Workplace Violence, Organizational Culture, and Registered Nurses' Incident Reporting Patterns in Acute Hospitals in California

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WORKPLACE VIOLENCE, ORGANIZATIONAL CULTURE, AND REGISTERED NURSES’ INCIDENT REPORTING PATTERNS IN ACUTE HOSPITALS IN CALIFORNIA

A Dissertation Presented
to
Organization and Leadership Program
The Faculty of the School of Education

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
M. L. Feodora Jacobsen
San Francisco
May 2016
ABSTRACT

The purpose of this study was to increase understanding of the reporting patterns of WPV Type II in acute hospital settings. Although some patients are abusive toward nurses, that the abuse is underreported to hospital administrators. Qualitative studies identified common themes for underreporting including fear of being blamed, abuse considered part of the job, and not having sufficient time to fill out a formal report. This study is the first quantitative study to explore the changes in mean scores of organizational-culture factors under two mutually exclusive conditions: registered nurses (RNs) who do not report hospital incidents and RNs who do report them. Findings include several statistically significant mean score differences in the two groups of nurses on organizational justice and safety-culture scales. This is also the first study to determine if WPV Type II is underreported to a higher degree than other types of hospital incidents such as needle stick injuries, patient falls, and medication errors. The two highest rates for underreporting were verbal abuse at 65% and mild physical abuse at 51%. Higher rates were statistically significant. The percentage of RNs who experienced verbal abuse was 83% and mild physical abuse 54%. For every 100 nurses, 54 experienced and did not report verbal abuse and 28 experienced and did not report mild physical abuse. Examples of verbal abuse include patients or their families making graphic detailed threats to kill RNs.
This dissertation, written under the direction of the candidate’s dissertation committee and approved by the members of the dissertation committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Education. The content and research methodologies presented in this work represent the work of the candidate alone.

Feodora Jacobsen  

May 11, 2016

Date

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May 11, 2016

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May 11, 2016
DEDICATION

Thank you to my best friend, George A. Irving, who supported me in all ways imaginable and who spent his spare time shaping our slice of heaven that we now have time to enjoy.

Thank you to Dr. Patricia Mitchell. You are a true leader who embraces diversity and helps each individual under your tutelage to fully develop his or her unique contribution to the world.

This thesis is written to benefit nurses everywhere. You are courageous unsung heroes.
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CHAPTER I: INTRODUCTION

Statement of the Problem

Nurses are three times more likely to be assaulted (nonfatally) than any other professional group (Keely, 2002); nurses are more likely to be assaulted than police officers. Being assaulted in the workplace by patients, patient families, peers, and other team members is not part of a nurse’s job description; yet it happens frequently.

The American Psychiatric Nurses Association found that only one in five assault incidents were reported (APNA, 2014). Frontline nursing staff underreported verbal abuse, threats, and violent physical contact due to a number of factors. Staff, in previous qualitative studies listed organizational factors that aligned with not completing incident reports; an example of a factor was lack of a “safety culture” including the belief that a reported incident would not addressed (Gifford & Anderson, 2010, p. 292). A nurse expressed this lack of a safety culture as, “We’ve already written ten reports on this [violent] patient and nothing has been done.” Staff reported that abuse, threats, and physical violence all affected the quality of their work. Staff errors increased after experiencing workplace violence (WPV) (Roche, Diers, Duffield, & Catlling-Paull, 2010).

WPV continues to occur at a high rate. It is underreported, it has significant practical impact on nurses’ and patients’ lives, and it is increasing (Privitera, 2011).

Background and Need

Nurses experience WPV in acute hospitals. APNA (2014) published a position paper in 2008 on WPV. They identified that safety is the main concern of registered nurses (RN), listing that 74% of participants in a large international study reported WPV,
and nearly 26% experienced physical violence. The level of WPV incidents prevalence varies from study to study. WPV incidents are increasing due to decreased length of hospitalizations and the resulting increases in average patient acuity and waiting time (Privitera, 2011). However, the exact prevalence is difficult to determine because incidents are underreported (Gifford & Anderson, 2010), hospitals keep this sensitive material private, and the variation in definitions of WPV used in hospitals and research studies limits comparisons.

Organizations, staff, and patients face many negative consequences when WPV does occur (Demir & Rodwell, 2012; Gates, Gillespie, & Succop, 2011; Roche et al., 2010). Examples of consequences include increased medication errors, increased patient falls, nurses not finishing tasks on time, and increased nursing intent to leave the organization. WPV incurs direct and indirect costs to the organization including legal cases, paid time off for injured employees, replacing employee time off, medical costs, decreased productivity, and damage to hospital property (Pam, 2013).

Factors chronicling WPV are complex and include characteristics of the patient, characteristics of the staff, changes in healthcare that increase wait times and acuity, and organization culture. The emerging concept, “organizational violence,” is thought to increase acceptability and occurrence of WPV and decrease the likelihood that staff will report it (Privitera, 2011). An example of organizational violence is administrators diminishing staffing levels resulting in higher workloads, leading to nursing fatigue and nursing errors. Another example is a nurse being blamed by management for making errors without considering other factors. An example of verbal abuse occurs in operating
rooms when physicians belittle nurses in public, their behavior is unchallenged, and then becomes the norm. Nurses feel humiliated and make mistakes in patient care.

When nurses report incidents, such as public belittling, their report becomes part of the hospital’s “process improvement” data. Hospital’s use these data to develop and implement corrective action plans. If data are missing, the sense of urgency to fix a problem can be low or the corrective action plan can fail to address the right problem. Nurses, in qualitative studies, have identified barriers to reporting incidents including fear of being blamed, no time to complete reports, not knowing how to complete reports, working in a culture that discourages reporting, belief that nothing will be done to prevent future incidents, fear of disciplinary action, and fear of litigation (Gifford & Anderson, 2010; Jennings & Stella, 2011). Researchers have not measured organizational factors quantitatively to discern if any relationship exists in incident reporting patterns. All types of incidents are underreported (Jennings & Stella, 2011). Anecdotal reports suggest that WPV is underreported more often than other incidents, but prior to this study, no research studies have quantified that information.

Purpose of the Study

The purpose of this study was to investigate how indicators of suboptimal organizational culture in acute hospitals relate to RNs’ incident reporting patterns and to observe if differences emerged in incident reporting patterns depending on the type of incident. The factors that build suboptimal organization culture are many; this study focused on burnout (Maslach & Jackson, 1981), organizational justice (Hansen, Byrne, & Kiersch, 2013), and safety culture (Sexton et al., 2006). The incidents chosen for this study were needle stick injuries, patient falls, medication errors, verbal abuse, mild
physical abuse, and moderate-to-severe physical abuse. The perpetrators of violence against nurses in this study were patients and patients’ family members.

**Conceptual Framework**

Healthcare setting personnel are gaining interest in “organizational violence” (Privitera, 2011) and “toxic” organizational culture (Porter-O’Grady & Malloch, 2007) in healthcare settings. Organizational violence, also known as WPV Type IV, “involves organizations knowingly and unnecessarily placing their workers or clients in dangerous or violent situations or allowing a climate of abuse, bullying, or harassment to thrive in the workplace” (Privitera, 2011, p. 47). Leader’s antisocial behavior, toxic mentoring, neurotic behavior, and self-defeating behavior characterize toxic organizations (Porter-O’Grady & Malloch, 2007). These leader behaviors result in disfranchised employees who face a dichotomy between the compassionate care they are trying to provide and the lack of compassion they experience.

Previous studies on WPV viewed it in the context of violent or toxic organizational cultures (Roche et al., 2010; Squires, 2011). This approach can be conceptualized as a cycle starting with violent/toxic organizational culture that supports WPV to occur, and then back to the violent/toxic culture that does nothing to address the issue. This circular pattern can aid in understanding the persistence of WPV; however, it also encourages a blame mentality (blaming the organization). Blaming is a part of toxic hospital cultures (Porter-O’Grady & Malloch, 2007). An alternative approach would decrease direct blame on the organization and focus on the organization as the context for incident reporting (see Figure 1).
Rather than use the terms organizational violence or organizational toxicity, the researcher uses the terms *suboptimal organizational culture* and *organizational-culture factors*. Suboptimal organizational culture means the collection of factors, including processes, practices, procedures, and norms, that knowingly or unknowingly inhibit optimal professional staff behaviors and support an environment of hostility, aggression, or violence. Organizational-culture factors were measured using established surveys, such as the Safety Attitude Questionnaire (Sexton et al., 2006); the factors chosen for the survey could theoretically build an optimal or suboptimal organizational culture.

In summary the model for understanding the repetitive nature of WPV changed the context of violence from the organization to the understanding that WPV does occur as it does in society. After a WPV incident occurs it may not be reported; this decision may be influenced by organizational-culture factors. Once underreporting of WPV occurs, the hospital lacks urgency to change (see Figure 1) and the cycle continues.

*Figure 1. Workplace-violence cycle.*
Research Questions

The study addressed the following research questions.

1. What organizational-culture factors of burnout, organizational justice, and safety culture aligned with differences in incident reporting patterns for needle stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse?

2. What differences accrued in how often nurses reported needle-stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse?

Delimitations

The largest delimitation of this study was using a convenience sample of RNs in California who worked in an acute hospital setting and chose to respond to the survey. Using a convenience sample supports the concept that this study was exploratory in nature. The results of this study will direct further studies rather than generalize conclusions to all hospitals in California.

Limitations

An online survey instrument limited the results obtained due to reliance on participants’ memory of events, the variation in participants’ understanding of the terms used in the survey, and participants’ own biases related to patient/patient family on nurse
WPV. Self-reporting data may have been less objective than trained rater-observation data due to participants’ social-desirability bias (Kreuter, Presser, & Tourangeau, 2008). However, using an online survey minimized social-desirability bias compared to other electronic methods such as voice-recognition surveys (Kreuter et al., 2008).

The researchers’ biases may have limited the study; these included believing that men have experienced more power and privilege in the workplace compared to women; acute hospitals have more female nurses than male nurses and some of the challenges nurses faced were due to working in a female-dominated occupation; WPV was too high for nurses; WPV involving nurses was an international issue; hospitals have done too little to protect nurses from WPV; hospital administrators were doing the best they could in a service industry that had many external pressures, including decreasing revenues; hospital administrators would have provided more protection for nurses if they had been more aware of WPV prevalence; and hospital administrators would have provided more protection if there had been improved mandates from regulatory bodies.

The researcher also believed that the relationship between the nurses and administrators affected relationships between nurses and patients. Every relationship at every level impacted all the relationships above and below it in the hospital hierarchy, yielding “parallel organizational relationships.” Caring was part of the service provided by the nurses in the study. This caring should have been evident at all levels of the organization. Included in caring for nurses was the level of protection from violence provided and level of blaming nurses for mistakes that had several other contributing causes. If hospitals did not care for nurses then the potential for nurses to care for others likely diminished.
Educational Significance

Ideally, this study will helped to create a sense of urgency to address WPV in acute hospitals. Many processes in hospitals have already changed when information has reached a high level of urgency. For example, in the past, nurses lived with needle stick injuries commonly caused by manually “recapping” needles after an injection. The consequences of needle stick injuries reached a high enough sense of urgency to decrease the risk. The National Institute for Occupational Safety and Health (NIOSH, 2006) developed mandates to reduce the prevalence of these injuries. The State of California went further than NIOSH mandates and included additional measures to protect nurses, including posting information on needle stick injuries on every nursing unit. Nurses now have needleless devices and safety syringes. Safety syringes either automatically withdraw the needle into the barrel of the syringe or have a hinged side cap that snaps into place without the nurse holding the cap. In hospitals where nurses are educated and use safety syringes, the rate of injuries has decreased (Higginson & Parry, 2013).

Other mandates include reporting patient-care errors to regulators and financial penalties tied to patient outcomes. These mandates have improved patient outcomes in hospitals where the researcher has worked. Effective mandates to decrease WPV are not as well developed as those that address needle stick injuries, patient falls, and medication errors. WPV in acute hospitals has not reached the critical level of urgency that demands change. When it does, hospitals and nursing schools will be required to increase their efforts in a meaningful ways to reduce the incidence of WPV.
Definitions

The following terms have been operationalized for this study.

*Burnout.* Burnout is a measure of employees’ ability to positively function in work life, affected by the demands of the job. Jobs with high workload, intense involvement with very ill patients, high levels of shifting priorities, and life or death situations can increase burnout. Nurses who are burned out feel drained, lack compassion, are cynical, and feel a low sense of accomplishment.

*Incident report.* Incident reports are written reports completed by the person involved in, or witness to, an event that is unexpected or dangerous, resulting in increased medical risks, security risks, or legal risks.

*Organizational-culture factors.* Organizational-culture factors are aspects of an organization that can be described and given a name. Examples include burnout, organizational justice, and safety culture.

*Organizational justice.* Organizational justice is the sense of fairness that individuals experience in an organization. The level of organizational justice, or sense of fairness, aligns with outcomes in the organization. An example is a high level of fairness resulting in low turnover of employees.

*Organizational violence.* Organizational violence occurs when leaders make decisions or take actions that knowingly put employees at risk for WPV.

*Physical abuse.* Physical abuse includes mild and moderate-to-severe physical abuse. Mild physical abuse includes receiving deliberate or inadvertent physical contact with another person that results in restriction of freedom of movement or causes
pain/discomfort resolving within 2 hours. Mild physical abuse includes gestures and movement that imply a threat of bodily harm. Moderate-to-severe physical abuse includes receiving deliberate or inadvertent physical contact with another person that results in loss of physical function, body part or limb; pain lasting longer than two hours, or having a possibly injury that needs to be assessed by a healthcare professional. Moderate-to-severe abuse includes deliberate physical contact that is sexual in nature or being threatened with a weapon such as a gun or knife.

*Safety culture.* Safety culture is the level of commitment of the organization to identify and address safety issues in a meaningful and effective manner.

*Suboptimal organizational culture.* Suboptimal organizational culture is the collection of organizational factors including processes, practices, procedures, and norms that knowingly or unknowingly inhibit optimal professional-staff behaviors and support an environment of hostility, aggression, or violence.

*Verbal abuse.* Verbal abuse includes name calling, insults, swearing, public reprimands, yelling at victims when there is no reason to yell, using a harsh or condescending tone, making vague verbal threats, and making sexually inappropriate comments.

*Workplace violence.* WPV occurs when an employee is verbally or physically abused by another person. The abuser can be a patient, patient family member, visitor, peer, colleague, or supervisor. Patient/patient family member on nurse abuse is a specific example of WPV referenced as WPV Type II in current literature (Privitera, 2011).
Summary

Violence is a fact of life in communities and workplaces. Nurses experience more WPV than those in other professions and do not report most violent events to hospital administrators. Researchers have started to collect qualitative data to understand what barriers exist that prevent nurses from reporting these assaults. Some emerging barrier themes relate to organizational culture. Two major themes are “nothing will be done” and fear of being “blamed.” When nurses are physically and verbally assaulted, they may receive many direct and indirect negative consequences. The consequences can be grouped into the categories of nurses experiencing a decrease in well-being, nurses making mistakes that lead to poor patient outcomes and decreased patient satisfaction, and increased costs for the hospital.

Too little is done to care for nurses whereas the violence they experience is increasing. More data on the incidence and consequences of WPV would elicit support for change from the highest levels of hospital management and force regulators and law makers to mandate higher standards to protect nurses. Support for these changes may be found in quantifying the barriers that lead to underreporting, mitigating the barriers, increasing WPV incident reporting, and amassing a larger amount of data that is harder to minimize or ignore.

This study put organizational culture in a framework of a workplace-violence cycle, conceptualized and focused on collecting data on suboptimal culture factors that may contribute to underreporting. Because all hospital incidents have been underreported, data were also analyzed to see if WPV incidents were underreported more often than other types of incidents.
Chapter 2, a literature review, describes the current research on elements in the conceptual framework of the WPV cycle. The cycle begins with the knowledge that WPV exists, followed by nurses deciding to forego reporting incidents in the context of suboptimal-organizational cultures, resulting in underreporting, and the lack of data that maintains the lack of urgency to make changes to increase safety for nurses. Chapter 3, describes the methodological process on the survey development. The chapter includes the reliability and validity of the surveys used to build the final survey used in this study. Experts and a pilot study were used to identify validity issues. Chapter 3 also includes analysis of the data to answer the research questions. Chapter 4 reports descriptive data, quotations from participants, and inferential statistical analysis. The analysis was exploratory and the $p$ values were reported rather than being subjected for statistical significance. Chapter 5 discusses the results and includes recommendations for how hospital and educational organizations can decrease WPV.
CHAPTER II: LITERATURE REVIEW

Introduction

The purpose of this study was to investigate how indicators of suboptimal organizational culture in acute hospitals relate to RNs incident reporting patterns and observe if there was a difference in incident reporting patterns depending on the type of incident. The factors that build suboptimal organization culture are many; this study focused on burnout (MBI) (Maslach & Jackson, 1981), organizational justice (OJ) (Hansen et al., 2013), and safety culture (SAQ) (Sexton et al., 2006). The incidents chosen for this study were needle stick injuries (TO STAFF), patient falls, medication errors involving patients, verbal abuse, mild physical abuse, and moderate-to-severe physical abuse. In this study, perpetrators of violence against nurses were limited to patients and patient family members.

In chapter 1, the workplace-violence cycle was visually conceptualized (see Figure 1). The cycle starts with understanding the four types of WPV, reviewing WPV Type II (patient on nurse violence) prevalence, and high risk areas in the hospital. Incidence of violence takes place in the context of the organization. The culture in the organization may increase the risk of violence occurring and may related to incident reporting patterns. Aspects of organizational culture include the organizational-culture factors chosen for this research: level of burnout, perceived organizational justice, and perceived safety culture. Organizational culture is potentially affected by external forces, such as regulations and laws. In this chapter, the regulations and laws that have the greatest impact in California are reviewed.
The nurse who has just been assaulted faces a choice about whether to report the incident. This decision takes place in an organizational culture. Researchers have discerned barriers to reporting incidents in qualitative studies that allowed barrier themes to emerge from the data provided by participants (Blando, Ridenour, Hartley, & Casteel, 2015; Gifford & Anderson, 2010; Hogarth, Beattie, & Morphet, 2015; Mountzoglou, 2010; Prang & Jelson-Jorgensen, 2014; Speroni, Fitch, Dawsen, Dugan, & Atherton, 2014). Although researchers have studied barriers to reporting clinical mistakes and barriers to reporting WPV (Cafaro, Jolley, LaValla, & Schroeder, 2012; Chiang, 2010; Fitzgerald, Cawley, & Rowan, 2011; Hashemi, Nasrabad, & Asghari, 2012; Haw, Stubbs, & Dickens, 2014; Jennings & Stella, 2011; Khammarnia, 2014; Lederman, Dreyfuss, Matchan, Knott, & Milton, 2013; Nuckols, Bell, Liu, Paddock, & Hilborne, 2007; Malik, Alam, Mir, Malik, & Abbas, 2010; Sato, Wakabayashi, Kiyoshi-Teo, & Fukahori, 2013; Waters, Hall, Brown, Espezel, & Palmer, 2012), they have not done so in the same study. In this chapter, the current body of knowledge on barriers to reporting incidents in acute hospitals are reviewed.

The desired educational significance for this research is to provide more information on barriers in hospitals in California and encourage change at different levels ranging from state laws to nursing school education. Understanding the impact of WPV, postevent care, and what stakeholders need to support change comprise the final circle of the workplace-violence cycle.
Workplace Violence

Understanding WPV starts with reviewing the types of WPV that can occur in any profession, how often the WPV occurs, and the areas in the hospital that are at the highest risk (see Figure 2.).

Figure 2. Workplace-violence cycle: Understanding prevalence.

Workplace Violence Typology

Four types of WPV happen: Type I is criminal acts by an intruder, Type II is client on staff violence, Type III is staff on staff violence, and Type IV is organizational violence or domestic violence that takes place at the organization (Privitera, 2011), depending on a study’s framework. This study focuses on WPV Type II, which is the patient or the patient’s family being verbally and physically abusive to nurses.

Prevalence Workplace Violence Type II and Prevalence in High Risk Areas

As previously mentioned, it is difficult to know the true prevalence of WPV Type II due to many factors including underreporting. The following information provides the
scope and severity of violence. Although this study is based in California, violence against nurses is an international problem.

In a retrospective survey conducted in 2011 involving physicians and nurses in five publically funded Palestinian hospitals, researchers used a self-administered survey to collect data using a stratified proportional random sample (Kitaneh & Hamdan, 2012). Participation rate for the random sample of 271 staff yielded an 88.7% participation rate. Results for participants were that 19.6% experienced no violence, 59.6% experienced non-PV (verbal abuse, threats, sexual harassment), and 20.8% experienced PV (16.7% of respondents experienced both forms of violence). Most commonly, victims were female nurses, 31–40 years old, with 6–10 years of experience, a bachelor’s degree, a shift worker, working in a medium-sized hospital in a medical/surgical or emergency department. Most commonly, perpetrators were men, 19–35 years old, unimpaired (so behavior was likely intentional), and a visitor or family member. Significant results included the following:

1. Male staff experienced more physical violence (PV) than female staff.
2. Staff with less experience (less than or equal to 10 years) experienced more PV and non-PV than experienced staff (8 times more likely).
3. Staff with less education (less than a bachelor’s degree) experienced more PV.

An extensive study in an emergency room found no statistical differences in the gender of the victims (Kowalenko, Gates, Gillespie, Succop, & Mentzel, 2012). The researchers included six hospital emergency departments (EDs) from two different states. Selected participants matched the composition of typical ED staffing (by occupation, RNs being the largest group). The authors selected enough participants to obtain
sufficient statistical power for inferential statistic testing using repeated measure linear regression and other models. Kowalenko et al. (2012) used a combination of baseline surveys, monthly surveys, and violent event (VE) surveys. They collected data over 13 months including 1,795 monthly surveys and 827 reported VEs; only 42% of the 827 completed an incident report for hospital administrators and 5% filed a police report. Of the 827 reported VEs, 72.7% (601) were threats and 27.3% (226) were physical assaults. Extrapolated rates for the 827 VEs resulted in a prevalence of four threats per person per year and 1.5 assaults per person per year. The staff composition included RNs, paramedics, medical doctors (MD), licensed practical nurses (LPN) and personal care assistants (PCS). Total VEs experienced by RNs were 61%; by PCAs, 58%; by paramedics, 39%; and by MDs, 28%. Statistical significance emerged for differences between the following:

1. Higher VEs for RNs than MDs.
2. Higher VEs for PCAs than MDs.
3. More threats to RNs (46%) than MDs (21%).
4. More PVs of PCAs (21%) than MDs (7%).
5. More PVs of RNs (15%) than MDs (7%).
6. RNs felt less safe than MDs.
7. MDs felt more confident in managing violent patients than RNs.
8. RNs felt more confident in managing violent patients than PCAs.
9. RNs were more likely to experience acute stress than MDs.
10. Acute stress reduced productivity.
RNs spend more time with patients so it makes sense that they are more likely to experience more threats and assaults. The rates gleaned from the Kowalenko et al. (2012) may be lower than in other studies that rely on retrospective self-reports of threats and actual physical assaults. The study increased reliability because it was longitudinal. No significant differences arose in gender of victim, age, years of experience, time of day, or hospital type. Only a few more men than women were perpetrators. More than 50% of this cohort did not receive violence prevention training even though the ED is one of the departments most at risk for violence perpetrated by patients.

A master’s research thesis submitted to Gardner-Webb University School of Nursing (Roakes, 2012) included original research to answer the question, “Does a registered nurses department, medical-surgical versus emergency department, change the amount of WPV they may experience?” The author used a nonexperimental quantitative approach including a survey collecting retrospective data on the nurses’ last 2 years of work life. Key points in the literature review follow:

1. Three of four nurses experience WPV; only one in six report it (Lowry, 2010).
2. Nurses leave their profession based on emotional violence more than PV or threats of PV (Roche et al., 2010).
3. 94% of ED nurses have at least one symptom of posttraumatic stress disorder (PTSD) after WPV (Gates et al., 2011).
4. 79.7% of nurses made an increased number of errors after verbal abuse (Judkins-Cohn, 2010).
5. Nurses experienced more fear if they saw a peer assaulted and injured rather than being personally assaulted (McClellan, 2011).
Roakes (2012) included 27 nurses in the study: 14 worked in the ED and 12 worked in a medical/surgical department (MSD); one did not designate. The Roakes study used self-reports of incidents occurring over the last 2 years: 77.3% experienced threats of PV, 81.8% experienced bullying, and 54.5% experienced PV. In the Roakes’ study, consistent with other studies (Privitera, 2011), most perpetrators of violence against nurses were patients (86.4%). Younger nurses experienced a higher prevalence of WPV, which the author attributed to less life experience. All ED nurses experienced threats, disruptive behavior, threats of physical force, and intimidation. “ED nurses reported having higher risk for physical WPV where medical surgical nurses have more emotional violence” (Roakes, 2012, p. 40) but the author did not include the partition by department. The study results supported the concept that ED nurses do experience more WPV than MSD nurses. Roakes did not imply that MSD nurses have an acceptable level of WPV.

