Violence & Aggression in Health Care

Assessing Health Care Worker Exposure to Acts of Violence and Aggression in the Workplace: A Pilot Study

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NH Healthcare Violence Prevention Workgroup

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Executive Summary

Introduction

Healthcare workplace violence is a significant, yet elusive, public health problem. According to a 2016 review article in the New England Journal of Medicine, "Healthcare workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored." The statistics are startling: 75% of the 24,000 workplace assaults occurring annually between 2011 and 2013 were in healthcare settings (Phillips, 2016) and healthcare workers are 20% more likely to become victims of violence than workers in any other industry (The Joint Commission, 2018; Harrell, 2011; Groenewold, Sarmiento, Vanoli, et al., 2018).

These numbers do not capture the true incidence of violence, largely due to underreporting by as much as 70% (Phillips, 2016). Data related to incidence of verbal aggression, such as threats, verbal abuse, hostility, and harassment towards staff by patients has not been collected at a national level (Phillips, 2016). Experienced by many healthcare workers on a daily basis, verbal aggression is the most common form of violence in healthcare (Renwick, Steward, Richardson, et al.; 2016; Renwick, Lavelle, Brennan, et al., 2016), yet it is the least likely to be reported or addressed in the workplace because it is seen as "part of the job" (Campbell, Messing, Kub, et al., 2011). Healthcare workplace violence has major consequences, as it contributes to staff burnout, PTSD, leaving the job, anxiety, and depression (Camerino, Estryn-Behar, Conway, et al., 2008; Foster, Bowers, Nijman, 2007; Mobaraki, Aladah, Alahmadi, et al., 2020), and adversely affects the quality and safety of patient care (Arnetz, J. E., Neufcourt, Sudan, Arnetz, B. B., Maiti, T Viens, F. 2020).

In an effort to address this serious public health issue, the Joint Commission recommended that healthcare organizations "clearly define workplace violence and put systems into place across the organization that enable staff to report workplace violence instances, including verbal abuse," as well as to "capture, track and trend all reports of workplace violence – including verbal abuse and attempted assaults when no harm occurred" (The Joint Commission, 2018).

In 2016, the New Hampshire Senate voted against a bill to require all state-licensed healthcare facilities to perform an annual workplace violence risk assessment and develop written violence prevention plans with specific actions to reduce risk. In following up, Senator James P. Gray asked for an assessment of the current situation in New Hampshire regarding workplace safety/violence. In response, we developed a survey intended for a cross-section of one county in the state with the goal of beginning to quantify the pertinent issues from the perspectives of all healthcare providers and administrators, from home healthcare workers to hospital CEOs.

Methodology

Between 1/15/2020 and 3/30/2020, an anonymous survey implemented via RedCap by Dr. Lisa Mistler was distributed to New Hampshire health providers. As

contact lists of healthcare providers were not readily available, a snowball sampling design was used, and agency contacts were asked to share the survey link with interested staff. Project staff contacted multiple organizations, of which three agreed to send out information to their members. No incentives were offered for survey completion. By the close of the survey process, 244 healthcare staff from a variety of disciplines had participated in the survey.

Critical Findings

Startingly, 73% of responding healthcare providers experienced some form of violent incident during the previous six months, including verbal, physical, harassment, intimidation, or sexual aggression.

Aggression was experienced "at least a few times per week" by half of the respondents subjected to verbal (55%), intimidation (48%), or harassment (46%). This also occurred among 37% of those experiencing physical aggression, and 7% of those experiencing sexual aggression. However, only two-thirds of those impacted by aggression (68%) reported the incident, with those working in emergency department settings the least likely to report at 58%.

As a result of these events, not only are the lives of staff put at risk, but those of patients as well. Over half of the violent events occurred during patient care (53%), while over one in four (30%) occurred during medication administration.

Unsurprisingly, when respondents were asked whether they felt protected from the threat of violence at work, 62% said no. However, of the 38% who did feel protected, many identified and contributed to a list of protective factors. Highest among these were the presence of an onsite security team, clear support from supervisors, presence of other staff, and specific security protocols.

Limitations of the Study

As the study relies on a convenience sample from a specific geographic area in New Hampshire, as well as feedback from mostly female nurses working full time, these findings are not generalizable to the broader population of healthcare providers. Analysis presented herein was limited to areas where the denominator was at least 15. Additionally, a number of research questions would need to be asked to help fill in some of the gaps in knowledge and address potential assumptions when interpreting the data. Recommended adjustments for future work have been included in the "Recommendations" section.

With those limitations in mind, there is ample evidence that, based solely on the information provided by those responding to the survey, violence in the healthcare workplace presents a serious and credible risk to healthcare providers and patients.

Recommendations

Based on the responses provided by over 200 New Hampshire health care workers, as well as what is already known from the national literature, both additional study and immediate action steps are called for to reduce risk and keep staff and patients safe in the short and long term. These include organizational action to take immediate steps for improved worker safety; new research to identify prevalence of and contributing factors to workplace violence; a multi-agency quality improvement effort to adopt and learn from best practices in the field; as well as statewide policy improvements to ensure consistency in approaches to workplace safety.

Survey Findings

Demographics

244 healthcare providers responded to the survey invitation, with 87% completing the survey. Most respondents were female (89% of 244), 9% were males, others identified as non-binary (1%), and less than 1% did not respond to the question about gender. Age of respondents ranged from 18-28 (14%), 29-45 (31%), 46-65 (48%), and those 65 and over (6%). Less than 1% of respondents did not provide an age.

Most had worked at least 10 years in healthcare (65% of 243), with about one in five working five to 10 years (21%) and about one in seven (14%) working less than five years. Two-thirds of participants were registered nurses (68% of 244), while about one in four (26%) were licensed nursing or medical assistants. Other groups with less than 5% representation included physicians (3%), contractors (1%), administrative (1%), medical technicians (1%), and dining services (<1%).

Participants generally worked full-time (64% of 252), with an even amount working evenings (18%) or nights (16%), and about 10% with a variable schedule. In terms of hours worked, a little over half (51% of 242) worked five to 10 hours a day, and about one in four worked 10 to 12 hours (26%) or over 12 hours per day (22%). Less than 1% worked one to five hours. Overall, 82% of 243 were full-time, 12% part-time, 6% per diem, and less than 1% served as volunteers or consultants.

