CHAPTER 5

Confronting Workplace Violence: Creating and Sustaining a Healthy Place to Work

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A healthy work environment is essential for quality patient care. Environments that are highly stressed, morally uninhabitable (Peter, Macfarlane, & O'Brien-Pallas, 2004), demoralizing, and abusive are associated with high registered nurse (RN) turnover rates (Hayes et al., 2006; Way & MacNeil, 2006) and an increased number of errors (American Association of Critical-Care Nurses [AACN], 2016). Many factors encourage a sick organizational dynamic. These factors include but are not limited to opportunities and triggers for both physical and verbal assaults, heavy workloads with long hours, power differentials, and poor, ineffective work relationships.

Advanced nurses have opportunities to positively influence these concerns by working to reduce opportunities for workplace violence (WPV) of all types, establishing positive communication processes, developing interprofessional communication opportunities, and enhancing efforts to address workload concerns. Nurses in advanced roles need to contribute to WPV reduction efforts by collecting data that can be used to determine whether policies, procedures, and planned interventions designed to reduce WPV are effective. They also need to consider both research and evidence-based practice initiatives to counter the gamut of violence in all its forms. This chapter offers information, strategies, and resource suggestions that will be useful to nurse leaders working toward healthy work environments through creative and comprehensive violence-reduction strategies.

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Workplace Violence

As society becomes more violent, WPV, also known as occupational violence (Shea, Sheehan, Donohue, Cooper, & De Cieri, 2017), becomes more commonplace. Workplace shootings accounted for 405 fatal injuries in 2010 and comprised 78% of all workplace homicides (Bureau of Labor Statistics [BLS], 2015). WPV is recognized as an occupational hazard for health care providers, including nurses. BLS compiles data concerning workforce statistics and organizes these data by occupational sectors and supersectors. The Health Care and Social Assistance sector, comprised by establishments that provide health care and social assistance for individuals (BLS, 2017a), is included in the education and health services supersector (BLS, 2017a).

BLS tracks work-related fatalities, injuries, and illnesses and defines "work-related" as when a work environment event or exposure caused or contributed to the resulting condition or significantly worsened a preexisting condition (BLS, 2017b). There were 123 work-related fatalities attributed to the health care and social assistance sector in 2015; a fairly consistent number over 4 years of data collection and ranging from 121 to 123 fatalities (BLS, 2017b). Nonfatal occupational injuries and illnesses resulting from violence and other injuries caused by persons or animals for those working in health care and social assistance roles in private, state, and local government totaled 14 events (BLS, 2016a). The victims of nonfatal WPV in 2014 were predominately female (67%) and approximately two-thirds worked in the health care and social service industry. Nearly one-quarter of victims needed 31 days or more of recovery time away from work while 20% required 3–5 days of work release time (National Institute for Occupational Safety and Health [NIOSH], 2017a).

In response to the impact of WPV on health care and social services employees, several labor unions, AFL-CIO, American Federation of Teachers, Communications Workers of America, International Brotherhood of Teamsters, Service Employees International Union, and United Steelworkers petitioned the Secretary of Labor with the claim that the Occupational Safety and Health Administration (OSHA) efforts to protect these health and social services workers are inadequate and the unions used BLS data to support their position. Subsequent to this petition, National Nurses United sent a separate petition. Both petitions included proposals for training programs, record keeping, and a prevention plan (Safety + Health, 2016).

ECRI Institute, formerly known as the Emergency Care Research Institute, is a nonprofit organization focused on applying scientific research to improve patient care outcomes (ECRI, 2017a). This organization, as well as others, makes the case that violent events are underreported in the health care setting (ECRI, 2017b). Given that nurses, in particular, underreport for many reasons including the belief that violence is an expected part of nurses' work and a fear of retaliation, sobering BLS data and NIOSH reports present advanced nurses with an open challenge to create evidence-based strategies to eliminate WPV and ensure that nurses have a safe place within which to provide excellent care.

The violence problem is serious and insidious yet remains inconsistently regulated. Some states require employers to administer WPV programs, including California, Connecticut, Illinois, Minnesota, New Jersey, and Oregon. New York requires public employers to run such programs. Washington does not require WPV programs but does require WPV incident reporting (American Nurses Association [ANA], 2017a). Approximately 42 states have regulations providing penalties for assault charges and specifically including nurses in the language of the law. There are some states that

have setting-specific regulations related to violence against personnel; settings include emergency departments (EDs), mental health/psychiatric facilities, or public health.

Contributing to the legal morass are laws that approach WPV in health care from a different perspective. In addition to penalizing those who assault nurses, Ohio authorizes hospitals to post warnings about violent behaviors; Hawaii passed a resolution encouraging employers to develop and implement conduct standards and policies to reduce workplace bullying (ANA, 2017a). Trotto (2014) points out that this state-level push is directed toward reducing violence risk for those working in the health care professions. These laws are often modifications of existing codes to include nurses and/or first responders designed to charge perpetrators of violence with felonies in response to assaulting or committing battery against designated personnel.

The ANA (2017b) provides a model bill for states, entitled "The Violence Prevention in Health Care Facilities Act." This bill is developed in recommended language that includes background facts that lend support to the need for such a bill. One critical point is the assertion that it is realistic to decrease and allay the impact of violence (ANA, 2017b). The model bill provides definitions of covered health care facility, health care worker, and violence or violent act. Recommended provisions include the establishment of a violence prevention program and a violence prevention committee that include nurses with direct care responsibilities. Other committee members need to have some sort of expertise or experience in violence prevention. The model bill charges covered health care facilities with responsibility for education, training, record keeping, and establishing a postincident response system. The proposed bill asserts that the covered agency shall not retaliate against any health care worker for reporting occasions of violence (ANA, 2017b).

Compounding the contextual complexities of violence in health care, WPV is inconsistently defined, and differences between violence and aggression are not established (Rippon, 2000); and there is a dearth of intervention studies (McPhaul & Lipscomb, 2004) examining the effectiveness of implemented programs, policies, and procedures designed to reduce the incidence or severity of violent behaviors. Some scholars suggest that the conceptualization of WPV needs to be reconsidered to a more holistic and comprehensive conceptualization that does not rely on the notion of a paid workplace (Van De Griend & Messias, 2014). A concern with a narrow WPV understanding that connects work to income is that this perspective excludes consideration of the many types of unpaid work that women perform. The violence that occurs in these unpaid situations is certainly experienced within a *work* context.

Van De Griend and Messias (2014) assert that the current definition is andocentric and excludes much of the work that women do in places that are not formal workplaces. This is an important concern that warrants attention and consideration, particularly given the nursing profession's undeniable connection to traditionally labeled "women's work"; however, for purposes of this chapter and its particular attention on the paid health care setting environment, WPV will be traditionally considered while still noting that there is much work to be done within the broader context of violent events or risk of violence in places in which work of any sort is done.

The health care culture is resistant to recognizing that nurses are at risk and demonstrates complacency related to accepting the idea that violence is simply part of the job of nursing. Despite the increasing attention paid by health care professionals to the topic and experience of violence, there is little evidence that systems of care are successfully intervening to reduce occasions of violence and to assure nurses that they are safe at work. There is a good bit of published literature examining the

stories of violence and sharing the details of WPV and its intended and unintended consequences but not the necessary science aimed to fix the problem.

Advanced nurses are uniquely positioned to address all types of WPV and to promote healthy work environments. There is a broad spectrum of violent behaviors in health care, including violence directed horizontally or vertically between health care providers or violence focused on nurses from patients, families, and visitors. Bullying behaviors, including between students and nurse educators and between new and established employees also require remedy. Cyberbullying is increasingly problematic and can be quite damaging to the individuals against whom the attacks are directed. Advanced nurses need to also consider opportunities for eliminating social media bullying, including threatening, uncivil email correspondence.

Background Information

The NIOSH is a research agency of the Centers for Disease Control and Prevention (CDC) in the U.S. Department of Health and Human Services (DHHS) (NIOSH, 2016). Its mandate is to "develop new knowledge in the field of occupational safety and health and to transfer that knowledge into practice" (NIOSH, 2018). It is easy to confuse NIOSH with OSHA (Occupational Safety and Health Administration), but they are different. OSHA is a regulatory agency in the U.S. Department of Labor that is responsible for ensuring the safety and health of American workers.

NIOSH and OSHA are excellent government resources for advanced nurses intrigued by the science of WPV and interested in possible risk-reduction strategies. Both agencies host websites that offer continuing education opportunities; multimedia resources; and other downloadable materials, including scientific reports. A particularly good resource is the online course for nurses addressing WPV offered by NIOSH (2017b) (https://www.cdc.gov/niosh/docs/2017-114/). Since NIOSH and OSHA are government agencies, materials are free and permissions for use are not required.

Definitions of Workplace Violence

There are many definitions of WPV and varying types of violence ranging from offensive language to homicide. WPV may also be referred to by its synonym, occupational violence. NIOSH (2017c) defines WPV as "the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty" WPV includes any act or threat of physical violence, harassment, intimidation, or other threatening behavior occurring at the workplace (OSHA, n.d.[a]) and psychological violence, abuse, mobbing or bullying, racial harassment, and sexual harassment. Cyber-based or Web-based bullying related to work encounters or relationships is another form of WPV.

Advanced nurses need to keep in mind that although bullying and uncivil behaviors are often acknowledged in nursing literature as forms of violence, these potentially damaging behaviors are not tracked as data indicators of WPV. Although bullying, harassment, and incivility do affect retention, patient safety, and professional engagement and may escalate to episodic or sustained injury that leads to missed days of work or other measurable outcomes, these behaviors are not included in WPV datasets and may be best remedied using different strategies and interventions than those used to reduce occupational violence associated with assault and/or fatalities.

The Pervasiveness of Violence: Who Is Hurt?

The U.S. Department of Justice delivered a 2011 report on WPV that compiled and examined data from 1993 to 2009. This report included data from the National Crime Victimization Survey (NCVS) and the BLS Census of Fatal Occupational Injuries (Harrell, 2011). Key points of this summary analysis include the following: (1) Law enforcement employees experienced the highest proportion of WPV followed by those in retail sales, but approximately 10% of WPV victims worked in medical occupations. The rate of WPV per 1,000 employed nurses from 2005 to 2009 was 8.1; physicians' rate was 10.1 and the rate for professionals working in mental health was 17 per 1,000 employees. (2) The percentage of WPV experienced in the total medical occupation category from 2005 to 2009 was 10.2% and the percentage for the total mental health occupation category, including professional, custodial care, and others, was 3.9%. (3) From 2005 through 2009, strangers committed the greatest proportion of WPV acts with approximately 53% of events against males and 41% against females. The proportions of males and females were roughly the same when examining victims of intimate partner violence in the workplace. (4) Current or former coworkers committed 16% of WPV against males and approximately 14% against females. Of note, patients were more likely to direct violence in the workplace against females than males (Harrell, 2011).

