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Violence & Aggression in Health Care

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Violence & Aggression in Health Care

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A report prepared for the

NH Health Care Violence Prevention Consortium

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NH Occupational Health Surveillance Program

ENDOWMENT *for* Health

**Special thanks to members of the
NH Healthcare Violence Prevention Workgroup:**

Contents

EXECUTIVE SUMMARY

Introduction

In 2020, a group of concerned healthcare workers and public health advocates in New Hampshire launched a pilot study to assess the prevalence of violence experienced by fellow healthcare staff across a variety of healthcare facilities. This resulted in a first-of-its-kind report in New Hampshire documenting the frequency and type of violence directed toward staff at participating hospitals and suggested solutions to address this growing problem (available here: https://iod.unh.edu/sites/default/files/media/NHOHSP/Pubs/violence_in_health_care_oct_2021_final_0.pdf). One of the recommendations from this work was to conduct additional research focusing on violence occurring within hospital emergency departments as these sites reported the highest rates of violence experienced by healthcare staff.

As a result, a new online survey-based study was conducted to explore staff experiences of violence in the emergency departments in six participating hospitals across New Hampshire. To be eligible to partake in the survey, individuals had to have been employed by the hospital for at least 6 months[1], be 18 years of age or older, and voluntarily consent to participate. This project was approved by the UNH IRB under the title: NH Workplace Violence Prevention Project (IRB-FY2022-367). This report provides a summary of key findings drawn from the results of the online survey.

For the purposes of this study, five types of violence were identified in the survey. They are listed and defined as:
- 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, threatening, name-calling, blaming and/or inappropriate verbal sexual advances.

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[1] About 12% of statewide respondents indicated that they had been employed for less than 6 months but had still completed the rest of the survey. Upon review of the data, the project team determined that retaining the information provided would still be of use to this study. As a result, the data presented in this report may include responses from those who had agreed to participate in the research, are 18 years or older and who have been employed for less than 6 months.

- Harassment: any repeated behavior that is troubling or provoking.
- Intimidation: the act of coercing or frightening someone to do (or not do) something against their will.

Methodology

During the summer of 2022, an anonymous online survey implemented using Qualtrics by Peter Antal, Ph.D. and Karla Armenti, Sc.D. was distributed to six New Hampshire hospitals. These hospitals included: Parkland, Exeter, Littleton, Elliot, Southern New Hampshire Health, and Dartmouth Health. The survey was sent to healthcare staff, including managers and administrators, involved in the provision of patient care at hospital emergency departments. Participants completing entry requirements were included in a random drawing for one of five $100 gift cards. By the close of the survey process, 233 healthcare staff across the state representing a variety of positions had participated in the survey.

The material presented in this report focuses on the data collected from participants at all six sites. Of the 891 healthcare staff members invited to participate, 233 responded to the survey (26%).

Critical Findings

Seventy-five percent of responding healthcare staff (75% of 233) shared that they had experienced some form of violence (verbal aggression, physical aggression, sexual aggression, harassment, or intimidation) during the previous six months.

These events were experienced "at least a few times per week" by two-thirds of those subjected to violence. More than half experiencing violence reported that they were subjected to verbal aggression (68% of 158) and nearly half were subjected to intimidation (46% of 132) regularly. Other types of violence reported as occurring at least a few times per week by participants included: harassment (41% of 123), physical aggression (31% of 140), and sexual aggression (11% of 104).

Participants shared that their experiences of violence had negative impacts on their health and wellbeing, including a mental and/or physical injury (41% of 157), feeling unsafe at work (45% of 150), considering leaving their job (40%) and even considering leaving their profession (37%).

When violence occurs, not only healthcare staff health and wellbeing is at risk, but the health and safety of patients is likely compromised. Participants indicated that nearly two-thirds of the violent events occurred during primary

assessment (62% of 157), direct patient care (55%), or patient discharge (50%), interrupting and potentially adversely affecting patient care and outcomes.

When asked whether incidents of violence were reported to administration, just over half of all those impacted (57% of 161) reported the incident. Among those reporting, only 25% (N=93) indicated that there was any type of follow-up with them in response to their reporting.

