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Clinical Practice Guidelines for Assessing and Reporting Workplace Violence Against Nurses

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This is to certify that the doctoral study by

Janice Lynn Canfield

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Walden University
2021

Abstract

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MS, New York University, 2009

BS, New York University, 1998

Project Submitted in Partial Fulfillment

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Abstract

Workplace violence consists of physically and psychologically damaging actions while on duty. In healthcare, under a cloak of secrecy concerning workplace violence, an underreported epidemic exists. This problem is important to address because workplace violence can affect the quality of care delivered and patient care outcomes. The purpose of this project was to develop a nursing clinical practice guideline (CPG) to assist hospital-based nurses to identify risk factors for workplace violence, identify strategies to mitigate violence, and report workplace violence. This CPG can be an effective tool for nurses to better understand the scope and nature of violence in the workplace. Knowles's theory of adult learning and the John Hopkins nursing evidence-based practice model guided development. A comprehensive review of the literature was conducted to determine what evidence was available to identify best practices for developing a quality CPG that addresses workplace violence. A three-member doctorate-prepared nurse educator expert panel on workplace violence rated the CPG using the AGREE II tool. The composite scores among the three reviewers ranged from 55%-88% across the six domains, with a mean of 68.33%. The overall quality assessment score was completed by two of the three experts based on a Likert scale ranging from 1 (*lowest possible quality*) to 7 (*highest possible quality*). The two reviewers scored the CPG as 5 and 2, respectively, for an overall guideline assessment mean of 33%. All three panelists recommended the CPG, two of them with modifications. The CPG may promote social change by equipping nurses with the knowledge to identify workplace violence risk factors, mitigate violence, and report behavioral warning signs.

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Dedication

This project is dedicated to all the strong-minded, empathetic, versatile, respectful nurses who have physically and emotionally endured workplace violence. To all the future nurses, I hope this paves the way for a safer, healthier environment in which to work.

Acknowledgments

First and foremost, I would like to thank my husband, Kevin, for supporting me throughout this process, constantly pushing me, believing in me when I didn't believe in myself, and keeping our dirty little secret. To my four beautiful children, Tyler, Courtney, John, and Cameron, I love you so much. I hope you are not upset that I kept this journey a secret. You were all busy with your own college experiences, high school, sports, and life, and I did not want to take anything away from that. Look at this moment as a shining example of how you can do anything you put your mind to. Always shoot for the stars, the moon, and the rainbows. Mom and Dad, thank you for bringing me into this world and loving me. I am forever grateful for having you both in my life. I hope you enjoyed this surprise as much as I enjoyed surprising you. There were many times I wanted to reveal my secret. Always concerned for how much I take on, I did not want to worry you any more than necessary. However, Mom and Dad, know that your daughter did it, Dr. Janice Lynn Canfield. Thank you to all my family members for just being you.

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Section 1: Nature of the Project

Introduction

Workplace violence consists of physically and psychologically damaging actions at work while on duty (Centers for Disease Control and Prevention [CDC], 2002). The Bureau of Labor Statistics releases annual reports about injuries and illnesses resulting in increased absenteeism and decreased productivity in the United States (American Nurses Association [ANA], 2021). According to the ANA (2002), 1 out of 4 nurses is assaulted on the job. Nurses are at high risk of becoming victims of workplace violence or aggression (Song et al., 2021). A guideline preventing workplace violence should include a system for documenting incidents, special steps to be taken in the event of incidents, and open communication between employees and staff (CDC, 2004). The CDC (2004) has stated that all employers and workers should assess the risks for violence in their workplace and take appropriate action to eliminate those risks. In healthcare, there remains a giant cloak of secrecy over workplace violence. As a result, an underreported epidemic exists, devastating the healthcare industry (ANA, 2021). Studies show that workplace violence can affect the quality of care delivered and patient care outcomes (ANA, 2021). In addition, it contributes to the development of psychological conditions such as low self-esteem and a reduction in job satisfaction and organizational commitment (ANA, 2021). While there are many articles about workplace violence, there is not a consistent guideline to report violence or aggression toward nurses in the literature. Diminishing workplace violence toward nurses can improve job satisfaction (Arnetz et al., 2015; Roche et al., 2010).