One particularly interesting finding revealed by the data analysis was the relationship of alcohol or drugs to WPV. Nurses often attribute violence in the ED to the influence of alcohol or drugs; however, approximately 40% of WPV did not involve an offender under the influence of alcohol or drugs as compared to 22% of nonworkplace-related violence. The report also noted that drug/alcohol use of about 36% of the offenders in WPV events and 41% in non–WPV events were not known (Harrell, 2011).

Violent behaviors include interactions that occur between coworkers, supervisors, patients, families, visitors, and others (McPhaul & Lipscomb, 2004). Research findings suggest that nonphysical violence is highly associated with physical violence and should be seriously addressed as part of comprehensive WPV prevention plans (Lanza, Zeiss, & Rierdan, 2006).

An Organizing Framework for WPV: Violence Typologies

Established typologies are helpful organizing frameworks and provide a context for developing interventions and researching the effectiveness of these interventions. Capozzoli and McVey (1996) developed a typology over two decades ago that organizes occasions of violence based on where it originates and where it occurs. This WPV categorization describes three types:

Type 1: Violence originates in the workplace and occurs in the workplace.

Type 2: Violence originates in the workplace and occurs outside the workplace.

Type 3: Violence originates outside the workplace but occurs in the workplace.

An example of Type 1 violence is when a hospital worker perceives that he or she has been victimized by an arbitrary evaluation that has led to a suspension. The employee comes to the work setting looking for retribution and directs this hostility toward the manager or to anyone else in the hospital. Type 2 violence is exemplified by

the nurse who has a disagreement with the nightshift charge nurse. The nurse learns the charge nurse's home address and spray-paints his automobile. Property destruction is considered a violent act, although many people might first think of murder or physical assault as examples for this type of violence. Type 3 violence may be illustrated by the shooting death of a nurse in the parking lot of the hospital by an estranged spouse.

Capozzoli and McVey's (1996) violence typology differs in structure from the categorization offered by the Federal Bureau of Investigation (FBI) National Center for the Analysis of Violent Crime (NCAVC), Critical Incidence Response Group (CIRG). The FBI taxonomy identifies four broad categories of WPV that focus on perpetrator and victim characteristics within the broad context of the workplace (Rugala, Isaacs, & NCAVC, 2003). The FBI typology is used by NIOSH (2006) (**TABLE 5-1**).

TABLE 5-1 FBI Violence Typology with Nursing Practice Examples

Violence Type	FBI Definition (Rugala et al., 2003)	Exemplar
Type 1 (criminal intent)	Violent acts by criminals who have no other connection with the workplace, but enter to commit robbery or another crime.	Nurses working in the intensive care unit return to their locker room at the conclusion of their shift to find that the lockers have been forcibly opened. Credit cards, cash, and electronic devices have been stolen. Hospital security and police suspect that outside thieves entered the facility pretending to be visitors.
Type 2 (customer/ client)	Violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.	An emergency department nurse is pushed by an angry family member because of a delay in receiving laboratory results.
Type 3 (worker-on-worker)	Violence against coworkers, supervisors, or managers by a present or former employee.	A nursing assistant (NA) is suspended from work as a result of a serious and witnessed patient care incident that compromised safety. The NA waited in the parking lot until the nurse witness finished the shift and accosted the nurse.
Type 4 (personal relationship)	Violence committed in the workplace by someone who doesn't work there, but has a personal relationship with an employee—an abusive spouse or domestic partner.	A physician's spouse enters the patient care unit to confront the physician about domestic issues. The discussion escalates into verbal abuse and threats of physical battery.

Data from Rugala, E. A., & Isaacs, A. R. (Eds.). (2003).

Violence Resulting from Criminal Intent (Type 1)

Type 1 (criminal intent) violence preventive strategies include physical security measures including bright lighting, alarms, lock placements, cameras, and equipment designed to reduce outside accessibility (Rugala et al., 2003). These strategies are unique to this type of violence because the perpetrator has no connection to the workplace unlike the other violence categories. Type I violence accounts for about 80% of workplace homicides often because the criminal is carrying a weapon. For the most part, this type of violence is directly related to vulnerabilities associated with job characteristics (e.g., taxi drivers or late-night retail clerks). Victims often work in isolation and, sometimes, in dangerous locations. Accessibility to cash amplifies the risks (Rugala et al., 2003).

While nurses are not often working in these sorts of circumstances, they do conclude shifts at times of night and early morning that may contribute to lonely walks to parking garages or to public transportation sites. Health care employees also are often required to go to isolated areas of hospital facilities by themselves to complete certain tasks or retrieve necessary care-related items. Nurses and other health professionals work in increasingly diverse types of health care facilities and each work setting and its associated environment likely has its own opportunities for criminally motivated violence.

High Frequency Categories of Nurse-Targeted WPV

The majority of threats and assaults against care providers come from patients, families, and visitors (McPhaul & Lipscomb, 2004; NIOSH, 2006; Rugala et al., 2003) and are reflective of Type 2 WPV. This is a particularly high-frequency category of WPV as related to health care provision, particularly in settings recognized as risky for occasions of violence. Nursing home settings, psychiatric/behavioral health facilities, and EDs provide opportunities for close contact with patients and families under circumstances that can be stressful and fast paced for all concerned. Additionally, care demands are often high and patient/family expectations may be unmet contributing to a pressure-cooker environment that may trigger violent interactions.

Types 3 and 4 violence may have associated clues or warning signs prior to an act of WPV. Observed behaviors that evoke an intervention, even if this response is in the form of reporting the concerning comportment or action, are welcome and should be encouraged by advanced nurses. With warning, preventive measures can be taken prior to escalated aggression including assault, battery, or homicide.

Although the Capozzoli and McVey (1996) and FBI (Rugala et al., 2003) typologies differ, both are useful to law enforcement, policymakers, and advanced nurses and administrators because they organize a complex phenomenon, WPV, into manageable and meaningful categories. Categorization facilitates pattern recognition when attempting to research the effectiveness of interventions based on type of violence. The typologies offer opportunities for considering a variety of preventive strategies that may target different aspects of WPV. These approaches potentially work synergistically to protect nurses and other employees and providers practicing in diverse health care settings.

Legal and Regulatory Requirements—Healthy and Safe Work Environments

Employers are legally and morally obliged to promote a safe work environment that is free from violence in all its forms. Advanced nurses need to be well aware that hospital

employment is hazardous work that requires a robust arsenal of preventive strategies to create a healthy and secure work environment. OSHA (n.d.[b]) has regulated through Section 5(a)(1) of the Occupational Safety and Health Act of 1970 (OSH Act of 1970) that employers have a duty to provide each worker both "employment and a place of employment which are free from recognized hazards that are causing or likely to cause death or serious physical harm" to the employees (OSH Act of 1970, Sec. 5. Duties). There are also OSHA-approved state plans that are supplemental to the federal OSHA program. Twenty-six states, Puerto Rico, and the U.S. Virgin Islands have these plans in place. There are also nine states that require certain types of health care facilities to have WPV prevention programs in place. Enforcing these state regulations is the responsibility of state-designated authorities rather than OSHA. The OSH Act, Section 11(c), also provides protections to employees who exercise the rights granted to them under the act (OSHA, n.d.[b]). These protected rights fall under the domain of the Whistleblower Protection Programs (OSHA, 2017).

In addition to federal regulations as enforced by OSHA, The Joint Commission (TJC), an independent accreditation body for health care organizations, has responded to WPV concerns in health care settings given the adverse impact that violence, including bullying, has on patient care outcomes. TJC issued a directive in 2009 that mandated a hospital response to disruptive behaviors perpetrated by employees, including physicians (Johnson, Boutain, Tsai, & de Castro, 2015). TJC has since crafted several standards related to WPV. These standards relate to a variety of organizational types including hospitals, nursing homes, behavioral health facilities, and others. Standards relevant to WPV include Environment of Care, Emergency Management, Leadership, and Performance Improvement. Much of the systemwide focus on WPV reduction includes partnership between patient safety and worker safety programs within the context of a culture of safety that includes high reliability principles and a just culture (OSHA, n.d.[c]).

TJC offers a variety of reports that provide executive-style summaries of timely concerns while offering insights, recommendations, and resources to those advanced nurses who are seeking guidance in the select subject domain. One example is an edition of *Quick Safety: An Advisory on Safety and Quality Issues* that addresses WPV and provides an overview of prevention strategies to reduce WPV risk factors. Resources with hyperlinks are provided and these resources include a variety of cutting-edge agencies including CDC and the National Research and Training Center (TJC, Division of Health Care Improvement, 2014). Nurses in advanced roles may find these briefs useful as staff education tools while also having utility for guiding working groups focused on violence reduction.

Causative Factors of Violence

Approximately one-third of violent events in the general public are caused by personality conflicts and related stressors (Capozzoli & McVey, 1996). Published literature supports that the health care sector experiences violent behaviors across all types of settings (NIOSH, 2002a; Trossman, 2006) but most frequently from patients, visitors, and patients' family members in EDs and psychiatric facilities (Edward, Ousey, Warelow, & Lui, 2014; McPhaul & Lipscomb, 2004; NIOSH, 2002b; Shea et al., 2017). Health care workers are frequently assaulted by patients, particularly those with dementia or schizophrenia (Denenberg & Braverman, 1999; McGill, 2006).

Ascertaining an accurate count of the frequency and types of violent incidences in health care settings on a national level is not currently possible, as there is no database or mandatory reporting mechanism in place. However, the number of states requiring WPV reports from hospitals is increasing. One such example is the California Division of Occupational Safety and Health (Cal/OSHA) mandatory WPV reporting system. This statewide online reporting program pertains to general acute care hospitals, psychiatric hospitals, and special hospitals and follows requirements of Senate Bill 1299 including a public report issued annually by January detailing the total number of reported incidents, names of reporting hospital facilities, outcomes of related investigations, any citations issued against a hospital, and a plan for violence prevention (Cal/OSHA, 2017). Not too many years ago, hospitals rarely volunteered information about the occasions of violence occurring in their facilities; rather, violence was considered the cost of doing business (Love & Morrison, 2003). Reporting programs provide an optimistic opportunity to collect and use real data to create effective violence-reduction programs.