The results of the survey indicate that fewer than half of participants felt safe in their work environment. When asked whether they felt protected from the threat of violence at work, only 46% of 212 responded positively. These participants identified and contributed to a list of protective factors. Highest on the list was the presence of an onsite security team, training to prevent and manage potentially violent situations, and access to safety equipment such as stab vests and handcuffs. Conversely, one of the most frequently cited challenges identified by participants who did not feel safe was the lack of sufficient numbers of security personnel to be available when needed.

Limitations of the Study

As participation was voluntary and limited to six facilities, these findings are not generalizable. Data presented in this analysis represent responses to survey questions where there were at least 10 respondents.

Despite these limitations, the results of the survey indicate violence in the healthcare workplace at these facilities pose a serious and credible risk to staff sense of safety and job satisfaction as well as the safe and effective provision of healthcare.

Recommendations

Based on the responses collected as well as what is already known from the workplace violence literature, several next steps are recommended. These include: reviewing and implementing interventions identified as effective by hospital staff, ensuring that the hospital is in compliance with recently passed legislation concerning the implementation of violence prevention programs and supporting additional legislation to enhance protection of healthcare workers, documenting perspectives of all those involved in aggressive events (including perpetrators) to identify and address the root causes of violence, and adapting measures to ensure staff and patient safety as identified in the literature and identified as effective in practice across the state of New Hampshire and beyond.

SURVEY FINDINGS

Demographics

Of 891 healthcare staff invited to participate in the survey, 233 responded (26%). Most participants identified as female (75% of 233) and 24% identified as male. Fewer than 1% either identified as non-binary or indicated that they did not want to respond to the question about gender. Reported ages ranged from 18-28 (21%), 29-45 (43%), 46-64 (32%), and those 65 and over (3%). Two percent of participants preferred not to answer the question about age.

Many participants had worked at least 10 years in healthcare (54% of 233) and approximately one in four had worked 5 to 10 years (23%) or fewer than 5 years (23%) in healthcare.

Primary Role, N=222

Role	Percentage
Registered Nurse	35.1%
Patient Care Tech	11.3%
Medical Tech	9.9%
Administrative	9.9%
Security	7.2%
Physician Assistant	7.2%
Paramedic / EMT	5.4%
Management	3.6%
Patient Sitter	2.3%
Physician Assistant	1.8%
Pharmacist	1.4%
Nurse Practitioner	1.4%
Dining/Food	1.4%
Lic Prac Nurse	0.9%
Environmental	0.9%
Facility Support	0.5%
Transporter	0.0%
Intern	0.0%
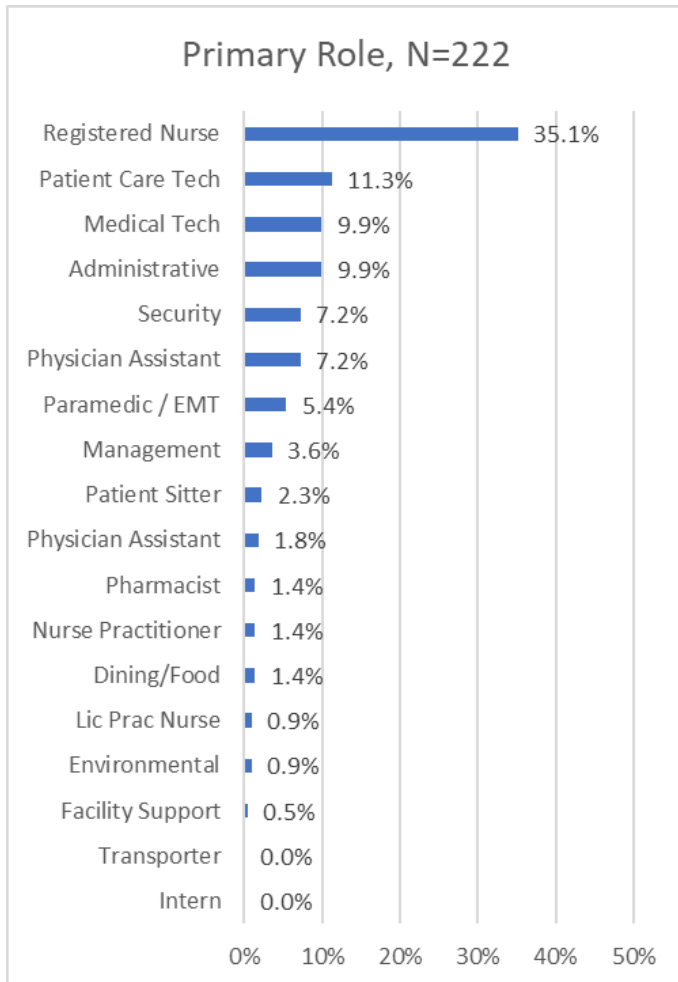
Participants identified themselves as registered nurses (35% of 222), patient care technicians (11%), medical technicians (10%), administrative staff (10%), security personnel (7%), physicians (7%), and paramedics (5%). Fewer than 5% identified themselves as: management, patient sitters, physician assistants, pharmacists, nurse practitioners, dining/food staff, licensed practical nurses, environmental support staff, and facility support staff. In some cases, respondents selected "Other" and chose to write in positions including case management, emergency clinician, interpreter, mental health technician, respiratory therapist, social worker, and sonographer.

