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In Conversation with... Cheryl Jones about Addressing Workplace Violence and Creating a Safer Workplace

October 31, 2023
Jones CB. In Conversation with.. Cheryl Jones about Addressing Workplace Violence and Creating a Safer Workplace. PSNet [internet]. 2023.
https://psnet.ahrq.gov/perspective/conversation-cheryl-jones-about-addressing-workplace-violence-and-creating-safer

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Editor's note: Cheryl B. Jones is a professor, director of the Hillman Scholars Program, and interim associate dean of the School of Nursing's PhD program at the University of North Carolina at Chapel Hill. We spoke to her about workplace violence trends in healthcare settings and how we can create a safer work environment for healthcare staff.

Sarah Mossburg: Can you tell us about yourself and your current role?

Cheryl B. Jones: I am a Professor at the University of North Carolina Chapel Hill, and currently I serve as interim associate dean for our PhD program and PhD/post-doctoral programs. I'm also the Director of the Hillman Scholars Program, a BSN through PhD pathway for nurses to be prepared as nurse scientists.

Sarah Mossburg: Can you describe, at a high level, the focus of your research and its intersection with workplace violence?

Cheryl B. Jones: I've been studying the healthcare workforce for over 30 years. I began by looking at the cost of nurse turnover, and later I examined the relationship between turnover and the work environment. I have also studied other aspects of the work environment, like staffing, and more recently, workplace violence with my colleague, Dr. Sinhye Kim, with whom I've coauthored three papers. My work largely focuses on the organization, delivery, and financing of care, and how the healthcare system and the workforce affect care delivered to patients and their families. I focus on how we can improve the work environment for staff, and, in turn, the care for patients and families.

Sarah Mossburg: What types of violence are healthcare workers experiencing? For example, patient/family to workers, staff to staff? And what forms of violence are we seeing: Is it physical, verbal, something else?

Cheryl B. Jones: Violence can take any of the forms you mentioned. There is certainly violence from patient and family toward staff, but also bullying and other negative behaviors occur between staff, both among the same kinds of professionals and across professional groups. When you're working in an organization where there are clear power differentials and stressful conditions, there's always potential for some level of tension, some of which may lead to violence.

Workplace violence has always been present in healthcare. We've seen increased reporting coming out of the pandemic, especially violence from patients and families toward healthcare providers. Workplace violence can take a broad spectrum of forms, from verbal abuse to mild and more violent physical acts against healthcare workers. Based on findings from our team's research, there's a greater potential for verbal violence, and there is increasing fear about acts of physical violence targeting healthcare providers.[1] We've seen recently in the press that shootings have occurred in healthcare organizations, with patients or family members targeting healthcare providers, so workplace violence can have devastating effects.

Sarah Mossburg: You mentioned increased reports of violence during the pandemic. Do you think that the incidence of violence is increasing, or are we just shining a spotlight on it?

Cheryl B. Jones: I think it could be a little of both. In social media and the traditional press, we have seen the public reporting of specific violent events that have occurred. In some cases, it's hard to discern if the reporting is true, if the incidence of workplace violence has really increased, or if better reporting is shining the spotlight on it. Regardless, this important organizational and patient safety concern deserves focused attention.

Sarah Mossburg: Are there certain types of workplace violence that are more common?

Cheryl B. Jones: We hear more about the verbal and physical violence from patients and families directed toward healthcare workers today. We're also seeing more about bullying among staff in the workplace. Our findings indicated that verbal violence from patients (e.g., insults, threats, screaming, cursing) occurs most frequently, followed by verbal violence from visitors (including family members) and physical violence from patients (e.g., hitting, grabbing, biting, scratching).

Not always "framed" as violence, bullying may involve some behaviors, such as micro-aggressions, that could be considered violence-like behaviors, especially verbal bullying. I think the most concerning, at least in the immediate sense, is the violence that occurs from patients and family toward healthcare providers because the exposure of clinicians to patients is broad and sometimes longer-term. Also, providers are vulnerable if they lack information about high-risk situations, the processes and systems available to help address them, and the resources needed to respond to an act of violence that may be aimed at them.

Sarah Mossburg: Are there certain settings that have higher incidence of workplace violence?

