Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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COMMENTARY

The Joint Commission's New and Revised Workplace Violence Prevention Standards for Hospitals: A Major Step Forward Toward Improved Quality and Safety

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Workplace violence poses a significant threat to the health, safety, and well-being of health care workers[1] and has negative implications for their productivity,[2] retention,[3,4] and the quality of care they provide to patients.[5-7] The problem is not new. Violence from patients toward health care workers has been recognized as an occupational hazard for decades, with the earliest studies coming from psychiatric/mental health settings.[8,9] By the early 1990s, violence was becoming a recognized occupational risk in general health care settings as well.[10] Since then, research on violence in health care has increased exponentially,[11-13] helping to raise awareness of the problem. Despite this, the incidence of violence has increased,[14] including during the ongoing COVID-19 pandemic.[15,16] Estimates of costs associated with non-fatal workplace violence in health care settings range from $109,000 per year for treatment and indemnity among injured nurses[17] to over $330,000 per year in a single hospital system.[18] These estimates do not include the costs of the psychological trauma, fear, and work dissatisfaction that may develop in employees' response to workplace violence[11] or patient-related costs.[7] Patient-related costs may be due to direct injury caused by a violent act, but they can be indirect as well, resulting from gaps in care due to staff absences caused by violence-related injury.[7]

LEGISLATION AND REGULATIONS

While some states have instituted legislation to protect health care workers from violence, [19] the only federal regulation currently in place is the General Duty Clause of the Occupational Safety and Health Act of 1970. This clause requires employers to provide a work environment "free from recognized hazards that are causing or likely to cause death or serious physical harm."[20] However, the general duty clause offers no specific recommendations regarding management of workplace violence. The Occupational Safety and Health Administration (OSHA) issued guidelines for workplace violence prevention for health care and social service workers. First issued in 1996 and subsequently updated,[21] the guidelines are only advisory. Federal legislators have proposed the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (H.R. 1195) that would direct the Department of Labor to issue standards requiring employers to protect health care sector workers from workplace violence. The bill was passed by the House in April 2021 but has not yet been brought to a vote in the Senate.[22]

The Joint Commission's new and revised workplace violence prevention standards that went into effect on January 1, 2022, are therefore an important and welcome step toward enhanced awareness, prevention, and management of violence in accredited hospitals. The standards apply to all hospitals and critical access hospitals seeking Joint Commission accreditation.

WORKPLACE VIOLENCE IN HEALTHCARE: MAGNITUDE OF THE PROBLEM

National incidence data on workplace violence in the health care and social assistance sector is reported by the US Bureau of Labor Statistics (BLS). Data indicate an annual rate of workplace violence–related nonfatal injuries and/or illnesses of 10.4 per 10,000 full-time workers.[14] At that rate, US health care workers in the private sector are 5 times more likely to experience nonfatal violence-related injury compared to workers in all other private industries combined, where the annual incidence rate is 2.1.[14] Looking specifically at employees in general hospitals, the violence rate is even higher, 12.8. Of special concern is the fact that rates have increased steadily over time from a rate of 6.4 in 2011. Overall, nearly three-quarters of all violence-related nonfatal injuries and illnesses in 2018 were incurred by health care workers.[14]

UNDERREPORTING

As alarming as these data are, they do not present a complete picture of workplace violence experienced by health care workers. First, BLS data are limited to violent events that result in at least one lost day of work due to injury by

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another person. Thus, these data are likely capturing the most serious incidents that require time off for medical attention and/or recuperation. Second, knowledge of the full spectrum and nature of violence toward health care workers is hampered by underreporting.[1,23,24] One study that compared health care workers' reports of workplace violence via questionnaire with recorded events in a health care system's central database found that 88% of workers did not formally document any incidents in the database.[23]

The reasons for underreporting are multifactorial and complex. Some of the reasons more commonly given by health care employees include the following:[23]

1. Patients who are not in their "right mind" cannot be held accountable for their actions. This would encompass patients under the influence of drugs or alcohol or individuals suffering from mental illness, cognitive impairment, dementia, or delirium.
2. Reporting can be time consuming and difficult for health care employees working under high-stress conditions.
3. Fear of retaliation from management and/or colleagues who are concerned that reports of violence can reflect poorly on a health care team/workplace.
4. There was no injury or time lost because of the incident, or the violence wasn't physical.
5. Varying definitions of what comprises violence.
6. Employee perceptions that reporting never leads to any improvements or changes.
7. The widespread belief that violence is simply "part of the job." [25]

WHY IS WORKPLACE VIOLENCE SO DIFFICULT TO ADDRESS?

