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Workplace Violence in the Healthcare Setting

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Literature Review: Workplace Violence in the Healthcare Setting

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Literature Review: Outline

I.   **Introduction:**

- An introduction to workplace violence (WPV) with an emphasis on the risk factors for WPV and the ubiquitous nature of the problem. Address the fact that there is international interest and concern regarding WPV including the recognition of the problem by the World Health Organization (WHO) and the International Council of Nurses (ICN).

- Identify the main consequences of WPV to support the thesis that the healthcare sector could potentially lead the development of effective interventions aimed at decreasing WPV and increasing productivity within the health sector.

- A statement describing the method of literature search.

II. **Body of the Paper:**

- Categorization of the main themes as reported by the literature. Risk factors for WPV and the consequences of WPV:

     A.   Category: Risk factors identified in the culture of nursing

     B.   Category: Psychological and physiological effects of WPV

     C.   Category: Strategies nurses and organizations use to deal with WPV

     D.   Category: Financial implications of WPV

III. **Conclusion:**

- Summary to address the urgent need for strategies to resolve WPV. The costs to nurses and the healthcare sector supports attention now.

Literature Review: Workplace Violence in the Healthcare Setting

Workplace Violence (WPV) is an all-encompassing term used to describe abusive behaviours directed at another with the intent to cause harm. Although the definition varies according to situations and practice settings, there is agreement that WPV has a negative impact on the health and wellbeing of nurses and the delivery of quality nursing care (Choiniere, MacDonnell, & Shamonda, 2010; Higgins & MacIntosh, 2010; Registered Nurses Association of Ontario [RNAO], 2008; Hsinag-Chu & Lee, 2011; Vessey, DeMarco, Gaffney, & Budin, 2009). The growing epidemic of violence in the workplace is of great concern for employees, employers and government agencies and is recognized by the World Health Organization (WHO) and the International Council of Nurses (ICN) as a major health priority (Hinchberger, 2009). WPV occurs between nurses, between nurses and physicians and between nurses and patients and their families. In order to implement effective strategies aimed at diminishing WPV an investigation of the multi-layered risk factors must first be explored. The RNAO (2008) suggests taking "a broad approach, examining societal, workplace, and individual factors and recognizing the dynamic relationship between them" (p.2). This literature review aims at identifying and examining the risk factors for WPV; the psychological and physical effects experienced by nurses due to WPV; the strategies nurses employ to decrease violence in the workplace; and the personal and professional costs associated with WPV. Understanding the risk factors and associated consequences of WPV on the healthcare sector could potentially lead to effective interventions aimed at decreasing WPV and increasing productivity within the health sector.

A literature search was conducted using the off-campus online access to the University of Western Ontario's library, using the Scopus database. Keywords used to search were, workplace violence, horizontal violence, lateral violence, healthcare, registered nurses, physicians, and

community care. The search was narrowed by, limiting findings to the English language,

research articles only, and dates ranging from 2006 – 2012. Included is one seminal journal

article from 2003 because it adds a concept not found in more current studies together with two

web-based document from the RNAO and the ICN.

Risk Factors for WPV in Healthcare Settings

The contributing risk factors for WPV are multifaceted and can be attributed to a variety

of contexts and organizational cultures. The studies by Higgins and MacIntosh (2010), and

Vessey et al. (2009) found that WPV was common in areas of high acuity where technical

expertise was valued over interpersonal relationships. They also noted that less experienced

nurses' were at greater risk for WPV, perpetrated by colleagues, due to their lack of speed and

skill. Higgins and MacIntosh's (2010) qualitative study of 10 operating room (OR) nurses added

that OR nurses in charge positions, and new OR nurses, perceived their roles as a risk factor for

abuse. Charge nurses often felt blamed by physicians when cases before them ran late resulting

in delays beyond the nurses' control. New OR nurses felt physicians were inpatient and easily

frustrated as they struggled to keep up. The most common type of abuse was psychological and

it came in the form of yelling, belittling, and ignoring. Physical abuse included shoving, kicking,

and throwing instruments. These findings are consistent with the study by Choiniere et al.

(2010) who added, "there is a perception-if not a reality-that employers have very little control

over physicians if we're talking about physician harassment" (p. 11). Numerous studies,

including the RNAO (2008), have cited that power-differentials between the female-dominated

nursing vocation and the traditionally male-dominated medical profession presents as a risk

factor for WPV. Nurses feel that organizations are either reluctant to discipline physicians or

tend to take the physicians side (Higgins & MacIntosh, 2010; Choiniere et al., 2010).