In terms of work settings, about one in three worked in inpatient care (34% of 244), about one in five in ambulatory settings (22%), or nursing home care (18%), one in six in emergency departments (16%), and less than one in 10 in assisted living (9%) or home care (9%). 12% of respondents identified other settings.[1]

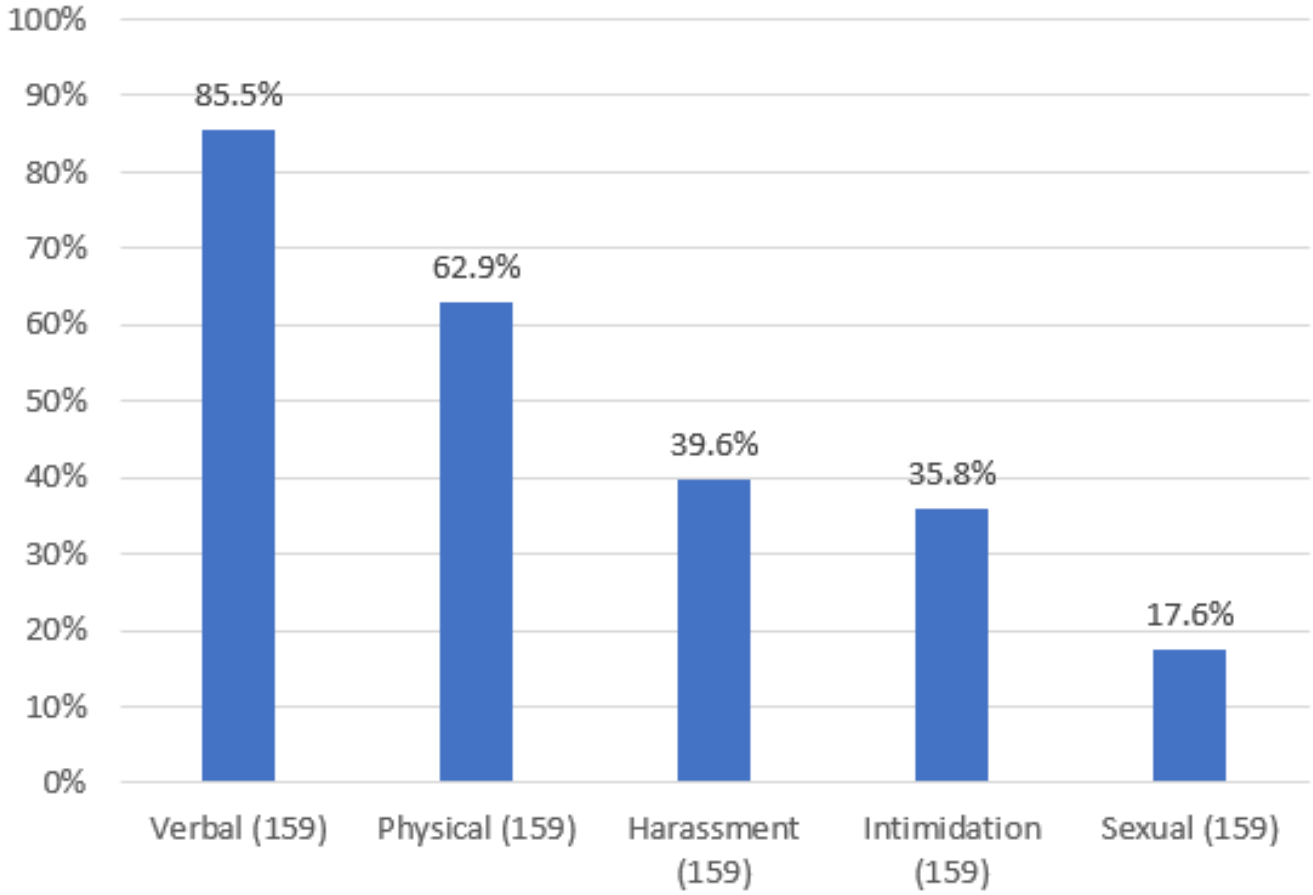
Incidence of Violence Among Healthcare Providers

73% of 219 responding healthcare providers experienced some form of violent incident over the previous six months, including verbal, physical, harassment, intimidation, or sexual aggression (see Figure 1). Aggression was experienced by men (85% of 20) and women (72% of 195), with those working less than five years (82% of 27) or 5-10 years (83% of 48) more likely to report than those with more than 10 years of experience (67% of 143). Those working evenings were the most likely to indicate a violent event (98% of 40), followed by those working nights (83% of 36), and daytime (66% of 143). In terms of hours per day, those working more than 12 hours were the most likely to relate an incident (88% of 51), followed by 74% (N=54) of those working 10-12 hours and 65% of those working under 10 hours (N=112). Of the 11 respondents who worked evenings and greater than 12-hour shifts, all 11 reported a violent event in the past six months.

Types of aggression experienced included verbal (86% of 159), physical (63%), harassment (40%), intimidation (36%), and sexual aggression (18%). Aggression was experienced several times per week by

1 20% of respondents selected two or more work settings

Figure 1: Type of Aggression Experienced (N=159)



about half of the respondents subjected to verbal violence (55% of 134), intimidation (48% of 56), or harassment (46% of 63). A similar frequency also occurred among 37% of those experiencing physical aggression (of 99), and 7% of those experiencing sexual aggression (of 28).

These events were most commonly due to patient action (81% of 159), followed by a relative of the patient (23%), or visitors (13%). **Of note, a scan of the comments shared under "other" comments indicated another employee as the source of the aggression in 15% of the cases.**

Where Aggression Occurs

In terms of where aggression occurs[2], staff working in emergency departments (93% of 29) and inpatient (85% of 53) were the most likely to have reported a violent event in the past six months. This was followed by those working in nursing homes (76% of 21) and ambulatory care settings (58% of 33) (see Figure 2).

Based on respondent feedback (N=159), Figure 3 shows two thirds of violent events occurred
in patient rooms (66%) followed by the hallway (45%) and nurse's stations (29%). Other areas identified include waiting areas (17%), patient bathrooms (13%), and patient examination rooms (12%). Less than 5% were reported for the patient/family members home[3] (3%) and medication room (3%). 20% identified locations in other areas.

2 Analysis based on respondents identifying only one type of facility as part of their work history.

3 Note that there were a limited number of respondents working in a home environment, so this number is not surprising given the demographics of respondents.

