Emergency Nurses Association
Docket No. OSHA–2016–0014
April 6, 2017

Response to RFI: Prevention to Workplace Violence in Healthcare and Social Assistance

This document was prepared by the Emergency Nurses Association (ENA) in response to a Request for Information (Docket No. OSHA—2016–0014) solicited by the U.S. Department of Labor, Occupational Safety and Health Administration. The enclosed response addresses specific questions about the prevention of and response to workplace violence in U.S. emergency departments (ED), based on research conducted with emergency nurses from 2009 to 2015.

Section III: Defining Workplace Violence

Question III.1: CDC/NIOSH defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty" (CDC/NIOSH, 2002). Is this the most appropriate definition for OSHA to use if the Agency proceeds with a regulation?

Response

An accepted definition generally includes any physical assault, emotional or verbal abuse, threatening, harassing, or coercive behavior in the work setting that causes physical or emotional harm. Additionally, there are numerous types of violence that occur in healthcare settings and it would be advantageous to have some further delineation, to support data-driven prevention and response efforts. Bowie (2002) has posited the following typology of violence that could be used to guide the development of a more nuanced definition:

Type 1 External/Intrusive violence
Criminal intent by strangers
Terrorist acts
Protest violence
Mental illness or drug related aggression
Type 2 Consumer/Client related violence
Consumer/clients/patients (& family) violence against staff
Vicarious trauma to staff
Staff violence to clients/consumers
Type 3 Relationship violence
Staff on staff violence & bullying
Domestic violence at work
Type 4 organizational violence
Organizational violence against staff
Organizational violence against consumers / clients / patients.

Question III. 2: Do employers encourage reporting and evaluation of verbal threats? If so, are verbal threats reported and evaluated? If evaluated, how do employers currently evaluate verbal threats (i.e., who conducts the evaluation, how long does such an evaluation take, what criteria are used to evaluate verbal threats, are such investigations/evaluations effective)?

Response

ENA research suggests that reporting of verbal threats is problematic for several reasons: 1. Overall, reporting tends to be onerous and not a systematic requirement 2. Verbal threats, name-calling, and other forms of verbal harassment seem to be taken far less seriously because no physical violence happened; however, continual verbal assaults can lead to toxic, high-stress workplaces that contribute to job dissatisfaction and staff turnover. ENA conducted the *ED Violence Surveillance Study* (EDVS) over a two-year period from 2009-2011 (ENA, 2011) and results from emergency nurses who responded to the 69-item questionnaire (N = 7,169) include reports of 3,235 incidents of verbal assault that occurred while working in the ED. The types of verbal assaults reported were being cursed at (89%) or called names (68.2%), verbal sexual harassment (22.7%), and legal (51.8%) and physical threats (19.8%). About half (49.7%) of the participants who were victims of verbal assault indicated that no action was taken and more than a quarter (28.5%) reported that the perpetrator was only given a warning; 14.8% indicated that the perpetrator was asked to leave the emergency department, while 7.5% stated that perpetrator left before any action could be taken. Regarding the hospitals' response to nurses who experienced verbal abuse, more than three-quarters (80.6%) of the nurses indicated that they did not yet receive a response from their hospital.

Question III.3: Though OSHA has no intention of including violence that is solely verbal in a potential regulation, what approach might the Agency take regarding those threats, which may include verbal, threatening body language, and written, that could reasonably be expected to result in violent acts?

Response

OSHA recommendations and training materials could include specific guidance and language necessary to assist healthcare employers with: 1) a clear definition of verbal assault; 2) development of workplace violence prevention policies that prohibit verbal and written threats; and 3) outlining an appropriate response strategy that includes enforcement, reporting, and documentation. Additionally, the employer response to those threats should not be punitive to healthcare workers. Rather, employees should be encouraged to report incidents of verbal abuse so that appropriate action can be taken toward the perpetrator and to provide health care workers with the support and training they need to recognize cues for potential violence so they can maintain personal and workplace safety.

Section IV: Scope

Question IV.3: The only comparative quantitative data provided by BLS is for lost workday injuries. OSHA is particularly interested in data that could help to quantitatively estimate the extent of all kinds of workplace violence problems and not just those caused by lost workday injuries. For that reason, OSHA requests information and data on both workplace violence incidents that resulted in days away from work needed to recover from the injury as well as those that did not require days away from work, but may have required only first aid treatment.

