Workplace Violence Prevention & Management in the Healthcare Setting: Legislation & Accreditation

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Background & Context

Healthcare workers face numerous occupational health risks and hazards within the workplace among which is workplace violence. Workplace violence is defined as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty" (Centers for Disease Control and Prevention/National Institute for Occupational Safety and Health, 1996, p.1). Violence can be classified into four types: Type I (Criminal Intent), Type II (Customer/client), Type III (Worker-on-Worker), and Type IV (Personal Relationship) (University of Iowa Injury Prevention Research Center, 2001). Exposure to workplace violence has detrimental individual and organizational consequences to both the front-line health-care workers and patient safety (Lipscomb & El Ghaziri, 2013).

This paper focuses on Type II (Customer/client) and Type III (Worker-on-Worker) workplace violence in the healthcare sector in both the United States (US) and Lebanon, with the purpose of providing a brief overview of the US regulatory and accreditation strategies to prevent and manage these prevalent types of exposures, along with the challenges and opportunities to address workplace violence in both countries.

In the United States (US), 409 workers in the private and public sectors were victims of workplace homicide in the year 2014 (Bureau of Labor Statistics (BLS), 2014). For the same year, 15,980 workers in the private industry experienced non-fatal workplace-violence-related injuries of whom 69% worked in the healthcare and social assistance industry sector (BLS, 2014). Among public sectors employees, in a large northeast U.S. state, 10.0% of the respondents indicated that they had been bullied at work during the prior 6 months, which is similar to the prevalence rates reported in Europe and Scandinavia (5%–30%) (Lipscomb, et al., 2015).

Lebanon is one of the few developing countries that recognized the significance and the impact of workplace violence in the healthcare setting early on, as evident in the 2002 report sponsored by the International Labor Office, International Council of Nurses, World Health Organization, and Public Services International (Deeb, 2003; Di Martino, 2002). Among healthcare workers, verbal abuse was the highest (41 %), followed by being bullied /mobbed (22.4%), physically attacked (6 %), racially harassed (4.9%) and sexually harassed (2.4%) (Deeb, 2003). In a recent study, four in five emergency department employees in Lebanon reported verbal abuse in the last 12 months, and one in four reported physical assault (Alameddine, et al., 2011). In a study among Lebanese nurses, two thirds of the participants reported experiencing verbal abuse and 10% experienced physical violence (Alameddine, et al 2015).

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Management and Prevention of WPV in the Healthcare Setting

There has been a collective global effort to issue guidelines and position statements to recognize and address Type II and Type III workplace violence in the healthcare sector by several agencies and organizations, nationally in the US (examples include Occupational Health and Safety Administration (OSHA), American Nurses Association), and internationally (examples include the World Health Organization, International Labor Organization, European Union, and the International Council of Nurses). Similarly, in Lebanon, the Lebanese Ministry of Public Health, the Syndicate of Hospitals in Lebanon, the Order of Nurses in Lebanon, the Lebanese Order of Physicians, and other agencies, have been actively working on managing and preventing WPV in the healthcare setting. In 2015, the American Nurses Association issued a position statement on incivility, bullying, and workplace violence calling on registered nurses and employers to share responsibility to create a culture of respect and to implement evidence-based strategies for incivility, bullying, and workplace violence prevention (ANA, 2015).

Australia, Canada, and the European Union nations have been more progressive to push for legal protections against Type III workplace violence, or workplace bullying, compared to the US (Yamada, 2010, 2011, 2012, 2015). The US is still lagging behind in issuing federal or state laws for the prevention of workplace bullying. The latest legal initiative to prevent and manage bullying exposure in the workplace is the Healthy Workplace Bill (Yamada, 2015).

In the US, and despite the prevalence and impact of Type II workplace violence, there is no federal legislation to address this type workplace violence. The federal effort for the prevention and management of workplace is limited to the voluntary Occupational Health and Safety Administration (OSHA) guidelines (U.S. Department of Labor & OSHA, 1996; 2004) and the Section 5 (a) (1) of the OSHAct, or the OSHA General Duty Clause. The OSHA General Duty Clause mandates that employers provide their employees a workplace that is free from recognized hazards that might lead or likely lead to death or serious physical harm. The OSHA guidelines for the management and prevention of workplace involve: management commitment and employee involvement, worksite analysis, hazard prevention and control, training and education, record keeping and program evaluation.
Despite the lack of the federal legislation, several states such as California, Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington have enacted workplace violence prevention and management laws. These legislations are mostly built on the foundational elements of the above mentioned OSHA guidelines (Lipscomb & London, 2015). However, most of the state laws do not identify the enforcements aspects of the enacted laws to a specific state agency.

In the US, healthcare accreditation agencies, such as The Joint Commission and the American Nurses Credentialing Center (ANCC) Magnet Recognition Program have recognized the magnitude of the problem and addressed the prevention and management of workplace violence, for both Type II and Type III, in their standards and guidelines (ANCC, 2008; Joint Commission, 2008, 2010). At the organizational level, key mechanisms for the prevention/elimination and management of workplace violence can be fostered through the hierarchy of controls such as: adopting engineering controls, administrative controls (policies), training and ensuring employee involvement.

The US OSHA guidelines, US State workplace violence legislations, and accreditation standards serve as conceivable tools for healthcare organizations to address workplace violence. However, having workplace violence legislations limited to few states, coupled with the voluntary nature of the OSHA guidelines and accreditation standards, highlights the need for federal mandatory standards to address enforce the prevention the hazard of workplace violence. In Lebanon, the Lebanese Ministry of Public Health (LMOPH) hospital accreditation standards include key elements pertaining to "patient safety" and "occupational health and safety"(LMOPH, n.d.). However,

there is no specific standard or legislation that addresses workplace violence prevention and management.

A comprehensive and participatory approach with stakeholder involvement (Lipscomb & El Ghaziri, 2013), while taking into account the particularities of each country, is key for the prevention and management of workplace violence in the healthcare sector. Researchers in both the US and Lebanon have acknowledged the political and economic challenges for such multi-stakeholder initiatives to prevent and manage workplace violence (Alamdeddine & Yassine, 2013; Deeb, 2003; Lipscomb & London, 2015). This is coupled with the challenges for the support, buy in, and enforcement of such standards and legislations for the prevention and management of workplace violence.

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