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Addressing Workplace Violence in Healthcare

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Dr. Kathy DesRoches said, “When they see that you have graduated from the UNH Master’s program, they will know you earned it.”

ADDRESSING WORKPLACE VIOLENCE IN HEALTHCARE

Abstract

This research paper explores the prevalence, consequences, and mitigation strategies for workplace violence in healthcare. The literature focuses on the importance of leadership's involvement of the implementation of change, providing programing, and obtaining buy-in from staff to combat what has consistently been a factor leading to employee burnout, assaultive behavior, and compromised patient safety. It shows that workplace violence has been a constant in healthcare, however, has escalated post COVID-19 pandemic. Research and statistics show that workplace violence in healthcare is more prevalent than in other fields and is on the rise. The information contained in this research was obtained primarily from the University of New Hampshire Library, peer reviewed articles, journals and website searches. A multiple-choice survey was conducted using Survey Monkey, and electronic feedback was gathered. Questions asked were specific to workplace violence (physical assault) victims. Responses were collected anonymously. Data was then reviewed in a continuous effort to support staff, encourage leadership support and offer tailored training programs. The research showed ways that recipients of workplace violence can best be supported by leadership and what processes need to be improved.

Keywords: Workplace Violence, Healthcare assault, Healthcare burnout, Patient assault, and Post-COVID-19 violence.

Addressing Workplace Violence in Healthcare

As the Security Program Manager in a large New Hampshire hospital, I began to research the statistics of employees, particularly healthcare workers, who have experienced workplace violence while on duty in the hospital. Within the hospital where I work, there are an average of 7-13 physical assaults against staff per month. Staff members are hit, grabbed, kicked, spit on, and verbally assaulted.

To quantify the prevalence of violence, statistics are collected through Security reports, Employee Health reports, and system reporting. These statistics are provided to the State of New Hampshire Department of Health and Human Services. In addition, a workplace violence committee was established at the hospital to discuss trends, specific events, and mitigation strategies.

The consequences of these assaults are damaging to both the recipients of violence and the overall organization. Fatigue, burnout, PTSD, missed workdays, and attrition are just a few of the effects realized from workplace violence. There is also an adverse impact on the quality of patient care. Lack of empathy, stress, and errors result in factors that can be detrimental to the patient. Psychological effects on the staff lead to errors in medical diagnosis, medicine administration, and treatment planning. It also creates an atmosphere of mistrust, fear, and a lack of communication. The combining of these consequences breakdown quality patient care which are essential for a successful patient-centered outcome.

This research paper aims to explore ways to prevent and mitigate violence, and how leadership can support the employees and effect a positive change. Change must be leadership driven, employee focused, and establish a culture that promotes reporting, access to services, and training.

Training is often referenced to in research that pertains to workplace violence. Hospitals are required by the Occupational Safety and Health Administration (OSHA) to have written workplace violence policies with a focus on training (OSHA, 2016). Currently, there are only two departments within the hospital where training is mandatory in verbal de-escalation and physical defense skills. The emergency department and behavioral health require their staff to take this training, yet other departments realize the same violence and do not make it a requirement. The assault percentage is less involving employees who attend the training, and they are allowed to refresh their skills annually.

Most importantly, the needs and feelings of the affected employee must be kept in focus. Leadership must first establish a culture of trust, where staff feel safe and empowered to report events. The organization then needs to provide workplace violence related training that provides useful information to support the employee in recognizing signs of violence, conflict resolution techniques, and stress management strategies.

Literature Review

Workplace Violence in a Healthcare Setting

Workplace violence within a hospital has become its own pandemic in recent years. According to 2018 data from the Bureau of Labor Statistics, the most common source of nonfatal injuries and illnesses requiring days away from work in the healthcare and social assistance industry was assault on the healthcare worker. Healthcare and social services workers are five times as likely to suffer a workplace violence injury than workers overall (U.S. Bureau of Labor Statistics, 2018). Over 70% of emergency nurses reported physical or verbal assault by patients or visitors while they were providing patient care in the emergency setting (Wolf et al., 2014). Individuals who commit the assaults come from a diverse background and generally cannot be

singled out to one category. Workplace violence comes from a wide range of sources, such as patients, and their relatives (Mento, et al., 2020). Healthcare workers regularly face the risk of violent physical, sexual, and verbal assault from their patients (Brophy et al., 2018). Workplace violence is a grave issue that affects both workers and leadership (Beech & Leather, 2006).

