Response to Violence

30

Jeffrey Strickler

30.1 Introduction

Violence against healthcare workers is a widespread problem impacting care providers across the globe. This violence is coming from patients, family members, visitors, and even interpersonal violence from other employees. Such episodes of violence require health workers to be ever mindful of their risk and to develop new skill sets enabling them to better manage these incidents. In turn, it is requiring healthcare organizations to better prepare both staff and their facilities in ways to mitigate this violence. This chapter will look into the incidence of violence, describe how to assess for the factors putting individuals and organizations at higher risk, and most importantly prepare themselves and their organizations so that they can respond in a stronger and more proactive fashion to these threats.

30.2 Epidemiology

Hospitalization is stressful for all involved and navigating medical care can be frustrating for patient and family alike. As care providers, we need to understand that some individuals will respond to this stress and frustration with aggressive behavior. The challenge for healthcare workers is how to provide care to those under their watch while recognizing and responding to the cues of dissatisfaction and/or escalation so that a therapeutic relationship and environment can be maintained.

30.2.1 Incidence

The incidence of violence in a health setting is becoming more prevalent. A landmark study by the Emergency Nurses Association (ENA) in 2009 brought attention to this problem by showing that half of the emergency department (ED) nurses in their sample stated that they had been either verbally or physically assaulted in the previous 7 days with 12% suffering physical violence and 59% experiencing verbal abuse [1]. Further description revealed that 97% of this reported violence was perpetrated by patients and most nurses in the sample believed that the incidence of violence in their daily work had increased. This study revealed that incidences of violence had precipitated 25% of nurses to consider leaving the profession whereas 10% actually did leave. This study showed that greater than half did not feel safe or prepared to handle a violent encounter [2].

Although this example highlights that many incidents of violence are related to emergency

J. Strickler, DHA, RN, NEA-BC (✉)
UNC Health, University of North Carolina Health Care, Cary, NC, USA

K. A. Gross (ed.), *Advanced Practice and Leadership in Radiology Nursing*,
https://doi.org/10.1007/978-3-030-32679-1_30

care (80%), this problem is not unique to the ED. Other units such as the intensive care unit, psychiatric, pediatric, obstetric, and neonatal departments, as well as nursing homes or other long-term care facilities, are all shown to be at an increased risk for violence [3, 4]. According to the Occupational Safety and Health Administration (OSHA), 75% of the 25,000 annual workplace assaults occurred in the healthcare and social service setting and healthcare workers are four times more likely to be a victim of violence than workers in the private sector [5]. The National Crime Victimization Survey showed a 20% higher chance for healthcare workers to be a victim of violence compared to other workers [6]. A survey by the American Nurses Association (ANA) showed similar results to the ENA study with 21% of nurses reporting physical assault and 50% being verbally assaulted [7]. Further evidence of this increase, the Morbidity and Mortality Weekly reports showed that injuries from workplace violence doubled between 2012 and 2014 and workplace assaults averaged 24,000 incidents per year (2011–13) representing a 75% increase in workplace violence in healthcare [8]. Such statistics show that healthcare workers are now a common target for violence and our encounters with violence are unfortunately ubiquitous. Regardless of your practice setting, workplace violence is an increasing concern and one that all should be prepared to meet.

30.2.2 Definition

Workplace violence is considered to be any act of aggression, including any physical assault, emotional or verbal abuse directed toward persons at work or on duty [5]. These assaults or threats include physical, psychological, and verbal violence such as threats, verbal abuse, and harassment. Given this broader definition, it is clear that unfortunately many nurses have personal experiences with workplace violence.

30.2.3 Impact

These violent acts against healthcare workers have a profound impact on our profession. Hospitals have a direct cost for such acts for the treatment of any employees but also indirect cost for lost days from work. As a point of comparison, healthcare and social assistance have a greater than fourfold incidence of violent injuries resulting in days away from work as compared to other industries [5]. In addition to such financial indicators, the less visible but more impactful effect on nurses who encounter aggression in the workplace is that they often have feelings of anger, frustration, and hopelessness as well as more concerning issues with hyper-vigilance, post-traumatic stress disorder, depression, and anxiety all which may precipitate some to leave the profession. There are also other indicators such as resultant fatigue and stress leading to higher rates of medication errors and patient infections [5].

