Briefing Note

Protecting Health Workers from Exposure to Occupational Violence

K2P Briefing Notes quickly and effectively advise policymakers and stakeholders about a pressing public issue by bringing together global research evidence and local evidence. K2P Briefing Notes are prepared to aid policymakers and other stakeholders in managing urgent public health issues. K2P Briefing Notes describe priority issues, synthesize context-specific evidence, and offer recommendations for action.

Briefing Note

+ Included

Description of a priority issue

Synthesis of contextualized evidence

Recommendations for addressing the issue

× Not Included

Does not conduct a **comprehensive review of the literature** but relies on a quick assessment of databases

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K2P Briefing Note

Protecting Health Workers from Exposure to Occupational Violence

Knowledge to Policy Center K2P

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Contents

Speaking Notes

Speaking Notes

- Workplace violence (WPV) has serious consequences on human resources for health and if not dealt with may lead to lack of productivity, turnover and sub-optimal patient outcomes.
- An alarmingly high prevalence of WPV has been reported (62% verbal abuse and 10 % physical violence among nurses), to which professional burnout and likelihood-to-quit have been significantly associated.
- Despite the alertness of the media and its promptness in shedding light on the matter, recent reports of WPV incidents in hospitals in Lebanon are absent. This can be linked to the problem of under-reporting which is associated with the absence of established reporting systems at Lebanese health care institutions.
- The integration of a section related to the presence and enforcement of antiviolence policies and procedures into the occupational health chapter of the national accreditation requirements of health care facilities in Lebanon has become a necessity.
- The development of anti-violence reporting tools and mechanisms will support and protect health workers.
- The establishment of a multidisciplinary Occupational Health and Safety committee and a national public awareness campaign is needed to shed further attention on this critical matter.

Executive Summary

Purpose

The purpose of this Briefing Note is to elucidate the current prevalence of occupational violence within the health care setting in Lebanon and offer recommendations to protect health care workers from exposure to occupational violence.

Issue

Occupational violence in health care settings is a global phenomenon (Beech & Leather, 2006; McPhaul & Lipscomb, 2004; Taylor & Rew, 2011; Whelan, 2008), and various studies have revealed that Lebanon is no exception in that regard (M. Alameddine & Yassin, 2013; M. Alameddine, Kazzi, El-Jardali, Dimassi, & Maalouf, 2011, Deeb, 2003). Whether verbal or physical, vertical or horizontal, workplace violence (WPV) has serious consequences on human resources for health and if not dealt with may lead to lack of productivity, turnover and sub-optimal patient outcomes (Fernandes et al., 1999; Jenkins, Rocke, McNicholl, & Hughes, 1998; Kowalenko, Walters, Khare, Compton, & Michigan College of Emergency Physicians Workplace Violence Task Force, 2005; Pich, Hazelton, Sundin, & Kable, 2010). Addressing WPV in health care organizations should become an urgent national priority, and attention/efforts on behalf of policy makers towards this issue may alleviate the associated burden.

Background and Current Situation

Studies conducted within the health care sector in Lebanon have revealed a high prevalence of workplace violence; one study revealed 62% verbal abuse and 10% physical violence among nurses (American University of Beirut, 2012). Moreover, an assortment of factors has been significantly associated with exposure violence, including professional burnout and intention to quit. Findings also revealed some serious shortcomings with the security measures in place at surveyed health care organizations, which are amenable to interventions. These include, but are not limited to, the lack of antiviolence policies and regulations in most health care facilities in Lebanon (M. Alameddine et al., 2011; American University of Beirut, 2012). Not to

mention that there are no guidelines in the Ministry of Public Health (MOPH) accreditation standards addressing WPV. As such, there is no national WPV reporting system for the health sector and no established body responsible for dealing with incidents.

What the Evidence Says

Health care managers worldwide have been urged to deal with violence prevention within the workplace setting as an institutional priority, working towards the creation of a zero tolerance policy. Several national and international agencies for workplace safety have already mandated such policies (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005) as they have already been established as a means to decrease violence in the workplace (Gallant-Roman, 2008; Whelan, 2008). Guidelines adapted for addressing WPV in the health sector revolve around: preventing WPV, dealing with WPV, mitigating the impact of WPV, supporting victims of WPV, and ensuring sustainability of interventions. Such action may entail the involvement of individuals at different levels: policy-makers, organizations/institutions, regulatory bodies, and individual professionals.

Recommendations

- Integrate a section related to the presence and enforcement of anti-violence policies and procedures into the occupational health chapter of the national accreditation requirements of health care facilities in Lebanon.
- Develop anti-violence reporting tools and mechanisms that allow workers exposed to WPV to report incidents of violence. Timely investigations of incidents by an Occupational Health and Safety Committee should be initiated and action taken according to a designed decision matrix.
- Conduct a national awareness campaign in collaboration with media outlets and other stakeholders, to build a real understanding of the issue among health care personnel at all levels as well as the general public and foster positive attitudes and behaviours.

Content

Purpose

The purpose of this Briefing Note is to elucidate the current prevalence of occupational violence within the health care setting in Lebanon and offer recommendations to protect health care workers from exposure to occupational violence.