Researchers of a comprehensive study in 94 MSDs in 21 hospitals in Australia (Roche et al., 2010) collected data from 2004 to 2006. The survey yielded an 80.3% response rate for 2,487 nursing staff members. Researchers asked nurses about their WPV experiences in the last five shifts they worked (most surveys ask for the last year). Of the nurses, 14.4% experienced PV; 20.8% experience threats of violence (TV); and 38.2% experienced emotional abuse (EA). The primary perpetrators for all forms of violence were patients, 88.4%, 77.6%, and 39.6%, respectively. Thus, others such as peers, supervisors, and physicians perpetrated more than half of the verbal abuse. The purpose of the study was to focus on MSDs because most research focuses on Emergency and Psychiatric Departments and relate the frequency of the violence to environmental
factors and patient outcomes. The variation in findings linked more to unit circumstances rather than to patient populations. This is an encouraging outcome as it means it is possible to decrease the risks of WPV.

WPV not only affects ED and MSD nurses, it affects all nurses working in acute settings (Speroni, Fitch, Dawsen, Dugan, & Atherton, 2014). The high risk areas are usually the ED and the psychiatric department (PD), depending on the study. It is difficult to compare statistics from one study to another due to variation in definitions of violence, data collection processes, and time frame parameters. In the study by Roakes (2012) 100% of all ED staff experienced threats, disruptive behavior, threats of physical force, and intimidation, and more than half of combined ED and MSD nurses experienced PV. Psychiatry is also a high risk area: as cited in a 2008 position statement (APNA, 2014) completed in 2008, lifetime PV occurred in 75–100% of psychiatric department (PD) nursing staff (Hatch-Maillette, Scalora, Bader, & Bornstein, 2007) and 54% of PD nurses have been assaulted more than 10 times (Poster & Ryan, 1989). The APNA position paper is included in this dissertation, even though it is somewhat older, because it is the current position paper posted on the website, and is written by a large respected professional group that summarizes and conducts research. The APNA conducted a follow-up study in 2012 that confirmed that WPV in PD nursing is still an issue (Cafaro, Jolley, LaValla, & Schroeder, 2012).

Organizational Culture

When patients or their family members verbally and physically attack nurses, the abuse takes place in an organization that has an organizational culture. Organizational culture includes all processes, policies, norms, history, and practices that influence what
and how individuals and groups in the organization behave. Organizational culture grows through interactions between members over time (Johnson, 2012) and then becomes an entity unto itself that has enough stability that the members can change but the culture stays the same (Geertz, 1977). Individuals and groups can change the culture but change takes a high level of commitment across all levels of the organization (see Figure 3).

Figure 3. Workplace-violence cycle: Understanding organizational culture.

Workplace Violence Type IV

Organizational culture can include organizational violence, also known as WPV Type IV (WPV IV), defined as involving “organizations knowingly and unnecessarily placing their workers or clients in dangerous or violent situations or allowing a climate of abuse, bullying, or harassment to thrive in the workplace” (Privitera, 2011, p. 47). Using this perspective, an implied cause-and-effect relationship exists between WPV IV leading to WPV II (patient/patient family on nurse violence). In this conceptual framework of the workplace-violence cycle the organization follows the event of WPV to focus on possible underreporting barriers. The two frameworks are not mutually exclusive; they are
overlapping. The latter perspective provides a focus that rests less on blaming hospital organizations for WPV and more on promoting understanding of WPV incident reporting patterns.

WPV IV aligns with top-down decision making and financial constraints leading to high workloads, downsizing, and decreased benefits (Privitera, 2011). Many consider hospital environments to be “toxic” and “oppressive” (Porter-O’Grady & Malloch, 2007) and particularly so to nurses who have high responsibility but low authority compared to physicians and administrators. Toxicity is also increasing (Cafaro et al., 2012; Porter-O’Grady & Malloch, 2007; Privitera, 2011) with escalating costs of healthcare coupled with decreased reimbursement for care provided. When hospitals are oppressive and toxic to employees, the following behaviors emerge: chronic unresolved conflict (particularly between front-line staff and upper levels of administration), increased grievances, increased union activity, ineffective communication, blaming other disciplines or service units, decreased morale, increased cynicism, decreased work quality, increased sick time, increased turnover, and decreased productivity.

**Suboptimal Organizational Culture**

Suboptimal organizational culture is my softer but broader redefinition of organizational violence. Organizational violence occurs when leaders make decisions or take action that knowingly put staff at increased risk of violence. Suboptimal organizational culture is the collection of organizational factors including processes, practices, procedures, and norms that knowing or unknowingly inhibit optimal professional staff behaviors and support an environment of hostility, aggression, or violence.
Organizational factors provide a context in which WPV can exist but also provide barriers to reporting incidents. The organizational factors for this study include subscales from established surveys: they include burnout (MBI) with a focus on emotional exhaustion (MBI/EE) (Maslach & Jackson, 1981), organization justice (OJ) (Hansen et al., 2013) including distributive justice (OJ/DJ), procedural justice (OJ/PJ), interpersonal justice (OJ/Intj) and informational justice (OJ/Infj), and safety culture (SAQ) that includes teamwork (SAQ/TW), safety climate (SAQ/SC), perception of management (SAQ/PM), and working conditions (SAQ/PM) (Sexton et al., 2006). If employees experience burnout from an excessive workload, feel their organization is unfair, and perceive a lack of concern for safety, they are less likely to take the time to fill out an incident report.

Suboptimal Organizational-Culture Factors

Burnout

In the 1970s, the term burnout was coined, largely based on qualitative data; in 1981 Maslach and Jackson (1981) developed and validated the Maslach Burnout Inventory (MBI). Burnout is high in service occupations and particularly high in healthcare (Ribeiro et al., 2014), it is increasing (Madathil, Heck, & Schuldburg, 2014), and it is higher for nurses in acute setting than nurses in nonacute settings (McHugh et al., 2011). In the study by McHugh and others (2011), using a survey of 95,499 nurses, the burnout rate was 34% for hospital nurses. Ribeiro and others (2014) studied 188 surgical nurses and found a burnout rate of 10.1% with an additional 55.4% having a propensity to develop burnout. In the same study a review of international studies revealed a wide range of burnout rates ranging from 4.7 to 49.7%. Burnout is not
considered clinical depression but does share characteristics with it; in a study of 5,500 school teachers 90% of the teachers met some of the criteria for clinical depression (Bainchi, Schonfeld, & Laurent, 2014). It is likely that some employees in the helping professions, like any profession, have genetics that predispose them to developing depression (Halter, 2014), but this does not discount that workplace demands also have an impact on well-being. Burnout is a serious issue because it not only affects quality of life but can lead to a mental health disorder that can include inability to work, profound hopelessness, and suicide.

Researchers have used the MBI widely to measure burnout (Ribeiro et al., 2014). The three subscales of the MBI are emotional exhaustion, personal accomplishment, and depersonalization. Burnout includes a depletion of interest in work, a decrease in emotional and physical strength to meet the demands of the job, feeling overextended and unable to achieve quality work, apathy, and cynicism. The MBI represented emotional exhaustion by statements participants endorse, such as “I feel emotionally drained from my work,” “I feel used up at the end of the day,” and “I feel frustrated by my job” (Maslach & Jackson, 1981). Lack of feelings for patients and personal accomplishments marks depersonalization and relates to nurses’ sense of competence and success (Maslach & Jackson, 1981). Hospitals have processes that increase the likelihood of burnout: high workloads, shift work, unexpected double shifts, constantly changing priorities, life and death responsibilities, complexity, and working with patients who need an intense level of emotional and physical care.
Organizational Justice

Organizational justice is the employee’s perception of “fairness” (Hansen et al., 2013). Colquitt developed 20 items to measure aspects of fairness in 2001. The Colquitt survey contains four subscales: distributive justice, procedural justice, interpersonal justice, and informational justice. Examples (respectively) are, “Does your [outcome] reflect what you have contributed to the organization?”; “Have you been able to appeal the [outcome] arrived at by those procedures?”; “Has [he/she] treated you with respect?”; and “Has [he/she] explained the procedures thoroughly?” When employees feel their organization is not fair they can develop “counterproductive work behaviors” (Hansen et al., 2013) that could include not completing an incident report when a serious incident has occurred.

Safety Culture

Safety culture can mean the organizations collective behaviors that support or hinder safe patient care and work environment (Sexton et al., 2006). The Safety Attitudes Questionnaire (SAQ) measures the organizational-safety culture through the perceptions of front-line staff. The SAQ has six subscales: teamwork, safety climate, job satisfaction, stress recognition, perceptions of management, and working conditions. Examples are, “Nurse input is well received in this clinical area,” “Medical errors are handled appropriately in this clinical area,” “I am proud to work in this clinical area,” “Morale in this clinical area is high,” “I am more likely to make errors in tense or hostile situations,” “Fatigue impairs my performance during emergency situations,” “Management doesn’t knowingly compromise patient safety,” and “Trainees in my discipline are adequately
supervised.” If staff have positive perceptions of the safety culture, they are like to believe incident reporting could make a difference; conversely, if they perceive that information they provide makes no difference, they could view reporting as a useless activity.

**Regulations & Laws**

Regulations that include items pertaining to the development of a safety culture and laws that define violence against nurses as a criminal act influence hospital organizational culture.

*The Joint Commission*

The Joint Commission (TJC, 2015) is a national nonprofit organization that provides in-depth reviews of hospital practices and outcomes, compares them to TJC standards, and grants “accreditation.” Many healthcare insurance companies require hospitals to have TJC accreditation before they will refer and pay for patients’ care. The mission of TJC is “To improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value” (TJC, 2015, p. 1). In 2009, TJC required healthcare organizations to have a formal process to manage violence (APNA, 2014).

The initial focus for managing violence was on protecting patients, through standard R1.01.06.03. It stated that patients needed to be free from verbal, mental, physical, and sexual abuse and neglect or exploitation. A focus on WPV experienced by employees emerged, but the concern was on civility between members of the organization. Lack of civility between employees is part of WPV (referenced as
horizontal violence, vertical violence, or WPV Type III) but patients and their families are responsible for most WPV incidents (Privitera, 2011). The current standards include a requirement that hospitals conduct an annual safety-risk assessment that addresses all forms of WPV including all potential victims and perpetrators. The plan must include prevention of WPV and how to respond to violent incidents. The researcher has participated in these risk assessments and plans and found the overall idea to be very good but no specific requirements “have teeth”. The Joint Commission offers guidelines for “suggested actions” that hospitals can take to prevent WPV, but they are voluntary.

The National Institute for Occupational Safety and Health

The National Institute for Occupational Safety and Health (NIOSH) is a section of the Centers for Disease Control and Prevention (CDC) that publishes best practices to protect employee safety. The California Division of Occupational Safety and Health (Cal/OSHA) is the state labor entity that publishes and enforces regulations related to best practices. It offers no specific requirements for prevention of WPV in healthcare (State of California Department of Industrial Relations, 2015). This means that when a hospital employee calls Cal/OSHA regarding a WPV complaint, Cal/OSHA can do very little. Cal/OSHA just finished developing a new, comprehensive, 13-page proposed state standard. In the next year it will be open for public comment, be presented at a hearing for administration law adoption, and be scheduled to be in effect by July, 2016. However, delays are expected (B. Nakamura, personal communication, October 13, 2015). It will appear in Title 8, Chapter 4, Subchapter 7, section 3342: Workplace Violence Prevention in Healthcare.
State Assembly Bill 1083

State Assembly Bill 1083 (AB 1083) passed in 2009 after a California nurses’ union presented survey results from their membership on WPV to the California legislature. The bill mandated hospitals have annual safety-plan updates that address multiple issues including staffing levels, training for staff to prevent WPV, availability of security staff, providing alarms to staff to notify the security department when an assault occurs, tools for predicting violence from patients, and analysis of WPV trends. The California Department of Public Health (CDPH, 2015) enforces the bill’s provisions, including licensing and certification. When a new hospital opens, CDPH completes an onsite visit to ensure the hospital complies with all regulations. After the hospital is open, CDPH will conduct site visits based on complaints received from patients or employees. CDPH can fine the hospital and request an action plan to fix the problem. I have participated in both of the activities above. Shortcomings may ensue in how the hospital implements the safety plan even when it is approved by CDPH; and CDPH can take up to seven years to investigate a complaint.

The annual plan is the responsibility of the security department. AB 1083 includes staffing as an issue to be addressed. However, that provision is meaningless because security has no authority over nursing staffing levels.

Penal Codes

In California, the legal penalties are higher for assaults against nurses than against members of the general population (Legislative Counsel of California, 2015) but only reaches the threshold as a felony assault if a firearm or deadly weapon is involved. Assault and battery against another person can result in 6 months in jail or a $1,000 fine,
or both; if the assault and battery is against a healthcare provider, the penalty increases to
12 months in jail or a $2,000 fine, or both. It is important to know that healthcare
personnel protected in this penal code references emergency personal only and not nurses
providing care elsewhere in the hospital. Another limitation is the perpetrator knows that
the victim is an emergency room nurse.

The State of California is behind other states in increasing criminal charges
against perpetrators of violence against nurses. The current law reduces most patient-on-
staff violence as a misdemeanor. When the patient has committed a misdemeanor, they
are “cited” and left in the hospital unit. This means they receive a court date for their case
to be heard. When the assault is deemed a felony, the police take the patient into custody
and admit the patient to a jail unit in a hospital until they go to court. In other states, a
physical assault against a nurse is a felony, even if no weapon is involved, and police take
the patient into custody, making it much safer the nurse to continue to work.

In summary, regulations do exist and more are being developed. Current
mandates do not have sufficient specificity to ensure a quality WPV prevention program.
In the limitations section, the researcher noted the belief that administrators are doing
their best, given the intensity of their work; however, other researchers suggest the only
way to improve employee safety is to increase real data collection and increase the
“teeth” in the regulations (APNA, n.d.).

Underreporting

Incidents, including WPV, occur in the context of complex hospital organizations
that provide services to people with medical emergencies, medical diseases requiring
treatment, and biological processes benefitting from medical assistance (such as delivery
of a healthy infant). Well over half the employees in the hospital are nursing staff. They provide direct care 24 hours a day and coordinate the care of patients. They make mistakes, they find mistakes made by non-nurses, and they also catch mistakes before they affect the patient. Nurses complete most incident reports (see Figure 4).

Figure 4. Workplace-violence cycle: Understanding underreporting.

Estimates for Underreporting

The APNA (2014) published a 69-page position paper on WPV experienced by psychiatric RNs. APNA conducted a large review of research, most of it from the United States. APNA reviewed five nursing issues:

1. High rates of nonfatal assaults.
2. Underreporting.
3. Physical and emotional consequences.
4. Institutional costs for recruitment and retention.
APNA identified safety the main concern of psychiatric RNs. However, nurses reported only one in five WPV incidents (Mayhew, 2000). A follow-up study by an APNA working group in 2012 confirmed that the majority of nurses still do not report WPV incidents. In another study, the prevalence rate for experiencing some form of violence for all acute nurses in acute hospitals was 76% over a 1-year period; however 45.1% of the nurses never reported PV over the lifetime of their careers (Speroni et al., 2014).

**Barriers to Reporting**

Mistakes in clinical care are one type of incident that can occur. Frequent mistakes include medication errors including the patient receiving the wrong medication, the wrong dose, the wrong time, or not receiving a medication that was prescribed for them (Nuckols, Bell, Liu, Paddock, & Hilborne, 2007). Other clinical care mistakes include wrong surgery, surgery on the wrong limb, retained gauze or instruments after surgery, mismanagement of blood-sugar levels, misdiagnosis with failure to provide timely treatment, failure to rescue a patient when they become more ill, hospital-acquired infections, patients leaving the hospital against medical advice or disappearing, patients committing or attempting suicide, and hospital-acquired bed sores (Levinson, 2012). Other clinical incidents may include human error or are simply bad outcomes, due to the risks that are somewhat expected in medically ill patients. Examples include a patient falling or a patient dying from a natural and unpreventable cause. Additional types of incidents include patient complaints, security issues, harm to staff (back injury, WPV) and regulatory noncompliance (Levinson, 2012). Regulatory noncompliance can result in fines or loss of accreditation.
RNs are the ones who discover and report most incidents. Hospitals expect them to complete reports during their shift when they are already very busy with clinical work because hospitals rarely provide protected dedicated time. The RN has a choice: stay after the shift to complete the report, which results in scrutinized overtime, or “clock out” first and complete the report (Nuckols et al., 2007). The latter is against labor laws and can result in legal cases for the hospital. The unit nurse manager generally receives reports of incidents in the unit for investigation.

After the investigation, the manager submits the report to other departments for further investigation if indicated, or forwards the report to risk management. Incidents being tracked will be summarized in a dashboard by the manager or the quality improvement department. Dashboards are the foundation for process improvement in the hospital. Many goals are set based on dashboards, and regulatory bodies share the data from dashboards with corresponding “action plans.” Some data are publically posted in “report cards” about different hospital organizations. These public report cards are misleading, due to underreporting (Nuckols et al., 2007).

Staff sometimes document WPV incidents in other processes but do not make it to dashboards because staff do not complete additional incident reports. Other processes include security-department reports if the nurse called the security staff for help, and human resources if a workman’s compensation claim was involved. My experience working in acute hospitals includes the observation that hospitals do not have a central database for WPV incidents that includes security reports, incident reports, and workers’-compensation claims. I have anecdotal information gleaned from other Californian nurse managers, particularly those who work in psychiatry and emergency departments, that
nurses underreport WPV incidents more often than other incidents. Part of this research project entailed collecting data to support or refute this anecdotal information.

Previous studies on barriers include qualitative approaches with thematic analysis, surveys using identified themes, clinical errors such as medication errors, and WPV. This researcher found no studies that included both clinical errors and WPV. Information on barriers to clinical errors is important as they share themes with underreporting WPV. Table 1 summarizes barriers identified in 25 recent studies. The unshaded barrier types apply to clinical errors and WPV incidents; the grey shaded areas are barrier types that only apply to WPV incidents.

Many barrier types link to leadership behaviors. Many theories describe effective and ineffective leadership behaviors. A consensus among leadership theorists, based on 25 years of studies, was that personality traits, referred to as the “big five,” link to effective leadership (Northouse, 2010). The traits, in order of impact, are extraversion, conscientiousness, openness, low neuroticism, and agreeableness. The definition adjectives listed in Northouse’s text follow the table.

1. Extraversion—sociable, assertive, and positive energy
2. Conscientiousness—thorough, organized, controlled, dependable, and decisive
3. Openness—informed, creative, insightful, and curious
4. Neuroticism—depressed, anxious, insecure, vulnerable and hostile
5. Agreeableness—accepting, conforming, trusting, and nurturing
Table 1

Barriers to Reporting Incidents Including Acute Hospitals And Psychiatric Units

<table>
<thead>
<tr>
<th>Barriers type</th>
<th>Article number</th>
<th>n</th>
</tr>
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<tbody>
<tr>
<td>Lack of feedback and action: no acknowledgement that incident occurred, no feedback to staff, no changes, no personal benefit to completing report</td>
<td>1, 2, 3, 24, 4, 6, 7, 9, 10, 11, 13, 15, 16, 20, 21, 22, 25</td>
<td>17</td>
</tr>
<tr>
<td>Lack of clarity: lack of definitions of violence, lack of definition on what constitutes an incident, staff not aware of policies related to incident</td>
<td>1, 2, 6, 7, 9, 10, 11, 13, 14, 21, 22, 24, 25</td>
<td>13</td>
</tr>
<tr>
<td>Shame and blame: Staff blamed for causing violence, blamed for error when other factors contributed to error, want to avoid hostility from peers who made error, may be seen as negligent or incompetent, negative experiences after previous incident report, sign of weakness if need support after being assaulted</td>
<td>1, 3, 4, 6, 7, 9, 11, 13, 15, 19, 21, 22, 25</td>
<td>13</td>
</tr>
<tr>
<td>Burden of reporting: process too long, too complicated, too confusing, too many tick boxes that are not related to the incident, workload too heavy to allow time to complete report, new awkward computerized incident reporting system (particularly difficult for older nurses), investigation of all factors would take too long</td>
<td>1, 3, 6, 7, 8, 9, 13, 16, 21, 22, 24, 25</td>
<td>12</td>
</tr>
<tr>
<td>Fear disciplinary measures: including job loss, deportation after job loss, being reported to licensing board</td>
<td>1, 9, 13, 15, 16, 22</td>
<td>6</td>
</tr>
<tr>
<td>Verbal reports: instead of formal written incident reports (information stays in the department only)</td>
<td>1, 3, 7, 11, 13</td>
<td>5</td>
</tr>
<tr>
<td>Fear lawsuits</td>
<td>3, 6, 9, 10, 15</td>
<td>5</td>
</tr>
<tr>
<td>No or inadequate training: on incident reports, no training when change made from hard copy incident reporting to computerized incident reporting</td>
<td>6, 7, 11, 13, 24</td>
<td>5</td>
</tr>
<tr>
<td>No, little, or no lasting harm: procedural/policy or regulation non-compliance that did not directly harm the patient, error caught in time, error not caught in time but no harm done, error not caught in time but harm minimal or treated quickly leaving no lasting harm, “retroactive” reporting only if there was sustained harm</td>
<td>1, 3, 14, 22, 25</td>
<td>5</td>
</tr>
<tr>
<td>Self-blame: not wanting to dwell on error in order to avoid negative feelings towards self, inexperienced nurses increased in self-blame</td>
<td>1, 4, 11, 20</td>
<td>4</td>
</tr>
<tr>
<td>Customer is always right: staff do not complain about patient’s because they are expected to give patients leeway in abusive or violent behavior, management does not want patient to give the hospital a low patient satisfaction rate, no zero tolerance policy exists, staff did not want manager to interview patient and patient file a counter grievance against the staff</td>
<td>2, 4, 8, 16</td>
<td>4</td>
</tr>
<tr>
<td>Excusing the staff error: “it happens all the time”, peer may have meant to complete report but forgot, it has never happened before but if it occurs again it will be reported, could not be helped considering the circumstances</td>
<td>7, 14, 22</td>
<td>3</td>
</tr>
</tbody>
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Table continues
<table>
<thead>
<tr>
<th>Barriers type</th>
<th>Article number</th>
<th>n</th>
</tr>
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<tbody>
<tr>
<td><strong>Permissive physician culture:</strong> physician’s draw patients to the hospital and “get away with” bullying and verbal abuse of other staff, nurses are more likely to report errors by nurses than errors made by physician’s, physician’s do not self-report or even know that they made an error</td>
<td>2, 17</td>
<td>2</td>
</tr>
<tr>
<td><strong>Financial penalties:</strong> not related to job loss</td>
<td>6, 15</td>
<td>2</td>
</tr>
<tr>
<td><strong>Support for team members:</strong> as long as team member was aware of the problem there was no reason to report it, did not want team member to “get into trouble”</td>
<td>7, 22</td>
<td>2</td>
</tr>
<tr>
<td><strong>Incident defined as an expected risk or side effect</strong></td>
<td>14, 22</td>
<td>2</td>
</tr>
<tr>
<td><strong>Culture of no reporting:</strong> staff discouraged to report by peers or management</td>
<td>7, 25</td>
<td>2</td>
</tr>
<tr>
<td><strong>Lack of staff professionalism and willingness to be accountable</strong></td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td><strong>Documentation in the patient’s chart:</strong> instead of formal written incident reports</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td><strong>Lack access:</strong> not enough computers to complete computerized reports, no privacy while completing report, cannot find forms</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td><strong>Fear of leak to media press</strong></td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td><strong>Inurement to violence:</strong> violence is expected as part of the job, chronic exposure, believe it is too costly to prevent workplace violence, no “real” harm to staff, violence in the emergency room is less likely to be reported than violence in other areas of the hospital</td>
<td>1, 4, 7, 11, 18, 19, 21, 23, 3</td>
<td>9</td>
</tr>
<tr>
<td><strong>Excusing the patient’s violent behavior:</strong> attributing patients violent behavior due to mental illness or confusion, if behavior deemed unintentional</td>
<td>1, 8, 20</td>
<td>3</td>
</tr>
<tr>
<td><strong>No serious physical injury:</strong> staff not considering verbal abuse, bullying, verbal threats, sexual harassment, abuse of power, grabs and slaps resulting in momentary pain, mild/mod bruising, sprain or light scratch as violence</td>
<td>8, 20, 21</td>
<td>3</td>
</tr>
<tr>
<td><strong>No support for the victim of assault:</strong></td>
<td>19</td>
<td>1</td>
</tr>
</tbody>
</table>

Reviewing one trait at a time, starting with extraversion, a theme in what nurses’ report as barriers links to adjectives in the leadership traits. One theme mentioned in virtually all studies (a study in Ireland being an exception) lists fear as a barrier to reporting incidents. The fear can be worrying about bullying from a superior (Blando, Ridenour, Hartley, & Casteel, 2015), unsupportive responses from administrators including receiving disciplinary actions (Chiang, Lin, Hsu, & Ma, 2010), and job loss (Hashemi, Nasrabadi, & Asghari, 2012). Fear of job loss was more profound if nurses were on a working visa and losing the job would result in deportation (Lederman, Dreyfuss, Matchan, Knott, & Milton, 2013).

