together" a comprehensive picture of Healthcare WPV.

Specific topics in this paper include:

- The problem, its magnitude, consequences, and current laws regarding workplace violence.
- Causes of Workplace Violence.
- Challenges in preventing Workplace Violence.
- Current and evolving best practices to prevent Workplace Violence.
- Understanding and addressing the needs of those making WPV strategy and investment decisions.

Last, while the accrediting agency referred to in this document is The Joint Commission, other agencies and United States government agencies also have workplace violence definitions which extend the definition of Workplace Violence beyond physical actions to words.

Note: *The opinions expressed herein do not represent Sam Houston State University (SHSU) or The Institute For Homeland Security (IHS) at SHSU.*

SHSU Resources Referenced

This paper incorporates information primarily from sis SHSU-sponsored papers. They are:

The Rise of Workplace Violence: Addressing Healthcare's Greatest Threat, Driving Transformational Change in Healthcare Security was a primary source for this paper. It discusses the scale, nature, and impact of workplace violence in US healthcare. It also discusses challenges and best practices in WPV prevention, makes a strong business case for WPV prevention and highlights the need for leadership involvement and accountability in WPV prevention.

Countering Workplace Violence in Healthcare: Voices from the Field provides statistical data on the extent of WPV, an overview of current legislation, challenges associated with WPV, current and emerging best practices for dealing with WPV, and the need for executive leadership support. It makes use of interviews of nine healthcare security executives, each an IAHSS-Certified Healthcare Protection Administrator (CHPA), and Subject Matter Expert in the field.

A Framework for Understanding Disaster-Related Violence Against the Public Health Workforce is a literature scan which discusses how five themes contributed to WPV against Public Health Workers (PHWs) during the Covid-19 pandemic. These included: people not recognizing the experience of PWHs, insufficient infrastructure to straining the healthcare system, the "villainization" of PHWs, the politicization of public health, and disillusionment of PHWs during the pandemic. The paper makes several organizational, local, and state-level policy recommendations to avoid the conditions leading to WPV.

Toward a More Effective Policy Model for Responding to Workplace Violence in the Texas Healthcare System. The intent of this paper is to provide policymakers and corporate leaders with an introduction to WPV violence in the context of factors social contributing to it, whether occurring from patient, organizational or societal. It then discusses regulatory and corporate WPV mitigation policies, their effectiveness, and advocate for potential ways to increase the effectiveness of Texas S.B. 240 (the Workplace Violence Prevention Act).

Safe & Secure - Addressing Workplace Violence
This paper focuses on advocating for employee-friendly policies regarding preparing for and recovering from WPV, including planning, analyzing incidents, and training,. It focuses extensively on ways companies might support employees affected by it.

Workplace Harassment and Violence: A Primer on Critical Strategies for Small and Medium-Sized Businesses is written from a perspective of computer science as a WPV prevention tool. The paper focuses on the necessary digital ecosystem to prepare for potential violence and sources, respond to them, preserve evidence, conduct post-incident analysis, and update threat management tools or policies.

Biographies for the authors of these papers are in Appendix 1.

Acknowledgements

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WORKPLACE VIOLENCE AND ITS CONSEQUENCES

Workplace Violence – An Evolving Definition

The definition of Workplace Violence (WPV) is evolving, and now encompasses a wide range of behaviors, from physical to verbal, to non-verbal. The 2023 Joint Commission "Workplace Violence Prevention Standard" expands the definition of healthcare workplace violence as:

> *"An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."* [4]

This expanded definition now includes verbal interactions which people may not have previously thought of as WPV.

Classifications of Workplace Violence

WPV is commonly broken down into four "types," based on the relationship of the attacker to the employee. They are:

Type 1: By outsiders with "criminal intent."
These have who have no relationship with the business or its employees. Robbers or random outside attackers would fit this category.

Type 2: By customers, clients, or patients.
They are not employees, but might be a customer, vendor, or a family member of a customer.

Type 3: By employees who attack a co-worker.
Whether from anger, frustration, sexual or other causes.

Type 4: By outsiders who have a personal relationship with an employee.
This typically occurs when domestic disagreements or arguments spill over into the workplace. An example might be a jilted boyfriend.

As a criminal charge, authorities typically break down "assault" categories into:

Aggravated: Intended to cause severe injury or death, and usually involving a weapon.

Simple: Usually neither involving weapons nor causing great bodily injury. In some cases, threatening a person can constitute criminal assault.

Workplace Violence Rates in Healthcare

That workplace violence in healthcare is increasing is well publicized and shown in Chart 1. [5]

WPV occurs in virtually all healthcare settings, but is most frequent in acute-care, psychiatric, geriatric and community care facilities. [6]

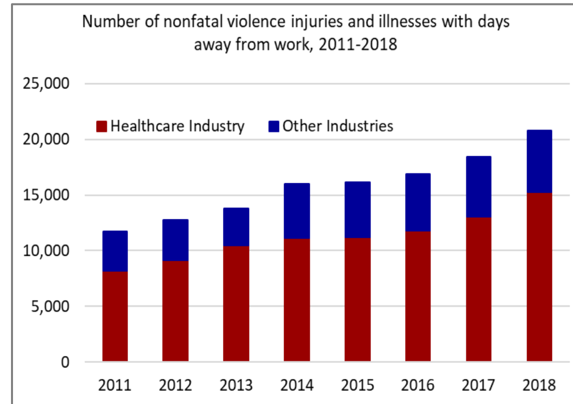


Chart 1: Increasing Healthcare Workplace

Who Are the Victims?

Nurses, physicians, and others directly involved in patient care are most victimized by WPV.[7,8,9] They are particularly vulnerable to WPV, as they work directly with people who may be violent, in pain, going through withdrawal, disoriented, or have aggressive family members present.

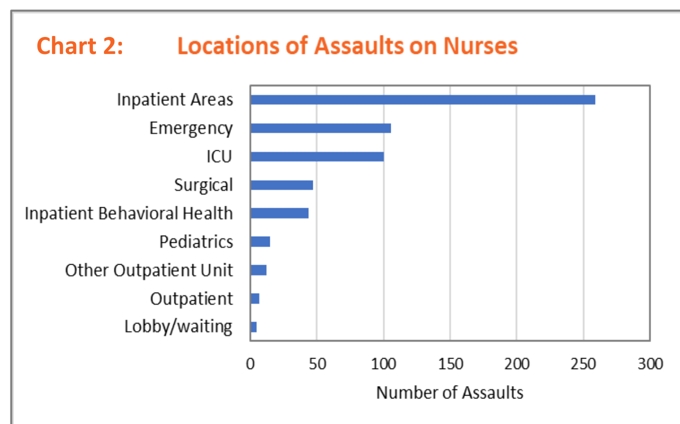
Nurses experience the greatest WPV impact. [10,11]

Staff Type	Verbal Assault	Physical Assault
Nurses	68% - 100%	44% - 82% [a]
Physicians	75% - 88%	21% - 88.3%
Psychiatric Clinicians	43%	25% - 34%
Home Care Workers	50%	26% - 50% [b]

Female nurses suffer violence far more frequently (93% vs 7%). [12]

Most assaults per department happen in Emergency Departments. However, the greatest overall number of assaults happen in other areas of the hospital. Per one study, while 18% of assaults happened in the ER, almost four times that happened in other areas (see chart 2). [13]

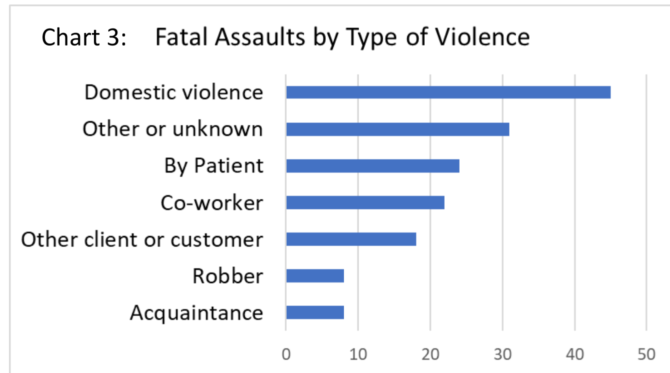
For this reason, it is important to look both at rates in departments and overall incident quantities across all departments when evaluating hospital violence.



[a] 28% of nurses reported experiencing abuse more than once.

[b] Between 13% and 26% of Home Care Workers reported sexual aggression or harassment

Some WPV results in fatalities. It primarily come from domestic violence (employees attacked by estranged partners who work at hospitals). Chart 3 at right shows relationships of those causing fatal attacks to their victims: [14]



Data like this may be valuable in understanding healthcare violence sources and locations. Facilities can then use it to understand potential vulnerabilities.

Home Care Workers

Protecting home healthcare workers is a growing concern as healthcare transitions away from hospitals. Home care workers are particularly at risk. They operate in an environment outside the reach of hospital security, where no one screens patients and visitors for weapons. There are more items which attackers can use as weapons (kitchen utensils, etc.). Last, there is no way to ensure patients are behaving safely.

Studies report home care worker assaults over 12-month periods at unsettling rates: [15,16]

Verbal aggression	50.3% - 65%
Workplace aggression	26.9%
Workplace violence	23.6% - 44%
Sexual harassment	25.7% - 41%
Sexual aggression	12.8% - 14%

One nurse stated that “it puts you in a difficult position as you now have an uncomfortable and potentially dangerous environment, but you can’t leave without completing the care.” [17]

Who Are the Perpetrators?

Depending on the study, Type 2 assaults (committed by patients and their families) typically commit 80% - 93% of all assaults. Type 3 assaults from co-workers make up 6% to 18% of all assaults. The highly publicized “active shooters” only 0.02% (two one-hundredths of one percent) of WPV:

Most patient-generated assaults are Simple Assaults (without weapons). The percentage of Aggravated Assaults (involving weapons) increases with outsider attacks (Type 1 and Type 4 assaults). [18] Understanding the most likely locations for Aggravated Assaults may give some limited guidance on where to anticipate attacks involving weapons.

	Simple Assaults	Aggravated Assaults
Type 1 (Outsider)	3%	7%
Type 2 (Patient)	93%	83%
Type 3 (Co-Worker)	2%	4%
Type 4 (Relationship)	2%	6%
Totals	100%	100%

Patients, Family Members and Other Patient Relations

Patients usually commit more violence than do visitors, with verbal violence being the most common. *Perpetrators are most frequently white male patients, aged 26 to 35 years, most commonly under the influence of alcohol or drugs*. Nurses experiencing abuse experienced the following forms: [19]

Abuse Type	Patients	Visitors
Shouting or yelling	60.00%	35.80%
Verbal abuse	54.20%	32.90%
Swearing or cursing	53.50%	24.90%
Grabbing	37.80%	1.10%
Physical abuse	29.90%	3.50%
Scratching or kicking	27.40%	0.80%

Many registered nurses have reported fearing patient family and friends as much or more than their patients.[20]

Consequences Of Healthcare Workplace Violence

While healthcare staff experience the most direct consequences of workplace violence, those consequences extend to the facility and its ability to perform its mission.

Workforce Turnover

One source reported that over 600,000 nurses are planning to leave the field by 2027, due to stress, burnout, and retirement.[21] Increasing workplace violence will not be likely to help this attrition.

Staff Recruiting

WPV has become a consideration in recruiting staff. Per Kimberly Urbanek, an expert in WPV prevention strategies, WPV has become more frequently discussed during recruiting. "From a nurse's viewpoint, where will they go if they have a choice of hospitals to work at and the pay and job responsibilities are similar? To the employer that has their back – to the setting where there is a strong commitment to investing in WPV programs and where the leadership's executive focus is on keeping their community safe. Nurses do not want to fear abuse or violence day-to-day at work." [22]

Healthcare Quality and Patient Safety

If fewer healthcare workers are available and / or those workers are suffering from mental and physical stress, it can result in interrupted patient care and resulting liability.

Economic Costs

Clay's "The Rise of Workplace Violence" provided the following economic costs of WPV. [23]

> "..hiring and training replacements for nurses leaving typically costs between $50k and $90k."

"In addition to staff shortage and replacement costs, the American Hospital Association (AHA) stated that the 2016 cost of proactive and reactive workplace violence response in US hospitals and health systems was $2.7 billion. These costs included:

- $280 million for violence preparedness and prevention
- $852 million for victims' unreimbursed medical care
- $1.1 billion for security and training costs
- An additional $429 million for medical care, staffing, indemnity.
- Other costs arising from violence against hospital employees." [24]

Reputation

These days, customers and prospective staff are both more likely to select their hospital based on its reputation. What has changed over the past several years has been the increase of online reviews making that information more readily available.

> "Reviews make all the difference. The healthcare systems with highest Reputation Scores accumulate an average of 232% more reviews than the laggards. A provider's front-line staff matters more than ever. Staff and bedside manner are the two main drivers of positive sentiment. Wait times and emergency room care are the two biggest drivers of negative sentiment."[25]

"It takes 20 years to build a reputation and five minutes to ruin it.

If you think about that, you'll do things differently."

Warren Buffet

Healthcare Workplace Violence Regulations

Increasing violence in healthcare has led to application of existing law and creation of new ones.

Federal

As of the beginning of 2024, there has been no federal workplace violence legislation passed. Federal laws indirectly related to WV include:

1. Occupational Safety and Health Administration (OSHA) requires all employers to provide safe and healthy working environments for employees. OSHA can cite employers for failing to take necessary measures to prevent or manage the consequences of workplace violence.
2. When employees suspect workplace violence perpetrators motivated by the victim's race, color, religion, sex, or national origin, The Civil Rights Act of 1964 has provisions to protect them.
3. The Americans with Disabilities Act provides protections for cognitively or physically disabled workers. [26]

State

Most U.S. states have elevated penalties for assault against specific types of healthcare workers. California, Connecticut, Illinois, Maryland, Minnesota, New Jersey, Oregon, Washington, and Texas have laws requiring employers to implement workplace violence prevention programs.[27]

Most require healthcare facilities to develop workplace violence prevention plans, record WPV incidents, and provide WPV training to staff members. In some states, certain employees are mandatory reporters when they become aware of violent incidents.

Texas

In the 2023 legislative session, Texas passed S.B. 240, otherwise known as the "Workplace Prevention Act." [28] The bill makes Texas a national leader in developing workplace violence prevention policies.

Briefly, S.B. 240:

1. Directs healthcare facilities to establish a workplace violence prevention plan.
2. Implements a workplace violence and recording system.
3. Outlines new anti-retaliation protections.