Figure 2: Experienced Violence by Type of Health Facility

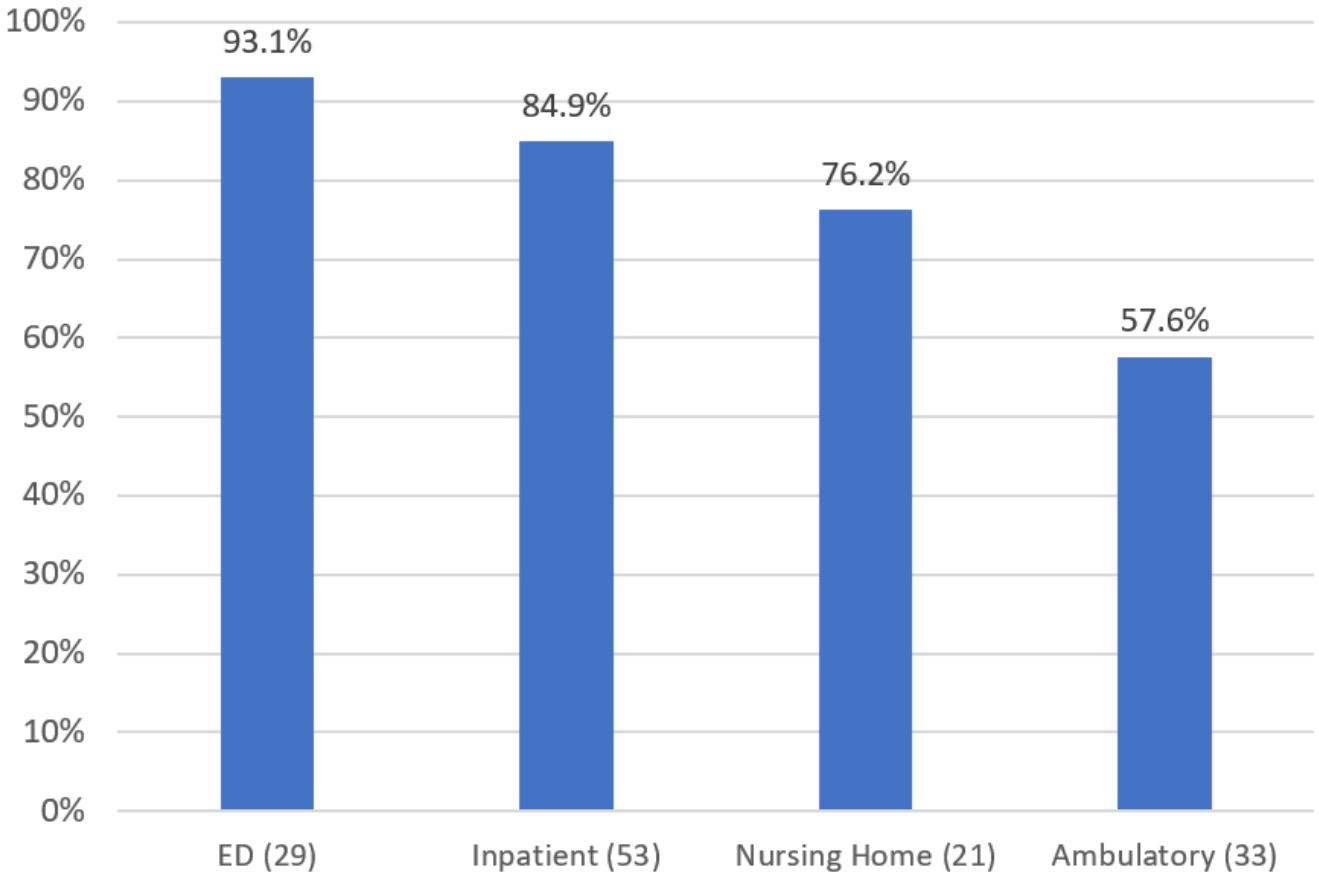


Figure 3: Where did violence occur? (N=159)