In one study, 67% of nurses listed “administrative sanctions” as a barrier to reporting (Malik, Alam, Mir, Malik, & Abbas, 2010). Fear can flourish if leaders lack “positive energy.” Certainly these punitive measures are not very sociable and violated principles of assertive behavior. Assertive behavior principles include “speaking up” without violating the rights of others; many in the studies felt blamed and shamed for their mistakes or wrongly accused of something for which they were not responsible, which is more aggressive than assertive (Fornell & Westbrook, 1979).

Nurses reported lack of action after reporting an incident and lack of management accountability (Blando et al., 2015, p. 1) as barriers. Most studies found lack of feedback, which included lack of public acknowledgement that the incident occurred and lack of action to prevent future occurrences (Chiang et al., 2010; Fitzgerald, Cawley, & Rowan, 2011; Hashemi et al., 2012; Hogarth, Beattie, & Morphet, 2015; Lederman et al., 2013; Malik et al., 2010; Moumtzoglou, 2010; Prang & Jelson-Jorgensen, 2014). In the study completed by Malik et al. (2010), lack of postincident feedback was the most prevalent
barrier listed by 88.5% of doctors and 88.4% of nurses. The leadership trait of conscientiousness can be lacking in the eyes of study participants in that leaders cannot be depended on to share information, and they are not thorough in trying to address and prevent incidents. One nurse described repeatedly reporting the same types of errors but never heard responses about the following:

1. The prevalence of the problem.
2. If there were any policies and procedures that could help her or others to prevent reoccurrence.
3. If any changes were made to policies or procedures.
4. If any staff training or problem solving to prevent recurrences was available.

The nurse felt helpless and hopeless because leaders were not “conscientious.”

Nurses were unsure how to define an incident or did not know how to report it, pointing to a lack of hospital organization (Lederman et al., 2013; Prang & Jelson-Jorgensen, 2014; Waters, Hall, Brown, Espezel, & Palmer, 2012). These examples may point to lack of the leadership characteristic of openness. If leaders did not provide feedback, they were also lacking in curiosity about the factors contributing to the incidents—good managers may investigate reports further by talking with staff involved in the incident—and they did not display any insight into needed process changes.

Low neuroticism is a helpful leadership trait, and includes low hostility. The nurses in the studies frequently listed the culture of shame and blame as creating a hostile environment that discouraged them from reporting. Excerpts from one study (Hashemi et al., 2012) included, “We are not treated right, we are humiliated, they establish feelings of incompetence in us” and “When we report our errors we face harsh and unfair
behaviors. … Should an error be reported in such a milieu?” Many hospitals are trying to change the shame and blame culture to a learning culture or blame-free culture by analyzing the systemic issues that promote individual errors and by having anonymous reporting; however, this negative shame and blame culture is still the norm in most hospitals (Porter-O’Grady & Malloch, 2007).

Leaders also create barriers with low levels of agreeableness (accepting, conforming, trusting, and nurturing). When leaders blame and shame, they are not accepting that to “err is human.” In my experience, nurses feel badly about the mistakes they have made; it is unhelpful for their supervisor is chastise them.

Hospitals are viewed as toxic environments in which to work (Porter-O’Grady & Malloch, 2007). Ironically, people usually view going to a hospital as going to a helpful and healing place; however, staff have a different experience. Porter-O’Grady and Malloch (2007) list 10 sources of toxicity in hospital organizations:

1. Vertical authority structure.
2. Inequitable reward and recognition practices.
3. Abuse of power.
4. Lack of respect for the work force.
5. Failure to manage unmotivated employees.
6. Intolerance of antisocial behavior.
7. Toxic mentoring.
8. Inconsistency and dishonesty.
9. Imbalance between work and personal life.
10. Advocacy gone awry.
Several of these concepts can be linked to barriers to reporting incidents. The concept of a vertical authority structure is characterized by the following:

1. Hierarchy that is rigid and authoritarian, as evident in top-down communication.
2. Top-down communication travelling through multiple layers of middle management.
3. Leaders demonstrating excessive controlling behavior and expecting obedience.
4. Leaders not trusting the front-line staff.
5. Fearing change and clinging to ritualistic behavior.
6. Discouraging emotional expression and outbursts.
7. Separating people into departments (instead of functional units), thereby reinforcing different levels of power for people at the top.

These organizational characteristics lead to undesirable outcomes including feelings of fear, anger, suspiciousness, and lack of trust, resulting in decreased dialogue and creativity from the front-line staff. When staff work in this toxic environment, they may not make suggestions on how to prevent future problems, may lack energy when asked to contribute to problem solving, or may not document errors when they occur. The unit structure may encourage midlevel managers to secure resources for their units and discourages them from developing and sharing resources to benefit all patients. The unit structure reinforces an acrimonious stance that prevents those using a systems approach from understanding WPV.
The abuse of power results in a high level of turnover in midlevel leadership (Porter-O’Grady & Malloch, 2007). Midlevel leaders are sandwiched between front-line staff and upper leadership with an imbalance, trying to take on a high level of responsibility and accountability with a low level of authority. The high level of turnover leads to filling management positions with nurses with experience in the specialty but who generally lack management experience or development. They have little support and can abuse their new found power, such as by mandating overtime to survive the high risk fast-paced setting. Adversarial relationships develop between these leaders and front-line staff and reinforces the likelihood of underreporting. Staff often find reasons to leave the position for another position; leaders accepted these reasons although the real reasons include that they are “quitting their boss”; the result is a high level of turnover in the front-line as well as middle management. With this turnover, mistakes are more likely to occur.

Abuse of power goes hand-in-hand with lack of respect for front-line staff. Leaders may view staff as expendable and these leaders do not attend to staff’s individual concerns. If managers experience a high level of turnover, they do not invest in the current staff because they do not want to feel dependent and vulnerable. However, their apparent disinterest in staff, and sometimes rudeness toward staff, encourages an attitude of reciprocity and thinking such as if the leader is uninterested in the staff, then the staff should be uninterested in the leader and will hesitate to inform them of incidents in the unit.

Some unreported incidents are antisocial behaviors experienced in vertical and horizontal abuse from peers, bosses, and physicians. A culture form and has stability;
people leave the setting and new people enter while the same culture continues (Geertz, 1977). The unit leader fails to manage the antisocial behavior, staff see no change or attempt to change the current culture, and staff lose interest in completing incident reports. Seasoned nurses in this culture, particularly as a result of horizontal abuse, may hold back support from new nurses and place emotional hurdles before them to master on their own.

The lack of support for new employees in the unit is matched by “toxic mentoring” for new nursing leaders. The current wisdom is to not mentor new leaders; rather, the preference is to have them observe, read, listen, and work on their own to develop “new” approaches to age-old problems. This process reflects the belief that mentoring new leaders is to “spoon feed” them and pass on “antiquated wisdom” (Porter-O'Grady & Malloch, 2007). The reality of new leaders feeling lost, incompetent, and solution-less replaces the desired outcome of generating new solutions. The front-line staff feel the same emotions and apathy ensues: apathy is a barrier staff identify in decreasing the likelihood they will report an incident.

Factors in toxic organizations contribute to an environment where phronesis and praxis should exist to provide best care for the patient but do not exist or exist in limited ways. Phronesis is the ultimate state of reasoning and includes a genuine seeking to understand and accept universal principles. Praxis is making informed decisions in response to reasoning and moral responsibility (Bernstein, 1983).

Organizations consist of relationships and individual relationships mirror other relationships in the hospital (Koloroutis, 2004). Midlevel leader’s relationships with the front-line staff mirrors the relationship between the CEO and the vice president and,
ultimately, the relationship between front-line staff and the patients receiving care. Hospitals want to provide the best care but toxic organizational factors increase the likelihood that incidents can occur and that when they do occur, they are increasingly unlikely to be reported.

In summary, barriers to reporting exist in hospital cultures and their existence means that stakeholders do not know what really happens to patients and staff. Many types of barriers can link to toxic hospital cultures and lack of effective leadership. Because barrier types link to leadership, an opportunity exists to improve leadership through mentoring and training. In reviewing the 25 studies, the following common types of barriers emerged: lack of feedback and action, lack of clarity, a shame and blame culture, the burden of reporting, and inurement to violence. These barriers can change with better leadership.

Lack of Urgency

Cal/OHSA is increasing the sense of urgency in passing a new section, “Workplace Violence Prevention in Healthcare,” to Title 8 regulations. Many states are passing laws that increase penalties for assault and battery against nurses and many are making it a felony assault (Papa & Venella, 2013). In California the penalties are higher for assaults against nurses than the general population (Legislative Counsel of California, 2015) but, as discussed previously, the assaults only reach the threshold as a felony assault if the assault involves a firearm or deadly weapon. Too many violent patients are left in their unit in the hospital instead of being taken into police custody and admitted to a psychiatric jail or jail medical unit (see Figure 5).
Hospitals use state laws to develop hospital policies. Many hospitals have zero-tolerance policies against WPV but do not enforce them (APNA, 2014; Papa & Venella, 2013) and nurses generally feel their direct supervisors are supportive but higher administrators do nothing to address WPV (Wolf, Delao, & Perhats, 2014). Administrators discourage nurses from completing a police report (Privitera, 2011), so even if the patient’s behavior is criminal, it does not come under legal scrutiny. Whether or not administrators take action to reduce WPV has direct and indirect costs to patients, nurses, and administrators (Wolf et al., 2014). Below, I review the impact of WPV, the impact of postevent care, and change theory.

![Figure 5. Workplace-violence cycle: Understanding lack of urgency.](image)

*Workplace Violence Impact*

Qualitative studies obtain the perspectives of the nurses in the field and provide rich data on the impact of WPV. (Patton, 2002). Researchers conducted one such study in Philadelphia (Zuzelo, Curran, & Zeserman, 2012). The nurses in the study noted that staff in psychiatry formed strong bonds due to the stress of working in an emotionally volatile,
unpredictable environment and the need for interdependence. The nurses wanted to help the patients and when patients assaulted them, they felt betrayed. The nurses were not educated on how to respond to feeling betrayed and developed their own ways to navigate between helper and victim. Staff were angry with patients after an assault; some staff could go back to a caring stance, whereas others found they defaulted to “mechanical caring.” Mechanical caring increased when the assault was criminally motivated and not solely due to psychiatric issues. Staff felt they were targets unlike those in other departments because the perpetrator patient was ambulatory and knew that staff could not fight back. Patients were ambulatory in psychiatry, which increased the risk of assault. Staff believed some patients belonged in jail and others were viewed more positively, if they expressed remorse for their behaviors.

As in many studies, many staff in the present study did not seek help after violence. Staff lacked consensus on best approaches to manage violent patients and inconsistency (particularly in limit setting), which led to more violence. Although staff felt violated by assaults, they stated it was important to depersonalize incidents. Nurses found they felt rewarded when a violent patient was better at the end of hospitalization and thanked staff for the care the patient received.

Researchers used qualitative studies to further understanding of the consequences of WPV. Using a cross-sectional survey design and a convenience sample of nurses working in an Australian hospital, Demir and Rodwell (2012) collected data on many variables including aggression antecedents from “internal” sources (other hospital employees) and “external” sources (patients, patients’ family, and hospital visitors) including emotional abuse, bullying, threats of assault, physical assault, sexual
harassment, and other antecedents (job control, demand of the job, supervisor support, coworker support, outside support from family and friends, and personal attributes of negative affect). Most nurses denied they had experienced workplace aggression; however, when asked specific questions, they did endorse it. This outcome supports other research that indicated nurses become desensitized to aggression and do not count verbal violence or PV unless there is an injury. Consequences of WPV included changes in organizational commitment, job satisfaction, and psychological distress. The researchers found the following statistically significant relationships (when one varied the other also varied):

1. Bullying—low job commitment.
2. Internal emotional abuse—low job commitment.
3. Bullying—higher distress.
4. External verbal sexual harassment—higher distress.
5. Low supervisor support—more bullying.
6. Low coworker support—more internal emotional abuse.
7. Low job control—more internal job abuse.
8. Increased job demands—increased external threat of assault.

Other researchers also reported that bullying and emotional abuse from peers, bosses, and physicians linked to nurses leaving the position; bullying leads to distress, increased nursing mistakes, and increased job demands. These factors result in patients’ increasing frustration with services, which, in turn, increases the external (patient-related) threats of assault. The researchers concluded that bullying between employees or patients and employees is a gateway to increasing rates of PV (Demir & Rodwell, 2012).
A cross-sectional study using two surveys to collect data from ED nurses (Gates et al., 2011) focused on PTSD and productivity. Results included that 94% of nurses experienced at least one PTSD, and 17% exhibited symptom and experienced enough PTSD symptoms to meet criteria for a clinical diagnosis of PTSD. The highest scoring symptoms were intrusive symptoms: intrusive thoughts, nightmares, re-experiencing the event, and negative imagery. Thirty-seven percent had lowered productivity scores. Correlation between the two surveys had near significance \( (p = .07) \) between PTSD-like symptoms and lower productivity. The evidence did support that nurses experienced negative symptoms after an assault and that their work was also negatively affected (Gates et al., 2011).

In a comprehensive study of 94 MSDs in 21 hospitals in Australia, Roche et al. (2010) collected data from 2004 to 2006, yielding an 80.3% response rate for 2,487 nursing staff members. The researchers asked nurses about their WPV experiences in the last 5 shifts they worked. The purpose of the study was to focus on MSDs because most researchers focused on EDs and PDs to relate the frequency of the violence to environmental factors and patient outcomes. Findings varied widely on similar types of units linked more to unit circumstances than patient populations, meaning people have some control over decreasing the risks of WPV. Most surveys ask for nurses’ point of view on environmental factors related to WPV risks. The Roche et al. study provided inferential statistics based on observed data. Correlations reaching statistical significance follow:

1. Emotional abuse (EA) was lower when leadership and nurse autonomy were higher.
2. EA was higher when patient’s acuity changed.
3. When EA increased, nurses took longer to get to and complete tasks.
4. Threats of violence (TV) decreased as positive relationships increased between nurses and doctors.
5. Increased TV aligned with an increase in nursing tasks not finished at the end of the shift.
6. Physical violence (PV) and TV increased when the number of nurses present was less than the number of nurses required, based on the patient-acuity tool.
7. Perceived PV and TV decreased when staffing mix included more RNs compared to nursing support staff, such as aides.
8. Perceived PV decreased with more RN education.
9. PV and TV increased as patients waiting for care increased.
10. PV and TV decreased as planned admissions increased.
11. Increased EA increased nurses’ intent to leave their position.
12. Increased PV aligned with increased patient falls.
13. Increased PV aligned with increased medication errors.
14. Increased PV aligned with late administration of medications.

Hospital size, unit size, or location (rural versus urban) did not impact the variables. The validity of the present study improved because recall of events was limited to the last five shifts worked and some data were collected through observations in addition to self-reports.

A research article that included a survey and retrospective reviews of workplace-injury reports at a large community urban hospital employing 5,000 nurses yielded a
survey response rate of 15.2% \((N = 762; \text{ Speroni et al., 2014})\). Researchers ensured the sample size would provide a 95% confidence interval based on published WPV rates. The foci were types of violence and abuse, causes, causes for the most severe violence, reporting barriers, types of training programs, treatment, and indemnity charges. The annual costs of WPV for treating reported injuries was $94,156 in the Speroni et al. (2014) study. Left unknown was what threshold of the costs of WPV will inspire administrators to invest resources in prevention. Many other direct and indirect costs follow WPV.

A study conducted in Nigeria (Pam, 2013) attempted to qualify the costs of enforcing a zero-tolerance WPV policy. Pam (2013) found that WPV frequency and consequences are no different in developing countries than in the United States. “Violence prevention and protection is impacted by early identification of certain risk factors by 82%” (p. 225). The study included all types of WPV, including the four types commonly referenced as criminal (kidnapping), consumer on provider (patient punches nurse), colleague on colleague (doctor screams at nurse in the operating room), and domestic (spouse comes to the hospital to attack the spouse who is a hospital employee). Insurance often covers direct legal costs for a homicide or medical care of the injured and is measurable. Indirect costs are three or four times more expensive and must be covered by hospital revenues. The cost of WPV is 10 times the cost of strikes; yet the cost of strikes is discussed more often than the indirect costs of violence. Indirect costs include the following:

1. Employee wages for time off.
2. Damage to materials and equipment.
3. Overtime for other staff to cover for employees off work.

4. Recruitment and training of new staff to cover or replace employees off work due to WPV.

5. Decreased productivity when injured staff continue to work.

6. Uninsured medical costs.

7. Investigation time for managers and executives.

8. Cost of cleaning up after the event.

These indirect costs overlap with those listed in the APNA follow-up study (Cafaro et al., 2012); their list included staff turnover, absenteeism, decreased staff morale, increased problematic patient outcomes, compassion fatigue, substance abuse, PTSD, and other psychological issues. In summary, increased direct and indirect costs result from WPV. These costs include financial costs, poor patient outcomes, physical nurse injuries, and emotional nurse injuries.

Postevent Care

Some consequences can be attributed directly to the act of violence; however, postevent care from direct supervisors and administrators can increase or decrease the negative impact (Privitera, 2011). As discussed in the section on barriers to reporting, the fear of being blamed is a common barrier, known as “blaming the victim” (Vynckier, 2012) and increases the negative impact of a patient-on-staff assault (Lanza, 2011). Hospitals widely used “Critical Incident Stress Debriefing” a few decades ago, which included recalling the violent events in vivid details. However, that method increased PTSD symptoms (Bonner & Wellman, 2010) and fell out of favor. However post incident debriefings are now common to meet process-improvement requirements by the TJC
(2015). The process usually includes ensuring everyone is all right, identifying triggers that may have contributed to the patient being violent, patient warning signs, and updating the patient’s care plan. In general, staff found it helpful (Bonner & Wellman, 2010).

In the exploratory research for this paper, the researcher observed and interviewed several nurses in an acute locked psychiatric unit as well as managed acute psychiatric units for many years. One theme nurses identified in the observations was that nurses’ primary source of support was from peers. Nurses did not feel supported by administrators. Nurses were in shock immediately following the event and 24 hours later were flooded with feelings. The most important supportive behavior from direct supervisors was to be called at home to “check in” on how they were managing physically and emotionally. After that, if they were off work, they felt supported and more connected to the unit if the supervisor kept in touch with them by phone. Many supervisors did not keep in touch with injured nurses except to complete investigations, the nurses did not feel supported in those cases.

Another theme arising from the observational interviews was the vicarious trauma experienced by those who witnessed the event or heard about the event. One meeting after the event to meet requirements for TJC was not enough. Nurses felt supported when leaders held a series of meetings to discuss what happened and provided ample time to suggest changes to processes or simply talk about how they felt. Nurses also wanted to hear about their injured peer, and in most cases, the peer had given permission for this.
Change Theory

How people feel is central to change. Kotter (2012) included “emotional commitment” from leaders in eight steps of change, Toprak and Summack (2014) talked about “affective commitment to change” from the frontline as the most important element to support change. Goleman (1998) talked about “emotional intelligence” as an essential characteristic in effective leaders.

The steps for change included in Kotter’s discussions were the following:

1. Create a sense of urgency that requires giving convincing reasons to start people thinking about change and asking for support from external shareholders.
2. Form a powerful coalition that includes a diverse group of people and find a true leader in the organization who will make an emotional commitment to support the change.
3. Create a vision for change including linking the values of the organization to the reasons for change and ensure coalition members can articulate the vision in 5 minutes or less.
4. Communicate the vision frequently, address people’s anxieties, and lead by example.
5. Remove obstacles by recognizing people who are resisting change and helping them see the need for change, rewarding people who support the change, and removing barriers to change quickly to maintain momentum.
6. Create short-term wins by finding inexpensive and easy goals to start the process of change.
7. Build on change by not declaring victory too early and practice the principles of kaizen (continuous improvement).

8. Anchor the changes in corporate culture by telling stories of success often, including the change in orienting new employees and replacing key leaders with like-minded leaders as the original leaders move on.

Preventing WPV starts with support from external stakeholders such as unions, governments, and regulators to insist on more specific and binding rules to protect nurses. Hospitals are extremely busy with regulatory and legal changes, leaving few resources for internal proactivity, so external forces should be exploited to increase the priority of WPV prevention. Another key issue is to develop key leaders in the organization who will support changes; it is less effective when a request for change comes from a group limited to front-line nurses. Barriers to change include the time and money required. Key leaders need to support the investment and may do this if change agents propose some smaller pilot projects. Change takes a long time. A high percentage of change managers must commit to the change to make it effective.

Not only do managers need to commit to the change; front-line staff needs to commit as well (Toprak & Summack, 2014). It makes sense that nurses would support change to decrease the risk of WPV, but if leaders do not include nurses in shaping the change, nurses can develop negative attitudes. Some negative attitudes cannot be overcome and lead to sabotage. Front-line nurses need to express their opinions and be involved in change activities such as training. Highly counterproductive to achieving change is when an organization asks for staff input but does not use any of it; in contrast,
Consensus on decisions is highly productive (CHCM, 2003). Consensus is defined by the following characteristics:

1. Each person has an opportunity to voice his or her opinions, concerns, and questions.
2. If a person makes a contribution, they feel their idea has been heard and given consideration.
3. All members can support the final decision, even if it is not entirely what they would choose if they had sole authority to make the decision.

Leaders working with front-line staff directly benefit in the process of change if they have a high level of emotional intelligence (Goleman, 1998). The characteristics of high emotional intelligence include the following:

1. Self-awareness: recognizing one’s own mood and motivation and how it affects others. Self-awareness may manifest by listening to the motivation of others rather than pushing one’s own agenda.
2. Self-regulation: the ability to control disruptive moods and impulses. Followers should not pander to the moods of the leader during the change process.
3. Motivation: a passion for work that goes beyond money or status. The leader needs a strong desire to achieve, and to achieve goals, the leader needs to be consistent in change efforts, including maintaining optimism in the face of failure.
4. Empathy: understanding and working with people based on how they feel. To reduce WPV, the leader must put high value on nurses’ expressed fear and other strong emotions.

5. Social skill: managing relationships and finding common ground. The leader can build common ground by using the process of consensus.

Change is a long process that requires perseverance, emotional commitment, and internal and external driving factors. Change starts by creating a sense of urgency that something must be done to address a problem. The urgency to prevent WPV for nurses is intensifying, but it has not yet reached “critical mass.”

Summary

In summary, the conceptual model of the WPV cycle starts with the reality that patients attack nurses in hospitals. Some studies show that the rate for violence against nurses is the highest for customer violence towards service provider compared to all professions, including law enforcement. WPV occurs in the context of an organizational culture. Organizational culture is built over time and becomes a stable force that is difficult to change if there is no sense of urgency. Violence is not always reported and violence may not be reported more often than other types of incidents. Underreporting may relate to organizational factors that are part of its culture.

