# 6 Health Care Workplace Violence Prevention

## *Strategies for Risk Reduction and Prevention*

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Violence is a serious problem in many countries, and research by the World Health Organization indicates that violence in the health care workplace is actually a global phenomenon. Crossing borders, cultures, work settings, and occupational groups, violence in the health care workplace is at very high level. New research shows that more than half of the health sector personnel surveyed had experienced at least one incident of physical or psychological violence in the year previous to the study.

## INTRODUCTION

Domestically, the impact of workplace violence in the United States became widely exposed on November 6, 2009, when 39-year-old Army psychiatrist Maj. Nidal M. Hasan, MD, a 1997 graduate of Virginia Tech University who received a medical doctorate in psychiatry from the Uniformed Services University of the Health Sciences in Bethesda, Maryland, and served as an intern, resident, and fellow at the Walter Reed Army Medical Center in the District of Columbia, went on a savage 100-round shooting spree and rampage that killed 13 people and injured 32 others. In April 2010, he was transferred to Bell County Jail in Belton, Texas. An Article 32 hearing, which determined whether Hasan would be fit to stand trial at court martial, began on October 12, 2010. Hasan was subsequently deemed fit and was arraigned on July 20, 2011, and his trial is scheduled for March 2012.

## DEFINITION OF HEALTH WORKPLACE VIOLENCE

Is this a direct quote? If so, please check whether it exactly matches the original, as there seem to be some punctuation errors.

Having established the reality of violence as an issue in the health care industry, Barry W. Nixon, MS, of workplaceviolence911.com, defines the meaning of workplace violence as "violent acts including assaults and threats which occur in, or are related to the workplace and entail a substantial risk of physical or emotional harm to individuals, or damage to an organizations resources or capabilities." More specifically, it includes

- Actual violence that causes or is intended to cause injury or harm to a person or property
- Threatening remarks and/or behavior in which intent to harm is stated or implied or indicates a lack of respect for the dignity and worth of an individual
- Verbal abuse
- Mobbing, bullying, or emotional abuse
- Possession of a weapon while working or on company property

## EFFECTS OF WORKPLACE VIOLENCE

The effects of workplace violence are pervasive, and the health care sector continues to lead all other industry sectors in incidents of nonfatal workplace assaults. For example, in 2000, 48% of all nonfatal injuries from violent acts against workers occurred in the health care sector. Nurses, nurses' aides, and orderlies suffer the highest proportion of these injuries. Nonfatal assaults on health care workers include assaults, bruises, lacerations, broken bones, and concussions. These reported incidents include only injuries severe enough to result in lost time from work. Of significance is that the median time away from work as a result of an assault or other violent act is 5 days. Almost 25% of these injuries result in longer than 20 days away from work. Obviously, this is quite costly to the facility as well as to the victim.

A study undertaken in Canada found that 46% of 8780 staff nurses experienced one or more types of violence in the last five shifts worked. Physical assault was defined as being spit on, bitten, hit, or pushed.

Both Canadian and U.S. researchers have described the prevalence of verbal threats and physical assaults in intensive care, emergency departments, and general wards. A study in Florida reported

that 100% of emergency department nurses experience verbal threats and 82% reported being physically assaulted. Similar results were found in a study undertaken in a Canadian hospital. Possible reasons for the high incidence of violence in emergency departments include presence of weapons, frustration with long waits for medical care, dissatisfaction with hospital policies, and the levels of violence in the community served by the emergency department.

Similar findings have been reported in studies of mental health professionals, nursing home, and long-term care employees, as well as providers of service in home and community health.

Violence in hospitals usually results from patients, and occasionally family members, who feel frustrated, vulnerable, and out of control. Transporting patients, long waits for service, inadequate security, poor environmental design, and unrestricted movement of the public are associated with increased risk of assault in hospitals and may be significant factors in social services workplaces as well. Finally, lack of staff training and the absence of violence prevention programming are associated with elevated risk of assault in hospitals.

Although anyone working in a hospital may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk. Other hospital personnel at increased risk of violence include emergency response personnel, hospital safety officers, and all health care providers. Personnel working in large medical practices fall into this category as well. Although no area is totally immune from acts of violence, it most frequently occurs in psychiatric wards, emergency rooms, waiting rooms, and geriatric settings.

Many medical facilities mistakenly focus on systems, operations, infrastructure, and public relations when planning for crisis management and emergency response; they tend to overlook the people. Obviously, no medical facility can operate without employees who are healthy enough to return to work and to be productive. Individuals who have been exposed to a violent incident need to be assured of their safety.

The costs associated with workplace violence crises are not limited to health care dollars, absenteeism rates, legal battles, or increased insurance rates. If mishandled, traumatic events can severely impair trust between patients, employees, their peers, and their managers. Without proper planning, an act of violence can disrupt normal group processes, interfere with the delivery of crucial information, and temporarily impair management effectiveness. It may also lead to other negative outcomes such as low employee morale, increased job stress, increased work turnover, reduced trust in management and coworkers, and a hostile working environment.

Data collected by the U.S. Department of Justice shows workplace violence to be the fastest growing category of murder in the country. Homicide, including domestic homicides, is the leading cause of on-the-job death for women and is the second leading cause for men. The National Institute for Occupational Safety and Health (NIOSH) found that an average of 20 workers are murdered each week in the United States. In addition, an estimated 1 million workers—28,000 per week—are victims of nonfatal workplace assaults each year.