30.2.4 Causative Factors

The cause for this epidemic in violence directed toward healthcare workers is multifactorial. Some precipitating issues could be increased ED wait times, the unrestricted movement of the public in hospitals, decreased mental health funding and the resulting number of beds, increased patient acuity, increased use of hospital by law enforcement for those detained, and a general decrease in resources. Also, economic reasons such as the reduction in funding for mental health and substance abuse leading to drug seeking behavior or ED crowding with patients under the influence could be another factor [9]. Similarly, state reductions in mental health funding has put more such patients in emergency departments where staff are often unprepared to deal with violent outbursts [10]. Such closures have caused the number of mental health or substance abuse cases seen in EDs to

climb from 1.6 million in 2005 to over 2 million in 2008 [11]. It is also important to consider some of the underlying social determinants of health such as unemployment, poverty, and homelessness. These all lead to feelings of hopelessness compounded by societal changes leading to decreased family and community support fractured families and fragmented services [12].

30.3 Assessment

There are several risk factors which increase the likelihood of an act of workplace violence with a prior history of assaultive behavior being deemed especially predictive. Other causes are age <40, clinical conditions with paranoia or poor impulse control, and a lifestyle with little or no social contact [13]. The DANGEROUS Behavior Screening Guide (Table 30.1) and the STAMP Nursing Assessment framework (Table 30.2) are valuable tools in highlighting these indicators.

The first warning sign of a possible violent encounter is agitation. Agitation is an acute behavioral emergency requiring immediate intervention. Agitation is further defined as anxiety leading to a private, chronic reaction to unmet emotional needs and stress resulting from experiencing life as a series of unpleasant events. Some of the warning signs for an agitated or anxious individual are exaggerated physical demonstrations such as pacing, finger tapping, loud and boisterous behavior; yet, it is important to note that others may be quiet and withdrawn. Eventually, the person may begin to lose rationality and the ability to think clearly. The second warning sign of an agitated person is defensiveness. The defensive patient exhibits irrational behavior such as challenging questions, verbally acting out, and attempting to intimidate staff with threatening behavior. Nursing staff should begin intervening when these signs are demonstrated. The final warning sign can be exhibited through violent behavior. Unfortunately, there are no diagnostic measures to determine violence, yet a history of violence is the best predictor of future violence, so a prompt recognition of patients with history of violence as soon as they present is imperative (see Table 30.3) [14].

When a patient becomes aggressive, the staff should ***take the threat of violence seriously***. Staff should isolate the patient by moving other individuals out of the area and removing all extraneous furniture and equipment. When approaching a violent and agitated person, one should approach with caution with a non-intimating and non-threatening appearance [14]. In such situations, it is important to maintain one's own behavior to diffuse anger and know in advance the steps to help to assist in diffusing a situation. One method for recalling these de-escalation

Table 30.1 DANGEROUS behavior screening guide for higher risk of violent behavior

D—deviant thinking
A—alienation
N—negative home environment
G—gang affiliation
E—exposure to or history of violence
R—rebellion and poor socialization skills
O—obsession with violence
U—underachievement
S—substance abuse

Source: Adapted from [15, 30]

Table 30.2 STAMP nursing assessment framework for potential violent behavior

Staring
Tone of voice
Anxiety
Mumbling
Pacing

Source: Adapted from [31, 32]

Table 30.3 Signs of impending violence

- Flushed face
- Hand-waving and finger-pointing
- Direct, prolonged eye contact
- Encroachment into your personal space (closer than 3 ft but varies due to cultural norms) rapid, deep breathing
- Clenched teeth or hands
- Lack of response to verbal commands
- Defensive/offensive stance (lowering of center of balance, hands moving up and out)
- Searching for an exit or object to use as a weapon
- Brandishing of a weapon (e.g., firearm, knife, or any other item)

Source: Adapted from [28]

Table 30.4 Responding to escalation

L = listening to what they are saying, E = empathizing with their point of view, A = asking reflective questions, P = paraphrasing what you heard, S = summarizing what your expectations of behavior

Source: Adapted from [28]

Table 30.5 Strategies to de-escalate situations

• Let the individual vent • Be assertive in your verbal communication • Use a person's name frequently when addressing him or her • Remain composed, use a firm but even-toned voice; set and enforce reasonable limits • Redirect a person's anger by using the substitution technique (e.g., "I can't solve this problem, but let me check with Mr. Jones"); your subsequent call to "Mr. Jones" can actually be a call for assistance

Source: Adapted from [28]

techniques is the LEAPS acronym (listening, empathizing, asking, paraphrasing, summarizing) (see Tables 30.4 and 30.5) [15].

