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**Workplace Violence Incident Reporting in Maine Hospitals**

***February 2024***

**Situation:**

Hospitals and health systems have long had protocols and procedures in place to prevent and mitigate workplace violence against their team members; however, since the onset of the pandemic, violence against hospital employees has markedly increased and there is no sign of it receding. Workplace violence has severe consequences for our hospitals and communities. Not only does violence cause physical and psychological harm to our care team members, but violence also makes it more difficult to provide quality care and respond to the needs of the community.

**Background:**

We’ve all heard the statistics – according to government data, healthcare workers are five times as likely to experience workplace violence (WPV) as other workers—and we’ve certainly seen the impact of workplace violence on healthcare workers and organizations. To understand the scale of this challenge, here are some additional sobering statistics:

* The Occupational Safety and Health Administration (OSHA) estimates that nearly 75% of about 25,000 workplace assaults reported annually happen in healthcare settings.[[1]](#endnote-1)
* Data from Press Ganey showed that 5,200 nurses were assaulted in the second quarter of 2022 alone. On average, two nurses were assaulted every hour, which is about 57 assaults a day. The analysis found that the majority of attackers were patients.[[2]](#endnote-2)
* According to a study conducted in a tertiary care hospital in the USA, 34.4% of the health workers reported verbal or physical WPV. Among those who experienced physical or verbal WPV, 60.2% showed at least one post-traumatic symptom, 9.4% lost their jobs, and 30.1% considered quitting their careers [[3]](#endnote-3)

While there is consensus that workplace violence is a significant threat to our workforce and the care we provide, there is no standardized system used for data collection in Maine hospitals, thus we cannot fully appreciate the scale of its impact. Hospitals report that information related to a workplace violence incident is collected; however, the systems for collecting this information vary from hospital to hospital and the specific elements collected differ greatly within each organization. We contend that standard data documenting the prevalence, type, location, etc., would allow for actions and solutions that are grounded in data rather than anecdote.

Additionally, we know that workplace violence incidents are significantly underreported with national data estimating that only 15 to 20% of all incidents are captured or formally reported.[[4]](#endnote-4) One Maine hospital identified that they were capturing only about 15% of all incidents with current reporting processes. There may be many factors affecting a healthcare worker’s ability and desire to report an incident, but several have been identified and should be considered as we move forward with establishing standard workplace violence data collection.

1. ***Time to complete report is too long or onerous***. Examples included having to stop work and go to a computer where one can access the hospital intranet, log into the software, and complete a form, which asks too many questions or questions unrelated to the event. “I don’t have time for it.”
2. ***Too many incidents occur in a shift.*** “I could conceivably spend all my time submitting reports and not get any work done.” Healthcare workers may experience various incidents to different degrees over the course of a shift making it unrealistic to report all of them.
3. ***Nothing will change by reporting an event***. Often, care team members may feel that the report goes into a “black hole” and that reporting does not change the environment or the organization’s response.
4. ***It’s just a part of the job***. Hospitals, departments, or individuals may feel that some aspects of workplace violence are part of the job and cannot be stopped or changed.

In summary, standardized reporting is critical to understanding the full impact of workplace violence on hospitals and to support changes to policies, procedures, education, and resource allocation. Furthermore, reporting must be normalized and easy, and hospitals need to act using the resulting information.

**Assessment:**

The first step to understanding the scope of workplace violence in hospitals is to define “workplace violence.” The subcommittee produced the following definition of workplace violence, incorporating the two definitions established by OSHA and the Joint Commission. The Committee intends that this statement is accepted as a baseline definition of workplace violence for the purposes of reporting and tracking incidents. The definition is:

*“Workplace violence is any act or threat of physical violence, harassment, bullying, intimidation, humiliation, sexual harassment, or threatening behaviors that occur at the work site. This includes all behaviors impacting an employee’s ability to work at their full potential. Workplace violence includes digital platforms and phone calls. It ranges from threats and verbal abuse to physical assaults and even homicide; concerning clinical and non-clinical staff, patients, or visitors.”*

As a second step, the Committee identified the baseline data that should be collected by hospitals following a workplace violence incident. The Workplace Violence Data Collection Tool was developed with input from subcommittee members and MHA Board leaders and has had multiple iterations over the period of nine months. Please see a copy of the Data Collection Tool attached to this letter.

**Recommendation:**

A standardized data collection tool should be implemented statewide across all hospitals. All reporting should contain specific elements, with hospitals’ ability to add additional elements. The developed and approved data collection tool is split into two sections: Phase I and Phase II.