The text of S.B. 240 is shown in Appendix 3.

The Joint Commission

Probably the most significant regulatory changes are from the Joint commission, an accreditation organization which certifies 80% of US hospitals. In 2022, the Joint Commission implemented new requirements for hospitals and healthcare system executives. Per the Joint Commission web site:

> "The new and revised Joint Commission standards provide a framework to guide hospitals in developing effective workplace violence prevention systems, including leadership oversight, policies, and procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence. [29]

By allowing de-accreditation of nonconforming hospitals, the new WPV rules constitute a tremendous economic weapon in requiring healthcare facilities to implement and enforce WPV accountability.

A few of the new relevant Joint Commission Standards are referenced in Appendix 4.

CAUSES OF HEALTHCARE WORKPLACE VIOLENCE

Several forces can drive Healthcare Workplace Violence. They include societal, economic, and even political issues. Some of them are listed below.

Patient Causes of Violence

Below are some possible drivers for attacks by patients, their families, or other relations.

Physical Situation

Patients are often highly stressed or confused. Some are "out of their minds" with pain, whether from wounds, wound treatment, or transport. Some struggle as they try to refuse medical care.

Gender and Age

Men attack nurses at much higher rates than women do. Most attacks by men occur in patient rooms or other isolated and non-emergency room locations, while most attacks by women occur in the ER as shown by Speroni: [30]

Perpetrator Gender	ER Nurses (11.1%)	Non-ER Nurses (66.9%)	All Nurses (78.1%)
Male	55.30%	63.50%	62.40%
Female	35.30%	26.30%	27.60%
Both male and female in 1 incident	9.40%	10.20%	10.10%

In Speroni's study, the greatest number of perpetrators (37.6%) were between the ages of 25 and 35, followed be those over 65 (17.6%, those between 36 and 45 (18.8%) and those under 25 (14.1%).

Family members

Family members are often highly stressed because of the situations in which they and their family members find themselves, manifesting that stress in violence. This violence most frequently occurs in emergency departments, waiting rooms, psychiatric care facilities, and geriatric settings. Examples of causal conditions might include:

- Long wait times and overcrowded waiting rooms.
- Visiting while drunk or abusing drugs.
- Demanding immediate treatment for relatives in pain.
- Disagreements between patients and family members
- Escalating when staff asks them to leave.
- Wanting to intervene in treatment, regardless of the patient's interest or wishes.
- Treatment expectations, unrealistic or not.
- Grief over patient's condition or diagnosis.
- Dissatisfaction of patients with the quality, delay, or lack of care.
- Critically ill children

Other With Relationships to Patients

People hostile to patients (Gangs, ex-boyfriends, etc.) have been known to instigate attacks on patients.

Substance Abuse

Increasing drug use and potency, new drug types and drug additives have all led increasing numbers of overdose victims arriving at hospital emergency rooms. Drug or alcohol users may exhibit symptoms such as psychosis, disorientation, paranoia, fighting restraints and other violent behavior.

A literature review of papers from 1997 to 2018 showed that over 50% of ER violent events occur in the context of alcohol or drug abuse. [31] Among violent events, up to 66% were associated with the exposure to drugs and alcohol. In studies focusing on alcohol as a cause of ED violence, researchers reported it as accounting for as much as 98% of escalations.

It has been challenging for medical staff to accept that drug users are frequently not charged for the violence they cause. This is perceived as doubly harmful by medical staff, first when they are injured and then when those causing it aren't held accountable for the harm they cause. Workers have found violence harder to accept when patients are suffering from "self-inflicted" conditions such as drug use.

Mental Health

Police regularly encounter people with mental and/or behavioral problems. Symptoms of mental health and drug use problems are often similar. This leads police to deliver those with mental health problems to emergency rooms for medical (instead of psychiatric) treatment.

Patients with psychiatric disorders such as schizophrenia, or anxiety, cognitive disorders are common sources of violence. In a study of assaults on nursing home assistants, dementia was linked to 87% of assaults.[32] In a hospital study, 49.9% of assaults on nurses were linked to dementia.[33]

In non-nursing home healthcare settings, other psychiatric disorders account for a large proportion of violence against caregivers.

Patients with histories of aggressive behavior or behavioral health problems also account for a large proportion of violence against caregivers, with one person surveyed stating that 80%-90% of their ER WPV issues are behavioral health patients.[34]

Note that health care workers have been reluctant to report violence in places where the patient might have a congenital condition such as "in pediatric facilities where compassionate clinical staff dealing with challenges such as adolescents with autism might be generally reluctant to report incidents on WPV in the first place." [35]

Communication Challenges

Patients and family member violence can quickly escalate when:

- There are language barriers between a caregiver and a patient.
- When they grow frustrated because they cannot understand treatment plans or acts of caretaking they perceive as frightening.

Causes of poor communication can include:

- Illiteracy or language barriers in patients who can't understand or speak the language. This especially in areas with high language diversity such as border towns or those with large immigrant populations.
- Temporary medical conditions rendering patients unable to speak.
- Patients with conditions preventing them from communicating, such as autism or Downs syndrome.
- Patient or family member stress.

These communication barriers, especially in unfamiliar settings like ERs, can more easily escalate to violence by patients.

Last, poor interpersonal communication skills between healthcare employees, particularly in high-stress situations such as emergencies or surgery, can lead to verbal abuse WPV.

Facility Locations and Types

The location or specialization of a facility can raise its risk for WPV. At-risk locations might include:

- Facilities in locations where homelessness, drug addition, gang violence and criminal behavior are more prevalent.
- Facilities specializing in overdose or trauma care. Some of these "knife and gun clubs" have been invaded by gang members seeking friends or to finish the job on an enemy.
- Public hospitals treating low-income patients (as opposed to private, more "upscale" hospitals), where patients are less likely to communicate well in English.
- Hospitals experiencing mass-scale disruptive events. For example, the Covid pandemic raised hospital occupancies and worker tensions due to wait times, patient and family fears, staff shortages, long hours, and other factors.
- Psychiatric facilities.

Staff Causes of Violence

Staff can inadvertently contribute to or cause violence. This can include Type 2 (patient generated) violence or Type 3 (violence toward fellow staff members). Causes may include:

Inadequate Training

Staff without de-escalation training may unwittingly cause violence, regardless of patient condition(s). This is particularly true for staff not trained specifically for mental, behavioral, cognitive or addiction patients. They are likely to find themselves in situations where, not knowing how to deal with a condition, they cause patient escalation.

Job Expectations

Staff may perpetuate workplace violence by assuming it is "part of the job" and not addressing it.

Healthcare professionals often accept the stereotype of workplace violence (physical, verbal, sexual, etc.) being inherent to their profession, and simply endure it. It is perpetuated when new staff sees co-workers tolerating unsafe workplaces and feel pressured to not be disruptive but go along with it. When staff with these (incorrect) expectations do not report WPV, management is less likely to address the problem. Ironically, the frustration they experience from continual WPV has led many healthcare employees to leave the profession.

Job Stress

Research showed that a significant amount of workplace violence is Type 3 (caused by co-workers). Some have cited their inability to plan, carry out tasks in an orderly manner, or not being able to care properly for patients. Long hours, difficult co-workers and other factors that contribute to their stress, with day-to-day dissatisfaction ultimately leading to workplace violence.

Policy Or Management Flaws Resulting in Stress

Facility policies can contribute to increased violence. Among others, reasons for this may include:

- Insufficient funding for staff
- Employee stress from overwhelming workloads.
- Employees working outside their area of expertise.
- Hospitals employees pulled in multiple directions because of accountability to multiple managers.
- Being unable to report violence for fear of retaliation or workplace "cultures of silence" can increase employee stress.
- Managers without adequate training, or abilities to manage the complexities of healthcare may contribute to violence as their staff are frustrated by their actions.

The effects of policy flaws will trickle down through organizations. These can lead to mismatches of patient needs to staff capability, excess overtime and fatigue, bad employee decisions, promoting efficiency above safety, improper incident records, inadequate training, not disciplining violence perpetrators, and other issues.

Inadequate Resources

Most US psychiatric hospitals have few mental health beds or specific services for mental health, behavioral health, and addiction patients. This leads to patient overflow to other hospitals where staff aren't trained for them. However, many of these overflow hospitals don't have sufficient specialist staff (psychiatrists, psychotherapists, social workers, and pediatricians) for their "customers".

These resource deficits can result in staff being forced into situations where they are unable to communicate effectively with patients or are not trained in how to handle psychiatric patients.

Sexual Violence

Sexual violence is an overarching factor across the categories above, factoring into Type 2 and Type 3 violence, perpetrator motivations, where it occurs, whether it is verbal or physical, etc. It occurs not only from patients to workers and between workers, but also against residents and nurses by those in authority over them. Like WPV, it is highly underreported.

The good news is that sexual violence is becoming better understood and new TJC requirements reinforce the importance of reporting. The bad news is that, according to a 2020 study, is there "little evidence that this has improved since it was first reported more than 20 years ago." [36] Further, getting victims to report it remains a challenge.

As expected, the victims are primarily female, whether nurses, physicians, or home-health workers.

Sexual Violence Victims - Nurses

A survey of 2,000 nursing staff and students[37] showed that:

- Three in every five nurses had been sexually harassed at work.
- 39% had witnessed a colleague being harassed.
- Many had been made to believe that enduring such behavior is "just part of the job."
- Only 27% of sexually harassed respondents reported it to their employer.
- The most common form of sexual harassment was verbal (56% of all respondents).
- More than a third (37%) of respondents had experienced physical harassment.
- Nurses were conflicted between the need to protect themselves and continuing patient care.

Of the perpetrators:

- 58% were patients.
- 26% were medical colleagues.
- 24% were nursing colleagues.
- 19% were patients' family or friends.

One primary care nurse said sexual harassment was "not taken seriously" in her surgery, noting a time when she told the GP that a patient had behaved inappropriately but was subsequently still asked to return to the room alone with the patient to take their blood pressure.

In terms of gender, sexual harassment was more common among respondents who identified as female (62%) compared with those who identified as male (51%).

Sexual Violence Victims - Home Care workers

As noted previously, sexual violence is unfortunately common in-home care environments, with 25.7% - 41% reporting sexual harassment and 12.8% - 14% reporting sexual violence over a single year. [38, 39]

> "One nurse recalled a particular patient who would expose himself to her while she was kneeling to dress his leg, and this later escalated to him masturbating in front of her. " [40]

Several community nurses also mentioned knowing of a policy of going to a home in pairs when there were known issues with problem patients, but it did not always happen due to staff shortages.

A study in Japan pointed out that, while physical violence from those with psychological disorders is common, sexual violence more frequently comes from those without psychological disorders. This may speak to premeditation on the part of those perpetrating sex crimes.

Sexual Violence Victims – Residents and Faculty

An analysis by Lindsay Arnold showed that resident physicians in training have regularly been subject to Type 3 (from co-workers) violence. [41]

- Two-thirds of GI, Internal Medicine and Pediatric residents surveyed reported being exposed to sexual harassment at some point in their medical training.
- 83% of female residents experienced sexual harassment vs. 44% of males. Offensive and/or suggestive jokes and comments were the most common type of harassment experienced.
- 60% of female vs. 30% of male residents responding reported sexual harassment by a superior.
- In a separate study of 82 internal medicine residents, 73% of female residents reported being sexually harassed at least once during their training (vs. 22% of male residents).

Female medical faculty also suffer from sexual violence. In a 2014 survey of new recipients of National Institutes of Health (NIH) Career Development Awards (K-awards), 30% of women reported having personally experienced sexual harassment vs 4% of men.

Among the 150 women reporting harassment:

- 59% perceived a negative effect on confidence in themselves as professionals.
- 47% reported that these experiences negatively affected their career advancement.

In a study of women with K08 and K23 (career advancement) Awards who reported having experienced harassment, response rates were as follows: [42]

92.0% reported sexist remarks or behavior.
41.3% reported unwanted sexual advances.
9.3% reported coercive advances.
6.0% reported "subtle bribery to engage in sexual behavior."
1.3% reported threats to engage in sexual behavior.

Note: Totals over 100% because respondents indicated all that applied.

Sexual Abuse Reporting of Type 3 Violence

Arnold [43] also reported that sexual violence commonly goes unreported in the medical field. Following are statistics regarding reporting cited in that paper:

- Only 20% of harassment victims reported their experiences.
- Of those, only 42.1% were "satisfied" or "very satisfied" with the outcome.
- Most residents were unlikely to report the offender (87% of females, and 93% of males).
- 89% of victims had not reported harassment and 84.2% had not confronted them. The most cited reason for not reporting was because of the trainee "not thinking it was a big deal."
- While 77% of residents believed their program would support them if they reported a sexual harassment event, only 43% were aware of institutional support in place for victims at their program. Many said they were not sure what reporting avenues were available.

Challenges in Sexual Abuse Definition and Reporting

Many people now commonly use language in the workplace which would have been rare 20 years ago. People can easily interpret now-common language as harassment. The US EEOC Fact Sheet "Sexual Harassment Discrimination" bases harassment on the interpretation of the hearer. [44]

> "...verbal or physical conduct of a sexual nature constitute sexual harassment when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment."

The fact sheet statements about sexual harassment include:

- The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee.
- The victim can be anyone affected by the offensive conduct (not just the victim).
- Unlawful sexual harassment may occur without economic injury to or discharge of the victim.
- The harasser's conduct must be unwelcome.

The EEOC website states that: [45]

- Harassment does not have to be of a sexual nature, however, and can include offensive remarks about a person's sex. For example, it is illegal to harass a woman by making offensive comments about women in general.
- Although the law doesn't prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, harassment is illegal when it is so frequent or severe that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as the victim being fired or demoted).

As society's standards of acceptable language and conduct have changed, many have brought previously "unacceptable" language into the professional environment. And much coarse language references sex, body functions, and body parts. Therefore, people commonly hear language in the workplace that can qualify as WPV verbal harassment because it:

- Is sexual in nature.
- Is common to the person using it.
- Was found to be intimidating or otherwise unwelcome.
- Was not directed toward the person affected by it.

Challenges: Black and White, Gray, and Excuses

Most people have experienced situations where miscommunication led to greater misunderstandings. This is and will continue to be an issue with sexual violence, and many people will have to retrain and adapt their language to the new verbal WPV regulations.