30.3.1 Physical Plant Considerations

Physical space can also be a consideration leading to increased risk for violent encounters. Space that is poorly designed with blind spaces out of view may put one at an increased risk. Other poorly light spaces such as parking lots are also concerning [16]. However, it is important to remind that many studies showed that in the majority of cases patients and relatives were the perpetrators of these violent incidences and as such the patient's room is the general site of these violent occurrences [2].

It is also important to consider administrative decisions in the context of the physical plant. Understaffing may lead to increased violent occurrences with an increased occurrence during times of increased unit activity such as meal times or visiting hours. A related risk factor is a staff member working alone or in isolation as the presence of a coworker was considered a potential deterrent. Similarly, timing of the day is also a consideration in that periods of peak census such as shift change inversely can lead to isolation in a room putting one at greater risk [13].

30.3.2 Personal Considerations

As to specific actions, it is critical that healthcare workers develop a greater awareness of the risk and potential for violence. One's personal behavior may also put one at a higher risk. Interpersonal interactions which are directly confrontational only increases the risk of a violent encounter. When communication is effective, mutual respect is maintained and the ability to openly talk ensures more effective interactions. Specific techniques that facilitate teamwork and communication include maintaining situational awareness, providing mutual support, and having a shared mental model. Situational awareness enables one to be aware of the surroundings and not be so focused on tasks that one loses sight of the patient and circumstances. Providing mutual support ensures that the entire team is providing backup and has the resources to complete the task at hand. Having a shared mental model assures that the entire team is on same page and sharing necessary knowledge and facts in order to complete the task [17].

30.4 Interventions

Such statistics are compelling but even more so when it is considered that such violence often goes under-reported by as much as 70% [8]. Furthermore, the ENA study showed that 72% of the staff did not feel safe nor prepared to handle such a situation [2]. Other surveys have shown that up to 74% of employers had no protocol for responding to such workplace violence [18]. In this same survey, 74% of the participants unfortunately relayed that there was no response by their employer after episodes of workplace violence and in 44.9% of the cases no action was ever taken against the perpetrator of the violent act. These points are particularly concerning since the ENA study showed that hospitals without

such policies had an 18.1% physical violence rate as compared to only 8.4% for those institutions with a zero-tolerance position on workplace violence [13].

Such unpreparedness leads to significant personal costs in lost time, productivity, and turnover [8]. The ENA study looked at the reasons for this lack of reporting and identified five barriers to this reporting. These barriers are a fear of retaliation, the fact that there was no physical injury sustained, or that it was inconvenient to report. More surprisingly was the concern that reporting would adversely affect their customer service scores, or the acceptance that it was just a part of the job [2]. This issue with no action and a lack of reporting speaks to the significant part of the problem which is the apparent acceptance of this behavior from patients and families. Changing this paradigm is a major step for resolving this issue.

Many regulatory agencies in the United States have made positions statements related to workplace violence. The ANA adopted a Bill of Rights [19] where it noted that nurses have a right to work in an environment safe for themselves and their patients. Both NIOSH (National Institute for Occupational Safety and Health) and OSHA (Occupational Safety and Health Administration) developed national mandates where healthcare organizations have a duty to provide safe work environments [20]. The Joint Commission also has a leadership standard stating that institutions must "create and implement a process for managing disruptive and inappropriate behavior" [21]. It is therefore important that institutional leadership and other professional organizations adopt a policy where it is no longer acceptable to be assaulted while at work.

30.4.1 Organizational Plan

It is critically important that hospital leaders both develop the awareness of this problem and also adopt a zero-tolerance policy to this problem (violence-free culture) [22]. Frontline employee involvement on committees and in developing polices that create a safe workplace is equally critical. This involvement creates greater awareness of the issue and allows for change in the culture of acceptance around these instances while also enabling management to better understand the workplace environment and the particular threats encountered by their staff. A worksite analysis is a critical step in evaluating an institution's particular risks as such an analysis leads to both hazard prevention and control.