Issue

Occupational violence in health care settings is a global phenomenon (Beech & Leather, 2006; McPhaul & Lipscomb, 2004; Taylor & Rew, 2011; Whelan, 2008), and various studies have revealed that Lebanon is no exception in that regard (M. Alameddine & Yassin, 2013; M. Alameddine et al., 2011). A study on Emergency Department (ED) workers in six tertiary hospitals revealed that a disquieting proportion of 81 % of surveyed ED staff was subject to Verbal Abuse (VA), and even more alarmingly, 34.6% of nurses have been subjected to physical violence (PV) during that period (M. Alameddine et al., 2011). Whether verbal or physical, vertical or horizontal, workplace violence (WPV) has serious consequences on human resources for health and if not dealt with may lead to lack of productivity, turnover and sub-optimal patient outcomes (Fernandes et al., 1999; Jenkins et al., 1998; Kowalenko et al., 2005; Pich et al., 2010). This was observed in the Lebanese context where 35% of ED workers conveyed intent to leave their jobs and 20% are uncertain whether to stay or leave (M. Alameddine et al., 2011). Moreover, there was a reported absence or unawareness of the presence of anti-violence policies in their institutions amongst two thirds of the workers with only a quarter of ED staff confirming that ED policies, when present, are being enforced (M. Alameddine et al., 2011). Such findings become more alarming when coupled with the high reported attrition of nurses from the Lebanese market and the reports that indicate that Lebanese nurses suffer from low job satisfaction, poor retention and high turnover (El-Jardali, Dumit, Jamal, & Mouro, 2008; El-Jardali, Dimassi, Dumit, Jamal, & Mouro, 2009). Addressing WPV in health care organizations should become an urgent national priority, and attention/efforts on behalf of policy makers towards this issue may alleviate the associated burden.

Background to Briefing Note

A K2P Briefing Note quickly and effectively advises policymakers and stakeholders about a pressing public issue by bringing together global research evidence and local evidence.
A K2P Briefing Note is prepared to aid policymakers and other stakeholders in managing urgent public health issues.

A K2P Briefing Note describes priority issues, synthesizes context-specific evidence, and offers recommendations for action.

The preparation of the briefing note involved six steps:

1) *Identifying and selecting a relevant topic according to K2P criteria*
2) *Appraising and synthesizing relevant research evidence*
3) *Drafting the Briefing Note in such a way as to present concisely and in accessible language the global and local research evidence;*
4) *Undergoing merit review*
5) *Finalizing the Briefing Note based on the input of merit reviewers.*
6) *Submitting finalized Briefing Note for translation into Arabic, validating translation and disseminating through policy dialogues and other mechanisms.*

Background

Within the Lebanese context, studies revealed the high prevalence of WPV, whether VA or PV. A study examining health workers' exposure to violence at Lebanese EDs revealed that 70% of surveyed ED workers were exposed to violence at least once over the last twelve months prior to the survey. It also showed that public hospitals displayed a significantly higher level of exposure to occupational violence compared to academic medical centers and private hospitals. This study further revealed an assortment of factors that are significantly associated with exposure to both verbal abuse and physical violence, including: professional burnout, likelihood-to-quit, nurse status (Registered Nurse versus Registered Practical Nurse) and public hospital employment. Findings also revealed some serious shortcomings with the security measures in place at surveyed health care organizations, which are amenable to interventions. Most importantly, the study showed that the causes behind most incidents of violence are amenable to interventions (M. Alameddine et al., 2011).

A more recent study focused more on nurses' exposure to occupational violence and revealed that 62% of nurses in Lebanon are being subjected to VA in the workplace while 10 % are being subjected to PV. The study, which was conducted in 2012, found that 32% of the surveyed nurses indicated likelihood to leave their jobs while another 22% were undecided. Surveyed nurses exhibited clear signs of occupational burnout with 54% reporting high levels of emotional exhaustion, 29% reporting high levels of depersonalization, and 24.1% reporting low levels of personal accomplishment (American University of Beirut, 2012).

Moreover, antiviolence policies and regulations are lacking in most health care facilities in Lebanon. The study conducted by Alameddine et al. (2011) for instance revealed that only one third of surveyed employees have confirmed the presence of anti-violence policies in their institutions, with the rest indicating either the absence of such policies or that they had no knowledge of their presence/absence (M. Alameddine et al., 2011). Not to mention that there are no guidelines in the Ministry of Public Health (MOPH) accreditation standards addressing WPV. As such, there is no national WPV reporting system for the health sector and no established body responsible for dealing with incidents.