Problem Statement

The local nursing practice problem is workplace violence. Healthcare workers face significant risks of job-related violence (Occupational Safety and Health Administration [OSHA], n.d.). Workplace violence applies to situations in which nurses are harassed, threatened, or assaulted on the job (Chaiwuth et al., 2020). Violence and assaults against nurses are rising, and some studies suggest that violence has spiked nearly 100% (OSHA, 2020). Workplace violence is a critical global occupational health problem (Chaiwuth et al., 2020). Studies show that violence against healthcare workers is more common than people realize (Stephens, 2019). OSHA (2020) stated that between 2002 and 2013, incidents of serious workplace violence were 4 times more common in healthcare than in private industry on average. According to the Bureau of Labor Statistics, 27 out of 100 fatalities in healthcare and social services in 2013 were due to assaults and violent acts. In addition, workplace violence is underreported (OSHA, 2020). One survey of 4,738 Minnesota nurses found that only 69% of physical assaults and 71% of nonphysical assaults were reported, while another hospital center found that 50% of assaults by patients against nurses were never reported in writing (OSHA, 2020). There is a gap in evidence-based clinical practice guidelines (CPGs) for the assessment and reporting of workplace violence. This Minnesota survey found that healthcare workers underreport incidents because of a lack of reporting policy, a lack of faith in the reporting system, and fear of retaliation (OSHA, 2020).

In addition to understanding why healthcare workers underreport workplace violence, assessing workplace violence risks and incidents is essential. Focusing on the circumstances surrounding workplace violence helps form the basis of the guidelines

(Bromley & Painter, 2019). Circumstances such as poorly lit entrances and exits, hallways, and rooms with unattended facility, dietary, or housekeeping carts with sharp or heavy objects, and high-level stress and volume departments put nurses at risk for workplace violence. These baseline assessments provide data to use for comparison following recommended guidelines and safety interventions.

In a cross-sectional survey by Rosenthal et al. (2018), many healthcare workers indicated feeling threatened by patients and families, and the overall numbers were far higher than the formal system reports suggested. Hospital areas most affected are large-volume and large-stress departments such as the emergency department, medicine floors, psychiatry unit, and critical care areas. Nurses have a right to a safe working environment to provide quality patient care. Nurses should also freely report any workplace violence without fear of retaliation. This doctoral project holds significance for the field of nursing practice because diminishing workplace violence can improve workplace health and well-being (Sheehan & Griffiths, 2011).

Purpose

The purpose of this doctoral project is to identify and address the gap in nursing practice and develop a CPG for reporting workplace violence against healthcare workers. Having a guideline available with steps to address and report patient and family behavior that are considered abusive, including physical assault of staff, should improve direct caregiver response and reporting (Sato et al., 2012). In addition, it would provide the steps with which to report any aggression or violent act toward a caregiver by a patient. In preparation, scholarly articles were reviewed to identify the need for this project and common themes associated with workplace violent or aggressive acts. Workplace

violence is unacceptable, yet a common feature of nursing work and the more knowledge generated, the more chance a reduction of workplace violence and aggression in the healthcare environment will be better (Hutchinson et al., 2013).

Practice-Focused Question

Will the development of a nursing clinical practice guideline for assessing and reporting workplace violence provide an effective tool to assess and provide strategies for workplace violence incidents?

P: Nurses and other healthcare workers.

I: Develop nursing clinical practice guidelines for assessing and reporting workplace violence based on evidence-based practices.

C: Compared to the current practices of reporting workplace violence in most settings.

O: Improved assessment of what workplace violence consists of and an increased reporting of workplace violence.

Nature of the Doctoral Project

The nature of this project involves the development of a CPG. This guideline was written using the Walden Manual for Clinical Practice Guideline Development (Walden University, n.d.). In addition, a search of the literature was performed using Pub Med, Walden University Library, CINAHL, Google Scholar, Medline, Science Direct, Science Direct, Sage Journals, and ProQuest Dissertations and Theses Global. The specific areas reviewed included scholarly articles related to reporting systems of aggressive and violent acts toward nurses. I focused on scholarly articles that involved frequency and barriers in reporting workplace violence. The most common reasons for not reporting

workplace violence were that nurses were unaware of how to report and what types of violence to report (Song et al., 2021). In addition, hospitals typically pay more attention to patients than to nursing staff (Song et al., 2021).