Most participants worked full time (83% of 232). Per Diem workers accounted for 13% of participants and 3% of the participants worked part time. About half of the participants (53% of 232) worked day shifts, 6% worked evening shifts, 18% worked night shifts, and 23% stated that they worked a variety of shifts.

Regarding hours worked per shift, fewer than 1% (of 233) worked 1-5 hours per shift, 37% worked 6-10 hours per shift, 31% worked 11-12 hours per shift, and 31% worked 12 or more hours per shift.

Incidence of Violence Experienced by Healthcare Providers

Seventy-five (75% of 233) of participants reported experiencing some form of violence (defined as verbal aggression, physical aggression, sexual aggression, harassment, or intimidation) during the previous six months.

The most frequent types of violence experienced were verbal aggression (96% of 162), followed by physical aggression (67%), intimidation (60%), harassment (43%, and sexual aggression (20%).
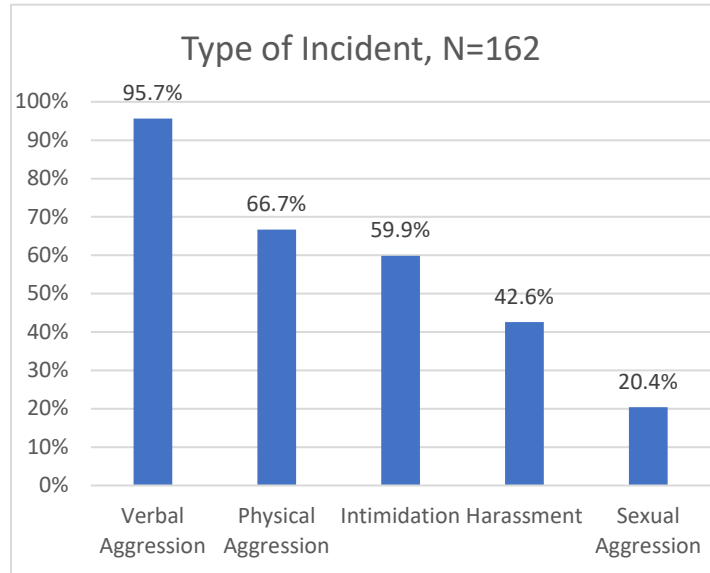
These events were experienced "at least a few times per week" by two-thirds of those subjected to violence. More than half experiencing violence reported that they were subjected to verbal aggression (68% of 158) and nearly half were subjected to intimidation (46% of 132) regularly. Other types of violence reported as occurring at least a few times per week by participants included: harassment (41% of 123), physical aggression (31% of 140), and sexual aggression (11% of 104).

Most of the violence directed at healthcare staff was enacted by patients (96% of 160), a relative/family member of the patient (57%), visitors (45%) or other staff members/co-workers (11%). One respondent shared that they had been sexually assaulted by a vendor.

When asked to provide additional information about factors they believed contributed to the violence they had experienced, participants listed patients' psychiatric or substance use issues, increasing numbers of patients presented to the ED with dementia, long ED wait times, and/or aggressive co-workers.