Response

The ENA EDVS study did not collect data on lost workday due to injuries sustained during a violent incident. However, in the sample of emergency nurses who participated in the survey (N = 7,169), the frequency of physical violence and verbal abuse during a seven-day period (during which the participants worked an average of 36.9 hours in an emergency department) was high (54.5%). During a seven-day period, 12.1% of participants reported experiencing physical violence (with/without verbal abuse) and 42.5 % verbal abuse. Of the participants who were victims of workplace physical violence (n = 789), 13.4% sustained a physical injury, with the most common type of injury being a bruise/contusion/blunt trauma (60.0%). For nurses who indicated experiencing verbal abuse, over half (58.4%) reported feeling angry about the verbal abuse that they experienced, 39.2% indicated that the incident(s) made them feel anxious, 29.9% felt indifferent to the verbal abuse, and 19.2% felt frightened.

Patients were the main perpetrators in all cases with 97.8% (n = 760) of physical violence incidents and 92.3% (n = 2,918) of verbal incidents. Over three-quarters (82.0%) of the incidents of physical violence occurred in a patient's room, 24.0% in a corridor, hallway, stairwell, or elevator, and 14.6% at the nurses' station. The most frequently reported activities that emergency nurses were involved in at the time of a violent incident were triaging a patient (40.2%), restraining/subduing a patient (34.8%) and performing an invasive procedure (29.4%).

Question IV.7: Are there special circumstances in your industry or establishment that OSHA should take into account when considering a need for a workplace violence prevention standard?

Response

An effective violence prevention standard would need to address the institutional practices and cultural paradigms that prevent nurses, their employers, and adjudicators from recognizing, preventing/mitigating, reporting, and responding to incidents of workplace violence. Several studies have suggested that an important contributing factor is the normalization of violence

within the nursing profession (Wolf, 2016; Trepanier, 2013 and 2016) and the criminal justice system. In a qualitative study by Wolf et al. (2014), nurses described responses from hospital administrators that were punitive, blaming, dismissive, or discouraging of further action. Those who attempted to press criminal charges were frequently met with resistance from public officials (e.g., police, state attorneys, or judges) who would not charge the perpetrators. One judge said to a nurse plaintiff, "Well, isn't that the nature of the beast, being in the emergency room and all?" The lack of appropriate action left nurses feeling discouraged about reporting incidents of workplace violence and the protection of their safety on the job.

Section V: Workplace Violence Prevention Programs; Risk Factors and Controls/Interventions

Worksite Analysis and Hazard Identification

Question V.27: What do you know or perceive to be risk factors for violence in the facilities you are familiar with?

Response
ENA has conducted both qualitative and quantitative research on emergency nurses' experience and perceptions of workplace violence; relevant findings on emergency nurses' perception of risk factors are summarized below.

Qualitative Study 1 (n = 46; Wolf, 2014): Physical environment, personal characteristics, and institutional culture as risk factors

This study used a qualitative exploratory design to solicit written narratives from 46 emergency nurses' who described their experience of violence while providing patient care at work. Narrative analysis points to a confluence of high-risk environments (e.g., crowding, long wait times) and high-risk persons (e.g., drug-impaired, agitated) that act as precursors to violence in the ED. Environmental risks include physical features of the emergency care setting (e.g., nonfunctioning security alarms, isolated hallways, inadequate staffing) as well as the dominant institutional culture (e.g., co-worker attitudes, management response). A workplace culture that tolerates violence contributes to risk by creating conditions in which nurses accept violence as a part of their job, as well as a lack of implementation and enforcement of safety policies and other preventive mechanisms (e.g., staff training, security personnel). A permissive environment can act as a barrier to reporting incidents of workplace violence, making it difficult to document, intervene and respond appropriately when incidents do occur. Another reported risk factor was poor cue recognition or inability of nursing staff to recognize antecedents and conditions that increase the likelihood of a violent incident. Complacency and a lack of managerial and legal response to incidents left nurses feeling disempowered to reduce the risks associated with ED workplace violence. These working conditions lead to lost productivity,

contribute to attrition from the emergency nursing profession, and impede nurses' ability to effectively deliver patient care.