Table 30.6 Summary of recommendations

1. Perform workplace analysis
2. Create comprehensive organizational violence prevention program
3. Adopt "zero tolerance" policy
4. Report violent events through organizational documentation system
5. Develop violence response plan
6. Perform post event reviews
7. Monitor key metrics
8. Provide de-escalation training for staff
9. Develop behavioral response team

A comprehensive organizational violence prevention program (see Table 30.6) has three necessary components. First, a reporting and documentation system must be in place to capture and trend data on violent incidents. Secondly, policy should note specific strategies to institute in the event of an incident. Finally, and perhaps most importantly, are post event incidence management and the necessary support for the staff impacted by the violent event. Other needed items are an employee identification system, improved access control, redesign for better security and management [23]. A family advocate program can provide specially trained staff that can intervene in crisis situations when hospital staff must focus on the care of the patient. Units should have standardized team huddles to increase staff's awareness of potentially violent patients [9]. Additional items in an organization response plan are the ability to flag dangers on electronic health records so that others may have proper situational awareness [12].

30.4.2 Training

Adequate training and education are of critical importance to improve the recognition and ability to safely respond to these situations. This training

is focused on improving skills in communication and de-escalation techniques while also relaying important skills for self-protection if an encounter should turn violent. Such training should emphasize that anticipation is the most effective strategy as aggression rarely occurs without warning signs.

Detection and early intervention are essential to achieve desirable outcomes. Staff must be able to intervene appropriately when a patient or family member's behavior reflect anxiety or frustration. If staff members don't respond properly during the initial stages, then an agitated person may act on their emotions. A patient who progresses to acting on his or her emotions is an indication that staff have not responded during the initial stages [14]. During such a situation, the practitioner has three objectives: ensure safety of all, help the person become aware of their emotions so that they may re-gain control, and facilitate collaboration of patients and staff so that they may participate in the treatment plan at the direction of the healthcare team [14]. As mentioned, behaviors which point to an increased potential for violence are a patient exhibiting tension or anxiety through increased physical activity, such as pacing being particularly concerning. Skills such as active listening, a willingness to apologize and empathize, and utilizing distraction or deflection can be useful to prevent such a situation from escalating.

Verbal de-escalation requires staff to focus not only on what the patient is saying but also on nonverbal cues. Responses should be simple and direct as agitated individuals are less likely to understand complex responses. Staff should also respect physical boundaries. To establish verbal contact, only one staff member should interact with the individual to prevent unwarranted escalation. The staff member should speak calmly and concisely using simple words and short sentences, so the patient has time to process what has been said. The staff should expect to use repetition while speaking to an agitated person. A fourth area of de-escalation involves listening to what is said and identifying the needs as well as the wants of the individual. One should expect to exercise empathy while setting clear limits. The person should be told in clear simple language what is acceptable and unacceptable behavior. The staff should emulate respectful behavior while setting these limits. The final and most important consideration is debriefing after any involuntary intervention. It is the responsibility of the clinician to restore the therapeutic relationship as any coercive intervention is traumatic in nature and will aid in decreasing the risk of additional violence [14].

When working with an agitated patient the nursing staff should know that physical techniques are available for self-protection and control; however, such interventions should be considered a last resort. Healthcare workers should always focus first to ensure that basic needs are being met and that updates on the plan of care is provided; however, staff must also be able to use enhanced verbal and physical skills to successful deal with keeping patient and staff safe. Such physical techniques are best employed by a well-trained team for the safety of patient and staff alike and basic self-defense classes are not adequate or appropriate for such a response. Specific recommended interventions are that organizations should have an identified response team with skills in verbal de-escalation and non-coercive medication administration [14].

Other key points are to remember include wearing appropriate clothing that minimizes grabbing and choking hazards. In interactions, always maintain the appropriate positioning by maintaining a safe distance and use of a supportive stance when dealing with agitated person (see Fig. 30.1). Any situation in which a patient or family member feels helpless or trapped is cause for heightened awareness. In these situations, allow a safe distance between yourself and the individual of 4–6 ft, or at least farther than two steps or arm distance between yourself and the other person. The supportive stance places one at an angle from the patient and avoids face-to-face contact. Staff should keep their hands where the patient can see them at all times [14, 24]. Perhaps the best individual protective strategy to simply instruct the person to stop being violent is effective [25].

