INSTITUTE FOR HOMELAND SECURITY

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THE RISE OF WORKPLACE VIOLENCE:

ADDRESSING HEALTHCARE'S GREATEST THREAT

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Driving Transformational Change in Healthcare Security

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Abstract

Workplace violence (WPV), specifically Patient-Generated Violence (PGV) committed in healthcare facilities represents a significant threat to not only caregivers, but to access to quality healthcare and patient outcomes. PGV is the most common form of violence in the healthcare setting, occurring in emergency departments, inpatient units, behavioral health units, and home health settings. Current research has identified staff, environmental, and patient risk factors as the major precursors of WPV committed by patients. Healthcare workers experience significant physical and psychological consequences as a result of PGV. A review of the evidence, alongside interviews with industry thought leaders, was conducted to identify current evidence-based interventions that can help healthcare organizations eliminate or reduce incidents of PGV.

Keywords

Workplace violence; patient-generated violence; healthcare settings; healthcare security

About the author

Eric Sean Clay is a transformational security executive with more than three decades of law enforcement and security experience. As a subject-matter expert in security issues, he frequently delivers

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Mr. Clay also serves as the Vice President of Security Services for a major healthcare system, providing security leadership for 450 security and law enforcement officers at the system's 17 hospitals and 250 care sites. He previously held the post of Homeland Security Advisor to Missouri's governor. He has also worked as a security consultant overseas, traveling to over 35 countries and providing services to diverse clients.

Mr. Clay has a bachelor's degree in Criminal Justice, a master's degree in Criminology, an MBA, and a graduate certificate in Police Leadership. His other qualifications include that of Certified Healthcare Protection Administrator from the International Association of Healthcare Services & Security (IAHSS) and the American Society for Industrial Security's (ASIS) "triple crown", through the attainment of the Certified Protection Professional, Physical Security Professional, and Professional Certified Investigator certifications.

Foreword

Workplace Violence (WPV) is one of the greatest threats to US healthcare today. Throughout my career, I have witnessed the changing landscape of workplace violence, its escalating nature, and its harmful impact on the provision of services, the associated costs, and individuals affected.

We face the harsh reality that WPV is a complex and growing problem. US healthcare systems face enormous pressure from rising patient demand and the difficulty in recruiting and retaining staff, which is caused, in part, by workplace violence. It is widely acknowledged that incidents are grossly under-reported. Thus, the accurate scale of the problem is not fully understood. Far more must be done to understand WPV, its impact, and how to address it to keep healthcare workers safe.

Industry collaboration is the key to innovation and transformational change – with cooperation occurring across healthcare systems, industry associations, institutions, and representative bodies, alongside suppliers and technology companies. There is enormous value in mutual support and information exchange.

Although this paper focuses on security and safety issues across the US healthcare system, the discussion will provide insight, new perspectives, and inspiration for national and international audiences. It supports the mission of the IAHSS to collaborate across the international healthcare security community, including the National Association for Healthcare Security (NAHS) in the UK.

Lastly, this paper will interest a multi-disciplinary audience in healthcare—including healthcare executives, police leaders, and security practitioners, as well as clinical and non-clinical staff involved in workplace violence prevention and mitigation programs. It contributes to existing literature, highlighting interventions and strategies that have yet to be fully explored.

I am deeply indebted to the healthcare and security professionals that have contributed to this paper. Thank you for sharing your personal experiences and insights, and for your passionate belief that we all need to come together and act to address healthcare's greatest threat. I would also like to thank the membership of the International Association for Healthcare Security and Safety for being such an important voice on the issue, my research partner Sally Donohoe for all of her efforts, and Sam Houston State University for publishing this paper.

Executive summary

This paper discusses the scale and impact of workplace violence in US healthcare and explores current best practices and innovations in preventing and mitigating violence.

Section 1 sets the scene by explaining workplace violence's scale, nature, and impact in the sector. According to the US Bureau Of Labor Statistics (USBLS), 73 percent of nonfatal workplace injuries and illnesses with days away from work due to violence in the US occur in a healthcare setting (USBLS, 2018). Despite a widespread issue with the under-reporting of violence, incident rates are also on the rise.

One of the barriers to tackling workplace violence is a misunderstanding of its nature. Sensationalist media stories about external perpetrators, such as active shootings and terrorist attacks,

frame the public perception. However, the vast majority of violence is actually generated by patients – a fact not always understood by hospital leadership. Focusing on patient-generated violence through a clinically led approach is critical to achieving meaningful change.

The impact of workplace violence cannot be overstated in building the business case for investment in prevention programs. Workplace violence does not just impact the affected staff members – it disrupts caregiving and treatment; it harms patient care and damages a hospital's or healthcare system's reputation.

Workplace violence also has a financial impact, particularly in the area of nurse attrition, recruitment, and training. According to the American Hospital Association (AHA), proactive and reactive violence response activities cost US hospitals and health systems $2.7 billion in 2016. This includes $280 million for violence preparedness and prevention, $852 million for victims' unreimbursed medical care, $1.1 billion for security and training costs, and an additional $429 million for medical care, staffing, indemnity, and other costs as a result of violence against hospital employees (Van Den Bos et al., 2017).

According to Strategic Security Management Consulting (SSMC), the cost of hiring and training a new nurse is an estimated $50–90K. Furthermore, the loss of nurses, partly due to workplace violence, costs the sector an estimated $1–1.62 billion annually (SSMC, cited by American Society for Healthcare Risk Management, 2023). Additionally, the fear of violence adds to the harm of actual violence. Anxiety and stress are a major threat to healthcare provision as drivers of reduced performance, higher absenteeism rates, long-term sickness, and resignations.

Section 2 demonstrates why there is cause for optimism in combating workplace violence. The launch of updated standards on workplace violence from The Joint Commission (TJC) in 2022 has defined new requirements for hospitals and healthcare system executives and provides a solid framework for building an effective workplace violence prevention program.

Key TJC themes are leadership accountability and creating multi-disciplinary teams to lead on workplace violence, rather than leaving the responsibility solely to security teams. We also look at

proven best practices recommended by TJC, namely Threat Assessment Teams (TATs) and Behavioral Emergency Response Teams (BERTs).