Underreporting and the resulting lack of accurate prevalence and incidence data is a major deterrent to the development of interventions for workplace violence. However, other factors contribute to making this a difficult problem to address[26]:

1. Violent events in US hospitals may be perpetrated by outsiders to the health care organization (Type I violence), patients or their family members/visitors (Type II violence), co-workers or supervisors (Type III), or personal/domestic partners of an employee (Type IV). While Types II and III are by far the most common, all types of violence do occur.[27]
2. Violence may range from verbal abuse, to bullying, to threats, to physical assault, each with different risk factors, making it difficult to establish effective interventions.
3. Hospital units care for different kinds of patients, depending on their illness and diagnosis. Risk factors for violence will therefore differ between care settings, and health care staff on some units, such as emergency departments or mental health units, may be more accustomed to dealing with aggressive and violent patients than staff on units where violence is less prevalent.
4. Risk factors for violence are well-known in certain hospital environments, but much of the violence that occurs is unpredictable.

The combination of different perpetrators, forms of violence, and care environments presents a challenge to the development of violence interventions.[26] While a "one size fits all" approach may not be viable,[1] research and practice have shown that certain key elements are critical to the management and prevention of violence in hospitals.

Organizational and Management Support for Workplace Violence Prevention

Health care organizations with a pervasive safety culture have a strong commitment to protecting both patients and employees from harm.[28,29] A culture of safety entails open, non-punitive communication regarding adverse events and commitment to learning from such events to avoid their recurrence.[30] Violence prevention climate refers specifically to an organization's efforts to protect employees and patients from any form of violent behavior.[31,32] This includes policies for workplace violence, an incident reporting system and requirements for non-punitive reporting, and resources for education/training and safety measures.[21] A strong violence prevention climate has been shown to be a protective factor against both verbal and physical violence in hospitals.[29]

Stakeholder Engagement

In addition to organizational and management support for violence prevention, active engagement of employees and unit-level managers is critical.[7,21] Allowing employees autonomy and flexibility in violence prevention activities at the hospital unit level, within a greater framework of an organizational culture of safety, has been shown to be effective in reducing incidents of violence and related injury over time.[26,33] The prevalence and nature of violence are not the same across all hospital units; risk factors may differ, and preventive strategies may therefore also differ. Unit supervisors and employees know their work environment best and are highly motivated to play an active role in enhancing and protecting unit safety, both for staff and for patients.[26]

Education and Training on Workplace Violence

This is important for all employees, especially those in high-risk environments, and serves to keep employees abreast of organizational policies and practices related to violence prevention.[21] These may include information on reporting requirements, safety protocols, available tools and resources, and specific training modules, such as de-escalation training.

Table 1. Overview of the Joint Commission Workplace Violence (WPV) Prevention Standards

Domain	Standards	Requirements	Description
Environment of Care (EC)	EC.02.01.01	EP17	Annual worksite analysis and management of risks
	EC.04.01.01	EP1	Continuous data monitoring and reporting
		EP6	Risks related to WPV
Human Resources (HR)	HR.01.05.08	EP29	Staff education and training
Leadership (LD)	LD.03.01.01	EP9	WPV prevention program

Data-driven Analysis

A substantial body of research has underscored the critical importance of continuous data collection and monitoring of violent events at individual worksites as well as for the organization overall.[33-36] On an organizational level, rates of violence should be included as part of a hospital's quality improvement dashboard. With regular monitoring, hospital executives can examine trends in violence over time; data monitoring can also help executives evaluate the effects of any violence prevention efforts that are implemented. Regular review of workplace violence data is also necessary at the unit level.[26,33] All unit staff should be aware of violent events that occur and should be given the opportunity to review violence data and discuss violent events that have occurred.[33,34] Data should include details of the nature and characteristics of specific incidents, as well as rates of occurrence over time.[37] Continuous monitoring of workplace violence data at both the organizational and hospital unit level provides the foundation for ongoing violence prevention activities and evaluation of any interventions. This is the foundation of basic quality improvement[38] and is key to better management and prevention of hospital violence.