Definition and Types of Workplace Violence

Workplace violence is defined as "any act or threat of physical violence, harassment, intimidation, or other disruptive behavior that occurs at the worksite" (OSHA, 2016). This definition encompasses a wide range of behaviors and actions that can create a hostile or unsafe work environment. The following categories are listed in order of their occurrence in a healthcare setting.

Verbal Abuse

Verbal abuse in the workplace can take various forms, including derogatory remarks, insults, shouting, humiliation, offensive jokes, and threats. It involves the use of language or communication that is intended to harm, intimidate, or belittle a coworker or employee (Hershcovis et al., 2007).

Physical Violence

The World Health Organization (2012) defines physical violence as the intentional use of physical force or power against another, such as beating, kicking, slapping, stabbing, shooting, pushing, biting, or pinching.

Sexual Harassment

The Equal Employment Opportunity Commission (U.S. EEOC, 2009) defines sexual harassment as any unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. It can also come in written form that include harassment of a sexual nature, including jokes referring to sexual acts.

The result of such workplace violence can have a negative affect on an individual's employment, interfere with their work performance, and create an intimidating, hostile, or offensive work environment. According to a meta-analysis of 47 observational studies, the overall prevalence of workplace violence against healthcare professionals was as follows. Verbal abuse accounted for the highest majority (61.2%), followed by psychological violence (50.8%), threats (39.5%), physical violence (13.7%), and sexual harassment (6.3%) (Lim et al., 2022).

Evidence that there is a Problem

The statistics speak volumes when compared to other work sectors. Healthcare support occupations have an assault-injury rate nearly 10 times the general sector (Kowalenko et al., 2013). Working in a hospital can now be viewed as being subject to violence more than other traditional career fields used to experiencing violence. Healthcare workers are now at a greater risk of being assaulted than police officers and prison guards (Brophy et al., 2018). Some of the risk factors that attribute to the exposure to violence include working directly with the public, working with people who are more likely to exhibit violence, working early morning hours, working in a community setting and working alone (Gillespie et al., 2010). Between 2011 and 2013, there were averaged 24,000 workplace assaults nationally with 75 percent of these occurring within healthcare (Phillips, 2016). Nurses are four times more likely to experience assaults than any other national healthcare worker, student nurses and those in psychiatric and learning disability areas at highest risk (Brophy et al., 2018).

In a study published in the Journal of Nursing Administration that involved registered members of the Emergency Nurses Association, 25% of the respondents reported being a victim to physical violence 20 times within a three-year period. 20% reported nearly 200 incidents of verbal violence within the same period (Gacki-Smith et al., 2009). Along with violence directed

towards nurses, physicians are also a frequent recipient of violence. OSHA reports that 48% of non-fatal workplace incidents occur in a healthcare setting and up to 50% of healthcare workers are the victim of violence at some point in their career (Caruso et al., 2022).

Statistics during the COVID-19 pandemic show that there has been a dramatic increase in assaults on healthcare workers and there does not appear to be an immediate return to pre-pandemic levels. In 1002 documented events, there was a significant increase of assaults from .05/1000 per month pre-pandemic to 4.3/1000 per month following (Brigo, et al., 2022).

Risk Factors

There are many risk and contributing factors to workplace violence. Violence erupts due to a number of circumstances to include staff behavior, patient behavior, setting, long wait times in the emergency room, and emotions involved. A 2017 study involving physicians and nurses in a large university hospital that focused on the primary cause of violence, 39% referred to staff behavior, 26% to the patient, 17% to conditions, and 10% to wait times (Shafran-Tikva et al., 2017). These numbers show that it is not always the external force that instigates the violence.

Healthcare worker behavior, such as exhibiting a dismissive attitude, disrespect, using a blunt tone, or displaying arrogance can contribute to the presentation of violence (Shafran-Tikva et al., 2017). These behaviors, the result of fatigue and burnout, can affect the nature of the interaction and be a precursor to violence. Burnout is attributable to enhanced workload, chronic fatigue, compassion fatigue, a loss in confidence, and an inappropriate work-life balance (Wood & Killion, 2007). While burnout specifically is caused by working in burdensome organizations, compassion fatigue occurs from dealing with traumatic experiences often (Slatten, et al., 2011).