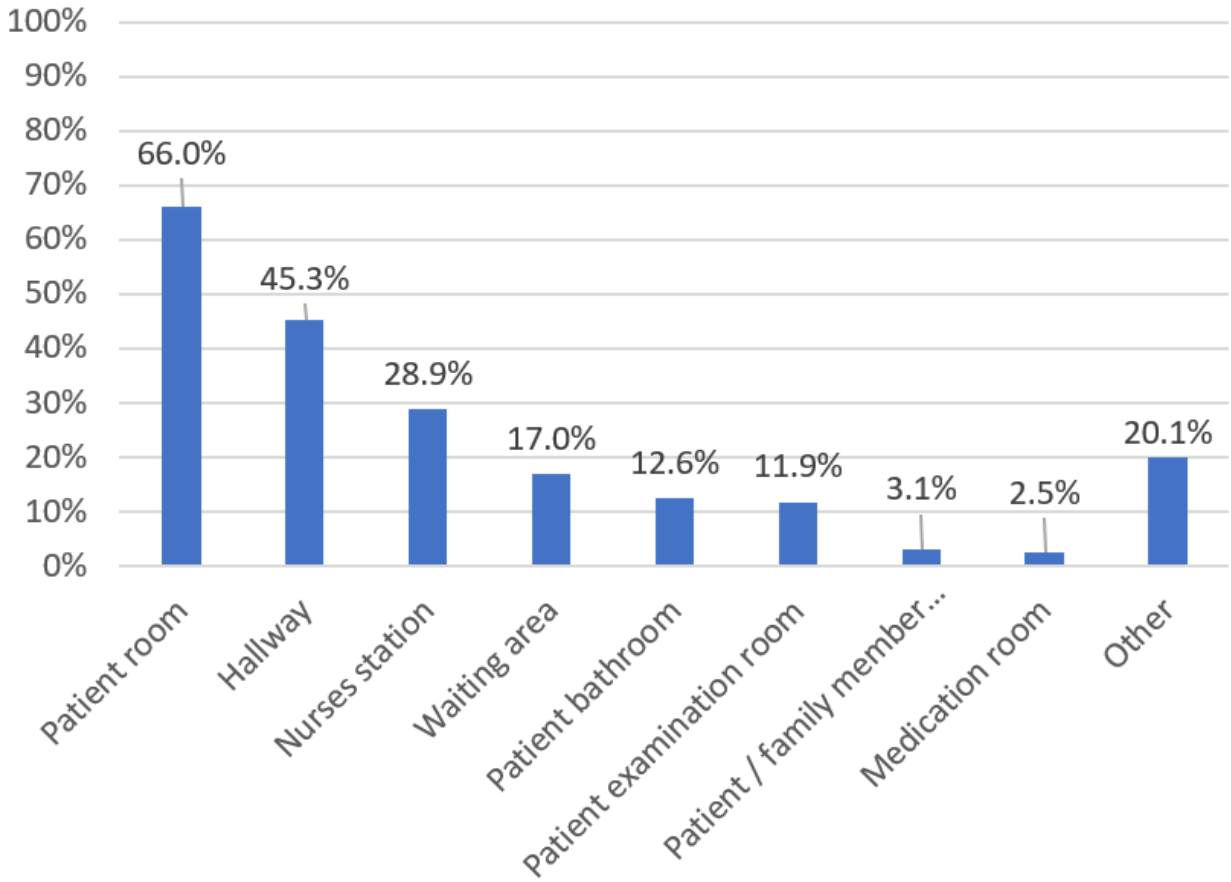
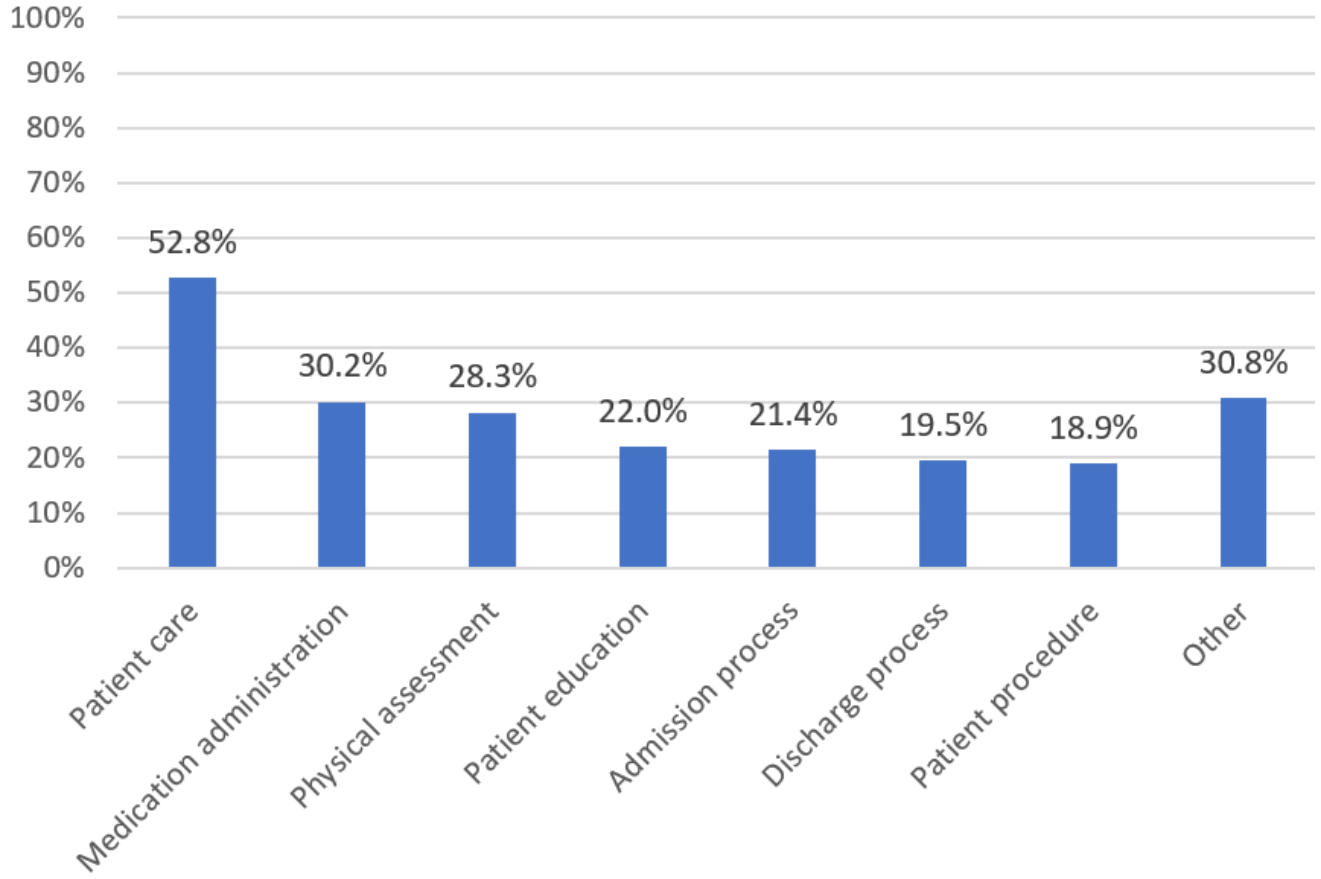


Figure 4: What activities were underway? (N=159)



Impact of Aggression

16% of those impacted reported receiving an injury as a result of the aggressive act (N=157). Of these, 22 respondents cited a range of injuries, including herniated discs and other back injuries, contusions, pulled muscles, sprains, testicular trauma, bruising, bites, slash marks, and scratches. Even though actual incidence is likely much higher, **only two individuals mentioned injury related to their mental health.**[4] One respondent reported damage to personal property.