Here are a few examples chosen from the 96 descriptions provided by participants who chose to share details about their experiences:

- "Confused patient taking walker and trying to shove at staff. Believed they were at home and staff were intruders, verbal and physical abuse requiring security throughout night and family member as well as medical management of aggression."
- "Confused patient that attempted to elope multiple times requiring sitter, attempted to bite, kick and punch staff requiring IM medication multiple times suffering from delusions"
- "Get yelled at, cursed at, and threatened all the time while at work. Patients try and hit staff while staff administers medications as well while under the influence of drugs and alcohol."
- "I've had a patient scream at me that she was going to break into my house in the middle of the night"
- "I've had a patient's husband physically threaten me while [treating] his wife. I've had countless patients try to punch or otherwise hit me."
- "It's not always so much one event that causes harm - some weeks the verbal and physical aggression just… stacks up. It's hard to pinpoint anyone that definitively causes direct harm- but it sucks. Berated by unhappy patients in triage about how bad of a job we're doing, being threatened with lawsuits, being threatened by mental health patients. All these things add up. It makes me feel like the job I do is never good enough. Makes me not want to be a nurse."

Where Violence Occurs

Survey results indicated that violence occurred most often in patient rooms (85% of 162), in hallways (62%), and in waiting areas (53%). Other areas where participants reported violence occurring included: over the telephone (45%), at the nurse's station (38%), in patient exam rooms (29%), in patient bathrooms (12%), in office spaces (3%), and in the medication room (<1%). Other places or instances where violence occurred identified in the free text comment boxes

Where Aggression Occurred, N=162

Patient Room	Hallway	Waiting Area	Verbal Abuse During Phone Call	Nurse's Station	Patient Exam Room	Patient Bathroom	Office Space	Medication Room
84.6%	61.7%	52.5%	45.1%	37.7%	29.0%	12.3%	3.1%	0.6%
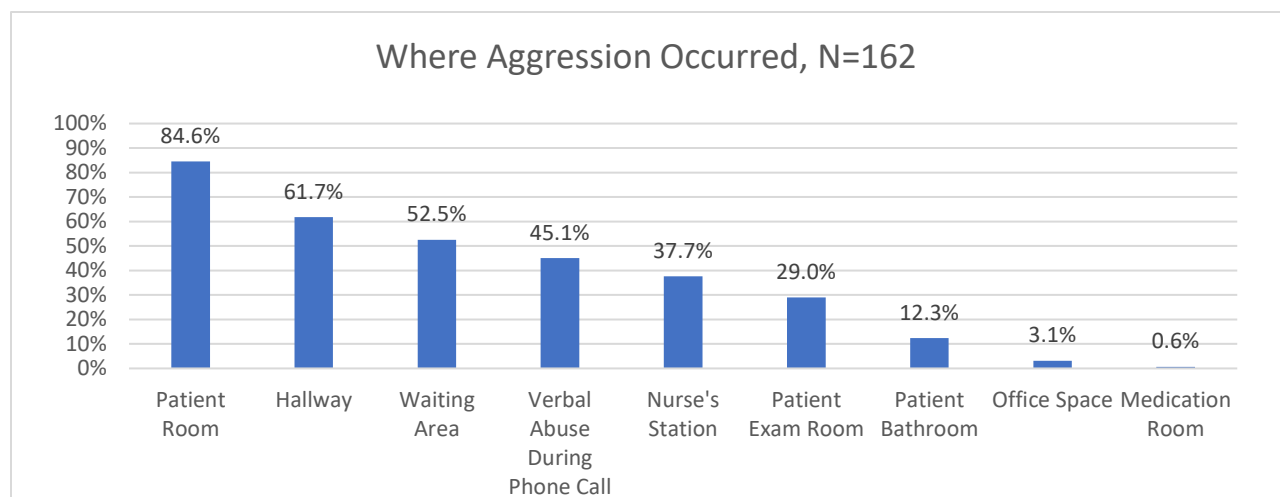
included: the ambulance bay, the parking lot, ER while giving a report, in patient common areas, and at triage.

Impact of Violence and Aggression
On Staff

Of the 175 participants who indicated that they had experienced violence, 150 (86%) shared additional feedback about the impact on their health and wellbeing, personally and professionally.

Impact of Event, N=150

Category	Percentage
Feel Unsafe at Work	45.3%
Consider Leaving Job	40.0%
Consider Leaving Profession	36.7%
Ability to Work with Patients	28.0%
Broken Trust with Employer	26.0%
I am not sure	22.0%
Sought Additional Mental Care	12.7%
Ability to Work with Staff	10.7%
Lost Work Time	8.7%
Sought Additional Physical Care	5.3%
Lost/Destroyed Personal Items	3.3%

As a result of their experience, more than one in three participants who provided additional feedback shared that they felt unsafe at work (45% of 150), considered leaving their job (40%), or considered leaving their profession (37%). About one in four shared that it had impacted their ability to work with patients (28%) or resulted in a broken sense of trust with their employer (26%). One in ten stated that they sought additional mental health care (13%), had decreased ability to work with other staff (11%), or lost work time (9%). Five percent sought additional physical health care and three percent had personal property that was lost or destroyed because of the violence. Twenty-two percent indicated that they were not sure of the impact.