Current Situation

The results of the study mentioned above prompted the organization of a multi-stakeholder Policy Forum on Violence and Aggression in Emergency Departments in Lebanon that was held in April 2011 (M. Alameddine & Yassin, 2013). Policy and decision makers along with other key actors were invited to participate in a discussion around possible actions that would decrease the exposure of health care workers to violence. The 25 participating stakeholders included both state actors (MOPH and the Internal Security Forces) and non-state actors (international non-governmental organizations (NGOs), national NGOs, media representatives, and representatives of the Order of Physicians, Syndicate of Nurses and Syndicate of Private Hospitals), as well as leaders/administrators from major public and private hospitals. Stakeholders' recommendations involved those at the policy level that entailed the legislation of mandatory reporting of any acts of violence, which would be coupled with the formation of a "National Commission" to manage all reports on incidents of violence. WPV, an issue consistently reported in the literature, is largely associated with a lack of clear policies and procedures defining acceptable behavior and to an absence of systematic mechanisms to address unacceptable behavior (Forster, Petty, Schleiger, & Walters, 2005). As such, stakeholders underscored the need to establish anti-violence policies that require hospitals to take the necessary action to protect their staff (M. Alameddine & Yassin, 2013).

These research activities on violence within the health sector in Lebanon have received much attention from the media. Two television interviews in July 2010 and one radio interview in September 2010 have tackled violence at EDs in Lebanon. In September 2010, as well, the results of the study "Determinants of Violence in Emergency Departments in Lebanon" were published in all local newspapers and many regional news outlets. This attests to the significance of the topic that has prompted media to actively report and shed light on the matter. Such momentum should be drawn on to push this issue forward.

In addition to the alertness of the media, regional experts in the field of human resources have expressed great interest in the topic of WPV and have conveyed enthusiasm to join efforts and collaborate in bringing this area of concern to the agenda of decision and policy makers in the health care sector. However, recent reports of WPV incidents in hospitals are absent from the media. This can be linked to the problem of under-reporting which is associated with the absence of established reporting systems at Lebanese health care institutions. Such a finding further exacerbates the urgency of

establishing rigorous reporting systems as soon as possible. Noteworthy is the positive role played by the Lebanese Order of Nurses which has built on reported violence incidents and research findings by spearheading multiple initiative aiming at creating a positive and safe work environment for Lebanese nurses over the last three years. Such initiatives included writing up letters to Lebanese officials including the Minister of Health, Directors of hospitals and other Orders and Syndicates. It further included organizing an anti-violence workshop, a press conference, key note speeches, as well as writing up of articles and editorials. Last but not least, the Order of Nurses had a number of media appearances and produced a short TV spot to improve awareness on this issue.

Efforts exerted towards tackling the issue of WPV are highlighted in the timeline below

