Are Healthcare Professionals Optimistic about Workplace Violence?

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Article

Abstract

Healthcare workers are at an elevated risk of workplace violence. Optimistic bias is the misperception that bad things happen to other people. This article discusses the study methods that included a convenience sample (n = 488) of healthcare professionals in multiple hospitals in one region. A survey of these professionals to explore potential bias related to workplace violence found that participants exhibited realistic (or pessimistic) risk perception about the likelihood of experiencing workplace violence. Front-line workers (e.g., nurses and interns) exhibited pessimistic bias, believing they were more likely than professionals in other fields to experience physical violence at work. Risk perception was related to age with young professionals being more optimistic. The discussion section offers implications for practice to incorporate safety measures that can mitigate risk of workplace violence.

Key Words: workplace violence, nursing, optimistic bias

Workplace violence (WPV) is the intentional use of power, threatened or actual, against another person or a group, in work-related circumstances that may result in injury, death, or psychological harm (Cooper & Swanson, 2002). It includes any act or threat of physical violence; harassment (including racial, ethnic, religious, or sexual harassment); intimidation; or other threatening disruptive behavior that occurs at the work site. WPV threatens the victim's health, safety, or well-being and can have mild, moderate, or severe effects on physical and mental health, morale, and productivity. In healthcare or social services settings, workplace violence affects and involves employees, clients, patients, customers, consumers, and visitors.

Workplace violence costs the United States $151 billion per year, with an average of $250,000 per incident. These figures do not capture hidden costs of WPV-related incidents, such as emotional pain, depression, isolation and anxiety (United States [U.S.] Department of Labor, 2022).

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> Healthcare workers are 20% more likely than other workers to experience violence by other employees

Seventy five percent of the nearly 25, 000 workplace assaults reported annually occurred in healthcare and social services settings (Occupational Safety and Health Administration [OSHA], 2016). Healthcare workers are 20% more likely than other workers to experience violence by other employees (The Joint Commission, 2018). They are four times more likely to take time off work for workplace violence-related injuries than for other injuries. Eighty-five percent of non-fatal workplace violence-related incidents occur in healthcare or social service-related industries (McPhaul & Lipscomb, 2004).

Workplace Violence

According to the U.S. Bureau of Labor, OSHA (2016), several factors put healthcare workers at higher risk of serious WPV than those who work in many other industries. The first and largest category of risk factors includes patients with altered mental states due to dementia, delirium, intoxication, withdrawal from alcohol or controlled substances, mental illness, and trauma. When healthcare providers must deliver bad news, patients or family members may lash out verbally or physically. Patients, family members, and friends who are engaged in domestic violence or violent criminal or gang-related activity often bring their conflicts into hospital emergency departments. In some circumstances, they are already under arrest or are arrested at the hospital. Home healthcare workers alone in-patient residences are at higher risk of violence in their patients' homes or high-crime neighborhoods. Pre-hospital care providers, such as ambulance drivers and emergency medical technicians, may encounter weapons and therefore have greater risk of physical injury (Cooper & Swanson, 2002).

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> The most common organizational risk factor is the lack of a clearly written, publicized, communicated, and enforced WPV policy.

The second category of risk factors for WPV against healthcare providers relates to the organizations where they work. The most common organizational risk factor is the lack of a clearly written, publicized, communicated, and enforced WPV policy (SIA Health Care Security Interest Group International Association for Healthcare Security & Safety Foundation, 2017). Even when organizations have anti-violence policies in place, they often lack basic or ongoing staff education and training to recognize, manage, and de-escalate hostile, harassing, and assaultive behaviors by patients, clients, visitors, or staff. Security departments are often inadequately staffed or trained. Understaffing, especially during meals, visiting hours, shift changes, nights, and holidays, increases employee isolation and access to support and help from co-workers, supervisors, and security or mental health workers when conflicts arise and escalate (SIA Health Care Security Interest Group International Association for Healthcare Security & Safety Foundation, 2017).

Nurses and doctors tend not to report minor verbally or physically aggressive acts. Reports and other data are typically collected only for those situations that involve intentional injuries by another person" that require time off, medical treatment, use of company provided health insurance, and/or filing of worker's compensation claims (Stephens, 2019).

Optimistic Bias

In lay terms, optimistic bias (Weinstein, 1980) is the misperception that bad things happen to other people. The phenomenon is well documented in a variety of contexts, including recent studies on susceptibility to illness (Guo, Tang, Zhang, Lommel, & Chen, 2019), accidental injuries (Masson, Lamoureux, & de Guise, 2020), and even the likelihood of experiencing terrorist attacks (Hoffman & Shelby, 2017). The literature also documents a link between risk perception and behavior. For instance, snowboarding instructors who believe they are less likely than others to have an accident are also less likely to wear helmets on the slopes (Masson et al., 2020). Others have found similar links between the perceptual bias and self-protective behaviors (Bryant, Zucca, Brozek, Rock, & Bonevski, 2015; Flanagan, Marvinney, & Zheng, 2015). The application to WPV is clear. Healthcare professionals who exhibit optimistic bias are less likely to take self-protective measures or report abuse.