Patient-related factors have a profound effect on workplace violence. Patients with mental health conditions or psychiatric disorders, such as schizophrenia, bipolar disorder, or

severe depression, can lead to unpredictable behaviors and outbursts of aggression (Phillips, 2016). In these cases, healthcare workers are more likely to encounter violent incidents due to patients' impaired judgment and impulse control.

Substance abuse is another patient-related factor that contributes to workplace violence. Patients who are under the influence of drugs or alcohol may become agitated, irrational, and prone to violent outbursts (Chapman et al., 2009). Moreover, healthcare workers may need to administer treatments or interventions that patients perceive as uncomfortable or intrusive, leading to confrontations. Examples are treating withdrawal symptoms and denying the access to certain medications.

Cognitive impairment, often seen in elderly patients with conditions like dementia, Alzheimer's, or delirium can also contribute to workplace violence. Patients with cognitive deficits may become disoriented, confused, or paranoid, leading to aggressive reactions when they perceive a threat (Pich et al., 2011). Social isolation during the COVID-19 lockdowns has had a detrimental effect on this population, leading to increased stress and anxiety (Encheva-Stoykova & Kalfin, 2022).

Diverse cultural backgrounds in the patient population can present challenges in communication due to language barriers or cultural differences. Misunderstandings can escalate into confrontations or violence if patients feel unheard or disrespected (World Health Organization, 2012).

Patients lacking adequate family or social support systems are more vulnerable to frustration and anger. They may feel isolated or overwhelmed, leading to heightened emotional states that can manifest as violence toward healthcare providers (Arnetz et al., 2015).

Finally, are patients with a history of violence. Patients with a history of violent behavior, either within or outside healthcare settings, pose a considerable risk. Past violent tendencies are strong predictors of future violent incidents (Mossman, 1994).

Consequences of Workplace Violence on Healthcare

The consequences of workplace violence have an effect on the healthcare worker, the patient, their family, and the entire healthcare system. Violence and stress can cause long term problems involving the employee's tenure, working environment, and worker relationships (Di Martino, 2002). Workers subject to workplace violence have an increased number of missed workdays, decreased job satisfaction, and an overall decreased level of feeling safe (Phillips, 2016).

Workplace violence can have severe physical and psychological consequences. The physical injuries can range from minor bruises to life-threatening conditions. Additionally, healthcare workers exposed to violence often suffer from psychological distress, including post-traumatic stress disorder (PTSD) and burnout (Wang et al., 2022).

Another significant consequence of workplace violence is its adverse impact on the quality of patient care. Impaired job performance, reduced concentration, and diminished empathy towards patients that can lead to medical errors, delayed care, and compromised patient safety (Gerberich et al., 2004). High turnover rates among healthcare workers following an event of workplace violence affects the organization and the patient. The fear of violence and the trauma associated with it can lead employees to leave their jobs or the healthcare profession altogether. This turnover results in staff shortages, which can further strain the healthcare system and compromise patient care (Winter et al., 2020). Recruiting and training replacements are costly and time-consuming processes that can disrupt the quality of patient care.

Turnover creates a financial burden that is placed upon both the institution and the worker, resulting in sizeable costs (Hassard et al., 2019). Workplace violence affects the mental health of employees, leading to lengthy periods away from work and can result in substantial financial losses for the employees and the organization (Caruso et al., 2022).

Strategies for Preventing and Mitigating Workplace Violence

Preventing and mitigating workplace violence in healthcare is crucial for the safety and wellbeing of the workers. A multifaceted and multidisciplinary approach will be the best avenue to generate results and programs must be fit to the specific location (Phillips, 2016). Involving teams, with a focus on the mission and vision of the organization is crucial to effect change in policy, training, and reporting. A vision requires the team to think about the future and what could be achieved (Payne, 2005).

It is the responsibility of the employer to provide a safe workplace and address violence (Gallant-Roman, 2008). OSHA violence prevention guidelines state that management commitment must be evident in the form of high-level involvement and support in the form of a written workplace violence policy and its implementation. Training and education follow policy, physical, and organizational changes.