Although the circumstances and context of WPV varies, it is not uncommon for health care workers to unintentionally aggravate stressful situations (Duxbury & Whittington, 2005; Hollinworth, Clark, Harland, Johnson, & Partington, 2005). When work environments are stressed and highly charged, nurses, physicians, or other health care workers may escalate aggressive behaviors by responding rudely, callously, or impatiently to patients, families, or coworkers. Duxbury and Whittington (2005) found that patients from inpatient mental health units perceived poor communication to be a significant precursor to aggressive behaviors.

Findings from a study that explored nurses and behavioral health associates' (BHAs) responses to violent inpatient interactions that occurred on a behavior health unit suggest that nurses and care associates recognized that there are often opportunities for improving communication and for enhancing professional behaviors (Zuzelo, Curran, & Zeserman, 2012). Findings revealed that behavioral health unit nursing staff appreciated the value of empathy and de-escalation techniques but also acknowledged that dealing with the emotional and physical aftermath of violence directed at them from patients is difficult. They described that feeling violated, angry, and scared are common reactions that affect the nurse-patient dynamic during future encounters, particularly if the interaction feels risky (Zuzelo et al., 2012). These sorts of patient care encounters support that one of the most common types of WPV occurs when the verbalization or behavior of another employee, a patient, or a visitor is perceived as threatening (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005; Edward et al., 2014).

Nurses interact with patients or family members who are under the influence of drugs or alcohol and these interactions require a level of finesse and communication expertise that may be in short supply when staffing levels are inadequate and staff is fatigued. Significant and chronic staff shortages, high acuities, and more violence-prone patients, including elders with dementia and patients with substance abuse or metabolic issues, increase the likelihood of violent encounters (McPhaul & Lipscomb, 2004).

Besides personality conflicts, violence perpetrated by employees is often related to a threat to job, threat to person, and extended working hours (Capozzoli & McVey, 1996). Job threats trigger employee worries about meeting basic needs for survival. Many employees live check by check without the means to afford housing, food, or family expenses during a period of unemployment. Although most people solve their needs using socially acceptable methods, when an employee believes that these

acceptable methods are ineffective, he or she may resort to unacceptable tactics. Even people who are usually balanced and reasonable may reach a breaking point (Capozzoli & McVey, 1996).

When employees perceive that they have been victims of unfair or capricious treatment, they may respond violently. Capozzoli and McVey (1996) noted that in most cases of employee or ex-employee violence, the event was preceded by an event or sequential events in which the individual perceived that he or she was treated unfairly by superiors. Extended working hours can also be stressful and may trigger helplessness. If other employees do not mind the extra hours, the stressed employee may also feel isolated and ostracized, worsening the potential for violent behavior (Capozzoli & McVey, 1996).

Conceptual Frameworks for Understanding Violence

Conceptual frameworks have been developed to explain the theoretical underpinnings of WPV and each theory offers a different way to consider the WPV phenomenon. The Haddon Matrix, developed by William Haddon, Jr. (1968), approximately five decades ago, connects public health domains to WPV (Runyan, 1998; Safety Lit, n.d.). The matrix includes such factors as host, agent, disease, and phases; and primary, secondary, and tertiary to explore and assess the many factors associated with injuries and their severities (Safety Lit, n.d.). The host is the victim, whereas the agent or vehicle is a combination of the perpetrator, weapon, and force of the assault. The environment is split into the physical and social environment. The matrix is a tool that is useful when selecting strategies for injury prevention measures.

The matrix is constructed with four columns and three rows combining the concepts of pre-event, event, and post-event phases (rows) to the factors (columns). The factors, host, agent/vehicle, physical environment, and social environment interact with each other. Injuries are usually the result of sequential events rather than a discrete moment in time (Runyan, 1998; Safety Lit, n.d.).

A helpful example of the Haddon Matrix is when a patient fall is the culmination of a pain experience requiring narcotic analgesia with a call bell out of reach and side rails in the up position. The patient, or host, may have urinary urgency and impulsivity concerns related to a previous stroke. The floor may be slippery, and the patient may be barefoot. The patient's room may be situated far from the nurses' station. In addition, other patients' family members may have heard the patient yell for help prior to climbing out of bed and falling but did not know how to alert staff and were uncomfortable going into the patient's room. These factors, if more fully developed on a Haddon Matrix, would provide insight into interventions that would fit into each cell, thereby generating a variety of strategies for addressing this particular problem.

A second theory, the Broken Windows Theory (Kelling & Wilson, 1982), is a popular criminal justice theory that has had significant influence on law enforcement and local activism (McPhaul & Lipscomb, 2004) and may have applicability to medical environments (Zhou et al., 2017). The theory asserts that when low-level crime is tolerated or ignored, the environment becomes increasingly conducive to more serious crime. In other words, environments with broken windows, stripped vehicles, and graffiti-clad buildings will have more serious crime than a neighborhood with clean walls, well-maintained yards, and no visible debris or destruction.

Advanced nurses need to know that there has been some controversy surrounding police programs purportedly based on the Broken Windows Theory and its presumed

connection to high-arrest programs. In 2015, Kelling defended the theory and asserted that it was being used in ways contrary to its meaning. Kelling reinforced that the theory is about reducing the level of disorder in public spaces.

The Broken Windows Theory may not be uniquely relevant to health care, but perhaps it offers insight into the possible influence of environment on patient and family behaviors. For example, a dirty, trash-strewn waiting room area without windows and no magazines or toys may be more highly associated with hostility as compared to a waiting area that is clean, fresh-smelling, with a television, current magazines, newspapers, and various comfort supplies. This example is hypothetical but does have commonsense appeal.

Another example of the relevance of the Broken Windows Theory is offered by Zhou et al. (2017) in their examination of factors that contributed to hospital WPV as informed by hospital administrators and patients. Zhou et al. postulated that the medical environment consists of a hardware environment and a social environment and suggested that recognizing a **first** broken widow can be an opportunity for administrators to respond and repair the broken entity so that an orderly environment is restored. The purpose of the study was to use the theory to reduce opportunities for violence by establishing strategies to eliminate hospital WPV triggers that corresponded to six factors: medical staff, patient-related, hospital environment, policy and institutional, social psychological, and objective events (Zhou et al., 2017). Study methods and findings offer interesting use of the Broken Windows Theory and point out opportunities to frame WPV within a theoretical construct that offers advanced nurses intriguing possibilities for viewing WPV through a unique lens.

Injury epidemiology, occupational psychology, and criminal justice offer strategies for understanding generalized society violence and more circumscribed occasions of violence, including those occurring in health care settings. An additional perspective described in nursing literature relates to violence as a response to oppression (Hedin, 1986; Hutchinson, Vickers, Jackson, & Wilkes, 2005; Roberts, 1983, 2000, 2015). Horizontal WPV, lateral violence, or bullying is a significant concern in nursing, although it is not a phenomenon unique to the nursing profession (Hutchinson, Vickers, Jackson, & Wilkes, 2006). It has been suggested that bullying requires examination beyond the confines of oppressed group behavior theory to include broader environmental and organizational perspectives (Hutchinson et al., 2006; Hutchinson, Wilkes, Vickers, & Jackson, 2008). Roberts (2015) suggests that purposeful leadership and nursing empowerment are two essential components to bullying reduction efforts. These efforts need to include resources available to encourage culture shifts and intervening to influence the power dynamics that contribute to lateral violence (Roberts, 2015).

Setting the Stage for Understanding Hospital Violence

"WPV is one of the most complex and dangerous occupational hazards facing nurses working in today's healthcare environment" (McPhaul & Lipscomb, 2004, p. 1). This danger reflects the risk of violent behavior victimization within society at large but may also be related to hesitancy and uncertainty within the health care system. Hospitals are concerned with patient satisfaction and recognize that health care consumers feel a sense of entitlement in terms of the quality of service.

Patient satisfaction is an important health care outcome measure. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is the

first national, standardized survey of patients' perspectives of hospital care. Results are publicly reported (HCAHPS, 2018). Since July 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) of the Centers for Medicare and Medicaid Services (CMS) have been required to fully participate in HCAHPS to receive full annual payment (HCAHPS, 2017). The Patient Protection and Affordable Care Act of 2010 (also known as Obamacare) included HCAHPS performance as a component of the calculation of hospital payment received through the Hospital Value-Based Purchasing program (HCAHPS, 2017).

Most advanced nurses recognize the significance of patient satisfaction on their response to the HCAHPS survey, officially titled, *CAHPS® Hospital Survey*. It may be challenging for advanced nurses and other health care system leaders to underscore the importance of treating staff with respect and using nonviolent methods of communication while simultaneously emphasizing the institution's friendliness, approachability, and interest in meeting individual "customer" needs. It is also probable that hospital employees and administrators may be less likely to redirect and, if needed, reprimand families and patients who exhibit and verbalize unsafe behaviors or violence toward staff. In addition, because the culture of health care settings is to promote empathy and understanding, agencies may unintentionally create an environment in which there may be acceptance of unacceptable behavior (Rew & Ferns, 2005).

In response to violence perpetrated by the public against the United Kingdom (UK) National Health Service (NHS) staff, the health service established the Campaign to Stop Violence Against Staff Working in the NHS: NHS Zero Tolerance Zone (NHS, 1999). At the time of the campaign start, NHS health care workers were four times more likely to experience WPV than the general public. Estimates suggested that health care workers were approximately 26 times more likely to be seriously injured than members of the general public (Rew & Ferns, 2005). The Zero Tolerance Campaign focused on reinforcing to the public that violence against NHS health care workers is unacceptable while assuring staff that violent and intimidating behavior will not be tolerated.

WPV continues to be a concern across the NHS with a persistently low level of reporting. Some fear that care providers, including physicians, may perceive WPV as inevitable (BBC News, 2008). Published resources support that verbal and physical abuse of NHS staff persist (Health and Safety Executive, n.d.; NHS Wales, 2013); however, health care agencies are persistently advancing this issue with the public and with health and social care employees. Regulations reinforce that WPV perpetuated by the public—specifically, patients and family members—will not be tolerated and is in fact illegal. A flyer written by a medical practice in England provides one example of an educational handout that details the Zero Tolerance policy and procedures of its medical practice (Hope Farm Medical Centre, 2016).

The NHS structure provides opportunity for a single voice message about WPV and the health care system's stance on zero tolerance. Complexities of the U.S. health care system and the lack of singular focus within a care system model that encourages competition among provider entities may contribute to barriers in WPV reduction efforts. Perhaps advanced nurses need to consider strategies to build coalitions and partnerships that commit to providing public education about zero tolerance toward violence and employee harm. Nurses in all sorts of roles need to work with interprofessional colleagues to make certain that violence is not tolerated as just part of the expected daily work of health care providers.