Workplace attacks, threats, or harassment can include the following monetary costs:

- $13.5 billion in medical costs per year
- 500,000 employees missing 1,750,000 days of work per year
- 41% increase in stress levels with the concomitant related costs

## UNDERSTANDING THE RISKS

More assaults occur in the health care and social services industries than in any other. In 2000, Bureau of Labor Statistics (BLS) data show that 48% of all nonfatal injuries from occupational assaults and violent acts occurred in health care and social services. In 1999, 637 nonfatal assaults on hospital workers occurred—a rate of 8.3 assaults per 10,000 workers—and NIOSH confirmed this ratio in April 2002, reporting that U.S. hospital workers suffer nonfatal assaults at more than four times the rate of overall private sector workers, which is 2 per 10,000 workers. Almost two-thirds of

the nonfatal assaults occurred in nursing homes, hospitals, and establishments providing residential care and social services.

Several studies indicate that violence often takes place during times of high activity and interaction with patients, such as at meal times, during visiting hours, and during patient transportation. Assaults may occur when service is denied, when a patient is involuntarily admitted, or when a health care worker attempts to set limits on eating, drinking, or tobacco or alcohol use.

The issue of assaults against health professionals is not new. Between 1980 and 1990, 106 occupational violence-related deaths occurred among the following health care workers: 27 pharmacists, 26 physicians, 18 registered nurses, 17 nurses' aides, and 18 health care workers in other occupational categories. Using the National Traumatic Occupational Fatality database, the study reported that between 1983 and 1989, there were 69 registered nurses killed at work. Homicide was the leading cause of traumatic occupational death among employees in nursing homes and personal care facilities.

Of greater significance than these numbers is the likely underreporting of violence and a persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit (and may actually harm) them, or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

## Hospital Risks

NIOSH summarizes the risk factors for occupational violence to hospital workers. These include

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

Violence occurring in other occupational groups is most often related to robbery. In health care settings, however, acts of violence are most often perpetrated by patients or clients. Family members who feel frustrated, vulnerable, and out of control and colleagues of patients (especially when the patient is a gang member) are also identified as perpetrators of abuse.

However, the presence of coworkers has been identified as a potential deterrent to assault in health care.

Health care and social service workers face an increased risk of work-related assaults stemming from several factors, including the following:

- The prevalence of handguns and other weapons—as high as 25% among patients, their families, and friends. Handguns are increasingly used by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals.

- The increasing number of acute and chronically mentally ill patients now being released from hospitals without follow-up care, who now have the right to refuse medicine and who can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others.
- The availability of drugs or money at hospitals, clinics, and pharmacies, making staff and patients likely robbery targets.
- Situational and circumstantial factors such as
  - Unrestricted movement of the public in clinics and hospitals.
  - The increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members.
  - Long waits in emergency or clinic areas, leading to client frustration over an inability to obtain needed services promptly.
- Low staffing levels during times of specific increased activity such as meal times and visiting times, and when staff is transporting patients. This also includes isolated work with clients during examinations or treatment.
- Solo work, often in remote locations, particularly in high-crime settings, with no backup or means of obtaining assistance, such as communication devices or alarm systems.
- Lack of training of staff in recognizing and managing escalating hostile and assaultive behavior.
- Poorly lit parking areas.

The guidelines established by the Occupational Safety and Health Administration (OSHA) seek to set forth procedures leading to the elimination or reduction of worker exposure to conditions causing death or injury from violence by implementing effective security devices and administrative work practices, among other control measures. Health care professionals need to be aware that violence can occur anywhere and in any practice settings.

In hospitals and clinics, which are more likely to report incidents of violence than private offices, the most frequent sites are

- Psychiatric wards
- Acute care settings
- Critical care units
- Community health agencies
- Homes for special care
- Emergency rooms
- Waiting rooms and geriatric units

The impact of workplace violence is far-reaching and affects individual staff members, coworkers, patients/clients, and their families. Those who have been affected, directly or indirectly, by a workplace violence incident report a broad spectrum of responses—anger is the most common. There are also reports of

- Difficulty returning to work
- Decreased job performance
- Changes in relationships with coworkers
- Sleep pattern disturbance
- Helplessness and symptoms of posttraumatic stress disorders
- Fear of other patients
- Fear of returning to the scene of the assault

### Contributing Risk Factors

A number of factors may contribute to the risk of violence or potentially violent situations in the workplace, including but not limited to the following:

- *Characteristics of patients or clients:* History of aggressive or violent behavior; clinical conditions such as dementia, head trauma, hypoglycemia, or emotional disorders; or substance abuse.
- *Environmental factors:* Inflexible institutional rules and policies, restrictions on activities, noise or lighting levels, busy or high-activity times, invasion of personal space, layout of or overcrowding in units or areas housing patients/clients (e.g., emergency department settings).
- *Staff characteristics:* Staff dynamics (i.e., conflict among staff members); staff attitudes, such as anxiety or ambivalence toward the prevention or management of aggression; and staff behavior (e.g., tone of voice, body language, or overt aggression).
- *Organizational policies and educational programs:* A lack of policies or programs aimed at preventing and reducing the incidence and impact of workplace violence can in fact lead to increased risks.

"Environmental" factors meant?

## HADDON MATRIX FOR INJURY PREVENTION

An invaluable tool for prevention program establishment is the Haddon Matrix. In 1968, William Haddon, Jr., a public health physician with the New York State Health Department, developed a matrix of categories to assist researchers trying to address injury prevention systematically. The idea was to look at injuries in terms of causal factors and contributing factors rather than just using a descriptive approach. It is only recently that this model has been put to use in the area of workplace violence.

The matrix (see Figure 6.1) is a framework designed to apply the traditional public health domains of host, agent, and disease to primary, secondary, and tertiary injury factors. When applied to workplace violence, the host is the victim of workplace violence, such as a nurse. The agent is a combination of the perpetrator and his or her weapon(s) and the force with which an assault occurs. The environment is divided into two subdomains: the physical and the social. The location of an assault, such as the ER, the street, an examining room, or a hospital ward, is as important as the social setting in patient interaction, presence of coworkers, and supervisor support.