Nurses and patients experience consequences when WPV does occur. The nurse who has been attacked may make more clinical errors, take longer to complete tasks and resort to mechanical caring. The patients receiving care from this nurse may experience adverse events and not be satisfied with care. These consequences cause a ripple effect
leading to increased sick time and absenteeism as well as lower customer service ratings. Ultimately, the violence results in financial costs for hospital administrators.

The care the nurse receives after a violent event can potentiate the negative effects of WPV. Nurses report that they receive little support, and sometimes blame, when a patient has attacked them.

Changes in California are occurring, as seen in changing WPV regulations and laws, but personal safety is still the highest priority named by nurses. Changing the level of WPV risk in hospitals requires a higher sense of urgency than what is felt now.

This study examined reporting barriers at the organizational level. The current edge of knowledge includes qualitative data on themes to barrier reporting, and estimates of reporting prevalence. Prior to this study, researchers had not conducted quantitative studies on barriers; this study was the first to compare scores on organizational-culture factors with established survey tools in the groups that report incidents and the groups that do not. This was the first study to include several types of incidents including WPV and nonviolent events, and to observe if WPV reporting rates differed from rates of reporting other events. This study was designed to fill some of the gaps in the current WPV literature and delve into specific measurable organizational factors that can be mitigated or enhanced to increase WPV reporting. The study was exploratory and revealed data that will help organizations and nursing schools eradicate WPV reporting barriers. Such a result increases awareness of the prevalence and impact of violence experienced by nurses. Increased awareness will increase a sense of urgency to change the reporting of WPV and how nurses experience support in acute hospitals.
CHAPTER III: METHODOLOGY

Purpose

The purpose of this study was to investigate how indicators of suboptimal organizational culture in acute hospitals relate to RNs incident reporting patterns and to observe if a difference emerged in incident reporting patterns depending on the type of incident. Many factors build suboptimal organization culture; this study focused on burnout (Maslach & Jackson, 1981), organizational justice (Hansen et al., 2013), and safety culture (Sexton et al., 2006). The incidents chosen for this study are needle stick injuries, patient falls, medication errors, verbal abuse, mild physical abuse, and moderate-to-severe physical abuse. Perpetrators of violence against nurses were limited to patients and patient family members for this study.

Research Design

For this study, a nonexperimental study using a between-groups design (reporters and nonreporters; Gliner & Morgan, 2000) was employed. Data collection used an anonymous online method (Fink, 2013; Fowler, 2014; Orcher, 2007) to investigate relationships between the organizational-culture factors that indicate suboptimal organizational culture and incident reporting prevalence. Participants answered questions on their perceptions of organizational factors and if they reported different incidents the last time they experienced them. For each incident type a comparison between average mean scores on organizational-culture factors for reporters versus nonreporters was completed with a $t$-test analysis. In addition, the differences in how often participants reported the six types of incidents using descriptive data, analyzed using Cochran’s Q was displayed. The disadvantage to using Cochran’s Q was that it only applied to
participants who had experienced all six of the violent and nonviolent incidents; however, it is the best statistic for the type of data obtained (B. Baab, personal communication, May 5, 2015).

Organizational-culture factors included burnout, organizational justice, and safety culture using the three well-established surveys discussed below. Incidents included needle stick injuries, patient falls, medication errors, verbal abuse, mild physical abuse, and moderate-to-severe physical abuse. The perpetrators of abuse were limited to patients and patient family members for this study.

Setting

This study took place in California public acute-care hospitals and acute psychiatric hospitals. Acute-care hospitals provide care for people with severe and acute illness or injuries. They are different from long-term-care and rehabilitation hospitals in that they have an emergency department (ED) and provide surgery. Acute psychiatric hospitals may have a psychiatric ED or accept patients directly to a regular ED. Both types of facilities focus on acute care and crisis stabilization. These facilities discharge people to home or to a lower level of care when the person becomes “sub-acute.” Incidence of WPV involving patient-on-staff violence was higher in these settings compared to other levels of care such as physician offices or outpatient clinics (Privitera, 2011).

California was selected because the researcher had an interest in working with state agencies and hospitals to address WPV issues. Cal/OSHA will introduce a new mandate in July 2016 entitled “Workplace Violence Prevention in Healthcare.” Efforts to implement the plan may be aided by the results of this research. In addition, the California Board of Registered Nurses (RNs) provided demographic information on RNs
that allowed me to make demographic comparisons between board members and survey participants.

**Population**

The population was all RNs who observed an invitation to participate in the survey and who had at least six months of experience working in an acute hospital or acute psychiatric hospital in California and who had experienced verbal or physical abuse in the workplace from patients or their family members. Invitations were posted in printed nursing-trade magazines, online nursing-trade magazines, online professional-nursing groups, Facebook, LinkedIn, and Twitter social media. It is not known how many RNs saw the invitation and met the criteria for participation. The sample yielded 411 RNs.

The RNs in California were targeted because they experience more WPV compared to other disciplines such as physicians (Kowalenko et al., 2012). RNs are victims of violence due to the nature of their work with patients (APNA, 2014; Privitera, 2011); they ask patients to do things patients do not want to do and do not allow them to do things they do want to do. Nurses are physically close to the patient when providing care. The relationship between a nurse and a patient takes place in the context of increasing wait times in healthcare, which leads to patient frustration and increases the risk of patients being violent (APNA, 2014).

The RNs were invited to participate because they manage service units and front-line staff. RNs tasks include completing incident reports even when the incident involves other front-line staff. RNs, by virtue of training and professional license requirements,
have the literacy skills needed to understand and complete the survey, whereas other front-line staff may not.

Justification of the Survey Method

A Web-based survey was used to collect the data for several reasons. The Web-based survey allowed for data collection directly from nurses who experienced WPV, it was quick, and the results could be easily analyzed. The most ideal approach would have been direct observation; however, this would have required approval from the hospital institutional review board, which would be very difficult to obtain. Using a Web-based surveys had the highest likelihood of obtaining the most truthful answers compared to in-person interviews, telephone interviews, and electronic voice recognition telephone interviews (Kreuter et al., 2008). Nurses did not have to fear retaliation from their employers because the Web-based survey assured anonymity on this sensitive topic. Using a Web-based survey helped reach participants over a large geographic area and streamlined the process by electronically skipping questions when they were not applicable to the participant (Fink, 2013). Another advantage was that participants could complete the survey anywhere; if it had been limited to their work sites, they may not have had the time or energy to complete the survey.

The survey questions were a mix of closed-format questions that were easy to answer and analyze, and contained spaces for comments. WPV can elicit strong opinions and emotions thus participants’ frustration in answering closed questions may have been alleviated by encouraging comments (Fowler, 2014, p. 88). In addition, the researcher was able to find data in participants’ comments that could be included in future research.
Pilot Study

Several established survey items were included in the pilot study because they contained scales representing organizational factors identified as relevant in the literature on WPV, suboptimal organizational culture, and barriers to incident reporting (discussed later). The subscales and individual items selected from these surveys had the highest reliability and validity scores (discussed later). An additional item was added to the final survey, based on feedback from expert-panel members who suggested more items on organizational factors. This item was selected from the same established survey tools but with emphasis on common reported barriers found in qualitative studies (see Table I) rather than the highest validity and reliability. The added question was, “Have you been able to express your views and opinions during procedures to reduce workplace violence?”

Items from the established organizational justice survey included prompts (“outcome,” “procedure,” and “he/she”) to make the questions specific to the purpose of the study (Hansen et al., 2013). Items in the pilot survey that pertained to procedural justice assigned “scheduling” decisions as a specific procedure; this was changed in the final survey to refer to procedures to reduce WPV, to be more aligned with the purpose of the study. Wording of the remainder of questions and answers retained the wording of the original survey.

The expert panel (see Table II) identified that questions were sometimes confusing as to who was perpetrating the violence. Perpetrators can be peers, bosses, physicians, vendors, random criminals, domestic employee partners, patients, or patient
visitors. The perpetrators were specified as patients and patient families only, based on this feedback.

Survey Instrument Questions

The three original surveys included a total of 14 subscales and 78 items. I retained nine of the subscales and 26 items in this study. The full survey instrument is in Appendix A. Following are the items organized by original survey and subscales.

*Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981)*

*Emotional exhaustion.*

1. I feel emotionally drained from my work.
2. I feel used up at the end of the workday.
3. I feel frustrated by my job.

*Organizational Justice (Hansen et al., 2013)*

*Distributive justice.*

4. Does your paycheck reflect what you have contributed to the organization?
5. Is your last annual evaluation justified, given your performance?

*Procedural justice.*

6. Have you been able to express your views and opinions during procedures to reduce WPV?
7. Have these procedures been applied consistently?
8. Have these procedures been based on accurate information?
9. Have you been able to appeal the outcomes arrived at by the procedures?

*Interpersonal justice.*
10. Have physicians treated you in a polite manner?

11. Have physicians treated you with respect?

*Informational justice*

12. Have unit leaders explained the unit procedures thoroughly?

13. Were the unit leader’s explanations regarding the unit procedures reasonable?

14. Have unit leaders seemed to tailor their communications to individuals’ specific needs?

*Safety Attitude Questionnaire (SAQ; Sexton et al., 2006)*

*Teamwork*

15. Nurse input is well received in this clinical area.

16. Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).

17. It is easy for personnel here to ask questions when there is something that they do not understand.

*Safety climate*

18. Medical errors are handled appropriately in this clinical area.

19. I know the proper channels to direct questions regarding patient safety in this clinical area.

20. My suggestions about safety would be acted upon if I expressed them to management.

*Perceptions of management*

21. Hospital management supports my daily efforts.
22. Hospital management doesn’t knowingly compromise patient safety.

23. Problem personnel are dealt with constructively by our hospital management.

24. I get adequate, timely info about events that might affect my work from hospital management.

*Working conditions*

25. This hospital does a good job of training new personnel.

26. Trainees in my discipline are adequately supervised.

The data in two groups of RNs—reporters and nonreporters—for each different type of incident was compared in the final analysis.

The first question for each incident asked if the participant had experienced the incident. If they answered “Yes,” then they responded to whether they (or someone else) reported the incident. Below are the six incident items:

1. Have you ever experienced a needle stick injury? (Was an incident report completed?)

2. Have you ever experienced a patient falling to the floor with some force? (Was an incident report completed?)

3. Have you ever made a medication error that involved the patient? (Was an incident report completed?)

4. Have you ever experienced verbal abuse from a patient or patient family member in the workplace? (Was an incident report completed?)

5. Have you ever experienced mild physical abuse from a patient or patient family member in the workplace? (Was an incident report completed?)
6. Have you ever experienced moderate-to-severe physical abuse from a patient or patient family member in the workplace? (Was an incident report completed?)

Included in incidents types were incidents unrelated to WPV—needle stick injuries, patient falls, and medication errors—because patient falls and medication errors are the most common types of hospital incidents (Nuckols et al., 2007; Stalpers, de Brouwer, Kaljouw, & Schuurmans, 2015) and needle stick injuries are another type of staff injury that contrasts with WPV injury. Three levels of WPV were selected (verbal abuse, mild physical abuse, moderate-to-severe physical abuse) to represent the range of violence that can occur and because RNs may report incidents at different rates.

**Instrumentation**

The original survey instruments measuring suboptimal organizational culture in this study were the MBI (Maslach & Jackson, 1981), the Organizational Justice Survey (OJS; Colquitt, 2001; Hansen et al., 2013) and the SAQ (Sexton et al., 2006).

**Maslach Burnout Inventory (MBI)**

The MBI (Maslach & Jackson, 1981), first developed in 1981, formed the basis for specific service-industries surveys including the MBI-Human Services Survey. It had three subscales: Emotional Exhaustion (EE), Personal Accomplishment (PA), and Depersonalization (DP). Appendix B presents permission from Mind Garden to use the MBI survey items.

**MBI Reliability**

The Cronbach’s coefficient alphas follow: complete survey .83, EE .89, PA .74 and DP .77 (Maslach & Jackson, 1981). Test–retest correlations were EE .82, PA .80, and
DP .60 (Maslach & Jackson, 1981). Values for these tests that are above the .7 considered adequate (Tavakol & Dennick, 2011) and correlations higher than .85 meet high publishing standards (Orcher, 2007) and support that questions relate to each other, providing internal consistency and consistency over time.

The EE subscale was selected for inclusion based on having the highest reliability scores. Examples of EE items selected included, “I feel emotionally drained from my work,” “I feel used up at the end of the workday,” and “I feel burned out from my work.” The answer options were Likert-type frequency scales: never, a few times a month, monthly, every week, a few times a week, and every day. These three items were in the top four for loading on the underlying EE factors: .70, .70 and .64, respectively (Maslach & Jackson, 1981). Researchers must determine the cut off for an acceptable factor-loading level, but most will not include factors below .3 and many will not include factors below .4 (Brown, 2009); the items selected were well over .4. The EE subscale was also selected because the literature identified emotional exhaustion as the quintessential construct to measure burnout (Glasberg, Eriksson, & Norberg, 2007). This subscale was included because nurses who feel burned out could be both more likely to make mistakes and feel they do not have enough time or energy to report them.

**MBI Validity**

Several processes were used to establish MBI validity including external validation of personal experience, dimensions of job experience, and personal outcomes. Personal experience used mental health workers observing peers, and wives observing police men. Dimensions of the job experience included comparing MBI responses to other job experiences that could theoretically link to the MBI. Personal outcomes
compared results using other established surveys to results on the MBI. Discriminant validity compared constructs of job satisfaction and social desirability with scores on the MBI (Maslach & Jackson, 1981). Discriminant validity shows that one construct has little or no correlation with another construct that is considered unrelated to it (Salkind, 2011).

Organizational Justice Survey (OJS)

Colquitt and others developed the original list of organizational-justice questions in 2001. The survey included 20 items and four subscales. A subsequent study used a systematic process to reduce the 20 items to 12, retaining reliability and validity (Hansen et al., 2013). The OJS has four subscales: Distributive Justice (DJ), Procedural Justice (PJ), Interpersonal Justice (Intj), and Informational Justice (Infj). Appendix B presents permission to use the Organizational Justice Survey from Zinta S. Byrne.

OJS Reliability

The average alpha coefficient for the four subscales ranged from .85 to .90. Response options for the items were Likert-type and included to a very small extent, to a small extent, to a large extent, and to a very large extent.

OJS Validity

External validity for the items retained in the abridged measure of organizational justice compared job satisfaction, organizational commitment, and supervisor commitment in existing surveys to scores on the OJS. This type of external validity, construct validity, is an indirect measure comparing the variable being measured with another that is thought to be connected but is not measuring the exact same thing (Orcher, 2007). A panel of psychology experts tested judgment validity, with no knowledge of the
survey subscales; the experts sorted the survey items to match the descriptions of each subscale. The percentage of correct sorting ranged from 30 to 100%. Items with high correct sorting in this study’s survey instrument with the exception of two items with only 60% (Hansen et al., 2013) were included. The researcher retained these two items in this study due to particular interest: “Have you been able to appeal the outcomes arrived at by the procedures? Have unit leaders seemed to tailor their communications to individuals’ specific needs?”

An item example from the OJS is, “Is your last evaluation justified, given your performance?” The OJS items were included because nurses who feel they are not being treated fairly might not complete an incident report to avoid criticism.

*Safety Attitudes Questionnaire (SAQ)*

The SAQ contains 36 items and was tested using six surveys in three countries with a response rate of 67% yielding n = 10,843 respondents (Sexton et al., 2006). The SAQ has six subscales: Teamwork, Safety Climate, Job Satisfaction, Stress Recognition, Perceptions of Management, and Working Conditions. Appendix B presents permission to use the Safety Attitudes Questionnaire from the University of Texas at Houston–Memorial Hermann Center for Healthcare Quality and Safety Team.

*SAQ Reliability*

The reliability test, Raykov’s p coefficient, reported p = .9. Items with loading factors of .70 or greater were included in this study; they ranged from .71 to .91. The subscale Job Satisfaction was not in this study to limit the research survey instrument to 26 items. The subscale Stress Recognition was not included because it could overlap with the construct of burnout in the MBI.
SAQ Validity

The SAQ started with a refinement of the Flight Management Attitudes Questionnaire after the authors understood that most flight errors are due to breakdown in factors such as teamwork and could be conceptually linked to factors that lead to errors in hospitals. Validation started with discussions with healthcare providers and subject-matter experts. Researchers piloted the original Flight Management Attitudes Questionnaire items and an additional 100 items from two expert models (Vincent’s framework for analyzing risk and safety, and Donabedian’s conceptual model for assessing quality) for factor analysis in several settings. Six factors repeatedly emerged. The robustness for a six-factors model was higher than two-, three-, four-, and five-factor models. Researchers conducted pilot studies in 203 sites between 2000 and 2003, with additional pilot studies in the UK and New Zealand. Each time, researchers revised the survey to improve the robustness of the six factors.

An item example from the SAQ is “Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).” If nurses feel they lack credibility due to their role in the hospital, they may be less likely to disagree with others. At times, healthcare staff make decisions that may increase medical risks for the patient; a nurse who disagrees with the decision may not voice concern or complete an incident report to avoid a confrontation and possible humiliation (Chiang et al., 2010).

Survey-Instrument Reliability

Reliability is the consistency of an instrument to measure the same thing at different times or in different situations (Orcher, 2007). Instruments need to be reliable to
be valid (Orcher, 2007). Reliability in this study relied on the reliability reported for the items selected from the established surveys discussed above. As long as the items or answers to the items were not changed, using the established reliability from the original surveys is an acceptable standard (B. Baab, personal communication, May 5, 2015).

Survey-Instrument Validity

The items in this survey combined items from other surveys with adequate reliability and validity. Content validity for the instrument was established by asking experts, including other seasoned RNs who work in areas where WPV is a risk, to complete the survey and answer questions about the experience of completing the survey. The experts’ roles and experiences appear in Table 2, along with a summary of the responses to the validation questions. Based on expert feedback, additional questions were added, as described in Survey Instrument Questions. Perpetrator type was clarified as limited to patients and patient family members.

The survey-instrument validity was enhanced by keeping time to complete the survey under 20 minutes. Researchers identified that surveys that take longer to complete are less valid, as participants start to speed up and pay less attention to items. The quality of the answers decrease, dubbed survey fatigue (la Bruno & Rathod, 2005).
### Table 2

**Expert Ranges of Experience**

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were the instructions and wording clear and understandable?</td>
<td>6 of 6 answered yes</td>
</tr>
<tr>
<td>In your opinion were the questions about organizational factors (burnout, organizational justice and culture of safety) appropriate for a hospital setting?</td>
<td>6 of 6 answered yes</td>
</tr>
<tr>
<td>In your opinion were the definitions of verbal and physical abuse appropriate for a hospital setting?</td>
<td>5 of 6 answered yes</td>
</tr>
<tr>
<td>1 person stated that she was not sure what category of perpetrator was being included: Patient? Peer? Boss? Physician?</td>
<td></td>
</tr>
<tr>
<td>Were there enough questions to adequately cover the topics of organizational culture and workplace violence reporting?</td>
<td>4 of 6 answered yes</td>
</tr>
<tr>
<td>2 stated that more items on organizational factors could be added</td>
<td></td>
</tr>
<tr>
<td>Were there any irrelevant items?</td>
<td>6 of 6 answered no</td>
</tr>
<tr>
<td>Were there adequate answer choices and comment sections?</td>
<td>6 of 6 answered yes</td>
</tr>
<tr>
<td>Was the length of the survey too short, just right, or too long?</td>
<td>6 of 6 answered “just right”</td>
</tr>
<tr>
<td>Was survey access convenient?</td>
<td>6 of 6 answered yes</td>
</tr>
</tbody>
</table>

*Note.* The 6 experts had the following ranges of experience: years in nursing in general 35–51 years; nursing in acute hospitals 35–45 years; working in mental health 35–51 years; being a manager/leader of a unit, service, clinic or hospital 25–33 years; being an educator 8–25 years; being a researcher 0 years.

#### Researcher’s Background

The researcher is an RN with more than 35 years of experience. The researcher has worked in all levels of care from psychiatric outpatient services to psychiatric inpatient services as well as other nursing specialties. In the first half of the researcher’s nursing career, the researcher was a front-line nurse, predominately in inpatient hospital units and in psychiatric services. The second half of the researcher’s career, the researcher was in middle and executive management of acute psychiatric units, including a jail-psychiatric unit, and served as the Chief Nursing Officer for a start-up acute psychiatric hospital.
When the researcher moved into management, the researcher became active in WPV prevention and care, particularly preventing patient-on-staff violence. The researcher served on several WPV prevention committees, became a certified trainer in many WPV prevention models, obtained a $60,000 grant to develop and implement a WPV prevention plan at a large acute urban hospital, presented at WPV prevention conferences, and wrote an article entitled, “Type II Workplace Violence in an Urban Acute Hospital: How do we Know if We’re Creating a Safer Environment for Patients and Staff?” published in the *Journal of Safe Management of Disruptive and Assaultive Behavior* (Jacobsen, 2012).

The researcher interest in violence prevention and care is not limited to WPV, as the researcher volunteered at a rape crisis center, taught in the “Assaulted Women’s and Children’s Counseling Advocate Program,” and worked as a sexual-assault examiner for many years. The researcher completed nursing school, a bachelor’s degree of science in zoology, a master’s of education in counseling psychology, and is currently completing a doctorate in education in organization and leadership. The researcher’s mission in life and work is to reduce suffering, solve problems, and help build healthy systems. The researcher has a keen interest in shining a spotlight on WPV issues to understand them more fully and pursue potential solutions.

**Sampling and Data Collection**

Data was collected using an anonymous online survey using a convenience sample. Participants were RNs who worked in an acute hospital or acute psychiatric hospital in California, and had experienced some form of verbal or physical abuse at work from patients or patient families. The survey was managed in Qualtrics and the link
was posted on the Web, on Facebook, in trade-related publications, in trade-related organizations, and sent it to a network of nurses by e-mail. Ideally, the sample frame would be all nurses in California who work in an acute hospital, but the study sampling frame was limited to nurses who saw the link to the survey and met criteria for inclusion in the study. The minimum number of participants was set at 100; of the 411 participants obtained, 148 surveys were deleted because they had a Qualtrics IP addresses outside of California, yielding a final $N = 263$. The sampling was purposeful in that participants were limited to RNs and their demographics were compared to demographic statistics provided by the California Board of Nurses.

The following steps were used to ensure the minimum number of participants:

1. **Coffee cards**: Online participants were encouraged to e-mail the researcher with their contact information in a separate process unassociated with survey submission, and they received a return e-mail including a $20 coffee card. The researcher assumed that most participants asking for a coffee card truly did complete the survey; however they were also requested to send a screen shot of the last page of the survey. The researcher also assumed that participants were RNs and met criteria for inclusion in the study. As the results grew, several indicators flagged some responses as invalid (i.e., IP address outside of California); these responses were deleted, thereby decreasing the number of participants.

2. **All participants were entered into a $500 cash prize draw**, once the survey ended.
3. Participants who referred another participant were added an additional time into the draw.

4. Advertising: The survey link was posted on the Web and on Facebook.

5. Researcher peers at the Managers of Acute Psychiatric Services (MAPS), Bay Area” to post the link in their hospitals received the link to the survey.

6. The Qualtrics survey was designed to fit on the screen of a mobile device, making it easier for participants to access the survey.

Ethical Issues

The Institutional Review Board for Protection of Human Subjects (IRBPHS) at the University of San Francisco reviewed the study for ethical issues. Review Board approval appears in Appendix C.

Potential Risks

Potential risks to participants included reframing a past event that was not considered violent to see it as violent. Reframing could have resulted in a participant experiencing strong and negative emotions. Another risk was re-traumatization from recalling VEs. I included resource phone numbers for participants, if they needed help.

Minimizing Risk

Risks were minimized to participants through the use of a consent form (Appendix D). The consent form included a caveat regarding the risks, the voluntary nature of the survey, and that participants could stop the process at any time. The consent form listed resources for the participant if they needed help or had questions. Participants were reassured of the confidential nature of the survey, no identifying information was asked about the participant or the hospital where they work. The survey was short but
included areas for comments to reduce participant frustration with fixed-answer choices (Fowler, 2014). Participants could complete the survey anywhere, including their home, which may have increased their comfort.

*Potential Benefits*

Participants may have found the survey process to be cathartic. They may have benefitted by having a witness to their experiences. They may have been inspired to take action to understand and prevent WPV. Participants and the public have access to the survey results at http://www.hospitalviolenceprevention.com.