Cheryl B. Jones: Hospitals are a common setting because they admit large numbers of patients and employ large numbers of healthcare professionals, with opportunities for workplace violence events to occur. Although we think that certain units may have a patient population that may predispose workplace violence to occur, the reality is that we see workplace violence across all types of units, even perinatal care. Opportunities for workplace violence occur in long-term care facilities because of their patient

population and the types of care they deliver.

Sarah Mossburg: What are some of the challenges in understanding workplace violence?

Cheryl B. Jones: I think that challenges on multiple levels—societal, systemic, and organizational—give rise to violence. It's not as simple as one level versus another, but rather it's a multilevel problem. There are even challenges at a unit level, to some degree, where staff working on certain units within hospitals are more familiar with exposure to violence arising from patients or family members. Patients admitted to the emergency department with problems may predispose them to exhibit aggressive behaviors, or the unit may be short-staffed, or care provided on the unit may be delayed. These and other factors in the emergency department environment could elicit violent behaviors.

At the organizational level, systems may be lacking for staff to safely report incidents of violence, which makes it hard to understand the real magnitude of the problem. There are also issues with staffing. Nurse staffing has been a great challenge to address coming out of the pandemic. If patients and families don't feel they are receiving proper care or if there are not sufficient staff to care for their loved ones, then they may be more likely to act out violently in some way.

Also, I think it's important to acknowledge challenges at the societal level. In recent years, in addition to workplace violence events that may occur in healthcare organizations, many violent incidents have been reported across the country. These events threaten the safety of all of us. Patients and families assume that healthcare providers and organizations are safe places—they actually *treat* victims of physical and psychological violence. But because violence is occurring across the country and workplace violence is occurring in healthcare organizations, patients and families may be hesitant to seek care for fear of being exposed to violence. There should be a consensus at the societal and policy levels that healthcare providers are safe environments for everyone who seeks care.

Sarah Mossburg: You mentioned the potential for underreporting due to the lack of available reporting systems. Are there other factors that may contribute to underreporting?

Cheryl B. Jones: I think there are a few things. For example, some reporting systems that we do have are complicated, difficult to use, or not easily accessible. Clinicians are busy, and it's hard for them to find time to report, especially if that means taking time away from their patients. It is also one more thing for health professionals to do or to remember to do when they are already stretched. There is fear among healthcare clinicians of potential retribution from reporting. Staff could fear that reporting might negatively affect them, put their jobs at risk, or be shared with family members of, say, a patient exhibiting violent behaviors who could hold it against the clinician.

Staff may also believe that nothing will change or improve, even if they put time and effort into reporting incidents, and this belief discourages them from reporting. The absence or lack of system-level supports after an incident has been reported is also a factor contributing to under-reporting.

There are a number of challenges with reporting and making it easier for clinicians to report acts of violence when they occur. There is interest in electronic apps that would allow patients, families, and staff to report acts of violence more easily, but these solutions are not widely available at this time.

Sarah Mossburg: Do you think healthcare staff may see workplace violence as status quo? Meaning, do you think that staff are so accustomed to workplace violence that the line between verbal incivility and verbal violence is blurred, making it difficult for staff to recognize violence?

Cheryl B. Jones: Let's face it: Workplace violence is often tolerated by clinicians because they see it as a part of the job. A lot of violence, especially verbal, goes unrecognized or dismissed because clinicians expect it, and therefore they tolerate it on some level until it escalates.

Sarah Mossburg: What kinds of long-lasting impacts do you see on the workforce and individuals related to workplace violence?

Cheryl B. Jones: In some of the work I've done with Dr. Kim and other colleagues, we've reported a connection between workplace violence and burnout. We know that burnout can lead to an increase in sick time or missed time from work and, ultimately, staff departures from organizations. Right now, there is a shortage of healthcare workers, particularly in certain segments of the workforce, such as nurses. When violence is layered on top of an already stressful work environment, it could potentially escalate problems with burnout, turnover, and staffing shortages.

Sarah Mossburg: How do you think workplace violence impacts patient safety?