* Phase I data collection is the essential information that hospitals should collect from any employee affected by workplace violence. These are the minimum data that can provide insight into the volume and impact of workplace violence. The collection of the information is critical to developing an appropriate response to violence in hospitals, which may include policy change, advocacy, education, and training.
* Phase II data collection are elements that allow hospitals to better understand contributing factors to violence. Phase II data will help MHA member hospitals understand the necessary steps to prevent future incidents and support victims through the short-term and long-term impact of these events. Phase II data collection should be completed during further investigation of an initial report. Hospitals may choose to collect this information for each report or select a subset of the total reports to collect additional information.

In anticipation of implementation challenges, the MHA Workplace Violence Subcommittee has identified several approaches, including some best practices from other health systems across the country.

1. Use a Microsoft Form online that will provide easy access to a reporting form following an incident. Any employee can scan a QR code, which could be posted in nursing stations and employee break rooms, and within three minutes a person affected by violence could report the event. The online reporting form will allow hospitals to review and follow up on all reports through an easy-to-understand data summary page. The data summary page can show reporting trends in a graphic form, as well as in a spreadsheet.
2. Implement a 24/7 hotline where any staff member can report an incident, either by leaving a message or speaking to a team member who can document the event.
3. Use the reporting software already in use at your hospital but simplify the form to make it easier to complete and separate the form from other types of reporting events, such as medication errors or quality issues.

In addition to implementing the data collection tool, it is critical that hospitals develop a communication/marketing plan to emphasize that workplace violence is not part of the job and encourage all staff to report events. Furthermore, hospitals must follow up with team members after an event, which could entail having a copy of each report going to a direct supervisor so that the supervisor can reach out to the reporting individual.

And finally, the MHA Board asks that all data collected be provided to the MHA on a regular basis. MHA will publish an annual report, at a minimum, with aggregate hospital data on workplace violence.

**Workplace Violence Data Collection Tool Elements**

**Final Version January 23, 2024**

The following data collection tool has been developed by the Maine Hospital Association Workplace Violence Subcommittee to quantify the number of workplace violence incidents occurring in Maine hospitals. The data collection tool has been broken down into two sections: Phase I and Phase II.

Phase I data collection are the essential elements that hospitals should collect from any employee affected by workplace violence. These are the minimum data that can provide insight into the volume and impact of workplace violence. The collection of the information is critical to developing an appropriate response to violence in hospitals, which may include policy change, advocacy, education, and training.

Phase II data collection are elements that allow hospitals to better understand contributing factors to violence and provide more detailed information around the specifics of the incident, including those involved. Phase II data will help MHA member hospitals understand how to prevent future incidents and support victims through the short-term and long-term impact of these events. Phase II data collection would be completed while investigating the initial report. Hospitals may choose to collect this information for each report or select a subset of the total reports to collect additional information.

**PHASE I DATA COLLECTION:**

Information about Location of Event and Individual Affected:

* Facility Type [dropdown]
  + Acute Care Hospital (Department noted below)
    - Emergency Department
    - ICU
    - Med/Surg/Inpatient
    - Psychiatric
    - Other
  + Ambulatory Care Center
  + Long-Term Care
  + Home/Home Care
  + Skilled Nursing Facility
  + Assisted Living Facility
  + Psychiatric Hospital
  + Other
* Occupational category of person affected [dropdown]
  + Nurse (RN, LPN)
  + Physician/ Advanced Practice Provider
  + Allied Health/Technologist
  + Rehabilitation/ Therapy Services
  + Case Management/ Social Work
  + Education
  + Administration/Support Services
  + Facilities/ Plant Operations
  + Nutrition
  + Security
  + Other
* Department/office where incident took place.