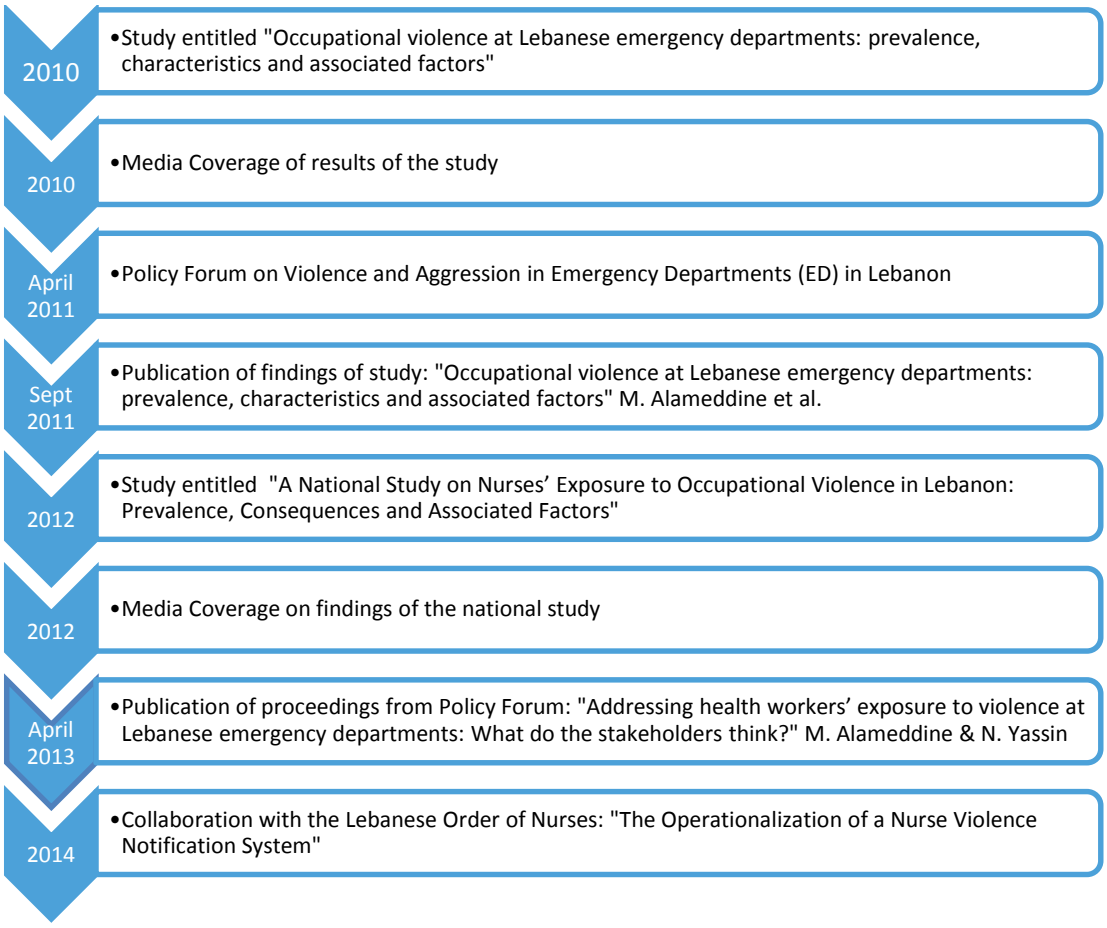

Figure 1 **Efforts towards tackling the issue of workplace violence**

What we know from Evidence

- Several national and international agencies for workplace safety mandated the implementation of zero tolerance policies as an effective means to decrease violence in the workplace (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005; Gallant-Roman, 2008; Whelan, 2008)

Anti-violence policies should be incorporated into a comprehensive multi-dimensional violence prevention program that addresses the full range of interacting system factors contributing to WPV (Bentley, Catley, Forsyth, & Tappin, 2014; G. L. Gillespie, Gates, Miller, & Howard, 2010; ILO, ICN, WHO, & PSI, 2002; Wand & Coulson, 2006) in order to ensure effective and sustainable risk management (Bentley et al., 2014; Kling, Yassi, Smailes, Lovato, & Koehoorn, 2011).

The introduction of the occupational health and safety concept into an institution has shown to provide several advantages from improving the workplace environment to improving the health status of workers and their families:

Increase productivity (Bertera, 1990; Goetzel & Ozminkowski, 2008)

Reduce risks related to the workplace (Waddell & Burton, 2001; Walker, 2003)

Improve the image of the institution and increase retention (Fernández-Muñiz, Montes-Peón, & Vázquez-Ordás, 2009; Michie & Williams, 2003; Schat & Kelloway, 2003)

Control major diseases through workplace prevention programs, as occupational health is a contributor to public health (Becker, Cone, & Gerberding, 1989; Mahoney, Stewart, Hu, Coleman, & Alter, 1997)

The framework elaborated by the ILO/ICN/WHO/PSI 2002 can be considered as a basic reference tool for guiding the development of comparable instruments adapted to different cultures, situations, and needs (ILO et al., 2002). The guidelines presented cover the following areas of action: preventing WPV, dealing with WPV, mitigating the impact of WPV, supporting victims of WPV, and ensuring sustainability of interventions. Such action may entail the involvement of individuals at different levels: policy-makers, organizations/institutions, regulatory bodies, and individual professionals.

Table 1 **What we know from Evidence**

Area of Action	Intervention	Rationale	References
Preventing WPV	Clear policy statement on zero tolerance for WPV should be issued by top level management	⇢ Displays real commitment of the institution towards placing WPV as a high priority issue ⇢ Warns that no violent behavior will be tolerated	(R. F. AbuAlRub, Khalifa, & Habbib, 2007; Hahn et al., 2012; ILO et al., 2002; Keely, 2002; Mayhew & Chappell, 2003)
	Structural design of workplace premises, such as proper illumination, alarm systems, surveillance cameras	Allow for safe work environment	(Cooper & Swanson, 2002; ILO et al., 2002; Mayhew & Chappell, 2003)
	Training/educational sessions on WPV	⇢ Increasing health workers' awareness related to risks and training them to cope with potentially aggressive individuals and situations by helping them develop the adequate skills ⇢ Practical education is argued to be crucial in fostering aptitude in the early recognition and de-escalation of aggressive behavior	(R. F. AbuAlRub et al., 2007; M. Alameddine et al., 2011; Anderson, Fitzgerald, & Luck, 2010; Chapman, Perry, Styles, & Combs, 2009; G. L. Gillespie, Farra, Gates, Howard, & Atkinson, 2013; ILO et al., 2002; Knowles, Holton, & Swanson, 1998; Wand & Coulson, 2006; Wassell, 2009)

Area of Action	Intervention	Rationale	References
Dealing with WPV	⇢ Establishment of a confidential violence reporting system using user-friendly and non-time consuming forms, with structured and regular feedback from supervisors, coupled with education sessions regarding correct usage of reporting forms; could be electronic and integrated into a centralized database for violent events ⇢ Adequate responses including timely incident investigations with perpetrators firmly sanctioned irrespective of their hierarchical position	⇢ Proven to increase the level of reporting ⇢ Explicit and visible management commitment ⇢ Provides support to victims of WPV ⇢ Showing demonstrable changes in the work environment is crucial in order to avoid fatigue and dissuasion of staff from reporting	(Anderson et al., 2010; Arnetz & Arnetz, 2000; Di Martino, 2002; ILO et al., 2002; Mayhew & Chappell, 2003; Richards, 2003; Azar et al. 2015) (Anderson et al., 2010; Di Martino, 2002; Gacki-Smith et al., 2010; G. L. Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014; Hahn et al., 2012; ILO et al., 2002; Magnavita, 2011; Mayhew & Chappell, 2003; Richards, 2003; Wand & Coulson, 2006)
Mitigating the impact of WPV & supporting victims	⇢ De-briefing sessions facilitated by appropriately trained individuals	⇢ Helps victims of WPV share personal experience with others to diffuse the impact of violence, offering re-assurance and support	(Di Martino, 2002; ILO et al., 2002)
	⇢ Counseling sessions for staff subjected to WPV	⇢ Necessary for victims in need for further support	Di Martino, 2002; ILO et al., 2002)
Ensuring sustainability of interventions	⇢ Mandate the establishment of these policies and procedures through standards included among the national accreditation	⇢ Various accrediting bodies have already covered WPV, such as the World	WHO OSHA Accreditation Canada QHNZ