Types of Violence in Health Care Settings

Health care settings around the globe are at risk for a variety of violent behaviors. Violence may be manifested as verbal abuse, sexual harassment, racial harassment, bullying, property damage, threats, murder, physical assault, and cyberbullying. Spector, Zhou, and Che (2014) conducted an integrative review of WPV perpetrated against nurses in the Anglo, Asian, European, and Middle Eastern regions and found that approximately 31.8% of nurses were exposed to physical violence, 62.8% to nonphysical violence, 47.6% to bullying, and 17.9% to sexual harassment during the year prior to data collection. In the United States, national data are not collected on verbal threats or assaults; BLS only reports on injuries severe enough to require time away from work. A direct result of inadequate or absent data collection specific to occasions of violence is the lack of clear descriptive statistics concerning the frequency of verbal and physical violence (Clements et al., 2005) and an accurate understanding of the measure of injuries resulting from violence (Love & Morrison, 2003).

Lateral or horizontal violence frequently occurs in health care agencies. Lateral violence is a form of bullying, nurse to nurse, and is usually directed toward nursing staff perceived as less powerful. Newly graduated nurses and younger nurses are particularly vulnerable to this form of violence (Edward et al., 2014; Roberts, 2015; Zhou et al., 2017). Hutchinson et al. (2008) define bullying as referring to a variety of hidden behaviors that are difficult to substantiate: "Perpetrators aim to harm their target through a relentless barrage of behaviours that may escalate over time and include being harassed, tormented, ignored, sabotaged, put down, insulted, ganged-up on, humiliated, and daily work life made difficult" (p. 21). Examples of lateral violence include nonverbal expressions of disdain or skepticism, rude or belittling comments, sabotaging another nurse by withholding relevant information, scapegoating or blaming, passive aggressive communication, and gossiping (Griffin, 2004). Bullying is tolerated because many nurses experienced it as a rite of passage and regard it as normal. Newly licensed nurses are one such group vulnerable to lateral violence during their early practice (Blando, Ridenour, Hartley, & Casteel, 2014; Goldberg, 2006; Griffin, 2004). This type of violence may be considered an undesirable form of hazing as graduate nurses are initiated into the ranks of professional nurses (**EXEMPLAR 5-1**).

EXEMPLAR 5-1 Horizontal Violence: Confronting a Saboteur of New Nurse Success

Oleksandr Bondar, RN, BSN, is a recently graduated professional nurse who was hired directly into a busy 12-bed medical intensive care unit (MICU). He was initially very enthusiastic about the employment opportunity, although a bit concerned about the demanding expectations that he recognized would be particularly challenging given his lack of MICU experience and his novice RN status. At the time of his job offer, the MICU nurse manager assured him that he would be well supported by an expert and professional nursing staff and a carefully constructed, individualized orientation program. Oleksandr had done quite well in his baccalaureate program and was considered a top-performing student. He had previously worked as an emergency medical technician and also had a military background. During his previous work

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EXEMPLAR 5-1 Horizontal Violence: Confronting a Saboteur of New Nurse Success *(continued)*

experiences, he demonstrated mature thinking and an optimistic, positive presence that typically led to positive performance evaluations and leadership opportunities.

Oleksandr's orientation experience started in the classroom and he excelled in both simulated and computerized activities. After 4 weeks of intense academic preparation, he was assigned to work with Melanie Schrift, RN, a highly experienced critical care nurse with a reputation for a no-nonsense approach to practice and an occasionally formidable personality that some found to be intimidating.

During the first few shifts of the clinical preceptorship experience, Oleksandr shadowed Melanie. She explained to him that she was legally responsible for the quality of his care and she needed to be confident that he would not "screw up." He worked diligently to meet her expectations and to acquire an understanding of MICU processes. Melanie increasingly focused on his assessment skills and his knowledge of pathophysiology. She would often quiz him in front of other staff members and, occasionally, in front of patients. The questions were challenging and if he answered incorrectly or with less detail than she required, Melanie would correct him and chastise him in front of observers. These behaviors increased in frequency over the subsequent shifts and, eventually, Melanie incorporated nonverbal expressions of dissatisfaction or irritability that included deep sighs, eye rolling, and sarcastic comments about him to other staff members.

Oleksandr grew increasingly frustrated and felt disempowered. He recognized that his confidence was shaken by these experiences. Accustomed to hard work yielding successful outcomes, he was somewhat taken aback by Melanie's aggressiveness. He began to consider her interactions with him as demonstrations of bullying. Oleksandr was concerned about the effect of this bullying on his status within the staff group and potentially on patients and families as they witnessed passive-aggressive "coaching" at the bedside. He recognized that job opportunities were reasonably plentiful and that he could likely find a different job; however, he determined that it was important for him to address the situation and do what he could to stop the bullying behaviors directed at him. He was also committed to preventing similarly uncivil experiences for other new MICU hires.

Oleksandr devised a personal action plan that included the following activities:

1. Discuss the situation with the nurse manager and the nurse educator. Present his perspectives, concerns, and specific examples with a request for acknowledgement of his viewpoints and verbalization of support.
2. Utilize literature-supported strategies for directly confronting the bullying behaviors demonstrated by Melanie at the time of occurrences.
3. If bullying persists, directly speak with Melanie about his concerns in the company of a third party to ensure that mutual understanding was achieved with a satisfactory action plan.

Oleksandr followed through on his plan as devised. The nurse manager expressed concern for him and a keen interest in retaining him on the staff while assuring him of readily available support. She acknowledged that his preceptor could be "rough" but also shared that Melanie had demonstrated excellent supervisory and coaching skills during previous preceptorship experiences. The manager encouraged Oleksandr to implement his plan and to alert her if managerial input was required. She made clear to Oleksandr that bullying of any sort would not be tolerated and if the situation did not improve or if it worsened, an immediate response to support him would be evoked.

EXEMPLAR 5-1 Horizontal Violence: Confronting a Saboteur of New Nurse Success *(continued)*

The nurse educator concurred and provided him with her cell phone number to facilitate a rapid response to problems, if needed.

Oleksandr then considered recommendations offered by the literature and discussed during one of his undergraduate leadership courses. He considered that some nurses might justify behaviors characterized as rigorous or "tough love" (Leong & Crossman, 2016, p. 1357) as acceptable to encourage resilience; however, tough love or rigor may also be euphemisms for horizontal or workplace violence and these behaviors should be categorized as violent and immediately terminated. He reflected on the value of direct and clear communication between nurses and the confrontation avoidance tendencies that many nurses display in the workplace.

Oleksandr reviewed published literature that he had explored while in school, including *Crucial Conversations* (Patterson & Grenny, 2011) and *Crucial Accountability* (Patterson, Grenny, McMillan, & Switzler, 2012). He also read about cognitive rehearsal (Bowllan, 2015) and began practicing responses to the verbal and nonverbal messages that were frequently offered by Melanie and working on scripting a response to eye-rolling, public chastisement, and aggressive posturing during question and answer sessions. Oleksandr discussed these techniques with colleagues external to the workplace, shared his rehearsed responses with the nurse manager and the nurse educator responsible for his orientation program, and role-played with his friends from school. After a few days, Oleksandr felt prepared to confront the behaviors.

During each bullying encounter with Melanie, including condescension, nonverbal aggressions, or unwarranted criticisms and sarcastic comments, Oleksandr directly and calmly countered with a statement that compelled acknowledgement. One such example occurred at the end of the shift when Oleksandr was providing report to the incoming staff. Melanie interrupted and rolled her eyes. Oleksandr countered, "I see that you rolled your eyes in response to my report. I may have missed an important point. Please share your concern and I will address it." Another situation arose at the bedside of a newly admitted patient. When Melanie began to quiz Oleksandr using rapid-fire speech and aggressive body language, Oleksandr responded by noting, "Mr. Smith is in need of getting comfortable. Let's have this conversation outside the room once we have tended to his care priorities." Each time that Oleksandr directly responded to the disrespectful comment or behavior, Melanie appeared unsettled and stopped.

After a few confrontations, each handled calmly and respectfully, Melanie's behavior shifted and Oleksandr's confidence increased; he felt a sense of renewed accomplishment and confidence. His nurse manager met with him and commended him for his response to the event. She also noted that although the bullying had improved, she would need to discuss the behavior with Melanie to make clear that the bullying had been observed and would not be tolerated, particularly if she was interested in future opportunities to precept new hires.

Approximately 6 months later, Oleksandr successfully completed his orientation requirements and his probationary period. He and Melanie had developed a stable professional relationship. Oleksandr was asked to provide his department with an overview of his orientation experience and he determined that one aspect of this presentation would be horizontal violence or bullying. Oleksandr was particularly interested in contrasting a rigorous approach to orientation versus an approach akin to bullying. His perspectives were well received and discussion opportunities included feedback from the more-senior staff specific to the overwhelming responsibilities

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EXEMPLAR 5-1 Horizontal Violence: Confronting a Saboteur of New Nurse Success *(continued)*

of supervising while managing an assignment, feeling uncertain about the best approaches to coaching a new nurse, and a distaste for orientation evaluation processes. The staff determined that it needed to explore opportunities to develop programs and policies around the following priorities:

1. Evaluation strategies that support the new nurse while also responding to the need to accurately determine whether the orientee is competent in nursing care priorities.
2. Recognition of bullying behaviors and individual/team responsibilities to halt such behaviors, particularly when witnessed.
3. Strategies that support robust and rigorous learning experiences within a context of kindness and caring.
4. Direct, clear, and honest communication techniques.
5. Skillful dialogue techniques to use when important conversations or critical confrontations need to occur.
6. Opportunities to nurture new nurses in ways that enhance team and confidence building.
7. Consistently applied policies to support a zero tolerance approach to workplace violence, particularly between staff and team members but also including patients and visitors.

When students or newly licensed nurses are victims of bullying behaviors, they may view such interactions as the norm in nursing and perpetuate the violent behaviors as they, in turn, progress to work with new nurses or students (Longo & Sherman, 2007). As with other types of violence, if institutions do not proactively protect staff through zero tolerance policies, lateral violence goes unrecognized and unpunished, allowing it to perpetuate. Advanced nurses need to keep in mind, however, that antibullying policies do not necessarily provide victims with sufficient protection against bullying and they do not assure victims that there will be expert guidance available to them from human resource staff about the best ways to manage bullying events (Cowan, 2011).

Violent verbal outbursts, aggressiveness, inappropriate criticisms, and publicly humiliating tirades are not atypical behaviors in health care organizations. Verbal abuse is common in the operating suite (Buback, 2004; Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013) and is largely unprovoked and unexpected when directed at a nurse or other operating room employee from a surgeon. Nonphysical violence is normative in health care settings, and those employees who experience nonverbal violence are more than seven times more likely to experience physical violence (Lanza et al., 2006). A systematic review of nursing and workplace aggression found that the highest incidence of collegial aggression occurred from physician to nurse, although nurse-to-nurse aggression was also as high as 32% within clinical areas (Edward et al., 2014).