While some participants were unsure about the impact of their violent experience or felt they were not impacted, others shared: they felt worn down as multiple aggressions continued, chose to transfer to another department, had decreased empathy and heightened anxiety, and wondered what they could have done differently. One staff member stated that they would rather be unemployed [than stay in their position and risk violence].

Forty-one percent (41%) of participants responding to a question concerning whether an injury occurred (N=157) reported sustaining an injury. Of the 64 reporting an injury, most reported a mental or emotional injury (88%) or a

physical injury (42%). When asked to provide further details about the types of injuries sustained, 43 respondents shared examples of physical injuries resulting from being spit at, exposed to disease, kicked, punched, twisted, bruising and/or fractures and/or mental injuries including anxiety, emotional scars, PTSD, and other conditions.

One participant described being assaulted by various patients over time, sharing examples where: a patient tried to break their arm, another tried to choke them, another sexually assaulted and threatened them with their life, another tried to spread their disease by spitting on them, and another example where the family of the patient followed them outside of work and threatened them.
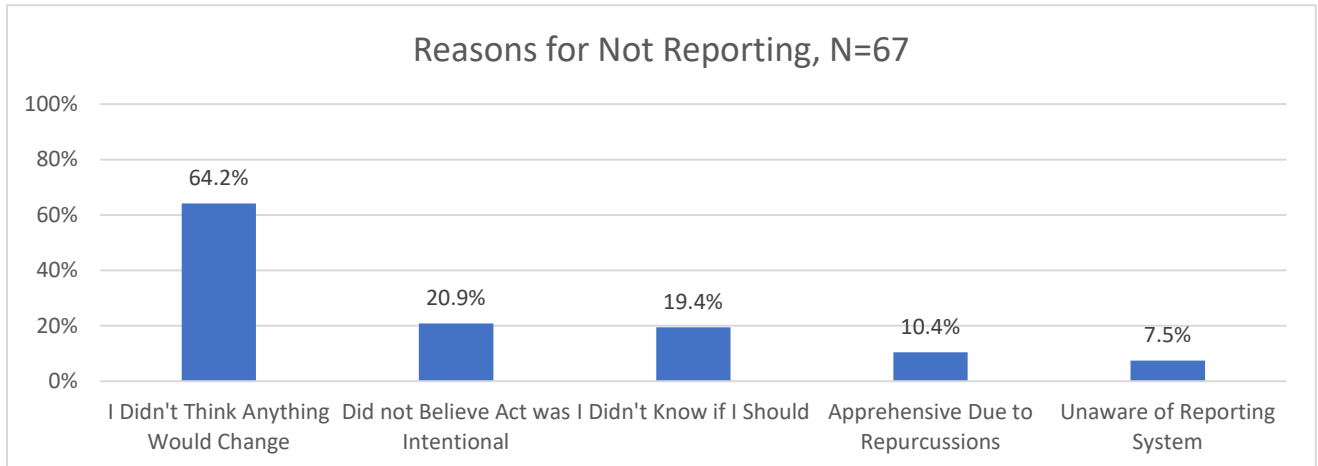
On Patients

In addition to potential and/or actual harm to healthcare staff, it is important to note that violence in healthcare settings put patient health and safety at risk as well. When asked what activities were underway when participants' experiences of violence took place, over half of the participants reported the aggression took place during primary assessment (62% of 157), direct patient care (55%), or during the discharge process (50%). Over one in three identified violence occurred during physical assessment (47%), the admission process (40%), or during medication administration (34%). Over one in four reported the violence taking place during a patient procedure (32%) or while providing patient education (29%). Other situations where violence was experienced included: while calling in other patients, during nurse rounding, while re-directing, when called to assist with difficult patients / visitors and meeting with families.