Subsequent versions of the matrix (see Figure 6.2) divide the environment into physical environment and social, socioeconomic, or sociocultural environment. Each factor is then considered a preevent phase, an event phase, and a postevent phase.

Figures 2, 3, and 4 are tables. Should these be renumbered as tables? Also, no titles or captions provided.

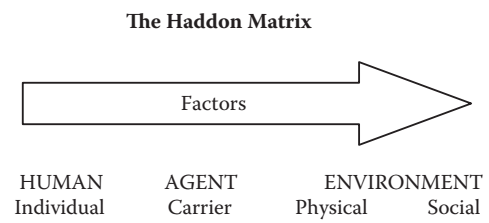


**FIGURE 6.1** Haddon Matrix.

| | |
|---|---|
| Preevent | Are we psychologically prepared for the event |
| Event | What is the level of exposure of the individuals? |
| Postevent | What will the outcome be? |
| Results | Distress responses, behavioral change, psychiatric illness |

**FIGURE 6.2**

| Phases | Host | Agent | Physical Environment | Social Environment |
|---|---|---|---|---|
| Preevent (prior to assault) | Knowledge<br>Self-efficacy<br>Training | History of prior violence communicated | Assess objects that could become weapons, actual weapons, egress (means of escape) | Visit in pairs or with escort |
| Event (assault) | De-escalation<br>Escape techniques<br>Alarms/two-way phones | Reduce lethality of patient via increasing your distance | Egress, alarm, cell phone | Code and security procedures |
| Postevent (postassault) | Medical care/ counseling<br>Post-event debriefing | Referral<br>Law enforcement | Evaluate role of physical environment | All staff debrief and learn<br>Modify plan if appropriate |

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* Home Health Workplace Example

**FIGURE 6.3**

The Haddon Matrix lends itself to a medical setting in that it uses a classical epidemiological framework to categorize preevent, event, and postevent activities according to the infectious disease vernacular, host (victim), vector (assailant or weapon), and environment. The strength of the Haddon Matrix is that it includes the ability to assess preevents or precursors in order to develop primary preventive measures.

Figure 3 (6.3) meant? Previous figure is 2

Figure 4 shows how the Haddon Matrix categorizes the influence of

- Human or host behavior
- Agent or vehicle of situation
- Physical and sociocultural environment
- Preevent, event, and postevent
- Gaps and opportunities for improvement

From the perspective of administration, the Haddon Matrix does not implicate policy. This means that the matrix does not necessarily guide policy. When implemented, the Haddon Matrix can be a "politically" neutral, trans- or multidisciplinary, objective tool that identifies opportunities for intervention. Furthermore, it outlines sensible targets of change for the physical and social environments.

| Phase | Affected Individual and Population | Agent Used | Environment |
|---|---|---|---|
| Preevent | Psychological first aid | Communicate efforts to limit action | Have plans in place detailing agency roles in prevention and detection |
| Event | Population uses skills | Mobilize trauma workers | Communicate that response systems are in place |
| Postevent | Assessment, triage, and psychological treatment | Communicate, establish outreach centers | Adjust risk communication |
| End results | Limit distress responses, negative behavior changes, and psychological illness | Minimize loss of life and impact of attack | Minimize disruption in daily routines |

**FIGURE 6.4**

Please verify that Figure 4 is not called out in the text, and that the Figure3 callout above was misnumbered as Figure 4.

## ESTABLISHING A VIOLENCE PREVENTION COMMITTEE FOR GUIDELINES

According to Nixon, management must demonstrate a commitment by taking workplace violence seriously and appointing an influential manager to be responsible for the workplace violence prevention effort. This manager should establish a workplace violence prevention committee (also referred to as a threat management committee). Participants on the committee should include representatives from security, human resources, occupational health and safety, legal, finance, risk management, public relations, doctors, nurses, and union, if applicable. Smaller-sized firms that do not have these specific dedicated resources should designate an operations person to put together an appropriate team to address the issue using available resources.

### Eliminate at-Risk Behaviors

The committee should focus on creating a violence-free work environment by eliminating at-risk behaviors on both an individual and organization level. One of the key responsibilities of the committee should also be to establish a workplace violence zero-incident policy (see model policies at (www.workplaceviolence911.com/ModelPolicies). Note that a zero-incident focus is a proactive approach that targets prevention and goes beyond zero tolerance that generally focuses more on reacting. An example of addressing an at-risk behavior in a medical center could be to have a procedure for flagging the charts of high-risk patients to give early alert to staff or remind them to check for weapons and to keep security on standby.

### Establish a Prevention Policy

A cornerstone of your program is to establish a clear workplace violence prevention policy that will set the framework and provide guidance to managers, doctors, nurses, and employees. The focus should be on violence prevention, with the ultimate goal being zero incidents. In addition, the policy should make the concept of treating people in a respectful manner and maintaining their dignity a central theme that is integrated into the policy and its communication (see www.workplaceviolence911.com for information on the ultimate workplace violence prevention policy).

Should this read, "No Weapons in the Workplace" or "No-Weapons" Policy?

### No Weapons in the Policy

Incorporate a "no weapons in the workplace" provision into your workplace violence prevention policy or establish a separate policy that clearly establishes that no weapons are allowed on the

premises and that employees are prohibited from possessing a weapon while on duty. Medical centers and hospital emergency rooms should also conspicuously post signs clearly stating that all weapons are prohibited on the premises for the public and patients to see.

### Define Entities at Risk

The workplace violence prevention committee should also research the nature of risk to the health care company associated with the health care industry. Ask questions like

- How does violence from the surrounding community have the potential to affect your workplace?
- What services that you offer have a history of being exposed to violence in the industry (e.g., trauma or acute psychiatric care)? If so, what kind of incidents, type of facilities, geographic characteristics, and so forth?
- How frequently are assaultive incidents, threats, and verbal abuse occurring, and where? Who is involved?