Workplace violence against nurses has attracted increasing research attention (Song et al., 2021). Given their frontline position in the health care system, nurses are at higher risk of experiencing workplace violence. Spector et al. (2014) reviewed 136 articles involving 151,347 nurses from 160 samples and discovered that the overall violence exposure rates were 36.4% for physical violence and 66.9% for nonphysical violence. Despite the high prevalence of workplace violent acts and aggression toward nurses, underreporting is a worldwide phenomenon in the nursing profession (Song et al., 2021). Causes of underreporting are multifactorial and have not been earnestly studied (Song et al., 2021). A survey in Slovenia indicated that the rates at which nurses reported violent incidents in formal written form ranged from just 6.5% (verbal abuse) to 10.9% (physical violence; Kvas & Seljak, 2014). Some foreign studies have offered explanations for underreporting. Nurses may perceive aggressive behavior as unintentional and related to the patient's mental status, or they may feel reluctant to report an incident that they feel has had a mild impact on them. The most significant reasons for underreporting are that nurses believe that workplace violence is the norm and part of the job (Song, 2021). Another common reason is that nurses believe that no preventative measures will occur after a violent incident and that reporting the incident will not lead to any positive change (Song et al., 2021). Other barriers to reporting workplace violence are a lack of clear guidelines, nurses' ideas of time-consuming reporting procedures, lack of managerial support, fear of blame, fear of losing one's job,

and no encouragement to report (Song et al., 2021). It was noted that the significance of a noncomplicated, unified written or electronic reporting system improved the process of reporting (Song et al., 2021). However, the simplification of the reporting system was not enough; managerial support was necessary (Song et al., 2015). Frens et al. (2005) suggested that CPGs and management support can increase nurses' self-value and confidence to report violent incidents. Developing a CPG to increase workplace violence reporting can increase retention rates, improve job satisfaction, and improve patient care delivery.

Significance

Workplace violence in healthcare organizations is a serious global occupational health problem (Chaiwuth et al., 2020). Nurses and other healthcare workers are at a high risk of experiencing violence aimed toward them by patients (Fuente & Schoenfisch, 2019). Nurses and other providers are more likely to suffer an aggressive act than any other profession (Papa & Venella, 2013). In a 2016 Bureau of Labor Statistics survey of nonfatal injuries, the healthcare industry had an incident rate of 14.3 per 10,000 full-time workers for injury caused by another person, where the national rate was 1.7 for all other industries (Bureau of Labor Statistics, 2017). Patient and visitor aggression impacts nurses, systems, and outcomes in many ways (Papa & Venella, 2013). Exposure to violent acts leads to decreased productivity in providing emotional support for patients and demonstrating empathy (Gates et al., 2011). An additional study found that violent acts negatively affect the workplace and nurses' personal lives (Fuente & Schoenfisch, 2019). Job burnout is high among nurses who have been victims of violent acts (Viotti et al., 2015). Physical violence correlates with increased absenteeism, decreased

productivity, and increased errors, affecting patient outcomes (Arnetz et al., 2015; Roche et al., 2010). With increased aggression and violent acts, there is an identified need for CPGs on reporting workplace violence. This CPG holds significance for the field of nursing practice. Diminishing workplace violence or aggressive acts toward nurses can increase retention rates, increase job satisfaction, improve working relations, and improve patient care outcomes (Arnetz et al., 2015; Roche et al., 2010).

Summary

In this section, I addressed the definition of workplace violence and my project's nature, purpose, and significance. Workplace violence in healthcare organizations remains a serious global occupational health problem (Chaiwuth et al., 2020). With an effective practice guideline on reporting violent acts toward them, nurses will feel empowered. This CPG's professional and social significance resides in its potential to improve staff satisfaction, performance, productivity, workplace health, and well-being (Sheehan & Griffiths, 2011). The following section addresses the concepts, models, and theories that guided this doctoral project. In addition, the project's relevance to nursing practice, the local background and context, my role in the project as a Doctor of Nursing Practice (DNP) student, and definitions of terms are addressed.

Section 2: Background and Content

Introduction

The practice problem that I have sought to address is the lack of a CPG for reporting violent workplace acts. Nurses are in the frontline positions in the health care system, making them more susceptible to violent acts of aggression (Song et al., 2021). Underreporting remains a phenomenon in the nursing profession (Song et al., 2021). Nurses are systematically being prepared to assess and intervene in potential and actual workplace violence situations (Ming et al., 2019). Aggressive behavior and violence toward nurses by patients are increasing worldwide (Sato et al., 2012). In Section 2 of this proposal, I discuss concepts, models, and theories by examining the practice problem. In addition, the relevance of this project to nursing practice, the local background and context, and my role as a DNP student are discussed.