Perpetrators of verbal sexual violence may say their bad language was not maliciously intended, that a victim is "too sensitive," that their language was not a big deal, or that "it's a grey area." This "grey area" defense might, at least partially, explain the lack of reporting because of victims "not thinking it was a big deal" and not reporting it. The EEOC tries to give some leeway in stating the law "doesn't prohibit simple teasing, offhand comments, or isolated incidents that are not very serious…"[46]

All this speaks to a need for clear and explicit training as to what language or conduct is (or is not) appropriate, and consequences for policy violations. Not doing so allows the excuse to remain. Further, some perpetrators may use the lack of clarity as permission to push further into unwelcome inappropriate conduct.

Therefore, being able to provide corrective feedback, and have it received without retaliation or fear of retaliation, is a critical part of reducing sexual violence.

Covid-19 And Hospital Violence

Much has been said and written about violence during the Covid-19 pandemic. The pandemic was indeed a "perfect storm" of causes of healthcare violence. Countless news videos showed how the various factors above (communication, staff training, resources, job expectations, stress and organizational issues all contributed to a volatile environment.

- Concerned patients and families could not communicate with loved or staff.
- Shortages of facilities and treatment equipment drove uncertainty and fear.
- Those healthcare workers available worked long shifts.
- Statements made by politicians were often at odds with those from other politicians, bureaucrats, and healthcare workers. This led to an erosion in trust toward medical providers and clinical staff.
- People passionately debated masking, isolation, and travel requirements. In fact, 72% of pandemic WPV events were associated with masking requirements.
- Many (especially the elderly) suffered mental declines in isolation.

That said, it is important to note that most WPV during the pandemic did not occur in healthcare, because hospitals were largely shut down to visitors. Instead, WPV exploded in the service industry, as shown in a 2020 Bureau of Labor & Statistics report. [47]

Occupational Group	% of Total	Number Of Intentional Injuries by Another Person
Service	52%	18,690
Healthcare practitioners and technical	24%	8,590
Educational instruction and library	15%	5,470
Transportation and material moving	4%	1,560
Management, business, financial	4%	1,360
		35,670

Indeed, the practice of limiting access to hospitals reduced healthcare WPV during the pandemic relative to other industries. When authorities relieved restrictions, WPV incidents decreased.

From a perspective of public health, the SHSU-sponsored paper "A Framework for Understanding Disaster-Related Violence Against the Public Health Workforce" identified five themes contributing to attacks on healthcare workers. These included people not recognizing the experience of Public Health Workers (PHWs), insufficient infrastructure to straining the healthcare system, the "villainization" of PHWs, the politicization of public health, and disillusionment of PHWs during the pandemic.. [48]

CHALLENGES IN ADDRESSING HEALTHCARE VIOLENCE

Challenges to developing WPV prevention are significant, with some challenges growing as healthcare is pushed out from hospitals into communities. The most frequently listed challenges correlate to issues mentioned previously. Note that much of the focus is on challenges in changing our perceptions in understanding and addressing WPV.

Perceptions and Mindsets

People frequently have misconceptions as to what workplace violence is, whether or how big a problem it is, whose responsibility it is, etc. Examples of perception and mindset issues include:

Understanding Current Definitions of Workplace Violence

Patients and workers will need to learn that workplace violence includes verbal abuse. Likewise, defining what verbal interactions constitute abuse will require extensive, careful definition.

This will be complicated by changing standards of what is socially acceptable, cultural differences, workplace types, workplace stress and individual sensibilities. Long-common practices of verbal interaction (especially in high-stress environments such as ERs) will now expose staff, patients and hospitals to liability suits or criminal charges.

It will be difficult for people to change their verbal practices to conform with new regulations.

Where Workplace Violence Occurs

As mentioned, WPV rarely comes from the widely publicized "external shooters unrelated to the hospital." While this is rarely the case, it can lead to misallocation of financial resources by focusing on tools like as X-ray machines preventing outside access, while ignoring internal needs.

Perhaps the biggest WPV Prevention issue hospitals face is the need to change their understanding of WPV, then gathering data to help them understand where their specific problems arise.

Physical Security as The Only Security Paradigm

A typical physical security response has been to reactively call security for incidence of violence. This carries several flaws:

- Security staff cannot be everywhere, meaning tense situations must wait for them to arrive.
- The sight of uniformed personnel often raises tension levels among patients and families.
- Coming from police or military backgrounds, security personnel are often trained to exert physical control over those causing trouble. This can trigger patients or family members to escalate to violence.
- Physically restraining people can lead to injury, leading to lawsuits and harm the hospital's reputation.
- Physical security is not as successful as other paradigms such as de-escalation.
- Implementing new de-escalation approaches require retraining security staff.

Unsupported Victims

Healthcare professionals often feel unsupported by administrators and law enforcement personnel.

When WPV victims need post-incident medical treatment, physical therapy, recovery time off work, post-incident counseling, and psychotherapy, they may feel abandoned if those needs aren't met by administration.

Additionally, when healthcare WPV is viewed as a "societal" problem, perpetrators may not be viewed as responsible for their actions. This may lead to police not taking reports or prosecutors not charging attackers. WPV victims have then reported believing that:

- Police are making medical decisions about perpetrator capacity and control over their actions, when not qualified to do so. They then misjudge assaults as ones where the perpetrator was not in control of their actions.
- Their (healthcare staff) professional medical judgment of healthcare staff about perpetrators is not being valued.
- Though the victims want culpable perpetrators held responsible, they will not be.

Medical personnel want law enforcement officers to understand that, regardless of mental health or behavioral health component, they have been assaulted and often significantly injured by patients. When that does not happen, WPV victims are frustrated, demoralized, and less likely to report WPV.

Inadequate Reporting and Data Collection

In a world where threats are multiplying both in type and frequency, incidents must be reported, documented, and accessible to those developing the WPV Prevention Plan.

Not While there are many possible reasons WPV is not reported, not doing so prevents us from understanding WPV, understanding its drivers, and addressing them.

Healthcare WPV is commonly underreported. Reported reasons include: [49]

- Unclear definitions of what constitutes abuse, verbal or physical.
- Not suffering physical injury or lost time.
- The perception that violence is simply "part of the job."
- No reporting guidelines or policy.
- Time-consuming incident reporting procedures.
- Fear of losing anonymity, loss of privacy or being stigmatized.
- Lack of supervisory or coworker support.
- Victims blaming themselves for incidents.
- Belief that nothing will change or that perpetrators will go unpunished.
- Fear of reprisal, retaliation, (especially when abusers hold career power over victims).
- Especially in pediatric facilities, compassionate staff being attacked by adolescents with autism might be reluctant to report incidents on WPV. The same may apply when nurses don't believe patients are responsible for their actions. 50

Increasing Psychiatric Loads

Regardless of whether organic or drug-induced, one area which does reflect societal issues is the growing number of psychiatric patients showing up at hospital Emergency Rooms.

- Psychiatric facilities typically do not create revenue. Therefore, they are often supported by limited state funding. As a result, many have closed.
- Psychiatric facilities or programs are often not designed for prolonged patient stays.
- Facilities are often not physically close to patients or their families. Patients committed to psychiatric hospitals require transfers to appropriate long-term behavioral care facilities. This process can be complex and require longer-distance travel. In the meantime, the patients need care in their locality.
- Patients with cognitive impairment, delirium, dementia, psychosis, or withdrawals may display agitation related to an acute clinical emergency. By default, this requires they be delivered to hospital ERs.
- Because mental health patients are difficult to prosecute and "get off the street," many law enforcement agencies do not arrest or seek prosecution for their crimes. Instead, they are released, only for the cycle to repeat.
- Cost reduction is moving behavioral health care toward virtual (computer-based) support, a method not well suited to psychiatric patients. The reduced quality of care is more likely to lead to violent episodes.

Each of these potentially violent patients entering ERs, for which ERs are neither trained nor prepared.

Physical Isolation of Workers

Security cannot be everywhere, yet organizations have an obligation to protect their employees across the full campus. Even in optimal environments, patient care often involves being alone, whether in patient rooms, getting supplies, parking lots, and other locations. Isolation often leaves workers vulnerable and unprotected from attackers.

While remote video cameras have some preventative benefits, they can only document events. Therefore, the challenge to leverage security practices to places security personnel cannot be.

Traditional approach: Place wired or wearable alarm systems and duress buttons in the emergency department and certain units and rooms. Cost means hospitals will only likely have 10–20 percent coverage for their alarm systems. Effectively, their staff will always be exposed in some areas.

Remote workers

Of special concern is the threat for those working alone in the community. This is especially the case with one study stating that 25 percent of healthcare will be delivered in the community by 2025.

- Protecting workers working remotely from hospitals or clinics is challenging for several reasons:
- Workers are out of range of conventional Wi-Fi personal security alarms.
- Workers are out of range of rapid physical (security) response.
- Isolated and uncontrolled work situations increase hospital liability exposure.
- Remote staff are not formally trained on how to handle problem patients.

- Workers may need escorts to provide physical security with some patients, raising labor costs.
- Updating alarm technology may be expensive.
- Carrying video (body) recorders into homes may raise privacy concerns.
- While patient violence information should ideally be shared between hospitals, remote workers, local clinics, and community-based teams, this communication may raise privacy concerns.

Inadequate or Unbalanced Technological Deployment

Security technology can be helpful, especially as capabilities evolve. Technology deployment issues to be aware of include:

- Frequently, technology-based security systems are deployed as a “quick fix,”, triggered by incidents. To be most effective, technology expenditures should be allocated according to the threats they can address and their magnitudes.
- When facilities select highly visible technology (such as X-ray systems at entrances), other more cost-effective security solutions may go wanting for lack of funds. Hospitals don’t always consider whether the highly visible (and expensive) security practices are the most effective.
- Most technology involves information communication. However, many systems don’t communicate seamlessly and automatically. For example, violence records associated with individual patients may not be available to security, ER staff or the front desk. This reduces the ability of those areas to anticipate and mitigate threats.
- As weapons technology evolves, existing scanners may not. For example, metal detectors may pick up guns, they do not detect ceramic or other non-metallic weapons.

Cost of WPV Prevention Measures

Any WPV equipment expenditure or prevention program will involve expenditures. Whether in government or corporate-owned facilities, costs and budgeting cycles may cause delays in implementing WPV Prevention measures. Some cost-driven reasons for not implementing WPV Prevention include:

- Facilities may not consider themselves able to afford access control or security systems.
- Leadership may not consider training as tangible as physical safety equipment.
- Specialized behavioral health staff in general emergency rooms may be considered too expensive to pursue.
- The benefit/cost ratio was poor because project proposers did not include all quantifiable savings in the analysis.
- Leadership may be under investor pressure to minimize operating costs.

Another cost-related challenge is nurse-to-patient ratios. A critical component of WPV Prevention is Relational Security. Described further down, part of this comes from staff having time to listen to and interact with patients in a therapeutic manner. When staff is spread thinly across multiple patients, the time they have for these interactions is limited.

Leadership

WPV prevention programs can be effective, but not without leadership support. Yet a lack of leadership buy-in is often cited as a blocker to improved security. Some reasons for a lack of leadership support include:

- Hospital leadership does not always understand either the scope or sources of WPV, whether patient-generated or internally generated.
- Leadership not understanding that patient-generated violence is the primary driver of healthcare workplace violence, the costs of different types of violence (for example patient-generated vs. outsider violence), or the availability of low-cost prevention solutions.
- Security has typically not been a leadership-level focus, but reactive. As a result, security measures may have been knee-jerk reactions and quick fixes in response to previous violent incidents. However, standalone measures are typically not as effective as integrated systems and solutions.
- Until recently, there has been little or no universal consensus on what WPV prevention solutions work.
- Some security teams have not been able to boost C-suite understanding of key issues while putting forward a solid business case for investment.

Lack of Training

Training is important, and will continue to be, in avoiding WPV. Employees need to be trained to:

- Understand WPV is not "part of the job."
- Avoid situations which could lead to WPV.
- Escape WPV situations.
- Recognize and report incidents.
- Not inadvertently violate employer WPV policies.
- Encourage or support others being exposed to WPV.

When these situations occur, it points to a lack of personnel training.

Legislation

Specific issues to address might include: [51]

- Ensuring those passing state laws build in enforcement mechanisms. Laws are only effective with implementation, enforcement, and appropriate penalties for noncompliance.
- Clarifying the culpability of behavioral and mental health patients for WPV.
- Implementing these standards on a nationwide basis to ensure uniform conduct.

The Joint Commission should help with much of this through its ability to decertify non-complying hospitals. However, this only applies to Joint Commission facilities.

BEST PRACTICES – CREATING A WPV PREVENTION PLAN

"If you fail to plan, you are planning to fail." Benjamin Franklin

The following sections summarize recommendations or best practices on understanding, preventing and recovery from Workplace Violence. However, this is only a summary. For each of these steps, material is available in greater detail from multiple sources.

Developing WPV Prevention Plans

Workplace Violence Prevention Planning is the process by which a facility:

1. Identifies threats.
2. Quantifies the risk they propose.
3. Develops methods to address the threats.
4. Prioritizes solutions.

Creating and implementing a WPV Prevention (WPVP) plan requires the following basic steps:

1. Build a Workplace Violence Prevention team.
2. Conduct a needs assessment.
3. Identify threats and consequences.
4. Prioritize responses.
5. Evaluate and choose solutions.
6. Create a WPVP plan.
7. Create Supporting Policies.
8. Implement.
9. Review.

Both Texas S.B. 240 and The Joint Commission require hospitals to develop WPV prevention plans.

Build a Workplace Violence Prevention Team

Violence affects multiple departments, and each department can help prevent WPV incidents without even calling security or upsetting patients, staff, or visitors. Therefore, the best team to address WPV will recruit members from each hospital department.

These members will work to:

1. Understand each department's needs, and those of the organization.
2. Conduct risk assessments.
3. Prioritize solutions.
4. Develop prevention policies and tactics.
5. Help leadership understand WPVP needs, options, and required investments.
6. Develop employee training.
7. Monitor plan effectiveness, reviewing it as necessary.

The most effective plans will be those that build teams which work together across the enterprise, building strategies from data gained through that analysis.

Team members might include:

- Clinical Staff
- Nursing Staff
- Security
- Emergency Room Staff
- Executive Staff
- Clinical Education
- Off-site / Community Healthcare
- WPV Subject Matter Expert
- Risk Management
- Emergency Managers
- Legal
- Human Resources
- Social Workers
- Facilities

It is important that the team include, security, clinical and training representation. While historically led by security, there is increasing evidence that clinical staff and de-escalation training can prevent many psychiatric and behavioral emergencies and intervene before situations require security interventions.