Where there are known hazards that exist within this type of business, industry, or geographic area, specific actions should be taken to mitigate and address the problems. This is essential because these are the signs that indicate the greatest potential for violence to occur and commensurately represent the highest potential liability.

### Facility Assessments

Conduct periodic facility risk assessments to identify unsafe areas, hazards, or vulnerabilities that exist in your physical facilities that could contribute to significant risk. For example, are there access doors that have broken locks? Are effective access controls processes in place and enforced? Are there dimly lit stairwells or an external entrance door that is regularly propped open?

Edit OK? Unsure where this part of the sentence fits in (the other parts describe unsafe conditions).

### Organizational Assessments

Conduct periodic organizational violence assessments to identify management practices, employee behaviors, and perceptions that are not conducive to creating a violence-free workplace (e.g., terminating employees via e-mail, harassment of employees, and incongruent policies). The assessment should closely review safety records for a history of violent incidents and close calls. This data can help you determine trends, conditions, circumstances, and underlying causes of violence as well as identify cultural norms and behaviors. One such behavior is bullying, which often is endemic in a given firm, and this can substantially contribute to undue stress or conflict in the organization. This is of particular importance since studies are starting to show that bullying often precedes actual violence erupting. Therefore, it should be considered as a potential warning sign. Collect utilization data from the employee assistance program and analyze the results. This type of data can be key in identifying at-risk factors on the organization level. Also conduct a "dignity and respect" audit of all human resource, security, safety, and operational policies to ensure they are designed to treat employees in a sensitive and respectful manner.

Edit OK or "date" as meant (or something else)?

The above point is particularly true for designing termination, layoff, and discipline procedures that are sensitive to ensuring fair, respectful, and dignified treatment of employees. According to *The Disposable Worker: Living in a Job-Loss Economy* (published by the Center for Workforce Development at Rutgers University), the vast majority of employers are ignoring this advice. The study states that workers laid off from their jobs during the past 3 years received no advance notice, no severance pay, and no career counseling from their employers. This flies in the face of strong evidence that employers who are arrogant, abrupt, rude, stingy, or just plain gutless in their practices

are courting aggression and violence. Dick Ault, PhD, a former FBI agent specializing in profiling, put it well by stating that special precautions should be taken when at-risk behaviors are present. His view that "you have to approach the firing of anyone with the utmost of dignity, even people who really don't deserve it," are words that employers should heed.

Full spelling needed?

### Individual Threat Assessment

Identify external experts experienced and thoroughly trained in how to professionally assess the violent nature of an individual and the likelihood of an employee becoming violent. It is important to have a resource on contract prior to the need for their services.

### Enhance Physical Security

Enhance physical security measures and establish workplace violence audit team(s) to conduct ongoing assessments and effectiveness of security efforts. Some common security-sensitive areas are the following:

- Emergency department
- Pharmacy and medical records department
- Mother/infant care
- Cashiers and general outpatient clinics
- Specialized outpatient clinics (substance abuse, abortion, etc.)
- Animal research and mental health units

In addition, to harden targeted areas or improve control, use security prevention through environmental design engineering/architectural controls processes when building or retrofitting facilities to maximize crime prevention. For example, set up emergency rooms so that there are barriers (e.g., doors requiring key card access) to the public accessing areas where patients are being kept. Have intake personnel protected by bullet-resistant plastic barriers or an overly wide counter that cannot be easily reached over.

Provide nursing personnel with handheld alarms or noise devices and/or communication devices to be able to get help (e.g., cellular phones, pagers, whistles, or mobile alarms) to use while on duty, and establish processes for pinpointing their whereabouts using Global Positioning System technologies.

### Synchronize Personnel, Security, and Safety Policies

Synchronize your personnel, security, and safety policies to ensure they create an integrated workplace violence prevention effort.

### Develop Crisis Response Procedures

Establish a crisis response team (specially trained to deal with crisis) and develop crisis response procedures to deal with an incident. Select members based on preestablished criteria, which should include their ability to remain calm during a crisis or pressure situations, special skills related to handling crisis or emergencies, as well as technical competency related to health care, knowledge of facilities, public relations, security, and so forth. The team should put a crisis communication and public relations plan in place before a crisis occurs. Additionally, preestablish a critical incident debriefing process and skilled counselors to be able to assist victims after an incident.

Keep in mind that the speed at which you are able to address the needs of employees who have experienced a traumatic event will dictate how fast you are able to return work levels to normal

operations. Within the following few days of an incident, reactions such as fear, anxiety, exhaustion, as well as anger may surface. In the long run, lack of confidence, depression, and the development of posttraumatic stress disorder are possible outcomes.

### Emergency Police Protocol

Edit OK to clarify that the "contacts" are from the police department.

Create an emergency protocol with the police. This should include identifying the contact person at the police department when an incident needs to be reported. It is also important to identify a backup contact and make sure that contact knows who from your firm is responsible for getting in touch with them. You should also have the police visit your site and learn your facility layout. In addition, you should make your address and building numbers clearly visible. Where there are multiple buildings, make address numbers clearly visible on the front and top of each building.

### Enhance Hiring Procedures

Enhance hiring procedures to include health care organization employment-screening processes focused on screening out violence-prone applicants before they are hired. Use critical behavior traits to identify behavior-based interview questions. Screening tools can include

- Reference checking regarding previous employers
- Background checks (e.g., for a criminal background)
- Verification of identity
- Driving record and credit history
- Drug testing and psychological assessments
- Critical behavior traits

### Promote an Employee Assistance Program

Actively and regularly promote your employee assistance program and train supervisors on how to make an effective referral. If you are in a smaller organization that does not have an employee assistance program, establish a list of local service providers in your community that employees can be referred to.