Upward vertical bullying occurs when staff members antagonize and continually challenge people in legitimate positions of authority (Goldberg, 2006), including new nurse managers or others new to formal advanced roles. It is also not uncommon for

nurses to bully new residents or medical students or for physicians to abuse nurses with such regularity and aggressiveness that nurses are fearful to telephone or page with legitimate patient care concerns. Pharmacists also experience bullying and abuse, particularly from prescribers of all types, including physicians (Institute for Safe Medication Practices [ISMP], 2004a, 2004b).

Risk Factors for Violent Behaviors

Nurses and other health care providers work directly and intimately with unpredictable or explosive people thereby increasing exposure to violence risk. Patients may demonstrate unpredictability as a result of their medical condition such as brain injury (Pryor, 2005), psychiatric illness (Nachreiner et al., 2007; Zuzelo et al., 2012), or dementia. Diagnoses most often associated with violent behaviors include schizophrenia, bipolar manic illness, and comorbid substance abuse (Amoo & Fatoye, 2010). Some perpetrators exhibit explosiveness due to alcohol or drug use. Nursing work often requires one-on-one time with patients and family members. There are times when being alone increases vulnerability to violence, particularly when patients or family are impulsive, angry, and frustrated (**BOX 5-1**).

Family members and visitors may present to health care facilities in angry or impaired states. Too few staff and staff members working alone either during direct care interventions or simply as a result of a decreased personnel pool compound the risk for violence (McPhaul & Lipscomb, 2004). Long wait times (Pich, Hazelton, Sundin, & Kable, 2011), anxiety, and miscommunications; or lack of communications can also trigger violence. These risks for violence relate to Type II, customer/client violence (McPhaul & Lipscomb, 2004), personality conflicts, or any of the three types of violence described by Capozzoli and McVey (1996).

Other risk factors for victimization do not directly relate to patient care but are connected to types of health care–related enterprises or characteristics of individual nurses. Nursing educators are experiencing an increasing number of assaults by angry and violent students, particularly perpetrated by students who are failing or performing poorly (Love & Morrison, 2003). These violent episodes have the potential to spill into clinical education settings. In addition to setting, there are data suggesting

BOX 5-1 Examples of Opportunities for Nurse Assault

1. Transporting a patient to a department for a necessary test during off-business hours with an on-call employee opening the department
2. Traveling in an elevator confined with a confused, combative, or angry patient
3. Transporting a deceased patient to the morgue, if the morgue is in a low-travel area
4. Providing patient care in a room with doors closed and equipment or furniture blocking easy exit
5. Sharing information with angry family members regarding a highly stressful patient care event
6. Traveling to and from the parking facilities, particularly if it is later or earlier than the common shift end and start times
7. Picking up medications or supplies during off-peak hours in distant, poorly monitored areas of the building

that nurses with a history of victimization are more vulnerable to WPV (Anderson, 2002a, 2002b; Edward et al., 2014), and risk of violence varies by nurse license type (Nachreiner et al., 2007).

Larger societal influences directly affect the risk for violence in health care settings. Stress, substance abuse, economic pressures, and life's uncertainties contribute to the likelihood of violence. During the first half of 2016, violent crime increased by 5.3% inclusive of murder, rape, robbery, aggravated assault, property crime, and burglary (FBI, n.d.[a]). In the United States in 2015, the population based on U.S. Census Bureau estimates was 321,418,920 people and of this group, 1,197,704 were victims of violent crime and 15,696 were homicide victims (FBI, n.d.[b]). Domestic violence is commonplace, manifested by high rates of spousal, child, and elder abuse. Individuals living in a violent home learn that violence is a normal coping mechanism. Over time, achieving a feeling of normalcy by behaving violently becomes a positive reinforcement (Capozzoli & McVey, 1996). Individuals who are accustomed to using violence to solve problems and who use anger as an early response to stress pose particular problems in hospitals when confronted with uncertainty, delays, confusion, grief, and perceived power inequities.

There were 8,318,500 people employed in the BLS Major Group of 29-0000 Healthcare Practitioners and Technical Occupations in 2016 (BLS, 2016b) and an additional 4,043,480 individuals working in the BLS Major Group of 31-0000 Healthcare Support Occupations (BLS, 2016c). Community and Social Service Occupations, BLS Major Group of 21-0000 and comprised of counselors, therapists, social workers, health educators, and others had 2,019,250 employees (BLS, 2016d) yielding a combined total of over 14 million people working in some sort of health care–related capacity in the United States in 2016. This is a staggering number of citizens employed in settings related to health care provision. As hospitals struggle to provide care within an environment of fiscal shortages and resource competition, and health care delivery systems respond to market and reimbursement uncertainties, there are times when workforce reductions occur. Layoffs and terminations are highly stressful events and may trigger violent outbursts. Hospitals are not immune from personnel problems that may or may not be related to downsizing. Suspensions and other forms of disciplinary actions may also lead to violence.

In summary, many factors contribute to WPV and place nurses at risk. Typical interactions with patients, family, and visitors are potentially dangerous depending on the context of the interaction, the stress levels of the individuals involved, and the personal attributes and behavior patterns of each. Nursing is a "people business" and, as such, is risky. This risk is compounded by inadequate, inconsistent, or nonexistent policies and procedures regarding WPV. Assaults, particularly verbal, occur between health care workers of all types, including physicians, nurses, ancillary staff, and multidisciplinary team members. An apathetic response to WPV in hospital settings contributes to the acceptability of lateral and vertical violence.

Hospitals are microcosms of society and, as such, encounter similar problems as society-at-large. Larger economic forces on local, regional, and national levels, reimbursement challenges, and resource shortages create circumstances addressed through labor downsizing, layoffs, and terminations. These few examples suggest that WPV is a multifaceted event with the potential to increase in frequency and scope. Advanced nurses need to have an understanding of WPV in all its forms so that responsive systems can be designed that intervene in effective, efficient, and meaningful ways.

The Challenges of Establishing Violence Reporting Systems

Defining characteristics of violent behaviors are frequently assumed to be clear and well established. Some types of violence initially appear to be rather simple to describe and commonly understood; bullying or lateral violence may be a more abstract concern than more tangible types of violence such as physical assault. Johnson et al. (2015) caution that there is a lack of conceptual clarity that can make it difficult for managers to identify, label, and discipline perpetrators of workplace bullying. Critical discourse analysis of language used in workplace bullying policies of health care organizations and regulatory agencies reveals that workplace bullying is not discussed as an occupational health issue despite the adverse health outcomes experienced by bullying victims and witnesses (Johnson et al., 2015). Frequently used terms in policy documents included *disruptive behavior, harassment,* and *bullying*. Rarely were documents referenced to external sources. Findings support that varying words are used to describe unwelcome workplace dealings and these words are often not defined in meaningful and consistent fashion (Johnson et al., 2015; Roberts, 2015).

Johnson et al. (2015) found that there are often multiple workplace documents addressing bullying and other behaviors associated with violence, and documents within the same organization often differed in their definitions and descriptions. An additional problem is that many of the health organizations' documents were influenced by TJC, as mentioned, an organization primarily focusing on patient safety rather than worker safety, rather than relying on work efforts of agencies responsible for workplace concerns (Johnson et al., 2015).

Perhaps related to the individuality of health care organizations' policies and the associated definitional deficiencies, violence reporting rates are low (Edward et al., 2014), even though WPV is increasingly recognized as problematic and important. Rationales for low reporting rates vary. Explanations offered specific to NHS staff include nurses' belief that they are "too busy" to take time out for reporting and also nurses' belief that some violent situations are not worth reporting, including unintentional aggression manifested by confused or disoriented patients and verbal abuse from elderly or pain-ridden patients (Ferns & Chojnacka, 2005).

A systematic review by Edward et al. (2014) of the literature pertaining to WPV reveals several barriers to reporting, including:

1. Absent or murky policies and procedures pertaining to violence reporting
2. Poor or missing management support for the victim
3. Previous experiences of nurses who did report without an administrative response, who elect to not report subsequent events
4. Fear of retribution

Other WPV underreporting influences include ingrained perceptions of violence as normative in the caregiving environment (Pich et al., 2010) and a legal system that often discourages nurses from pursuing charges against perpetrators (Wolf, Delao, & Perhats, 2014).

The empathetic and caring nature of nursing care may also countermand a responsibility to report violence of any type. When patients react poorly to a diagnosis, for example, and lash out at the nurse, this behavior tends to be legitimized as a stress response. The threats of irate family members or verbal assaults of patient visitors

are often rationalized as being a reaction to anxiety or an inappropriate response to a legitimate problem (e.g., a lengthy wait in the holding area of the ED or an unanswered call bell).

Contributing to the inclination to not report may be that when nurses recognize systems problems but feel unable to correct them, they are more likely to excuse inexcusable behaviors. Reporting such behaviors and getting the patient, family, or visitor "in trouble" may seem an injustice. Ferns and Chojnacka (2005) suggested that nurses need to begin putting themselves first rather than prioritizing the patients in an effort to change the status quo perspective that violence is an inherent part of the work of nurses.

Advanced nurses need to contemplate whether nurses are socialized to expect violence from physicians, managers, or those in roles perceived as powerful (Ferns & Chojnacka, 2005). Certainly the literature supports the premise that nurses in advanced roles, including formal administrative positions, are not perceived as advocates for staff specific to WPV (Edward et al., 2014; Wolf et al., 2014). When violent events occur, nursing work must continue. Patients require care and attention, services need to be provided, and schedules must be followed. As a result, it may be that nurses are accustomed to carrying on regardless of violent exchanges, whether physical, emotional, or psychological assaults. There is little time to step back and step out from work and actually contemplate the impact of the event. An interesting aspect of this socialization is that nurses who experience occupational burnout are more likely to abuse other nurses (Rowe & Sherlock, 2005), and nurses who regularly experience verbal abuse may be more likely to experience burnout, thus perpetuating the cycle of violence.

Addressing the underreporting of violent incidences is a critical concern that must be corrected as an early step in violence prevention. Available data are incomplete, and the effectiveness of interventions cannot be fully researched without an accurate representation of the baseline characteristics and frequencies of violent events. A first step to collecting data is to develop consistent operational definitions of injuries and defining characteristics of violent event types that can be monitored using institutional and, eventually, national databases.

The Lingering Effects of Violence

Victims of violent behaviors have diverse responses to the events. Victims may internalize their feelings regarding verbal assault events or minimize the event (Antai-Otong, 2001) with initial reactions including anger, humiliation, shock, or surprise (Buback, 2004). Acute stress reactions are likely to follow traumatic encounters involving actual or threatened death, physical harm, or other threats to the physicality of self or others (Antai-Otong, 2001). Victims of lateral violence, particularly newly licensed nurses, often react to the violence by seeking other employment, particularly within the first 6 months (Griffin, 2004).