The team chairperson should ensure no one person monopolizes the team to the detriment of a comprehensive security evaluation.

Assess Needs

To understand and prioritize needs, the team will need to:

1. Develop a list of threats.
2. Identify goals and objectives for each threat.
3. Work with each department or area of the facility to understand their operation and needs. They will undertake a process which includes gathering data, analyzing threats, conducting risk analyses for identified threats, and developing ways to address those threats.

Gathering Incident and Threat Data

Accurate data is critical to understand where problems occur and their magnitude. It must be accurate, specific, and recordable to help the team to understand both threats and underlying causes. Without data, a team is only guessing at their problems.

Specific data can be turned into specific solutions (training, equipment, etc.) which are more cost-effective than globally imposed ones. On an ongoing basis, it lets the hospital look at the effectiveness of WPV prevention efforts. Gathering good data requires:

- A common understanding each type of violence.
- Educating departments in current violence definitions.
- Complete and accurate reporting.
- Participation from all departments.
- A method for analyzing data, whether manual or computer.
- Commitment from management to full, timely, and accurate reporting.

At a minimum, the type of data gathered should include:

- Descriptions of Incidents (including what led up to them.
- Incident resolution.
- Injuries incurred.
- Department / Physical Location.
- Perpetrator identity (if appropriate).
- Perpetrator relationship to the facility (WPV type).
- Prevention response technique used.
- Effectiveness of the WPV response techniques.
- Victim Name(s), unless redacted to prevent retaliation.
- Date / Time.
- Lessons learned.
- Other as necessary.

It can be helpful to gather data on follow-on associated activities, such as consequential medical or psychological care, time lost, and associated costs. These will allow the team to quantify:

- Both direct and indirect costs of workplace violence.
- The benefits of workplace violence reduction investments

Note that maintaining this log and making some of its information available (electronically) to security may provide an early warning if "repeat offenders" enter the facility.

Analyze Threats

The committee will want to look at historic incidents, new WPV definitions, and an updated site evaluation to develop a list of possible threats. Historical data should be gathered in a common format and put into a database to allow analysis of:

- Incident types.
- Incident rates.
- Incident causes.
- Locations needing increased security.
- Violence trends.
- Personnel threat issues.

The last part of the needs assessment is analyzing the data. From this, the team can determine:

1. Where the most frequent incidents occur.
2. When most violence occurs.
3. That is the impact of each threat, individually and collectively.
4. The personnel costs of violence by type or department.
5. The economic costs of violence type or department.
6. Effectiveness of various responses in dealing with threats.
7. The effect of incidents on patient care.

Conduct A Risk Analysis for Each Threat

Conducting a risk analysis for each threat helps the team in several ways:

1. Helping to identify and quantify threats.
2. Allowing the WPV Prevention team to prioritize which threats to address.
3. By creating an economic model to prioritize risks, it can help leadership make actionable investment decisions based on data.

A general formula to use in calculating risk is:

$$Risk = Likelihood \times Impact \times Quantity$$

Likelihood: Is the likelihood that an incident will occur. One percent would be extremely unlikely. 100% means it will happen. For example, the likelihood of a patient attacking a nurse might be 100% over a year, while the likelihood of a helicopter crash on the landing pad might be one percent.

Impact: Is the economic effect the incident will have on the organization. It may include medical bills, counseling, lost reputation (cost of lost business) or any other effects the incident will have.

Quantity: While not normally a part of risk quantification, some hospital violence (e.g., attacks in the ER) can be expected to happen repeatedly. It may be appropriate to add this factor into risk calculations.

Identifying and quantifying each risk is a powerful tool in analyzing threats. Once done, it allows decision makers decide how to address or manage it. Generally, this will fall into one of four categories:

Acceptance An explicit or implicit decision not to take an action that would affect a particular risk.

Avoidance A strategy or measure which effectively removes the exposure of an organization to a risk.

Control Deliberate actions taken to reduce a risk's potential for harm or maintain the risk at an acceptable level. *This is where having cost data for WPV prevention helps leadership make investment decisions.*

Transfer Shifting some or all the risk to another entity, asset, system, network, or geographic area.

Risk management does <u>not</u> mean risks will necessarily be dealt with by a "Control" action. It means <u>only</u> that leadership has decided on how they will address the potential consequences of threats.

Note that economics will not be the only decision driver in addressing risks. But the calculation CAN give WPV prevention teams a data-driven means of prioritizing threats.

Prioritize Threats and Evaluate Solutions

Use threat analysis tools to estimate the likelihood of specific events and the liabilities associated with them. The risk assessment process will help with this. Each threat has a probability of occurring and will not be addressed by an "all-in-one" solution.

Note that, when capital is limited, the team may need to consider less capital-intensive solutions or consider solutions which leverage existing technologies to reduce costs. This will, in turn, require working with the departments managing those technologies to evaluate possible solutions.

Create A Solutions Package

With an understanding of threats and the risks imposed by each, the team can use its medical, security, and legal expertise to develop WPV prevention and response proposals.

In proposing solutions for each threat, the team may wish to consider the following:

- What is the Risk (see above) associated with each threat (to personnel and economically)?
- Clearly identify what goals or objectives a solution needs to meet. This is critical to ensure everyone (including vendors) has a specific target. It will also be key in any regulatory and benefit / cost analysis.
- What preventive tactical, personnel or equipment solutions are available? What effect would they have on "Likelihood" in the risk equation?
- Multi-component solutions are often the most effective (see below). Can these be applied to identified risks?
- Estimate the relative effectiveness of proposed solutions? Will they affect "likelihood" in the Risk equation?
- Get security and medical staff feedback to analyze and help fine-tune proposals.
- Can proposed solutions practically be implemented in the facility?
- Can disruptions to operations be minimized during implementation?
- When estimating implementation cost: Gather as much cost detail as possible. Include equipment, software, software programming / installation, installation, training, startup and ongoing staff requirements, subscription or maintenance costs and any other information possible.
- Understanding the implementation timeline for each proposed solution.
- What are the advantages and disadvantages of each proposed solution.

This is not an instantaneous process. Not all these steps may be possible, or practical in a short time frame. But when included, they should enable the team to make well-informed decisions.

Develop Policies and Content

Creating the plan involves prioritizing threats, developing solutions, and developing policies to support the solutions.

The benefits of strong WPV cultures and policies may see multiple benefits.

- Reduced workplace violence and injuries as potential incidents are de-escalated or prevented.
- Avoided legal, financial, and reputational consequences from WPV incidents.
- Increased employee engagement, productivity, satisfaction, and retention rates (Neuman & Baron, 1998).
- Employees who believe they can trust the security team are more likely to share potentially sensitive information correctly. 52
- Increased trust and credibility in the marketplace, enhancing the organization's reputation.
- Increased trust and accountability can lead to enhanced resilience in the face of potential crises or emergencies, maintaining business continuity.

All these can help the organization save money, leading to long term profitability and stability.

Several other possible policy ideas for consideration can be found in the document "Safe and Secure." [53]

Policies and Culture

"Culture is defined by what we permit and do not permit. It is defined by how we treat individual circumstances. There are cultural challenges if the default position does not protect the nurse – sometimes the default is only to protect the patient." - Steve Edwards, former CEO, CoxHealth, Missouri

"The premise is that we need to make sure that people are safe. Just as importantly, we need to ensure people feel safe." - Brain Uridge, Michigan Medicine Security, University of Michigan

"We have to stand our ground and say that violent and abusive behavior will not be tolerated. Staff need to know that they are supported." - Kimberly Urbanek, Workplace Violence Prevention Consultant

Following are WPV policy recommendations to create and reflect a culture where staff understands that:

- WPV as an occupational hazard is unacceptable.
- There are clear expectations for employee behavior and performance.
- WPV includes both verbal and physical abuse.
- Management advocates for processes, practices, and equipment that help protect employees.
- The institution has zero tolerance to workplace violence.
- The hospital protects its staff from abuse as well as its patients, but it will not protect abusers.
- All WPV incidents will be recorded and acted upon
- Reporting of WPV incidents is readily available.
- A WPV violation "scale" is in place, identifying what violations will result in verbal warnings (with quantity), written warnings (with quantity) and termination.

- Victims are protected by WPV incidents being immediately addressed.
- Feedback from staff on improving reporting programs is welcome.
- Clinical, security, and other staff can view each other as allies.
- Leadership will back up the policies, regardless of who is involved.

Each facility is different and requires work to create site specific WPV prevention programs and reporting mechanisms. It is best to modify any "off-the-shelf policies" for ones' facility.

Determine Policy Content

Policies are the backbone and drivers that guide, communicate, and allow enforcement of the company's WPV Prevention Plan.

Creators of WPV Prevention policies must ensure the policies include compliance with:

- The Joint Commission (or other governing agency over facility certification).
- State and Federal Laws.
- Executive Leadership Requirements.
- Others as determined necessary.

In an article on their web site, The Society for Human Resource Management lists the following recommended components in developing a policy: [54]

- Identify the Need for a Policy.
- Determine Policy Content. This might include:

Purpose statement:	Why is the policy being created and what the desired outcome will be.
Specifications section:	Details about the policy or regulations, requirements, or behavior standards the policy is creating.
Implementation section:	Who is responsible to carry out the policy, and how they will ensure adherence to the policy.
Effective date:	After what date will the policy be in effect and people responsible to comply with it.

- *Glossary:* Defining any necessary terms.
- Obtain Stakeholder Support. Ensure those responsible for policy implementation and compliance have been consulted with prior to its implementation and given the resources to do so. They should understand what the policy is, why it is being implemented, what training will be required. They should also be given an opportunity to communicate any concerns about its implementation.
- Communicate with Employees – what the policy is, why it exists, including training, resources, reporting and accountabilities.
- Update and Revise the Policy, including updating risk assessments into WVP Prevention Plan.

Clearly Define WPV for Different Situations

WPV definitions must be clearly defined and reinforced so people can "become current" on them. Whether or not people agree, they must understand the boundaries for acceptability.

Regardless, verbal, or physical WPV will still occur, requiring different responses because:

- Patients will still be medically driven by conditions making them prone to causing WPV.
- Family members or other visitors will be frustrated, afraid, or impatient with hospital processes.
- Patients wanting to be treated as "customers" may feel entitled to treating others badly.
- Perception of what is actually "verbal violence" will vary from person to person.
- Some will, without malice, be slower to break their long-term habits or cultural norms.
- Some will choose to ignore policies or push the boundaries.
- In emergency situations, tension may be high. Words said in moments of frustration may be perceived not as corrective, but as hurtful.
- Busy people may not perceive themselves as having time to slow down and consider the feelings of others around them.
- Those "higher up the food chain" may feel entitled to not treating others well.
- The United States brings in people from all over the world, with different cultural norms and communication styles. These often lead to miscommunication and misunderstandings.

The team will wish to identify train staff to handle WPV incidents appropriately in the situation.

Consequences for WPV Policy Violations

Anticipate creating different consequences for different WPV violations. Type 2 (patient-generated) WPV will be treated in some cases differently than Type 3 (employee-generated) WPV, and mild verbal abuse should be treated differently than aggravated assault.

For both patients and employees, the team will wish to plan for <u>clear</u>, <u>graduated</u>, and <u>enforced</u> consequences for WPV violations.

- For patients, consequences may include verbal warnings, reduced visitor privileges, relocation, enhanced monitoring (even at their expense, if possible) expulsion, or criminal charges.
- For employees, consequences may include informal verbal, formal verbal, written, counseling, transfer, and termination.

Regardless, the team should be clear in enforcing identified policies via internal counseling, security, or law enforcement if necessary.

The team may also wish to consider a reconciliation process between perpetrators and victims. This should be optional for victims who may feel it traumatizing.

1. Enhanced monitoring of those perceived as potentially dangerous.
2. Transfers to other departments, assuming (1) the victim does not perceive themselves as being punished and (2) perpetrators are not allowed to continue their abuse.

Last, the team may wish to include policies and actions communicating that the facility will make extra efforts to protect employees with domestic violence concerns.

Ensure Robust Reporting

As stated above, both TJC and general best practices require mandatory reporting. This preserves accountability and lets users document trends.

1. As previously stated, it must be possible to preserve reporter anonymity and confidentiality.
2. "Third party" reporting is a method by which observers of WPV incidents can act on behalf of victims unwilling to come forward.
3. Preservation and access to video and audio records will allow investigators to objectively evaluate incidents.
4. When implementing a reporting policy, it is important to remember that training staff on reporting data collection will often show an increase in violence. This sometimes simply reflects that WPV incident rates were higher, but previously under-reported.
5. Standardized reporting systems are essential to easily analyze data and trends.
6. Ensuring reporting systems are readily accessible, well-advertised, and allow rapid entry of information will help staff use them effectively.
7. A person is to be designated to review incidents and trends of WPV.

The IHS-Sponsored paper "Workplace Harassment and Violence: A Primer on Critical Strategies for Small and Medium-Sized Businesses" offers guidance on integrating computer and network systems with WPV prevention planning, communication, hardware and software support, threat detection, post-incident analysis, and other topics. [55]

Collaborate With Outside Agencies

Collaborating with outside agencies allows the team to understand trends in the community and learn what local resources are available to support hospital staff and patients. Groups with which an organization might collaborate include:

- Law enforcement agencies (resources and emergency response protocols)
- Emergency management agencies
- Fire departments
- Social support agencies
- Clergy
- Violence prevention / education groups

Communicate The Policy

Management must communicate their support for eliminating WPV, and that employees share that responsibility. Management should also emphasize to employees that:

1. The organization is committed to workplace safety.
2. The organization has comprehensive policies to protect employees.
3. The policies include specific prohibited behaviors, as well as the consequences of violating them.
4. The organization has training and other initiatives to keep employees informed, involved and safe.
5. Management will make extra efforts to protect employees where there is anxiety about domestic violence.

6. Management will provide clear avenues for employees to push for accountability when faced with unsafe situations.
7. Staff has confidential and accessible reporting channels like hotlines or online portals.
8. Staff reporting violence are assured confidentiality and protection from retaliation.

Regular and / or ongoing awareness campaigns can help inform employees about workplace violence prevention and response initiatives.

Conduct Ongoing Reviews

Workplace violent incident policies must be reviewed and modified to incorporate lessons learned during incidents to avoid future ones.

