Perspectives in Ambulatory Care

Distinctions in Workplace Violence in Ambulatory Care

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Workplace violence comprises a spectrum of behaviors, ranging from threats, verbal abuse, sexual harassment, bullying, physical harm, or other troublesome behaviors involving staff, providers, patients, or visitors (The Joint Commission [TJC], 2023). According to the National Institute of Occupational Safety and Health (Centers for Disease Control and Prevention, 2022), classifications of workplace violence consist of criminal intent, customer/client, worker on worker, and personal relationship types. In 2020, health care practitioners and technical workers suffered 8,590 intentional injuries by another person, resulting in a day or more of missed work (see Table 1) (U.S. Bureau of Labor Statistics, 2022). Nurse leaders ranked workplace violence, bullying, and incivility in fourth place on a list of challenges and areas needed for support (American Organization of Nurse Leaders [AONL], 2023).

There are numerous elements to consider when addressing workplace violence, particularly in ambulatory care. The American Academy of Ambulatory Care Nursing (AAACN) highlights the location, community population, type and size of an organization, practice hours, physical environment, and resources as factors creating complexity in managing workplace violence (Fletcher et al., 2023). In addition to these influences, workplace violence occurs in person, via telephone, email, patient messages in the electronic health record, telehealth, and social media. Nonviolent acts may be perceived as less impactful to health care workers than violent acts, although they occur more frequently (Liu et al., 2019). The most common forms of nonviolent acts are verbal abuse, threats, and sexual harassment (Liu et al., 2019).

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Workplace violence in ambulatory care is less controlled than in inpatient settings due to a variety of factors, including location, patient population, volume of visits, hours of operation, physical environment, and availability of resources. Personal knowledge, skills, and ability, as well as data and organizational resources, are needed to mitigate events. Continued research, publication of evidence-based practice, and advocacy for laws protecting health care workers in ambulatory care are necessary. The development of workplace violence risk assessments, violence screening questions, and national nursing quality indicators are needed to help move the prevention needle in ambulatory care settings.

Keywords: Ambulatory care, workplace violence, workplace safety, bullying.

Risk and Other Factors

Location

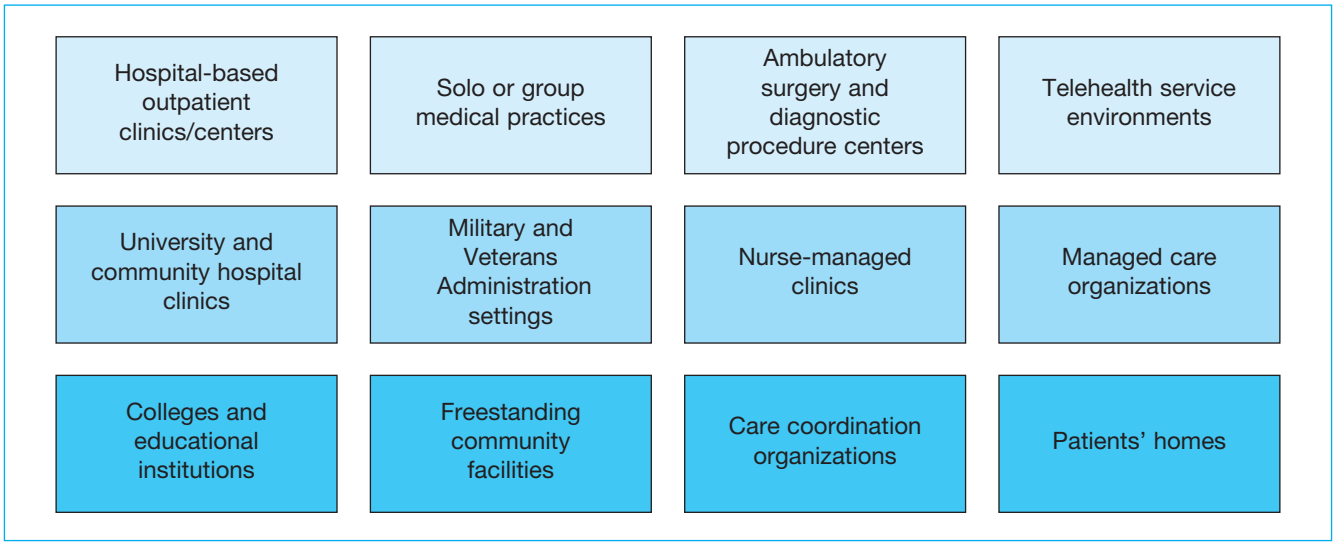
By nature, ambulatory care delivery occurs in various settings that offer convenience to patients, whether urban or rural (see Figure 1). They may be in a medical office building or co-located with other ambulatory clinics, infusion centers, or surgery centers. However, they may also be in a strip mall, free-standing building, or retail health setting, such as a large chain drug store. Care may also occur via telephone and video visits rather than in physical locations.