Area of Action	Intervention	Rationale	References
	standards for health care institutions	Health Organization (WHO), the Occupational Safety & Health Accreditation (OSHA), Accreditation Canada, the European Agency for Safety and Health at work and Quality Health New Zealand (QHNZ)	

Recommendations

Recommendations

Recommendation 1

Based on evidence, an essential step towards enforcing a system that could ensure safety and protection of health care workers is for the MOPH at a national/macro level to integrate a section related to the presence and enforcement of antiviolence policies and procedures into the occupational health chapter of the national accreditation requirements of health care facilities in Lebanon. Compliance with the standards set on workplace safety should be mandatory for accreditation. Accreditation standards present as an opportune entry point for efforts directed towards protecting health workers from WPV, as various positive factors have been associated with hospital accreditation. Health care staff in Lebanon reported improvements in quality, safety, and patient satisfaction in their hospitals as a result of the process (El-Jardali, Jamal, Dimassi, Ammar, & Tchaghchaghian, 2008; Saleh, Bou Sleiman, Dagher, Sbeit, & Natafgi, 2013). The proposed standards are written in the format of the actual MOPH standards (Annex I).

Recommendation 2

At the national level as well, Orders and Syndicates of health care workers should develop anti-violence reporting tools and mechanisms that allow workers exposed to WPV to report incidents of violence. Such initiatives have been shown effective in improving violence monitoring and in preventing the occurrence of further incidents (Cooper & Swanson, 2002; Warshaw & Messite, 1996). A multidisciplinary Occupational Health and Safety committee should be established that has the responsibility to collect and assess reports of WPV from the accredited institutions across the country. Timely investigations of incidents should be initiated and with adequate responses and follow-up according to a designed decision matrix, including sanctions for perpetrators and assistance for both victim and perpetrator. Proper monitoring and evaluation for the violence reporting system would be under the jurisdiction of the Orders and Syndicates.

Recommendation 3

"Knowledge and awareness building" is the first among a list of best initiatives whose adoption is recommended to tackle WPV in the health care sector (Di Martino, 2002). Moreover, media advocacy efforts have proven effective in advancing policy making and thus promoting public health (Wallack & Dorfman, 1996). In the context of WPV, this entails raising

awareness and building a real understanding of the issue among health care personnel at all levels, in addition to fostering positive attitudes and behaviors (Di Martino, 2002). This must necessarily be accompanied by a widespread publicity (information and media) campaign, involving trade unions and professional-occupational organizations in order to increase public awareness of this problem and to ensure that expected standards of behavior are known (Di Martino, 2002; Mayhew & Chappell, 2003). The development of a series of national initiatives to promote awareness is therefore crucial (Di Martino, 2002).

As such, a national awareness campaign must be conducted, in collaboration with media outlets and other stakeholders, in order to:

a) Enhance the public awareness regarding the roles of the different members of health care teams, particularly nurses. This is recommended by several studies which have shown that nurses are the most vulnerable category of health workers to WPV, and which have categorized the lack of social and cultural awareness regarding their role as one of the factors contributing to WPV (R. F. AbuAlRub & Al-Asmar, 2011; R. F. AbuAlRub & Al-Asmar, 2014; M. Alameddine et al., 2011).
b) Enhance the public awareness on the perils of WPV and about what is unacceptable behavior and how it is sanctioned. Informing patients about the measures taken and about what is unacceptable behavior in health care organizations' premises (i.e. excessive noise, general verbal abuse, racial and sexual abuse, malicious allegations, offensive gestures, drug and alcohol abuse, damage, theft, threats and violence) is indeed the starting point of any WPV prevention strategy in order to build understanding among all parties concerned at all levels (Di Martino, 2002; Richards, 2003). Publicity about the application of sanctions will reflect to the community the serious enforcement of the zero tolerance policy (Mayhew & Chappell, 2003).
c) Raise awareness of health workers on the appropriate standards of behavior and the established systems of response and reporting.

References

References

AbuAlRub, R. F., & Al-Asmar, A. H. (2011). Physical violence in the workplace among jordanian hospital nurses. *Journal of Transcultural Nursing, 22*(2), 157-165.

AbuAlRub, R. F., & Al-Asmar, A. H. (2014). Psychological violence in the workplace among jordanian hospital nurses. *Journal of Transcultural Nursing : Official Journal of the Transcultural Nursing Society / Transcultural Nursing Society, 25*(1), 6-14.