The practice problem was the following: Will the development of a nursing clinical practice guideline for assessing and reporting workplace violence provide an effective tool to assess and provide strategies for workplace violence incidents?

Concepts, Models, and Theories

In the Occupational Safety and Health Act of 1970, Congress created OSHA to provide workers safe and healthful working conditions by enforcing standards and providing training, outreach, education, and assistance (OSHA, n.d.). OSHA is part of the CDC (OSHA, n.d.). Healthcare workers face serious risks of job-related violence, and it is OSHA's mission to help employers address these serious hazards (OSHA, n.d.). Efficient clinical practice guidelines are vital to the reduction of workplace violence. OSHA's violence prevention guidelines are based on industry best practices and feedback

from stakeholders (OSHA, n.d.). In addition, OSHA gives recommendations for creating policies and procedures to eliminate or reduce workplace violence in healthcare settings (OSHA, n.d.).

The theoretical models that guided this doctoral project were the following:

- the Walden University Manual for Clinical Practice Guideline Development (May 2019),
- Knowles's theory of adult learning, and
- The John Hopkins nursing evidence-based practice (JHNEBP) model.

Knowles's theory of the adult learner was chosen to accommodate the preferred learning style of adults and strengthen it through the application of the experiential learning cycle to assist in adapting to new guidelines (Mukhalalati & Taylor, 2019). His theory works on two levels and features a four-stage learning cycle with four different learning styles (Mukhalalati & Taylor, 2019). Knowles's adult learner theory is concerned with the learner's internal cognitive process and how learning involves concepts that can be applied in various situations (Mukhalalati & Taylor, 2019). In his theory of the adult learner, Knowles (1984) stated that learning is the process whereby knowledge is created through experience transformation. This learning process is essential to understand and learn new practice guidelines and apply them to current practice.

The JHNEBP model was developed due to the collaborative work of leaders in nursing education and practice at Johns Hopkins Hospital and the Johns Hopkins University School of Nursing (Newhouse et al., 2007). This model offers tools for process and critique, including question development, an evidence rating scale, and

research and nonresearch evidence appraisal (Schaffer et al., 2012). The JHNEBP model was used to critically appraise the evidence from the literature.

In addition, the Walden University Manual for Clinical Practice Guideline Development requires a systematic method. Therefore, the Appraisal of Guidelines Research and Evaluation (AGREE) II model provided the structure to drive CPG development. The AGREE II consists of six domains:

- Domain 1: Scope and purpose
- Domain 2: Stakeholder involvement
- Domain 3: Rigor of development
- Domain 4: Clarity of presentation
- Domain 5: Applicability
- Domain 6: Editorial independence

Relevance to Nursing Practice

The American Association of Colleges of Nursing (AACN, 2006) discussed DNP Essential VII: Clinical prevention and population health for improving the nation's health. Clinical prevention includes risk reduction for individuals. Population health affects many areas, including occupational dimensions of health. For a DNP student, it is crucial to engage in leadership to institutionalize evidence-based clinical prevention and population health services for populations (AACN, 2006). These competencies are relevant to analyzing occupational data in developing a CPG on reporting workplace violence. Workplace violence is commonly experienced by nurses globally (Chaiwuth et al., 2020). International reports have indicated that 10–50% of healthcare staff are exposed to violence every year and fear that this rate may reach over 85% (Li et al.,

2018). Workplace violence has negatively impacted some nurses' lives. For this DNP clinical practice guideline, workplace violence describes incidents where staff are abused and/or assaulted during work, creating a challenge to their safety, well-being, or health (Li et al., 2018). Other terminology used includes, but is not limited to, *aggression* (Li et al., 2018), *harassment* (Griffin, 2004), and *patient safety* (World Health Organization [WHO], n.d.). Workplace violence is a serious issue that threatens patient safety, nurse safety, sanity, and the nursing profession's reputation (Li et al., 2018).