Table 1.
Nonfatal Workplace Intentional Injuries Requiring at Least a Day Away from Work, Selected Occupational Groups, 2020

Occupational Group	Number of Intentional Injuries by Another Person
Service industry	18,690
Health care practitioners and technical	8590
Educational instruction and library	5470
Transportation and material moving	1560
Management, business, financial	1360

Source: U.S. Bureau of Labor Statistics, 2022.

Figure 1.
Examples of Settings for Ambulatory Care Delivery



Source: American Academy of Ambulatory Care Nursing, 2017.

Population

The population serviced by an ambulatory care clinic is complex given the array of diagnoses a patient may present with (AAACN, 2017). Patients may have unknown underlying behavioral or mental health conditions, leading to potentially volatile interactions. At times, a patient's medical condition is a contributing factor to a patient's escalating verbal violence.

Vulnerable Populations

Each clinical encounter situation dictates a unique and well-planned approach for the safety of the staff member and the patient. Although there are particular challenges with each of these populations identified below, all patients deserve respect and equitable treatment. It is important to maintain self and situational awareness throughout the encounter.

Inmates

Officers accompany inmates to their medical visits. Be sure to inquire if the inmate is from a maximum-security prison to help determine if there is an additional level of risk. Inmates from this setting may have the mindset that they do not have anything to lose. Regardless of the situation, be mindful that the inmate can overpower the guard,

and there is always a risk of escape. Do not take items into the room with you, minimize interactions, be direct, do not share personal information, consider removing name badges before entering the room, and redirect the conversation, if needed. In addition, if family members call for information about appointments, they must be directed back to the prison. Given the above, consult policies and procedures on caring for inmates if there are questions.

Mental and Behavioral Health Diagnoses/ Cognitive Issues

Become familiar with common diagnoses and learn about trauma-informed care. Tailoring an individualized approach to the care of patients who live with these diagnoses and developing an understanding of the diagnoses that present a higher risk of misconduct is imperative. Regular outpatient care helps patients stay on course with their treatment.

Organizational Characteristics

Ambulatory care clinics may be single, stand-alone private practices or part of a large hospital system with many offsite locations across a region. Leadership in these clinics may be present on a day-to-day basis but are more than likely supervising multiple clinics across a region. Front desk employees may receive the brunt of violent outbursts from patients in person, over the phone, or via patient portal message.

Often, the provider in a clinic is considered the onsite leader if a workplace violence event occurs. Although these providers are highly trained as clinicians, they may not have training on how to best handle volatile situations. In fact, sometimes the increased percentage of providers or administrators onsite in a clinic can create tension that can lead to tension in the clinic space.

Daily Operations

There is a high turnover of visit volumes in ambulatory care settings. Appointment length can vary from mere minutes for a follow up to over an hour for evaluations. The acuity of patients may impact the provider's ability to stay on time and cause delays for patients. Delays are a common catalyst for misconduct among patients and visitors. Frustrations from delays are often directed toward the administrative staff working at the check-in or check-out area. Beyond the in-person encounters, there is extensive activity from patients calling or messaging through the electronic health record. Patient misconduct often manifests from delays in responding to these inquiries or not getting the outcome desired from the request. These misbehaviors are often directed at the nursing team verbally or in writing. Misconduct from patients often affects other patients and visitors, in addition to the impact on the staff.

Other factors to consider in daily clinic operations are the start and stop times for employees, which may involve starting early and ending late. Predictable start and stop times for employees can be problematic, especially in high crime areas and for those who may be going through a personal relationship violence situation.

Physical Environment

Often, the physical environment of an ambulatory care clinic is dictated by the facility in which it is located. The practice or associated hospital system may own the facility or lease it from a property owner. In the latter case, addressing facilities' concerns can sometimes be challenging. Safety concerns may exist on the exterior, such as dark parking lots, overgrown landscaping, and poor visibility when stepping outside the building. Access may be a concern on the interior, with the placement of locked doors or doors with badge swipe entry.

Support Resources

Support for clinic settings can vary greatly, depending on the size of the practice. Clinics associated with large hospital systems may have the help of a security company or law enforcement division that can assist with performing walk-throughs of clinic sites to assess for safety or risk concerns. Onsite security and training on active shooter response and de-escalation tactics may also be provided. Clinics may have funding for devices or equipment that enhance security and impact the staff's perception of safety. Additionally, a Workplace Violence Committee may be working to address the

ambulatory care teams' safety. Support systems, such as an Employee Assistance Program and various educational resources, may also be available.