AbuAlRub, R. F., Khalifa, M. F., & Habbib, M. B. (2007). Workplace violence among iraqi hospital nurses. *Journal of Nursing Scholarship : An Official Publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau, 39*(3), 281-288.

Alameddine, M., & Yassin, N. (2013). Addressing health workers' exposure to violence at lebanese emergency departments: What do the stakeholders think? *Journal of Hospital Administration, 2*(4), 31-36.

Alameddine, M., Kazzi, A., El-Jardali, F., Dimassi, H., & Maalouf, S. (2011). Occupational violence at lebanese emergency departments: Prevalence, characteristics and associated factors. *Journal of Occupational Health, 53*(6), 455-464.

American University of Beirut. (2012, December). AUB study: Nurses subjected to higher levels of occupational violence than security guards [press release]. Message posted to http://www.aub.edu.lb/news/2012/Pages/nurses-violence.aspx

Anderson, L., Fitzgerald, M., & Luck, L. (2010). An integrative literature review of interventions to reduce violence against emergency department nurses. *Journal of Clinical Nursing, 19*(17-18), 2520-2530.

Arnetz, J. E., & Arnetz, B. B. (2000). Implementation and evaluation of a practical intervention programme for dealing with violence towards health care workers. *Journal of Advanced Nursing, 31*(3), 668-680.

Azar, M., Kurdahi Badr, L., Samaha, H, Dee, V. (2015) Does administrative support negate the consequences of nurse abuse? Journal of Nursing Management. In press.

Becker, C. E., Cone, J. E., & Gerberding, J. (1989). Occupational infection with human immunodeficiency virus (HIV). risks and risk reduction. *Annals of Internal Medicine, 110*(8), 653-656.

Beech, B., & Leather, P. (2006). Workplace violence in the health care sector: A review of staff training and integration of training evaluation models. *Aggression and Violent Behavior, 11*(1), 27-43.

Bentley, T. A., Catley, B., Forsyth, D., & Tappin, D. (2014). Understanding workplace violence: The value of a systems perspective. *Applied Ergonomics, 45*(4), 839-848.

Bertera, R. L. (1990). The effects of workplace health promotion on absenteeism and employment costs in a large industrial population. *American Journal of Public Health, 80*(9), 1101-1105.

Chapman, R., Perry, L., Styles, I., & Combs, S. (2009). Consequences of workplace violence directed at nurses. *British Journal of Nursing (Mark Allen Publishing), 18*(20), 1256-1261.

Clements, P. T., DeRanieri, J. T., Clark, K., Manno, M. S., & Kuhn, D. W. (2005). Workplace violence and corporate policy for health care settings. *Nursing Economic$, 23*(3), 119-24, 107.

Cooper, C. L., & Swanson, N. (2002). *Workplace violence in the health sector: State of the art* International Labour Organization.

Di Martino, V. (2002). *Workplace violence in the health sector. country case studies brazil, bulgaria, lebanon, portugal, south africa, thailand and an additional australian study*

Deeb, M. (2003) Workplace violence in the health sector: Lebanon country case study. Joint programme on workplace violence in the health sector. International Labour Organization. Geneva, Switzerland. (http://who.int/violence_injury_prevention/violence/en/wpv_lebanon.pdf?ua=1)

El-Jardali, F., Dimassi, H., Dumit, N., Jamal, D., & Mouro, G. (2009). A national cross-sectional study on nurses' intent to leave and job satisfaction in lebanon: Implications for policy and practice. *BMC Nursing, 8*, 3.

El-Jardali, F., Dumit, N., Jamal, D., & Mouro, G. (2008). Migration of lebanese nurses: A questionnaire survey and secondary data analysis. *International Journal of Nursing Studies, 45*(10), 1490-1500.

El-Jardali, F., Jamal, D., Dimassi, H., Ammar, W., & Tchaghchaghian, V. (2008). The impact of hospital accreditation on quality of care: Perception of lebanese nurses. *International Journal for Quality in Health Care : Journal of the International Society for Quality in Health Care / ISQua, 20*(5), 363-371.

Fernandes, C. M., Bouthillette, F., Raboud, J. M., Bullock, L., Moore, C. F., Christenson, J. M., et al. (1999). Violence in the emergency department: A survey of health care workers. *CMAJ : Canadian Medical Association Journal = Journal De l'Association Medicale Canadienne, 161*(10), 1245-1248.

Fernández-Muñiz, B., Montes-Peón, J. M., & Vázquez-Ordás, C. J. (2009). Relation between occupational safety management and firm performance. *Safety Science, 47*, 980.

Forster, J. A., Petty, M. T., Schleiger, C., & Walters, H. C. (2005). kNOw workplace violence: Developing programs for managing the risk of aggression in the health care setting. *The Medical Journal of Australia, 183*(7), 357-361.

Gacki-Smith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2010). Violence against nurses working in US emergency departments. *Journal of Healthcare Protection Management : Publication of the International Association for Hospital Security, 26*(1), 81-99.

