Workplace Abuse: Finding Solutions

Executive Summary

- The atmosphere within the work setting speaks volumes about your culture, and is often a primary factor in recruitment and retention (or turnover) of staff.
- Workplace tension and abuse are significant contributing factors as to why nurses are exiting workplaces — and even leaving the profession.
- Abuse can take many forms from inappropriate interpersonal communication to sexual harassment and even violence.
- Administrators should adopt a zero tolerance policy towards abusive communication.
- Addressing peer behavior is essential, but positive behavior must also be authentically modeled from the CNO and other nursing leaders.
- Raising awareness and holding individuals accountable for their behavior can lead to a safer and more harmonious work environment.

Work Environment Is Key

As we seek solutions to the nursing shortage, one area that deserves analysis is the quality of the work environment in each unit or department. The atmosphere within the work setting speaks volumes about your culture, and is often a primary factor in recruitment and retention (or turnover) of staff. The way staff members and physicians interact along with factors like staffing ratios, pace, volume, and acuity of patient flow, the unit or department physical layout, and having the tools and support staff to do great work shape and influence these environments tremendously.

In acute hospitals that operate 24/7, the culture, camaraderie, and vibe of a unit or department can change from shift to shift, or from weekdays to weekends, just as much — or more — as staffing numbers change across the continuum.

With increased patient acuity and shortened length of stay in most settings, the intensity in health care work environments has increased dramatically. In some settings, staffing shortages can overextend the workforce to dangerous levels (Gilmore-Hall, 2001).

The pervasive increase in tension and acuity can easily erupt into workplace abuse or even violence. And this workplace tension and abuse are significant contributing factors as to why nurses are exiting workplaces — and even leaving the profession.

How Big Is the Problem?

International researchers found that nurses are 16 times more likely to experience abuse than other health care professionals (Canadian Nurses Association, 2002). In health care settings, nurses report the majority of incidences of workplace abuse, although the U.S. Bureau of Labor Statistics (BLS) and the Occupational Safety and Health Administration (OSHA) both concur that workplace abuse in health care settings is grossly underreported (National Institute for Occupational Safety and Health, 1997; OSHA, 2004).

Abuse can take many forms from inappropriate interpersonal communication to sexual harassment and even violence. In fact in the United States, homicide is the second cause of occupational death among working women (BLS, 2004).

Verbal abuse is the most common form of abuse inflicted on nurses; patients, patients’ families, and physicians are most often cited as the source of that abuse (Ulrich et al., 2006). Verbal abuse is defined as communication via behavior, tone, or words that patronize, demean, isolate, disparage, threaten or accuse, or intend that the individual feel attacked or humiliated.

A RE ANY OF THESE SCENARIOS currently playing out at your organization?

Does one of your highest producing physicians verbally or sexually harass staff? If you bring it up for solution, will the CEO and administrative team back you in disciplining this individual? Or will it take massive nursing turnover or even a lawsuit before anyone takes it seriously?

Does one of your “best” preceptors snap like an alligator at everyone, but is allowed to persist unchecked in the behavior “because he/she is an outstanding clinician”?

Does the nursing division “throw its weight around” in a bullying manner when negotiating on salary, recruitment, or other issues? Are your leaders demonstrating excellence in their interpersonal and interdepartmental communications?

Do you see evidence of staff turnover or injuries due to staffing ratios or physical isolation of staff members within units or departments?

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Horizontal violence among nurses within their own peer group is also sadly prevalent. This type of unacceptable communication includes belittling, back-stabbing, personal insults, undermining behavior, isolating a co-worker with the silent treatment, and creating inequitable patient assignments.

Although these largely verbal forms of abuse would seem harmless, the last two Institute of Medicine (IOM) reports (2005, 2006) acknowledged the need for increased collaboration among health care professionals to prevent errors leading to adverse patient outcomes (Cook, 2001). The IOM concluded that abusive behavior and fear of retribution impacts both the quality and timeliness of reporting patient complications. In some instances, it even prevents caregivers from bringing patient issues to the forefront, resulting in patient complications and even death.

Abuse can also take more threatening forms. When a nursing scholar in Australia conducted interviews with staff RNs regarding sexual harassment and verbal abuse in the workplace, she found that most of the RNs reported several indicators of sexual harassment, but rarely recognized these unwelcome sexualized behaviors for what they actually were (Madison & Minichiello, 2001; Mayhew & Chappell, 2005; Gribbin, 2002). Some of these indicators included lack of respect, overly friendly or sexualized behavior, and invasion of personal space with an intention to intimidate.