Qualitative Study 2 (n = 16; Wolf, 2015): Nurse fatigue as a risk factor for violence

A recent mixed-methods study analyzed combined data from an online survey and focus group interviews to explore emergency nurses experience of working while fatigued. Participants in both study arms reported high levels of mental, emotional, and physical fatigue that compromised patient care, had a negative effect on their personal lives, and created a toxic unit environment. Lateral violence was an element of toxic work environments that acted as both a cause and effect of mental and emotional fatigue, contributing to a unit culture in which nurses were more likely to act out aggressively toward one another. Focus group participants described emotional exhaustion (as opposed to physical exhaustion) as a type of fatigue that is more difficult to manage and recover from.

Quantitative Study (n = 3,465; Gacki-Smith, 2009): Nurse attitudes and beliefs as risk factors

Emergency nurses completed a 69-item online survey about the respondent's personal experience with physical violence and verbal abuse in the ED, hospital policies and procedures, and the respondent's beliefs about the precipitating factors of violence and barriers to reporting violence in the ED. Nurses who felt that violence from patients/visitors is an unavoidable part of the job were more likely to have experienced frequent ED physical violence. In contrast, nurses who felt that there were no barriers to reporting ED violent incidents were much less likely to have experienced frequent ED physical violence than were other nurses.

Question V.36: Does your facility have controls for workplace violence prevention (security equipment, alarms, or other devices)?

Response

Among EDVS participants (N = 7,169) who worked in diverse sample of hospital emergency departments (ENA, 2011), the five most commonly reported ED environmental controls were well-lit areas (91.5%), physical/leather restraints (88.2%), security cameras (86.1%), locked/coded ED entries (81.9%), and a code alert to notify staff (77.8%).

Approximately three-quarters of nurses reported that their facility had hospital-employed security personnel (72.1%) and that security was provided to the ED around the clock (70.1%). For those EDs without continuous availability of security personnel (29.9%), they averaged 7.2±7.2 hours of security personnel coverage per day.

Question V.41: Do you have information on changes in work practices or administrative controls (other than engineering controls and devices) that have been shown to reduce or prevent workplace violence either in your facility or elsewhere?

Response
Survey findings (N = 3,465; Gacki-Smith, 2009) showed that a reduced risk of experiencing physical violence in the ED was associated with having facility policies for reporting workplace violent incidents, facility responses to such incidents, and hospital and ED administration commitment to eliminating workplace violence against emergency nurses.

Question V.42: Do you have a zero tolerance policy? If so, please share it. Do you think it has been successful in reducing workplace violence incidents? Why or why not?

Response
EDVS results ((N = 7,169; ENA, 2011) indicate that a higher commitment and the presence of reporting policies (especially zero tolerance policies) was associated with lower odds of physical violence and verbal abuse. Hospitals with no reporting policy had an 18.3% rate of physical violence, hospitals with a reporting policy not identified as zero tolerance had a 13.7% rate of physical violence, and the lowest rate was in zero-tolerance settings (9.1%). In general, nurses whose hospital administration and ED management have a commitment to workplace violence control were less likely to experience workplace violence.

Safety and Health Training

Question V.48: What occupations (e.g., registered nurses, nursing assistants, etc.) attend the training sessions? Are the staff members required to attend the training sessions or is attendance voluntary? Are staff paid for the time they spend in training?

Response
In the EDVS survey (N = 7,169; ENA, 2011), 19.9% of emergency nurses reported that they had never attended training for handling ED workplace violence prevention/diffusion; half of those whose workplace had training (53.1%) reported that training was mandatory within their hospital.

Additional measures found that over half (57.7%) of participants did not feel safe from workplace violence while working in the ED (mean = 5.1±2.1) and 52.3% felt unprepared to handle violence from ED patients and/or visitors (mean = 5.4±2.2). In general, higher workplace safety ratings (obtained from survey respondents) were associated with lower rates of physical violence (odds of physical violence dropped approximately in half for every 1 standard deviation on the rating). Attending a training course, or providing training (mandatory or otherwise) showed no substantial impact on PV rates.

Recordkeeping and Program Evaluation

Question V.60: Are you aware of any issues with reporting (either underreporting or overreporting) of OSHA recordables and/or "accidents" or other incidents related to workplace violence in your facility and if so, what types of issues?