Gallant-Roman, M. A. (2008). Ensuring nurses' safety in violent workplaces. *AAOHN Journal : Official Journal of the American Association of Occupational Health Nurses, 56*(2), 51-52.

Gillespie, G. L., Farra, S. L., Gates, D. M., Howard, P. K., & Atkinson, K. L. (2013). The qualitative learning experience of healthcare workers completing a hybrid workplace violence educational program. *Journal of Nursing Education & Practice, 3*(11), 54-64.

Gillespie, G. L., Gates, D. M., Kowalenko, T., Bresler, S., & Succop, P. (2014). Implementation of a comprehensive intervention to reduce physical assaults and threats in the emergency department. *Journal of Emergency Nursing: JEN : Official Publication of the Emergency Department Nurses Association,*

Gillespie, G. L., Gates, D. M., Miller, M., & Howard, P. K. (2010). Workplace violence in healthcare settings: Risk factors and protective strategies. *Rehabilitation Nursing : The Official Journal of the Association of Rehabilitation Nurses, 35*(5), 177-184.

Goetzel, R. Z., & Ozminkowski, R. J. (2008). The health and cost benefits of work site health-promotion programs. *Annual Review of Public Health, 29*, 303-323.

Hahn, S., Hantikainen, V., Needham, I., Kok, G., Dassen, T., & Halfens, R. J. (2012). Patient and visitor violence in the general hospital, occurrence, staff interventions and consequences: A cross-sectional survey. *Journal of Advanced Nursing, 68*(12), 2685-2699.

ILO, ICN, WHO, & PSI. (2002). *Framework guidelines for addressing workplace violence in the health sector*. Geneva: International Labour Office.

Jenkins, M. G., Rocke, L. G., McNicholl, B. P., & Hughes, D. M. (1998). Violence and verbal abuse against staff in accident and emergency departments: A survey of consultants in the UK and the republic of ireland. *Journal of Accident & Emergency Medicine, 15*(4), 262-265.

Keely, B. R. (2002). Recognition and prevention of hospital violence. *Dimensions of Critical Care Nursing : DCCN, 21*(6), 236-241.

Kling, R. N., Yassi, A., Smailes, E., Lovato, C. Y., & Koehoorn, M. (2011). Evaluation of a violence risk assessment system (the alert system) for reducing violence in an acute hospital: A before and after study. *International Journal of Nursing Studies, 48*(5), 534-539.

Knowles, M. S., Holton, E. F., & Swanson, R. A. (1998). *The adult learner*. Houston: Gulf Publishing.

Kowalenko, T., Walters, B. L., Khare, R. K., Compton, S., & Michigan College of Emergency Physicians Workplace Violence Task Force. (2005). Workplace violence: A survey of emergency physicians in the state of michigan. *Annals of Emergency Medicine, 46*(2), 142-147.

Magnavita, N. (2011). Violence prevention in a small-scale psychiatric unit: Program planning and evaluation. *International Journal of Occupational and Environmental Health, 17*(4), 336-344.

Mahoney, F. J., Stewart, K., Hu, H., Coleman, P., & Alter, M. J. (1997). Progress toward the elimination of hepatitis B virus transmission among health care workers in the united states. *Archives of Internal Medicine, 157*(22), 2601-2605.

Mayhew, C., & Chappell, D. (2003). Workplace violence in the healthcare sector - A case study in australia. *Journal of Occupational Health and Safety, 19*(6), 1-48.

McPhaul, K. M., & Lipscomb, J. A. (2004). Workplace violence in health care: Recognized but not regulated. *Online Journal of Issues in Nursing, 9*(3), 7.

Michie, S., & Williams, S. (2003). Reducing work related psychological ill health and sickness absence: A systematic literature review. *Occupational and Environmental Medicine, 60*(1), 3-9.

Pich, J., Hazelton, M., Sundin, D., & Kable, A. (2010). Patient-related violence against emergency department nurses. *Nursing & Health Sciences, 12*(2), 268-274.

Richards, J. (2003). *Management of workplace violence victims*. Geneva: ILO/ICN/WHO/PSI Joint program on workplace violence in the health sector.

Saleh, S. S., Bou Sleiman, J., Dagher, D., Sbeit, H., & Natafgi, N. (2013). Accreditation of hospitals in lebanon: Is it a worthy investment? *International Journal for Quality in Health Care : Journal of the International Society for Quality in Health Care / ISQua, 25*(3), 284-290.

Schat, A. C., & Kelloway, E. K. (2003). Reducing the adverse consequences of workplace aggression and violence: The buffering effects of organizational support. *Journal of Occupational Health Psychology, 8*(2), 110-122.

Taylor, J. L., & Rew, L. (2011). A systematic review of the literature: Workplace violence in the emergency department. *Journal of Clinical Nursing, 20*(7-8), 1072-1085.

Waddell, G., & Burton, A. K. (2001). Occupational health guidelines for the management of low back pain at work: Evidence review. *Occupational Medicine (Oxford, England), 51*(2), 124-135.