Then, we examine strategies and interventions that healthcare organizations are deploying successfully to tackle workplace violence. These include better collection and use of data, the delivery of targeted training programs, and adopting a community-based approach to hospital security.

Section 3 shifts the focus to the biggest challenges the healthcare sector faces in tackling violence and suggests solutions where they exist. You will see that a lack of leadership buy-in is a crucial blocker to progress. Security teams need to boost C-suite understanding of key issues while putting forward a solid business case for investment. A further challenge is the failure to adopt a clinically led approach to assessing and managing new patients who may exhibit violent behavior. This section also highlights the problem of underreporting of workplace violence – you cannot truly develop an effective violence mitigation plan if you do not have an accurate picture of its prevalence.

One of the most daunting challenges in security is the protection of staff across the entirety of the hospital setting to ensure safety everywhere, not just in hospital buildings, parking areas, and office buildings, but also in the community where home health is administered. With an estimated 25 percent of healthcare to be delivered in the US home environment by 2025 (McKinsey, 2022), healthcare organizations need to develop solutions for providing situational awareness, maximized deployment of resources, and protection for workers wherever they are.

Finally, we address the tendency for knee-jerk reactions and quick fixes in response to previous violent incidents. Implementing standalone measures has not proven effective when compared to joinedup systems and solutions. The recommendation is to create a long-term plan for phased technology investment, which leverages the existing technologies that hospitals have already installed.

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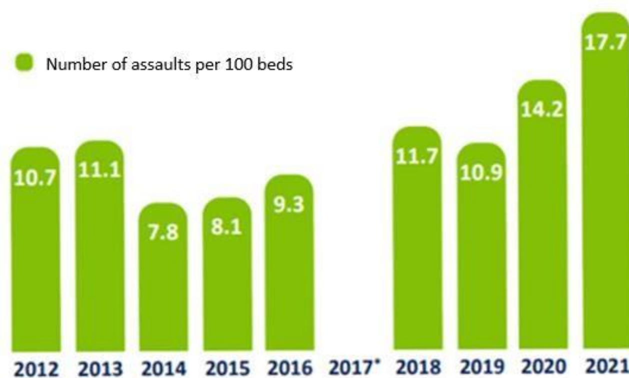
SECTION 1: The scale, nature, and impact of workplace violence.

We will start by highlighting the scale of the WPV problem and by identifying the most common types of violent incidents. Then, we will assess the damaging impact of violence on employees, healthcare organizations, and patient care.

1.1 Scale: Workplace violence is endemic in US Healthcare – and getting worse.

The Healthcare Crime Survey in 2019 conducted by International Association for Healthcare Security and Safety Foundation (IAHSSF) reported that the assault rates against healthcare workers increased from 9.3 incidents in 2016 to 11.7 per 100 beds in 2018. In its 2021 report, assaults against healthcare workers post-pandemic reached an all-time high in 2021 at 17.7 per 100 beds (IAHSSF, 2021) (*Figure 1*).

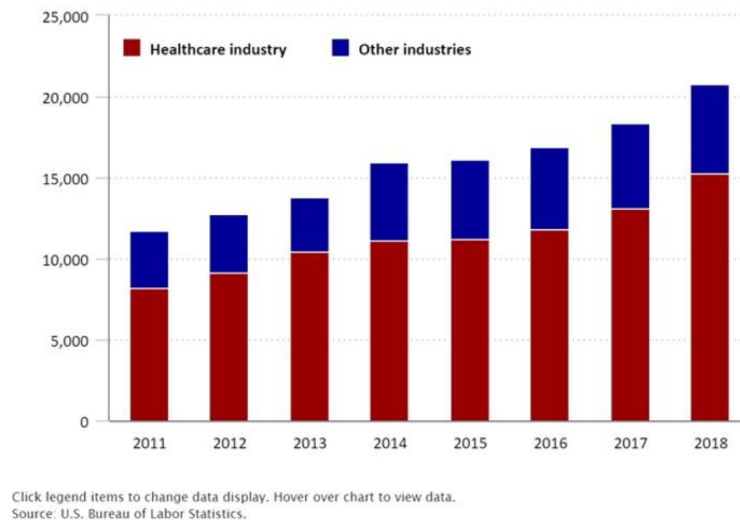
Figure 1: Rates of assaults in hospitals 2012–21 (IAHSSF Annual Crime Survey)



As the statistics above illustrate, the US healthcare sector faces a serious and growing issue with violence towards its employees. Although workplace violence occurs in every industry, the problem is especially profound in healthcare. According to the US Bureau Of Labor Statistics (USBLS), 73 percent of nonfatal workplace injuries and illnesses with days away from work due to violence in the US occur in a healthcare setting (USBLS, 2018).

Figure 2 shows that 15,000 nonfatal workplace violence injuries and illnesses reported in the healthcare sector in 2018 resulted in days away from work (USBLS, 2018).

Figure 2: Number of nonfatal workplace violence injuries with days away from work, 2011–18



Although this percentage is eye-catchingly high, it is widely accepted that violent incidents in our healthcare facilities are under-reported and under-recorded (see Section 3.3). The true scale of the problem is even greater than the statistics suggest.

Why is WPV on the increase in the healthcare industry? Two decades ago, it was blamed on the combined effects of rising workloads, work pressures, excessive work stress, deteriorating interpersonal relationships, social uncertainty, and economic restraints (Lim et. al., 2022). All of these factors are still valid today, with the added issues of staff shortages, bed shortages, and a rise in behavioral health challenges among patients.

1.2 Nature: Most violence in healthcare is patient-generated.

To address the issue of WPV in healthcare, it is imperative to target the most common types of incidents. A key factor holding back successful action is a widespread misunderstanding of the nature of threats to employees in healthcare facilities.

The public perception of WPV in healthcare is shaped by sensational stories amplified by traditional and social media. On the news, you will hear about incidents such as shootings or protests and bomb threats. The media, however, sensationalizes incidents caused by 'strangers' or external threats, such as active shootings and bomb threats. In reality, these remain rare.