Findings from a content analysis of data acquired via focus groups comprised of nurses and BHAs revealed that participants had varied emotional responses to assault behaviors perpetrated by patients toward staff (Zuzelo et al., 2012). Nurses and BHAs who were victims of WPV on behavioral health units described themselves as worrying about preventing further episodes so that they could avoid repeat victimization (Zuzelo et al., 2012). Staff was conscious of personal responses to violence and appreciated that an angry nurse response to violence could have

a ripple effect during interactions with other patients. Participants occasionally resented the perpetrators. They worried about the safety of the care environment. Each occasion of WPV reminded staff members of their vulnerability to serious injury, which evoked feelings of fright. The nurses and BHAs felt violated by violent patients (Zuzelo et al., 2012).

Needham, Abderhalden, Halfens, Fischer, and Dassen (2005) explored the nonsomatic effects of patient aggression on nurses by conducting a literature review spanning publications printed from 1983 to 2003. Edward et al. (2014) reviewed similar literature extending through 2013. Findings from both reviews indicated that nurses experienced anxiety or fear post WPV events. A minority experienced posttraumatic stress disorder (PTSD) or some symptoms of it (Needham et al., 2005). There were a variety of cognitive effects including victims feeling disrespected, unappreciated, violated, humiliated, compromised, or robbed of rights. Some shared feelings of guilt and shame, whereas others became more callous toward patients and were doubtful of their personal security and competency (Needham et al., 2005). Published literature also revealed nurses' losing confidence, missing work, and avoiding the workplace in response to WPV (Edward et al., 2014).

A specific form of violence that may trigger nonsomatic effects in nurses is verbal abuse. Rowe and Sherlock (2005) investigated stress and verbal abuse in nursing using survey methodology. Respondents (N = 213) completed an adapted survey that incorporated the Verbal Abuse Scale and the Verbal Abuse Survey. The sample included RNs and LPNs employed at a Philadelphia teaching hospital with Level I trauma designation. The response rate was 69%. Interestingly, the respondents had been verbally abused by a diverse group of people including patients (79%), other nurses (75%), attending physicians (74%), patients' family members (68%), resident doctors (37%), interns (24%), and others (19%). The most frequent source of verbal abuse reported by these nurse respondents was nurses (27%) followed by patients' families, doctors, patients, residents, others, and interns. Staff nurses were the most frequent nursing source of abuse, responsible for 80% of the events, followed by nurse managers at 20%. Although most of the respondents were able to handle the anger, judging, criticizing, and condescension that were most often encountered as the abusing tactic, many did report response patterns of silence, passivity, calling out sick after the encounter, and having negative feelings about the workplace and the job (Rowe & Sherlock, 2005).

Roberts (2015) reviewed the published literature pertaining to lateral violence in nursing that has been produced over the past 30 years. Similar to the findings of Rowe and Sherlock (2005), Roberts found that bullying leads to reduced job satisfaction, enhanced stress, depression, anxiety, and intent to leave the practice setting. The desire to leave the employment setting is frequently attributed to lateral violence or bullying in the workplace.

Advanced nurses recognize that not all violent events are nonphysical. Homicides, although uncommon, do occur. The *Workplace Violence, 1993–2009 Special Report* compiled and published by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2011) reveals that nurses have an 8.1 rate of WPV per 1,000 employed persons. Mental health workers, professional, custodial, and other occupations have markedly higher rates of WPV. If an employee is injured as a result of a workplace injury, including WPV, workers' compensation insurance usually covers the expense (OSHA, n.d.[d]). For those organizations that are self-insured, the financial implications are staggering.

OSHA (n.d.[d]) notes that nurses and other caregivers are driven by injuries and stress to leave the profession. Advanced nurses must keep in mind that it is expensive to replace a nurse: approximately $27,000 to $103,000. When this sum is considered within the context of treatment expenses and lost wages, each and every nurse's WPV-related physical or nonphysical injury is fiscally costly. When nurses make decisions to leave the employment setting as a result of lateral violence or bullying, replacement costs are high. Additionally, advanced nurses may want to consider the expense associated with a nursing department or unit reputation as unsafe, unfriendly, and not collegial. The key takeaway message is that the expense of violence is high, not only in terms of human suffering but also in economic costs.

Strategies for Violence Reduction

A comprehensive view of WPV encourages appreciation of its multifaceted nature and justifies the repeatedly published calls to establish robust and highly utilized reporting mechanisms, national databases, policy changes, institutional programming, and multidisciplinary task forces. Advanced nurses of all types and across all roles are uniquely suited to participate in these activities given their advanced educational preparation, leadership skills, and, likely, willingness to dig in and contribute to the hard work involved in creating, managing, and evaluating WPV systems.

There are resources available to advanced nurses and other health care leaders interested in effecting change in the phenomenon of violent workplaces. Formal study of threat assessment and WPV curtailment did not begin until the late 1980s with more obvious efforts in the 1990s that have persisted and increased. As a result, this field of study is relatively new, particularly as it relates to health care systems, and much of the work related to nursing has been descriptive. Nonetheless, there is some beginning evidence and certainly a good bit of descriptive data that may be used to inform potential intervention studies.

Establishing a Policy of Nonviolence

It is probably wise to begin with suggestions related to policy environment specific to WPV. Policy is not generally emphasized as a vehicle for change within programs of nursing education. Policy shapes what nurses do (Malone, 2005), and although not all nurses can be policy experts, it is important for advanced nurses to understand that policy environment provides the context and boundaries in which nursing is practiced. Malone (2005) offers a working framework for assessing the policy environment. Although published over a decade ago, this framework is useful for evaluating the policy environment specific to WPV and the deficiencies and strengths of such an environment.

Malone (2005) asserted that policy is a process rather than a static point and puts forth four distinctive policy characteristics that advanced nurses should consider:

1. A policy is always general.
2. A policy establishes a norm of behavior. Policies formalize decision making about what course of action is good or better than alternative actions.
3. Policy has scale and is intended to apply to different levels of a social organization.

4. There is always someone who makes policy decisions. The advanced nurse must figure out who this individual is within the health care system as part of assessing the policy environment of the system.

Ten questions drive the policy environment assessment (Malone, 2005). The questions provide a useful organizing framework when assessing the policy environment specific to WPV. Each question should be considered carefully to identify gaps and opportunities and to develop an appropriate plan for WPV reduction that encompasses policy change rather than simply rule approval, a less-substantive change. Policy requires "ongoing implementation activities, monitoring, and evaluation" (Malone, 2005, p. 137). The questions have been addressed based on the information provided in this chapter. Policy framework questions should be applied to the advanced nurse's practice setting. Answers may vary depending on the characteristics and circumstances of the institution under consideration.

What Is the Problem?

The problem of note is the occurrence of violent behaviors in hospitals and other health care settings directed toward all types of care providers, including nurses. Behavior categories include verbal and physical assaults, threats, and occasions of lateral or horizontal violence. To provide a more accurate definition of the *what* of this problem, it is necessary to define violence and to determine how to apply this definition when it is related to patient physical or mental illness. Is violent behavior, when part of a medical condition, a policy problem or a medical management problem? One example is aggressive behaviors manifested by elderly patients with dementia and consisting of hitting, scratching, pinching, or screaming at nurses. These behaviors are violent and undesirable. They may be reflective of inadequate medical management or ineffective nursing interventions. They also put nurses at risk for injury and contribute to an unsafe work environment.

Using the FBI model (Rugala et al., 2003), it may be reasonable to view all violent behaviors as unacceptable and reportable. In the example of the elderly patient with dementia attempting to strike a nurse while verbally abusing staff, the behaviors would be reported, but management of the situation would rely on medical and nursing interventions. This situation is different than a violent threat of harm from directed toward a nurse from an ED visitor who is under the influence of alcohol. Both behaviors would be reportable, although the interventions triggered by each would be markedly different.

The policy problem includes the lack of national reporting mechanisms and the often confusing and unclear definitions and reporting methods used by individual institutions. The lack of robust data collection systems creates deficient benchmarking processes, incomparable intervention studies, and inconsistent trending. One contributing factor to this problem may be hospitals' current emphasis on patient satisfaction and service. Perhaps the current emphasis on servicing patient and family needs contributes to a sense of entitlement that encourages the belief of patients, visitors, and families that they may act in ways that are socially unacceptable but are forgiven in the hospital setting due to the stressful effects of illness, anxiety, and pain. This perspective minimizes the value of staff and negates the importance of civility and respect in all forms of human interaction. It also encourages staff to avoid reporting violent incidences.

An additional problem is that while many health care professionals report experiences as victims of violence, there is scant published literature addressing the various ways that nurses and other providers potentially contribute to hostile interactions. Negative staff interactions characterized by hostile or aggressive responses to patient, family, or visitor encounters do contribute to an escalation of anger and negative inpatient cultures (Duxbury & Whittington, 2005). Violence-enhancing reactions may relate to personal tendencies to address emotionally heightened encounters with aggression (Anderson, 2002a). There may also be a need for nurses to learn and practice communication techniques designed to establish therapeutic rapport with patients in the early phase of a potentially volatile situation (Casella, 2015). Active violence prevention on the part of providers by using verbal and nonverbal communication techniques is an important component of any WPV initiative in health care.

Nurses experiencing burnout may be more vulnerable to aggression (Winstanley & Whittington, 2002), and nurses with unresolved issues of childhood abuses may have an increased susceptibility to violence, particularly during their early years of professional practice (Anderson, 2002a). Advanced nurses need to consider that staff involved in perpetrating violence, including lateral WPV, may be disinclined to identify themselves as abusers and may require opportunities for candid dialogue and introspection following occasions of nonphysical or physical violence.

Where Is the Process?

The process of garnering attention for policy issues related to WPV is not simple given the many competing demands for resources within the health care system. Keep in mind that the generalized administrative ambivalence to violence directed toward nurses and other employees demonstrates that WPV recognition and reduction efforts are not often organizational priorities. WPV is a wicked problem that is not readily solved and any proactive approach runs the risk of creating problems and issues for the institution and its leadership. It is preferable to draw attention to this workplace issue before a dramatically violent event unfolds. Violence should be addressed proactively rather than reactively.

The insidious nature of lateral or horizontal violence and incivility in the workplace has far-reaching implications in terms of human and economic costs. The NHS campaign of the United Kingdom offers ideas for advanced nurses employed in a variety of roles within the U.S. health care system. As mentioned, a major thrust of the NHS Zero Tolerance Zone Campaign is educating the public that violence against NHS staff is unacceptable. The American public may require similar reminders.