Hsinag-Chu and Lee's (2011) study of risk factors for WPV in clinical RNs working in Taiwan suggested nurses with lower levels of education were at greater risk for physical violence whereas Vessey et al. (2009) reported that individuals who hold an advanced degree are at greater risk for WPV from more experienced nurses who may be resentful of their advanced educational preparation. In addition risks for violence increased with any major characteristics that differed from the group norm such as, experience, gender, age, race or personality traits (Vessey et al. 2009). In contrast, Anderson and Parish's (2003) study claimed that personal characteristics, aside from gender, were not found to be associated with WPV but that past childhood and/or adult experiences with violence presented as significant risk factors, and nurses with a past history of victimization reported higher levels of WPV. Choiniere, MacDonnell, and Shamonda (2010) discovered racialized nurses experienced WPV due to language and cultural differences and, an overly large amount of racialized nurses' practice in mental health and long-term care facilities where WPV is predominant. Their findings imply racialized nurses experience WPV from colleagues, patients and their families, as well as systematic discrimination related to employment opportunities and workload distribution.

Luck, Jackson, and Usher's (2007) investigation on WPV and emergency department (ED) nurses assert that risk factors are related to the emotionally stressful presentations of hospitals and client characteristics such as fear, anxiety and hopelessness, which can be exacerbated by the chaotic hospital environment and result in violent behavior. In addition the process of diagnosis to outcome can add to a client's feelings of loss of control and frustration and can lead to clients and or their family or friends, acting violently towards staff. Another noteworthy risk factor offered by Luck et al. (2007) was the administration of certain medications that have the potential to disorient clients, which can result in violent behaviors.

The authors McPhaul, Lipscomb, and Johnson (2010) studied the risks for violence associated with home health visits. Homecare nurses (HCNs) clients include the mentally ill, cognitively impaired and those with substance abuse disorders. HCNs safety risks are intensified by, working alone, working at night, working in areas of crime, and working in homes with animals and other household members. The authors also note that HCNs working in rural and remote areas are further compromised by isolation and the lack of cell phone service. Approximately 11% of the 192 HCNs surveyed reported being physically assaulted by a client or member in the home and 9.6% required an ED visit or visit with their physician. Another 16.2% reported being threatened verbally with assault and 61.4% reported being yelled at or sworn at while at work. Authors Opie et al. (2010) followed 349 nurses working in very remote Australia over a twelve-month period. Their results revealed 79.5% of nurses had been verbally abused and a staggering 28.6% of nurses were the recipients of physical violence, 31.6% had their property damaged and 22.6% had been sexually harassed. Another 4.9% had been stalked and 2.6% sexually assaulted.

Hinchberger's (2009) research of 126 student nurse participants found100% of the student nurse respondents had either observed or experienced violence during their clinical rotations. Predisposing factors that sustain violence against women employed in healthcare included the occurrence of weapons within the community as well as among patients and their families. In addition hospitals are often used by law enforcement as criminal holds and care of mentally ill and acutely violent persons. Student nurses often see themselves as being powerless while in the student role yet WPV exposure was on par with that of staff nurses (RNAO, 2008). The perpetrators were largely staff members (50%) followed by patients (25%) and family and friends (25%). The most common type of WPV was psychological, a finding consistent with

most studies in the literature (Higgins & MacIntosh, 2010; Opie et al, 2010; McPhaul et al, 2010; Hsinag-Chu & Lee, 2011; Vessey et al. 2009). The authors Woelfle and McCaffrey's (2007) study of 26 new nursing graduates on WPV revealed that, "bullying was found to be a common experience in the transition to becoming a nurse. Students were bullied and also witnessed patients being bullied by qualified nurses" (p. 127). Student nurses, who lacked the personal and professional experience to challenge such behaviors, are at risk to conforming to the unit's culture by incorporating bullying strategies into their everyday practice (Hinchberger, 2009; RNAO, 2008; Woelfle & McCaffrey, 2007).

Hsinag-Chu & Lee (2011) studied WPV in clinical registered nurses in Taiwan via an exploratory survey completed by 521 RNs and discovered 19.6% of the respondents reported physical violence and 51.4% reported psychological violence. The most frequent perpetrators were clients and their families followed by colleagues and managers. The only risk factors offered by the authors were the lack of organizational support to decrease WPV.