Fig. 30.1 Supportive stance

30.4.3 Plant Improvements

In addition to awareness and de-escalation, the physical plant can be improved to lessen or mitigate incidents of violence. Recommended actions would be access control to clinical areas, in particular high-risk units such as the ED, intensive care units, psychiatry, obstetrics, etc. Metal screening at high-risk entry points such as the ED can also be a useful deterrent. Given the influx of behavioral patients in areas not historically designed for such patients such as the ED, the inclusion of behavioral health rooms into the design can enable staff to be more effective and safer. Inpatient units can be rearranged so that the environment can minimize risk of injury by better lighting and visibility. The IAHSS Security Design Guidelines (available at https://www.iahss.org/page/guidelines) are a useful guide for hospital design considerations [24].

30.5 Active Shooter Incidents

Increasingly, there are episodes of active shooter situations noted in the media. These multiple casualty events often capture the attention of the nation. As a large public venue, events impacting a hospital or other healthcare site have the potential for being an increasingly considered target. An active shooter incident is a situation in which "an individual [is] actively engaged in killing or attempting to kill people in a confined and populated area" [26, 27]. In the United States the Federal Bureau of Investigation (FBI) has identified 160 discrete incidents between 2000 and 2013 with 486 people killed and an additional 557 wounded. In the first half of that period, there were an average of 6.4 active-shooter incidents per year in the United States (US), but in the latter half of that period the number more than doubled to 16.4. Recently released FBI data reveal

that the rate increased again in 2014 and 2015 to 20 incidents per year. Another study examined all US hospital shootings between 2000 and 2011 in which there was at least one injured victim and noted 154 incidents in 40 states causing death or injury to 235 people [26]. More specific to healthcare, the U.S. Bureau of Labor Statistics showed that the healthcare industry had a total of 19 homicides in 2015 with 16 due to gun violence representing a 46% increase from 2014 [27] (Table 30.7).

Although such events occurring in hospitals are still rare compared with other shooting sites, occurrences have increased in healthcare facilities with the emergency department being reported as the most common site for shootings followed by parking lot and patient rooms. These shootings were more common in larger (>400 beds) hospitals [27]. It should be noted that healthcare institutions present unique challenges for an active shooter event. Some challenges relate to the potential with large populations of vulnerable patients, 24-h-per-day operations, and reduced staff during off hours. These situations are also complicated by patients or staff who are unable to evacuate because of age, illness, or an ongoing medical procedure, and staff who may believe that they cannot leave patients or that they should respond to the injured [28]. Because most shootings have concluded before the police arrive, it is imperative that hospital staff be prepared to respond. One of the first keys for lessening such occurrences or mitigating the damage and lives lost is through hardening of the campus.

Table 30.7 Best practices in an active shooter event

- If you are in an office, stay in place and secure the door by barricading with furniture or office equipment.
- If you are in a hallway, get into a room and secure the door. Silence cell phones or any other devices that might reveal your location. Close all blinds and curtains, turn off the lights, and move away from the door. Remain quiet.
- Remember, there is a difference between cover and concealment. Cover, such as a heavy desk, provides some protection from bullets such as a heavy desk, while concealment simply hides you from the shooter's direct line of sight.

Source: Adapted from [28]

The same activities mentioned throughout this chapter to address physical violence can be used to prevent access or movement of a perpetrator. Examples are identification (ID) badges, closed card reader access to units, and metal screening at high-risk locations such as ED. Similarly, discussing and securing a patient's belongings, which might include a handgun, lessen the risk of inadvertent discharge of a firearm. One of the facility challenges is that most hospitals are designed vertically with heavy reliance on elevators for transportation. Such design leaves small, narrow stairwells as alternative escape routes, which can become crowded choke points [26]. Also, unlike schools or office buildings, the treatment areas of hospitals have open designs with large common areas containing very little furniture, intersecting walls, or equipment to hide behind. For these reasons, safe rooms should be identified which include a door that can be locked or barricaded. These rooms should ideally not include any windows. If a window is present, staff should either cover this window or hide out of view of such windows. Staff should remain sheltered in place until area is safely secured and they are directed by police to exit. Under facility emergency plans should be a notification system that will allow personnel at the point of initial contact to trigger an alert that is immediately disseminated to the entire facility. The alert should be a simple, clear message that uses redundant pathways such as overhead speaker, paging, and texting systems [26].