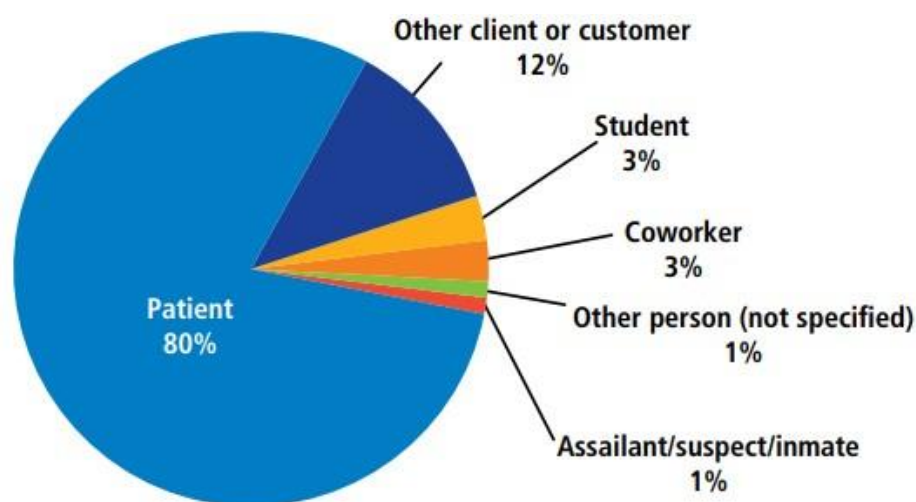
Brian Uridge, Senior Director Department of Public Safety and Security at the University of

Michigan, explains, "*One of the things you hear about all the time is active shooters. However, no one ever looks at the data to find that mass shooters/active shooters account for less than two-tenths of 1 percent of all homicides in the US. (National Council for Behavioral Health [NCBH], 2020). However, it is the number-one thing people want training on because the media has sensationalized it, and therefore people are worried the most about it.*"

According to the Occupational Safety and Health Administration's (OSHA) report on workplace violence in healthcare in 2015, approximately 80 percent of violence is perpetrated by patients: such incidents are patient-generated violence.

Figure 3 shows patients are statistically the most frequent aggressors in healthcare, followed by other clients or customers (12%), co-workers (3%), and persons with no legitimate relationship to the organization, such as those who are only there to commit violence (2%) (OSHA, 2015).

Figure 3: Healthcare worker injuries resulting in days away from work by source.

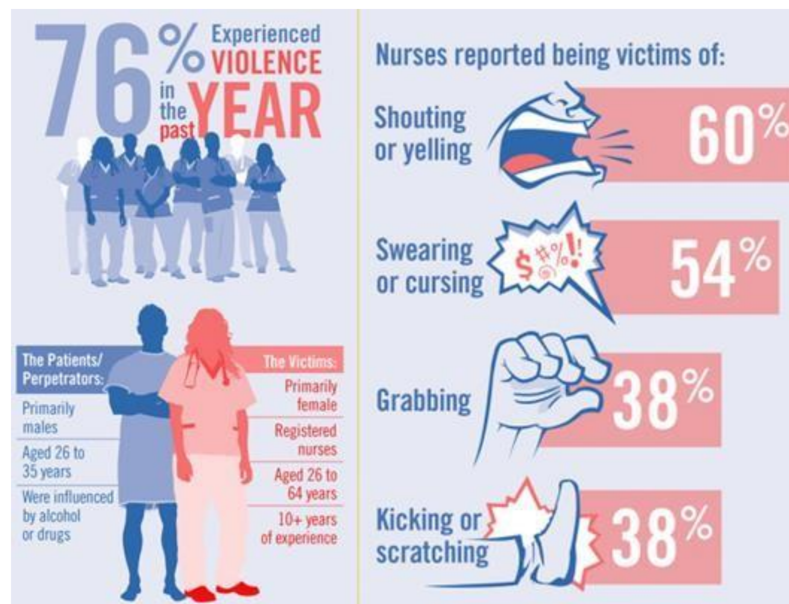


Data source: Bureau of Labor Statistics (BLS), 2013 data. These data cover three broad industry sectors: ambulatory healthcare services, hospitals, and nursing and residential care facilities. Source categories are defined by BLS.

The most vulnerable healthcare workers victimized are staff in emergency departments, especially nurses and physicians, and other staff directly involved with in-patient care (World Health Organization, 2021). A separate study by the Journal of Emergency Nursing in 2014 found that victims of

patientgenerated violence are predominantly female nurses, with 76 percent claiming to have experienced violence at work in the previous year (*Figure 4*).

Figure 4: Characteristics of patient-generated violence inflicted on nurses.



(Source: Journal of Emergency Nursing, 2014)

1.2.1 Behavioral health issues are driving the problem.

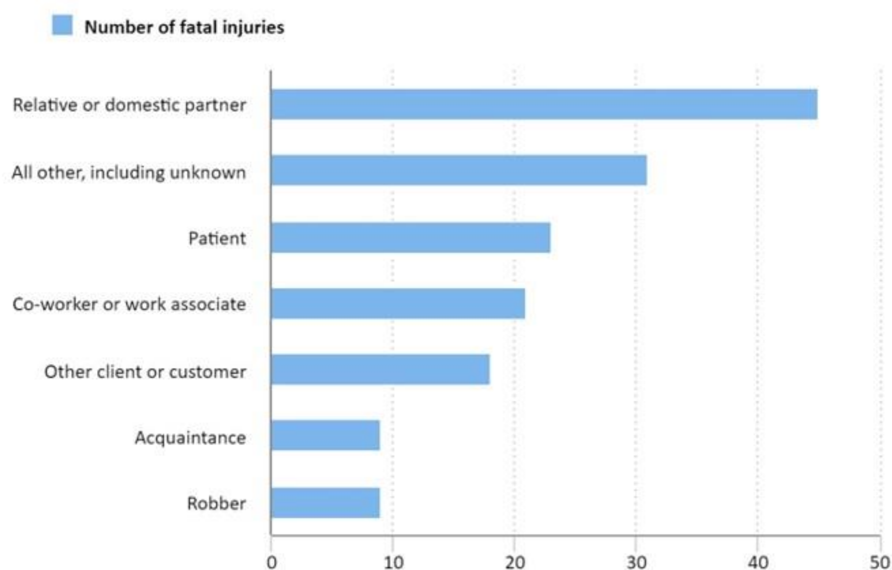
The study by the Journal of Emergency Nursing in 2014 also found that most workplace violence is generated by patients directed at nurses is primarily males, aged 26 to 35 and influenced by alcohol, drugs and mental health issues. The ECRI (Emergency Care Resource Institute) conducts annual research on the top patient safety concerns. For 2020–23, the increase in behavioral health patients was cited as number one, and workplace violence was number two.