*Data Analysis*

The demographic data from the nurse participants was compared to the demographic data available from the California Government Board of Registered Nurses. This site was selected because all RNs who work in California must register for a license with the Board, and most nurses who are registered work in direct care of patients. The most easily obtainable demographics were age, gender, and race. Figure 6, 7, and 8 show some differences between the pilot sample group and the California Board of Registered Nurses. Clearly, the pilot sample did not resemble the nurses who registered with the California Board of Registered Nurses. Survey participants’ demographics are reviewed in Chapter 4.
Figure 6. Percentage of registered nurses comparing gender between 2008 California Government Board of Registered Nurses and the 2015 pilot nurse survey.

Figure 7. Percentage of registered nurses comparing race between 2008 California Government Board of Registered Nurses and the 2015 pilot nurse survey.

Each participant had a score for each of the three organizational factors (burnout, organizational justice, and safety culture), and a positive or negative response to having experienced each of the six types of incidents (needle stick injuries, patient falls, medication errors, verbal abuse, mild physical abuse, and moderate-to-severe physical
abuse). Participants who did experience an incident stated if an incident report was or was not completed. An example of the individual results in Qualtrics appears in Table 3.

Figure 8. Distribution of registered nurse ages comparing 2008 California Government Board of Registered Nurses to the 2015 pilot nurse survey.

Table 3

Raw Data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Burnout</th>
<th>Org. just.</th>
<th>Safe. cult.</th>
<th>Needle</th>
<th>Fall</th>
<th>Med. error</th>
<th>Verbal abuse</th>
<th>Mild physical</th>
<th>Mod/Sev. physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.0</td>
<td>6</td>
<td>3</td>
<td>yy</td>
<td>yy</td>
<td>n</td>
<td>yn</td>
<td>yn</td>
<td>yy</td>
</tr>
<tr>
<td>2</td>
<td>3.2</td>
<td>3</td>
<td>5</td>
<td>yn</td>
<td>yy</td>
<td>n</td>
<td>yn</td>
<td>yn</td>
<td>yn</td>
</tr>
</tbody>
</table>

Note. Key: n = did not experience the incident; yn = yes, experienced the incident but did not report it; yy = yes, experienced the incident and yes, it was reported.

The first research question was, What organizational-culture factors of burnout, organizational justice, and safety culture aligned with differences in incident reporting patterns for needle stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse?

Table 4 shows an example of answers included a result charts for each of the six incident types, an accompanying t-test for analysis between the two groups (not reported,
reported), and their scores on each scale. The Statistical Package for the Social Sciences (SPSS) version 20 was used to calculate the independent $t$-tests.

Table 4

Scores

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not reported</td>
<td>5.5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Reported</td>
<td>3</td>
<td>4</td>
<td>4.7</td>
</tr>
</tbody>
</table>

*Note.* Maslach Burnout Inventory scores go up with increased participant burnout. Organizational justice scores go down with an absence of organizational justice. Safety Attitudes Questionnaire scores go down with an absence of teamwork, safety, good management, and good work culture.

A pilot study using the survey yielded the data in Table 5, but due to the small sample size ($N = 20$) and the sample size being unrepresentative, the data was not analyze further.
Table 5

Organizational Factor Scores From Registered Nurse Participants

<table>
<thead>
<tr>
<th>Scale/subscale</th>
<th>Number of participants</th>
<th>Organizational factor scores</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>MBI/EE</td>
<td>20</td>
<td>4.0</td>
<td>1.3</td>
</tr>
<tr>
<td>OJ</td>
<td>18</td>
<td>2.8</td>
<td>0.8</td>
</tr>
<tr>
<td>OJ/DJ</td>
<td>18</td>
<td>1.7</td>
<td>0.5</td>
</tr>
<tr>
<td>OJ/PJ</td>
<td>18</td>
<td>3.0</td>
<td>1.2</td>
</tr>
<tr>
<td>OJ/Intj</td>
<td>18</td>
<td>3.1</td>
<td>0.7</td>
</tr>
<tr>
<td>OJ/Infj</td>
<td>18</td>
<td>2.9</td>
<td>1.0</td>
</tr>
<tr>
<td>SAQ</td>
<td>18</td>
<td>2.8</td>
<td>0.6</td>
</tr>
<tr>
<td>SAQ/TW</td>
<td>18</td>
<td>2.9</td>
<td>0.8</td>
</tr>
<tr>
<td>SAQ/SC</td>
<td>18</td>
<td>3.0</td>
<td>0.6</td>
</tr>
<tr>
<td>SAQ/PM</td>
<td>18</td>
<td>2.6</td>
<td>0.6</td>
</tr>
<tr>
<td>SAQ/WC</td>
<td>18</td>
<td>2.6</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Note. MBI/EE = Maslach Burnout Inventory-Emotional Exhaustion; OJ = Organizational Justice; OJ/DJ = Organizational Justice-Distributive Justice; OJ/PJ = Organizational Justice-Procedural Justice; OJ/Intj = Organizational Justice-Interpersonal Justice; OJ/Infj = Organizational Justice-Informational Justice; SAQ/TW = Safety Attitudes Questionnaire-Teamwork; SAQ/SC = Safety Attitudes Questionnaire-Safety Climate; SAQ/PM = Perceptions of Management; SAQ/WC = Safety Attitudes Questionnaire-Working Conditions. Ranges for each factor are 1 to 4 except MBI/EE is 1 to 7. Note that MBI scores are opposite in value compared to OJ and SAQ scores; low MBI scores are desirable whereas high OJS and SAQ scores are desirable.

The second research question was: What differences accrued in how often nurses reported needle-stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse?

For each incident that nurses experienced, some reported the incident and some did not. Table 6 offers an example showing the percentages of not reporting and reporting. A Cochran’s Q test analyzed if any differences in reporting patterns. I used SPSS to calculate the Cochran’s Q.
Table 6

Percentages for Reporting and Not Reporting Incidents

<table>
<thead>
<tr>
<th>Incident status</th>
<th>Needle</th>
<th>Fall</th>
<th>Med</th>
<th>Verbal</th>
<th>Physical mild</th>
<th>Physical mod/sev</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Not reported</td>
<td>20</td>
<td>10</td>
<td>20</td>
<td>80</td>
<td>60</td>
<td>63</td>
</tr>
<tr>
<td>% Reported</td>
<td>80</td>
<td>90</td>
<td>80</td>
<td>20</td>
<td>40</td>
<td>37</td>
</tr>
</tbody>
</table>

Note. MBI/EE = Maslach Burnout Inventory-Emotional Exhaustion; OJ = Organizational Justice; OJ/DJ = Organizational Justice-Distributive Justice; OJ/PJ = Organizational Justice-Procedural Justice; OJ/Intj = Organizational Justice-Interpersonal Justice; OJ/Infj = Organizational Justice-Informational Justice; SAQ/TW = Safety Attitudes Questionnaire-Teamwork; SAQ/SC = Safety Attitudes Questionnaire-Safety Climate; SAQ/PM = Perceptions of Management; SAQ/WC = Safety Attitudes Questionnaire-Working Conditions. Out of interest, the number of incidents nurses ever experienced is in Table 7. No analysis was conducted, as nurses had a high variance of work longevity and training; this would have made the analysis invalid.

Table 7

Incident Frequency in Sample Group of Registered Nurses

<table>
<thead>
<tr>
<th>Needle</th>
<th>Fall</th>
<th>Med</th>
<th>Verbal</th>
<th>Physical mild</th>
<th>Physical mod/sev</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>63%</td>
<td>30%</td>
<td>80%</td>
<td>80%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Note. Needle = needle sticks; Fall = patient falls; Med = medication errors; Verbal = verbal abuse; Physical mild = mild physical abuse; Physical mod/sev = moderate-to-severe physical abuse.

Chapter 3 reviewed the design, setting, population, sampling methods, and instrumentation used for this research. It included the changes made to the survey, based on the results of the pilot study. The chapter included the researcher’s background and reviewed the IRBPHS process. Chapter 4 provides a demographic overview of the participants and the mean scores for the organizational-culture factors. Statistical analysis of the results using independent \( t \)-tests and the Cochran’s Q answer the two research questions.
CHAPTER IV: RESULTS

Introduction

The purpose of this study was to investigate how indicators of suboptimal organizational culture in acute hospitals relate to RNs incident reporting patterns and observe if there was a difference in incident reporting patterns depending on the type of incident. The factors that build suboptimal organization culture are many; this study focused on burnout (Maslach & Jackson, 1981), organizational justice (Hansen et al., 2013), and safety culture (Sexton et al., 2006). The incidents chosen for this study were needle stick injuries, patient falls, medication errors, verbal abuse, mild physical abuse, and moderate-to-severe physical abuse. In this study, perpetrators of violence against nurses were limited to patients and patient family members.

This chapter reviews the results of the survey and the statistical analysis of the results. The demographic categories for nurses include gender, race, age, and longevity. Gender, race and age demographics were compared from the California Board of Registered Nurses to the sample. Hospital demographics include type of geographic area (urban, suburban, and rural), profit status (private-for-profit, private-nonprofit, and county), and other descriptors such as magnet status and union status.

In this chapter, organizational-culture factors are described, the number of participants who answered the items on each factor (scale or subscale) are provided, the mean score for each factor, and the standard deviation for each factor, are listed. The organizational factors included the MBI/EE (only one subscale, emotional exhaustion, was used from this inventory); all the subscales of the OJS: Distributive Justice (OJ/DJ), Procedural Justice (OJSPJ), Interpersonal Justice (OJ/Intj), Informational Justice
and all subscales of the SAQ: Teamwork (SAQ/TW), Safety Climate (SAQ/SC), Perceptions of Management (SAQ/PM), and Working Conditions (SAQ/WC).

The six incidents queried were needle stick injuries, patient falls, medication errors, verbal abuse, mild physical abuse, and moderate-to-severe physical abuse. The two mutually exclusive conditions were the group of nurses who did not report the incident and the group of nurses who did report the incident. An independent t-test for each of the 66 pairs (11 organizational factors multiplied by 6 incident types) are calculated. The pairs yielding a low probability of a false real difference between the mean scores are reported.

The proportions of nurses who experienced and did not experience the incident are provided, separating the group of nurses who experienced the incident into two groups: nonreporters and reporters. Reporters are those nurses who completed a formal incident report they submitted to the department manager for investigation, who then forwarded it to a quality or risk-management department. Executive managers track and review these incidents; they publicly post some; and regulatory agency review most reports. The proportions of nonreporters and reporters are provided. A nonparametric Cochran’s Q test for nurses who experienced all six incidents are performed and again for nurses who experienced all three levels of abuse. Comparisons, for each incident type, are graphed for percentages of nonreporters in the whole sample, nonreporters in the group that experienced all six incidents, and nonreporters in the group that experienced all three levels of abuse. A test that was not part of the research plan was accidently completed and included in the results.
The mean score for each organizational culture factor is calculated for each of the six incident types under two mutually exclusive conditions: the group of nurses who experienced the incident type and the group of nurses who did not experience the incident. In the summary of this chapter, I recall the two research questions, answered using the survey data.

Findings

Registered-Nurse Demographics

The gender distribution in the final study was closer to the gender distribution in the California Government Board of Registered Nurses than in the pilot study. The Board distribution was 86.2% female and 13.8% male; the survey was 84% female and 16% male (see Figure 9), and the pilot yielded 94.1% female participants and 5.9% male participants.

Figure 9. Percentage of registered nurses comparing gender between 2008 California Government Board of Registered Nurses and the 2016 nurse survey.
The race distribution in the final study was closer to the race distribution in the California Government Board of Registered Nurses than in the pilot study. The Board distribution was 58.6% Caucasian, 18% Filipino, 8.6% Asian, 7.5% Hispanic, 4.1% African American, and 3.2% other, the survey was 60.4% Caucasian, 1.8% Filipino, 12.6% Asian, 13.5% Hispanic, 5.4% African American, and 6.3% other (see Figure 10), and the pilot yielded 100% Caucasian participants.

![Race Distribution](image)

*Figure 10. Percentage of registered nurses comparing race between 2008 California Government Board of Registered Nurses and the 2016 nurse survey.*

The age distribution in the final study was not closer to the age distribution in the California Government Board of Registered Nurses than the pilot study. The orange dashed trend-line slope representing the RNs in the studies changed from fewer younger nurses and more older nurses in the pilot study to more younger nurses and fewer older nurses in the actual study (see Figure 11). A possible explanation is that the study used social media to find participants and younger nurses may have been more active on social media compared to older nurses.
Figure 11. Distribution of registered nurse ages comparing 2008 California Government Board of Registered Nurses to the 2016 nurse survey.

The RNs in the survey had a range of longevity (years of experience) from 1 year to 46 years in the field. The distribution was skewed to fewer years with the highest percentage being 5 to 9 years, accounting for 31.5% of participants (see Figure 12). The skew of longevity to fewer years makes sense based on the ages of participants.

Figure 12. Distribution of survey registered nurse longevity (years of experience).
Hospital sizes, location types, and status types varied in this sample. The range of hospital bed size (see Table 8) was less than 49 beds up to more than 950 beds. About 50% of the hospitals had bed capacity of 249 or fewer. The three most common hospital sizes were 200–249 beds (15.3%), 300–349 beds (12.2%), and 50–99 beds (10.5%; see Table 8).

Table 8

Hospital Size: Number of Beds

<table>
<thead>
<tr>
<th>Number of beds</th>
<th>Number of hospitals</th>
<th>Percentage</th>
<th>Cumulative percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–49</td>
<td>14</td>
<td>6.1</td>
<td>6.1</td>
</tr>
<tr>
<td>50–99</td>
<td>24</td>
<td>10.5</td>
<td>16.6</td>
</tr>
<tr>
<td>100–149</td>
<td>21</td>
<td>9.2</td>
<td>25.8</td>
</tr>
<tr>
<td>150–199</td>
<td>20</td>
<td>8.7</td>
<td>34.5</td>
</tr>
<tr>
<td>200–249</td>
<td>35</td>
<td>15.3</td>
<td>49.8</td>
</tr>
<tr>
<td>250–299</td>
<td>13</td>
<td>5.7</td>
<td>55.5</td>
</tr>
<tr>
<td>300–349</td>
<td>28</td>
<td>12.2</td>
<td>67.7</td>
</tr>
<tr>
<td>350–399</td>
<td>12</td>
<td>5.2</td>
<td>72.9</td>
</tr>
<tr>
<td>400–449</td>
<td>11</td>
<td>4.8</td>
<td>77.7</td>
</tr>
<tr>
<td>450–499</td>
<td>14</td>
<td>6.1</td>
<td>83.8</td>
</tr>
<tr>
<td>500–549</td>
<td>14</td>
<td>6.1</td>
<td>90.0</td>
</tr>
<tr>
<td>550–599</td>
<td>3</td>
<td>1.3</td>
<td>91.3</td>
</tr>
<tr>
<td>600–649</td>
<td>10</td>
<td>4.4</td>
<td>95.6</td>
</tr>
<tr>
<td>700–749</td>
<td>3</td>
<td>1.3</td>
<td>96.9</td>
</tr>
<tr>
<td>800–849</td>
<td>4</td>
<td>1.7</td>
<td>98.7</td>
</tr>
<tr>
<td>900–949</td>
<td>2</td>
<td>0.9</td>
<td>99.6</td>
</tr>
<tr>
<td>950–999</td>
<td>1</td>
<td>0.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>229</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
When the range is changed to hospital size based on 100 bed increments, a curve skewed to the left forms (see Figure 13). Participants were asked to pick hospital descriptors in an all the apply questions. Results included 41.8% teaching hospitals, 38% urban hospitals, 21.3% suburban hospitals, 5.3% rural hospitals, 15.6 magnet status hospitals, 25.5% unionized hospitals, 21.7% private-for-profit hospitals, 23.2% private-nonprofit hospitals, and 10.6% county hospitals.

**Figure 13.** Distribution of hospital sizes in survey sample.

**Mean Scores Organizational-Culture Factors**

Table 9 shows the mean scores for each of the organizational-culture factors represented by the 11 scales and subscales. The directions of the scales are different: the MBI scores increase with an increasing level of burnout, whereas the OJ and SAQ scales increase as nurses view the organization in a more positive light.
### Table 9

**Organizational-Culture-Factor Scores from Registered Nurse Participants**

<table>
<thead>
<tr>
<th>Scale/subscale</th>
<th>Number of participants</th>
<th>Organizational factor scores</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI/EE</td>
<td>260</td>
<td></td>
<td>4.1</td>
<td>1.40</td>
</tr>
<tr>
<td>OJS</td>
<td>260</td>
<td></td>
<td>2.6</td>
<td>0.57</td>
</tr>
<tr>
<td>OJS/DJ</td>
<td>256</td>
<td></td>
<td>2.7</td>
<td>0.70</td>
</tr>
<tr>
<td>OJS/PJ</td>
<td>257</td>
<td></td>
<td>2.3</td>
<td>0.77</td>
</tr>
<tr>
<td>OJS/Intj</td>
<td>259</td>
<td></td>
<td>3.0</td>
<td>0.67</td>
</tr>
<tr>
<td>OJS/Infj</td>
<td>259</td>
<td></td>
<td>2.6</td>
<td>0.78</td>
</tr>
<tr>
<td>SAQ</td>
<td>260</td>
<td></td>
<td>2.9</td>
<td>0.54</td>
</tr>
<tr>
<td>SAQ/TW</td>
<td>258</td>
<td></td>
<td>2.9</td>
<td>0.67</td>
</tr>
<tr>
<td>SAQ/SC</td>
<td>258</td>
<td></td>
<td>3.0</td>
<td>0.54</td>
</tr>
<tr>
<td>SAQ/PM</td>
<td>258</td>
<td></td>
<td>2.8</td>
<td>0.63</td>
</tr>
<tr>
<td>SAQ/WC</td>
<td>259</td>
<td></td>
<td>2.8</td>
<td>0.66</td>
</tr>
</tbody>
</table>

*Note. MBI/EE = Maslach Burnout Inventory-Emotional Exhaustion; OJS = Organizational Justice; OJ/DJ = Organizational Justice-Distributive Justice; OJ/PJ = Organizational Justice-Procedural Justice; OJ/Intj = Organizational Justice-Interpersonal Justice; OJ/Infj = Organizational Justice-Informational Justice; SAQ/TW = Safety Attitudes Questionnaire-Teamwork; SAQ/SC = Safety Attitudes Questionnaire-Safety Climate; SAQ/PM = Perceptions of Management; SAQ/WC = Safety Attitudes Questionnaire-Working Conditions. Ranges for each factor are 1 to 4 except MBI/EE is 1 to 7. Note that MBI scores are opposite in value compared to OJ and SAQ scores; low MBI scores are desirable whereas high OJS and SAQ scores are desirable.*

The overall MBI/EE nurses’ ratings had a mean of 4.1, which corresponds to experiencing EE (the items included: I feel emotionally drained from my work, I feel used up at the end of the workday, I feel frustrated by my job) a few times a month on a scale of 1–7 (1 = never, 7 = everyday). Overall nurses’ ratings on all subscales of the OJ corresponded to the midpoint between agree to a small extent and agree to a large extent. The four subscales of the OJ mean scores leaned toward nurses’ agreement to a small extent on OJ/PJ statements: Have you been able to express your views and opinions during procedures to reduce WPV? Have these procedures been applied consistently? Have these procedures been based on accurate information?
Have you been able to appeal the outcomes arrived at by the procedures? The highest mean score, 3.0, represents nurses’ agreement to a large extent on OJ/IntJ statements: Have physicians treated you in a polite manner? and Have physicians treated you with respect?

Overall nurses’ ratings on all subscales of the SAQ almost corresponds to agree on scale of 1 to 4 (1 = strongly disagree, 4 = strongly agree with the statement). The SAQ scale comprises four subscales. The lowest mean score indicated nurses leaned toward nurse’s agreement to SAQ/WC statement: This hospital does a good job of training new personnel, trainees in my discipline are adequately supervised. The highest mean score represented nurses’ with the SAQ/SC statements: Medical errors are handled appropriately in this clinical area, I know the proper channels to direct questions regarding patient safety in this clinical area, and My suggestions about safety would be acted upon if I expressed them to management. Nurses rated safety factors in hospitals at a higher level than justice factors in hospitals.

Research Question 1 asked, What organizational-culture factors of burnout, organizational justice, and safety culture aligned with differences in incident reporting patterns for needle stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse?

The nurses who experienced an incident were partitioned into two mutually exclusive groups: nurses who did not report an incident and nurses who did report the incident. An independent t-tests for each organizational-culture factor including mean scores for each scale and subscale were calculated. The research was exploratory and the
practical significance of making a Type I error was low; thus, results with a $p = .11$ or lower (see Table 10) are reported. The risk in this approach is that the difference between two mean scores may be included but is not statistically significant because the difference is simply due to chance (Salkind, 2011).

Table 10

*Differences in Organizational-Culture Factor Mean Scores Between Nonreporters and Reporters by Incident Type*

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Organizational culture factor</th>
<th>Mean score nonreporters</th>
<th>Mean score reporters</th>
<th>$t$-test $p$ values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2-tailed</td>
</tr>
<tr>
<td>Needle stick injuries</td>
<td>OJ</td>
<td>2.74</td>
<td>2.55</td>
<td>.105</td>
</tr>
<tr>
<td></td>
<td>OJ/PJ</td>
<td>2.74</td>
<td>2.32</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>OJ/Infj</td>
<td>2.69</td>
<td>2.52</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>SAQ</td>
<td>3.10</td>
<td>2.81</td>
<td>.003</td>
</tr>
<tr>
<td></td>
<td>SAQ/TW</td>
<td>3.17</td>
<td>2.78</td>
<td>.011</td>
</tr>
<tr>
<td></td>
<td>SAQ/SC</td>
<td>3.14</td>
<td>2.99</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>SAQ/PM</td>
<td>2.99</td>
<td>2.71</td>
<td>.019</td>
</tr>
<tr>
<td></td>
<td>SAQ/WC</td>
<td>3.12</td>
<td>2.77</td>
<td>.000</td>
</tr>
<tr>
<td>Patient falls</td>
<td>OJ/DJ</td>
<td>3.00</td>
<td>2.56</td>
<td>.006</td>
</tr>
<tr>
<td></td>
<td>OJ/PJ</td>
<td>2.74</td>
<td>2.27</td>
<td>.042</td>
</tr>
<tr>
<td></td>
<td>OJ/Intj</td>
<td>2.67</td>
<td>3.02</td>
<td>.086</td>
</tr>
<tr>
<td></td>
<td>OJ/Infj</td>
<td>2.78</td>
<td>2.49</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>SAQ</td>
<td>3.09</td>
<td>2.81</td>
<td>.089</td>
</tr>
<tr>
<td></td>
<td>SAQ/TW</td>
<td>3.17</td>
<td>2.83</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>SAQ/PM</td>
<td>3.01</td>
<td>2.67</td>
<td>.092</td>
</tr>
<tr>
<td></td>
<td>SAQ/WC</td>
<td>3.04</td>
<td>2.78</td>
<td>—</td>
</tr>
<tr>
<td>Medication errors</td>
<td>OJ/Intj</td>
<td>2.78</td>
<td>3.04</td>
<td>.082</td>
</tr>
<tr>
<td></td>
<td>SAQ</td>
<td>2.67</td>
<td>2.92</td>
<td>.109</td>
</tr>
<tr>
<td></td>
<td>SAQ/TW</td>
<td>2.71</td>
<td>2.94</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>SAQ/SC</td>
<td>2.73</td>
<td>3.06</td>
<td>.061</td>
</tr>
<tr>
<td></td>
<td>SAQ/PM</td>
<td>2.59</td>
<td>2.80</td>
<td>—</td>
</tr>
</tbody>
</table>

*Table continues*
<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Organizational culture factor</th>
<th>Mean score nonreporters</th>
<th>Mean score reporters</th>
<th>( t )-test ( p ) values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse</td>
<td>OJ/Infj</td>
<td>2.50</td>
<td>2.69</td>
<td>.099 1 tail 0.50</td>
</tr>
<tr>
<td></td>
<td>SAQ</td>
<td>2.80</td>
<td>2.93</td>
<td>.097 1 tail 0.49</td>
</tr>
<tr>
<td></td>
<td>SAQ/TW</td>
<td>2.81</td>
<td>2.98</td>
<td>.090 1 tail 0.45</td>
</tr>
<tr>
<td></td>
<td>SAQ/WC</td>
<td>2.72</td>
<td>2.92</td>
<td>.036 1 tail 0.18</td>
</tr>
<tr>
<td>Moderate-to-severe physical abuse</td>
<td>OJ/DJ</td>
<td>2.22</td>
<td>2.61</td>
<td>— 1 tail 0.088</td>
</tr>
<tr>
<td></td>
<td>SAQ/PM</td>
<td>2.24</td>
<td>2.58</td>
<td>— 1 tail 0.087</td>
</tr>
</tbody>
</table>

*Note.* No differences in mean scores for nurses who experienced mild physical abuse who did not report the abuse and those who did not. All \( p \) values .11 or lower reported due to exploratory nature of research. MBI/EE = Maslach Burnout Inventory-Emotional Exhaustion; OJ = Organizational Justice; OJ/DJ = Organizational Justice-Distributive Justice; OJ/PJ = Organizational Justice-Procedural Justice; OJ/Intj = Organizational Justice-Interpersonal Justice; OJ/Infj = Organizational Justice-Informational Justice; SAQ/TW = Safety Attitudes Questionnaire-Teamwork; SAQ/SC = Safety Attitudes Questionnaire-Safety Climate; SAQ/PM = Perceptions of Management; SAQ/WC = Safety Attitudes Questionnaire-Working Conditions. Ranges for each factor are 1 to 4 except MBI/EE is 1 to 7. Note that MBI scores are opposite in value compared to OJ and SAQ scores; low MBI scores are desirable whereas high OJS and SAQ scores are desirable.