Best practices here include:

- Regularly evaluating the effectiveness of existing policy and intervention techniques.
- Revisit the plan regularly to reprioritize threats as needed.
- Using WPV data to know where to expand or refine your organization's WPV program.
- Assessing physical security and implement necessary measures in response to data.
- Conducting interviews with departing employees to gain insight into policy effectiveness or workplace violence issues or concerns not have been previously reported.
- Reviewing and updating WPV policies to ensure they comply with laws and regulations.

Note that data on incident rates, WPV costs, employee morale, feedback, employee retention and other data can also be used to identify employee causes, guide future security investments, provide positive public information on workplace safety and justify the benefits of employee training.

BEST PRACTICES – STRATEGIES AND TACTICS

This section is intended to outline current and emerging best practices for WPV Prevention. It encompasses three important and overlapping strategies:

- Multicomponent Solutions – Using several methods to create a comprehensive security plan.
- Relational Security – Using Customer Service models to calm patients, visitors, or fellow staff.
- Anticipating and Responding to WPV via Threat Assessment and BERT Teams.

While there are many "best practices," two primary factors are key starting points in building out strategies and tactics: Multicomponent Solutions and Relational Security.

Best Practices - Multicomponent Solutions

Single threat mitigation tactics are almost never as effective as "multicomponent" approaches. These combine multiple tools, many of which may be existing. A 2007 article describes how this security structure as including: [56]

Procedural security: Much of this is outlined above in the WPV Prevention team planning. It provides policies and procedures to give people confidence in what they are doing and ensuring they are all doing the same thing. Commonly used policy documents must be highlighted on training events. These will ideally be built into the WPV Prevention Plan.

Relational security: This covers several areas, including training on customer service, de-escalation training, and security staff visiting patient rooms for conversation. All of these can create or reinforce professional boundaries while helping patients feel secure. It also should include setting boundaries of conduct for all parties, both patients and staff.

Physical security: This encompasses controlling access to different areas and monitoring people in those areas. They can be as simple (locked doors), include multiple layers of armed guarded posts, and scanning for banned items before entry past a secure perimeter video, personal alarms, and other devices.

Hospitals will already have some tools of these tools available. Leveraging these should help reduce implementation costs for the entire WPV Prevention program. Combining physical, procedural, and relational security has been shown to lower healthcare WPV and reduce legal liability more cost-effectively than expensive single-component solutions.

Multicomponent ER example:

Below is a possible example of a multicomponent solution in an ER.

- Physical security via access control (locking doors) and /or weapons scanners.
- Signs highlighting a zero-tolerance policy toward yelling or violence.
- Visible video surveillance.
- Security staff (the ER is a high-risk area) with relational training and non-threatening uniforms.
- Staff training on customer service to address patient and family fears and anxiety, including:
- De-escalation training.
- Patient and Family Resource availability.
- Treatment information.

- Personal or ER pull-alarms.
- Clinical interventions as necessary (medication management).

Multi-components approaches can also work in patient rooms. Examples shown effective may might combine signage, customer service and de-escalation training, and possibly body cameras with audio.

Best Practices - Relational Security

Relational security has become a healthcare "best practice" which can reduce WPV rates and security costs. It can also improve hospital reputations in the community.

Several types of Relational Security are outlined below. Not all may fit or apply in each case. But they have one thing in common – the ability to reduce WPV incidents by allowing patients and staff members a feeling of security and helping them control emotional and / or violent outbursts.

A Tale of Two Security Incidents

Below are two 2023 incidents as described by a SHSU Institute of Homeland Security staff member.

Conventional security response
The following occurred late one night at a suburban branch of large hospital system:

> "A man came running out of an ER exam room pulling off medical equipment and tubes as he went. He was dressed in jeans, a hospital robe, and barefoot. Someone on hospital staff had referred to him as having mental health issues. He didn't, but he was angry. He headed out of the ER doors, followed by nurses, one or two doctors, and medical staff, while waiting ER patients, reception desk personnel, and other medical staff watched in concern.
>
> About the time the nurses and doctors were getting him calmed down two large security officers in uniforms came running down the hall and out to the patio area. They were forceful in both their entry and engagement, and the patient and situation escalated again."

Customer-Service Security Response
On another night, at the Texas Medical Center:

> "Two individuals began a heated exchange which escalated quickly into name calling, accusations, and threats. Patients waiting in the ER became concerned and started moving away from the two individuals, while nurses taking inbound patient information grew visibly concerned.
>
> Then a young man walked in quietly and unassumingly, wearing a hospital uniform and security windbreaker. He approached one of the individuals and spoke to her in a quiet, considerate manner, his voice so low you could hear little of the dialogue. Within a couple minutes, the woman quieted down, visibly nodding in agreement with the security officer, then apologized and sat down. The officer then went to the other individual, repeated the process, and had the same outcome.
>
> I followed the officer out to the hallway, introduced myself, and asked if he had used de-escalation training. He responded that he had only been on the job three weeks and had not gone through all the training yet. But he did share that he had worked retail for many years and simply used the significant customer service training he had received. He related that he just spoke to and treated them as angry customers who needed assistance."

Customer Service Models

A component of relational security is how we listen to and interact with customers. Two companies which excel in this area are Starbucks and Marriott. Common to both are customer service models which involve actively listening to customers, and ensuring the customers both know that they were heard, and that the organization is acting.

Starbucks© "LATTE" model

- Listen to the customer.
- Acknowledge the problem/situation.
- Take action and solve the problem.
- Thank the customer.
- Explain what you did (to resolve the problem)

Marriott© "LEARN" Model

- Listen
- Empathize
- Apologize
- Respond
- Now / Notify

These models both address four important aspects of customer service:

- Letting customers know they have been heard.
- Acknowledging how the problem is affecting them.
- Taking action to resolve the problem where possible.
- Feeding back to the customer that action was taken (or just giving them information).

This approach has been shown as an effective way to reduce healthcare WPV.

Client Service Ambassadors

Client Service Ambassadors (CSAs) embody customer service and are being placed in some of the busiest ED waiting room areas with family members. They monitor patient and visitor behaviors to identify signs of escalation towards aggression, and then intervene early. They might also provide comfort to those waiting by offering coffee or blankets, etc.

CSAs have also been an integral part of Safety Huddles for situational awareness, understanding concerns, and planning for patient discharge. For example, they have might help smooth the path for homeless people being returned to shelters by helping facilitate transportation.

A formal 6-month pre and post evaluation conducted at one of the three test sites piloting CSAs saw a 23% reduction in physical aggression in those ERs.

Community Based Policing / Customer-Service Approach and Training

An approach to WPV prevention shown to be successful involves incorporating a community policing-based philosophy.

Security staff often come from military or law enforcement backgrounds, with a compliance-focused training. These approaches, or even officer appearance, can "trigger" patients or staff who have previously been traumatized by encounters with police or security staff. Community-based policing instead uses a more empathic approach to customers, having officers build relationships based on trust with staff and patients.

Methods by which this is done include:

- Training in empathetic communication, listening and showing patients they care about them.
- De-escalation training.
- Walking around, engaging patients, families, and staff in conversation.
- Changing uniforms away from traditional “cop” appearance. Non-uniformed officers might wear polo shirts, creating a “softer” presence for individuals who might be triggered to violence by uniforms.
- Changing titles to non-threatening ones, such as “Relational Support Officers.
- Proactively checking in with patients or families in the waiting room.

Examples of what this type of policing might look like include:

- “Every day, we tell our security staff to meet a patient they have never met and engage them in a two-minute conversation about anything – sports, movies, music, whatever. They also meet a staff member they have never met for a two-minute conversation. This simple exercise is brilliant for reducing staff and patient anxiety." 57
- Security offers may use dogs from “floppy ears” breeds that do not intimidate patients, or “canines trained in passive signaling” 58
- Ensuring security personnel have an acute awareness of patients and their surroundings, as well as how to anticipate, de-escalate and ultimately prevent aggression.”

Training security to operate in this way is relatively inexpensive and may already be part of security officer’s experience. It may also be more fulfilling to officers than traditional security. According to one hospital administrator, “When trained properly, they can work alongside the clinical staff, using empathy to help navigate or negotiate with the person that may perpetrate violence." [59]

The trust this allows them to generate is also invaluable because employees are far more likely to share concerns or tips if they feel they 'know' the security team and can trust them to use potentially sensitive information correctly.[60]

Trauma-Informed Care

Patient backgrounds can affect how they respond in unfamiliar or frightening areas like emergency rooms. Trauma-informed care is a way to help avoid triggering violent responses in those situations.

> “Trauma-informed care acknowledges the need to understand a person’s life experiences in order to deliver effective care and has the potential to improve patient engagement, treatment adherence, health outcomes and provider and staff wellness” [61]

Trauma-Informed Care is an aspect of customer service which helps staff understand issues surrounding patients and families, anticipate possible needs, and address them to help calm all involved. It involves:

- Understanding that trauma can have long-term and hidden consequences.
- Understanding that previously traumatized patients (especially children) may not react well to “scary” places like ERs.
- Understanding that parents and caregivers are not always well equipped to handle the needs of sick, injured, disabled, or mentally challenged, and may arrive at the hospital worn down and unable to deal with their situations.
- Recognize signs and symptoms of trauma in individual clients, families, and staff.
- Work actively to not re-traumatize these patients during care.

Several Trauma-Informed care policies identified by Denham & Denham include:

- Creating "Parent Ambassador" positions to decrease parent escalations by advocating for them within the healthcare system and helping them find local support resources.
- Having a "Client Service Ambassador" (CSA) in ER waiting rooms trained to monitor behavior, intervene before behavior escalates, and comfort people by offering blankets, coffee, etc.
- Assisting homeless patients at discharge by arranging transportation to those leaving hospitals for shelters
- Understanding patient concerns at discharge and helping to plan for or address them.

Note that in British Columbia, "a formal 6-month pre and post evaluation conducted at one of the three test sites piloting CSAs saw a 23% reduction in physical aggression in those EDs." [62]

Relational Security and Boundaries

Security provides the framework within which care and treatment can be safely provided. Neither patients nor staff can participate positively in the activities of the service unless they feel safe first.[63]

Relational security allows patients and staff to feel safe enough to communicate to ensure therapeutic treatment. It sounds "touchy-feely," but is not, as it cannot function without professional boundaries between patients, staff, and all others involved. Relational security is well described by "See Think Act", a booklet written primarily for those working in secure (jail or prison) mental health services, published by The Royal College of Psychiatrists Centre for Quality Improvement. [64] While focused on mental health patients, it can well be applied to other medical facilities. The two primary components of the framework, Relational Security and Professional Boundaries, are described below.

Relational Security

"Relational security is not simply about having 'a good relationship' with a patient. Safe and effective relationships between staff and patients must be professional, therapeutic and purposeful, with understood limits. Limits enable staff to maintain their professional integrity and say 'no' when boundaries are being tested.." [65]

Patients knowing that they are safe and secure is important to therapeutic treatment. They are less likely to act up when they feel secure. This happens when staff creates an environment where:

- Patients feel physically, mentally, and emotionally safe.
- The team engages proactively and therapeutically with patients, providing a clear plan of care.
- Patients believe staff understands and cares about how they feel. "Staff who don't and who are passive or insensitive can do more harm in a service than good. They create feelings of resentment and mistrust, undermining the whole team."
- Staff knows that some events can act as triggers for patients, know patient histories and understand how they feel.
- Patients know that how they behave affects staff's ability to treat them.

Providing emotionally secure environments calms customers by addressing their fears, helping them know they are safe, and letting them know the people around them care about them and their healing.

Professional Boundaries

Professional boundaries help provide the framework for patient communication and treatment. "See Think Act" discusses how Relational Security is created using clear professional boundaries:

"See" Means clearly identifying boundaries - physical, procedural, and relational. Both patients and staff need to understand the importance of maintaining professional boundaries and how they contribute to therapeutic treatment. Being clear and communicating them is crucial.

"Think" Means talking with teammates to identify which boundaries need to be maintained, evaluating how boundaries are maintained, which might be negotiable, whether anyone is violating those boundaries, etc.

"Act" Means doing what it takes to improve relational security. Some methods include:

- Identifying negotiable and non-negotiable boundaries.
- Communicating boundaries to patients and staff.
- Being clear about how you will evaluate boundaries and being consistent in doing so.
- Letting the team know when on applies their judgement about boundaries.
- Staying aware of your own feelings and behavior, and how it might affect others.
- Being alert to potential or actual manipulation by patients or staff.
- Being prepared to raise any issues about patient or staff boundary management.
- Recognizing and affirming proper boundaries.
- Treating everyone consistently, with dignity and respect.
- Being prepared to work as a team to discuss and get help with these issues.

In an ideal form, a facility would be able to provide both therapeutic treatment and clear behavioral expectations of patients and staff.

Best Practices - Threat Assessment Teams (TATs)

Sometimes it is not possible avoid patients or families known to represent threats. When this happens, Threat Assessment Teams (TATs) help anticipate potential problems and assess how to deal with them.

TATs work to prevent violent incidents through a behavioral-based, deductive process:

1. Learning of a person who may pose a threat.
2. Investigating them.
3. Evaluating whether they pose a threat to others.
4. Developing and implementing a plan to eliminate or reduce the threat.

TATs use information from patient records, employee records or other sources to counter situations presenting a threat to staff or other patients. Situations triggering a Threat Assessment might include:

- Stated or implied threats from patients, their families or others associated with them.
- Police or inbound ambulance notices about violent patients.
- Patients with history of causing violence.
- Domestic violence patients.

- The mentally ill.
- Substance abusers.
- Terminated employees.

When individuals trigger a Threat Assessment analysis, the team would essentially do a Risk Analysis and evaluate ways to head off potential violence. The team can then take actions to:

- Trigger Do Not Acknowledge (DNA) notes in patient files to protect them from unwelcome visitors or contact inquiries.
- Flag medical records for patient (or parent) behavioral or substance abuse issues. These can be used to alert medical staff to potential dangers.
- Review patient social media postings which might warn of planned patient violence or patient presence at a facility.
- Add staffing at patient locations.
- Alert staff to upcoming critical dates (such as court dates) for patients charged with criminal activities.
- Implement Violent Trauma Access Control plans. These would, upon notification from the emergency department inbound patients suffered violence-related injuries, allow the hospital to shift its security posture to limit or lock down ER access.