Paul Sarnese of Secured and Prepared Consulting, LLC, and former President of the IAHSS, says, "*Our hospitals have seen a significant increase in patients presenting to the Emergency Departments with mental health issues and addiction issues. Many hospitals struggle with appropriately treating and managing these patients due to the lack of behavioral health and addiction services resources. Most US hospitals have very few mental health beds or specific services around mental health. This is exacerbated by low numbers of specialist staff: psychiatrists, psychotherapists, social workers, and pediatricians. Patients with behavioral and addiction issues are being treated on regular floors by nurses and doctors who may not have the proper training to appropriately deal with them.*"

1.2.2 Recognizing the domestic violence risk.

Although this paper has focused on patient-generated violence, it is essential to highlight the risk to employees from domestic violence. The nexus between WPV in the healthcare setting and domestic violence is not given enough attention, even though the largest number of deaths of healthcare workers in hospitals are related to domestic violence, according to the USBLS (USBLS, 2018).

Figure 5: Workplace homicides to healthcare workers, by assailant, 2011–18



(Source: US Bureau of Labor Statistics)

According to a study published in the BMC Women's Health Journal, approximately 45 percent of healthcare workers (the large majority of whom are female) have been victims of domestic violence (Bracken et al., 2010). Even with restraining orders in place, nurses are still targeted by intimate partners at work, with domestic violence-related incidents occurring in the hospital.

Healthcare organizations need to communicate a strong message that they will make extra efforts to protect employees where there is anxiety about domestic violence. It is also important for security teams to build trust and be a regular presence to help reduce anxiety (see Section 2.4).

1.3 Impact: the negative consequences of workplace violence.

It is not overdramatizing the problem to claim that workplace violence threatens the health of patients, healthcare providers, and healthcare workers. This section discusses the key consequences that are affecting US healthcare systems.

1.3.1 Direct impact of incidents.

There is a direct impact on patient care at a micro level whenever a violent incident occurs. When an incident kicks off from a starting point of aggression, a facility's attention focuses on these incidents. WPV is disrupting frontline services and taking care away from other patients, which can have a negative effect on patient outcomes and increase the threat of regulatory action or litigation.

From the employee perspective, violent incidents hurt the morale of the entire workforce, with a potential knock-on effect on employee engagement and performance (see Section 1.3.4).

If victims have to take time off work due to physical injuries or mental ill health, the healthcare provider faces the cost and inconvenience of covering their role. In a worst-case scenario, the employer may face workers' compensation claims or personal injury lawsuits. Just one incident can have significant consequences. The cumulative effect of multiple incidents can significantly damage the healthcare organization.

1.3.2 Reputational damage.

Incidents of workplace violence may draw negative media exposure or attention on social media platforms, creating negative perceptions amongst patients and prospective patients. A significant negative consequence is the impact on the 'employer brand' and future recruitment efforts. Kimberly Urbanek, an expert in workplace violence prevention strategies and Public Safety Manager of Administration and Training at Northshore Edward-Elmhurst Health, says, "*Workplace violence is now a topic often raised by nurses during recruitment. If we look at it 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.*"

1.3.3 Skill shortages.

It is a concern that nurses, doctors, and clinicians are leaving the profession in droves. 'Personal safety risk' is cited as a reason for quitting, along with the perception of poor pay/compensation and working conditions (Advisory Board, 2021).

The shortage of nurses in the US is of particular concern. The American Nursing Foundation reports that one in five new registered nurses (RNs) leave their first job within a year. A separate report by the National Council of State Boards of Nursing (NCSBN) found about 100,000 registered nurses in the US have left the profession since 2020. More than 600,000 intend to leave by 2027 due to stress, burnout and retirement (NCSBN, 2023).

For individual healthcare organizations, the need for nurses puts the future quality of patient care at risk due to under-resourcing and added workloads for the remaining staff.

Looking at the bigger picture, staff shortages threaten to lower the overall standard of healthcare provision in the US. Access to healthcare services may also be reduced in the future, particularly in rural locations and deprived communities. Now is the time to act to prevent dangerous gaps in the US healthcare workforce.

Of course, the impact of employee attrition is also financial. According to Strategic Security Management Consulting (SSMC), the cost of hiring and training a new nurse is an estimated $50–90K. Furthermore, the loss of nurses, partly due to workplace violence, costs the sector an estimated $1–1.62 billion annually (SSMC, cited by ASHRM, 2023). For individual healthcare providers, the cost of nurse attrition can have a major impact on financial performance and stability.

These costs show why there is such a strong business case to invest in workplace violence programs – savings on attrition, recruitment, and absenteeism will outweigh the cost of transformational change.

1.3.4 Anxiety and stress.

The negative effect of workplace violence is not just caused by experiencing an incident. The fear of violence has a significant impact on employees. Mel Cortez has had a career in nursing for over 10 years and is the founder of Cortex Gold, a leading consultant on US healthcare workplace violence programs.

She believes the psychological impact of just the threat of violence on healthcare workers is often underestimated. She says, "*Neurologically speaking, the threat of violence presents the same trauma to an individual as an actual physical assault. The organization's responsible for making people feel safe and keeping them safe to reduce anxiety. They do not have a great security program if they cannot make their nurses and caregivers feel safe*."