### Train Managers, Supervisors, Doctors, Nurses, and Employees

Provide ongoing training for managers, supervisors, doctors, nurses, and employees. Training should be provided in the following areas:

- Implementation of workplace violence prevention policy
- How to identify early warning signs in patients, the public, and employees, and how to appropriately intervene
- Importance of reporting, taking threats seriously, and responding
- How to deescalate potentially hostile situations, including treating patients, the public, and employees in a respectful manner
- Effective ways to deal with domestic violence situations in the workplace
- If deemed appropriate for your setting, training in how to safely restrain patients

### Involve Employees in Prevention Efforts

Make sure all employees know that workplace violence prevention is everybody's business and help them understand the important role they can play in reducing violence. A truly effective prevention effort must maximize the participation of employees and their support. By encouraging the

following practices, employers can enlist employee support, and they will contribute substantially to a successful effort to prevent violence at work:

- Reporting of threats, suspicious activities, or actions of violence regardless of whether you personally believe the threat is serious.
- Avoiding horseplay, practical jokes, harassment, or other risky behaviors that could lead to injury, creating animosity or shame or invoking angry reactions.
- Treating all employees, customers, and contractors with dignity and respect. *How* something is said is just as important as *what* is said.
- When feeling overly stressed, seek help from an employee assistance program or other support services designed to act relief valves for frustrations or problems (e.g., church, family, or friends).
- Actively follow the firm's policy regarding workplace violence and the procedures for dealing with workplace threats and crisis.

Edit OK?

Additional interventions that employers can use to focus on preventing workplace violence include

- Publish a list of whom to call and resources available to assist with issues
- Use of external resources as appropriate for the following:
  - Individual threat assessments
  - Legal
  - Facility risk assessment
  - Security protection firm
  - Employee assistance program support
  - Organizational threat assessment

## ASSESSMENT

Physicians, advisors, nurse-executives, administrators, and many managers view workplace violence as the sole responsibility of a deranged, psychopathic, or troubled employee, while the truth is closer to the reality that an outbreak of violence in an organization is often the result of chronic unresolved conflict that should have been noticed and properly managed. Despite our best attempts to place the blame on the individual's behavior, the organization is not blameless. Violence is the tragic aberration of an organization's culture—the culmination of personal frustration that has built to a crescendo because of perceived injustice, humiliation, loss of dignity, shaming, and loss of value and control that ultimately explode into a desperate act.

Acts of health care organization workplace violence can be reduced, and the many human and financial costs that result can be avoided with forethought and strategic and progressive action. Attending to workplace conflict is not simply "soft-hearted" or humanitarian—it is prudent business and risk reduction planning.

Yesterday, organizations that ignored the quality challenge did not survive—recall American automobile manufacturers who faced the "quality invasion" of Japanese imports in the 1970s. Most companies responded well, hence Ford's slogan "Quality is Job 1." Today, product and service quality management initiatives such as total quality management, continuous improvement, and customer satisfaction programs are unquestioned requirements for business success.

Please verify if this is the intended meaning.

For tomorrow, the competitive and leadership advantage of the 21st century for the industry may be strategic conflict management, and it may be the separating factor in determining who survives in the global competitive marketplace.

## CONCLUSION

Violence in the hospital or medical workplace is an emerging safety and health issue. Its most extreme form, homicide, is the fourth-leading cause of fatal occupational injury in the United States, according to the BLS Census of Fatal Occupational Injuries.

## OSHA PUBLICATIONS

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## ACKNOWLEDGMENTS

Thanks are due to Barry W. Nixon, MS, of www.workplaceviolence911.com, for technical assistance in the preparation of this chapter.

### CASE MODEL

### BOULDER-CREST MEDICAL CENTER (BCMC)

NEWS FLASH! The news report comes in: Two employees at the Boulder-Crest Medical Center have been killed in the workplace, and two have been wounded. A witness has called 911, and the police as well as other emergency personnel are at the scene. The perpetrator (a former employee of the medical center) has been taken into custody, the victims are being treated, and the police are interviewing witnesses and gathering evidence.

In this situation, the medical center's crisis response plan called for the immediate involvement of an official from the public information office (PIO) in addition to the following BCMC employees:

1. A top management representative
2. A security officer
3. A human resources (HR) specialist
4. An employee assistance program (EAP) counselor

*Top management representative:* The deputy hospital administrator coordinated the response effort because she was the senior person on duty at the time. In addition to acting as coordinator, she remained available to police throughout the afternoon to make sure there were no impediments to the investigation.

She immediately called the families of the wounded and assigned two other senior managers to notify the families of the deceased. She also arranged for a friend of each of the deceased coworkers to accompany each of the managers. She took care of numerous administrative details, such as authorizing expenditures for additional resources, signing forms, and making decisions about such matters as granting leave to coworkers. It was necessary for the medical center to remain in operation, and it was impossible to allow all of the employees to go home for the rest of the day.

To ensure a coordinated response effort, she made sure that medical center personnel directly involved in the crisis had cell phones for internal communication while conducting their duties in various offices around the building.

*Security staff:* The security staff assisted the police with numerous activities including locating witnesses and preserving the crime scene.

*HR representative:* The HR specialist contacted the medical center's corporate office and alerted them to the situation so that they could immediately begin to monitor any criminal and other legal proceedings. He made a detailed written record of the incident but did not take statements from witnesses, because to do so might have impeded the criminal investigation and possible subsequent prosecution of the case. He also helped the HR supervisor with internal documentation related to the incident.

*Employee assistance program (EAP) counselor:* The medical center had only one EAP counselor available at the time of the incident. However, in prior planning for an emergency, the medical center had contracted with a local EAP provider to provide additional counselors on an as-needed basis. The one EAP counselor on duty called the contractor, and four additional counselors were at the medical center at the time. It was not possible to use the medical center's social workers, as one of the victims was a social worker. The counselors remained available near the scene of the incident to reassure and comfort the staff. Since they were not medical center staff, they wore readily visible identification badges.