Nurses need to be reminded that their safety is important. OSHA requires employers to take steps to ensure a safe and healthful workplace for employees (Capozzoli & McVey, 1996). Consistent with OSHA's stance, the ANA (2015) released its position paper, "Incivility, Bullying, and Workplace Violence." ANA supports zero tolerance for violence. The AACN (2004) has a "Zero Tolerance for Abuse" public policy that recognizes the relationship between abusive work environments and nurse turnover. AACN (2016) also has done significant work on healthy work environments based on its recognition of the indissoluble relationship among work environment, nursing practice, and patient care outcomes.

Advanced nurses must keep in mind that politics do affect policy. Effecting political change requires coalition-building activities and activism. Establishing WPV as

a political priority means that nurse leaders need to galvanize rank-and-file nurses to apply pressure on government officials and the public remembering that there are many worthwhile political issues demanding resources and recognition. It may be a struggle to move the issue of WPV into the forefront of policy making.

How Many Are Affected?

When a problem affects only a few people, it is difficult to get the problem addressed through policies. In the case of WPV, many health care workers are affected. There is a need to mobilize this large number of nurses and other health care providers to give weight to the significance of the problem. WPV is an international concern. The International Council of Nurses (ICN) prioritized violence in 2001 by partnering with the World Health Organization (WHO), the International Labour Organization, and Public Services International to develop an effective worldwide antiviolence campaign (ICN, 2007).

ICN has held several international conferences on "Violence in the Health Sector" and it persists in championing issues related to nurses and violence. ICN (2017) recently issued a statement that addressed a recent arrest of a nurse who was correctly carrying out her duty. ICN made clear in its statement that nurses have a right to work in a "safe environment, free from violence" WHO is also very engaged in addressing the concerns of nurses and other health care providers as they struggle with WPV risks. WHO (2016) led a study of midwives (N = 2,400) from 93 countries that describes poor working conditions, including harassment, lack of security, and fear of violence. WHO (2015) also reported that health care workers responding to the Ebola virus disease (EVD) experience many occupational hazards, including violence. These select examples demonstrate that WPV is a serious, worldwide concern for health care workers, including nurses. Care providers put themselves at risk in the practice environment to provide essential services to those in need. While some risks are not violence related, certainly eliminating WPV as one of the potential hazards of the job is a societal obligation, in addition to an employer responsibility.

What Possible Solutions Could Be Proposed?

Before committing to any single solution, advanced nurses should consider alternatives and the likely advantages of a multipronged approach to the WPV concern. Nurses in advanced roles should reflect on whether possible solutions are politically palatable, practical, or achievable. It is important to select interventions that are acceptable to hospital staff (McPhaul & Lipscomb, 2004). For example, metal detectors in the ED may be the most desirable strategy for eliminating weapons threats but may present insurmountable manpower and budgetary challenges in small hospital facilities. Restricted access to the ED setting by reducing the number of entrances or locking the doors during low- or high-activity periods may be less expensive and actually solve the concurrent problem of too many people in crowded, tense circumstances waiting for access to inpatient areas.

An ED shooting event during which a police officer was slain by a criminal suspect illustrates that both suburban and urban care settings have risk for WPV and offers some real-world considerations for promoting safety in EDs. After the tragedy, medical center staff reevaluated hospital security and made improvements after consulting with law enforcement officials (Roman, 2007). Improvements included

keeping criminal suspects separate from other ED patients, building a public safety room for the use of police officers taking suspects to the ED for testing, modifying entryways into the ED, bolting furniture to the floor in the sparsely furnished public safety room, and improving communication processes within the hospital. These interventions have led to effective improvements evaluated following a subsequent event of ED violence (Roman, 2007).

Advanced nurses may want to work with colleagues and use evidence-based tools for proactive identification of patients at risk for perpetrating violence. Kling et al. (2006) described the use of a violence risk assessment tool in an acute care hospital as a strategy for identifying potentially violent or aggressive patients. Nurse leaders may find it useful to consider options for identifying patients that may have a propensity for violence so that staff can implement strategies designed to deescalate aggression during care encounters.

What Are the Ethical Arguments Involved?

Distribution of resources (justice), privacy, nonmaleficence (do not cause harm), autonomy, veracity, and fidelity are key ethical principles requiring consideration when examining strategies for reducing WPV. It is just to allocate scarce resources to protect nurses and patients from violence, although these security expenditures may be chosen over competing and worthy budgetary demands. Patient and employee privacy must be maintained and protected to ensure that rights are not compromised. Autonomy relates to independent decision making based on honest information. Hospitals may need to consider both publicly acknowledging rates of violence and installing programs designed to curtail or eliminate assaults or threats in any form. Fidelity refers to promises and keeping vows. Certainly health care facilities are morally obliged to provide a safe environment for workers and patients.

At What Level Is the Problem Most Effectively Addressed?

WPV must be addressed on a variety of levels including policy making at federal and state levels. All states should have legislation that recognizes health care worker assault as a felony. Violence must be recognized as unacceptable, and the public needs to be informed that health care facilities are not required to tolerate violent behaviors. Consumer education should clearly notify patients, families, and visitors that violent behavior of any type will be reported and addressed, including law enforcement notification when assault or threats of assault are forthcoming during interactions with employees.

Health care agencies need to prioritize worker safety. To effectively address safety needs, hospitals and other facility types must establish safety systems with performance tracking that informs and measures employee safety improvement programs. The Joint Commission (2016) advises that many of the same standards and principles that have improved patient safety are applicable to worker safety. OSHA and TJC have partnered to provide information, guidance, and training resources related to employee health and safety. These materials may be accessed at www.jcrinc.com/about-jcr/osha-alliance-resources (TJC, 2016). One resource, "OSHA and Worker Safety: Assault Halt," provides access information to a compendium of OSHA resources available via the portal Worker Safety in Hospitals (TJC, 2016). The

intent of the OSHA and TJC alliance is to provide health care systems with the tools needed to implement comprehensive WPV programs.

Hospitals need to establish policies regarding lateral and vertical violence as well as policies and procedures concerning safety improvements in patient transport and security systems. Health care facilities should also consider broader programs that include institutional threat assessment (Turner & Gelles, 2003), signage, and flexible staffing levels to avoid nurses practicing in isolation without rapid access to emergency support. Antiviolence exercises, including active shooter drills, should be considered to support workplace readiness and response training. Hospitals are vulnerable to this type of violence, and risk naiveté should be corrected.

At the unit level, educational programs and staff training exercises may increase awareness of WPV and provide staff with the skills necessary to avoid escalating patient and family aggression, particularly since there is considerable evidence that some nurses may poorly handle aggressive encounters with patients (Duxbury & Whittington, 2005; Edward, et al., 2014; McGill, 2006), visitors, and colleagues, and also contribute to episodes of horizontal WPV (Longo & Sherman, 2007). Recognizing that health care providers and workers can find themselves in verbal power struggles with patients that are not productive, frustrating, and potentially risky, one agency encourages employees to recognize this type of situation when it occurs and "tap in" by telling the involved worker that he or she has a phone call that requires immediate attention or some sort of similar intervention (Relias, 2016). This "tap in" intervention assists the first employee with gracefully exiting and allows for a change in the communication dynamic with the patient. This example illustrates the importance of employee training, including those practicing at the sharp point of care.

Who Is in a Position to Make Policy Decisions?

Within health care systems, it can be challenging to determine where the "buck stops" in terms of policy making. Identifying a persuasive and powerful administrative champion is critical for success. A zero tolerance for violence policy as a method of risk management is appealing for a number of reasons including institutional protection from lawsuits and negative publicity. Advanced nurses should evaluate the health care facility's executive level to ascertain who might be in a position to either implement policy decisions or influence key individuals who are directly able to determine policy.

Health care system administrators are compelled by TJC to address concerns related to safety and security risks, including how agencies will coordinate security activities with community agencies. Preparing for the possibility of an active shooter falls within the domain of this emergency operations standard (OSHA, n.d.[a]). Advanced nurses should consider opportunities to parlay their understanding of accreditation standards and regulatory requirements into a strong and reasonable case for consideration by administrators with policymaking responsibilities.

What Are the Obstacles to Policy Intervention?

Nurses are good problem solvers but often address issues indirectly rather than directly. Nurses' reluctance to report violent or threatening behaviors elicited from patients, families, colleagues, and other employees is an obstacle to developing and implementing effective nonviolence policies. Nurses may also be reluctant to confront

perpetrators who may be dissatisfied with the suggestion that their behaviors need to be curtailed or modified. Advanced nurses need to have opportunities to build their anti-WPV skillset and since this topic is often not given required attention in graduate programs of studies or in workplace educational programs, nurses in advanced roles may feel unprepared to respond to policy inadequacies. Given that the number of doctoral prepared nurses is increasing, particularly those with doctor of nursing practice (DNP) degrees, it is likely that advanced nurses will increasingly find the peer support and expertise needed to effectively address WPV policy deficiencies.

What Resources Are Available?

Advanced nurses need to consider informational, advocacy, and economic resources (Malone, 2005). Nurses are positively viewed by the public with 84% of respondents to Gallup's annual survey of professions' ethical standards and honesty placing nurses in the top position (Gallup News, 2017). Nurses have high social capital but may need to more effectively use this social capital to the profession's advantage. Similar to the work of the NHS, public campaigns by the media and public service messages may be useful in directing attention to WPV in health care settings. Nursing organizations at the international, national, regional, and local levels may be useful allies.

Scholarly resources describing horizontal WPV including bullying and incivility are increasingly available through refereed publications. Developing a valid instrument for measuring workplace bullying would provide a potential mechanism for better understanding the WPV experience (Hutchinson et al., 2008). Quantifying the bullying phenomenon may provide advanced nurses with the means to measure the effect of programs designed to reduce workplace bullying in nursing.

Griffin and Clark (2014) offer cognitive rehearsal as an intervention against incivility and horizontal violence. This is an evidence-based strategy that was utilized in 2004 with graduate nurses as an intervention to respond to lateral violence experienced in nursing. A review of the published literature between 2004 and 2010 reveals that cognitive rehearsal offers value as a tool that enables nurses to shield themselves from oppressive and hostile behaviors. Griffin and Clark (2014) identified key points from the literature review, including building working definitions for incivility, bullying, and workplace mobbing; evidence that supports the use of cognitive rehearsal; and a common language to respond to incivility that empowers nurses to influence uncivil encounters by redirecting the focus on the priority concern of safe and high-quality patient care delivery.