**Incident Report Information:**

* Aggressor [dropdown]
  + Patient
  + Visitor
  + Employee (Lateral)
  + Other
* Type of Violence [multi-check option]
  + Physical
  + Verbal
  + Attempted Violence (near miss)
  + Written and/or Digital
* Primary Assault Description [multi-check]
  + Biting
  + Choking
  + Grabbing/Pinching/Scratching/Hair Pull
  + Harassment
  + Kicking/Hitting/Beating
  + Other
  + Posturing
  + Punched
  + Pushing/Shoving
  + Sexual Assault/Rape
  + Shooting
  + Spitting
  + Stabbing
  + Stalking
  + Throwing an Object/Breaking Object
  + Verbal Assault
* Assault Description (Free Text/Description)
* Primary Contributing Factors [multi-check]
  + Abandoned by Guardian
  + Altered Mental Status
  + Ambulance/Transport Unavailable
  + CCSU Bed Unavailable
  + Coming Out of Anesthesia
  + Community Services Unavailable
  + Crisis Services Unavailable
  + Detox Bed Unavailable
  + Homelessness/Lack of Housing
  + Inpatient Bed Unavailable
  + Jail / Corrections Placement Unavailable
  + Long Term Care /SNF Bed Unavailable
  + PNMI / Residential Placement Unavailable
  + Psychiatric Bed Unavailable
  + Removal Of Personal Belongings by Security/Care Team
  + Resource (Foster) Home Placement Unavailable
  + Self-Injurious Behavior
  + Under Influence of Substance(s)
  + Unknown
* Severity of Assault [dropdown]
  + None- No Contact / Unwanted Contact w/ no injury
  + Mild – Mild Soreness / Abrasions / Scratches / Small Bruises
  + Moderate – Major Soreness / Cuts / Large Bruises
  + Severe – Laceration / Fracture(s) / Head Injury
  + Death or loss of limb
  + Unknown
* Emotional and/or Psychological Impact [dropdown]
  + None – No emotional and/or psychological impact
  + Mild – Upset / Angry / Scared / Humiliated
  + Moderate – Moderate emotional and/or psychological impact with no missed work but return to work with modifications.
  + Severe – Significant Emotional and/or psychological impact resulting in missed or inability to return to work, interventions required.
  + Unknown
* Level of Care Needed
  + None
  + First Aid
  + Employee Health
  + Emergency Department
  + Unknown
* Response Action Taken [multiple checklist]:
  + No Security or Law Enforcement Called
  + Security Called
  + Law Enforcement Called
  + Police Report Completed
  + Physical restraints used.
  + Chemical Restraint/Medication administered.
  + Seclusion of Patient
  + Pepper Spray Used
  + Handcuffs/Shackles Used
  + De-escalation techniques
  + Emergency Call/Code

**PHASE II DATA COLLECTION:**

* Job Title of person affected.
* Years in occupation (not in specific job or at facility) [dropdown]
  + <1year
  + 1-2 years
  + 3-4 years
  + 5-9 years
  + 10-15 years
  + 16-20 years
  + 21-25 years
  + 26-30 years
  + 31+ years

**Information about Aggressor:**

* Gender of Aggressor [dropdown]
  + Male
  + Female
  + Transgender
  + Non-Binary
  + Other
* Age of Aggressor (in years)
* County of Residence [dropdown]
  + Maine Counties Listed
  + Other

**Prolonged Impact of Violence:**

* Emotional and/or Psychological Impact [dropdown]
  + None – No emotional and/or psychological impact
  + Mild – Upset / Angry / Scared / Humiliated
  + Moderate – Moderate emotional and/or psychological impact with no missed work but return to work with modifications.
  + Severe – Significant Emotional and/or psychological impact resulting in missed or inability to return to work, interventions required.

**Additional Contributing Factors to Violence:**

* Aggressor’s length of stay [dropdown]
  + Upon Arrival
  + <24 hours
  + 25-48 hours
  + 2-7 days
  + 7-14 days
  + >2 weeks

1. Trends, Policies, and Protocols Related to Healthcare Workplace Violence. Accessed on 1/31/24 at <https://files.asprtracie.hhs.gov> [↑](#endnote-ref-1)
2. 2022 Statistics on Healthcare Workplace Violence. Accessed on 1/31/24 at [www.ormanager.com](http://www.ormanager.com) (January 3, 2023) [↑](#endnote-ref-2)
3. Rosenthal LJ, Byerly A, Taylor AD, Martinovich Z. Impact and Prevalence of Physical and Verbal Violence Toward Healthcare Workers. Psychosomatics. 2018. Nov;59(6):584–90. doi: 10.1016/j.psym.2018.04.007 [[PubMed](https://pubmed.ncbi.nlm.nih.gov/29909013)] [[CrossRef](https://doi.org/10.1016%2Fj.psym.2018.04.007)] [[Google Scholar](https://scholar.google.com/scholar_lookup?journal=Psychosomatics&title=Impact+and+Prevalence+of+Physical+and+Verbal+Violence+Toward+Healthcare+Workers.&author=LJ+Rosenthal&author=A+Byerly&author=AD+Taylor&author=Z+Martinovich&volume=59&issue=6&publication_year=2018&pages=584-90&pmid=29909013&doi=10.1016/j.psym.2018.04.007&)] [↑](#endnote-ref-3)
4. Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents. Accessed on 2/5/2024: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5006066/> [↑](#endnote-ref-4)