The purpose of this study was to document healthcare professionals' risk perception about WPV at multiple hospitals within one region in western Pennsylvania, serving mostly urban and suburban communities. Hospital capacity ranges from 126 beds at the smallest location to 576 beds at the largest. The study contributes to the optimistic bias literature by considering pessimistic or realistic risk perception in a field with heightened actual risk. Based on the preceding review of the literature, the following research questions were posited:

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RQ1: Do healthcare professionals exhibit optimistic bias regarding workplace violence?

RQ2: Who do healthcare professionals believe are the most likely perpetrators of workplace violence?

RQ3: How are demographics related to optimistic bias regarding workplace violence?

Study Methods

Participants and Procedures

A convenience sample of healthcare professionals was recruited at the institutional level by a medical advocate. Healthcare professionals (n = 488) opted in through their institutions to attend in-person domestic violence training offered by an area domestic violence counseling and resource center. Participant gender was fairly evenly split at female (54%) and male (46%). Demographic breakdown of race and ethnicity, as identified by participants, was as follows: 66% Euro-American; 7% African-American; and 27% mixed or other. Age ranged from 18 to 68 (M = 28.9; SD = 12.4). Participants worked in three major categories of positions: (1) Nurses (31%) including registered nurses (RN), licensed practical nurses (LPN), and nurse practitioners (NP); (2) Nursing students and interns (41%); and other (28%) including administration, reception, social work, psychology, and case workers.

Descriptive surveys were collected on site using a pre-test and post-test process. Data about study variables (see additional information below) were collected prior to the training to avoid skewing the data. The study was approved by the university Institutional Review Board (IRB), as well as the local domestic violence center Board of Directors. Participants were able to complete the training without also completing the study, or skip individual items. The most skipped items were age (33 responses skipped) and race (137 responses skipped).

Materials

Optimistic bias was measured using a standard instrument (Weinstein, 1989): "Compared to people in other fields, my chances of being physically hurt on the job are..." Responses were on a Likert-type scale (-3 = Much less than others; 0 = About the same; 3 = Much greater than others). Optimistic bias is indicated by a mean significantly less than zero. A mean significantly greater than zero would indicate a pessimistic bias. This item was followed by an open-ended question: "If a workplace violence incident did occur, who would be the most likely source (patient, visitor, etc.)?"

Participants provided their gender, age, race, and position. Positions were first recorded as written (i.e., LPN, intern, case manager), but later recoded into the three broad categories described above. Recoding was done only after it was established there were no significant differences in study variables, such as those attributable to LPNs versus RNs in the Nursing category or case managers versus social workers in the Other category.

Results

SPSS software was used for analysis. T-tests and correlations are reported below.

RQ1 asked whether healthcare professionals exhibit optimistic bias regarding WPV. The optimistic bias scale ranges from -3 to 3, with a mean significantly different from zero indicating an optimistic or pessimistic bias. Participant ratings ranged from -2 to 2; no participants rated themselves at the top or bottom of the scale. A single sample t-test was done to document that participants exhibited pessimistic bias (M = 1.1, SD = 1.0), t (436) = 21.5, p< .000.

> This finding. suggests that healthcare professionals are more realistic about their chances of experiencing workplace violence...

Few participants (n = 29, 6%) exhibited optimistic bias, believing they were less likely than people in other professions to be physically harmed at work. An additional 23% (n = 112) believed their chances of experiencing WPV were 'about the same' as other professionals; and most (n = 347, 71%) believed they were more likely to experience WPV. This finding differed from most of the optimistic bias literature but suggests that healthcare professionals are more realistic about their chances of experiencing workplace violence as compared to most other fields.

RQ2 asked who healthcare professionals believe are the most likely perpetrators of WPV in their profession. A total of 387 participants wrote in responses to the open-ended question. The most frequent response was "patients" (n = 253, 65%). The next highest category was visitors (20%), with 16 participants specifying "family members" and the remaining 62 writing in "visitors." Thirty participants (8%) said that "other staff" would be the most likely perpetrators, with a few nurses (n = 3, 1%) specifying "doctors" as the most likely culprits. The last category (n = 18, 7%) was other. Participants wrote in either the word "other" or said it could be "anyone."