When Aggression Occurred, N=157

Primary Assessment: 62.4%
Patient Care: 55.4%
Discharge Process: 50.3%
Physical Assessment: 46.5%
Admission Process: 40.1%
Medication Administration: 34.4%
Patient Procedure: 31.8%
Patient Education: 28.7%
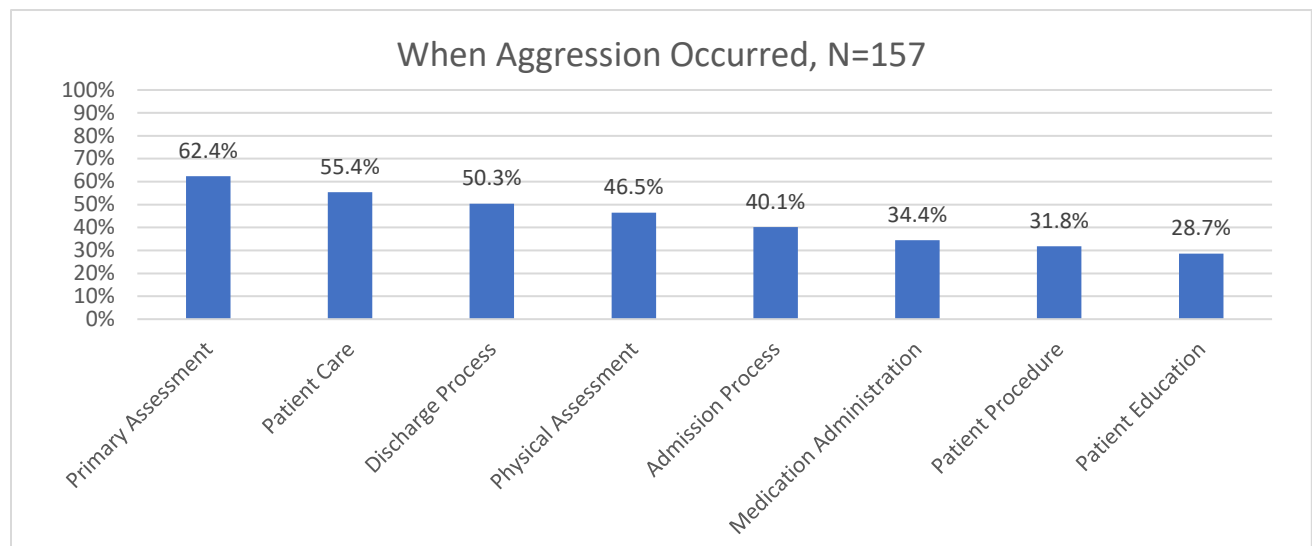
Reporting Violence

Just over half of staff impacted by violence (57% of 161) reported the incident, while 43% did not. Among those who reported (N=93), 46% indicated that someone followed up to gather additional information. Only 25% (N=93) of those who reported to administration indicated that there was any type of follow-up in response to their reporting.

Reasons for Not Reporting, N=67

Reason	Percentage
I Didn't Think Anything Would Change	64.2%
Did not Believe Act was Intentional	20.9%
I Didn't Know if I Should	19.4%
Apprehensive Due to Repurcussions	10.4%
Unaware of Reporting System	7.5%

Those who did not report were asked why they had not. Respondents most frequently shared that they didn't think anything would change (64% of 67), followed by: not believing the act was intentional (21%), not knowing if they should report (19%), were apprehensive to report due to potential repercussions (10%), or were unaware of the reporting system (8%).

Other reasons given for not reporting were shared by participants in a free-text box. These included: "it's just part of the job"," department too busy", "not enough time", "uncertainty as to where to draw the line for minor aggressive behaviors", "wasn't that affected", "would not document verbal aggression", "police would not do anything", "lack of administrative support", "the last nurse that reported was fired", and the perception that it wasn't their job if they were not involved.

Among those who were apprehensive to report due to potential repercussions, 12 respondents shared additional information about the perceived outcomes. Concerns were raised about potential repercussions from administration (75% of 12), the individual causing the incident (50%), a colleague (17%), or the family member of the patient (17%). One cited possible repercussion from the medical board as a cause for concern.

Protective Factors Against Violence

Sixty-eight percent of 214 respondents stated that their facility promoted a standardized tool, form or protocol for reporting violent events. Eighty-two percent (82%, N=212) shared that reporting was encouraged while only 36% (N=211) thought there was a standing committee to address violence within their facility. Of those who were not aware of a tool (N=69), 28% thought having a tool, form, or protocol would improve feelings of safety, 42% said it would not, and 30% were not sure.