More research is needed to establish evidence-based interventions for reducing WPV in high-risk areas, including the ED. Gillespie, Gates, Kowalenko, Bresler, and Succop (2014) designed a quasi-experimental, repeated measures design that collected survey data from ED employees pre and post a packaged intervention developed with multidisciplinary input specific to WPV that included an educational intervention, environmental changes, and policies and procedures. Effectiveness of the planned intervention was not demonstrated although there was a significant decrease in the number of violent events at two of the intervention sites. Likely more important than the results of this single study is the effort that was applied to addressing ED WPV via a well-designed research study that incorporated many voices. Advanced nurses should consider supporting these sorts of efforts and engaging when possible.

There are several commercial, contracted WPV training programs available for health care workers. Arbury, Zankowksi, Lipscomb, and Hodgson (2017) analyzed the program elements of 12 available programs. Each program differed in its approach and content. Arbury et al. (2017) noted that the most important content gap was inattentiveness to the unique needs of each facility related to risk assessment and policies. As mentioned, it is imperative for advanced nurses to address the potential risks associated with violence of all sorts, including homicidal violence perpetrated using guns and other weapons. The gap in facility-specific risk assessment and policies for risk deterrence, risk management, or responses to active shooters or hostage events is concerning. Arbury et al. (2017) provide an extensive list of criteria used to review the available training programs. Nurses in advanced roles may want to use these published criteria when considering programs that might be useful for unit, department, or systemwide WPV training.

NIOSH offers a web-based training program for nurses. The Occupational Violence program, entitled "Workplace Violence Prevention for Nurses," is a free, interactive course to help health care workers understand WPV (NIOSH, 2017; https://www.cdc.gov/niosh/topics/violence/training_nurses.html). Continuing education units are available upon course completion. Course objectives include (1) to identify institutional, environmental, and policy risk factors for WPV; (2) to recognize behavioral warning signs of violence in individuals; (3) to employ communication and teamwork skills to prevent and manage violence; (4) to identify appropriate resources to support injured health care workers; and (5) to take steps to implement a comprehensive WPV prevention program. The course has no prerequisites and there are 13 modules that take about 15 minutes each to finish.

How Can Advanced Nurses Get Involved?

Nurses in advanced roles should consider learning advocacy skills and developing an understanding of the political process. Becoming well informed is essential. Advanced nurses need to join lobbying efforts and initiate grassroots efforts to bring WPV topics to the forefront of public health discussion. Advanced nurses and those with whom they practice must commit to nonviolence in the workplace and model this behavior for their professional counterparts.

Whether addressing horizontal violence with newly licensed graduates or verbal assaults from colleagues, affecting changes in violence reporting policies and procedures related to patients and families, or forming and participating in multidisciplinary security task forces, nurses have the potential to positively influence the frequency and type of violent behaviors manifested in the work environment. Other strategies for eliminating health care violence include addressing personnel problems and establishing violence response teams.

Address Personnel Problems

Capozzoli and McVey (1996) offer suggestions for managing personnel problems with a focus on preventing WPV. Falcone (2017) suggests strategies for providing progressive disciplinary actions that may reduce the risk of a violent response. These recommendations may be viewed as preemployment, employment, and postemployment strategies. Advanced nurses may find themselves involved both peripherally and directly in personnel events, depending on the type of employee and associated job responsibilities.

Preemployment Strategies. Background checks of job applicants should be conducted to the full extent allowed by the law. It is important to ascertain the credibility of the applicant's work history, degrees, military record, and licensing. Negligent hiring suits are becoming more common, and employers are losing because they have performed inadequate background checks (Capozzoli & McVey, 1996). It may be reasonable to include personality testing and drug screening with preemployment testing, but institutions must bear in mind that personality tests must be administered by skilled professionals, and the Americans with Disabilities Act protects people with recognized disabilities. In addition, the preemployment interview is an important screening activity. There are times when advanced nurses lead or contribute to applicant interviews. Expertise in conducting interviews is an important advanced skill.

During Employment Strategies. Employee performance problems must be addressed in a timely fashion using accurate documentation. The institution's disciplinary process should be used, and employees should be afforded the protection and dignity of due process, as outlined in employee handbooks. Advanced nurses with managerial responsibilities should be trained in conflict resolution. If there is serious concern of violence from the employee in response to the disciplinary process, it is advisable to make certain that undercover security is available in close proximity. If such services are not available at the agency, the advanced nurse should discuss for-hire security services to ensure workplace safety (Falcone, 2017).

Postemployment Strategies. When the progressive disciplinary process ends and the employee is terminated, Capozzoli and McVey (1996) warn that terminated employees cannot be expected to act rationally. All termination paperwork should be ready at the time of the final interview. Immediately following this meeting, the employee should gather personal effects and collect the last paycheck. It is important to collect keys, identification badges, and any other items to avoid creating a need for the employee to return to the work setting. Security services should be readily available. Falcone (2017) shares that most WPV events occur on Mondays after a terminated employee has had the weekend to contemplate and stew over perceived wrongs. For this reason, Falcone (2017) recommends that disciplinary events take place early in the work-week so that the terminated employee has access to work services for questions and information. This consideration is also the rationale for scheduling progressive discipline and termination events early in the workday rather than at the end of a shift (Falcone, 2017).

Violence Response Teams

From a broader perspective, health care facilities should *anticipate* occasions of violence. There should be a crisis management plan for violent events, and security procedures should be developed and disseminated. It is helpful to hold security drills to ensure that employees know where panic buttons, alarms, and security phones are located and to make certain that employees recognize red flag behaviors and respond appropriately. The U.S. Department of Homeland Security (DHS, 2017) provides resources to assist workplaces in preparing and responding to an active shooter incident (**FIGURE 5-1**).

Homeland Security **Active Shooter Preparedness Program**

Active shooter incidents, in many cases, have no pattern or method to the selection of victims, which results in an unpredictable and evolving situation. In the midst of the chaos, anyone can play an integral role in mitigating the impacts of an active shooter incident. The Department of Homeland Security (DHS) provides a variety of no-cost resources to the public and private sector to enhance preparedness and response to an active shooter incident. The goal of the Department is to ensure awareness of actions that can be taken before, during, and after an incident.

Active Shooter Preparedness Program
DHS maintains a comprehensive set of resources and in-person and online trainings that focus on behavioral indicators, potential attack methods, how to develop emergency action plans, and the actions that may be taken during an incident.

Active Shooter Online Training
This one-hour online course (IS-907 Active Shooter: What You Can Do) provides an introductory lesson on the actions that may be taken when confronted by an active shooter, as well as indicators of workplace violence and how to manage the consequences of an incident. To access this course, please visit the Federal Emergency Management Agency (FEMA) Emergency Management Institute online training website at http://www.training.fema.gov/is/crslist.aspx and type Active Shooter in the search bar.

Active Shooter Preparedness Workshop Series
These scenario-based workshops feature facilitated discussions to inform participants on the best practices associated with preparing for and responding to an active shooter incident. Through a dynamic exchange of information, these workshops provide participants an understanding of how to plan and aid in the development of an initial draft of an emergency action plan for their organizations. For more information on these workshops, please contact the Active Shooter Preparedness Program at ASworkshop@hq.dhs.gov.

Active Shooter Online Resources
There are additional resources available online to inform individuals on how to prepare for active shooter incidents. These resources range from booklets and pocket guides, to a 90-minute webinar that explains the importance of developing an emergency action plan and the need to train employees on how to respond to an incident. To access these resources, please visit http://www.dhs.gov/activeshooter.

Contact Information
For general information regarding the Active Shooter Preparedness Program, please email ASworkshop@hq.dhs.gov.

FIGURE 5-1 DHS (2016). Active Shooter Preparedness Program

DHS (2017). Active Shooter Preparedness Program. Retrieved from https://www.dhs.gov/sites/default/files/publications/dhs-active-shooter-preparedness-program-fact-sheet-01-16-508.pdf

Advanced nurses need to think about the "what-ifs" surrounding potential WPV events. Hostage taking, gun violence, assault, and homicide are only a few of the more dramatic occasions of WPV. Consider whether staff on all shifts would know how to manage particularly dangerous episodes of violence (e.g., a gun-wielding family member, an employee's domestic violence dispute that presents as an enraged and violent significant other arriving at the workplace, a knife-carrying patient who holds a staff member hostage). These events may seem unlikely; however, current events suggest otherwise and advanced nurses need to prepare for the possibility of such events, no matter how seemingly unlikely.

Critical incident stress debriefing should be considered a key component of WPV recovery efforts. The goal of critical incident stress debriefing is to promote a sense of psychological closure with regard to the concerning event. It is structured to assist the employee in making sense of the violence. Part of the challenge of working with nurses who have experienced violence at work is their tendency to dismiss the event as a normal occurrence in health care.

Debriefing in some form should routinely occur within 24–72 hours after violent events in a safe, blame-free environment (Clements et al., 2005). Debriefing activities should be voluntary. Nurses should contemplate developing debriefing programs to assist nursing staff with the psychological, emotional, and physical responses to WPV. Event debriefing assists staff with addressing their feelings and responses post violence (Zuzelo et al., 2012). Some nurses might also benefit from employee assistance programs. Advanced nurses should encourage staff to take full advantage of these programs and should refer employees to the employee assistance staff as needed. Programs need to be evaluated to determine effectiveness and modified accordingly.

Conclusion

Advanced nurses have a critical role to play in ensuring that health care environments are healthy for both patients and employees. An environment is healthy when verbal and physical abuse of any kind is not tolerated, regardless of the social stature of the offender or the nature of the relationship in question. Incidences of WPV are increasingly frequent. The more typical violent behaviors may be limited to social bullying or terroristic email threats; however, these types of assaults have a significant cost in terms of nurse turnover rates and medical errors.

Hospitals and other types of health care agencies are historically open systems. Visitors enter at will with cursory security checks. Rarely is identification required, particularly during daylight hours. Opportunities for extreme violence, including hostage taking, physical assault, or homicide, are significant. Although national terrorism events have evoked significant changes in some aspects of society, most health care organizations have not yet attended to these issues in substantive or consistent ways.

Advanced nurses are in an ideal position to initiate WPV-focused discussions and development sessions. They should participate in interprofessional activities aimed at reducing the potential for violence and responding to occasions of actual violence with effective action that minimizes the likelihood of harm. Advanced nurses have expertise in varied areas with potentially wide nets for capturing the attention of a broad swath of key policy makers. Having a clear understanding of

the magnitude of WPV concerns in health care and developing familiarity with the available resources already accessible for employee education provides an excellent starting point. Advanced nurses are charged with nurturing a workplace culture that has no tolerance for violence while also recognizing that agencies have realistic risks of violence and there must be operational response plans that are familiar to staff should violence occur.

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