Arrangements for postincident traumatic stress debriefings were scheduled to begin in 2 days. The EAP counselor also arranged for two contract EAP counselors to be at the medical center for the next week to walk around the center inquiring how the staff members were doing and to consult with supervisors about how to help the staff in their recovery efforts.

*Public information officer:* The PIO handled all aspects of press coverage. She maintained liaison with the media, provided an area for reporters to work, and maintained a schedule of frequent briefings.

## KEY ISSUES

The community, patients, press corps, and employees of Boulder-Crest Medical Center realize there are no guarantees of personal safety and antiterrorism in the modern era. But BCMC was able to take lessons learned, boldly keep its commitment to safety and violence prevention in the medical workplace, and consider new solutions to the dilemma. Upon reviewing the situation at BCMC, consider the following questions:

1. How would your health care facility or hospital have obtained the services of additional EAP counselors?
2. How would or should employees be given information about this incident?
3. Who would clean up the crime scene?
4. Would you relocate employees who worked in the area of the crime scene?
5. What approach would you take regarding the granting of excused absence on the day of the incident and requests for leave in the days/weeks following the incident?
6. How would you advise BCMC management and administration to deal with work normally assigned to the victims?
7. What support would your organization provide to supervisors to get the affected work group(s) back to functioning?
8. What are the possible direct and indirect financial ramifications and recovery costs of the retroactive, crisis-prone approach to medical workplace violence used at BCMC?
9. What might have been the financial costs of using a more proactive, crisis-prepared approach to workplace violence at BCMC?

10. What might have been the financial cost savings at BCMC if a crisis-prepared approach to health care violence had been used?

## POSSIBLE SOLUTIONS:

### Financial and Economic Cost of BCMC Recovery*

(The Reactive Crisis-Prone Approach)

| BCMC Incident (Medical Workplace Violence Event) | Costs |
|---|---|
| 1. Incident debriefing with impacted employees (3 managers, 5 doctors, 10 nurses, and 27 employees working in impacted area) | $1,200.00 |
| 2. Center closed due to incident for 3½ days | $122,856.00 |
| 3. Revenue lost (assumes that for six weeks after the incident, there is a 25% productivity decline) | $1,724,694.00 |
| 4. Cleanup of incident area/crime scene | $2,000.00 |
| 5. Increase in annual health care premiums due to increased use of psychological services (20% of employees need counseling for 3 months, 10% for 6 months, and 1% for 12 months) | $5,000.00 |
| 6. Lawsuit settlement (assumed out-of-court settlement at 60% of the average settlement of $500,000.00) | $300,000.00 |
| 7. Public relations campaign, marketing, and communication strategy with stakeholders to counter negative press and restore confidence in company | $10,000.00 |
| 8. Replacement cost for 10% turnover of workforce (e.g., 25 managers and 75 employees; assumes 25% of salary replacement cost for managers and 10% for employees against national figures of 50% to 100% of salary for replacement cost) | $315,500.00 |
| Total | **$2,481,250.00** |

* Cost estimates based on workplace violence prevention software like that available from www.workplaceviolence911.com.

### Focus on Proactive Violence Prevention at BCMC*

(The Zero-Incident Crisis-Prepared Approach)

| Prevention Actions | Cost |
|---|---|
| Programmatic Steps | |
| 1. Establish a workplace violence prevention committee | $2,000.00 |
| 2. Focus on eliminating at-risk behaviors | Internal staff |
| 3. Establish a comprehensive workplace violence prevention policy | *$500.00 |
| 4. Policy of no weapons in the workplace* | |
| 5. Define the nature of the risk to the company | Internal staff |
| 6. Facility risk assessments | $2,000.00 |
| 7. Organizational violence assessments | $6,000.00 |
| 8. Individual threat assessment | $1,000.00 |
| 9. Enhance physical security | (Capital Budget $60,000.00) |
| 10. Synchronize your personnel, security, and safety policies | $2,000.00 |
| 11. Develop crisis response procedures | $4,000.00 |
| 12. Emergency protocol with police | Internal staff |
| 13. Enhance hiring procedures | $7,500.00 |
| 14. Promote your employee assistance program | Internal staff |
| 15. Training managers, doctors, nurses, and employees | $24,000.00 |
| 16. Involve employees in the prevention effort | Internal staff |
| Programmatic steps subtotal | $49,000.00 |

| | |
|---|---|
| Insurance | |
| 17. Employment practices liability insurance (assumes $100,000.00 deductible) | $35,000.00 |
| Insurance subtotal | $35,000.00 |
| Capital budget | $60,000.00 |
| Capital budget subtotal | $60,000.00 |
| Grand total | $144,770.00 |

* Cost estimates based on workplace violence prevention software like that available from www.Workplaceviolence911.com.

*BCMC econometrics:* $2,481,250.00 – $144,770.00 = $2,336,480.00 (retroactive costs) – (proactive costs)

*Potential BCMC cost savings:* $2,336,480.00 (zero-incident, crisis-prepared approach)

| **CHECKLIST 1: Medical Workplace Violence Risks** | **YES** | **NO** |
|---|---|---|
| *In preparation for the prevention and response to potential incidents of medical workplace violence, it is suggested that the following risk assessment areas be examined, within a total overview of the hospital facilities, clinic and/or medical office needs, and capabilities:* | | |
| Is our facility vulnerable in any of the following ways or areas? | o | o |
| Physical health care facility layout and access controls. (Use counters to control traffic, initiate escort service for visitors, or consider the use of convex mirrors). | o | o |
| Personnel and visitor control access. (Are there some areas that need to be made nonpublic? Are badges needed?) | o | o |
| Preparedness of the hospital's, clinic's or other health care facility's emergency response team. | o | o |
| Communication system and capabilities. (Panic alarms in reception areas, HR offices, social service offices; telephone connection with local law enforcement agency—can one get through to 911 directly, or does one have to dial 9 prior to getting an outside line? Make arrangements with the phone service provider to establish direct call 911. Modify phones so that when a 911 call comes in, it actually identifies the sector or telephone from which the call was placed.). | o | o |
| Provision for special needs ( e.g., interpreters or employees with physical disabilities). | o | o |
| Is a policy established to require all employees to advise of threats heard? | o | o |
| Is a policy established to require employees to immediately notify human resources when a restraining order has been introduced? | o | o |