For needle stick injuries, the mean scores decreased in the group of nurses who reported the incidents. In other words, the group that did report rated their organization less favorably. Organizational-culture factors mean-score differences with probabilities far below \( p = .05 \) were OJ/PJ, OJ/Infj, SAQ/TW, SAQ/PM, and SAQ/WC.

For patient-falls incidents, mean scores decreased with one exception (OJ/Intj) in the group of nurses who reported incidents. In other words, the group that did report rated their organization less favorably. Organizational-culture factors mean score differences with probabilities below \( p = .05 \) were OJ/DJ, OJ/PJ, OJ/Intj, SAQ/TW and SAQ/PM.

For medication errors, mean scores increased in the group of nurses who reported incidents. In other words, the group that did report rated their organization more favorably. Organizational-culture factors mean score differences with probabilities equal to or below \( p = .05 \) were OJ/Intj, SAQ, and SAQ/SC.
For verbal abuse, mean scores increased in the group of nurses who reported incidents. In other words, the group that did report rated their organization more favorably. Organizational-culture-factors mean score differences with probabilities equal to or below $p = .05$ were on the OJ/Infj, SAQ, SAQ/TW and SAQ/WC.

No differences emerged in organizational-culture factors between the group of nurses who did not or did report mild physical abuse. For moderate-to-severe-physical-abuse incidents, mean scores increased in the group of nurses who reported the incidents. In other words, the group that did report rated their organization more favorably. Organizational-culture-factors mean score differences with the lowest probabilities, .88 and .87 respectively, were: OJ/DJ and OJ/PM.

**Cochran’s Q Test for Reporting Patterns**

Research Question 2 was, What differences accrued in how often nurses reported needle-stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse? The first approach to answering this question was descriptive data. The prevalence of incident occurrence appears in Figure 14 and the incident reporting patterns in Figure 15. The prevalence of each incident in the survey sample, from highest to lowest, was verbal abuse (83%), medication errors (57%), mild physical abuse (54%), patient falls (54%), needle stick injuries (41%), and moderate-to-severe physical abuse (22%). The type of incident experienced by the largest number of nurses in the sample was verbal abuse from their patients or their patients’ family. The research did not measure the frequency of the incident; only if it had or had not occurred.
In addition to the prevalence of the incidents, the participants were asked for the reporting status of each incident. Participants indicated “No” or “Yes” after recalling the
last time they experienced the incident and asked if they completed a formal incident report. The percentage of incidents unreported in the survey sample, from highest to lowest was verbal abuse (65%), mild physical abuse (51%), needle stick injuries (28%), medication errors (17%), moderate-to-severe physical abuse (16%), and patient falls (9%). These data support that the two incidents least reported are verbal abuse and mild physical abuse. To test for true differences, a Cochran’s Q analysis was completed for all six incidents (see Table 11) and again for the three levels of patient-on-nurse abuse (see Table 12). The Cochran’s Q is a nonparametric statistical test that compares all the “no’s” and “yes’s” (did not report, did report) across different circumstances (types of incidents). It only applies to participants who indicated that they had experienced all of the incidents being analyzed.

Table 11

*Cochran’s Q Test for Differences in Reporting Patterns—Six Incident Types*

<table>
<thead>
<tr>
<th>Incident</th>
<th>Number who did not report</th>
<th>Number who did report</th>
<th>Cochran’s Q</th>
<th>df</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle stick injury</td>
<td>5</td>
<td>14</td>
<td>21.694</td>
<td>5</td>
<td>.001</td>
</tr>
<tr>
<td>Patient fall</td>
<td>4</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication error</td>
<td>3</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>13</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild physical abuse</td>
<td>7</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate-to-severe physical abuse</td>
<td>1</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Cochran’s Q test for participants who experienced all six types of incidents.
Table 12

_Cochran’s Q Test for Differences in Reporting Patterns—Three Levels of Abuse_

<table>
<thead>
<tr>
<th>Incident</th>
<th>Number who did not report</th>
<th>Number who did report</th>
<th>Cochran’s Q</th>
<th>df</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse</td>
<td>33</td>
<td>17</td>
<td>32.968</td>
<td>2</td>
<td>.000</td>
</tr>
<tr>
<td>Mild physical abuse</td>
<td>18</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate-to-severe physical abuse</td>
<td>7</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Cochran’s Q test for participants who experienced all three levels of abuse.

Both tests were statistically significant and indicated marked differences in reporting patterns between the two groups that are unlikely due to chance. The percentage of incidents not reported in the group of 19 participants who experienced all six incidents, from highest to lowest, was verbal abuse (68%), mild physical abuse (36%), needle stick injuries (26%), patient falls (21%), moderate-to-severe physical abuse (17%), and medication errors (16%). The percentage of incidents not reported in the group of 50 participants who experienced all three levels of abuse, from highest to lowest was verbal (66%), mild physical abuse (34%), and moderate-to-severe physical abuse (14%). Figure 16 compares percentages of incidents not reported in the three groups: the whole sample (*n* = 263), the group that experienced all six incidents (*n* = 19), and the group that experienced all three levels of abuse (*n* = 50).

The relative proportions of nurses who did not report incidents roughly followed the same pattern across incidents. Not reporting verbal abuse was the highest group (whole sample, 65%; group of 19, 68%; and group of 50, 66%) followed by not reporting mild physical abuse (whole sample, 51%; group of 19, 36%; and group of 50, 34%). The other incidents were reported more often.
Incidental Findings

Inadvertently, organizational-culture factors mean scores were calculated for the groups who had and had not experienced each incident. In the introduction, it was stated, “An alternative approach would decrease direct blame on the organization and focus on the organization as the context for incident reporting.” Having stated this, compelling results accrued that are worthwhile reporting. See Table 13 for the mean scores of the organizational-culture factors that are statistically significant for nurses who experienced a given incident compared to the nurses who did not.
Table 13

*Differences in Organizational-Culture-Factor Mean Scores Between Nurses Who Did Not and Did Experience an Incident by Incident Type*

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Organizational culture factor</th>
<th>Mean score no incident</th>
<th>Mean score experienced incident</th>
<th>(t)-test (p) values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2-tailed</td>
</tr>
<tr>
<td>Needle stick injuries</td>
<td>MBI/EE</td>
<td>3.88</td>
<td>4.36</td>
<td>.007</td>
</tr>
<tr>
<td></td>
<td>OJS/PJ</td>
<td>2.25</td>
<td>2.44</td>
<td>—</td>
</tr>
<tr>
<td>Patient falls</td>
<td>MBI/EE</td>
<td>3.68</td>
<td>4.44</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>OJ/DJ</td>
<td>2.77</td>
<td>2.59</td>
<td>.035</td>
</tr>
<tr>
<td></td>
<td>OJ/InfJ</td>
<td>2.71</td>
<td>2.50</td>
<td>.032</td>
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Note. No differences emerged in mean scores for nurses who experienced medication errors. MBI/EE = Maslach Burnout Inventory-Emotional Exhaustion; OJ = Organizational Justice; OJ/DJ = Organizational Justice-Distributive Justice; OJ/DJ = Organizational Justice-Procedural Justice; OJ/Infj = Organizational Justice-Informational Justice; SAQ/SC = Safety Attitudes Questionnaire-Teamwork; SAQ/SC = Safety Attitudes Questionnaire-Safety Climate; SAQ/PM = Perceptions of Management; SAQ/WC = Safety Attitudes Questionnaire-Working Conditions. Ranges for each factor are 1 to 4 except MBI/EE is 1 to 7. Note that MBI scores are opposite in value compared to OJS and SAQ scores; low MBI scores are desirable whereas high OJS and SAQ scores are desirable.

Organizational-culture factors appear to impact whether a nurse experiences a negative incident. Reviewing the results shown in Table 13, in all but one pair of means of the 31 pairs, the MBI/EE increases and all the OJS scales/subscales and SAQ scales/subscales decrease. Considering MBI/EE, the largest differences were an increase of .96 in the group that experienced moderate-to-severe physical abuse and an increase of .59 in the group that experienced mild physical abuse. Both of these had an extremely low probability of false real difference. MBI/EE was also higher in the group of nurses who experienced needle stick injuries. One way to interpret these findings is that higher EE aligns with the occurrence of needle stick injuries and being physically abused by patients. This makes intuitive sense but now one has quantitative data. No previous study compared organizational-culture-factor scores and incidence occurrence that included WPV incidents, injuries, and quality-outcome incidents in one study.
Considering each type of incident and the statistically significant decreases (viewing the hospital in less favorable terms) in mean scores on OJ and SAQ scales and subscales the biggest differences include patient falls with an increase in OJ/DJ and OJ/Infj, verbal abuse with a decrease in SAQ/WC, mild physical abuse with decrease in OJ/Infj, and moderate-to-severe physical abuse with a decrease in SAQ/PM.

**Summary**

The first research question was, What organizational-culture factors of burnout, organizational justice, and safety culture aligned with differences in incident reporting patterns for needle stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse? The results of this study support the answer: Nurses who report incidents rate organizational justice and safety attitudes differently from nurses who do not report incidents, and many of these results are statistically significant. The following highlights each incident type.

All needle stick injuries mean scores decreased in the group of nurses who reported incidents. In other words, the group that did report rated their organization less favorably. The organizational-culture factors with the highest mean score changes were PC, TW, and WC (with decreases of .42, .39, and .35, respectively).

All patient-fall-incident mean scores fell with the exception of OJ/Intj in the group of nurses who reported incidents. In other words, the group that did report rated their organization less favorably for all but one factor. Organizational-culture factors with
the largest mean score changes were: OJ/DJ, OJ/PJ, and OJ/Intj (with decreases of .44 and .47 an increase of .35, respectively).

All medication-error mean scores rose in the group of nurses who reported the incidents. In other words, the group that did report rated their organization more favorably. Organizational-culture factors with the largest mean score changes were Intj on the OJ and the combined subscales and SAQ/SC (with increases of .26, .25, and .33, respectively).

All verbal-abuse mean scores increased in the group of nurses who reported the incidents. In other words, the group that did report rated their organization more favorably. The organizational-culture factors with the largest mean score changes were OJ/Infj, SAQ/TW, and SAQ/WC (with increases of .19, .17, and .20, respectively).

No differences emerged in organizational-culture factors between the group of nurses who did not or did report mild physical abuse. For moderate-to-severe-physical-abuse incidents, all mean scores rose in the group of nurses who reported the incidents. In other words, the group that did report rated their organization more favorably. Organizational-culture factors with the largest mean score changes were OJ/DJ and SAQ/PM (with increases of .39 and .34, respectively).

The second research question was, What differences accrued in how often nurses reported needle- stick injuries, patient falls, medication errors, patient/patient family on nurse verbal abuse, patient/patient family on nurse mild physical abuse, and patient/patient family on nurse moderate-to-severe physical abuse? Results of this study support the answer: Verbal abuse is the least reported incident, followed by mild physical abuse. Nurses reported these incidents less often than needle stick injuries, patient falls,
medication errors, and moderate-to-severe physical abuse. The results are statistically significant with the low probability of a false real difference. The percentage of those who experienced verbal abuse and did not report it ranged from 66 to 68%. In contrast, those who experienced the other forms of WPV and did not report them ranged as follows: mild physical abuse, 34–51%; needle stick injuries, 26–29%; patient falls, 9–21%; medication errors, 16–17%; and severe physical abuse 2–16%.

The data in this quantitative study support the findings in qualitative studies and assumptions about underreporting of WPV II. In two incident types, organizational-culture-factor mean scores decreased and in the remaining four incident types, scores increased in the group of nurses who reported the incidents. In addition, nurses reported verbal abuse and mild physical abuse less often than other types of incidents.
CHAPTER V: DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

Introduction

This exploratory survey queried RNs working in California acute-care hospitals, including acute psychiatric hospitals. The survey yielded 411 responses, tallied in Qualtrics. Of the total number of completed surveys, RNs in California completed 263. The impetus for this research came from my concerns about the prevalence and effect of WPV Type II, where a patient or patient’s family member verbally or physically abuses the nursing staff, and that nurses underreport these events.

Reviewing the research over the last 5 years and some classic studies, it is clear that WPV Type II exists in hospitals, occurs at a high rate compared to other professions, is underreported, and aligns with unwanted negative outcomes for nurses, patients, and hospital administrators. Regulators and hospitals refine regulations and policies over time, based on trends found in incident reports. Although it is likely that hospital administrators know that WPV Type II exists, they may have insufficient motivation or knowledge to prevent it in a meaningful way. If nurses report more WPV Type II incidents, they can be harder to minimize or ignore. If regulatory bodies become more aware of the prevalence and effects of this violence, they can introduce more stringent mandates that can increase administrators’ sense of urgency to fix the problem.

This dissertation also reviews reasons nurses provided about why they do not always report hospital incidents and WPV incidents. Previous studies used qualitative approaches to group the reasons into themes. No previous studies used a quantitative approach to compare mean scores of organizational-culture factors between groups of nurses who do not and do report incidents. Studies have also quantified underreporting
rates. No studies have compared if differences emerge in underreporting WPV incidents compared to other types of incidents.

In this study, participants responded to items reflecting organizational-culture factors in the first section of the survey. In the second section, they provided information about specific incidents they experienced. If they indicated they had experienced those incidents, they indicated if they reported the incident to hospital administrators. In the final section, RNs provided demographic information.

Discussion

To answer the first research question the mean scores for 66 pairs between nurses who did not report and those who did report incidents were compared. Eleven scales and subscales represented organizational-culture factors: MBI/EE = Maslach Burnout Inventory-Emotional Exhaustion, OJ = Organizational Justice, OJ/DJ = Organizational Justice-Distributive Justice, OJ/PJ = Organizational Justice-Procedural Justice, OJ/Intj = Organizational Justice-Interpersonal Justice, OJ/Infj = Organizational Justice-Informational Justice, SAQ/TW = Safety Attitudes Questionnaire-Teamwork; SAQ/SC = Safety Attitudes Questionnaire-Safety Climate, SAQ/PM = Perceptions of Management, and SAQ/WC = Safety Attitudes Questionnaire-Working Conditions). For each of the six incident types (staff needle stick injury, patient falls, medication errors, verbal abuse, mild physical abuse, and moderate-to-severe physical abuse) the organizational-culture scores were calculated yielding the 66 pairs. Of these pairs, 25 showed differences in mean scores that were statistically significant with $p$ set at .11 or lower. This process captured moderate-to-severe physical abuse score and differences in mean scores for OJ/DJ and SAQ/PM with a low probability of a false real difference (.088 and .087...
respectively). When the $p$ value decreased to the standard level of .05 MBI/EE, mild physical abuse and moderate-to-severe physical abuse had no statistically significant mean scores. Here is the discussion for the differences with the biggest practical significance (largest numerical change in mean scores) and statistical significance ($p = .05$).

Patient-fall mean scores decreased in the group of nurses who reported needle stick injuries for OJ/PJ, SAQ/TW, and SAQ/WC, as well as patient falls for OJ/DJ and OJ/PJ. This is the opposite of what I expected. The researcher thought that nurses would be more likely to report incidents if their perceptions of the organizational culture were favorable. However, in these incidents, perceptions of the culture were more favorable in the group of nurses who did not report needle stick injuries and patient falls. For the other four incidents (medication errors, verbal abuse, mild physical abuse, and moderate-to-severe physical abuse), organizational factors increased in the group of nurses who reported the incidents, which is what the researcher expected. An explanation for the opposite trends could be a subject for further research. A possible explanation is that nurses who do not report needle stick injuries may feel that all that could be done to prevent them has already been done. If they feel that the organization has healthy OJ, they do not need to report the incident because little else can be done to improve safety in this area. In contrast, the group who did report needle stick injuries may feel that too little is done and they must report the incident in the hope that more steps can be taken to prevent future incidents. Patient falls may be viewed the same way.

Medication errors occurred in 57% of the sample; it had the highest prevalence of all three incidents unrelated to violence (falls, 54%; needle stick injuries, 41%). Mean
scores increased in all organizational-culture factors in the group (83% of the nurses who made the error) that reported the errors. The factor with the biggest rise was SAQ/SC, which included the following items: Medical errors are handled appropriately in this clinical area, I know the proper channels to direct questions regarding patient safety in this clinical area, and My suggestions about safety would be acted upon if I expressed them to management. Nurses who reported believed the errors would be handled appropriately and they could make suggestions for improvement.

Cause and effect cannot be assumed in this study. Mean scores could be different because nurses felt better about the safety climate in the organization and were more willing to admit their mistakes. Alternatively, they may have admitted their mistakes and the organization demonstrated a positive response that led the nurses to perceive the safety climate more positively. In the survey, items related to organizational-culture factors came first and the questions about recalling the experience of an incident, and the question about reporting the incident came later. A future study could focus on cause and effect, which may work in both directions, creating a very positive cycle of increased reporting.

For all three levels of patient or patient family abuse on nurses, organizational-culture factor mean score differences with low probabilities increased (rating the organization more favorably) in the nurse group that reported the incidents. Verbal abuse occurred for 83% of the nurses and 35% of the nurses reported the last incident they recalled. Mild physical abuse occurred for 54% of nurses and 49% reported the last incident they recalled. Moderate-to-severe physical abuse occurred for 22% of the nurses and 84% reported the last incident they recalled. These reports are internal hospital reports.
only. How many assaults nurses reported to police was not included in this study. To put the abuse in perspective, the following quotations from survey participants are offered.

Verbal Abuse Quotations

Although I have not experienced physical harm from a patient at my current employer I did have a patient’s family member threaten (in a very graphic way) to murder me after the death of their loved one. I also feel like this event escalated only after inappropriate (sic)/ineffective actions from security and administration. (The family member was instigated as opposed to being effectively de-escalated). (Participant 15)

As far as pts I have been sworn at, (sic) told to F off etc.. but I guess as a nurse I feel pts can be as obnoxious as they want. I can try to set limits but it is (sic) what it is. (Participant 37)

Verbal harassment (sic) and death threats when I wouldn’t disclose the status of a pediatric patient to parents of other kids who were around my patient, and were concerned about contagion. “I’ll get my gun and drive up there and shot you right in the face!” I (sic) called security and alerted my charge nurse/manager. I was not advised to fill out an incident report, and I did not. (Participant 45)

Mild Physical Abuse Quotations

Almost every day now, I have a patient who cusses me, strikes me, grabs me by my wrist an want (sic) let go or some similar activity. I frequently work without a nursing assistant and have 2 or more patients who are very high fall risk, or a patient who needs almost constant monitoring. In other areas it is just as bad and worse because now the atient (sic) is ALWAYS right in many many places
because if they fill out an HCCAPS (sic) [HCAHPS is a type of patient satisfaction survey] survey and complain, the hospital loses funds. (Participant 16)

I have been doing this for many years and have had MANY incidents of patients or family yelling at me, throwing a food tray, balling up their fists, etc. but unless I was actually hurt I haven’t reported it. (Participant 18)

My biggest incident was due to a nursing supervisor counter mandating a doctor order. The pt was supposed to be in locked seclusion but came out and came after me. The supervisor was told off by md and supervisor ever since treated me unfairly. (Participant 64)

My charge nurse was attacked by a patient in the middle of nurse station. Patient physically shoved my charge nurse in front of several witness. Patient sent a letter 2 member services stating “she (sic) was the victim.” My charge nurse got reprimanded. Nursss (sic) have no rights. (Participant 202)

I have been hit and verbally abused by patients never have I thought to do an incident. (Participant 88)

_Moderate-to-Severe Physical Abuse Quotations_

You cant (sic) report every minor abuse or you end up being labeled as a cry baby by other nurses. Only major incidents get reported. And sometimes if you get injured the organization treats you like a liar (sic) who made up the injury. (Participant 65)

I was grabbed by the wrist by a large male patient who demanded pain medication. He threatened to set my hair on fire. He had a working lighter in his other hand. I was able to get away. He started destroying the room. My manager
was in meetings. I called security (sic). They did not respond. The attending physician told me to call the police. I did. They arrived and had to physically remove the patient from our department. He had trashed the room and broken equipment and a window. My wrist was red and swollen…. My wrist was sprained and dislocated and I was put in a compression splint & written an off-work order for 2 weeks. When I returned my manager wanted to discipline me for calling the police, stating it was not hospital (sic) protocol. The attending physician involved defended our handling of the incident…. I ended up having surgery on my wrist and being on short term disability leave for a month, on modified duty for 3 and a year of PT. My manager hated me after all this and I eventually left the job…. My wrist hurts from typing all this! (Participant 98)

The quotations from participants illuminate the content of the different levels of abuse; they also highlight barriers to reporting found in qualitative studies. In Chapter 2, I summarized common barriers in 25 recent international studies in the section Barriers to Reporting. RNs in the present study provided examples of 22 of the 24 barriers (except “fear of lawsuits” and “staff worried about financial penalties not related to lost income”). The 22 barriers are lack of feedback and action, lack of clarity on policies, shame and blame culture, burden of reporting, fear of disciplinary measures, verbal reports instead of written reports, no or inadequate training, no or little lasting harm due to the incident, self-blame, customer is always right, excusing the staff error, permissive physician culture, incidents defined as an expected risk or side effect, culture of no reporting, lack of staff professionalism and willingness to be accountable, documentation in the patient’s chart instead of a formal written incident, lack of access to reporting
resources, inurement to violence, excusing the patient’s behavior, no serious injury to staff, and no support for the victim of assault. The comments in the survey included many that fit into the theme of “the customer is always right.” The high focus on the customer is discussed in greater detail in the section on recommendations for future practice.

When the customer is always right, it becomes harder to recognize and report verbal abuse. All reported incident mean scores that were statistically significant increased and the largest changes were OJ/Infj, SAQ/TW, and SAQ/WC. Items in OJ/Infj included Have unit leaders explained the unit procedures thoroughly? Were the unit leader’s explanations regarding the unit procedures reasonable? and Have unit leaders seemed to tailor their communications to individuals’ specific needs? Items in the SAQ/TW included, Nurse input is well received in this clinical area, Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient), and It is easy for personnel here to ask questions when there is something that they do not understand. Items in the SAQ/WC included, This hospital does a good job of training new personnel and trainees in my discipline are adequately supervised. If these organizational-culture factors were low scoring they could theoretically link to the barriers to reporting found in qualitative studies such as lack of clarity and no or inadequate training. Unwelcome questioning and unresolved may exacerbate the following barriers: lack of feedback and action, shame and blame mentality, fear of disciplinary measures, customer is always right, inurement to violence (it is part of the job), and no support for the victim of assault. Because 83% of nurses experienced verbal abuse from patients and only 35% reported it, implications arise for future practice, discussed later in this chapter.
Nurses underreport hospital incidents, though it is hard to know to what extent. For all hospitals incidents involving patients, the underreporting rate is 86% (Levinson, 2012) and different types of incidents have different underreporting rates, depending on the study. Nurses underreport patients’ and patient family members’ abuse with rates ranging from 1 in 5 (APNA, 2014) to 1 in 6 (Lowry, 2010). To understand nonreporting patterns as raised in the second research question, a Cochran’s Q analysis in this study supported that nurses underreport WPV II. Incidents that are verbal or mild physical abuse are the most underreported of all six incidents. The rates for nonreporting from highest to lowest are as follows: verbal abuse - 65%, mild physical abuse - 51%, needle stick injuries - 28%, medication errors - 17%, moderate-to-severe physical abuse - 16%, and patient falls - 9%.