Organizational structures related to restructuring, poor environmental design and inadequate policies, security measures and training for staff to deal with violence put nurses at risk for WPV (RNAO, 2008). In addition, impaired communication, professional disengagement, increased absenteeism, greater job turnover, staff and resource shortages (Vessey et al. 2009), insufficient post-episode support, decreased trust between management, nurses and patients, diminished worker morale, long hours (Hsinag-Chu & Lee, 2011), working alone, working in isolation (McPhaul, 2010), increases in patient acuity and unit cultures that condone abuse (Higgins & MacIntosh, 2010) have all contributed to stressful work environments and set the stage for WPV.

Psychological & Physical Effects of WPV on Healthcare

WPV is detrimental to recipients' physical and psychological wellbeing and has a negative effect on job satisfaction, work performance and patient outcomes. Lang and Fleiszer, and Sylvester and Reisener (as cited in McPhaul et al., 2010) state that, "Emerging evidence indicates that safety for staff is inextricably linked to client safety, suggesting that improvements to one may impact the other" (p. 279). Healthcare providers on the receiving end of WPV experience anxiety directly from assaults and from continuously altering their behaviours to avoid annoying their attacker (Vessey et al. 2009). Psychological distress symptoms range from stress (Hinchberger, 2009), post-traumatic stress disorder (PTSD) (Woelfle, 2007; Hsinag-Chu & Lee, 2011; McPhaul, Lipscomb, & Johnson, 2010), irritability, anxiety, depression, decreased self-esteem, loss of confidence, mood swings, and tearfulness (Vessey et al., 2009), feelings of worthlessness, feelings of isolation (Opie et al. 2010) and second guessing ones abilities (Higgins & MacIntosh, 2010). Physical symptoms included physical exhaustion, increased heart rate, excessive sweating, heavy breathing, weight-loss, gastrointestinal disturbances, headaches and backaches (Higgins & MacIntosh, 2010). In some cases physical violence required visits to the ED or family practitioner (McPhaul et al., 2010). In extreme cases death was the outcome of WPV (Pai & Lee, 2011).

Strategies nurses use to deal with WPV.

Roberts 1983 (as cited in Roberts, 2009) was the first scholarly analysis in the nursing literature that addressed oppressed group behavior (OGB). The author suggested that an understanding of OGB could not only explain and predict behaviors of nurses' in the workplace, but could be used to focus on strategies to break the cycle of OGB that keeps them powerless in the health care system (Roberts, DeMarco, & Griffin, 2009).

Despite a plethora of studies and scholarly papers since 1983, the problem of WPV continues to be reported. Authors Farrell, Bobrowski, and Borowski (2006) have suggested that, "few working environments were free of aggression" (p. 778).   A review of the literature reveals that few interventions have been developed to address the problem of WPV leaving nurses to determine strategies on their own. Farrell et al. (2006) analyzed 2407 specially designed questionnaires from nurses in Australia to investigate and collate strategies used to deal with WPV. Strategies employed to deal with verbal abuse included: Talk with a colleague (68.3%), talk with a family member (23.9%), talk with a manager (23.9%), talk with a friend (24.9%), talk with the abuser (16.5%), talk with a union or professional association (3.3), sought counseling (2.6%), talk with human resources (1.6%). Actions' taken by nurses included, filing a formal complaint (10.7%), and reporting to police (1.0%). Nurses' strategies and actions for physical abuse were similar to those for verbal abuse. Seven percent of nurses took no action for verbal abuse while four percent took no action for physical abuse.

The authors Luck et al. (2007) report on 16 ED nurses' revealed that nurses make judgments about particular occurrences of WPV and these judgments guide their reactions, internalization of the violence and decisions to report or not report. For instance, when nurses took WPV personally they experienced negative emotional sequelae and distress. When violence was aimed at the system, due to long wait times or poor outcomes, or was caused by a patient with cognitive difficulties such as dementia, nurses did not express emotional hurt and chalked the violence down to being part of their job. Personalization of WPV ensued when clients made derogatory remarks or advances directly at nurses. However, regardless of the meanings ascribed to the violence of the 16 observed episodes, both verbal and physical, none were reported. Underreporting has been listed as a key factor and barrier to understanding WPV

and implementing appropriate strategies at the organizational level (Anderson & Parish, 2003; Barrett, Korber, & Padula, 2009; Choiniere, 2009; Higgins & MacIntosh, 2010; Hinchberger, 2009; RNAO, 2008). Underreporting has also been widely attributed to ineffective organizational policies to deal with WPV (Hsinag-Chu & Lee, 2011) and in essence is utilized as a protective strategy due to fear of retaliation (Higgins & MacIntosh, 2010;Vessey et al. 2009).