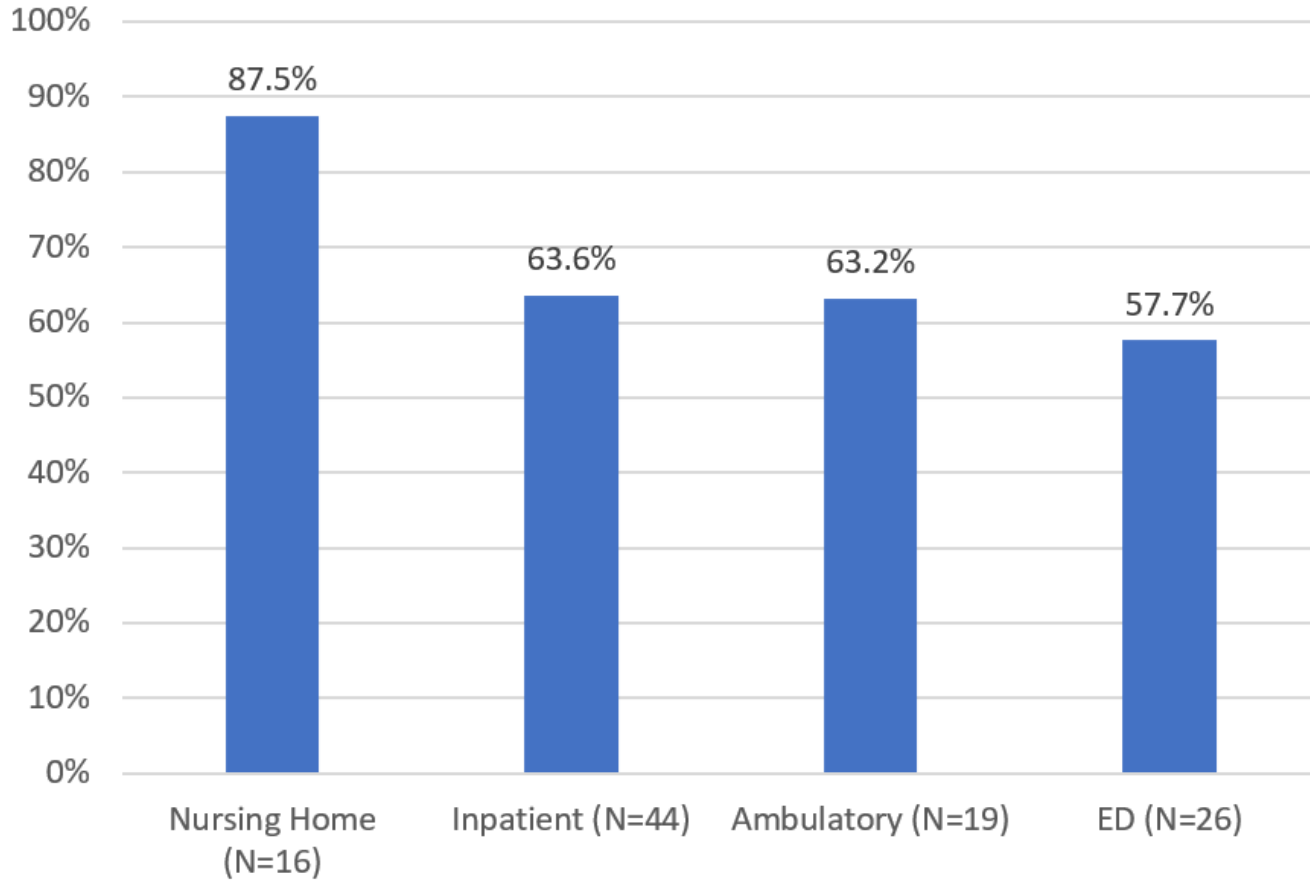
In addition to harm to the care provider, these events put patients at risk as well. When asked what healthcare activities were underway when the aggression took place, Figure 4 shows that respondents identified respondents identified a range of activity areas. Over half reported patient care (53% of 159), followed by medication administration (30%). One in four cited physical assessment (28%) and patient education (22%). About one in five identified the admission process (21%), discharge process (20%), and during a patient procedure (19%). 31% noted that the event happened during other activities.

Reporting Violent Aggression

Roughly two-thirds of respondents (68% of 157) reported the violent incident, while 22% did not. For this latter group, a follow-up survey question asked why they had

4 This likely reflects a shortcoming of the survey tool, which did not specifically ask if a mental health injury occurred. Based on the literature, incidence of mental health injury due to these types of events is likely much higher (12) and may be underreported due to stigma and misconceptions around mental health issues.

Figure 5: Percent Reporting Violent Event by Facility Type



not. Over one in three (38% of 53) indicated they did not believe the act was intentional; one in five reported they did not know if they should (21%) or were apprehensive due to repercussions (19%). 2% said they were unaware of a reporting system. Of the 11 who indicated some other reason, seven indicated that nothing would change, while two shared that verbal altercations typically go unreported.

Looking at reporting by facility type showed some variation. Figure 5 documents that those working in nursing home environments[5] were most likely to report a violent event when it happened (88% of 16). This was followed by those working in inpatient settings (64% of 44), ambulatory (63% of 19), and emergency departments (58% of 26).[6]

Protective Factors Against Violent Aggression

Although responses indicated violent aggression against healthcare providers occurred among nearly three-quarters of those responding to the survey, the presence of protective factors among respondents was far less consistent.

Only 56% of 213 respondents stated their facility promotes a standardized tool, form, or protocol. Of those who did report the presence of a tool (N=119), only 54% thought it positively impacted their environment. Of those who were not aware of a tool (N=89), a similar proportion (54%) thought it would positively impact their

5 Note small N of 16 for respondents from nursing home facilities and 19 for ambulatory. Results based on respondents with only one type of facility in their work history.

6 Analysis based on respondents identifying only one type of facility as part of their work history.

work environment if it were available.

When asked whether their supervisor encouraged reporting of violence regardless of circumstance (N=212), about two-thirds (63%) agreed. 62% of 218 respondents participated in training classes; of these (N=135), about 70% indicated the training was required. When asked whether the training was helpful (N=133), only 63% agreed.

Analysis of Protective Factors

A number of indicators related to protective factors against violence were assessed against whether a violent event was experienced (Table 1) and whether the event was reported (Table 2).

Table 1 documents that, among those responding to the survey, incidents of violence were substantially more likely (20-point difference) among those who shared that a tool or protocol for violence was NOT available (89%) or that a supervisor did NOT encourage reporting (87%). Whether or not they took violence intervention training did not appear to correspond to a higher incidence of violence.