Statistics show that the majority of physical attacks within the hospital workplace occur primarily in two settings, the emergency department (ED) and in mental health inpatient units. It is a fact that in emergency departments a majority of patients who present for treatment are under the influence of drugs or alcohol (which can decrease inhibitions) or have psychiatric disorders that distort their worldview, so the very potential for violence increases. And with fewer options for mental health treatment in most communities, the ED is rapidly becoming a primary treatment area for patients with psychiatric disorders (Gribbin, 2002; OSHA, 2004).

In the majority of incidents in which nurses are seriously injured or killed, patients, or their friends and family members are the perpetrators of violence (BLS, 2004; Gilmore-Hall, 2001; Mayhew & Chappell, 2005; Gribbin, 2002). Many social issues underlie the increasing violence seen in hospitals and other health care settings. Our society is increasingly disrespectful and violent, from people who "flip off" others in traffic to inciting violence seen in hospitals and other health care settings, the ED is rapidly becoming a primary treatment setting. Our society is increasingly disrespectful and violent, from people who "flip off" others in traffic to inciting violence seen in hospitals and other health care settings, the ED is rapidly becoming a primary treatment setting.

What to Do About it?

We must all do what we can to make our intense work environments as healthy, productive, and positive as possible. Health care settings are inherently dangerous places to work, but in the same way that our organizations purchase special equipment to reduce the number of needlesticks, steps should be taken to recognize, report, and eliminate workplace abuse, and to decrease potential for the escalation of violence and worker injury.

The first step is for organization administrators to adopt a zero tolerance policy towards abusive communication (Gilmore-Hall, 2001; Tabone, 2001). This includes citing physicians who yell, curse, or demean staff as a matter of daily course. Firing these physicians, or even suspending them, can help curb this urge to bully and send a strong message about how administration views this behavior. Mandatory attendance at anger management courses to repeat offenders will also telegraph the message that your organization means business.

Expected standards of behavior and communication should be provided to patients and family members. However, patients under the influence of drugs or alcohol, or those with mental illnesses may not be coherent. In that case, those RNs should be provided with extra support and a way to decompress when harassed.

Next, addressing peer behavior is essential, but positive behavior must also be authentically modeled from the CNO and other nursing leaders. Communica-
tion courses for new graduates, or a component on respectful communication as a routine part of orientation is an effective way to set desired standards. Repeat offenders within nursing should also be fined or suspended, and sent to anger management courses to change their behaviors.

For those who have been victims of abuse or violence, they should not be injured further by denying their physical or emotional injuries. Counseling and other supportive therapies should be offered, and victims encouraged to avail themselves of this therapy.

Adopting behavior and practice standards such as those touted in the American Association of Critical Care Nurses' (2005) Healthy Work Environments position paper will improve communication and respect. The standards address systemic behaviors that are often ignored, despite the fact that they contribute to unsafe or toxic work environments. One of the Beacon Unit standards maintains that nurses' communication skills must be as stellar as are their clinical practice skills. Another advocates fostering a culture of true collaboration as the basis of a safe and healthy practice setting.

Improving peer communication through adopting, modeling, and teaching appropriate standards is a fine first step, but more must be done. Analyze your own organization's pattern of violence, abuse, or injury to determine if policies or staffing must change, or if your staff members need additional training.

Raising awareness and holding individuals accountable for their behavior can lead to a safer and more harmonious work environment. Start by asking those tough questions.

REFERENCES

New Web Tool Provides Samples of Report Cards on Health Care Quality

With rising interest in information about the quality of care delivered by health care providers, the Agency for Healthcare Research and Quality (AHRQ) has developed a new Web tool demonstrating a variety of approaches for health quality report cards. The new Health Care Report Card Compendium is a searchable directory of over 200 samples of report cards produced by a variety of organizations. The samples show formats and approaches for providing comparative information on the quality of health plans, hospitals, medical groups, individual physicians, nursing homes, and other providers of care.

The Health Care Report Card Compendium can be found at http://www.talkingquality.gov/compendium/

New Research: U.S. Nursing Shortage Contributing to Death and Illness for U.S. Patients

The National Foundation for American Policy (NFAP), an Arlington, VA-based policy research group, released a new study finding the current nursing shortage is leading to increased death and illness for Americans at U.S. hospitals. A review of the medical literature finds that the aging U.S. population and low domestic production of nurses in the United States has created a nursing shortage that carries serious consequences for U.S. hospital patients.

The study recommends policymakers focus on the two most practical solutions to alleviate the impact of the nursing shortage on U.S. patients: (a) increase nursing faculty and school infrastructure and (b) raise immigration quotas to facilitate the entry of foreign nurses. The study "Deadly Consequences: The Hidden Impact of America's Nursing Shortage" can be found on the NFAP Web site (www.nfap.com).