THE JOINT COMMISSION AND WORKPLACE VIOLENCE PREVENTION

The key elements outlined above are included in the new Joint Commission standards, which also provide links to resources that can guide hospitals in efforts to fulfill the standard requirements. Workplace violence has been recognized as a serious issue by The Joint Commission for well over a decade. Since 2008, the Joint Commission has issued Sentinel Event Alerts[39,40] and Quick Safety newsletters[41,42] that have highlighted violence and the need for preventive measures. Topics have ranged from "behaviors that undermine a culture of safety"[39] to "physical and verbal violence against health care workers[40] to "de-escalation in health care."[42] In addition, The Joint Commission has published multiple blog posts[43] presentations,[44] and a podcast on workplace violence and its prevention in hospitals.[45]

The establishment of actual standards represents an important development in that they hold accredited hospitals and critical access hospitals accountable for workplace violence and provide them with a structure for prevention. The standards include a broad definition of workplace violence that includes any disruptive or potentially harmful behavior. Thus, violent behavior is not limited to acts of physical violence, but includes verbal aggression, threats, acts of intimidation, harassment, sexual harassment, bullying, and sabotage. This definition encompasses a wide umbrella of potentially harmful violent behaviors that can, when monitored over time, give hospitals enhanced awareness of the gamut of violent acts to which their employees are subjected. There are four new Joint Commission violence prevention standards encompassing two Environment of Care (EC), one Human Resource (HR), and one Leadership (LD) standard, and a total of 5 new elements of performance (EP) requirements. An overview of the new standards and requirements is presented in Table 1.

The elements of performance detail requirements for worksite analysis, data collection and continuous monitoring, identification of risks, hospital staff education and training, and establishment of a workplace violence prevention program. These reflect the critical elements of violence prevention in hospitals that were identified above and are well-grounded in research as well as the advisory OSHA guidelines.[21] In essence, the new standards provide a framework for development of hospital workplace violence prevention systems that include leadership structure; policies and procedures; reporting systems; data collection and risk analysis; post-incident strategies; and training and education to reduce violence. Important, the standards establish requirements for *what* is needed, but not necessarily *how* these elements should be implemented. While this may present a dilemma for hospitals aiming to meet the standards, it also provides them with the flexibility to do what works best within their individual organizations/systems. For example, the requirement for continuous data monitoring, reporting, and investigating violent events (EP1) is a broad requirement that allows hospitals the freedom to consider different modes of data collection. These might include formal electronic/written reports, verbal reports to unit supervisors, and/or brief staff surveys conducted on a regular basis.

However, the standards also necessitate the establishment of stricter protocols than those that may already be in place. EP17 requires an annual worksite analysis to identify risks related to workplace violence and barriers to removing those risks. At the same time, it will not suffice for hospitals to merely report that a worksite analysis has been conducted; actions to mitigate any risks that have been identified must be documented as well. Worksite analyses

are intended to serve as the foundation for interventions to mitigate identified risks and provide important feedback on how well violence prevention policies and practices are working. Requirement EP9 within the Leadership standard states that hospitals must have a workplace violence prevention program led by a designated individual and developed and supported by a multidisciplinary team. This requirement not only establishes clear lines of accountability within a hospital but can help to standardize policies and procedures for incident reporting and follow-up. In the long run, this can decrease variation in data collection and reporting, thus facilitating data review between units and over time.[35] Standardization of processes for data collection and reporting will ultimately allow hospitals to benchmark the efficacy of their workplace violence prevention programs with each other.[46]

The new Joint Commission standards are filling a gap in that they represent a first step in prevention of workplace violence in hospitals on a national scale. The new requirements underscore the fact that workplace violence is an organizational issue that necessitates a systems' approach. Moreover, ongoing data collection and analysis are key to violence prevention. Finally, these standards can help hospitals to establish a strong culture of safety and violence prevention. In time, the hope is that they will help to change the employee mindset that violence is "part of the job" to a view of workplace violence as an occupational hazard that can be managed and prevented.

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