Anxiety and poor mental well-being are a further threat to healthcare provision. They are drivers of higher absenteeism, long-term sickness, and resignations, which create higher staffing costs and disrupts service provision. Anxiety and its symptoms can also negatively affect the decision-making and performance of employees – a healthcare setting is where you need employees to be at their best, both physically and mentally.

SECTION 2: Positive momentum for countering workplace violence.

In this section, we will look at a number of strategies and interventions that are proving successful in preventing and mitigating workplace violence, drawing on real-life examples provided by the specialist contributors to this paper. Crucially, there is now academic research to show the efficacy of these best practices. It is recommended that any healthcare organization looking to tackle workplace violence should investigate these solutions in more detail.

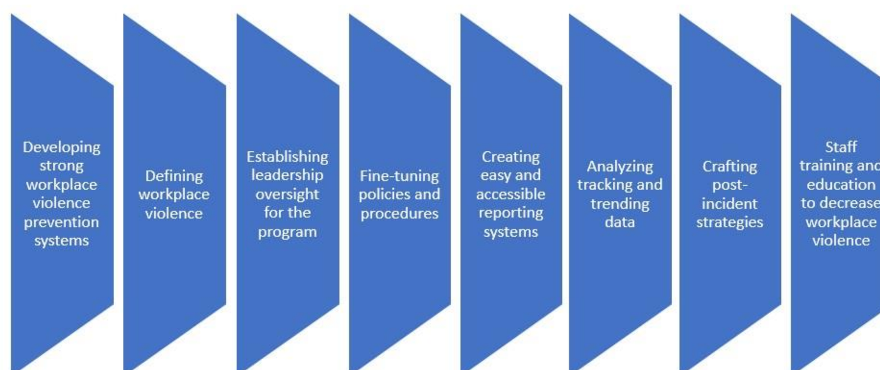
We will begin with the impact of a recent legislative change, providing a welcome spur for evidence-based change and improvement.

2.1 Joint Commission Standards launched in 2022.

The Joint Commission (TJC) is the independent, not-for-profit organization responsible for providing healthcare accreditation in the US. To gain accreditation, hospitals must meet specific Standards based on Elements of Performance (EPs) that hospitals must demonstrate.

On January 1, 2022, TJC added new Workplace Violence Requirements to its existing standards (*Figure 5*). According to Bill Marcisz, a nationally recognized healthcare security and workplace violence consultant, "*TJC has taken an important step forward to standardize certain requirements hospitals and healthcare systems must implement to prevent, mitigate, and respond to workplace violence.*"

Figure 5: TJC requirements for addressing WPV in the healthcare setting



(Source: The Joint Commission)

These new standards aim to compel hospitals to provide a safer care environment. The key point to stress is that healthcare organizations should view TJC standards as something other than an additional burden in maintaining accreditation and avoiding fines. Instead, the standards should be seen as providing a robust framework for a WPV program that will reduce WPV as a whole and patientgenerated violence in particular.

Additionally, the updated TJC performance requirements codify several existing healthcare industry best practices and also add accountability standards. As Marcisz (2021) explains, "*The new requirements clarify the roles of hospital staff and leaders who are responsible for administering their organization's workplace violence prevention and response.*"

It is valuable for organizations to look closely at the requirements when considering how to build a successful WPV program. For more information, visit:
https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/

2.1.1 Workplace Violence Leadership Standard.

Accountability at the highest level is crucial in driving change in workplace violence. A notable TJC standard is LD.03.01.01: the Workplace Violence Leadership Standard.

- Standard LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the hospital.
- EP9: The hospital has a workplace violence prevention program led by a designated individual and developed by a multi-disciplinary team.

It is important to note that the designated leader will be the executive owner of the WPV prevention program. They should be a senior manager with a 'C' in their job title – ideally, the Chief Medical Officer. The Maine Medical Center operates one example of a successful WPV prevention program in the US. A key factor in Maine's performance is that its designated leader is the president of the whole healthcare system. This individual chairs its WPV prevention committee meetings and is a high-profile champion of anti-WPV activities and collaboration.

2.1.2 Workplace violence prevention committees.

David Corbin is a consultant at Dynamic Security Strategies and the author of the Patient Violence

Prevention and Mitigation Field Manual. He advises that, "*Patient violence and other types of violence within a healthcare organization are not issues that can be solved by one person or even one department. It takes an entire organization's strength, support, engagement, and coordination, starting from the top, to build and sustain an impactful program and culture."*

In line with this guidance, TJC stresses the importance of multi-disciplinary collaboration; safety should not just be the sole responsibility of security. TJC recommends the creation of a committee of at most 12 members to oversee and inform the prevention program. It is advised that the following stakeholders should be represented on the committee:

○ Designated Leader/Executive Owner

○ ER, Clinical & Clinical Education ○

WPV/PGV Subject Matter Experts ○

Security ○ Risk Management ○ Legal ○

Human Resources

Bringing so many different voices to the WPV conversation allows for creating a rounded and truly joined-up prevention program.

2.1.2.1 State associations for WPV prevention committees

One interesting development is that WPV prevention committees are starting to emerge for state hospital associations. These associations create policies, influence legislative change, and offer educational support for all its member hospitals and across all disciplines.

Bonnie Michelman is the Executive Director of police, security, and outside services at Massachusetts General Hospital, and she chairs one such state association for 120 participating hospitals in Massachusetts. Bonnie explains, *"We gather survey data annually to see the WPV trends throughout the state. What is going up, what is going down, what is helping, what is not. It has allowed us to see what training and programs hospitals are doing and what these programs and the frequency and methodology of training has had an impact in reducing violence*."

2.1.3 Threat Assessment Teams (TATs).

It is obviously preferable to prevent violent incidents rather than respond to them. TJC advises creating a Threat Assessment Team (TAT) with a core membership of security, risk management, human resources, administration and legal, plus the flexibility to add clinical staff and subject-matter experts as the situation requires.

The TAT aims to prevent violent incidents through a behavioral-based, deductive process comprised of four components:

○ learning of a person who may pose a threat ○ investigating that person

○ evaluating whether the person poses a threat to others ○ developing

and implementing a plan to eliminate or reduce the threat

Of course, TATs cannot prevent the unintended or reactive violence often seen in the Emergency Department, which requires multi-disciplinary assessment procedures (see Section 3.2). However, TATs effectively counter other situations, such as stated or implied threats from patients or families, patients who have been violent during a previous visit or admission, intimate partner situations (domestic violence), and terminated/disgruntled employees.