Cheryl B. Jones: When workplace violence occurs, it can spill over and make others—patients, visitors, and staff—fearful about what might happen to them. Patients may worry about what could happen to them during their stay, and the uncertainty and at times abrupt occurrences of violence can make both patients and staff feel helpless or psychologically unsafe. The experience of a violent event can linger with a person for a long period of time. The person or persons who experience the event may feel the psychological effects into the future. Nurses, physicians, and other clinicians exposed to violence may experience burnout. With or without burnout, the disturbance of the event could change structures and processes in ways that both disrupt workflows and cause errors in care. Workplace violence can disrupt the patient safety culture and limit leaders' ability to create a safe patient environment. It can also cause patients, families, and clinicians to worry about their safety in the healthcare environment and erode trust in the organization and system.

Sarah Mossburg: What are some things we should think about at the organizational and systemic levels to reduce workplace violence?

Cheryl B. Jones: I think when addressing the problem of workplace violence, focusing on a provider or organizational level is only one piece of the puzzle. It really is a multilayered problem that starts with policymakers, payers, and providers, including healthcare organizations.

Organizations can create a better work environment that supports better care by addressing the organizational concerns that give rise to unhappy patients, including increasing staffing, addressing clinician burnout, and creating a safety culture for both patients and clinicians. When the healthcare workforce is tired, burned out, and stressed out, it's really important to address those issues so that the environment for care delivery is safe on a basic level.

Organizations can also think carefully about the organizational actions needed, including evidence from the literature, the Joint Commission, the National Academy of Medicine, and other national groups.[2] A broad organizational approach should include technologies that are needed to address challenges related to the reporting of workplace violence events and the collection of workplace violence event data. These technologies could be available to staff—and to patients and families—to engage those in the environment to report an event.

We hear a lot about de-escalation techniques, and I think those are important when it becomes apparent that a situation is going awry. But in some cases, these techniques are not enough. You probably heard about the recent incident in Oregon, where a security guard suffered a fatal injury from a patient's family member. At some point, it's almost too late for de-escalation when a situation reaches the point of reporting. Verbal violence may be a first indicator of potential physical violence, so it's important to be attuned to those acts when they occur, to take steps toward prevention of a workplace violence event, and to be vigilant about reporting. Reporting systems must be safe, convenient, and not overburdensome for staff. We must also educate workers at all levels to understand workplace violence, to know when and how to take appropriate actions, and to follow accepted organizational procedures and professional standards.

Sarah Mossburg: It sounds like you're advocating for addressing some of the root causes of an unsafe work environment that may contribute to workplace violence. Organizations should be thinking about staffing, policies around reporting, monitoring, and being alert to the signals they're seeing in those reports, so that they can identify early indicators of a rise in violence.

Cheryl B. Jones: Absolutely. We know that violence is occurring, so organizations have to be diligent, and situational awareness within an organization is important. Some requirements today, such as those from the Joint Commission,[3] require organizations to be more diligent and have systems and processes in place to protect patients and staff. Basic patient safety activities, which include promoting teamwork, good handoffs, timely responses to patients and families, appropriate sharing of information, and good transitions in care, help build a culture of patient safety. We know that a good patient safety culture is a culture where people feel psychologically safe working, where they can speak up when things are going wrong, and where they want to work.

Sarah Mossburg: What do you see as some of the greatest opportunities for improvement, as it relates to workplace violence?

Cheryl B. Jones: I think there are several opportunities to improve current approaches to addressing workplace violence, such as implementing safer, more convenient, and more user-friendly reporting systems. There is also an opportunity to help organizational leaders and managers improve responses to, and management of, workplace violence events. A recent Health Affairs blog outlined some of these opportunities,[3] and steps have been outlined from other professional and regulatory groups. Management and leadership support can really make a difference. When staff feel psychologically safe, feel heard by their managers and leaders, and believe managers and leaders will act on reported information, they are more likely to report workplace violence when it occurs.

Sarah Mossburg: What reporting methods or strategies would you recommend that organizations use to better understand how, where, and why workplace violence occurs?

Cheryl B. Jones: We should think about how we can leverage technology to address workplace violence and make it easier for clinicians and others to report. The systems that we've had in the past are complicated, time consuming, and often onerous to use. Having reporting systems in place that facilitate the reporting of events when they actually occur is important.

Sarah Mossburg: We've talked a lot about the big picture of addressing workplace violence at the organizational level. What are some ways on a day-to-day basis that frontline healthcare workers can address the violence that they're seeing and experiencing?