On the other hand, some clinical practices are free-standing and do not have any of these resources. Developing relationships with local law enforcement is fundamental to workplace safety in these cases. Local law enforcement will often partner to assess security risks, perform drills for active shooter events, and provide tactical education on responding to events.

Ensuring Awareness of Workplace Violence Risks

Personal

It is essential to consider how one's response to an escalating situation may exacerbate the issue. Self-reflection about past experiences, particularly related to traumatic events, helps develop an understanding of emotional, behavioral, and cognitive responses when experiencing a similar event. Insights gained from naming and evaluating triggers can help transition from unproductive to productive responses using simple techniques. Mindfulness in the moment focuses on the situation and is critical to keeping all individuals safe. Intentional breathing assists in counteracting any physiological and emotional responses. Do not wait for reinforcements to arrive if things are escalating or getting physical; remove yourself from the situation as soon as possible.

Situational

The number-one safety skill to identify potential issues and aid in planning is situational awareness. This simple skill is often overlooked in favor of interacting with technology. Questions to consider include:

- "What is going on around me?"
- "What could be used as a weapon?"
- "Is there any unusual or suspicious behavior happening?"
- "Where is the nearest exit if I need to get out of a situation?"

Advocacy

Failure to acknowledge the repercussions of workplace violence events can be financially costly and result in various adverse outcomes. These include heightened psychological or medical care expenses, staff burnout, high turnover rates, increased absenteeism, reduced productivity (presenteeism), job dissatisfaction, and a decline in overall morale. The stress from these incidents is further exacerbated when coupled with heavy workloads due to inadequate staffing and a pervasive lack of control. Gaining support for workplace violence prevention inside and outside of organizations puts structures and processes in place to enable more positive outcomes. Organizations such as the American Nurses Association, Emergency Nurses Association, AONL, and AAACN endeavor to educate and provide tools and resources to address workplace violence. Realizing all elements involved in workplace violence for ambulatory care nurses, AAACN created a Workplace Safety Task Force in 2023 to focus on tactics to address these special considerations. The AAACN Workplace Safety Task Force published a Position Statement on Workplace Violence, Incivility, and Bullying in Ambulatory Care (Fletcher et al., 2023). The task force will release a toolkit in 2024 specifically aimed at workplace violence in ambulatory care.

Reporting

The National Database for Nursing Quality Indicators [NDNQI] Assaults on Nursing Personnel metric is designed for hospitals to measure violence against nursing staff. There is not a nationally recognized nursing quality indicator that currently measures workplace violence in ambulatory care nursing. This is problematic in quantifying the significance of violence and for raising awareness.

Even the most basic level of onsite reporting may not be formalized, and general consensus is that workplace violence is highly underreported. There are barriers and facilitators to reporting workplace violence that can be associated with leadership behaviors and systems issues. Leadership behaviors that preclude reporting are instilling fear

or blame, lack of follow up, inadequate time for education, and lack of investigation. Leaders who demonstrate reinforcement, support through debriefing on incidents, investigation, and closed-loop communication facilitate reporting. Leaders may have good intentions, but never received the training and education needed to understand the foundations of high reliability organizations (HROs). HROs operate through the lens of five main characteristics: 1) preoccupation with failure, 2) reluctance to simplify, 3) sensitivity to operations, 4) deference to expertise, and 5) a commitment to resilience (Agency for Healthcare Research and Quality [AHRQ], 2019). Focusing on these principles of learning garners trust, which increases reporting and leads to improvements (TJC, 2021).

System barriers to reporting include a widely held belief that violence is a part of the job, and in ambulatory care, a lack of understanding that any form of violence that occurs should be reported, even if it is not physical in nature. Additional barriers include the turnaround time for improvements, which may be related to lack of structures and processes for team members to follow. This is exacerbated in ambulatory care because of the hierarchical nature of the settings where there may be the presence of multiple layers of leaders from across departments, such as physicians, administrators, and nurses. Organizations that clearly define and communicate the definition of workplace violence, educate employees on the mechanisms to report, use principles that encourage trust, and follow a fair and just culture mindset strengthen reporting behaviors (Al-Maskari et al., 2020; Chapman et al., 2010; Hogarth et al., 2016; Morphet et al., 2019; Schablon et al., 2018).