| **CHECKLIST 2: Initial Assessment** | **YES** | **NO** |
|---|---|---|
| *Prior to the establishment of a comprehensive medical workplace violence policy, and as an integral part of the policy development, it is necessary to conduct a survey in a number of areas.* | | |
| Does your survey cover security procedures? | o | o |
| Employee/visitor/guest identification? | o | o |
| Access control? | o | o |
| Prohibited items on facility property? | o | o |
| Drugs and other illicit substances? | o | o |
| Inspection of cars and personal items? | o | o |
| Security capabilities? | o | o |
| Crisis management team/plans? | o | o |

| | YES | NO |
|---|---|---|
| Does your survey cover human resources concerns? | o | o |
| Employment application screening? | o | o |
| Drug/alcohol testing policy? | o | o |
| Background investigations? | o | o |
| Psychological testing? | o | o |
| Minimum standards of conduct? | o | o |
| Sexual harassment? | o | o |
| Workplace violence? | o | o |
| Intolerance to infractions? | o | o |
| Disciplinary actions? | o | o |
| Termination procedures? | o | o |
| Posttermination monitoring? | o | o |
| Americans with Disabilities Act (ADA) compliance? | o | o |
| Does your survey cover EAP programs? | o | o |
| Availability of counseling? | o | o |
| Stress management programs? | o | o |
| Alcohol/drug treatment programs? | o | o |
| Does your survey cover medical/first aid capabilities? | | |
| In-house medical capabilities? | o | o |
| Private/public medical response capabilities? | o | o |
| Does your survey cover public/media relations responsibilities? | o | o |
| In-house capabilities? | o | o |
| Major incident/disaster response? | o | o |
| Does your survey cover legal requirements? | o | o |
| Review of and familiarity with issues involving workplace violence, negligent hiring, training, retention, termination, ADA, OSHA? | o | o |

| **CHECKLIST 3: Crisis Plan** | YES | NO |
|---|---|---|
| Have you determined: | o | o |
| Who calls 911? | o | o |
| Who is responsible (e.g., senior staff, person on duty at time of call)? Who is in charge? | o | o |
| Have you established procedures for calling: | | |
| Family members? | o | o |
| The media? | o | o |
| Have you made certain that sprinklers, fire extinguishers, fire alarms, and first-aid kits are all operational and fully stocked? | o | o |
| Are local law enforcement officers familiar with layout of facility? | o | o |
| Have you identified staging areas: | | |
| For emergency responders? | o | o |
| For employees to congregate? | o | o |
| For the press? | o | o |

| CHECKLIST 4: Training Programs | YES | NO |
|---|---|---|
| Have you trained all personnel to recognize "troubled" patients, family members, and fellow employees? | o | o |
| Have you provided training in the following: | o | o |
| Employee safety procedures for self-protection? | o | o |
| How to avoid becoming a victim? | o | o |
| How to escape? | o | o |
| How to respond if taken hostage? | o | o |
| Have you provided training in the following: | o | o |
| Conflict resolution? | o | o |
| How to recognize developing anger? | o | o |
| How to deal with difficult expressions of anger? | o | o |

| CHECKLIST 5: Training Program Topics | YES | NO |
|---|---|---|
| *This list of training topics is geared primarily to hospital supervisors and clinic managers and focuses on internal employees as opposed to the general public or patients. For unit managers, head nurse, or nursing supervisor, it is recommended that personal safety issues also be included. Are the following topics covered in the training program?* | | |
| Does the training program cover the following: | o | o |
| Improving employee performance? | o | o |
| How to conduct performance evaluations, including the proper way of providing feedback data? | o | o |
| How to document incidents—zero-tolerance for incidents of sexual harassment, stalking, or weapons on premises? | o | o |
| Understanding the policies and procedures of the practice, hospital, clinic, or other health care facility? | o | o |
| Have you trained personnel on the following: | o | o |
| Services and assistance available through the EAP? | o | o |
| How to refer to EAP? | o | o |
| Other resources available to employees? | | |
| Have you provided a comprehensive overview of the role of security, human resources, the medical department, and the crisis management team? | o | o |
| Does your training program cover indications of drug and alcohol use (including both legal and illegal substances)? | o | o |
| Does your training program include a complete overview of workplace violence, including a symptom recognition session? | o | o |
| *In this area, it is important not to focus on any one profile as it is too general. Rather, the emphasis needs to be placed on the recognition of behavioral changes. Also to be included in this block is the need for the supervisor to refer the affected employee to the EAP.* | | |
| Does your training program include procedure guidelines on how to terminate employees? | o | o |
| Does your training program include stress awareness and management including anger and conflict resolution? | o | o |

| CHECKLIST 6: Threat Incident Report | YES | NO |
|---|---|---|
| *Policy should require employees to report all threats or incidents of violent behavior that they observe or are informed about to the designated health care management representative (DHMR). The DHMR is to take the steps necessary to complete a threat incident report as quickly as possible, including private interviews of the victim(s) and witness(es). The report will be used by management to assess the safety of the workplace and to decide upon a course of action.* | | |
| Does your threat incident report include the following: | o | o |
| Name of the threat maker and his or her relationship to the health care facility (office or clinic) and to the recipient? | | |
| Name(s) of the victims or potential victims? | o | o |
| When and where the incident occurred? | o | o |
| What happened immediately prior to the incident? | o | o |
| The specific language of the threat? | o | o |
| Any physical conduct that would substantiate an intention to follow through on the threat? | o | o |
| How the threat maker appeared (physically and emotionally)? | o | o |
| Names of others who were directly involved and any actions they took? | o | o |
| How the incident ended? | o | o |
| Names of witnesses? | o | o |
| What happened to the threat maker after the incident? | o | o |
| Name of any supervisory staff involved and how they responded? | o | o |
| What event(s) triggered the incident? | o | o |
| Any history leading up to the incident? | o | o |
| The steps that have been taken to ensure that the threat will not be carried out? | o | o |
| Suggestions for future prevention? | o | o |