The Joint Commission advises creating a Threat Assessment Team (TAT) with a core membership of security, risk management, human resources, administration and legal, plus the ability to add clinical staff and subject-matter experts as the situation requires. [66]

Best Practices - Behavioral Emergency Response Teams (BERT)

"Behavioral Emergency Response Teams (BERT) provide a clinically led, rather than security-led de-escalation process. These teams help identify and deal with psychiatric behavioral emergencies and intervenes before situations require security interventions.

Uses calming techniques, models crisis intervention skills, suggests medications if necessary, conducts debriefings, suggests future education needs.

The approach has had some striking successes, with several research studies finding this clinically led de-escalation approach significantly decreases violence.

In one study, a BERT team was launched for a three-month pilot on a medical-surgical unit where the team responded to 17 behavioral emergencies. In one study, the positive impacts of the team were evident: [67]

Incident Quantity	Before BERT	After BERT	% Reduction
Assaults	10	1	90%
Security interventions	14	1	93%
Restraint use	8	1	87%

Another BERT pilot study revealed the program reduced security interventions (assaults and security interventions) by 83%, and the use of restraints decreased by 80%.

BERT teams typically consist of an administrative supervisor, designated employees who are formally trained and certified in de-escalating aggressive behavior and physical restraints with security staff as a backup. Clinicians lead the intervention and the de-escalation process, bringing in security as a last resort.

Ideally, the team will have a defined 'clinical chain of command' beginning with the administrative supervisor, with decision-making authority to address the clinical aspects of incidents.

The effectiveness of Behavioral Response teams is such that this training is a major theme in The Joint Commission's best practice on workplace violence.

them to education on what potential resources might exist in their communities such as Health Alliance for Violence (HAV), or social services, etc.

Trauma-informed care practices may include: [68]

- Training staff to recognize and work with traumatized patients.
- Screening patients for trauma at intake.
- Creating environments where traumatized patients feel safe.
- Providing a warm or welcoming social environment.
- Providing "Parent Ambassadors" who will advocate for parents of children with cognitive or developmental needs. They might assist parents to handle special needs children with education and coping skills, or awareness about resources to support their kids.
- Engaging services able to support patients in their specific type of trauma.

Best Practices - Technology

While there are numerous technological systems being developed to alert security of violence or threats of violence, it must be recognized that all technology has limits, and they should be considered when looking at technological solutions.

Some best practices in evaluating technology include:

1. Avoid knee-jerk reactions. Don't just install a weapons detection system. Look at individual measures in the context of the WPV Prevention Plan. Figure out if you need one first!
2. Recognize that technologies covering one entry point (such as X-ray or weapons scanners) may be necessary, they are low-percentage fixes and only cover a single point. It may be appropriate to ensure all other entries to a facility or area are locked and alarmed to indicate when left open.
3. Understanding the limitations of the equipment or system being considered. Ensure you identify blind spots, areas of no coverage, what happens when employees are working in the field, etc.
4. Before purchasing new equipment, reduce costs by leveraging existing technology in the facility as much as possible.
5. Make equipment audits mandatory to ensure equipment is calibrated and working properly.
6. Require input from IT on all technology solutions (see below).

Personal alarms

With the rise of remote work, it's essential to consider how workplace violence prevention measures can be adapted to protect employees working from home or in other non-traditional settings.

Personal or local alarm buttons are evolving to leverage hospital Wi-Fi networks, Bluetooth beacons and cellular networks:

Traditional panic alarms were fixed buttons in limited locations. "However, if built around a location (such as an ER), hospitals will have very limited coverage, leaving staff exposed in other areas. Any personal device should be able to annunciate, with location, across the full geographic range of possible exposure. Once away from that button, they could not readily alert security to attacks.

Modern panic alarms use using Wi-Fi networks and Bluetooth beacons to provide protection anywhere on or off campus (using cell phones). Smartphones can be enabled with software and used as personal safety devices – "enabling duress alerts, sharing location (check-in), and providing real-time information on patient aggression and violence. This empowers staff to report real-time issues such as suspicious behavior or incidents of verbal abuse." [69]

Real-time Coordination and Response (RTCR) can leverage these devices and networks to provide real-time positioning and coordination with security or law enforcement. Leveraging Wi-Fi access points, Bluetooth beacons, and mobile networks, RTCR offers real-time visualization of employee position, in turn allowing faster response on campus or connecting with law enforcement off campus. This type of command-and-control system acts as a force multiplier so lean security teams can cover large campuses and the broader healthcare footprint in more isolated areas.

All these give staff protection within the facility, out to parking lots or (via cellular) some protection in the community. "Wi-Fi supported systems worn on the person provide for a greater accessibility and response times." [70]

Because many hospitals have already invested in advanced wireless networking infrastructure to support clinical practice, it may be possible to provide personal alarms at a reasonable cost by not having to set up a new wireless network for alarms.

These systems may also allow users to send real-time alerts to both security leaders and fellow staff members, shortening alert time.

Camera systems

Monitoring high risk areas can help to mitigate risk. However, this is a reactive tool, requires continuous monitoring, and is unlikely to provide full facility coverage.

Technology is being developed to let cameras feed computers to automatically scan for aggressive actions or falls. AI will interpret camera system data to automatically detect unusual or inappropriate behavior – patient falls, assaults, cars parked in the wrong area, etc.

Body cameras, though limited in viewing scope, may also be able to capture audio. Privacy will obviously be a concern with these, for instance, when using bathrooms or having personal conversations.

Weapons detection systems

Weapons detection is rapidly evolving, moving from traditional handheld scanners and X-ray machines to camera systems linked to AI software, capable of automatically detecting attacks or alerting to aggressive behavior.

Newer weapon detection technologies are said to be better than traditional metal detectors, as they allow faster and more accurate rates weapons detection than older technologies.

The cost of these weapons detection systems varies widely, depending on the technology. They can range from handheld metal detectors at $150 - $500 to full body scanners at over $250,000. However, labor costs will add substantially to the cost of deployment (see "Operator Labor Costs" below).

Note that, while not as advanced as newer technology, X-Ray systems alone have been helpful: "staff at the Cleveland Clinic (which has been using metal detectors since 2016) confiscated 30,000 weapons (e.g., knives, box cutters, and guns) from patients and visitors in 2018 alone in its Northeast Ohio region." [71]

Patient Location Monitoring

For patients deemed potentially violent, it may be possible to affix body tags or wayfinding apps utilize indoor Wi-Fi networks to provide patient position. Obviously, they will need to be non-removable except via locks.

Technology Implementation Considerations

For effective and secure operation, the following components must be considered when evaluating technology solutions.

Coverage

1. Can the technology provide accurate three-dimensional positioning across the entire facility. If not, what areas are not covered?
2. If those areas are not covered, what would be required to include them, and at what cost?

IT System Integration and Security

IT should be brought in early in the security system selection process to ensure any system incorporating access to building wireless infrastructure will not threaten facility operation. They will be needed to evaluate:

1. Will the alarm technology will integrate with existing wireless or other facility infrastructure?
2. If the technology will not integrate with existing infrastructure, what will be the required changes, cost, and time frame to integrate the alarm technology.
3. It is important to decide whether any technology implemented will use open or closed protocols.
    a. Open systems may allow for integrating a range of technologies will use open protocol to allow them to easily communicate with other systems in place. This can reduce being tied to specific vendors and hostage to costs.
    b. Closed protocol systems may offer comprehensive solutions, but not "play well" with other security systems. They may be secure, but not communicate well with patient data (for risk analysis) or other hospital systems. This can also limit accessing new technologies from other vendors and being hostage to proprietary software and costs.

With computer networks under external attack and even internal equipment being used as attack vectors, security systems communicating across a facility network must be secured. They must:

1. Be isolated from hospital systems containing or transmitting patient information, inventories, orders, billing, etc. Secure access of security software with patient records must be carefully implemented to protect hospital records.
2. For cloud-based systems, be resilient against loss of internet connection.

Operator Labor Costs

If monitoring a security system requires an employee, the costs become significant, and may justify the higher cost of a system using AI. For example, a guard employed full time (regardless of whether using handheld scanners or monitoring a weapons detection system, is not free to perform other security tasks. The wage for security guards in Texas typically ranges from $15 to $19 per hour. When running 24/7, a 25% labor burden and 24/7 (three shift) operation, guards employed by the facility can be expected to cost between $163,800 to $207,480 per year. Contracted security guards will cost more.

When considering overall operating costs this may point to the benefits of AI-based systems which automatically alert security without using additional staff.

Note that some systems using remote monitoring are offered on a subscription basis. This can significantly reduce installation and monitoring costs.

Best Practices - Physical Security

Physical security continues to be a critical component of WPV prevention, though it too is evolving.

Layered Security

The most effective WVP plans will combine multiple measures – combining different layers of physical security and employee training. Facilities can implement them over time to spread out expenditures and focus on the most cost-effective solutions. An article about the Mountain Health Network described their hospitals adding weapons detection systems as part of "a three-year security master plan to bolster security at all of its facilities. Measures already in place include the addition of signage regrading aggressive behavior, staff training on de-escalation tactics and self-defense classes."[72]

Visitor Management Systems

Combining physical and digital access control are Visitor Management Systems (VMS).

Physical design limits entry to a minimum number of access points where visitors can be identified for security purposes. This reduces security costs, though the approach can create problems of waiting, and closeness to various departments in large hospitals. However, visitor management systems present a challenge for hospitals when they take away the welcome feeling of open access.

VMS implementation varies widely. Some hospitals limit them to sensitive areas such as pediatric units/infant or emergency departments. Some, such as Chicago's Lurie Children's Hospital, use single entry points "built with a single point of entry; it was hence designed with general funneling layout that allows for operationalization of a comprehensive VMS." [73] Last, some may implement VMS across multiple entrances: "A healthcare system in Delaware implemented an electronic VMS and has been tracking all data from all entrances" since 2018. This lets them know who is in the building at a given time." [74]

The latter system includes software which "includes visitor pre-registration, security, background checks, internal watchlists and flagging, automated notifications, ID scanning, badge printing with color-

coded destinations and duration in the facility, vehicle recognition, and cross references sexual offender databases." [75]

Violent Access Control Planning

Described above, this process will leverage Visitor Management Systems when inbound patients may bring violence with them. When security posture shifts, doors might be locked immediately to secure the ED and restrict ED access temporarily until a proper threat assessment can be done. [76]

Miscellaneous Improvements

Other successful practices identified include:

Signs regarding behavior
A system in Delaware placed "no firearms" sings on all their facilities. This led to decreases "in the number of weapon encounters with individuals carrying firearms particularly in rural areas where people typically carry."[77] Signs in EDs and other areas can set the tone about not tolerating violence, threats, obscenities, or sexual harassment (including banning or prosecuting violators).

Because local jurisdictions may consider verbal assaults as criminal (simple assaults). It may be worth deciding whether signs stating that verbal assaults can lead to arrest may be worth investigating as a WPV prevention tactic.

Amnesty boxes
These allow visitors to drop weapons before entering the ER and are becoming more common.

Physically secure furnishings
Locking down chairs and other heavy items can prevent them from being used as weapons.

"Do Not Acknowledge" Alerts
Do Not Acknowledge Tags on files indicate to staff not to release information about patients who may be targets of WPV. These might include abused spouses or ex-girlfriends or boyfriends, gang members, etc.

Daily safety huddles
These brief staff on behaviors individual patients have been displaying, possible patient violence triggers, and tactics on how to mitigate individual violence.

Best Practices - Preventing Type 3 Violence

"Type 3" (employee generated) violence is most frequently spoken of in terms of situational violence, relationship issues, sexual assault, and termination-related violence. While many "Type 3" WPV prevention practices are well known, following are some worthy of being reinforced.

Equal Policy Enforcement

Little discourages people from reporting violence like the belief that those in higher positions won't be punished if they are the abusers. Rather, employees become discouraged by the lack of justice, and their commitment to their job and institution often falls off. They become what is termed "quiet quitters," doing no more than is necessary and isolating themselves from additional involvement with others or their job.

However, statistics show that when people know polices (in this case, about violence) will be enforced, they become more likely to report it and believe in their employer's commitment to their safety. Therefore, non-retaliation policies, confidential reporting, and bystander training can contribute to worker safety, worker job satisfaction, accurate reporting, and justice for all involved.

Bystander Training to Address Verbal and Sexual Abuse

A means of encouraging people to either intervene in or report sexual harassment is Bystander Training.

In one study where individuals were observed witnessing harassment in operating room simulations, the participant demonstrated several behaviors showing that he or she recognized behavior as inappropriate but was unable or unsure of how to resolve the conflict.

To this end, bystander training is another effective avenue in preparing colleagues to recognize, intervene, and report harassment. In this study, we noted 42.9% of female and 30% of male residents had witnessed others being harassed.

Note that in this study, 46.8% of those surveyed stated they would feel more comfortable reporting sexual harassment if others came forward as well. These data support creating an environment that encourages reporting sexual harassment. [78]

Hiring

Employee screening: Implement thorough background and reference checks for potential hires to identify any history of violent behavior or other red flags. Comprehensive background checks on all potential hires can minimize the risk of hiring individuals with a violent history.

Employee Behavioral Monitoring

Early detection and action on warning signs, such as aggressive behavior, verbal threats, weapon possession, substance abuse, or sudden behavioral changes, can prevent violence and promote a safer workplace.

Supervisors and peers have the great potential to recognize poor decision making and intervene prior to harmful acts. Indicators of poor decision making that can lead to concerning behavior could include:

- Drastic and/or sudden changes in personality causing an increase in workplace conflicts.
- Decline in work performance.
- Behavior casting doubt on reliability or trustworthiness.
- Attempts to use unauthorized devices.
- Repeated security violations
- Suspicious travel
- Financial problems or change in financial situation.
- Behavior or comments, including on social media, suggesting violence or dissatisfaction.

According to a US Navy handbook, the potential for harmful acts (including workplace violence) "pose a great insider risk and insider threat," with the threat of insider risk typically developing in five stages: [79]

1. Poor decision making
2. Concerning behavior
3. Risk
4. Danger
5. Harm

Employees should be encouraged to take an active role in preventing workplace violence – "if you see something say something". Likewise, encourage those concerned about being attacked because of broken relationships, stalkers, etc. to report them to security.

Social media: Many violent events have been preceded by warning posts on social media. Within the law, it may be appropriate to for monitor potential workplace violence posts on social media platforms. Establish guidelines for monitoring and responding to these threats, while also respecting employee privacy and freedom of expression.