The 2016 OSHA guidelines list four main components to an effective safety and health program preventing workplace violence. They are management commitment and employee involvement, worksite analysis, hazard prevention and control, and safety and health training.

A change in the tolerance of an assault is central to the proper culture within healthcare. Police are often not called when an assault occurs, and charges are not brought or followed up. This may send a message to patients and others that there are no consequences for acts of

aggression (Brophy, et al., 2018). This culture within an organization is directly affected by management commitment and employee involvement.

An important tool to determine current hazard prevention is a periodic survey used as a screening tool that is sent to employees to identify or confirm the need for improved security measures (OSHA 2016). These surveys, conducted by an organization either annually or following an incident of violence, can help to determine gaps or failures in standard work, procedures or policy. The data collected from these surveys is used to update policy, reinforce physical safety measures and change work flow.

Management needs to involve and educate the employees to recognize workplace violence and provide the proper channels to report events and problems (Keely, 2002). Once employees are trained, reporting mechanisms must be put into place to aid in the support of the employee and the recognition of the events of violence. The facts of each event rely on the accurate reporting of each event (Gallant-Roman, 2008). When an episode or event of workplace violence is immediately addressed, it may prevent escalation (Phillips, 2016).

The reporting process, and the fashion in which notification is made must be known to the employee and can be an area for improvement (Antão, 2020). Requiring all employees to report an assault to a supervisor or manager can assist in determining future actions to deter further assaults (OSHA, 2016). If simple reporting procedures are put in place that protect the reporting party from retribution, ensure support from leadership, then employees may be eager to adopt better reporting (Phillips, 2016). Along with this, services such as medical care, mandatory reporting, counseling services, prompt discharge of the aggressor, possible criminal charges, and the ability for the employee to leave for the day if an event happens, should all be made available to the affected employee (May & Grubbs, 2002).

Training, when targeted to individuals and departments, can result in fewer and less serious incidents, improved response, and less phycological lasting effects (Beech & Leather, 2006). Whichever training program is chosen, it must be organization specific, be a living document that changes with the needs of the staff, and identify risks (Gallant-Roman, 2008). Worker training is a crucial part of any quality and complete workplace violence training strategy. Training should cover the policies and procedures for a facility as well as de-escalation and self-defense training. Both de-escalation and self-defense training should include a hands-on component (OSHA, 2016). Also critical is its frequency and educators (Arbury et al., 2017).

Education needs to start with the supervision and leadership who are essential in supporting the program and its success. Most studies have showed that interventions have lessened the impact of violence to the employee and better prepared them in its occurrence (Fricke et al., 2022). To be effective, any training program that is obtained from an outside vendor must be tailored to the specific facility using it to benefit its employees (Arbury et al., 2017).

Changes to Support Employees

The changes need to involve a focus on the employee, helping embrace new methodology, technology and ways of working (Sarayreh, 2013). People want to be active participants in the change process. They act more resourcefully when you involve them rather than if the process is just dumped on them (Stack, 2013).

In order to engage the employee in reporting an event of workplace violence, there must be a mechanism in place that allows a straightforward process. Currently, events are severely underreported (Arnetz, 2015). It is necessary for employees to be trained about violence control and also how to report events through legal channels.

Policy and training must follow, and the change involves leadership. It is imperative that healthcare leadership deliver a message to their employees that is both intelligent and emotional in an effort to empower their staff to work through the change (Delmatoff & Lazarus, 2014). Staff require training in a range of knowledge, skills and attitudinal areas, regularly updated, while managers need to discharge their responsibilities under Health and Safety legislation by organizing risk assessments, negotiating protocols, and organizing staff training based on particular identified needs. Therefore, a total organization response is needed with duties and responsibilities for all members of an organization (OSHA, 2016).

The New Hampshire Hospital Association sponsored legislation that was adopted in 2022 and effective in 2023 in an effort to further support changes protecting healthcare workers. The bill established healthcare workplace violence program standards. Senate bill 459 established the framework for NH RSA 151:53 relative to the workplace violence prevention program that is required of every healthcare facility within New Hampshire. The law requires that organizations implement and maintain a reporting process for workplace violence and hostile words. It also addresses establishing a process to report workplace violence internally and externally in order to analyze incidents and trends.