Local Context and Background

The local problem is workplace violence. Many studies on workplace violence concentrate their research on acute care hospitals, especially the emergency department (ALBashtawy et al., 2015). Workplace violence against emergency department staff (EDS) is one of the most widespread phenomena of violence in the hospital setting (ALBashtawy et al., 2015). A study by Kowalenko et al. (2012) showed that EDS face substantially higher workplace violence risks than those in other healthcare settings. A CPG is essential to assist nursing staff in reporting violent acts. The purpose of this doctoral project is to identify and address the gap in nursing practice and develop a CPG for reporting workplace violence against healthcare workers. The clinical guideline will provide steps in the assessment and reporting of workplace violence incidents.

Definition of Terms

Workplace violence: Incidents where staff are abused and/or assaulted during work, creating a challenge to their safety, well-being, or health (Li et al., 2018).

Nursing: Both an art and a science; a heart and a mind. At its heart lies an integral respect for human dignity and an intuition for a patient's needs. (ANA, n.d.).

Work culture: A healthy workplace culture that enables nurses to experience valuable learning in the workplace (Davis et al., 2016).

Patient safety: The absence of preventable harm to a patient during healthcare and reduction of the risk of unnecessary harm associated with healthcare to an acceptable minimum (WHO, n.d.).

Conflict: The process that starts when one person or group of persons perceives that another party has negatively affected something that the first party cares about (Anderson, 2006).

Empowerment: The ability to get things done, including a capacity to mobilize resources and provide support, opportunity, and information (Greco et al., 2006).

Incident report: All incidents, adverse events, irregular occurrences, or variances are to be reported in writing to be sent to the performance improvement department as per the specific facility's established policies (Evans, 2006).

Self-concept: As a person matures, the person's self-concept transforms from one of a dependent personality toward one of a self-directed human being. Adults should be involved in the planning and evaluation of their instruction (Knowles, 1984).

Experience: As individuals mature, they gain a growing reservoir of experience that becomes an increasing resource for learning. This experience provides the basis for all learning activities (Knowles, 1984).

Readiness to learn: As individuals mature in their readiness to learn, the developmental tasks of their social roles occur. Adult learners are most interested in subjects that have immediate relevance to and impact on their job or personal life (Knowles, 1984).

Orientation to learning: As people mature, their time perspective changes from one of postponed application of knowledge to immediacy of application, and learning shifts from subject centeredness to problem centeredness (Knowles, 1984).

Motivation to learn: As a person matures, the desire to learn becomes internal (Knowles, 1984).

Harassment: Abusive behavior with a systematic intent to damage the target (Griffin, 2004).

Communication: The exchange of information, thoughts, and feelings among people using speech or other means (Kourkouta & Papathanasiou, 2014).

Aggression: Violent behavior toward another (Li et al., 2018).

Role of the DNP Student

My role in this project was to develop a CPG, seek expert evaluators, and produce a final product suitable for implementation for inpatient care facilities. A DNP graduate must identify and address gaps in practice, develop approaches based on existing theories, implement changes that improve patient care, and bring about organizational changes (AACN, 2006). The motivation behind this doctoral project was to provide a platform for nurses to respond effectively to workplace violence and to keep nurses free from harm. Project development is consistent with DNP Essential VII: Clinical Prevention and Population Health for Improving the Nation/'s Health (AACN, 2006).

Summary

In this section, I addressed relevant concepts and models, described the project's relevance to nursing practice, and presented the local background and context, as well as my role in the project as a DNP student. Increased awareness of workplace violence

reporting systems will empower nurses to stand up to their aggressors. Knowles's theory of the adult learner, the Manual for Clinical Practice Guideline Development, the JHNEBP model, and the AGREE II tool were used to guide the development of a CPG for reporting workplace violence. Section 3 contains subsections addressing the project's practice-focused question, source of evidence, and analysis and synthesis, followed by a summary.

Section 3: Collection and Analysis of Evidence

Introduction

The clinical problem that this DNP project addressed was the lack of a CPG concerning reporting violent workplace acts. Nationally, there continues to be evidence of ongoing incidents of workplace violence, which has been shown to harm nursing performance and patient care (Sato et al., 2012). Aggressive behavior and violence directed by patients toward nurses are becoming more frequent (Sato et al., 2012). The purpose of this doctoral project was to identify and address the gap in nursing practice and to develop a CPG for reporting workplace violence against healthcare workers. The meaningful gap in nursing practice that I sought to address was the lack of a guideline for nurses responding to workplace violence incidents. Underreporting of workplace events is consistently cited in the literature and poses a serious barrier to evaluating intervention effectiveness, as it is challenging to understand the full extent of the problem (Arnetz et al., 2017). Workplace violence has been shown to impact job satisfaction, commitment, efficiency, stress levels, sleep patterns, and burnout (Liu et al., 2019).