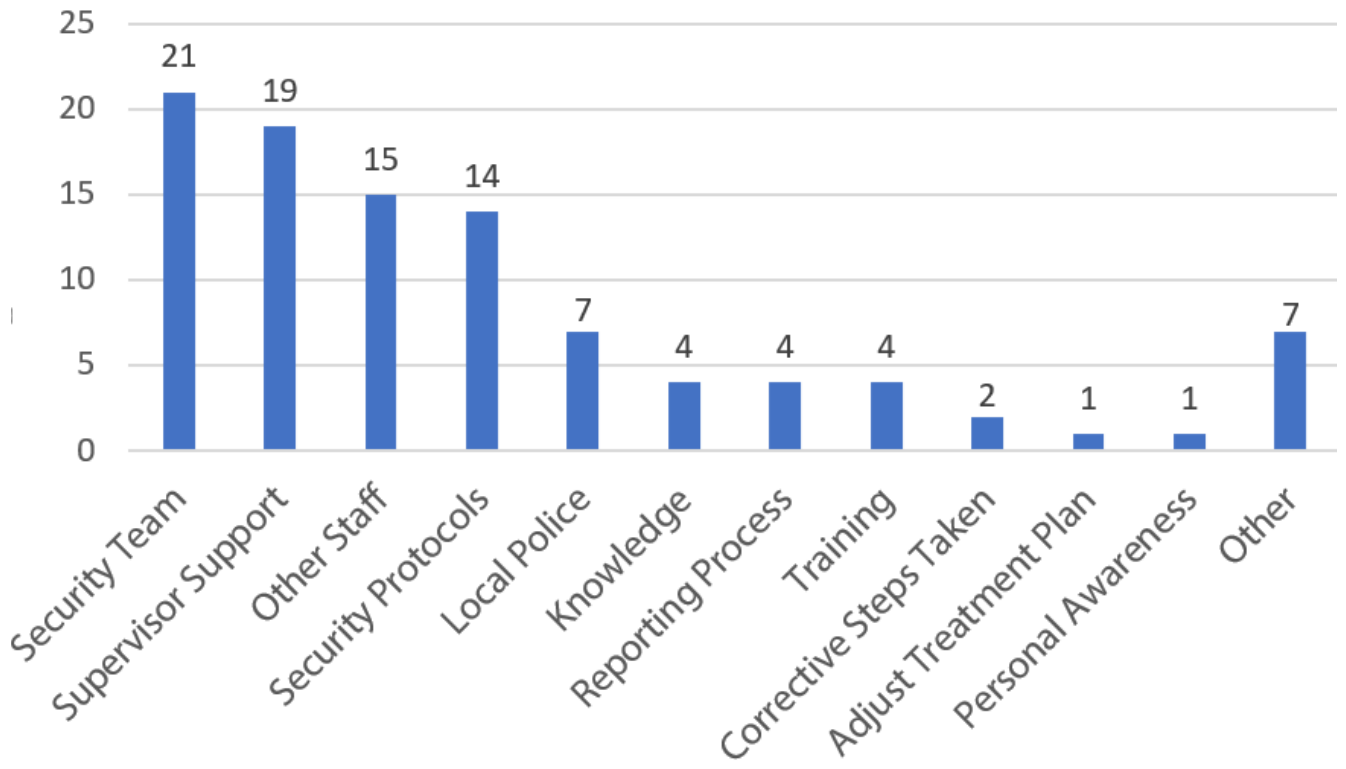
Table 1 - Experience of Violence by Presence of Protective Factors

Protective Factors	Percent Experiencing Violence
Tool or protocol available (N=120)	65%
UNSURE if tool or protocol available (N=49)	78%
Tool or protocol NOT available (N=44)	89%
Supervisor encourages reporting (N=134)	65%
Supervisor DOES NOT encourage reporting (N=78)	87%
Taken violence intervention training (N=136)	75%
DID NOT take violence intervention training (N=82)	68%

Table 2 - Reporting of Violence by Presence of Protective Factors

Protective Factors	Percent Reporting Violence
Tool or Protocol Available (78)	76%
UNSURE if Tool or Protocol Available (38)	45%
Tool or Protocol NOT Available (39)	74%
Supervisor Encourages Reporting (87)	78%
Supervisor DOES NOT Encourage Reporting (68)	54%
Taken Violence Intervention Training (101)	69%
DID NOT Take Violence Intervention Training (56)	64%

Figure 6: Why Healthcare Providers Feel Protected from Threat of Violence (N=65)



In terms of whether respondents were more or less likely to report a violent event, Table 2 shows that a similar proportion of respondents would report (about 75%) whether or not a tool or protocol was available. However, among those who were unsure, only 45% did so. The presence of violence intervention training, again, seemed to have little correspondence to likelihood of report, as each group showed similar proportions of respondents indicating that a report had been filed. **Among those with supportive supervisors, 78% said they reported the event, as opposed to only 54% among those without supportive supervisors.**

Interestingly, among those who indicated their violence intervention training was helpful, a notable difference arose. 69% of members of this group (N=84) indicated a violent incident had occurred compared to 88% of those who did not find it helpful (N=49). Percent reporting the event was the same (69%) regardless of whether they found the training helpful (N=58) or not (N=42).

Regarding whether the respondent felt protected from the threat of violence at work (n=213), 62% said no. For the 38% who did feel protected, a follow-up open comment question concerning why they felt protected yielded informative responses.

65 respondents shared comments about why they felt protected from the threat of violence at their facility. These responses were then coded based on 12 identified theme areasand presented in Figure 6. Most frequently cited reasons were the presence of an onsite security team (21) and clear support from supervisors (19), followed by the presence of other staff (15) and specific security protocols to be followed (14). Less frequent reasons for feeling protected included: access to local police (7), knowledge of how to appropriately deal with situations (4), awareness of a reporting process (4), training they received (4), organizational corrective steps were taken in the past (2), the ability to adjust treatment plans when needed (1), personal awareness (1), and other (7).

Comments shared around security protocols may be of value for additional review as respondents shared specific strategies that healthcare providers as individuals or organizations may be able to adopt. These included:

Security Teams

- Rapid response from security
- Visible and competent security
- 24/7 security coverage
- Security present when potential violent person scheduled

Duress/Panic Buttons

- Rooms with duress/panic button
- Laptops with duress/panic software
- Badges with duress/panic button

Room Security

- Badge access only rooms
- Locked doors
- Telesitter in high-risk rooms

Staffing Support

- Buddy system if feel unsafe
- Extra staff when needed

Phone System

- Unique ringtones in the call system
- Call codes for threats

Other

- Reorg assignments if staff feel unsafe

- Adjust screening process
- Access to physical restraints when needed
- Workplace violence committee

Conclusions

Despite the limitations of the study, largely due to sample size and non-random sampling, there are several findings which merit further attention. For example, among those participating in the study, violent events are experienced:

- across all age groups;
- all healthcare settings;
- occur multiple times per week for many; and
- originate from multiple sources, including patients, family members, and co-workers.

It was not surprising then to learn that 62% of healthcare workers did not feel safe at their place of employment.

Data suggest that availability of tools, protocols, and policies, as well as supervisory support, may be connected to lower incidence of violent experiences among the healthcare providers studied. For example, when tools/policies were available, 65% indicated a violent event occurred, as opposed to 89% if tools/policies were not available. Similarly, 65% experienced violence if a supervisor regularly encouraged reporting of violence at their facility vs. 87% of those with supervisors who did not.