Among those who thought that the provision of a tool would help, they offered that such a tool could help people to know how to handle different situations and what to do after an event occurred, provide a method for reporting, provide a feeling of safety as they wouldn't have to worry that the person harassing them would be protected, and let future staff know which patients may be a challenge. One noted that they would feel safer if the tool helped to prevent a problem from happening again. Another noted that it would only make them feel safe if immediate action were taken.

Seventy-one percent of respondents (71% of 209) indicated that they had participated in violence prevention training classes; of these (N=148), 94% indicated that training was mandatory. When asked whether the training was helpful when patients or visitors began to act aggressively (N=148), 64% agreed it was helpful. Respondents noted that the training (AVADE, CPI, MOAB were cited most frequently) helped with multiple areas, including:

- Improving Awareness
    - situational awareness
    - recognizing body language
    - signs to look for in patients and colleagues
    - identifying triggers/phrases to avoid
    - identifying potentially violent patients
    - looking beyond the patient acting out
    - safe distancing
- Managing Situations
    - tools for de-escalation
        - self-protection
        - managing conflict
        - managing aggressive behavior
        - how to respond
        - strategies to diffuse a situation
        - talk down vs takedown skills
- Personal Safety
    - disarming patients
    - how to get out of holds
    - self-defense
    - how to protect others
    - getting to safety

However, nine respondents noted that there were limitations to some of the trainings as they did not seem to cover more severe situations ("bigger, aggravated patients") or when insufficient staff were available, particularly in an ER setting. Two respondents noted that it had been some time since they last received training.

When asked if they felt protected from the threat of violence at work (n=212), less than half of the participants (46%) indicated they felt protected. These participants were provided with a follow-up question asking them to share why they felt protected in an open text box. Fifty-three shared detailed feedback. The most frequent reason identified for helping staff to feel safe was the presence of security (74%), followed by the training they received (23%), then availability of safety equipment (including restraints, handheld contact equipment, cameras, hotlines, panic buttons, code system - 7%). Other protective factors which were cited less frequently (by 5 or less respondents) included: coworkers, policies/protocols, organizational support, reporting mechanisms, and legislation.

For the 54% who did not feel protected, concerns raised included (n=79): lack of sufficient security (30%), lack of effective policies/ follow-up to address aggression (27%), feelings of helplessness to avoid the situation in the future (27%), lack of building safety (23%), lack of concern/ action by administrative staff (15%), need for better safety equipment (8%), limited training (5%), and other (5%).

 Recommendations drawn from these respondent comments include:

- Provide Physical Updates
  - Patient/Visitor screening (metal detectors)
  - Panic buttons accessible by all staff, particularly those sitting with potentially violent patients
  - Improved security of ambulance bay doors; ability for staff to secure doors remotely from desk or location
  - Added protection around nurses/doctor stations
  - Additional door to registration area
  - Room for practicing CPI self—protection techniques on a regular basis
  - Added protective features to the building
  - Better positioning of security so they are visible by public and can act as a deterrent
  - Posted signs warning against staff abuse and implications if carried out

- Improve Policies/Laws
  - Improved support from administration – before, during, and after events
  - Training to help provide care to mentally unstable patients or patients under influence of drugs or alcohol
  - Violent incident preparedness – job specific violent incident trainings
  - Implement consequences for inappropriate patient and staff behavior - Ensure there is some consequence for inappropriate behavior beyond saying staff are not allowed to press charges or won't be supported in doing so
    - Zero tolerance policy
    - Felony for healthcare worker or staff assault
  - Support laws that protect healthcare staff
    - Ensure Emergency Medical Treatment and Labor Act (EMTALA) laws address violent patient actions
  - Employee support if injured at work
  - Better communication between providers at patient handoff
  - Improve safety measures, prioritizing staff safety
  - Address timing of security/police response
  - Address lateral violence
- Personnel Updates
  - More security personnel/police officers to adequately cover needs, particularly during critical times
  - Equip security with proper physical training and equipment, provide protective equipment beyond pepper spray – additional tools such as handcuffs, ballistic / stab vest, and taser
  - Better teamwork

Final Thoughts

The final question in the survey asked respondents to share any additional comments or concerns that they would like the researchers to consider. Fifty-one provided feedback; general themes are identified below with participant illustrations

Consequences for violence against healthcare workers (39%)

"Law enforcement and EMS need to collaborate with hospital systems to determine what is a warranted ED visit, not every intoxicated or violent person needs to be brought to the ED. Hospital systems also need to adopt zero tolerance policies for violence that include removal of patients and visitors exhibiting such behavior. Healthcare systems also

need to advocate at the state and federal level for laws that penalize violence against healthcare workers."