2.1.4 Behavioral Emergency Response Teams (BERT).

A further recommendation from TJC is the creation of an Emergency Response Team, commonly referred to as a Behavioral Emergency Response Team (BERT). This is a multi-disciplinary group of designated staff who will respond to an ongoing threat or act of aggressive behavior.

As noted in Section 1.2.1, a lack of behavioral management resources is a key challenge for hospitals, so it is valuable to have a specialist team that is trained and ready to respond to difficult patients. Typically, the BERT will contain an administrative supervisor, security staff, and other designated employees who are formally trained and certified in de-escalating aggressive behavior and physical restraints.

The BERT should have a defined 'clinical chain of command' beginning with the administrative supervisor. This person should have the decision-making authority to address the clinical aspects of the

incident – deploying a clearly defined leader hastens decision-making and eliminates confusion. The aim is for clinicians in this scenario to lead the intervention and the de-escalation process, with security only jumping in if things get out of hand.

Several research studies have found that this clinically led de-escalation approach significantly decreases violence. In one study, a BERT team was launched for a three-month pilot on a medicalsurgical unit where the team responded to 17 behavioral emergencies. The positive impacts of the team were evident in the results: "The number of assaults decreased from 10 (pre) to 1 (post); security intervention decreased from 14 to 1; and restraint use decreased from 8 to 1." (Zicko et al., 2017, cited in Corbin, 2022).

2.2 Better collection and use of data.

Data is vital to understanding and countering workplace violence, particularly patient-generated violence. Historically, security departments have struggled to measure the right things, then analyze that data to translate into interventions and staff training.

Paul Sarnese says, *"Where the data side of things falls short is when the organization only looks at the frequency of incidents, whether going up or down. However, you need to look at the details and the variables. For example, organizations can analyze the number of assaults per patient day, the number of incidents per 100 beds, and incidents per Emergency Department visits. Also, knowing the type of incident – the occupation of the injured, the cause of injury, the type of injury, etc. is incredibly helpful in identifying gaps in training and education. Looking only at the frequency may not really provide actionable data."*

However, progressive healthcare organizations are now successfully using data analysis to identify patterns and trends and highlight where individual interventions are needed. For example, you may find that 80 percent of the issues arise from the same patients or the same staff. Certain team members may require extra training because they are unintentionally escalating situations. More complete data empowers you to deliver tailored interventions.

2.3 Cost-effective training programs.

Nurses and many other healthcare professionals rarely have sufficient training to deal with patients with behavioral issues and other conditions, such as dementia or severe autistic spectrum disorders. There can be problems with contract or agency staff who may have never worked on a particular ward. How do you equip that person with the knowledge to stay safe on their shift? In addition, nurses in community settings often lack the additional knowledge needed to protect themselves in patients' homes, such as situational awareness and environmental assessment basics.

It is no surprise, therefore, that training is one of the major themes in TJC's best practice on workplace violence. The advice is to match specific training interventions to certain roles and responsibilities. Unfortunately, the perceived cost of such widespread training has prevented training interventions in many healthcare organizations.

However, as the University of Michigan has proved, cost does not have to be a barrier. Brian Uridge is the organization's Senior Deputy Director for the Department of Public Safety. He explains, "*Everything that we are doing is open source. Everything is published. When we deliver presentations on workplace violence prevention, we give the content away for free. Other hospitals have adopted our approaches for their own needs. We are happy to share our practices if it helps keep one more nurse safe.*"

Uridge also outlines how the training style has made an impact. "*We have brought together nurse educators, security professionals, doctors, and law enforcement officers to meet in a multidisciplinary setting. Together, they develop and deliver scenario-based training using principles from law enforcement and a softer approach to de-escalation techniques. The results have been nothing short of amazing in terms of people feeling validated, supported and empowered*."

Updating the recruitment and training of security staff is also a significant benefit, according to Mel Cortez. *"The issue is that most security teams have been traditionally trained to meet force with force because many come from a police or military background. They have not had specific training in dealing with healthcare patients and clients. Instead, security should be using empathy and open body language. Through the inception of concepts like tactical empathy, they can better understand what is perpetrating the violence and try to predict what may happen. When trained properly, they can work*

alongside the clinical staff, using empathy to help navigate or negotiate with the person that may perpetrate violence."

2.4 Hospital communities built on trust.

One of the most effective ways to counter WPV is to build community and trust across the healthcare setting. The University of Michigan has 40,000 employees, 51,000 students, and four million patients through its doors each year. Brain Uridge describes his organization's approach to 'community-based security', which focuses on reducing risk and anxiety through building trust, scenario-based training, and technology.

Uridge believes this approach is critical for transformational change and states, "*It all starts with building trust. The premise is that we need to make sure that people are safe. Moreover, just as importantly, we need to ensure people feel safe. We have adopted a community policing-based philosophy – and applying it in healthcare has been very effective. One key aspect is that 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. Furthermore, they meet a staff member they have never met for a two-minute conversation. This simple exercise is brilliant for reducing staff and patient anxiety.*"

Indeed, we are seeing a shift of traditional security, policing, and enforcement models in healthcare towards a new approach that prioritizes community engagement, safety, well-being, and emergency preparedness. Security officers are now more capable, trained, and equipped than in years past. However, their enforcement roles are softening, focusing more on empathic communication, and fostering meaningful relationships based on trust.

Trust between staff and security 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. It is essential for security to communicate and educate the hospital workforce on what they are doing to keep them safe. Michigan Medicine, for example, sends out a bi-monthly update. Above all, employees want reassurance that the hospital has their back. Kimberly Urbanek says, "*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."

Steve Edwards, ex-CEO of CoxHealth in Missouri (13,000 employees and 86 clinics), points out, "*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.*"

SECTION 3: Continuing challenges – and potential solutions.