Violence intervention training itself may or may not be helpful to reduce violence occurrence (75% experienced violence if they had taken a training vs. 68% if they had not; (See Table 1). However, in instances where respondents found the training to be helpful, they were less likely to have experienced a violent incident in the past six months (69% of respondents who reported training as helpful experienced violence vs. 88% of those who reported training as not helpful experienced violence).

Care must be taken with interpreting results too broadly from the available data. Due to limited sample sizes, there are likely additional factors at work (e.g., differences in emergency department vs. ambulatory settings, rural vs. urban hospitals, time to provide quality care, provider burnout and stress, etc.) that we do not fully understand, which could shape the frequency and impact of violent events in healthcare settings. It will be necessary to take additional steps to both address the immediate action that is needed as well as bring in new information to help guide successful long-term strategies.

Recommendations

Primary recommendations for next steps center around 1) supporting action at the organizational level to ensure implementation of agency-level policies, training, and other services to improve staff and patient safety; 2) additional research on the prevalence, drivers, and protective factors of workplace violence; 3) a multi-organization quality improvement initiative to build upon lessons learned; as well as 4) statewide policy changes to ensure healthcare providers have adequate resources, organizational and management support, and supportive environmental and cultural redesign to systematically decrease risk to provide a safe, supportive environment for healthcare providers and patients.

Organizational Action

Based on the literature review and supplemental findings from the pilot study, several immediate steps are recommended for action by regional healthcare providers and organization leaders. Particularly important to consider are recommended best practices to better ensure the safety of staff who work in potentially dangerous environments.

Towards this end, four publications are critical for further review and consideration for action by hospital staff:

- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers by OSHA (https://www.osha.gov/sites/default/files/publications/osha3148.pdf)
- Recommended Practices for Safety and Health Programs by OSHA (https://www.osha.gov/sites/default/files/publications/OSHA3885.pdf)
- Sentinel Event Alert, Issue 59, April 2018 (https://www.jointcommission.org/-/media/documents/office-quality-and-patient-safety/sea_59_workplace_violence_4_13_18_final.pdf)
- Framework Guidelines for Addressing Workplace Violence in the Health Sector (https://apps.who.int/iris/bitstream/handle/10665/42617/9221134466.pdf?sequence=1&isAllowed=y)

Examples of recommended steps based on the above and the expertise of workgroup members include:

Crisis Prevention

- Management commitment and worker participation including training programs on workplace violence crisis response actions and policies
- Develop standard definitions and measures of violence and disseminate throughout the state
- Identify and assess risk factors for WPV in the following settings:
  - Organizational
  - Individual
- Engineering controls and workplace adaptations to reduce risk (e.g., improved lighting in parking lots; restricted access to certain areas)
- Training for administrative and treatment staff regarding therapeutic procedures that are sensitive to the

cause and stimulus of violence. For example, research has shown that Trauma Informed Care is a treatment technique that has been successfully instituted in inpatient psychiatric units as a means of reducing patient violence, as well as the need for seclusion and restraint.

- Crisis response training and simulation practice
- Development of crisis response procedures with local law enforcement and emergency responders
- Surveillance—injury record review to identify patterns of assaults or near misses

Crisis Management

- Crisis management team
- Crisis incident program in place: identification, reporting, activating emergency plan, knowing roles during incident emergencies
- Investigation of incidents (involve workers in the incident investigation)

Post-Crisis

- Reporting
  - Establishing policies that ensure the reporting, recording, and monitoring of incidents and near misses and that no reprisals are made against anyone who does so in good faith.
- Treatment
  - Employers should ensure that if an incident of workplace violence occurs, post-incident procedures and services are in place and/or immediately made available.
- Program evaluation, development of quality improvement initiatives, including changes to the physical environment, as well as work organization practices and administrative procedures
- Training of all staff

The approaches referenced in the sources above address fundamental issues which need to be addressed if we are ever to successfully improve current healthcare environments. Implementing best practice recommendations will not only decrease healthcare workplace violence but improve provider satisfaction and quality of patient care.

Research

While the pilot study helped to document the incidence of violence and aggression among a subset of healthcare providers and provided insights into the frequency and distribution of such events, it also raised more questions worthy of further study. For example, due to limited sample sizes, there is insufficient information to answer questions such as:

- Are certain types of aggression more common among those with limited experience in the field? Or among those who work part-time? Are certain types of training more or less beneficial to them?
- How does the incidence of aggression and its impacts vary by those working in emergency departments, as well as in assisted living and home care settings?
- What types of trainings, policies, and/or protocols seem most effective for different types of aggression?
- Is reporting more or less likely when a co-worker is involved in the abuse?

A broader study with a randomized stratified statewide sample with sufficient sample sizes for particular demographics would be beneficial to document the need for action, clarify multiple issues, and address some of the critical knowledge gaps in the current survey results.

In addition to gathering perspectives from staff involved in these events, it will also be critically important to gain a better understanding of patient and family perspectives surrounding each event. Insights provided by all parties involved may be instrumental in devising effective long term solutions to this complex challenge.

Quality Improvement Initiative

By combining the benefits of organizational action and ongoing research, a consortium of health organizations can work together to learn about the most effective steps which can be taken to improve staff and patient safety. In so doing, they not only add to the body of research on what works, but also are able to fine tune the application of best practice given the unique dynamics of each organization and can show systematic improvement in an area that can have far reaching implications on the ability of each organization to achieve its healthcare mission.

Policy

While steps can be taken at the organizational level as described above, additional statewide policies to supplement these activities would help to ensure that there is consistency in our efforts to protect the lives of those who may otherwise be left vulnerable to attacks born out of anger, fear, and confusion. For consideration, policy actions implemented by other states include:

- Employer-run workplace violence prevention programs
- Development and implementation of standards of conduct, as well as policies for managers and employees to reduce workplace bullying and promote healthful and safe work environments
- Amending existing statute for assaults of first responders by adding healthcare providers/nurses and/or increasing the penalty associated with such behavior
- Implementing an ID tag and badges law to relax the requirement of using full names on staff IDs
- Post warnings regarding violent behaviors in hospitals
- Update Injury & Illness Prevention Plans at least annually
- Set up committees to recommend updates and develop incident reporting procedures for patient assaults on employees to assist hospitals in better identifying the risks of such assaults.

Additional information can be found at: https://www.nursingworld.org/practice-policy/advocacy/state/workplace-violence2/.