Additionally, workplace violence may decrease nurse retention and quality of care (Liu et al., 2019). The JHNEBP model was used in this project as it supports evidence-based practice (Dang et al., 2022). Furthermore, this model is designed specifically to meet the needs of practicing nurses or other healthcare workers involved in direct patient care and involves keeping an open mind when researching an identified clinical problem (Dang et al., 2017). The goal of this model is to provide the latest research findings and appropriately incorporate them into practice. In addition to reviewing the literature about the clinical practice question, this model entails supporting the influence of expert

opinion and conducting an internal and external search for evidence (Dang et al., 2022). The model also involves appraisal of the level and quality of each piece of evidence, summary of the individual evidence, synthesis of findings, and then development of best evidence recommendations. Lastly, the JHNEBP model embraces 20 processes of developing a plan to share the findings with individual stakeholders and then disseminate the findings to a vast audience. Section 3 contains subsections on the practice-focused question, source of evidence, and analysis and synthesis, followed by a summary.

Practice-Focused Question

The practice-focused question for this project was geared toward an inpatient setting. The question was the following: Will the development of a nursing clinical practice guideline for assessing and reporting workplace violence provide an effective tool to assess and provide strategies for workplace violence incidents? Developing a CPG pertaining to increasing workplace violence reporting can improve job satisfaction, commitment, and efficiency; decrease stress; improve sleep patterns; and reduce burnout (Liu et al., 2019). The purpose of this doctoral project was to identify and address the gap in nursing practice and develop CPGs for reporting workplace violence against healthcare workers.

Sources of Evidence

The purpose of this doctoral project was to identify and address the gap in nursing practice and develop a CPG for reporting workplace violence against healthcare workers. This DNP project's sources included a systematic review of the literature grading system using the JHNEBP model and expert panel feedback to validate the content using the AGREE II tool. The JHNEBP model involves a three-step process called PET, which

stands for practice question, evidence, and translation. This process consists of identifying the practice question, identifying the best evidence to answer the question, and then translating the evidence into practice. The goal is to ensure that the latest research findings are appropriately incorporated into practice (Dang & Dearholt, 2017). The strength of evidence was graded using the five levels indicated in the JHNEBP model (Dang et al., 2022). Level 1 indicates that the research evidence was a randomized controlled trial (RCT), mixed explanatory methods, or systematic review of RCTs (Dang et al., 2022). Level 2 indicates the research was a quasi-experimental study, explanatory mixed-method design, or systematic review of RCTs or quasi-experimental. Level 3 represents research evidence from nonexperimental studies, systematic reviews of RCTs, and quasi-experimental or nonexperimental studies. It also includes exploratory mixed-method studies or qualitative studies.

Level 4 indicates nonresearched evidence from other CPGs or consensus panels. Lastly, Level 5 also indicates nonresearched evidence and experimental evidence, which include scooping reviews, integrative reviews, literature reviews, quality improvement, case reports, or the opinions of nationally recognized experts based on experiential evidence. This rating system is represented as a pyramid, with Level 1 on top showing the most substantial level of evidence and Level 5 is on the bottom signifying the weakest level of evidence.

After determining the level of evidence, the quality of evidence using the research evidence appraisal tool by JHNEBP was determined. Depending on the type of study, different considerations are accounted for determining the quality of evidence. Therefore, there are different levels of evidence depending on the type of study. Quality ratings for

the JHNEBP are then determined. Grade A indicates high quality, Grade B indicates good quality, and Grade C indicates low quality. The literature review included resources obtained from the following databases: PubMed, Wolters Kluwer, CINHAL, Medline, Science Direct, Sage Journals, OVID, Wiley Online Library, and ProQuest Dissertations and Theses Global. Additional nursing resources included the National Institute for Occupational Safety and Health, the ANA, the Bureau of Labor Statistics, and OSHA. The JHNEBP model assisted in eliminating findings when there was little evidence with inconsistent results, insufficient sample sizes, or conclusions that could not be drawn. The John Hopkins model was used to eliminate findings if there was a lack of clarity and coherence of reporting, a lack of transparency, or no insight into the phenomenon of interest (Dang et al., 2022).