The accidental findings in the analysis revealed large increases in the mean scores for MBI/EE when considering the two groups of those who did and those who did not experience a given incident. Specifically, nurses who experienced needle stick injuries, patient falls, mild physical abuse, and moderate-to-severe physical abuse had higher mean scores. The biggest change was MBI/EE rising almost one point in nurses who experienced moderate-to-severe physical abuse. The second largest change was an increase in MBI/EE increasing more than half a point in nurses who experienced mild physical abuse. These findings have implications for future research and practice, discussed later in the chapter.

Conclusions

In summary, differences in scores of organizational-culture factors align with violence incident reporting patterns by nurses and verbal abuse and mild physical abuse
occur at statistically significant higher rates compared to other types of incidents. All the mean scores measuring organizational-culture factors rated by the nurses scored less favorably (with one non-statistically significant subscale exception) in the group of nurses who did not report verbal abuse incidents and rated more favorably in the group who did report it. The nonreporters were more burned out, felt that the hospital had less organizational justice and was less safe when compared to the nurses who did report. The statistically significant scores were: OJ/Intj, SAQ, SAQ/TW, and SAQ/WC. Most of the mean scores for the organizational-culture factors were less favorable in the nurse who did not report mild physical abuse and more favorable in the group who did report it. These scores did not reach statistical significance. Most of the mean scores for the organizational-culture factors were less favorable in the nurse who did not report moderate-to-severe physical abuse and more favorable in the group who did report it. These scores did not reach statistical significance.

Patient and patient family members verbally abused nurses. Nurses either did or did not report the abuse. This study found statistically significant differences in how the nurses rated their organization in the two groups; the nonreporters rated the hospital less favorably and reporters rated the hospital more favorably in interpersonal justice, safety culture in general, safety culture in teamwork, and safety culture in working conditions.

How the nurses viewed their hospital influenced how often they reported incidents. Another question that was asked: are there differences in how often nurses experience different types of incidents. A statistically significant difference emerged in nonreporting rates due to high levels in underreporting verbal and mild physical abuse. Many nurses in the study experienced some form of abuse and did not report it. Of the nurses in this
study, 22% experienced moderate-to-severe abuse and 84% of them reported it. Thus, for every 100 nurses in the study, 18 would have experienced but not reported the abuse. Of the nurses in this study, 55% experienced mild abuse and 35% of them reported it. Thus, for every 100 nurses in the study, 28 would have experienced but not reported the abuse. Of the nurses in this study, 83% experienced verbal abuse and 84% of them reported it. Thus, for every 100 nurses in the study, 54% would have experienced but not reported the abuse. Verbal abuse occurs with a high prevalence and has the lowest reporting rate.

Implications

Patients and their family members physically and verbally abuse nurses. The abuse, even the verbal abuse, has a negative impact on the nurse, the patients receiving care from the abused nurse, and the administrative costs of running a hospital. When the hospital management and leadership allow a culture of abuse to exist the negative impact on all is increased. When the hospital management and leadership fail to address WPV nurses believe that nothing will be done to change the work environment. How the nurses feel about their organization makes a difference in how often they do or do not report personal safety issues.

Verbal abuse is a safety issue. Verbally abused nurses are slower, make more mistakes, and resort to mechanical caring. Verbal abuse in this study included descriptions of how the family members would murder the nurse. Verbal abuse is damaging and can be a precursor to escalating violence. The nurses’ quotations in this study showed that they felt patient satisfaction scores were more important than their own safety and integrity.
A study published in 2012 (Jackson, Hutchinson, Luck, & Wilkes, 2012) found that verbal abuse of nurses was gendered and sexualized in tone related to nursing being a female dominated profession. The abuse fell into three categories: sexual abuse that mostly targets women; insults (attacking the nurses competence, derogatory slurs such as “bitch”, “slut” and “whore”), ridicule; and unreasonable demands; and open hostility including threats and menacing behavior. As in this study, the 2012 study found that verbal abuse occurred at a high rate, that little was done to address it, and that it had negative impact on the nurses.

While most hospitals have a zero-tolerance policy addressing violence, many nurses are not aware of it or believe it is not enforced. In addition, they may not consider verbal violence as “real” violence and this attitude is reinforced by management and leadership in the organization.

The model for the workplace-violence cycle conceptualized by this researcher (see Figure 1) is supported by the literature, the quantitative data in this study, and the nurse participant quotations in this study. The model has four large concepts, they all interact but for purposes of the study they are put in a cycle where one concept influences the next concept. We start with the knowledge that WPV exists. The violence occurs in the context of an organizational culture which may be suboptimal. The culture can be measured by nurses working in hospitals using standardized tools. The culture has impact on the likelihood that nurse will or will not report incidents. When incidents are not reported less is known about them and the urgency to change is low. This allows the workplace-violence cycle to continue.
The implication is that as long as WPV is allowed to exist at its current level the hospital safety, the nurse’s moral, and the patient’s perception of care will continue to be broken.

Recommendations for Future Research

Future research could investigate the observation from this study that reporters of needle stick injuries and patient falls viewed organizational-culture factors less favorably rather than more favorably, and reporters of medication errors, verbal abuse, and moderate physical abuse viewed organizational-culture factors more favorably. As mentioned earlier, it is difficult, based on this information, to explain why some scores rose and others fell. Other variables may help understand these phenomena.

Although most nurses reported moderate-to-severe physical abuse, some did not. Participants who did not report incidents did rate their organization lower on OJ/DJ and SAQ/PM. The drop in the mean scores for these two factors had low probability but did not meet $p$ values equal to or lower than .05. It would be valuable to understand more fully which barriers nurses experienced who did not report this high level of abuse.

Another avenue of research could more clearly delineate the relationships and the direction of the relationships (cause and effect) between higher MBI/EE in the group of nurses who experienced mild physical abuse and moderate-to-severe physical abuse. Did MBI/EE increase after the abuse or was another variable involved that increased both MBI/EE and WPV II? MBI/EE was also higher in nurses who experienced needle stick injuries and patient falls. Abused nurses make more clinical errors (see Chapter 2) but the mechanism may relate to MBI/EE more than other variables. If this is true, then giving
nurses increased resources to prevent MBI/EE after an assault could prevent clinical errors.

Recommendations for Future Practice

Verbal abuse includes yelling, screaming, profanity, shaming, and even graphic death threats. WPV II aligns with increased nurses’ stress, increased intent to leave the profession, increased clinical errors, decreased patient satisfaction, and increased direct and indirect costs for the hospital. Verbal abuse from patients had the highest prevalence in this study compared to other types of incidents and is the least likely incident to be reported. Many studies focused on effects of “horizontal abuse” (Becher & Visovsky, 2012; Granstra, 2015; Lachman, 2015; Purpora & Blegen, 2015; Spence Laschinger & Nosko, 2015), fewer or no studies focused on the effects of only verbal abuse (excluding physical abuse) from patients. If one assumes, based on these pieces of knowledge, that verbal abuse leads to bad outcomes, then hospital administrators should actively promote reporting it. At present, nurses do not report WPV because they fear being seen as “a cry baby” (Participant 65) and they feel that patient satisfaction is more important than the nurse’s experience. Several participants mentioned patient satisfaction in their comments: “It is common that abusive patients are allowed to abuse nurses because management is worried about their satisfaction scores” (Participant 5). It may be time to find ways to promote patient satisfaction while promoting a healthy work environment for nurses. It may be time to not allow the concern about an individual patient’s satisfaction to inhibit support for nurses when verbal altercation ensue. Ironically, when patients abuse nurses, patient-satisfaction scores fall, as reviewed in Chapter 2. It may or may not be the
abusing patient’s score but the scores of other patients who suffer because the nurse suffers.

Nurses underreport verbal abuse and the effects and suffering it generates are not as well understood as lateral verbal abuse and PV. Many participants made comments about feeling drained from work, not enjoying time off, and not wanting to return to work, exemplified by this comment:

Sometimes what happens at work comes home, if you have had a hard day with difficult pt that maybe verbally attacked you or tried to discredit you as a person … you have tried really hard to provide excellent care-it makes it hard to coe (sic) back to work the next shift.

To increase knowledge about the effects of verbal abuse from patients, incident reports should include not just that the abuse occurred but also a follow-up with the nursing staff involved to understand the effects of the abuse. Based on the results of this study, particularly for verbal abuse, including the organizational-culture factor mean scores and comments, the following actions are recommended:

1. Prepare student nurses to expect WPV and provide tools for them to prevent it and report it.
2. Do all that is possible to reduce WPV in all of its forms.
3. Include the reality of WPV in nursing job descriptions.
4. Encourage unit-level communication between nursing staff and unit leaders that includes time for questions about what is included in verbal abuse, even if the discussion might lead to disagreement.
5. Increase support from higher administration for unit leaders to pursue an understanding of the amount and effects of verbal abuse in a protected process that is not curtailed by concerns about patient satisfaction.

6. Develop WPV II prevention policies and procedures based on nursing input.

7. Emphasize patients’ rights and responsibilities that are included in the patient admission packet if a patient is verbally abusive.

8. Offer support to the nurse who is verbally abused by setting therapeutic limits on the patient’s behavior; help the nurse formulate a communication plan before meeting with the patient and have a third person present during the conversation.

9. Time nurse–patient conversations when everyone has regained emotional control (and increased rationality) and focus on emotional resolution whenever possible.

10. When patients are unable to participate in these conversations, the nurse should have a short consultation with an advisor to express thoughts and feelings, so that they can feel supported and able to return to work effectively.

11. Develop a culture where “what is good for one is good for all” that reinforces respectful communication between all patients and staff regardless of role.

12. Provide additional paid time for nurses to complete incident reports.

13. Develop a specific incident report for WPV and include a tick box for verbal abuse.

14. Check in with the nurse after the abuse has occurred to discuss the effects and support the nurse in using coping skills.
Medication errors and patient falls often have their own specific incident report and all other incidents go on a generic form. A specific report for WPV would help highlight that it is an incident and including a tick box for verbal abuse would help emphasize that verbal abuse is included in WPV.

Discouraging verbal abuse is included in the admission packet under patient responsibilities; here is a typical patient responsibility given to a patient, found in the University of California San Francisco Medical Center (n.d., p. 6) admission packet: “To conduct yourself in a respectful manner in communications and interactions with UCSF staff, patients and visitors. This includes refraining from inappropriate, discriminatory, harassing or abusive language and behavior.” Patients do not follow respectful communication guidelines may experience increased irrationality that could escalate to PV (APNA, 2014). Violence-predictor tools include verbal cues, such as cursing, personal insults, and verbal threats as possible warning signs to pending increased risk of PV (Jacobsen, 2016). Hospitals need to assess and address verbal abuse not only to support nurses but also to prevent escalation to PV.

The researcher recommends nursing schools add more to the curriculum on WPV II prevention including addressing verbal abuse. One nurse made this comment: “Working as a nurse turned [out] to be very different than what we were thought in school it would be (sic).” Many nursing schools do not offer specialized training on how to manage violent patients. Most nursing schools do include tips on therapeutic conversations and patient satisfaction, but these do not provide the nurse with tools for therapeutic limit setting for verbal abuse. Nurses need the encouragement and the tools to set limits on patients’ verbally abusive behavior.
The researcher recommends regulators replace “guidelines” for WPV prevention with more specific, meaningful, and enforceable mandates. Hospital administrators are busy and often mandated behaviors take priority. In July 2016, Cal/OSHA will introduce more specific requirements (see Appendix E; B. Nakamura, personal communication, October 13, 2015). How Cal/OSHA finalizes, disseminates, and enforces mandates will be of interest. Unfortunately, Cal/OSHA only includes verbal abuse as WPV if the patient makes a verbal threat of physical harm.

Closing Remarks

Findings from this study are not extraordinary but do quantify other qualitative studies on barriers to reporting workplace incidents in acute hospitals. With the nursing shortage growing and with imminent Cal/OSHA mandates on WPV prevention in healthcare, now is a good time to increase understanding of all types of abuse and their effects. Nurses underreport all incidents. Focus on organizational-culture factors such as organizational justice and safety, which are rated more favorably in nurse reporters of abuse, may support greater reporting, leading to more knowledge and more effective prevention.

Patients verbally demean nurses and make verbal threats of physical harm at a very high rate—higher than physical abuse—and are the least reported. In this study nurses experienced at least once incident of verbal abuse and only 49% reported it. Language matters; what patients and their family members say to the nurse can vary in content, tone, volume, and cadence. The words that are spoken are accompanied by nonverbal facial expression, body posture and body movement. Many research articles describe the effects of verbal abuse from physician on nurse and nurse on nurse but little
research describes the effect of verbal abuse toward nurses by patients. What is known is that verbal abuse can be threatening and demeaning. Verbal abuse does have detrimental effects on nurses’ quality of work and home life, nursing turnover, clinical errors, and patient satisfaction with care. Workplace violence adds costs to operating a hospital, some studies state that prevention of WPV actually costs less than all the direct and indirect costs of WPV. Nurses need to report more, to make it harder to minimize or ignore the costs of verbal violence. Hospital management and leadership need to do more to ensure that nurses report more. Hospital management and leadership need to stop blaming the victim of violence, stop minimizing the impact of violence, and not allow worries about patient satisfaction take priority over nurse’s safety and wellbeing. Supporting nurses who are verbally abused does not have to be diminish patient satisfaction; rather, it can indirectly improve overall patient satisfaction. Providing support to nurses who face verbal abuse is mutually beneficial for nurses, patients and hospital administrators who are responsible for the fiscal result.

Workplace violence type II, where the patient or their family members, are abusive to the nursing staff is not knew, but it is increasing in frequency and intensity. It is time to interrupt the workplace-violence cycle and make hospitals a safe place to give and receive care.
REFERENCES


## APPENDIX A: FULL SURVEY INSTRUMENT

Please respond to the following statements based on the one option that best describes your experience.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>A few times a year or less</th>
<th>Once a month or less</th>
<th>Once a week</th>
<th>A few times a month</th>
<th>Once a week</th>
<th>Every day</th>
<th>A few times a month</th>
<th>Once a week</th>
<th>A few times a month</th>
<th>Once a week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel emotionally drained from my work</td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>I feel used up at the end of the workday</td>
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<tr>
<td>I feel frustrated by my job</td>
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</tbody>
</table>


Additional comments (optional): How does your job affect how you feel?

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Please respond to the following statements based on the one option that best describes your experience.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>To a very small extent</th>
<th>To a small extent</th>
<th>To a large extent</th>
<th>No opinion extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your paycheck reflect what you have contributed to the organization?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Is your last annual evaluation justified, given your performance?</td>
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<td></td>
</tr>
<tr>
<td>Have you been able to express your views and opinions during procedures to reduce workplace violence?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>To a very small extent</td>
<td>To a small extent</td>
<td>To a large extent</td>
<td>To a very large extent</td>
<td>No opinion</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Have workplace violence prevention procedures been applied consistently?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have workplace violence prevention procedures been based on accurate information?</td>
<td></td>
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</tr>
<tr>
<td>Have you been able to appeal the workplace violence prevention decisions arrived at by those procedures?</td>
<td></td>
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<tr>
<td>Have physicians treated you in a polite manner?</td>
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<td></td>
</tr>
<tr>
<td>Have physicians treated you with respect?</td>
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<tr>
<td>Have unit leaders explained the unit procedures thoroughly?</td>
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</tr>
<tr>
<td>Were the unit leader’s explanations regarding the unit procedures reasonable?</td>
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</tr>
<tr>
<td>Have unit leaders seemed to tailor their communications to individuals’ specific needs?</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Additional comments (optional): What is fair and not fair in your organization?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse input is well received in this clinical area</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>It is easy for personnel here to ask questions when there is something that they do not understand</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Medical errors are handled appropriately in this clinical area</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I know the proper channels to direct questions regarding patient safety in this clinical area</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>My suggestions about safety would be acted upon if I expressed them to hospital management</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hospital management supports my daily efforts</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hospital management doesn’t knowingly compromise patient safety</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Problem personnel are dealt with constructively by our hospital management</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
I get adequate, timely info about events that might affect my work from hospital management. □ Strongly disagree □ Disagree □ Agree □ Strongly agree □ No opinion

This hospital does a good job of training new personnel. □ Strongly disagree □ Disagree □ Agree □ Strongly agree □ No opinion

Trainees in my discipline are adequately supervised. □ Strongly disagree □ Disagree □ Agree □ Strongly agree □ No opinion

Additional comments (optional): What practice make your hospital safe or unsafe for patients & employees?

The questions below are about incidents you have experienced.

A **needle stick injury** is when a needle used on a patient punctures the skin of an employee.

Have you ever experienced a **needle stick injury**? □ □

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I DID NOT complete an incident report</td>
<td>I DID (or someone on my behalf did) complete an incident report</td>
</tr>
</tbody>
</table>

A **patient fall** is when a patient is observed or suspected of falling to the floor with some force, the fall may or may not result in injury.

Have you ever experienced a **patient falling** to the floor with some force? □ □

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I DID NOT complete an incident report</td>
<td>I DID (or someone on my behalf did) complete an incident report</td>
</tr>
</tbody>
</table>

A **medication error** is when a patient did not receive a regular or stat medication order, or received the wrong dose, the wrong time, the wrong form, or another patient’s medication.

Have you ever made a **medication error** that involved the patient? □ □

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, please recall the last incident and pick the answer below that best fits your experience.</td>
<td>If yes, please recall the last incident and pick the answer below that best fits your experience.</td>
</tr>
</tbody>
</table>
Verbal abuse includes others calling you names, insulting you, swearing at you, embarrassing or reprimanding you in public, yelling at you when there is no reason to yell, using a harsh or condescending tone, making vague verbal threats, and making sexually inappropriate comments.

Have you ever experienced verbal abuse from a patient or patient family member in the workplace?

If yes, please recall the last incident and pick the answer below that best fits your experience.

Mild physical abuse includes receiving deliberate or inadvertent physical contact with another person which results in restriction of freedom of movement, or causes pain/discomfort resolving within two hours. Mild physical abuse includes gestures and movements that imply a threat of bodily harm.

Have you ever experienced mild physical abuse from a patient or patient family member in the workplace?

If yes, please recall the last incident and pick the answer below that best fits your experience.

Moderate to severe physical abuse includes receiving deliberate or inadvertent physical contact with another person which results in loss of physical function, body part or limb; pain or discomfort lasting longer than two hours, or possibly injury being assessed by a health care professional. It also includes deliberate physical contact that is sexual in nature and being threatened with a weapon such a gun or knife.

Have you ever experienced moderate to severe physical abuse from a patient or patient family member in the workplace?

If yes, please recall the last incident and pick the answer below that best fits your experience.

Additional comments (optional). Comments can include details of incidents and how they affected you, barriers to reporting, and suggestions for change that would increase incident reporting.
Age: ______ Gender ____________ How many years have you been a nurse? ________

What is your role in the hospital? ____________________________________________

(Optional) How do you describe your cultural identity (list any race, ethnicity, culture or subculture that describes your identity): _________________________________

How would you describe your hospital (pick as many as apply):
□ Teaching hospital □ Urban □ Suburban □ Rural □ Magnet Status □ Unionized
□ Private for profit □ Private nonprofit □ County hospital
Other: _______________________________________________________________________

Approximately how many beds are in your hospital? ____________________________

Additional comments (optional)

Thank you very much for your time. Please return the completed survey to Feodora Jacobsen by email, feogeo@sbcglobal.net or in prepaid self-addressed envelope or in the plain envelope provided at an event.

Sincerely, Feo Jacobsen
APPENDIX B: PERMISSION TO USE THE INSTRUMENTS

From: Mind Garden
Sent: Tuesday, March 24, 2015 1:05 PM
To: feogeo@sbcglobal.net

Thank you for your order and for completing the Online Use Agreement. Please feel free to proceed with your study.

Best, Valorie Keller, Mind Garden, Inc.

On Tue, Mar 24, 2015 at 10:14 AM, <feogeo@sbcglobal.net> wrote:
Message-Id: <20150324170132.7F3AD6A01A9@web016.mivamerchant.net>
Date: Tue, 24 Mar 2015 13:01:32 -0400 (EDT)
Name: jacobsen, maria livina feodora
Email address: feogeo@sbcglobal.net
Phone number: 707-978-2705
Company/Institution: University of San Francisco
Order/Invoice number: 35574
Order Date: March 19, 2015
Project Title: Workplace culture, violence and incident reporting
Instrument Name: Maslach Burnout Inventory - Human Services Survey
I will compensate Mind Garden, Inc. for every use of this online form. I will put the instrument copyright on every page containing question items from this instrument. I will remove this form from online at the conclusion of my data collection. Once the number of administrations reaches the number purchased, I will purchase additional licenses or the survey will be closed to use. The form will not be available to the open Web. Ideal research practice involves knowing who is responding to my survey, although this is not always possible. I understand that Mind Garden recommends, but does not require, a unique login and password for every respondent. CAUTION: If I decide not to require a unique login for each respondent, the survey method I use may elicit a large number of responses to my survey. If the response count gets out of my control, I am responsible for compensating Mind Garden for every administration, regardless of circumstances. I will include info@mindgarden.com on my list of survey respondents so that Mind Garden can verify the proper use of the instrument. I will not send Mind Garden instruments in the text of an email or as a PDF file to participants. I understand that my use is governed by Mind Garden’s Terms of Service (http://mindgarden.com/tos.htm). The outside online survey website I will be using and how I plan to put this instrument online: I will be using Qualtrics and posting on the web. I will be using a few questions from the emotional exhaustion incorporated into my survey along with other questions. I will not require a password access to survey, so I will track how many accessed it and pay up if exceed license use.
Electronically signed on 3/24/2015 by m.l. feodora jacobsen.
Mind Garden, Inc.
info@mindgarden.com
Maslach Burnout Inventory™
Instruments and Scoring Guides
Forms: General, Human Services, & Educators

Christina Maslach
Susan E. Jackson
Michael P. Leiter
Wilmar B. Schaufeli
Richard L. Schwab

Published by Mind Garden
info@mindgarden.com
www.mindgarden.com

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For any other special purposes requiring permissions for reproduction of this instrument, please contact info@mindgarden.com.
From: zinta.byrne@colostate.edu
Sent: Monday, February 16, 2015 2:23 PM
To: feogeo@sbcglobal.net

Thanks so much for your email message Feodora. I’m sorry I missed your call and really appreciate you following up with email.

**Yes, you are more than welcome to use the items from the abridged measure.** Thank you for asking.

Best of luck with your research – I am intrigued by your passion and really hope you can make some progress in that effort.

If you have any desire to consider a measure of injustice, a former student of mine and I are seeking a collaborative organization to work with to further validate her measure of injustice. We have data from two samples of convenience, but really need an organization where there are major concerns surrounding injustice to confirm that our measure assesses those issues better than a measure of justice. Thus, we’d look to use both my abridged measure and the scale of injustice we developed. Let me know if you’re interested. Regardless, you are welcome to use the abridged justice measure.

Best regards, Zinta

Zinta S. Byrne, PhD | Professor, Industrial and Organizational Psychology

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**From:** feogeo@sbcglobal.net [mailto:feogeo@sbcglobal.net]
**Sent:** Monday, February 16, 2015 12:59 PM
**To:** Byrne,Zinta

**Subject:** Asking for permission to use Organizational Justice survey questions

Dear Dr. Byrne

I left you a voice mail message as well. I am a Doctoral student at University of San Francisco, School of Education, Organization and Leadership Department. I would like permission to use some of your questions in the **Abridged Measure of Organizational Justice survey tool.** The purpose of my research is to find correlations between the likelihood of reporting incidents in acute hospitals and organizational factors such as organizational justice.

I am also an exec hospital administrator and an adjunct nursing faculty. My passion is understanding and prevention workplace violence experienced by the front line nursing staff in acute hospitals.