Even from initial employment, supervisors should be trained to look for and note behavioral "red flags" indicating a propensity to violence. Some include:

- A chronic inability to get along with co-workers.
- Anger control issues or mood swings
- Indications of increased paranoia or persecution. "I am a victim."
- A history of emotional problems or violence within past jobs and and/or personal relationships
- An inability to resolve minor setbacks or disputes at work.
- A fascination with guns, weapons, or violent events (appropriate context)
- A sudden deterioration in workplace habits or personal grooming
- Signs of stress, depression, or suicidal indications
- A major life changes, i.e., divorce or significant legal problems

If anger issues arise, intervention (talking, counseling, psychological evaluation, etc.) should be offered to address any underlying mental health or personal issues. [80]

Terminating potentially violent employees

If necessary, employees can often be terminated without cause. Texas is an "employment-at-will" state, meaning that either the employer or the employee can terminate the employment relationship at any time and for any reason, providing it does not violate state or federal law or union agreements. This lets employers act quickly when necessary. However, in the context of workplace violence, it is important to recognize the trauma associated with termination.

When terminating potentially violent employees, best practices might include:

- Generating employee threat assessments.
- Separating the employee from the object of threats or anger. If a supervisor, it may be best to keep that person from being involved with the termination.
- Have security nearby – not necessarily in the same office, but close enough to act if necessary.
- Don't fall for the excuse of wanting of a break. There are numerous instances of an employee asking for a bathroom break only to use the break to retrieve a weapon.
- Allow the person as much dignity as possible. If possible, save the termination for the end of the workday so other employees are gone, and don't see them being terminated.
- Be brief and to the point. Do not get into a back and forth.
- Minimize reasons why the employee would have to revisit the workplace. Mail a check (or have it at termination), have uncollected belongings sent to the person's home via a delivery service.
- Emphasize any severance benefits and outsourcing help that may be available.
- As an option, offer the opportunity to resign as an alternative to termination. [81]

Best Practices - Training

Scientia Potentia Est (knowledge is power) [c]

A very positive change in countering violence has come from WPV Prevention training, predominantly for nurses and clinical staff. The numerous training types and models available typically revolve around providing staff with tools to de-escalate potentially violent people. Some will be discussed further below. Training may include:

Violence Prevention Training

There are many types of training available to organizations, whether internally or externally sourced. Training should include both clinical and security staff.

Training Goals - General

Best practices for WPV prevention training should:

1. Clearly communicate the organization's WPV Prevention policies.
2. Update staff on current definitions of verbal or physical WPV. Specifically incorporate The Joint Commission or other certifying agency definitions.
3. Make employees aware of WPV and confidentiality resources.
4. Be scenario-based and department-focused, and including clinical, security administrative and other department/employee roles.
5. Ensure staff know how to quickly access WPV Prevention resources.
6. Be reinforced at appropriate time frames, including updates based on new best practices. These policies are known to decrease WPV. However, like tools, require sharpening, maintenance, and instruction on their use.
7. If possible, do not rely on online training. Live, in-person training is much more effective for learning as it lets one see how others handle different scenarios.

Training Topics

WPV Training classes ideally would include:

1. Recognizing warning signs of violence.
2. Maintaining professional boundaries (for example as outlined in "See Think Act").
3. De-escalation / Violence Prevention / Violence Response.
4. Customer service, Behavioral Emergency Response Teams (BERTs) and CREW.
5. Self-defense, to allow workers to escape difficult patients.
6. Working with patients identified as violent.
7. Reporting procedures.
8. Employee conflict resolution.
9. Personal stress management and self-care.

[c] Sir Francis Bacon, Meditationes Sacrae, 1597.

Supervisor training

Additional training may be appropriate for management and HR teams to both create a positive environment and handle difficult employees. This might include:

1. Facilitating a positive work environment for employees through education programs regarding stress reduction, workload management, etc. to reduce staff burnout.
2. Training on specific conflict resolution strategies that can help to defuse volatile interactions between employees.

Emergency Response Plans

Because violence prevention training and educational programs DO NOT decrease rates of workplace violence on their own, facilities must develop emergency response plans. These should detail immediate actions, emergency contacts, and include law enforcement engagement. They must also be clearly communicated to staff with training and drills to familiarize employees with WPV incident procedures and protocols.

Best Practices - Post-Incident Recovery

Despite best efforts at prevention, there will still be incidents of violence. When this happens, it is essential to support affected employees.

Mental health support for WPV victims is clearly a significant need. Bureau of Justice Statistics data from 2015 – 2019 indicates that 74% of workplace violence victims reported post-incident socio-emotional problems. [82]

Level of emotional distress	Percent of victims
None	26%
Mild	**35%**
Moderate	**24%**
Severe	**15%**
Total	100%

Other documented post-violence consequences include:

Work / school problems [d]	20%
Family / friend relationship problems [e]	10%

[d] May include reporting significant problems with work or school, such as trouble with a boss, a coworker, or peers.

[e] Includes victims reporting significant problems with family members or friends, including getting into more arguments or fights than before the crime, not feeling able to trust them as much, or not feeling as close to them as before the crime.

In addition to any medical needs, best practices in Recovery and Resilience include Employee Assistance Programs (EAPs). These can help mitigate disruptions in the workplace resulting from post-incident recovery by providing:

- Post-Incident Support to help victims through immediate actions such as reporting and informing them about support resources.
- Short term counseling.
- Flexible work arrangements to have time for mental health appointments.
- Support resources family members of the affected employees.
- Stress management training, and mental health awareness.
- Ability to move between departments. (This should not be a way to separate victims from abusers instead of dealing with abuser conduct.)

Post-incident activities should also include:

- Conducting a root cause analysis to understand what caused the violence, determine what could have been done differently, and identify any gaps in existing policies and procedures.
- Incorporating outside external agencies and community organizations for any appropriate resources and advice.
- Using lessons learned to prevent or mitigate future repeats of the type of violence shown.
- Creating or updating the risk analysis as a basis for investments and decision-making.
- If appropriate, updating the WPV Prevention Plan to incorporate any lessons learned.
- If appropriate, updating WPV Prevention strategies and tactics accordingly.

These arrangements play a crucial role in assisting affected employees, as well as showcasing the organization's commitment to employee well-being.

BEST PRACTICES: LEADERSHIP INVOLVEMENT AND APPROVAL

This section is written primarily for teams wishing to submit proposals to leadership for project approvals. It deals not with hospital approval processes, but with factors which will encourage leadership to support projects – regulatory, economic, and reputational.

The Importance of Leadership Involvement

As stated above, a lack of leadership support is often cited as a reason for WPV programs not being effective.

Requirements from The Joint Commission require leadership involvement in WPV Prevention. This section is intended to help those working on these programs to support leadership by providing support for and giving ammunition to them as they do so. This is important, as executive-level sponsorship is critical for:

- Ensuring all staff levels and members are aware of leadership's investment in WPV Prevention.
- Creating the multi-disciplinary teams necessary to identify and address WPV.
- Ensuring all departments (security, clinical, etc.) work with each other to develop evidence-based, hospital-wide initiatives.
- Communicating what is necessary to gain leadership endorsement for WPV prevention measures, whether evidence-based, funding limits, return on analysis or other measures.
- Approving and supporting WPV Prevention measures for those measures to be successfully implemented.

The job of the Workplace Violence Prevention Team will be to give leadership what they need to not only approve a project, but to support it all the way through implementation and maintenance.

Leadership Decision Criteria

When it comes time for project approval, expect executive-level leaders to ask:

- Why this project and solution?
- How will the project benefit the institution?
- Why is it better than other options?
- How much will it cost?
- Will it create a payback or operating savings?
- What are next steps?

The WPV Prevention Team needs to be able to answer these questions in a clear and compelling manner.

Following are discussions of these points, written for those who may not be familiar with capital approval processes. However, note that <u>the best resources for justifying projects should come from within the organization</u>.

Why This Project, and this Solution?

Identify the problem needing action.

- Provide a clear and specific explanation of the problem, whether a function of regulations, incidents, economics, etc. Include any deadlines.
- Include any hard data on WPV incident frequency, costs, legal costs, etc.

Identify the consequences, risks, and costs of not acting? These might include:

- Economic costs of medical care, paid time off for injuries, etc.
- Costs for hospital-paid recovery time.
- Overtime or incremental costs to hire outside replacement staff.
- Regulatory or licensing.
- Fines or Penalties.
- Legal / liability costs.
- Facility or equipment damage from violence.
- Higher operating costs.
- Lost customers.
- Intangible reputational or morale costs.

How Will the Project Benefit the Institution?

Describe the proposed solution(s) and its benefits.

- Identify all needs the solution will address, and how. These may be safety, economic, regulatory, reputational, etc.
- Monetize any benefits possible, including any savings from improved reputation, employee morale, being a “first mover,” etc.
- Raise awareness that good safety and security directly correlate to recruiting qualified personnel.

Include how proposed solutions will enable regulatory compliance. For example, complying with The Joint Commission Standards EC.02.01.01, EC.04.01.01, EP1 and EP6 may help justify more sophisticated data collection and analysis tools which (1) comply with reporting requirements while (2) allowing users to analyze data to better identify WPV threats for targeting.

If it is not possible to quantify a benefit with certainty, specify how the benefit was estimated. However, specifically identifying what is behind the estimate (historical data or qualitative benefits) may allow management to put their own quantitative value to it.

Qualitative measures might include good PR, enhanced reputation, revenues gained or lost from security incidents or WPV prevention, regulatory compliance, and others. Any benefit to the facility should be itemized if possible.

Why is it Better Than Other Options?

Identify criteria used to evaluate solutions, alternatives considered and why the one selected is best. Since some in management or among those interviewed may an alternative solution, be ready to clearly identify explain clearly why one solution met identified needs another did not.

- Objective decision criteria and how each option met or did not meet it.

- Also, objectively identify any issues or vulnerabilities the proposed solution does not address and how those might be dealt with.

Identify Implementation Costs

Any WPV measure (even simple "no violence" signs in the ER) will have a cost. The team should understand any benefit / cost, ROI, or other investment criteria required for their facility. The team should be prepared to itemize how the system will be paid for, including:

- Installation costs (hardware, software, training, facility modifications, lost bed revenue, etc.)
- Operation & Maintenance (O&M) costs, including software licensing, ongoing training, maintenance contracts, etc.
- Whether the system will be purchased, leased, rented, etc.

Will it Create a Payback or Operating Savings?

WPV Prevention measures may not pay for themselves in the near term based on savings alone.

However, it will usually be helpful to prepare a benefit cost analysis to help leadership:

- Clearly identify project costs and benefits.
- Justify expenditures in tight fiscal environments.
- Compare and rank alternatives.

For facilities with limited capital, WPV Prevention investments may be made more palatable by:

- Using phased, scalable approaches. Leverage already-installed security technologies if possible.
- Use multi-year plans to provide predictable investment requests each year.
- Consider equipment leases instead of purchases.
- Reducing training costs (as one group described it) by: 83
    - Use open-source material developed for healthcare, adopting what other hospitals have used.
    - Instead of hiring outside training organizations, bringing together nurse educators, security professionals, doctors, and law enforcement officers to develop their own scenario-based training, using de-escalation techniques and principles from law enforcement.
- Including all quantifiable benefits in a proposal. For example, if de-escalation training reduces WPV incidents, staff turnover, and quantifiable reputation improvements, the economic benefits of all three should be included in the analysis.

WPV prevention teams who can provide clear and complete information addressing executive-level decision criteria move from being perceived as a cost burden to a valued partner to the executive team.

Note that specific SHSU resources for addressing executive leadership are found in:

- The Rise of Workplace Violence: Addressing Healthcare's Greatest Threat, Eric Clay.
- Countering Workplace Violence in Healthcare: Voices from the Field, Denham & Denham.

CONCLUSION

There is no question that healthcare workplace violence is increasing. Fortunately, both preventative and reactive solutions are growing as well, and the best are frequently not the most expensive. The medical community does not have to be behind the curve.

Implementing the most effective, and the most cost-solutions will require:

a. Threat and risk analysis.
b. Good data analysis to justify expenditures.
c. Prioritization of WPV Prevention measure implementation.
d. Secure data communication to maximize the effectiveness of mitigation strategies.
e. Leadership buy-in, throughout the process.

While this document provides a broad-based overview of SHSU research into workplace violence and mitigation strategies, it is not comprehensive. We encourage readers to identify their own needs and act on them to optimize their own security.

Acting will not only help healthcare facilities comply with TJC requirements, but (most importantly) help protect their staff, patients, and visitors from Workplace Violence.

APPENDIX 1 - PRIMARY CONTRIBUTOR BIOGRAPHIES

This paper is a combination of six research papers focused on workplace violence. Following are biographies of the authors, along with summaries of the papers they wrote:

Eric S. Clay is a Healthcare Security Executive and President-Elect of the International Association for Healthcare Security and Safety. He holds a BA in Criminal Justice, a MS in Criminology, a MBA, and a graduate certificate in Police Leadership. With over 30 years of law enforcement and security experience, he is a subject-matter expert in security and frequently delivers presentations at conferences, writes security articles, and is interviewed by security industry trade publications. Mr. Clay is also VP of Security Services for a major healthcare system, overseeing 450 officers at the system's 17 hospitals and 250 care sites. His other qualifications include being a Certified Healthcare Protection Administrator from the International Association of Healthcare Services & Security (IAHSS) and American Society for Industrial Security (ASIS) status as a Certified Protection Professional, Physical Security Professional, and Professional Certified Investigator.

Dr. Magdalena Denham is a Professor of Practice in the College of Criminal Justice, Sam Houston State University, previously having served as an Assistant Professor in the same college. Prior to this she served as a program coordinator, then program manager with SHSU's Law Enforcement Management Institute of Texas (LEMIT), and a Special Agent with the Federal Bureau of Investigations (FBI), Foreign Counterintelligence Squad. She holds a BA from the University of San Diego, an MA in Applied Linguistics from San Diego State University, a Doctorate in Educational Leadership from Sam Houston State University, and multiple related certifications and awards. She has authored and co-authored many peer-reviewed publications, made conference presentations both domestically and internationally, and recently became a co-recipient of a multi-million-dollar grant from Texas Department of State Health Services to study COVID 19 emergency response and produce regional and central After-Action Reports for waves 1 and 2 of the pandemic.