Walker, D. (2003). Cost and cost-effectiveness of HIV/AIDS prevention strategies in developing countries: Is there an evidence base? *Health Policy and Planning, 18*(1), 4-17.

Wallack, L., & Dorfman, L. (1996). Media advocacy: A strategy for advancing policy and promoting health. *Health Education Quarterly, 23*(3), 293-317.

Wand, T. C., & Coulson, K. (2006). Zero tolerance: A policy in conflict with current opinion on aggression and violence management in health care. *Australasian Emergency Nursing Journal, 9*(4), 163-170.

Warshaw, L. J., & Messite, J. (1996). Workplace violence: Preventive and interventive strategies. *Journal of Occupational and Environmental Medicine / American College of Occupational and Environmental Medicine, 38*(10), 993-1006.

Wassell, J. T. (2009). Workplace violence intervention effectiveness: A systematic literature review. *Safety Science, 47*(8), 1049-1055.

Whelan, T. (2008). The escalating trend of violence toward nurses. *Journal of Emergency Nursing: JEN : Official Publication of the Emergency Department Nurses Association, 34*(2), 130-133.

Annexes

Annexes

Annex I. Proposed standards to be added to the current MOPH accreditation standards.

I. Policy Statement

Under the current "Occupational Health & Safety" chapter Standard 2:

2.7 Either the committee or an ad-hoc one is responsible for implementing and evaluating the violence prevention program needs.

Under the current "Occupational Health & Safety" chapter Standard 4:

Policies and procedures exist for at least the following

4.14 Anti-violence

- Commitment by the employer to ensure a worker-supportive environment and a culture of safety and security for anyone entering the facility.
- Zero-tolerance policy for forms of violence or aggressive behavior whether verbal, physical, or sexual.
- Written violence prevention program for large health care organizations. For small establishments, a violence prevention program is required; yet, it doesn't necessarily have to be documented.
- Roles and responsibilities should be assigned in the violence prevention program for all working individuals to prevent violent incidents; it includes managers, supervisors and employees.
- Code of conduct that identifies acceptable from unacceptable behavior.
- Procedure for management of unacceptable behavior.
- Procedure identifying the process of communication with the police regarding severe violent incidents.
- Procedure for reprimands for the perpetrators and compensations for the aggrieved.

II. Safety Design

Under the current “Buildings” chapter additional standard:

Design work areas to ensure safety:

- Natural surveillance through use of equipment and attendance by safeguards to minimize/eliminate risks related to the physical environment.
- Installation of bullet-resistant walls and other barriers.
- Continuous maintenance of grounds and machines/equipment.
- Written procedure for identification of individuals entering the health care organization.
- Restriction of unnecessary access of the public to security sensitive areas.
- Proper establishment of waiting areas in terms of furniture and placement of doorways.
- Presence of emergency doors to avoid potential violent clients.
- Installation of proper internal and external lighting
- Allocation of specific rest rooms for staff.
- Ensuring a well-lit, safe, and a protected staff parking.
- Employers should provide the needed resources for communication between staff to enforce a culture of safety and security.

III. Violence Prevention Program

Under the current “Patient Safety & Risk Management” chapter Standard 3: Either the committee or an ad-hoc one is established for the following

In regards to hazard identification process

- Identify hazards at workplace related to environmental design.
- Identify hazards at workplace related to workplace layout.
- Identify hazards at workplace related to staff workload and work practices.
- Identify hazards at workplace related to staff-patient interactions.
- Identify hazards at workplace related to the nature of services offered at the facility.

- Attend to the hazards' nature, scope, and potential effect for workplace violence.
- Assessment of past reported incidents and associated control measures.
- Assessment of implementation of a reporting and data collection system.
- Documentation of risk assessments, safety meetings, and minutes of hazard identification.
- Assessment of proper documentation on risk assessments, incidents of violence, and the corresponding management strategies.
- Assessment of the training currently provided for staff for identifying and managing risks.
- Assessment of current security processes.

In regards to hazard and risk management

- Establish a continuous training education program for all staff.
- Train staffs on appropriate communication skills and behaviours that help diffuse volatile situations.
- Recognize corrective actions that may reduce exposures to workplace violence.
- Review past reports and identify management strategies.
- Involve actively staff in suggesting corrective strategies to safety and security procedures.
- Document the planned and implemented corrective actions.
- Train leaders on conflict management and coaching skills.
- Train leaders on elements of crisis management.
- Train leaders on grievance management.
- Establish a debriefing system.
- Inform individuals of potential risks and strategies to minimize their negative effects.
- Enforce the right for employees to refuse hazardous work.

- Emphasize on a reporting system and emergency calling that assures confidentiality and no reprimands from the side of the reporter.
- Ensure medical coverage and compensation provision for injured individuals.
- Formulate long-term objectives (to eliminate, isolate, or minimize risks) and monitor their effects.

All the aforementioned recommended standards are supported by at least two of the following

- Occupational Safety and Health Accreditation (OSHA)
- World Health Organization (WHO)
- Accreditation Canada
- European Agency for Safety and Health at Work
- Quality Health New Zealand (QHNZ)

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