I used evidence from the literature to determine the gap in nursing practice and CPGs for reporting workplace violence against healthcare workers. Evidence for this project was evaluated and displayed in a matrix and added to the CPG for ease of use by nursing staff or direct caregivers. The Walden University literature review matrix used the following key terms: *workplace violence*, *reporting*, *nurses*, *knowledge*, *work culture*, *empowerment*, *disruptive behaviors*, *healthy work environment*, *patient safety*, *zero tolerance*, and *conflict*. I also developed a CPG based on evidence-based practices noted in the literature review. In addition, I sought the approval of the Institutional Review Board (IRB) through Walden University. As previously discussed, I sought guidance from the JHNEBP model to appraise the evidence from the literature critically. In addition to the use of the AGREE II tool, a 23-item tool comprising six quality domains, an expert panel reviewed the guideline to validate the content. The purpose of AGREE II

was to assess the quality of the guideline, provide a methodological plan for developing the guideline, and inform what information and should be reported in the guideline and how it should be reported (AGREE, n.d.). The aim of the doctoral project is to provide nursing staff with a CPG for reporting workplace violence against healthcare workers to close the identified gap in nursing practice.

Analysis and Synthesis of the Literature

The system that was used to collect a large portion of the evidence related to this project was the administration of a literature review involving the following databases: PubMed, Wolters Kluwer, CINHAL, Medline, Science Direct, Sage Journals, OVID, Wiley Online Library, and ProQuest Dissertations and Theses Global. Additional nursing resources included the National Institute for Occupational Safety and Health, the ANA, the Bureau of Labor Statistics, and OSHA. I chose the following key search terms: *workplace violence*, *reporting*, *nurses*, *knowledge*, *work culture*, *empowerment*, *disruptive behaviors*, *healthy work environment*, *patient safety*, *zero tolerance*, and *conflict*. The integrity of all of the identified research articles was evaluated using the JHNEBP research evidence appraisal tool. This tool involved inquiries about the author, title, population, size, setting, kind of study, and study findings that helped in answering the EBP question. In addition, it inquired about the reliability and the validity of the instruments used and whether there were any limitations to the study. This DNP project was developed by using current evidence-based research and information to assess workplace violence underreporting and interventions to address this problem.

The JHNEBP model was used as a framework for developing a CPG. The JHNEBP model identifies practice questions and evaluates evidence (Schaffer et al.,

2013). This model includes tools for rating evidence and an action plan for implementation (Schafffer et al., 2013). There are three main components of the JHNEBP model: the practice question, evidence, and translation into practice (Schaffer et al., 2013). The problem that was identified was workplace violence underreporting and overall knowledge regarding how to report. The second step was to review the literature and rate the strength of evidence (Schaffer et al., 2013). The evidence was collected and appraised. The final step was to incorporate the evidence from the literature into the CPG for the nurses or healthcare workers to use in the clinical setting, which was done by creating a CPG for hospital use. The AGREE II tool was used to determine the quality indicated by the scientific evidence collected and the utility of the guideline (Walden University, 2019). The AGREE II assesses the quality of guidelines, offers a strategy for developing guidelines, and informs what and how information will be reported in the guidelines (Brouwers et al., 2010). An expert panel from the Walden nursing faculty was invited to evaluate the CPG for efficacy, quality, and efficiency in the clinical setting. The standards for the expert panel reviewers included their years of experience and knowledge as subject matter experts (SMEs) as healthcare educators and nursing clinicians. All expert panel participation was voluntary. The personal information of the participants was not used in this project.

Summary

The nature of this project involved the development of a nursing CPG. The purpose of this doctoral project was to identify and address the gap in nursing practice and develop a CPG for reporting workplace violence against healthcare workers. Using the JHNEBP model, I developed a CPG needed for increasing workplace violence

incident reporting and the AGREE II tool using an expert panel to validate the guidelines' content. The CPG focused on improving reporting of workplace violence. The literature review guided the development of a practice guideline informed by a systematic review of evidence. A practical CPG for reporting workplace violence may contribute to a better work environment, improve staff satisfaction, increase retention rates, and improve patient care outcomes (Kvas & Seljak, 2014).