Summary

Based upon my research, I have found the consequences of workplace violence on healthcare are damaging to both the recipients and the organization overall. Employees suffer from fatigue, burnout, PTSD, and missed workdays. The organization feels the effects of attrition, increased costs, and staff shortages. Patients may perceive healthcare facilities as unsafe or unresponsive to their needs.

There must be an organizational lead system in place to support the employee and mitigate the level of violence that affects employees. This system must involve support from leadership, education for the employee, and data to determine the origin of the violence.

Framework and Methodology

The framework and methodology used to compose this research paper was obtained primarily from the University of New Hampshire Library, peer reviewed articles, journals and website searches. Instrumental in this research was the Occupational Safety and Health Administration (OSHA) 2016 Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. These guidelines set the standard for a well-designed and required workplace violence program. Also, both recent and historical peer reviewed sources such as the Journal of Healthcare Management and the New England journal of medicine are included as evidence. The information collected for the literature review was both qualitative data and quantitative data. The methodology used to gather relevant information was searching for keywords such as workplace violence, healthcare assault, healthcare burnout, patient assault, and post-COVID-19 violence. The research revealed that workplace violence in healthcare is prevalent, on the increase post-covid-19, and can be mitigated through employee support and training. The literature focused on the risk factors, consequences, and mitigation strategies.

In order to determine what the hospital can do to support the employee and mitigate consequences of violence, I created questions to elicit information from the effected employee. My research question asks: What can the hospital and leadership do to support the employee, reduce workplace violence, and mitigate the effect? The individual questions focus on the event, support following, and employee needs.

Data was obtained, and approved for use by the hospital, for this research paper. The data collected consisted of a survey approved by an Internal Review Board of the University of New Hampshire and sent to recipients of workplace violence (physical assault). The survey was conducted using Survey Monkey, and electronic feedback was gathered (Appendix A). This survey was emailed to survivors of a physical assault, and their answers recorded anonymously. Questions asked were specific to workplace violence recipients, and their responses collected anonymously. Data was then reviewed in a continuous effort to support staff, encourage leadership support and offer tailored training programs.

Results and Data

The survey is attached in Appendix A. The survey was designed to identify if a recipient of workplace violence, specifically physical assault, felt supported by their leadership. It also asks the employee their view of the incident, to include intent, and the ability to report the incident to the police. The survey was emailed to each identified recipient of a physical assault within the hospital. 76 employees responded to the survey.

The first question, “In your opinion, did the person who assaulted you know what they were doing?” focuses on the intent of the event. As stated previously, cognitive impairment, often seen in elderly patients with conditions like dementia, Alzheimer’s, or delirium can also contribute to healthcare workplace violence. The resulting assault may not be intentional, but that of a perceived threat not based in reality.

Next, the question “At the time of the assault, did you know that you had the option to report the assault to the police?” This question points directly to management support towards the employee by establishing a culture that violence within the hospital will not be tolerated and offender may be criminally charged.

Third, “Do you believe the assault was preventable?” points to systems in place to keep the employee safe. This question addresses staffing, hazard prevention, physical environment, and security resources.

The fourth question asks, “What do you believe could prevent a similar assault in the future?” The respondent is given three choices. Nothing, violence awareness and prevention education (ie., gaining knowledge), and violence awareness and prevention training (ie., gaining skills). This question refers directly to training and the desire to learn more by the employee.

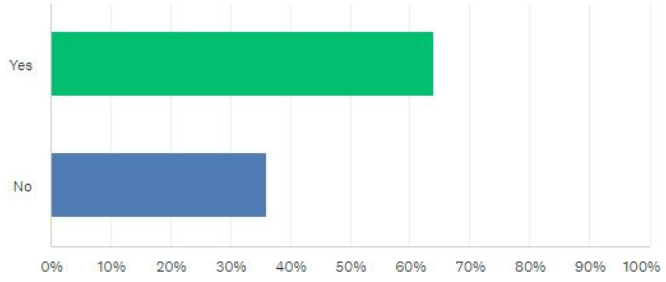
The last question asks, “In the hours, days, and weeks following the assault, did any of the following happen?” The choices include; I was asked by a manager or supervisor how I was feeling, I was offered employee assistance program services, I was afforded time to meet with employee assistance staff, I was offered workplace violence prevention related training and or education, I was afforded the time to attend workplace violence prevention related training or education, and if a critical incident debrief took place, were you invited to participate?. These questions point directly to the support that the employee feels, or did not feel, from their leadership. It points to support, inclusion, and the ability to receive support through employee assistance and specific training.