Mark Denham has a BS in Criminal Justice from the University of Southern Mississippi and a MS in Criminal Justice Leadership and Management from Sam Houston State University. He is a graduate from the Law Enforcement Management Institute of Texas Leadership Command College. Mr. Denham has enjoyed a passionate involvement with international police service training. He has received awards from local, state, and national agencies, holds multiple related certifications, and has made law-enforcement-related presentations domestically and internationally. He is an Adjunct Faculty for Sam Houston State University, College of Criminal Justice and College of Security Studies, as well as held teaching appointments with the nationally renowned Law Enforcement Management Institute of Texas (LEMIT). His public service career spans over four decades in local, state, and federal law enforcement, serving most of his career as an FBI Special Agent. He is currently Regional Director of Security for a major healthcare system in Houston, Texas.

Kelly Fitzgerald is a dedicated public servant with over 10+ years of professional experience in homeland security, emergency management, education, and training. She is passionate about creating knowledge-sharing ecosystems that strengthen community resilience. Formerly the Higher Education Program Manager for FEMA, she is currently a Training Specialist for U.S. Citizenship and Immigration Services. She holds a BA from the University of Maryland and an MA in Homeland Security Studies from the Naval Postgraduate School.

Alexander Kinney is an Assistant Professor in the Department of Criminal Justice and Criminology at Sam Houston State University. His research unpacks the dynamics of social control in gray markets, uses automated text modeling algorithms to study the logics of deviant behavior, and theorizes punishment in a cross-historical context. Recently, his work has been published in Social Problems, Law & Policy, and Sociological Inquiry.

Peter Lehmann is an Assistant Professor in the Department of Criminal Justice and Criminology at Sam Houston State University. His research interests include juvenile justice and delinquency, criminal sentencing, racial and ethnic disparities in punishment, school discipline and safety, and public opinion on crime and criminal justice policy. He has published in Justice Quarterly, Journal of Research in Crime and Delinquency, Crime & Delinquency, Punishment & Society, and other journals.

Griselda Y. Munoz is a Strategic Operations and HR Leader with over twenty years of experience in operational excellence, talent development, and strategic planning. She holds a Bachelor of Business Administration in Management and an MBA from the University of Texas. She has a robust HR and operations management background, of enhancing employee retention, developing multi-site HR strategies, and fostering skill development through partnerships with educational institutions. Munoz is passionate about creating positive, productive work environments. Her significant contributions to workplace safety and efficiency, including her work on "Safe & Secure - Addressing Workplace Violence," highlight her commitment to operational and employee well-being in healthcare and other sectors.

Dr. Cihan Varol is a Professor in the Department of Computer Science at Sam Houston State University. His research interests are in the general area of information (data) quality and its applications in Digital Forensics and Information Security areas, with specific emphasis on personal identity recognition, record linkage, entity resolution, pattern matching techniques, natural language processing, and web storage data. These studies have led to more than 110 peer-reviewed journal and conference publications and three book chapters. He has been an external reviewer for numerous prestigious journals, including IEEE Transactions on Automation Science and Engineering (IEEE TASE), ACM Journal of Data and Information Quality (ACM JDIQ), and Elsevier Expert Systems with Applications. He also co-chairs the International Symposium on Digital Forensics and Security (ISDFS) events.

Dr. Narasimha Shashidhar received his Bachelor of Engineering in Electronics and Communication Engineering from The University of Madras in 2001, and the M.S. and Ph.D. degrees in Computer Science and Engineering from The University of Connecticut in 2004 and 2010, respectively. He is currently a Professor in the Department of Computer Science at Sam Houston State University, Huntsville, TX. His research interests include Cryptography, Information Hiding, Steganography, Electronic Voting and Security, Peer-to-Peer/Sensor Networks and Context-aware pervasive communication. He has over 85 conference/journal publications, and also serves on the editorial advisory/review board and the Technical Program Committee (TPC) of a number of books, journals, and conferences.

Scott Lynn is a Project Manager for the Institute of Homeland Security. He holds a BA (double major) in Environmental Studies and Environmental Studies from UC Santa Barbara and a Master of Environmental Planning (Solar Energy) from Arizona State University. His career has focused on engineering and technical sales in manufacturing automation, process efficiency, energy savings, and logistics. Mr. Lynn has been a member of the American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE), a senior member of the Association of Energy Engineers. His primary focus at the Institute for Homeland Security is “translating” university-sponsored research papers from academic to information actionable by those protecting Critical Infrastructure.

APPENDIX 2 – GETTING WPV PREVENTION INFORMATION

This section is intended to help WPV Prevention teams gather information about the needs of different people and departments. It is supplied as a tool for use by those seeking to understand and evaluate possible WPV threats.

Getting and Understanding Information

Part of preparing a Workplace Violence Prevention Plan involves quantifying threats and analyzing the risk they present. WPV incidents can have multiple consequences, each cascading into other areas. Identifying and quantifying them is the task of those creating the Plan. This section is intended to offer information-gathering tools to those involved in the process.

"Types" of Questions to Ask

The following types of questions are intended to assist in understanding Threats and their associated Risks. Ideally, one wants to learn:

What — "What" describes the possible WPV issue. It describes the threat, whether physical protection or poor recordkeeping. For example: *"Do we have access control on all our outside doors?" or "Do we accurately track all verbal abuse events?"*

Why — The next questions ask why that issue is important: *"Why do we care if a outsider enters an uncontrolled door?" "What is the likelihood of it happening?"* "Why don't *we track verbal abuse?" "How many verbal abuse incidents do you think are we not tracking?"* These seek to understand why threats are important and their potential to occur.

Implications — This question seeks to identify the consequences of the threat occurring. Identifying them gives the team information they can use to understand both the human and financial effects of events.

Answers to each of the above questions can feed into the equation: "Risk = Likelihood x Consequences." The first question identifies the threat. The second identifies the likelihood of that threat occurring. The third helps identify possible consequences.

Note that one WPV threat may have multiple possible consequences. It pays to dig each of them out. Mitigating them could still feed into a benefit/cost analysis. For example, the threat associated with "uncontrolled access" might result in several quantifiable risks (WPV-related or not):

Threat Implication 1: Type 4 violence threats to staff:
Risk: Injury treatment costs, overtime costs to cover shifts for injured workers, legal exposure, employee turnover.

Threat Implication 2 Type 2 threats to patients.
Risk: Treatment costs for injuries, legal exposure, reputational costs.

Threat Implication 3 Kidnappings from obstetrics.
Risk: Legal costs, reputational costs.

Threat Implication 4 Outsider pharmaceutical theft (non-WPV)
Risk: Replacement costs, time spent updating inventories, making police and regulatory reports, other legal consequences.

The uncovering of consequences involved in this process may also help identify emotional "pain points" associated with WPV issues. These can also be helpful in in motivating people to address possible threats.

The most informed solutions will typically come from understanding potential problems and their consequences – whether to those affected or those responsible when incidents happen.

The "How" of Asking Questions

Asking questions properly is a crucial discipline when gathering information. Following are general ideas for doing so.

- Professional salespeople often use an "80/20 rule" in information gathering meetings: "Spend 80 percent of your time listening, and the other 20% talking. When you are talking, ask questions.
- Ask open-ended (not "yes/no") questions to understand situations, goals and needs. Ask clarifying questions as necessary and follow-up questions to ensure you understand what they said or the implications of their questions.
- When someone provides information, be sure you understand it. It may be appropriate to repeat it back to them in your own words, then ask if what you said is correct. If not, you can ask them to explain further.
- If someone has a suggestion you know won't work, be prepared to explain why to them. This lets them know you listened and heard them and may, in turn, build social capital when it is time to present or implement solutions.
- Note that working with multiple teams often leads to multiple and competing ideas. Rather than trying to answer all questions or solve all conflicts during a single meeting, it may sometimes be helpful to consider them afterwards. This gives you (and your team) the chance to decide what fits best into overall project goals while not under the pressure of a meeting.

APPENDIX 3 – TEXAS SB-240

S.B. No. 240

AN ACT relating to workplace violence prevention in certain health facilities.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Title 4, Health and Safety Code, is amended by adding Subtitle H to read as follows:

SUBTITLE H. HEALTH FACILITY EMPLOYEES

CHAPTER 331. WORKPLACE VIOLENCE PREVENTION

Sec. 331.001. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission.
(2) "Committee" means the workplace violence prevention committee or other committee responsible for developing a facility's workplace violence prevention plan under Section 331.002.
(3) "Facility" means:
    (A) a home and community support services agency licensed or licensed and certified under Chapter 142 to provide home health services as defined by Section 142.001 that employs at least two registered nurses;
    (B) a hospital licensed under Chapter 241 and a hospital maintained or operated by an agency of this state that is exempt from licensing under that chapter;
    (C) a nursing facility licensed under Chapter 242 that employs at least two registered nurses;
    (D) an ambulatory surgical center licensed under Chapter 243;
    (E) a freestanding emergency medical care facility as defined by Section 254.001; and
    (F) a mental hospital licensed under Chapter 577.

Sec. 331.002. WORKPLACE VIOLENCE PREVENTION COMMITTEE.

(a) Each facility shall establish a workplace violence prevention committee or authorize an existing facility committee to develop the workplace violence prevention plan required under Section 331.004.
    (b) A committee must include at least:
        (1) one registered nurse who provides direct care to patients of the facility;
        (2) except as provided by Subsection (c), one physician licensed to practice medicine in this state who provides direct care to patients of the facility; and
        (3) one facility employee who provides security services for the facility if any and if practicable.
    (c) If a facility described by Section 331.001(3)(A) does not have on staff at least one physician described by Subsection (b)(2), the facility is not required to include a physician on the committee.
    (d) A health care system that owns or operates more than one facility may establish a single committee for all the system's facilities if:
        (1) the committee develops a violence prevention plan for implementation at each facility in the system; and

(2) data related to violence prevention remains distinctly identifiable for each facility in the system.

Sec. 331.003. WORKPLACE VIOLENCE PREVENTION POLICY. (a) A facility shall adopt, implement, and enforce a written workplace violence prevention policy in accordance with this section to protect health care providers and employees from violent behavior and threats of violent behavior occurring at the facility.

(b) The workplace violence prevention policy must:
- (1) require the facility to:
  - (A) provide significant consideration of the violence prevention plan recommended by the facility's committee; and
  - (B) evaluate any existing facility violence prevention plan;
- (2) encourage health care providers and employees of the facility to provide confidential information on workplace violence to the committee;
- (3) include a process to protect from retaliation facility health care providers or employees who provide information to the committee; and
- (4) comply with commission rules relating to workplace violence.

Sec. 331.004. WORKPLACE VIOLENCE PREVENTION PLAN.

(a) A facility shall adopt, implement, and enforce a written workplace violence prevention plan in accordance with this section to protect health care providers and employees from violent behavior and threats of violent behavior occurring at the facility.

(b) A facility's workplace violence prevention plan must:
- (1) be based on the practice setting;
- (2) adopt a definition of "workplace violence" that includes:
  - (A) an act or threat of physical force against a health care provider or employee that results in, or is likely to result in, physical injury or psychological trauma; and
  - (B) an incident involving the use of a firearm or other dangerous weapon, regardless of whether a health care provider or employee is injured by the weapon;
- (3) require the facility to provide at least annually workplace violence prevention training or education that may be included in other required training or education provided to the facility's health care providers and employees who provide direct patient care;
- (4) prescribe a system for responding to and investigating violent incidents or potentially violent incidents at the facility;
- (5) address physical security and safety;
- (6) require the facility to solicit information from health care providers and employees when developing and implementing a workplace violence prevention plan;
- (7) allow health care providers and employees to report incidents of workplace violence through the facility's existing occurrence reporting systems; and (8) require the facility to adjust patient care assignments, to the extent practicable, to prevent a health care provider or employee of the facility from treating or providing services to a patient who has intentionally physically abused or threatened the provider or employee.

(c) The written workplace violence prevention plan may satisfy the requirements of Subsection (b) by referencing other internal facility policies and documents.

(d) A committee at least annually shall:

  (1) review and evaluate the workplace violence prevention plan; and

  (2) report the results of the evaluation to the governing body of the facility.

(e) Each facility shall make available on request an electronic or printed copy of the facility's workplace violence prevention plan to each health care provider or employee of the facility. If the committee determines the plan contains information that would pose a security threat if made public, the committee may redact that information before providing the plan.

Sec. 331.005. RESPONDING TO INCIDENT OF WORKPLACE VIOLENCE.

(a) Following an incident of workplace violence, a facility shall at a minimum offer immediate post-incident service, including any necessary acute medical treatment for each health care provider or employee of the facility who is directly involved in the incident.

(b) A facility may not discourage a health care provider or employee from exercising the provider's or employee's right to contact or file a report with law enforcement regarding an incident of workplace violence.

(c) A person may not discipline, including by suspension or termination of employment, discriminate against, or retaliate against another person who:

  (1) in good faith reports an incident of workplace violence; or

  (2) advises a health care provider or employee of the provider's or employee's right to report an incident of workplace violence.

Sec. 331.006. ENFORCEMENT. An appropriate licensing agency may take disciplinary action against a person who violates this chapter as if the person violated an applicable licensing law.

SECTION 2. Not later than September 1, 2024, a facility subject to Chapter 331, Health and Safety Code, as added by this Act, shall adopt a workplace violence prevention policy and adopt and implement a workplace violence prevention plan in accordance with Sections 331.003 and 331.004, Health and Safety Code, as added by this Act.

SECTION 3. This Act takes effect September 1, 2023.

APPENDIX 4 – WPV-RELATED JOINT COMMISSION STANDARDS

Following are some of new The Joint Commission standards cited as pertaining to WPV, effective 2022.

1. **Annual review of WPV issues: Standard EC.02.01.01**: The hospital manages safety and security risks, conducts an annual worksite audit, takes actions to mitigate WPV safety and security risks.
2. **Collect information to monitor injuries: Standard EC.04.01.01, EP1, EP6:** "The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating" injuries to patients or others, occupational staff injuries, incidents of property damage, and safety and security incidents involving patients, staff, or others within its facilities.
3. **Standard HR.01.05.03: Staff participate in ongoing education: EP 29**: The hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners, and "determines what aspects of training are appropriate for individuals based on their roles and responsibilities." Training is to include prevention, recognition, response, and WPV reporting, and includes training in de-escalation, verbal intervention skills, physical intervention techniques, and responding to emergency incidents.
4. **Leadership: Standard LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the hospital: EP 9**: The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes create policies and procedures to prevent and respond to workplace violence, report incidents, analyze incidents and trends, provide follow up and support to victims and witnesses affected by workplace violence, and report workplace violence incidents to the governing body

END NOTES

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