Training is another important aspect as staff should know how to respond in the event of an active shooter situation. Staff should be taught to shelter in place unless evacuation can be easily and safely accomplished for both staff and patients. In such situations, they need to know how to secure their work area to protect patients and staff. A three-tier training program is recommended for hospitals and similar healthcare facilities. The first tier is general awareness training that presents the fact of the challenges presented by healthcare facilities. Staff should be trained to take note of the two nearest exits in any facility you visit or work in. The second tier is training regarding strategies for handling ver-

bal aggression and intimidation. Tier three training is for staff in high-risk areas such as emergency departments and behavioral health units and encompasses more detailed skill and case-based training [27]. The above training should explain that healthcare workers should *not* attempt to disarm a subject if a weapon is seen or suspected [28].

The "*run, hide, fight*" directive [26] should be followed by any healthcare professionals, hospital workers, patients, and visitors who are able to comply with it; however, hiding can be problematic in the hospital setting as staff are responsible to care for patients who cannot run, hide, or fight owing to their medical condition. For this reason, a different set of responses should be considered—"*secure, preserve, fight*" [26]. This strategy includes the following actions—secure the location immediately, preserve the life of the patient and oneself, and fight only if necessary. The "*secure*" step would entail immediately securing patient care areas where essential life-sustaining treatment is being provided; deploying electronic or mechanical devices designed to barricade entrances into those areas so as to secure all access points from the inside; dimming or turning off all nonessential lights; and silencing telephones and pagers. In the "*preserve*" step, healthcare personnel should stay away from windows and doors and move patients into a sheltered area if possible, and provide only the essential medical care required to preserve life [26]. A wide range of inexpensive and easy-to-use products are available for installation on all types of doors. Similar to "*run, hide, fight*" strategy, fighting is a last resort effort in the "*secure, preserve, fight*" strategy and is reserved in the setting of contact with the perpetrator. This fighting is focused on incapacitating the individual and creating time and distance for escape. This defense uses any available items to use as a weapon and should be focused on particular vulnerable and disabling areas such as the eyes, throat, or groin.

Post-event mitigation can be improved by **Stop the Bleed** kits (see https://cms.bleedingcontrol.org/class/search). These kits should be considered similar to automatic external defibrillators and as such be available in all public areas. These kits contain essential supplies for hemorrhage control (a major cause of loss of life in such incidents) and contain gauze, gloves, and most importantly a medical grade tourniquet [26]. Facilities will also need a recovery plan including the notification system notifying families of patient status; a plan for rapid recovery and discharge of patients undergoing outpatient procedures; and a plan for media notification. A critical and often overlooked is attending to the psychological first aid needs of the patients, family, visitors, and healthcare workers who were present [26].

30.6 Legislative Action

For too long, the legal profession has not aggressively pursued cases of assault on healthcare workers. To address this problem, many US nursing, physician, and hospital groups have worked to introduce legislation making such violent acts a felony. Although this strategy does not address the root causes, it does provide a deterrent and sends the message that healthcare's difficult task should not be compounded by being concerned about staff safety. As of 2019, only 7 states have laws directing workplace programs, but 34 states have felony laws for assaults on healthcare workers [1, 29].

30.7 Conclusion

It is important that as professional nurses we work to better prepare ourselves to be alert practitioners. It is more important that we advocate within our hospitals and professional groups to have policies and procedures to better equip staff to handle these issues. Personal strategies such as always carrying a telephone or other communication device is critical. Perhaps most important that society works to address the poverty, homelessness, hopelessness, educational, and employment opportunities that has led to escalating levels of violence in our hospitals [12].

Acknowledgments Thank you to Rachel Ward BSN, RN, CCRN who provided invaluable assistance in the preparing of this manuscript.