Cheryl B. Jones: Certainly, if they're trained on organizational procedures and policies to address workplace violence when it occurs, and in de-escalation techniques, that will be important. I think it's easy to point to steps that workers can take, but addressing workplace violence is a systemic problem. It's important that staff know what to do if a situation escalates and what resources are available to them, but that's only a very small piece of the puzzle. Staff training is important, but organizational supports are critical.

When you look at the statistics, healthcare workers are four to five times more likely to be exposed to workplace violence than any other industry.[4] They operate in high-stress and often unstable environments that can put them in situations that expose them to violence.[5] We need to make workers feel safe and put resources at their fingertips.

You have to think about the people we serve in healthcare. They come in when they themselves or their family members are at their most vulnerable. If the healthcare work environment doesn't support the delivery of care, and patients and families don't feel that they and their loved ones are getting the care that they need, I think we can, on some level, understand why they might feel dissatisfied with care and lash out. But if the environment that exists doesn't give rise to those feelings of dissatisfaction to start with, then there we might see workplace violence decline.

Sarah Mossburg: What you just said makes me think that people are almost in a fight or flight response because they're just so overwhelmed in some situations. I agree with your point that you can understand, to some extent, where some of that violence comes from.

Cheryl B. Jones: I do understand where patients' and families' anger or concern may come from; but I don't truly understand where the *violence* comes from. However, the feelings of vulnerability in a system about your health and safety and that of your loved ones, or feelings that care is not delivered safely, could create a sense of urgency that pushes people over the edge at times.

Sarah Mossburg: You seemed to be making the point that we have to be careful not to rely solely on how healthcare workers can fix violence in the moment just because they happen to be the ones experiencing it. That seems to align with the way we often think about patient safety: just because a healthcare worker was at the blunt end of an error, doesn't mean that they were the cause of that error, and should be able to stop it from occurring next time. Do you agree with that framing?

Cheryl B. Jones: I absolutely agree. Patient safety approaches generally emphasize a "systems" approach to create safe work environments; thinking about workplace violence similarly could help address the root causes of workplace violence. If we give healthcare workers the tools and techniques to deal with workplace violence, as we do with patient safety—such as creating a patient-centered environment, examining the root causes of workplace violence, debriefing with staff when a workplace violence event occur, and creating response teams to address workplace violence events in the moment—then we could move toward creating an environment that is safer for patients, families, and staff. We know that there's a connection between patient safety culture and healthcare workers feeling like they're in an environment where they can practice safely. If we viewed workplace violence as part of that patient safety culture, then workers and patients may feel safer when they enter the healthcare setting and receive care.

Sarah Mossburg: You mentioned de-escalation techniques earlier. Are those effective, and are they being used?

Cheryl B. Jones: A lot of training around de-escalation is occurring across the country in hospitals and various healthcare settings. I think de-escalation techniques are necessary but are not sufficient. You need other areas of support, like leadership support, access to security staff, and supportive technologies because de-escalation can help, but it is unlikely to solve the problem entirely. It's a matter of having a system in place so that resources are available and easily accessible for staff when needed. It gets back to having a safe environment with resources in place in a way that individuals can access the resources, report an event when it happens, and quickly get help when they need it.

Sarah Mossburg: You just mentioned access to security. I've seen in the news and heard from colleagues that health systems are increasing security in response to the rise in incidents of workplace violence. Is that correct, and what are your thoughts about that?

Cheryl B. Jones: Yes, I'm reading and hearing about it in the press and on the news as you are. I've seen there are systems creating and deploying their own police forces. I think it's a sad state that we're here. Patients and families are at their most vulnerable when they come to receive healthcare. They come to us because they want or need our help. When the conditions are such that they don't get the help they need, don't get it fast enough, have to wait long periods of time with no response from providers, or come into the emergency department but are sent home only to bounce back again, it creates an environment where people stop trusting the system. It's a larger, systemic problem, it's an organizational problem, and then it's really a problem of public policy.

Sarah Mossburg: You've mentioned policy makers as one of the potential shareholders involved in addressing workplace violence. Do you have thoughts about what that might look like?

Cheryl B. Jones: There are different types of policy, including public policy, system policies (like the Joint Commission and other groups), and organizational policies. I think you really need policies at all those levels.