In Section 2, we saw that progress is being made in the fight against workplace violence. In this final section, we will consider some of the ongoing challenges that the healthcare sector faces in tackling violence – and we will look at potential solutions that drive transformational change.

3.1 Administrators are still not taking the lead.

To effectively address WPV, the solution must be a programmatic, evidence-based, hospital-wide initiative that is funded, supported, and visibly embraced by the C-suite. It will take the buy-in and involvement of hospital leadership to turn the dial on WPV.

One answer is for security to highlight to leaders that patient-generated violence is the primary driver of healthcare workplace violence, as discussed in Section 1.2. David Corbin claims, "*Concentrating on the issue of patient violence instead of all forms of violence in healthcare brings the strategies and tactics that lead to the greatest reductions in harm to staff into sharp focus.*"

Security must also sell the business case for investing in patient-generated violence mitigation strategies. It is vital to collect and harness the right data to illustrate the scale of the problem and identify the costs of inaction, as described in Section 1.3. When leaders understand the financial and performance implications of workplace violence, they are far more likely to step up to the challenge personally and start taking responsibility.

3.2 Security and safety provision is rarely clinician led.

Safety, security, and workplace violence are not taught in medical school. The mindset has been to compartmentalize WPV into the health and safety or security function. However, mitigating it is integral to the operational running of the healthcare organization. Because the majority of WPV is patientgenerated, it should be treated as a patient-management issue, with a focus on prevention and mitigation rather than responding to issues after they occur.

The prevention of violent incidents should start when a patient presents to the hospital, with a screening evaluation to identify any underlying behavioral health issues. A valuable tool for screening is the Dynamic Appraisal of Situational Aggression (DASA). This is an inpatient aggression risk assessment instrument initially developed for use in mental health facilities. It has been designed to identify the acute risk of patient aggression within 24 hours of the assessment. Its effectiveness has now also been confirmed in other healthcare settings, including the Emergency Department (Connor, et al., 2020).

Clinical strategies and interventions can be implemented if the screening identifies a potential risk of violence. For example, medication management may be required, one-to-one staff monitoring of the patient, or the assignment of a social worker. The goal should be to manage the patient through a plan of care and treatment that will allow a safe discharge.

Ideally, the planning will involve a team of doctors, a psychiatrist, a pharmacist, security, social workers, and clergy. Paul Sarnese advises, "*The organizations doing it well pull the team together at least twice a day if not more, to discuss those patients at risk of violence. Then they come up with a multi-disciplinary plan of care, which is in the clinical record. It is discussed at all the safety huddles and shift changes. Everybody has a voice at the table to develop the plan. Sometimes the plans of care are developed to manage particular patients. Sometimes it is to manage the employees.*"

3.2.1 Care plans that focus on staff behavior.

It is incredibly difficult to manage challenging behavior with some patients, such as people with severe learning disabilities or dementia. You may not be able to change the patient's behavior, but you can influence staff behavior to minimize the chance of incidents occurring. For example, advising staff to always work in pairs with a certain patient.

3.3 Workplace violence is under-reported.

WPV is acknowledged to be significantly under-reported. One key call to action from this paper is for healthcare organizations to understand the scale of the violence problem. If we do not fully understand the problem, how can it be effectively mitigated? How can we make decisions such as where, when, and how many security officers to deploy? Or which specific interventions to use?

Even though some institutions may have formal incident reporting systems, there are still many incidents, especially in the forms of bullying, verbal abuse, and harassment, that go unreported. According to the IAHSSF in its 2018 report, a *"lack of reporting guidelines or policy, lack of trust in the reporting system, and fear of retaliation" are among the many reasons for under-reporting".* Many healthcare employees mistakenly feel that workplace violence is just a part of their jobs and that they were unlucky enough to be in the wrong location at the wrong time. Steve Edwards believes that "*Culture is the most important underlying issue in addressing the workplace violence challenge. The hospital environment must embody a culture of zero tolerance to workplace violence or a categorical unacceptance that workplace violence is an occupational hazard that's part of the job, and employees will be impacted as a consequence.*"

Another cause of under-reporting is that many employees believe no action will be taken against the perpetrators. Or they refuse to endure the stigmatization and the inconvenience of filing reports and following through on legal proceedings. Cultural change must be complemented with the introduction of clear and easy reporting systems, including anonymous reporting.

3.4 It is hard to protect staff across the entire healthcare setting.

Organizations have a duty of care across the healthcare environment. You have the hospital itself, then the wider campus with its associated buildings, outbuildings, parking lots, etc. In addition, there may be independent satellite locations out in the community and people's homes (home health). It would be impossible for even the best-resourced hospital to cover its entire footprint with high-level security measures.

The difficulty is magnified when protecting staff working off campus. By 2025, 25 percent of healthcare will be delivered in the community (McKinsey, 2022). Many more behavioral health patients

will be treated in their homes due to hospital capacity issues. Unfortunately, patient-generated violence regularly transfers from the unit to the community. Hospitals often lack joined-up approaches to provide for the safety of employees that work off their campuses.

Hospitals often lack joined-up approaches to take care of the onward safety of employees. Problem patients will be known to hospitals. But how effectively are risks communicated to local clinics and community-based nursing teams? Is real-time information being shared on potential risks and how to handle them?

The traditional approach is for hospitals to place wired or wearable alarm systems and duress buttons in the emergency department and certain units and rooms. Hospital buildings and campuses are large areas that are expensive to cover with wired or wireless systems (integrated into real-time location systems). The cost issue means hospitals will only likely have 10–20 percent coverage for their alarm systems. Effectively, their staff will always be exposed in some areas.

A solution here is Real-time Coordination and Response (RTCR) technology providing coverage across the setting by leveraging Bluetooth beacons, Wi-Fi access points, and mobile networks. It offers real-time visualization of any arising situations and the ability to coordinate resources and optimally respond to incidents. This type of command-and-control system acts as a force multiplier so that lean security teams can cover large, complex hospital campuses and the broader healthcare footprint in more isolated areas. RTCR is a good example of how technology enabled by location sharing can provide unprecedented coverage of personal safety for healthcare workers and connect them with security or first responders in any location at any time of day for better incident outcomes.