References

1. Emergency Nurses Association and Institute for Emergency Nursing Research. Emergency Department Violence Surveillance Study. 2010. ena.org. Retrieved 22 Jun 19.
2. Gacki-Smith J, et al. Violence against nurses working in US Emergency Departments. J Nurs Adm. 2009;39(7–8):340–5.
3. Papa AM, Venella J. Workplace violence in healthcare: strategies for advocacy. Online J Issues Nurs. 2013;18:5.
4. The Joint Commission. Preventing violence in the healthcare setting. 2010. www.workplaceviolence-news.com/2010/06/08. Accessed 29 Jan 11.
5. Occupational Safety and Health Administration. Workplace violence in healthcare: understanding the challenge. 2015. https://www.osha.gov/Publications/OSHA3826.pdf. Retrieved 20 Jul 2019.
6. The Joint Commission. Physical and verbal violence against health care workers. Sentinel Event Alert, Issue 59. 17 Apr 2018. https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf. Retrieved 20 Jul 2019.
7. Chetwynd E. Workplace violence in healthcare. 2019. https://www.everbridge.com/blog/workplace-violence-in-healthcare/. Retrieved 20 Jul 2019.
8. Potera C. Violence against nurses in the workplace. Am J Nurses. 2016;116(6):20–1.
9. Martinez AJS. Managing workplace violence with evidence-based interventions: a literature review. J Psychosoc Nurs. 2016;54(9):31–6.
10. Campbell AF. Why violence against nurses has spiked in the last year. The Atlantic. 1 Dec 2016.
11. American Nurses Association. American Nurses Association Health Risk Appraisal (HRA): preliminary findings. Oct 2013–2014.
12. Stempniak M. Finding a hospital's role in curbing Chicago's violence. 2017. www.hhnmag.com. Accessed 7 Jul 17.
13. Strickler J. When it hurts to care: workplace violence in healthcare. Nursing. 2013;43:58–62.
14. Phillips J, Stinson K, Strickler J. Avoiding eruptions: de-escalating agitated patients. Nursing. 2014;44:60–3.
15. McEwan D, Dumpel H. Workplace violence: assessing occupational hazards and identifying strategies for prevention, part 2. National Nurse. Mar 2012.
16. Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers. 2016. https://www.osha.gov/Publications/osha3148.pdf. Accessed 21 Jul 2019.
17. Strickler J, Haynes J. Improving communication in healthcare. Nursing. 2014;44(1):62–3.
18. Shea T, Sheehan C, Donohue R, Cooper B, De Cieri H. Occupational violence and aggression experienced by nursing and caring professionals. J Nurs Scholarship. 2017;49(2):236–43.
19. American Nurses Association. Bill of Rights FAQ. 2019. Available at https://www.nursingworld.org/practice-policy/work-environment/health-safety/bill-of-rights-faqs/. Accessed 24 Jul 2019.
20. McPhaul KM, Lipscomb J. Workplace violence in healthcare. 2004. www.nursingworld.orgon. Accessed 21 Jan 11.
21. Schyve PM. Leadership in healthcare organization: a guide to Joint Commission Standards. The Governance Institute; 2009. http://www.governanceinstittue.com/ResearchPublications/ResourceLibrary/tabid/185/CategoryID/15/List/Level/a/ProductID/827/Default.asp?
22. Thompson P. Addressing violence in healthcare workplace. 2015. www.hhnmag.com. Accessed 8 Jul 17.
23. Clements PT. Workplace violence and corporate policy for healthcare settings. Nurs Econ. 2005;23(3):119–24.
24. Strickler J. Staying safe: responding to violence against healthcare staff. Nursing. 2018;48(11):58–62.
25. Gillespie GL, Gates DM, Miller M, Howard PK. Workplace violence in healthcare settings: risk factors and protective strategies. Rehabil Nurs. 2010;35(5):177–84.
26. Inaba K, Eastman AL, Jacobs LM, Mattox K. Active shooter response at health care facility. NEJM. 2018;379:6.
27. Sanchez L, Young VB, Baker M. Active shooter training in the emergency department: a Safety initiative. J Emerg Nurs. 2018;44(6):598–604.
28. Warren B, Bosse M, Tornetta P. Workplace violence and active shooter considerations for health care workers. J Bone Joint Surg Am. 2017;99:e88, 1–5.
29. Docksai R. Lawmakers and hospitals take action to curb violence against nurses. 2015. Available at from https://www.nursinglicensure.org/articles/workplace-violence.html.
30. Muscari ME. How can I detect the warning signs of extreme violence in my patients? J Clin Nurs. 2010;19:479–88.
31. Weeks SK, et al. Responding to an active shooter and other threats of violence. Nursing. 2013;43:34–7.
32. Luck L, Jackson D, Usher K. STAMP: components of observable behavior that indicate potential for patient violence in Emergency Departments. J Adv Nurs. 2007;59(1):11–9.