The data collected from the survey responses is as follows:

Q1

In your opinion, did the person who assaulted you know what they were doing?

Answered: 61 Skipped: 0

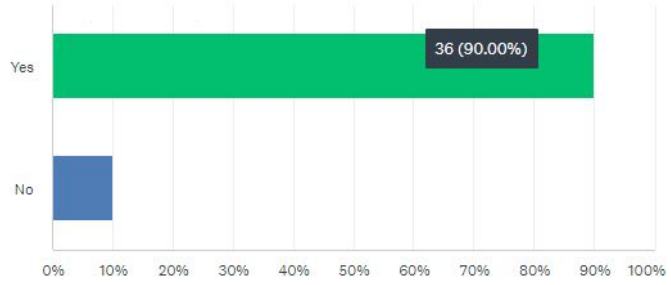


ANSWER CHOICES	RESPONSES	
Yes	63.93%	39
No	36.07%	22
TOTAL		61

Q2

At the time of the assault, did you know you had the option to report the assault to the police?

Answered: 40 Skipped: 21

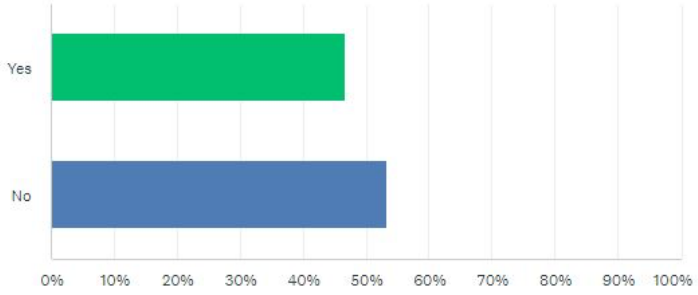


ANSWER CHOICES	RESPONSES	
Yes	90.00%	36
No	10.00%	4
TOTAL		40

Q3

Do you believe the assault was preventable?

Answered: 60 Skipped: 1

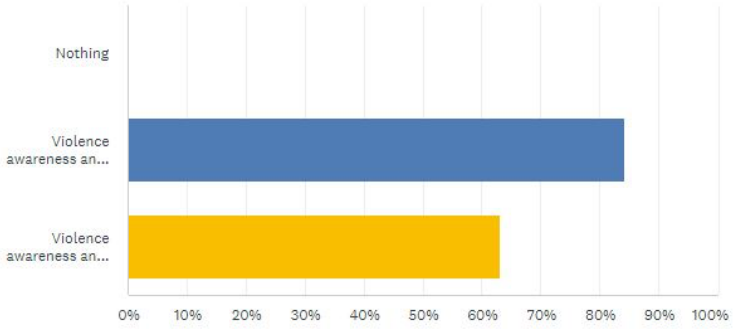


ANSWER CHOICES	RESPONSES	
Yes	46.67%	28
No	53.33%	32
TOTAL		60

Q4

What do you believe could prevent a similar assault in the future?

Answered: 19 Skipped: 42



ANSWER CHOICES	RESPONSES	
Nothing	0.00%	0
Violence awareness and prevention education (i.e., gaining knowledge)	84.21%	16
Violence awareness and prevention training (i.e., gaining skills)	63.16%	12
Total Respondents: 19		

Comments (0)

Q5

In the hours, days and weeks following being assaulted did any of the following happen?

Answered: 58 Skipped: 3

	YES	NO	UNSURE	TOTAL
I was asked by a manager or supervisor how I was feeling.	65.52% 38	32.76% 19	1.72% 1	58
I was offered Employee Assistance Program services.	35.09% 20	61.40% 35	3.51% 2	57
I was afforded time to meet with Employee Assistance staff.	29.82% 17	61.40% 35	8.77% 5	57
I was offered workplace violence prevention-related training and or education. (i.e., Management of Aggressive Behavior MOAB)	24.07% 13	62.96% 34	12.96% 7	54
I was afforded the time to attend workplace violence prevention-related training and or education.	25.93% 14	61.11% 33	12.96% 7	54
If a critical incident debrief took place, related to the assault, were you invited to participate?	23.08% 12	44.23% 23	32.69% 17	52

The results of the survey reveal the level of support and the needs of employees affected by workplace violence (specifically physical assault).