Interventions

Leader Development

Leader development is an essential initial intervention to facilitate staff engagement in preventing and preparing for a workplace violence event by providing resources for responding to and de-escalating the situation during an event, and then taking appropriate action after an event. Leaders should establish a safety plan specific to the clinic space.

Risk Assessments

A formal risk assessment should be accompanied by a walkthrough of the clinical space by someone from law enforcement to identify safety issues within the facility. During the walkthrough, security can specify safe areas when a workplace violence event escalates or during an active shooter situation. Health care workers' feeling of preparedness and perception of safety at work is essential.

De-Escalation

Training on de-escalation tactics should be provided to staff upon hire and at least annually to maintain competency. This training may come in the form of written resources or interactive training modules. It is helpful to provide scripted examples of specific verbiage for staff to use. The most important reason to use de-escalation techniques is to maintain a sense of safety. A secondary but significant benefit of a safe environment is its ability to contribute to the overall clinical success of patients served by enabling essential care to be provided without fear or harm to participants during an encounter. Many tactics can be used, but one of the most important is understanding the underlying reason for the behavior (Meyerson, 2023). By connecting with the patient through conversation and active listening, the staff member may find the patient is in pain, feels fearful or anxious, or feels misunderstood or unheard. Having this information will allow the caregiver to respond appropriately, often bringing resolution to the patient's concern.

Education and Training

Various forms of training exist in the public domain, but it is vital that different platforms are used to meet each person in the manner they best learn. One important facet of workplace violence training is developing a safety plan specific to the clinic. This safety plan should be reviewed annually with all staff and providers. Safety drills should accompany the plan to assess for appropriate responses during a serious workplace violence event.

Electronic Health Record Flagging

Patients may visit various clinics within the same hospital system; thus, electronic health record flagging helps ensure communication with clinic staff across visits. Many electronic health record systems have the functionality of a safety risk flag that can be used to identify the patient as being at risk for violent behaviors, describe what the behavior is, and identify any potential known triggers. Being aware of the potential for violent physical behavior or verbal outbursts ahead of a clinic visit can allow staff and providers to prepare.

Patient Rights and Responsibilities

Establishing expectations of mutual respect before care begins can be a valuable means of laying the groundwork for appropriate interactions moving forward. One way is to create a Patient Rights and Responsibilities document that the patient reviews and signs before their first visit. This document lists the mutually respectful means of patient and staff interactions and points necessary for a successful clinical outcome. This slightly differs from what some clinics call a Code of Conduct, which focuses on the patient's behavior without necessarily offering mutuality to clinic staff and providers.

Dismissals or Termination

If a patient visiting the ambulatory care clinic repeatedly exhibits behaviors that put staff at risk, those patients should be notified in writing of expectations at future clinic visits. If violent behaviors toward staff continue after expectations have been formally set, dismissal from care in that location or termination of the patient/provider relationship may be indicated. These patients cannot be denied care in an emergency department, even if associated with that clinic's hospital system.

Many organizations are encumbered by laws and regulations that prevent enforcing zero tolerance policies against workplace violence, necessitating a 'not tolerating' culture instead. This conflict leaves employees feeling unsupported. In response, many organizations set expectations for patients and visitors to give employees and their leaders a tool to reinforce and set boundaries. The Emergency Medical Treatment and Labor Act [EMTALA] requires health care institutions to provide a screening examination and emergency care, if needed, to any individual presenting to an emergency department (U.S. Department of Health and Human Services, 2012). Some EMTALA situations result in the hospitalization and reinstatement of ambulatory care to previously dismissed or terminated patients. Examples of accommodations are for patients who need continued care for 30 days post-surgery or for situations where there are no other care options outside the organization.

Conclusion

Many tools and resources to mitigate workplace violence are aimed at intervening in the inpatient environment. Workplace violence risk assessments geared toward ambulatory care would factor in ways violence occurs in assorted settings. Assessments need to address the verbal, written, and video violence health care workers experience so they may create preventative, actionable plans. Violence screenings tailored to the fast pace, range of staff credentials, and the mixture of patients and visitors in the setting are needed to provide a way to proactively tailor care to risk factors identified. National nursing quality indicators specific to ambulatory care will help spread awareness of the problem's pervasiveness and stimulate improvements for better outcomes for health care workers. $

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NOTE: The "Perspectives in Ambulatory Care" column makes sense of today's changing ambulatory care market. It is written by members of the American Academy of Ambulatory Care Nursing (AAACN) and edited by Mary Jo Vetter, DNP, RN, AGPCNP-BC, FAANP. For more information about AAACN, please visit www.aaacn.org; email aaacn@aaacn.org; or call (800) AMB-NURS.

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