Several studies (Gates, Gillespie, & Succop, 2011; Johnston, Phanbttharath, & Jackson 2009; Roberts & Griffin 2009; Vessey et al. 2009; Woelfle, 2007) have reported that nurses experiencing WPV have a higher rate of turnover and absenteeism suggesting that this may also be a strategy used to avoid WPV. Researchers Pich, Hazelton, Sundis, and Kable (2011) have identified the ED as a high-risk area for verbal and physical abuse, manifested daily, particularly in the specialty of triage nursing with patients being the perpetrators of the abuse. ED nurses have described abuses such as being slapped, kicked and hit by patients. Triage nurses have a safety-glass barrier at the triage desk and nurses' working in the ED frequently request to be escorted to their car. Although ED nurses' stated feeling frustrated at the violence in the ED, when questioned about strategies to deal with such frequent exposure to violence, the ED nurses stated that violence is so common that it has become, as they described, just part of the job, and is accepted as the norm. This finding is congruent with a multiplicity of studies found in the literature (Hinchberger, 2009; RNAO, 2008; Vessey et al. 2009; Woelfle & MaCaffrey, 2007).

While nurses have developed strategies to deal with WPV, there is mounting evidence that unhealthy work environments contribute to medical errors, ineffective patient care, interdisciplinary conflict, and stress, distrust and poor communication among healthcare professionals (Johnston, Phanbtbarath, & Jackson, 2009; Hsinag-Chu & Lee, 2011; Vessey et al., 2009).

Strategies organizations use to deal with workplace violence

Currently Japan and Hong Kong have no legislation to address WPV. However States across Australia the United Kingdom (UK), Europe, the United States (US), and Canada have required and variously defined 'zero tolerance' legislation (Pich et al. 2011). Many organizations provide policies and procedures related to WPV but they are left to the discretion of the employees to utilize. All too often nurses are unaware of these policies (McPhaul et al. 2010), have found them ineffective (Vessey et al. 2009) or feared retaliation from co-workers if they filed a complaint (Higgins & MacIntosh, 2010). Current organizational strategies have been largely ineffective and a gap in the literature exists surrounding the creation and implementation of effective strategies to decrease WPV.

Johnson, Phanbtbarath, and Jackson (2009) suggest reporting WPV to the organizations' human resource department. The National Labor relations Act and the Occupational Safety and Health Administration (OSHA) give individuals the right to report incidents without losing their jobs or suffering other reprisals. Other suggestions offered in the literature include, increasing the visibility of authority figures in the workplace (Higgins & MacIntosh, 2010); advocate for reporting guidelines and education of institutional policies and procedures to help reduce WPV (Anderson & Parish, 2003); establish zero tolerance assessment teams; implement education programs targeted at recognizing and managing WPV; create a mandatory reporting system (Ople, 2010) and; promote strategies aimed at improving relationships among nurses and group cohesion (Barrett, Korber & Padula, 2009). Future research is required to identify what strategies will provide lasting effective long-term solutions that take into account the experiences of all involved.

Financial Implication of WPV

Hutchinson, Vickers, Jackson, and Wilkes (2006) have addressed the fact that studies fail to acknowledge some of the wider environmental and organizational issues that are affected by WPV. Richardson (2003) as cited in Hutchinson (2006) identified that the central pressure within health-care is clearly cost containment (Hutchinson et al. 2006). For the employer, WPV impacts costs related to increased turnover, absenteeism, medical and psychological care, property damage, increased security, litigation, increased workers' compensation, job dissatisfaction, and decreased morale (Banaszak-Hall & Hines, 1996) as cited in Hutchinson et al. (2006).

Alarming financial costs of WPV have estimated that American employers costs are in the region of four to six billion dollars annually and in Australia workplace bullying alone is estimated to cost up to 13 billion Australian dollars annually (Farrell, Bobrowski & Bobrowski 2006). The RNAO (2008) found that, costs associated with WPV against nurses, is in the region of $35,000 per violence-related injury.

Conclusion

Until recently is has been unfashionable to talk about aggression occurring between colleagues in the same context as the caring role (Farrell, 2006). However, WPV has reached such epic proportions that the ICN (2001) has declared WPV as a global public health problem. Researchers have identified and examined the multiplicity of risk factors associated with WPV as well as their inherent consequences to the healthcare sector. It is imperative that future research, identify effective strategies that are sensitive to personal aspects aimed at decreasing WPV and increasing the health, integrity and productivity of the healthcare sector.

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