| CHECKLIST 7: Protecting a Medical Office | YES | NO |
|---|---|---|
| Are doors and windows locked at the end of each day? | o | o |
| Are file cabinets locked and other open temptations to theft removed each day? | o | o |
| Are clients/patients under supervision at all times in the office? | o | o |
| Is there an adequate waiting area? | o | o |
| Does the office layout help control the flow of clients and the public? | o | o |
| Are there blind spots to hide or where someone could be concealed without others finding out? | o | o |
| Are there furnishings that block your exit in the event of an emergency or an attack? | o | o |
| Are there objects such as plants, lamps, and others that could be readily used as a weapon against you? | o | o |
| Do you have access to a shield for use in your defense in case of attack? | o | o |
| Could you immediately summon help if needed? | o | o |
| Do you have alarms or keywords signaling others of danger or that help is needed? | o | o |
| Does your office routinely discuss ways to improve security after potentially dangerous situations? | o | o |

Please indicate the significance of footnote 1

| CHECKLIST 8: Ten Commonsense Ideas for Preventing Medical Workplace Violence Problems[1] | YES | NO |
|---|---|---|
| Have you installed metal detectors to identify weapons? | o | o |
| Have you installed alarm systems or panic buttons? | o | o |
| Do you use bright and effective lighting systems? | o | o |
| Do you use curved mirrors at hallway intersections or concealed areas? | o | o |
| Have you ensured all areas have two exits? | o | o |
| Have you arranged furniture to prevent entrapment? | o | o |
| Have you established "time out" or seclusion rooms? | o | o |
| Do you provide for adequate staffing, particularly during times of increased patient activities and during restraint procedures? | o | o |
| Have you trained employees to identify hazardous situations, in managing agitated patients or family members, and appropriate responses in emergencies? | o | o |
| Have you established liaison with local police? | o | o |
| To protect staff, do you provide: | o | o |
| Enclosures? | o | o |
| Deep service counters? | o | o |
| Bullet-resistant glass? | | |

| CHECKLIST 9: Safety Awareness | YES | NO |
|---|---|---|
| Are you familiar with the facility or office's evacuation plan? | o | o |
| Are you familiar with the exit to use to evacuate the work area? | o | o |
| Do you know the difference between the fire alarm for bomb threats versus other emergency alarms? | o | o |
| Do you know the location of fire extinguishers? | o | o |
| Do you know the location of first aid kits and what is to be done with them in case of an alarm? | o | o |
| Do you know who is responsible for contacting local authorities in the event of an emergency? | o | o |
| Do you know where you are to gather outside the building? | o | o |
| Do you know who is responsible for seeing that the office is cleared every time the alarm sounds? | o | o |
| Do you know the office procedures in the event of a telephone bomb threat? | o | o |

| CHECKLIST 10: Safety Tips for Hospital Workers | YES | NO |
|---|---|---|
| Have any of these signals, associated with impending violence, been exhibited: | | |
| Verbally expressed anger and frustration? | o | o |
| Body language such as threatening gestures? | o | o |
| Signs of drug or alcohol use? | o | o |
| Presence of a weapon? | o | o |
| Do you demonstrate the following kinds of behavior to help defuse anger: | | |
| Present a calm, caring attitude? | o | o |
| Do not give orders? | o | o |
| Acknowledge the person's feelings (for example, "I know that you are frustrated")? | o | o |
| Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly)? | o | o |

| | | |
|---|---|---|
| Do you: | | |
| Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor? | o | o |
| Remain vigilant throughout the encounter? | o | o |
| Avoid isolating yourself with a potentially violent person? | o | o |
| Always keep an open path for exiting—don't let the potentially violent person stand between you and the door? | o | o |
| Do you take these steps if you can't defuse the situation quickly: | | |
| Remove yourself from the situation? | o | o |
| Call security for help? | o | o |
| Report any violent incidents to your manager or management team? | o | o |

| **CHECKLIST 11: Safety Features** | **YES** | **NO** |
|---|---|---|
| Have we installed surveillance cameras at the entrance to and inside high-risk areas like the emergency department? (Inside cameras should be very visible.) | o | o |
| Have we conspicuously posted a sign by the entrance to high-risk areas stating that weapons of any kind are prohibited on the premises and all people entering are being photographed for security purposes? | o | o |
| Have we installed street-level cameras (similar to those at traffic signals that send tickets for running a light) to record license plate numbers? | o | o |
| Have we installed metal detectors at the entrances to high-risk areas? | o | o |
| Have we installed monitors to show those entering high-risk areas? | o | o |
| Have we worked with local police to establish a substation in or near the emergency department? | o | o |
| Have we installed cameras at the access door to where patients are being housed? | o | o |
| Have we installed panic buttons in high-risk areas such as at the admissions desks and emergency department patient rooms? | o | o |
| Have we given ER personnel mobile units to be able to alert security? | o | o |
| Have we placed curved mirrors at hallway intersections or concealed areas? | o | o |
| Have we reconfigured all treatment rooms in high-risk areas to have two exits? | o | o |

These seem to be footnotes, but there are none showing up. If they are, should they be merged with the "Additional References and Readings" as the bibliography? Some are already repeated there.

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