I think on a public policy level, legislation is needed to support and incentivize organizations to report workplace violence more accurately. Congress has introduced a bill called the Workplace Violence Prevention for Health Care and Social Service Workers Act, which has passed the house and is now in the

Senate. We need our legislators to take action to protect patients and healthcare workers when they are in healthcare settings.

In healthcare, policies have been created that require organizations to report patient outcomes, including satisfaction with care. Patient satisfaction is an element of healthcare reimbursement. What can happen is that organizations may fear having any reports released that indicates their system may have experienced a workplace violence incident. On a public policy level, attention should be given to supporting systems and organizations in more accurately reporting workplace violence, such as incentivizing them to use reporting systems and technologies that enable tracking of events. Thus, interventions are needed—through legislation and industry-wide changes—to address workplace violence.

Sarah Mossburg: What are some areas for future research in this field?

Cheryl B. Jones: We need to look at how clinicians, nurses, physicians, and others who experience workplace violence are affected. We've talked about how similar workplace violence is to quality and patient safety concerns. Research to develop, pilot, implement, evaluate, and modify interventions to address workplace violence, along with the measurement of workplace violence, are areas ripe for study. We can look to theories that come from within and outside of healthcare, including health services research approaches, organizational theory, and organizational psychology, as guides for the theoretical and conceptual framing of research.

We also need to look at the effectiveness of strategies such as technologies, de-escalation techniques, and programs to address workplace safety. We should examine the effectiveness as well as the cost and return on investment of implementing these kinds of programs. Because research on workplace violence is emerging, we need to focus on both the *substantive* areas associated with workplace violence, as well as the *methodological* areas to build the science and contribute to generalizable knowledge.

Sarah Mossburg: Are you aware of any promising research exploring ways to prevent workplace violence from occurring?

Cheryl B. Jones: The research emerging from local facilities and systems around the use of technologies, applications, and artificial intelligence (AI) for reporting are intriguing. For example, studies are underway examining the use of apps that allow clinicians and patients to report workplace violence. I'm sure there are potential AI uses and implications for workplace violence and patient safety that we're not adequately utilizing at this point. The world around technology and the use of AI is ripe for future research.

This focus goes hand in hand with some of the policy work that could be directed at addressing workplace violence, based on research supported through the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and private foundations. These efforts are critical. These groups support the implementation of local quality improvement initiatives that could focus on workplace violence.

Sarah Mossburg: Are there any new improvements that have been shown to be impactful on mitigating workplace violence?

Cheryl B. Jones: Organizations now have workplace violence or workplace safety committees, so I think those kinds of things should definitely be supported. We can use strategies we know work in patient safety and quality—such as root-cause analysis, rapid response teams, and event debriefing—to understand what happened during incidents of workplace violence, identify what processes and policies need to change, and determine what levers need to be pulled at the practice level to support quality improvement, and at the policy level to bring about meaningful changes in organizations.

I mentioned management and leadership support earlier. We know that in patient safety, safety champions are needed to support patient safety initiatives. Similarly, we need leaders to champion initiatives that address worker safety, protect and support staff when incidents happen, and ultimately protect patients.

Sarah Mossburg: That's a great suggestion. It was interesting to hear you talk about workplace safety committees as well. Before we close, is there anything that I didn't ask you that you think would be important to talk about?

Cheryl B. Jones: I'd like to reinforce the links among workplace violence, the work environment, and the quality and safety of patient care. We know that conditions in the work environment can lead to clinician burnout, feelings of being psychologically unsafe, and potentially to organizational turnover and departures from healthcare organizations and perhaps even the profession. We're in the midst of a healthcare workforce shortage. If we're serious about keeping our workforce healthy and in place, we must pay attention to workplace violence. It is one of those things that can tip people over in their decision to leave a unit, leave an organization, and maybe even to leave the workforce. At a time when we critically need healthcare workers, we need to appreciate the importance of addressing the work environment, including workplace violence.

The nature of violence is different in different situations. It can arise from patients and families, as well as among healthcare workers. We need to understand more about the workers themselves and what happens in the work environment, and we need to engage patients and families to understand and address what gives rise to violence, and how workplace violence affects patients and families. We need to understand all angles to identify strategies that address the antecedents, processes, and consequences of workplace violence.

Sarah Mossburg: That was such a perfect call to action for us to end on. Thank you so much for talking to us today.

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