Lack of action by administrative staff (18%)

"When staff members started reporting, management told the staff members that were consistent in reporting that it's their fault as they're the only one's violence happens too (even though it happens much much more to other employees who don't report it). This leads to a break down in reporting again, and a skew in how bad the violence has really become."

Challenges with how to best support psychiatric patients (10%)

"Emergency departments are one of the high-risk locations for violence to occur. It would be nice if the facility recognized this and hired more able-bodied security personnel, as well as staffed more than one security personnel on night shift for the entire hospital. In NH it is especially concerning as there are often multiple psychiatric holds in the ED while patients are waiting for beds to open up at inpatient facilities. While these patients are holding in the ED, they get little to no treatment for their conditions (except for emergency treatments mostly), they are held in small rooms, and can wait for upwards of 2-3 weeks for a bed depending on gender, insurance, and age. This can increase risk for violence as they get frustrated with waiting, they get frustrated that they can't go outside or even out of their room (except to use the bathroom), and they get frustrated that they have to wear … paper scrubs. The combination of all these factors put ED staff at increased risk for violence compared to other locations in the hospital. Administration does not seem to care about this, leaving employees feeling de-valued and unappreciated, which leads to staff burnout and a constant turnover of staff. It is a major problem that needs fixing!"

Other topics mentioned in feedback includes the lack of sufficient security, feeling like violence is just part of the job, concerns about staff aggression, and staff turnover. Only one participant used the feedback section to indicate that they felt safe in their facility.

CONCLUSIONS & RECOMMENDATIONS

Despite the limitations of the study, in part due to sample size and non-random sampling, there are several findings that merit further attention. Most notably, violence was experienced across all responding age groups and during multiple stages of patient care, occurring multiple times per week for many staff, and enacted by a variety of individuals, including patients, family members, and co-workers. Perhaps the most important finding is that 54% of healthcare workers did not feel safe at their place of work.

As staff determine possible paths forward to address these challenges, the NH Healthcare Violence Prevention Team offers the following recommendations:

- Focus on being proactive in preventing violence and aggression as much as possible, to prevent the risks associated with reacting to already escalated situations. Act on high priority items which can be implemented in the short term and develop a plan for the long term.
- Use data collection and analysis to identify common sources of increased risk for violence specific to the ED. Whenever possible, obtain information from person(s) committing violence to determine contributing and mitigating factors
- Support legislation that enhances protection of healthcare workers. In particular…
  - Ensure that hospital programs adhere to recently passed legislation concerning the implementation of violence prevention programs. Key elements include:
    - (a) Implementing policies and procedures (such as Zero Tolerance) to prevent and respond to workplace violence
    - (b) Providing appropriate training, education, and resources to employees based on their roles and responsibilities.
    - (c) A clearly defined process to report workplace violence incidents internally and externally to analyze incidents and trends
    - (d) A specific process for follow-up and support to victims and witnesses affected by workplace violence, including information about available counseling.
    - (e) A process to conduct an annual facility-specific risk assessment, which shall include employee participation and will:
      - (1) Examine all existing and potential workplace violence risks.
      - (2) Be used to develop recommendations to reduce the risk of workplace violence.

In addition to the above, the following resources 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
  - 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
  - Establish a crisis management team
  - Crisis incident program in place: identification, reporting, activating emergency plan, knowing roles during incident emergencies
  - Involve the person identified as enacting the violence or aggression in the incident investigation
- Post Crisis
  - Reporting
    - Establishing policies that ensure fair and blameless reporting (e.g., whistleblower protections), recording, and monitoring of incidents and near misses, as well as follow-up to reports made, ensuring that no retaliation takes place aimed at anyone who reports 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 and development of quality improvement initiatives including changes to the physical environment as well as

work organization practices, administrative procedures, and institutional culture.
- o Training of all staff

The approaches referenced in the sources above address fundamental issues which need to be addressed if we are 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.