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Appendix: Survey Tool

Please review the following definitions prior to beginning the survey, as the survey includes questions about different types of violence and aggression in the healthcare setting. For the purpose of this study, **violence** is defined as any form of physical or non-physical aggression, regardless of intent, including physical, sexual, or verbal aggression, harassment, or intimidation directed towards healthcare employees by patients, families, or visitors.

Physical aggression: behavior causing or threatening physical harm towards others. It includes hitting, kicking, biting, using weapons, or destruction of property.

Sexual aggression: any touching or grabbing that is performed without consent or makes the receiver uncomfortable in any way.

Verbal aggression: any words, phrases, or conversations that make the receiver feel threatened and/or affects them negatively. Verbal aggression includes yelling, name calling, and blaming.

Harassment: any repeated behavior that is troubling or provoking.

Intimidation: the act of coercing or frightening someone to do (or not to do) something against their will.

Part I: Demographics

1. What is your age (select one):

☐ 18-28

☐ 29-45

☐ 46-65

☐ 65+

☐ I prefer not to answer

2. How do you identify?

☐ Male

☐ Female

☐ Non-binary

☐ I prefer not to answer

☐ Other: _____

3. How long have you worked in a healthcare setting?

☐ Fewer than 5 years

☐ 5-10 years

☐ More than 10 years

4. Currently, what is your role/position in the healthcare field?

☐ Administrative or clerical (e.g., reception, accounting, customer service, and non-clinical support staff)

☐ Contractor or consultant

☐ Dining services

☐ Environmental services (e.g., housekeeping, maintenance, facilities, and security)

☐ Licensed nursing assistant or medical assistant

☐ Management

☐ Nurse practitioner or physician assistant

☐ Pharmacist

☐ Physician

☐ Registered nurse or licensed practical nurse

☐ Medical technician

☐ Volunteer

5. Are you employed:

(Please choose only one response)

☐ Part-time

☐ Full-time

☐ Per diem

☐ Volunteer/Consultant

☐ Contractor

5. Which do you normally work?

☐ Days

☐ Evenings

☐ Nights

☐ Varies

6. Approximate hours worked per workday:

☐ 1-5

☐ 5-10

☐ 10-12

☐ >12

7. Within the past six months, what type of facility have you worked in? (select all that apply)

☐ Hospital - inpatient

☐ Hospital Emergency Department

☐ Ambulatory setting, including primary care, urgent care clinic, Department of Health clinic, homeless clinic, mental health center, crisis beds

☐ Assisted living

☐ Nursing home/long-term care facility

☐ Home care or hospice agency

☐ Freestanding emergency medical facility

☐ Other: _____

Part II: Violence in the Healthcare Setting

8. Within the past six months, have you experienced a violent incident, including physical, sexual and verbal aggression, harassment, or intimidation at your place of work? If no, proceed to xxxx.

☐ Yes

☐ No, proceed to question 17

9. If you answered "Yes" to the previous question, how would you classify the incident(s)? (select all that apply)

☐ Physical aggression: behavior causing or threatening physical harm towards others. It includes hitting, kicking, biting, using weapons, or destruction of property.

☐ Sexual aggression: any touching or grabbing that is performed without consent or makes the receiver uncomfortable in any way.

☐ Verbal aggression: any words, phrases, or conversations that make the receiver feel threatened and/or affects them negatively. Verbal aggression includes yelling, name calling, and blaming.

☐ Harassment: any repeated behavior that is troubling or provoking.

☐ Intimidation: the act of coercing or frightening someone to do (or not to do) something against their will.

10. If you have experienced any of the acts of aggression and violence listed above within the past six months, how frequently have these incidents occurred?

	Everyday	A few times per week	A few times per month	Less than once a month
Physical Aggression	☐	☐	☐	☐
Sexual Aggression	☐	☐	☐	☐
Verbal Aggression	☐	☐	☐	☐
Harassment	☐	☐	☐	☐
Intimidation	☐	☐	☐	☐

11. Where were you when the violent act(s) occurred? (select all that apply)

☐ Patient room
☐ Patient bathroom
☐ Hallway
☐ Nurse's station
☐ Medication room
☐ Patient/family member's home
☐ Patient examination room
☐ Waiting area
☐ Other: _____

12. Within the last six months, during what activity(s) have you experienced workplace violence? (sexual, physical or verbal aggression, harassment, or intimidation) Select all that apply

☐ Patient care, e.g., ADLs, toileting, bathing
☐ Medication administration
☐ Physical assessment
☐ Patient education
☐ Patient procedure
☐ Admission process
☐ Discharge process
☐ Other: _____

13. Did an injury occur as a result of any of these incidents?

☐ No

☐ Yes.

If so, what was the injury? _____

14. Who committed the violence? (select all that apply)

☐ Patient/client

☐ Relative/family of patient

☐ Visitors

☐ Other: _____

15. Briefly describe the violent incident(s):

(Do not include identifying or confidential patient information in your response.)

_____

_____

_____

_____

16. When you've experienced violence while working in the healthcare setting, have you reported or documented it to a person in administrative leadership?

☐ Yes

☐ No

17. If not, what was your primary reason for not reporting?

☐ Unaware of reporting system in facility

☐ Did not believe act was intentional

☐ Apprehensive due to repercussions (victim blaming)

☐ I didn't know if I should

☐ Other:_____

18. Is there a standardized tool, form, or protocol in your facility to report violent acts committed by patients, family members, or visitors?

☐ Yes (go to question 19)

☐ No (go to next question)

☐ I am not sure (go to next question)

19. If you answered NO or UNSURE to question 17, would having a reporting tool, form, or protocol positively impact your work environment?

☐ Yes

☐ No

☐ I am not sure

If yes, in what way? _____

20. Does your unit coordinator, floor manager, or supervisor encourage you to report incidents of violence when they occur, regardless of circumstance?

☐ Yes

☐ No

21. Do you feel protected from the threat of violence at work?

☐ Yes

☐ No

If yes, how do you feel protected? _____

22. Have you as an employee taken any violence intervention and/or prevention training classes through your place of work? These can include CPI (Crisis Prevention Intervention) or MOAB (Management of Aggressive Behavior) training.

☐ Yes

☐ No

23. If you answered YES above, was this training required or optional?

☐ Required

☐ Optional

☐ Other: _____

24. Did you find the training helpful (or useful) when patients, family, or visitors begin to act aggressively?

☐ Yes

☐ No

☐ If yes, how was the training helpful? _____

25. Are there any additional comments/concerns you have as a healthcare worker that are important for us to consider? (Do not include identifying or confidential patient information in your response.)

_____

_____

_____

_____