3.5 Hospitals are using quick fixes instead of integrated strategies

In recent years, we have invested more in new security inventions such as concealed weapon detection systems, cameras with analytics, Body Worn-Cameras (BWC), TASERs, K9s, and environmental designs such as sloping front reception desks and violence-deterrent signage.

Tony York, Executive Vice President of Paladin Security Group and PalAmerican Security says, "*Innovation in individual technologies – and in particular environmental design for retaining a*

welcoming hospital atmosphere – is showing promise in preventing and mitigating violence and reassuring workers, patients, and hospital visitors of visible security intervention to keep them safe."

Investment in new technology such as this is a welcome intervention for the healthcare setting. However, there is a tendency for hospitals to look for a quick fix to WPV triggered by an incident and potential reputational risk, rather than consider the intervention necessary for the risk posed in the long term.

Paul Sarnese says, "*After an incident like a shooting, many hospitals will quickly install metal detectors in every entrance to respond to the incident and to demonstrate their commitment to staff and patient safety. Although these actions do improve the security posture of the organization, it may not actually address the real issues that contributed to the shooting.*"

Other quick fixes may be standalone interventions, such as installing duress buttons or cameras, which are practical and of value. However, there needs to be more evidence that these things in isolation are effective, as, for the most part, they are reactive tools.

A significant issue is that there is still no consensus on what works in the US healthcare system – even though proactive and reactive violence response activities cost US hospitals and health systems an estimated $2.7 billion (AHA, 2016).

David Corbin states, "*There is a startling lack of comprehensive research on patient violence prevention and mitigation, particularly regarding empirical evidence of which strategies and tactics are effective.*" Despite the gap in published research, there are still many best practices that professionals can share. Healthcare requires greater collaboration, embedded frameworks, and proper mechanisms to report, monitor and share data for driving transformational change.

3.6 The need for technology investment.

Ultimately, the solution for healthcare organizations is to lean towards a more integrated workplace violence strategy, based on a thorough risk assessment of the most common threats. In parallel, there is a need to unify technology systems. Different departments and stakeholders use different providers and systems in many healthcare settings. This prevents the sharing of data and hinders joined-up technology solutions.

Unfortunately, the cost of major technology investments is a barrier facing hospitals. David Corbin recommends a long-term plan, "*Capital investments, such as a mass communications system, access control systems, duress alarms and more, can be overwhelming requests for any organization. By offering a phased approach based on priority levels for making the environment safe and staff feel safe, you can offer a predictable investment request each fiscal year for the improvements based on a multi-year improvement plan*."

It is also advised that healthcare organizations look at open systems that allow for integrating a range of technologies rather than buying a company's proprietary product, which locks you into buying only its add-ons. In addition, hospitals should explore ways to leverage existing technology investments.

3.6.1 Leveraging existing hospital technology.

Employers are increasingly issuing smartphones to staff; clinicians now regularly use digital apps in their daily jobs to deliver care at the bedside. That same device can be used as a staff personal safety tool – 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.

Many hospitals have also invested in advanced wireless networking infrastructure to support clinical practice. This is ideal for security intervention because it features indoor location technology and a very high density of coverage. There is no need to duplicate spending on parallel security technology. Patient wayfinding apps are a further technology of value to security because they are based on indoor positioning infrastructure and offer sub-five-meter accuracy in any building, floor, or room.

SECTION 4: Conclusion.

The key message from this paper is that despite healthcare WPV growing in frequency and complexity, it can be effectively addressed.

The success of progressive healthcare organizations in tackling this challenge points a way forward for the wider sector. As we saw in Section 2, numerous strategies and interventions are improving the prevention of, and response to, violence – including a focus on training and culture, and better use of data.

Crucially, the launch of new TJC standards in 2022 has provided the impetus and clear direction for addressing the threat. Healthcare organizations will only achieve positive change by fostering leadership buy-in, seeking input from staff, and forming multi-disciplinary teams to head up programs, rather than leaving the responsibility solely to security.

Violence and the fear of violence damage healthcare systems' finances, reputation, and staffing levels, and ultimately, patient care. It is time for hospital leaders to recognize the specific threat of patient-generated violence, connect the hospital's mission to the need to address WPV, and the value of investing in robust workplace violence prevention programs. Moreover, hospital leaders must take more accountability for their program's delivery.

There is no avoiding the significant challenges that hospitals face in preventing WPV. The biggest issue facing healthcare leaders is how to protect staff across large campuses and out in the community delivering care in patients' homes. It will take investment and transformational change to truly achieve safety everywhere. Fortunately, a clear business case can be made for moving beyond quick fixes. The intelligent approach is to adopt integrated, tech-enabled solutions in combination with targeted training and cultural initiatives.

It is noteworthy that although technological upgrades, policy, and security officer skill improvements have accounted for most change programs in recent years, the most successful transformations have embodied a philosophy of community policing-based security built on trust, transparency, and training.

Moreover, this move away from traditional security, policing and enforcement models brings fresh approaches to team composition, uniforms, branding and job descriptions, placing higher value on

community engagement. Today, security and policing teams play a more central and visible role at the heart of the healthcare community.

As a final note, if addressing WPV is part of your professional remit, I wish you luck with your future efforts and I encourage your organization to collaborate with others. The better we work together, the better we can counter the workplace violence scourge.

Contributor biographies

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David Corbin is the owner and Principal Consultant of Dynamic Security Strategies, LLC, a security consulting firm focused on the healthcare industry. He is a Certified Protection Professional (CPP), a Certified Healthcare Protection Administrator (CHPA), and holds a master's degree in criminal justice from Northeastern University.

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Brian Uridge currently serves as the Senior Director at the University of Michigan Department of Public Safety and Security and oversees Michigan Medicine Safety and Security. He manages over 225 public safety staff members for a system that has 40,000 employees that see over four Million patients a year.

Brian holds a bachelor's degree in criminal justice and a master's degree in Public Administration. He is a graduate of the FBI National Academy, along with being a Certified Protection Professional (CPP), Certified Healthcare Protection Administrator (CHPA) and Certified Threat Manager (CTM).

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