RQ3 asked how demographics were related to risk perception regarding workplace violence. There were no significant differences in optimism/pessimism attributable to gender or race. Age was significantly related, with healthcare professionals becoming more pessimistic over time (r = -.15, p< .01). This could be attributable to age, but is more likely a function of experience on the job. One striking difference was found between nurses and other hospital-based professionals, including administrators, social workers, and psychologists. Nurses were more pessimistic (M = 1.2; SD = 0.9) than other hospital-based professionals (M = 0.8, SD = 1.1), *t* (124) = 1.9, p< .05, but both groups acknowledged a heightened risk. There was no significant difference between interns (M = 1.3; SD = 0.9) and nurses in terms of their risk perception.

There were no significant differences in optimism/pessimism attributable to gender or race.

Discussion

The findings contribute to the optimistic bias literature by documenting pessimistic (or realistic) bias by healthcare professionals. In some ways, this is good news, as realism or pessimism may likely result in more self-protective measures (Bryant et al., 2015; Weinstein, 1989). Nurses and other healthcare professionals need to be aware of risks and take self-protective measures, but this is only the first step. Broader cultural and environmental steps need to be taken to prevent and mitigate the impact of WPV.

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OSHA recommends several steps to mitigate risk of WPV.

The General Duty Clause, Section (5)(a) (1) of the Occupational Health and Safety Act (OSHA, 2016) directs employers to provide a place of employment that is free from recognized hazards that are causing or likely to cause death or serious harm. According to the report, workplace risk factors can be identified and the risk of verbal, physical, or sexual assault can be reduced or minimized if employers take appropriate precautions. OSHA (2016) recommends several steps to mitigate risk of WPV. The first step is to develop, implement, publish, and comply with strictly enforced WPV policies regarding all forms of violence in the hospital, facility, institution or community-based healthcare offices (OSHA, 2016; SIA Health Care Security Interest Group International Association for Healthcare Security & Safety Foundation, 2017).

The second step (OSHA, 2016) is to strike a realistic balance between security concerns and offering easy access for patients seeking care, visitors who come to support or visit them, and vendors. Accomplishing this second step may mean actions such as: use of metal detectors and confiscation of weapons or items that can be used as weapons; requiring badge access to the facility, care units, and healthcare offices or clinics to limit access to patients, visitors and vendors; maintaining police or security presence; installing and monitoring security cameras; and providing regular education and training for all staff on conflict de-escalation and resolution, emergency preparedness, and lockdown procedures.

The third step (OSHA, 2016) is to make the physical environment safer. This may include changes to the physical environment, installation of better lighting in hallways, patient rooms, staff workspaces, sidewalks, and parking lots.

The fourth step (OSHA, 2016) is to improve working conditions with actions such as:

- Hiring and scheduling sufficient staff across disciplines to reduce mandatory overtime and double shifts.
- Increasing team work to reduce worker isolation.
- Encouraging reporting, recognition, response, referrals, and access to resources regarding all incidents of workplace violence.
- Co-workers, supervisors, managers, and executives all need to support and actively assist victimized employees in assuring their safety. This support can include reporting incidents; obtaining treatment for mental, physical, sexual, and social injuries; taking legal action to obtain protection orders and/or criminal prosecution when appropriate; assuring ability to take time off as needed, and; protecting jobs of victims as they heal and regain their resilience.

The fifth step (OSHA, 2016) is providing live and virtual education, training, and skills development opportunities. Written and electronic materials should be easily accessible and include information about domestic violence and WPV; verbal and non-verbal communication skills; handling difficult conversations; de-escalation and resolution of conflicts; safety protocols; emergency preparedness; and active shooter training. Engaging employees and other stakeholders is vital to create a safe environment for all.

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Conclusion

A number of limitations should be considered before interpreting or applying these findings. While the sample was drawn from the field, the participating hospital systems, healthcare facilities, and nursing schools constitute a convenience sample from one Mid-Atlantic state. The findings thus may not be broadly generalizable. The sample did not include some high-risk healthcare personnel, such as emergency medical technicians who also treat patients in their homes and other public settings that may present different sets of risk factors. Finally, a non-experimental descriptive survey design was used.

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The literature has suggested that pessimistic or realistic risk-perception would result in increased vigilance in the workplace, (Bryant et al., 2015; Weinstein, 1989) but more research is needed. One question is whether there is also increased vigilance in healthcare settings. Emergency Departments, Intensive Care Units, Maternity Units, and Newborn Nurseries are now more likely to be locked units. Employees swipe badges to enter after passing through metal detectors. Patients or visitors access these areas after passing through metal detectors to get temporary badges. These are positive developments. Future research could continue to extend our findings by studying the behavioral component of pessimistic bias in WPV.

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