Thanks for your time and consideration

Feodora Jacobsen
707-978-2705
feogeo@sbcglobal.net
February 17, 2015

Dear Feodora Jacobsen,

You have our permission to use any of the following Safety Attitudes Questionnaires and the corresponding scoring keys:

- Safety Attitudes Questionnaire – Short Form
- Safety Attitudes Questionnaire – Teamwork and Safety Climate
- Safety Attitudes Questionnaire – Ambulatory Version
- Safety Attitudes Questionnaire – ICU Version
- Safety Attitudes Questionnaire – Labor and Delivery Version
- Safety Attitudes Questionnaire – Operating Room Version
- Safety Attitudes Questionnaire – Pharmacy Version
- Safety Climate Survey

Please note, we do not have editable versions for any of the SAQ surveys but feel free to modify the surveys to meet your research endeavors.

Respectfully,

University of Texas at Houston-Memorial Hermann
Center for Healthcare Quality and Safety Team
APPENDIX C: INSTITUTIONAL REVIEW BOARD APPROVAL

To: Feodora Jacobsen  
From: Terence Patterson, IRB Chair  
Subject: Protocol #416  
Date: 04/24/2015

The Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco (USF) has reviewed your request for human subjects approval regarding your study.

Your project (IRB Protocol #416) with the title Workplace culture, violence and incident reporting has been approved by the University of San Francisco IRBPHS as Exempt according to 45CFR46.101(b). Your application for exemption has been verified because your project involves minimal risk to subjects as reviewed by the IRB on 04/24/2015.

Please note that changes to your protocol may affect its exempt status. Please submit a modification application within ten working days, indicating any changes to your research. Please include the Protocol number assigned to your application in your correspondence.

On behalf of the IRBPHS committee, I wish you much success in your endeavors.

Sincerely,

Terence Patterson, EdD, ABPP  
Professor & Chair, Institutional Review Board for the Protection of Human Subjects  
University of San Francisco  
irbaphs@usfca.edu  
https://www.axiommentor.com/pages/home.cfm
APPENDIX D: CONSENT TO PARTICIPATE IN HOSPITAL CULTURE, VIOLENCE TOWARDS NURSES, AND INCIDENT REPORTING SURVEY FOR REGISTERED NURSES WORKING IN AN ACUTE HOSPITALS IN CALIFORNIA

This research study is conducted by Feodora Jacobsen, a graduate student in the Department of Organization and Leadership at the University of San Francisco (USF). The faculty supervisor for this study is Dr. Patricia Mitchell, Chair, Dept. of Leadership Studies, USF.

The purpose of this research study is to understand the relationship between workplace culture and how often Registered Nurses formally report different types of incidents. Incidents including workplace violence such as verbal and physical abuse perpetrated by patients and their patient families.

The survey will take approximately 20 minutes to complete. It is voluntary, anonymous, and confidential. No identifying questions will be asked about your name or location or the hospital you work.

Completing the survey may elicit strong emotions, you can withdraw your consent and discontinue your participation at any time during the survey. Resources are usually available to discuss strong emotions through confidential services at your hospital (EAP) or the nationwide 24 hour crises line 1-800-273-TALK (8255). The possible benefits to completing the study are: you may become inspired to help prevent workplace violence and you will have access to the results of the study.

When you complete this survey you are encouraged to email Feodora Jacobsen at feogeo@sbcglobal.net with your mailing address in order to receive a token gift coffee
card. No addresses, emails or contact information will be linked to completed surveys or used for any other purpose than what is stated above.

You can contact Feodora Jacobsen if you have questions during the study at feogeo@sbcglobal.net. If you have questions at a later date you should contact the faculty sponsor Dr. Mitchell at Mitchell@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board atIRBPHS@usfca.edu.

By checking the button below you are consenting to be a participant in this study.
APPENDIX E: CALIFORNIA’S OSHA PROPOSAL

STANDARDS PRESENTATION
TO
CALIFORNIA OCCUPATIONAL SAFETY AND HEALTH STANDARDS BOARD

PROPOSED STATE STANDARD,
TITLE 8, CHAPTER 4

Add new Title 8 Section 3342 to read:

§ 3342. Workplace Violence Prevention in Health care.

(a) Scope and Application.

(1) Scope. This section applies to the following health care facilities, service categories, and operations:

(A) Health facilities, as defined below;
(B) Outpatient medical offices and clinics;
(C) Home health care and home-based hospice;
(D) Paramedic and emergency medical services, including these services when provided by firefighters and other emergency responders;
(E) Field operations such as mobile clinics and dispensing operations, medical outreach services, and other off-site operations;
(F) Drug treatment programs;
(G) Ancillary health care operations.

(2) Application.

(A) All employers with employees in operations identified in subsection (a)(1)(A) through (a)(1)(F) shall comply with subsections (c), (d), (e), (f), and (h).

(B) General acute care hospitals, acute psychiatric hospitals, and special hospitals shall also comply with subsection (g).

(C) Ancillary health care operations shall comply with this section by ensuring that the elements included in subsection (c), (d), (e), and (f) are addressed by the host establishment’s injury and illness prevention program or a separate workplace violence prevention plan for the operation. Recordkeeping shall be in accordance with subsection (h).

(3) The employer shall provide all safeguards required by this section, including provision of personal protective equipment, training, and medical services, at no cost to the employee, at a reasonable time and place for the employee, and during the employee’s working hours.

(b) Definitions.

“Acute psychiatric hospital” (APH) means a hospital, licensed by the California Department of Public Health as such in accordance with Section 1250(b), Title 22, California Code of Regulations, and all services within the hospital's license including, but not limited to, emergency, outpatient observation, and outpatient clinics located at the hospital facility and all off-site operations included within the hospital's license.

“Alarm” means a mechanical, electrical or electronic device that does not rely upon an employee’s vocalization in order to alert others.
“Ancillary health care operation” means a health care operation located in a workplace other than those listed in subsection (a)(1)(A) through (a)(1)(F). Examples of ancillary health care operations include retail clinics, school nurse operations, and workplace clinics.

“Chief” means the Chief of the Division of Occupational Safety and Health of the Department of Industrial Relations, or his or her designated representative.

“Dangerous weapon” means an instrument capable of inflicting death or serious bodily injury.

“Division” means the Division of Occupational Safety and Health of the Department of Industrial Relations.

“Emergency” means unanticipated circumstances that can be life-threatening or pose a risk of significant injuries to the patient, staff or public, requiring immediate action.

“Emergency medical services” means medical care provided pursuant to Title 22, Division 9, by employees who are certified EMT-1, certified EMT-II, or licensed paramedic personnel to the sick and injured at the scene of an emergency, during transport, or during inter-facility transfer.

“Engineering controls” means an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between the worker and the hazard. For purposes of reducing workplace violence hazards, engineering controls include, but are not limited to: electronic access controls to employee occupied areas; weapon detectors (installed or handheld); enclosed workstations with shatter-resistant glass; deep service counters; separate rooms or areas for high risk patients; locks on doors; furniture affixed to the floor; opaque glass in patient rooms (protects privacy, but allows the health care provider to see where the patient is before entering the room); closed-circuit television monitoring and video recording; sight-aids; and personal alarm devices.

“Environmental risk factors” means factors in the facility or area in which health care services or operations are conducted that may contribute to the likelihood or severity of a workplace violence incident. Environmental risk factors include risk factors associated with the specific task being performed, such as the collection of money.

“Field operation” means an operation conducted by employees that is outside of the employer’s fixed establishment, such as mobile clinics, health screening and medical outreach services, or dispensing of medications.

“General acute care hospital” (GACH) means a hospital, licensed by the California Department of Public Health as such in accordance with Section 1250(a),Title 22, California Code of Regulations and all services within the hospital's license including, but not limited to: emergency, outpatient observation, outpatient clinics, physical therapy and ambulatory surgery services located at the hospital facility, and all off-site operations included within the hospital's license.

“Health facility” means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, or treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer. (Ref: Health and Safety Code Section 1250). For the purposes of
this section, a health facility includes hospital based outpatient clinics (HBOCs) and other operations located at a health facility, and all off-site operations included within the license of the health facility. The term “health facility” includes facilities with the following bed classifications, as established by the California Department of Public Health:

(1) General acute care hospital
(2) Acute psychiatric hospital
(3) Skilled nursing facility
(4) Intermediate care facility
(5) Intermediate care facility/developmentally disabled habilitative
(6) Special hospital
(7) Intermediate care facility/developmentally disabled
(8) Intermediate care facility/developmentally disabled-nursing
(9) Congregate living health facility
(10) Correctional treatment center
(11) Nursing facility
(12) Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)
(13) Hospice facility

“Individually identifiable medical information” means medical information that includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

“Outpatient medical offices and clinics” means establishments other than those listed under the license of a General Acute Care Hospital, Acute Psychiatric Hospital or Special Hospital where patients are provided with diagnosis and treatment for medical or psychiatric care, but are not admitted for a 24-hour stay or longer. These establishments include, but are not limited to, physician’s offices, phlebotomy drawing stations, therapy offices, imaging centers, ambulatory surgery centers, and clinics.

“Patient classification system” means a method for establishing staffing requirements by unit, patient, and shift based on the assessment of individual patients by the registered nurse as specified in Title 22 for General Acute Care Hospitals.

“Patient contact” means providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient.

“Patient specific risk factors” means factors specific to a patient, such as use of drugs or alcohol, psychiatric condition or diagnosis, any condition or disease process that would cause confusion and/or disorientation or history of violence, which may increase the likelihood or severity of a workplace violence incident.
“Threat of violence” means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

“Work practice controls” means procedures, rules and staffing which are used to effectively reduce workplace violence hazards. Work practice controls include, but are not limited to: appropriate staffing levels; provision of dedicated safety personnel (i.e. security guards); employee training on workplace violence prevention methods; and employee training on procedures to follow in the event of a workplace violence incident.

“Workplace violence” means any act of violence or threat of violence that occurs at the workplace. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

(A) The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

(B) An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

(C) Four workplace violence types:

1. “Type 1 violence” means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

2. “Type 2 violence” means workplace violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.

3. “Type 3 violence” means workplace violence against an employee by a present or former employee, supervisor, or manager.

4. “Type 4 violence” means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

(c) Workplace Violence Prevention Plan. As part of the Injury and Illness Prevention Program (IIPP) required by Section 3203, every employer covered by this section shall establish, implement and maintain an effective workplace violence prevention plan (Plan) that is in effect at all times in every unit, service, and operation. The Plan shall be in writing, shall be specific to the hazards and corrective measures for the unit, service, or operation, and shall be available to employees at all times. The written Plan may be incorporated into the written IIPP or maintained as a separate document, and shall include all of the following elements:

(1) Names or job titles of the persons responsible for implementing the Plan.

(2) Effective procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including their
participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents. This process shall also include the involvement of security personnel who are employees of the facility, or representatives of employees who provide security services to the employer.

(3) Methods the employer will use to coordinate implementation of the Plan with other employers whose employees work in the health care facility, service, or operation, to ensure that those employers and employees have a role in implementing the Plan. These methods shall ensure that employees of other employers and temporary employees are provided the training required by subsection (f) and shall ensure that workplace violence incidents involving those employees are reported, investigated, and recorded.

(4) A policy prohibiting the employer from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs. The Plan shall also include effective procedures to accept and respond to reports of workplace violence, including Type 3 violence, and to prohibit retaliation against an employee who makes such a report.

(5) Procedures to ensure that supervisory and non-supervisory employees comply with the Plan in accordance with Section 3203(a)(2).

(6) Procedures to communicate with employees regarding workplace violence matters, including:
   (A) How employees will document and communicate to other employees and between shifts and units, information regarding conditions that may increase the potential for workplace violence incidents;
   (B) How an employee can report a violent incident, threat, or other workplace violence concern;
   (C) How employees can communicate workplace violence concerns without fear of reprisal;
   (D) How employee concerns will be investigated, and how employees will be informed of the results of the investigation and any corrective actions to be taken.

(7) Procedures to develop and provide the training required in subsection (f). Employees and their representatives shall be allowed to participate in developing and delivering the training.

(8) Assessment procedures to identify and evaluate environmental risk factors, including community-based risk factors, for each facility, unit, service, or operation. This shall include a review of all workplace violence incidents that occurred in the facility, service, or operation within the previous year, whether or not an injury occurred.
   (A) For fixed workplaces: Procedures to identify and evaluate environmental risk factors for workplace violence in each unit and area of the establishment, including areas surrounding the facility such as employee parking areas and other outdoor areas.
Assessment tools, environmental checklists, or other effective means shall be used to identify locations and situations where violent incidents are more likely to occur. Procedures shall specify the frequency with which such environmental assessments will take place. Environmental risk factors shall include, as applicable, but shall not necessarily be limited to, the following:

1. Employees working in locations isolated from other employees (including employees engaging in patient contact activities) because of being assigned to work alone or in remote locations, during night or early morning hours, or where an assilant could prevent entry into the work area by responders or other employees;
2. Poor illumination or blocked visibility or where employees or possible assailants may be present;
3. Lack of physical barriers between employees and persons at risk of committing workplace violence;
4. Lack of effective escape routes;
5. Obstacles and impediments to accessing alarm systems;
6. Locations within the facility where alarm systems are not operational;
7. Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits;
8. Presence of furnishings or any objects that can be used as weapons in the areas where patient contact activities are performed;
9. Storage of high-value items, currency, or pharmaceuticals;

(B) For field operations such as mobile clinics and dispensing operations, medical outreach services, and other off-site operations: Procedures to identify and evaluate environmental risk factors, including those listed in subsection (A), at each site where services are provided, and procedures for communicating with dispatching authorities to identify any risk factors present at the scene and ensure that appropriate assistance will be provided by cooperating agencies if needed.

(C) For home health care and home-based hospice: Procedures to identify and evaluate – during intake procedures, at the time of the initial visit, and during subsequent visits whenever there is a change in conditions – environmental risk factors such as the presence of weapons, evidence of substance abuse, or the presence of uncooperative cohabitants.

(D) For paramedic and other emergency medical services: Procedures for communicating with dispatching authorities to identify any risk factors present at the scene and ensure that appropriate assistance will be provided by cooperating agencies if needed.

(E) For ancillary health care operations: Procedures to identify and evaluate environmental risk factors, including those listed in subsection (A), in the area where the health care operation is located and in other areas of the host establishment.
(9) Procedures to identify and evaluate patient-specific risk factors and assess visitors. Assessment tools, decision trees, algorithms, or other effective means shall be used to identify situations in which patient-specific Type 2 violence is more likely to occur and to assess visitors or other persons who display disruptive behavior or otherwise pose a risk of committing Type 1 workplace violence. This includes, as applicable, procedures for paramedic and other emergency medical services to communicate with receiving facilities, and for receiving facilities to communicate with law enforcement and paramedic and other emergency medical services, to identify risk factors associated with patients who are being transported to the receiving facility. Patient-specific factors shall include, but not necessarily be limited to, the following:
   - A patient’s mental status and conditions that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;
   - A patient’s treatment and medication status, type, and dosage, as is known to the health facility and employees;
   - A patient’s history of violence, as is known to the health facility and employees;
   - Any disruptive or threatening behavior displayed by a patient.

(10) Procedures to correct workplace violence hazards in a timely manner in accordance with Section 3203(a)(6). Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible. The employer shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards within seven days of the discovery of the hazard. When an identified corrective measure cannot be implemented within this timeframe, the employer shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures. Corrective measures shall include, as applicable, but shall not be limited to:
   - Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident.
   - Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.
   - Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.
(D) Removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2 violence are reasonably anticipated to be present.

(E) Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1 or Type 2 violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.

(F) Maintaining sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner.

(G) Installing an alarm system or other effective means by which employees can summon security and other aid to defuse or respond to an actual or potential workplace violence emergency.

(H) Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.

(I) Establishing an effective response plan for actual or potential workplace violence emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm.

(J) Assigning or placing minimum numbers of staff, to reduce patient-specific Type 2 workplace violence hazards.

(11) Procedures for post-incident response and investigation, including:

(A) Providing immediate medical care or first aid to employees who have been injured in the incident;

(B) Identifying all employees involved in the incident;

(C) Providing individual trauma counseling to all employees affected by the incident;

(D) Conducting a post-incident debriefing as soon as possible after the incident with all employees, supervisors, and security involved in the incident;

(E) Reviewing any patient-specific risk factors and any risk reduction measures that were specified for that patient;

(F) Reviewing whether appropriate corrective measures developed under the Plan – such as adequate staffing, provision and use of alarms or other means of summoning assistance, and response by staff or law enforcement – were effectively implemented;

(G) Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause of the incident, and whether any measure would have prevented the injury.
(d) Violent Incident Log. The employer shall record information in a violent incident log (Log) about every incident, post-incident response, and workplace violence injury investigation performed in accordance with subsection (c)(11). The Log shall be reviewed during the annual review of the Plan required in subsection (e). The information recorded in the Log shall include, but not necessarily be limited to:

1. The date, time, specific location, and department of the incident;
2. A section that each employee who experienced workplace violence shall be allowed to complete, including:
   (A) A detailed description of the incident,
   (B) A classification of who committed the violence, including whether the perpetrator was a patient/client/customer, family/friend of a patient/client/customer, stranger with criminal intent, coworker, supervisor/manager, partner/spouse, parent/relative, or other perpetrator,
   (C) A classification of circumstances at the time of the incident, including whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances.
3. A description of the incident that includes:
   (A) A classification of where the incident occurred, including whether it was in a patient or client room, emergency room or urgent care, hallway, waiting room, restroom or bathroom, parking lot or other area outside the building, personal residence, break room, cafeteria, or other area.
   (B) The type of incident, including whether it involved:
      1. Physical attack, including biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching, or spitting;
      2. Attack with a weapon or object, including a gun, knife, or other object;
      3. Threat of physical force or threat of the use of a weapon or other object;
      4. Sexual assault or threat, including rape/attempted rape, physical display, or unwanted verbal/physical sexual contact;
      5. Animal attack;
      6. Other.
4. Consequences of the incident, including:
   (A) Whether medical treatment was provided to the employee;
   (B) Who, if anyone, provided necessary assistance to conclude the incident;
   (C) Whether security was contacted and whether law enforcement was contacted;
   (D) Amount of time taken off work, if any;
   (E) Actions taken to protect employees from a continuing threat, if any.
5. Information about the person completing the Log including their name, title, phone number, email address, and the date completed.
STANDARDS PRESENTATION
TO
CALIFORNIA OCCUPATIONAL SAFETY AND HEALTH STANDARDS BOARD

PROPOSED STATE STANDARD,
TITLE 8, CHAPTER 4

Note to subsection (d): “Medical information” as defined by Civil Code Section 56.05(j) shall not be included in the Log.

(e) Annual Review of the Workplace Violence Prevention Plan. The employer shall establish and implement a system to review the effectiveness of the Plan at least annually, in conjunction with employees regarding their respective work areas, services, and operations. Problems found during the review shall be corrected in accordance with subsection (c)(10). The review shall include evaluation of the following:
   1. Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence;
   2. Sufficiency of security systems, including alarms, emergency response, and security personnel availability;
   3. Job design, equipment, and facilities;
   4. Security risks associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas and other outdoor areas.

(f) Training. The employer shall provide effective training to all employees, including temporary employees, working in the facility, unit, service, or operation. The training shall address the workplace violence hazards identified in the facility, unit, service, or operation, the corrective measures the employer has implemented, and the activities that each employee is reasonably anticipated to perform under the Plan. The employer shall have an effective procedure for obtaining the active involvement of employees and their representatives in developing training curricula and training materials, conducting training sessions, and reviewing and revising the training program. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.
   1. All employees working in the facility, unit, service, or operation shall be provided initial training as described in subsection (f)(1)(A) when the Plan is first established and when an employee is newly hired or newly assigned to perform duties for which the training required in this subsection was not previously provided, and shall also be provided additional training as described in subsection (f)(1)(B). An employer that employs proprietary private security officers, contracts with a private patrol operator or other security service to provide security guards, or hires or contracts for the services of peace officers, shall arrange for those personnel to participate in the training provided to the employer’s employees.
   2. Initial training shall include:
      1. An explanation of the employer’s workplace violence prevention plan, including the employer’s hazard identification and evaluation procedures, general and personal safety measures the employer has implemented, how the employee may communicate concerns about workplace violence without fear of reprisal, how the
employer will address workplace violence incidents, and how the employee can participate in reviewing and revising the Plan;
2. How to recognize the potential for violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence;
3. Strategies to avoid physical harm;
4. How to report violent incidents to law enforcement;
5. Any resources available to employees for coping with incidents of violence, including, but not limited to, critical incident stress debriefing or employee assistance programs;
6. An opportunity for interactive questions and answers with a person knowledgeable about the employer’s workplace violence prevention plan.

(B) Additional training shall be provided when new equipment or work practices are introduced or when a new or previously unrecognized workplace violence hazard has been identified. The additional training may be limited to addressing the new equipment or work practice or new workplace hazard.

(2) Employees performing patient contact activities and those employees’ supervisors shall be provided refresher training at least annually to review the topics included in the initial training and the results of the annual review required in subsection (e). Refresher training shall include an opportunity for interactive questions and answers with a person knowledgeable about the employer’s workplace violence prevention plan.

(3) Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior shall be provided training on the following topics prior to initial assignment and at least annually thereafter. This is in addition to the training required in subsection (a)(1). This additional training shall include:
(A) General and personal safety measures;
(B) Aggression and violence predicting factors;
(C) The assault cycle;
(D) Characteristics of aggressive and violent patients and victims;
(E) Verbal and physical maneuvers to defuse and prevent violent behavior;
(F) Strategies to prevent physical harm;
(G) Restraining techniques;
(H) Appropriate use of medications as chemical restraints;
(I) An opportunity to practice the maneuvers and techniques included in the training with other employees they will work with, including a meeting to debrief the practice session. Problems found shall be corrected.

(4) All personnel present in health care facilities, services, and operations shall be trained on the employer’s Plan and what to do in the event of an alarm or other notification of emergency. Non-employee personnel who are reasonably anticipated to participate in
The report to the Division any incident involving either of the following:

- The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
- An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

2. The report to the Division required by subsection (g)(1) shall be made within 24 hours, after the employer knows or with diligent inquiry would have known of the incident, if the incident resulted in injury, involves the use of a firearm or other dangerous weapon, or presents an urgent or emergent threat to the welfare, health, or safety of hospital personnel.

3. All other reports to the Division required by subsection (g)(1) shall be made within 72 hours.

4. Reports shall include, at a minimum, the following items:
   - Hospital name, site address, hospital representative, phone number, and email address, and the name, representative name, and contact information for any other employer of employees affected by the incident;
   - Date, time, and specific location of the incident;
   - A brief description of the incident;
   - The number of employees injured and the types of injuries sustained;
   - Whether security or law enforcement was contacted, and what agencies responded;
   - Whether there is a continuing threat, and if so, what measures are being taken to protect employees;
   - A unique incident identifier;
   - Whether the incident was reported to the nearest Division district office as required in Section 342.

   NOTE: This report does not relieve the employer of the requirements of Section 342 to report a serious injury, illness, or death to the nearest Division district office.

5. The report shall not include any employee or patient names. Employee names shall be furnished upon request to the Division.

6. The employer shall provide supplemental information to the Division regarding the incident within four hours of any request.
(6) Reports shall be provided through a specific online mechanism established by the Division for this purpose.

(b) Recordkeeping.
   (1) Records of workplace violence hazard identification, evaluation, and correction shall be created and maintained in accordance with Section 3203(b), except that the Exception to (b)(1) in Section 3203 does not apply.
   (2) Training records shall be created and maintained for a minimum of one year and include training dates, contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training sessions. Section 3203(b) EXCEPTION NO. 1 does not apply to these training records.
   (3) Records of violent incidents, including but not limited to, violent incident logs required by subsection (d), reports required by subsection (g), and workplace violence injury investigations conducted pursuant to subsection (c)(11), shall be maintained for a minimum of five years. These records shall not contain “medical information” as defined by Civil Code Section 56.05(j).
   (4) All records required by this subsection shall be made available to the Chief on request, for examination and copying.
   (5) All records required by this subsection shall be made available to employees and their representatives, on request, for examination and copying in accordance with Section 3204(e)(1) of these orders.
   (6) Records required by Division 1, Chapter 7, Subchapter 1, Occupational Injury or Illness Reports and Records, of these orders shall be created and maintained in accordance with those orders.

Authority: Labor Code Section 142.3. Reference: Labor Code Sections 142.3 and 6401.8.