Response

Among EDVS participants (N = 7,169; ENA, 2011), a majority of emergency nurses (77.6%) reported that their facility had a policy in place for reporting incidents of workplace violence and half (50.5%) indicated that this policy was a zero-tolerance policy. However, most participants who were victims of workplace violence did not file a formal report for incidents of physical violence (65.6%) or verbal abuse (86.1%). Most participants who experienced physical violence, however, tended to notify security personnel (65.7%), an immediate supervisor (64.2%), other emergency nurses (63.2%), and/or emergency physicians (54.6%). Similarly, most participants who experienced verbal abuse tended to report it to other emergency nurses (58.1%), an immediate supervisor (45.4%), security personnel (44.9%), and/or emergency physicians (37.9%). Only 8.0% of the participants who reported experiencing physical violence during the past 7 days did not notify anyone of the physical incident, while 16.9% of the participants who reported experiencing verbal abuse did not notify anyone of the verbal incident.

Of the emergency nurses who indicated experiencing physical violence, almost half (46.7%) reported that no action was taken against the perpetrator following the violent incident, and less than (20.4%) reported that the perpetrator was given a warning. When asked about the hospital's response or recommendation to the nurse, nearly three-quarters of nurses (71.8%) stated that the hospital gave them no response concerning the physical violence they experienced.

In the initial survey analysis (N = 3,465; Gacki-Smith, 2009), the following barriers to reporting violent incidents were associated with an increased risk of experiencing frequent physical violence:

- perception that reporting ED violent incidents might have a negative effect on customer service scores/reports; ambiguous ED violence reporting policies
- fear of retaliation from ED management, hospital administration, nursing staff, or physicians for reporting ED violent incidents
- failure of staff to report ED violent incidents
- the perception that reporting ED violent incidents was a sign of incompetence or weakness
- lack of physical injury to staff
- the attitude that violence comes with the job
- lack of support from administration/management.

Question VI.1: Are there additional data (other than workers' compensation data) from published or unpublished sources that describe or inform about the incidence or prevalence of workplace violence in healthcare occupations or settings?

Response

Results from a recent study on emergency nursing fatigue (Wolf, 2016), support the hypothesis that permissive environments result in normalization of bullying, thereby contributing to emotional workload, stress proliferation, and emotional fatigue among emergency nurses. A similar qualitative study conducted by Blando et al. (2015) also identified bullying as a barrier to addressing workplace violence originating from patients and visitors in hospital settings. This data reinforces the theory that a culture that is permissive of any violence in the ED workplace—including bullying—not only impacts nursing workload, job stress, and retention, but potentially affects the health and safety of the entire workplace (Wolf, 2016; Trepanier, 2016). Although more research is needed on the interactive effects of different types of violence, a standard for workplace violence prevention would be incomplete, and perhaps ineffective, if it solely focused on violence originating from patients and visitors and ignored violence stemming from bullying among healthcare workers.

Question VI.2: As the Agency considers possible actions to address the prevention and control of workplace violence, what are the potential economic impacts associated with the promulgation of a standard specific to the risk of workplace violence? Describe these impacts in terms of benefits from the reduction of incidents; effects on revenue and profit; and any other relevant impact measure.

Response

Among the emergency nurses who responded to the EDVS over a three-year period (N = 7,169; ENA, 2011), 33% reported that they were considering leaving their current ED position or the profession entirely, due to physical and verbal violence experienced on the job. Estimates indicate that it costs a hospital between $60-80,000 to replace a nurse who leaves the emergency department. Additionally, workplace violence contributes to high rates of turnover and lost productivity that negatively affect nurses' workloads and job stress (Gates, 2011), exacerbate workforce shortages, and strain hospital budgets that are impacted by these factors. As indicated by the results of ENA's studies of workplace violence (2009-2015), other potential economic benefits could arise from fewer violent incidents and injuries; improvements in reporting and surveillance; ongoing education for all employees and managers on the recognition, prevention, and appropriate response to incidents of violence; and changes in workplace culture that counter the acceptance of any form of violence (including bullying), decrease related job stress and attrition, and advance the health and safety of emergency nurses and the patients they care for.

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