- 64% of the respondents felt that the person who assaulted them knew what they were doing. This points directly to intent, and the need for the organization to support possible criminal charges.
- 90% of the respondents answered that they knew that they could report the assault to the police. This directly indicates that the culture realized within the hospital is that an assault will not be tolerated, and charges may be brought.

- 47% of the respondents believed that the assault was preventable. As more than half thought that the assault was not preventable, this answer lends itself towards increased training for safety and patient handling during possible violent interactions.
- 84% of the respondents stated that training, specifically training in violence awareness, could prevent such an assault in the future.
- 65% of the respondents said they were asked by a supervisor how they were feeling. This answer supports the fact that leadership is engaged, supportive of their staff, and aware of events within the hospital.
- 61% of the respondents stated that they were *not* afforded the opportunity to see employee assistance. As workplace violence can have severe physical and psychological consequences, this is a missed opportunity to support the employee following an event of violence.
- 25% of the respondents stated that they were afforded the opportunity to attend workplace violence related training. In addition, only 23% were included in a critical incident debrief.

Conclusion

Healthcare workers regularly face the risk of violent physical, sexual, and verbal assault from their patients (Brophy et al., 2018). It is up to the leadership within a healthcare organization to provide strategies to mitigate workplace violence and support their employees through training, prevention, and policy. Equally important is the availability of emotional support, such as employee assistance services. Next, affording the opportunity and resources to file criminal charges in the event of an assault shows organizational support and culture that violence is not acceptable, nor will it be tolerated.

While leadership is supportive of the employee in the moment, and immediately following an event, a focus must be placed on the availability of support services. The use of employee assistance services and counseling showed improvements in employee absenteeism, engagement, workplace distress, and work-life balance (Attridge, 2019).

Data from the survey showed a high percentage of employees desiring the the ability to attend training that is focused to workplace violence and practices to provide safe patient interactions. Conversely, it showed a low percentage of these employees being afforded the opportunity to attend training or critical debriefs. More work needs to be done in educating leadership to support their employees, create a culture that promotes reporting, and offers timely and relevant training with the opportunity to attend.

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Appendix A

To conduct the survey, an email is sent to each employee that is asked to participate. Once the results of the survey are received, they are tabulated anonymously with no direct correlation as to who answered the questions.

On XX/XX/XX, an assault was reported with you as a victim. The security department is assessing each assault report in order to better support the employee affected. Attached is a link to a very brief survey. I am requesting you take a moment and fill it out. The answers are anonymous, and it will help us in providing the best response for training, education and prevention.

https://www.surveymonkey.com/r/RVTJ7ZD

The questions within the survey are as follows:

1. In your opinion, did the person who assaulted you know what they were doing?
    a. Yes
    b. No
2. At the time of the assault, did you know you had the option to report the assault to the police?
    a. Yes
    b. No
3. Do you believe the assault was preventable?
    a. Yes
    b. No
4. What do you believe could prevent a similar assault in the future?

a. Violence awareness and prevention education (i.e., gaining knowledge)

b. Violence awareness and prevention training (i.e., gaining skills)

5. In the hours, days and weeks following being assaulted did any of the following happen?

    a. I was asked by a manager or supervisor how I was feeling.

        i. Yes

        ii. No

        iii. Unsure

    b. I was offered Employee Assistance Program services.

        i. Yes

        ii. No

        iii. Unsure

    c. I was afforded time to meet with Employee Assistance staff.

        i. Yes

        ii. No

        iii. Unsure

    d. I was offered workplace violence prevention-related training and or education. (i.e., Management of Aggressive Behavior MOAB)

        i. Yes

        ii. No

        iii. Unsure

    e. I was afforded the time to attend workplace violence prevention-related training and or education.

i. Yes

ii. No

iii. Unsure

6. If a critical incident debrief took place, related to the assault, were you invited to participate?

    a. Yes

    b. No

Certificate of Completion

University of New Hampshire acknowledges that

Eric Crane

has successfully completed

Human Subjects

on September 30th, 2023

University of New Hampshire

Certificate #170814