Section 4: Findings and Recommendations

Introduction

Workplace violence consists of physically and psychologically damaging actions while on duty (CDC, 2002). The Bureau of Labor Statistics releases annual reports about injuries and illnesses resulting in increased absenteeism and decreased productivity in the United States (ANA, 2021). Currently, an underreported epidemic exists (ANA, 2021). Studies show that workplace violence can affect the quality of care delivered and patient care outcomes (ANA, 2021). In addition, it contributes to the development of psychological conditions such as low self-esteem and a reduction in job satisfaction and organizational commitment (ANA, 2021). While there are many articles about workplace violence, there are no consistent guidelines for addressing or reporting violence or aggression toward nurses in the literature. The gap that I identified was the lack of a CPG to help nurses have a better understanding of what constitutes workplace violence, strategies on how to mitigate it, and how to report it. I studied this practice issue with the following practice-focused question in mind: Will the development of nursing clinical practice guidelines for nurses in a hospital setting for identifying risk factors of workplace violence, identifying strategies to mitigate violence, and educating nurses on how to report workplace violence provide an effective tool for nurses to have a better understanding of the scope and nature of violence in the workplace?

The practice problem addressed in this project was the absence of a nursing guideline to provide steps for nurses to follow in the clinical arena when patients or family members present a physical or emotional threat to staff. The purpose of this guideline is to help nurses in hospital settings better comprehend the scope and nature of

violence in the workplace. The nurses will learn to identify risk factors, apply learned strategies to mitigate violence, and report workplace violence.

Findings and Implications

The goal of CPG development for this project was for direct caregivers to have a better understanding of what workplace violence is and how to manage it. Staff nurses will use this evidence-based guideline to ensure that workplace violence is identified and reported. In addition, having a guideline available with the steps to address workplace violence, apply learned strategies to mitigate workplace violence, and report patient and family behavior considered abusive, including physical assault of staff, should improve direct caregiver response and report (Sato et al., 2012).

AGREE II provided the core structure that I used to guide the development of the CPGs. AGREE II consists of six domains: (a) Scope and Purpose, (b) Stakeholder Involvement, (c) Rigour of Development, (d) Clarity of Presentation, (e) Applicability, and (f) Editorial Independence. The content experts who rated the CPG using AGREE II were three professors of nursing with doctoral degrees and clinical expertise.

The expert panelists reviewed, appraised, and approved the CPG. Three of five invitees completed the AGREE II rating sheet. Of the three, two completed it in its entirety, and one left Items 4 through 6 in Domain 2 blank; Items 7 through 12 in Domain 3 blank; all of Domain 6 blank and stated that the entire proposal would be needed to rate these items. This response indicated either the inexperience of the rater on these items or further questions that staff nurses might have. The items for which the reviewers recommended modifications were revised, and the project committee concurred with the final edition of the clinical guideline. The expert panel reviewed, appraised, and approved

the CPG. Appendix A shows the raw composite scores of all three content expert reviewers. I used the raw composite results to identify areas of strength, limitations, and areas of revision. The composite scores from three reviewers ranged from 33% to 88% across six different domains, with an overall average of 68.33%. The lowest rating was within Domain 3, and the highest rating was in Domain 1. The results of this study could contribute to positive change among nurses. Based on feedback, all raters recommended the use of the CPG. The AGREE II tool does not give specifics of a threshold for composite scores that require adjustment to the guidance (AGREE Next Steps Consortium, 2017).

Implications for Social Change

In healthcare, there remains a giant cloak of secrecy over workplace violence. According to the ANA (2002), 1 out of 4 nurses is assaulted on the job. As a result, nurses are at high risk of becoming victims of workplace violence or aggression (Song et al., 2021). An underreported epidemic exists, devastating the healthcare industry (ANA, 2021). Studies show that workplace violence can affect the quality of care delivered and patient care outcomes (ANA, 2021). In addition, it contributes to the development of psychological conditions such as low self-esteem and a reduction in job satisfaction and organizational commitment (ANA, 2021). Frens et al. (2005) suggested that CPGs and management support can increase nurses' self-value and confidence to report violent incidents. Developing a CPG to help nurses better comprehend the scope and nature of violence in the workplace and equip them with knowledge of how to report such incidents can increase retention rates, improve job satisfaction, and improve patient care delivery.

The results of this study could contribute to positive change. With the use of an effective practice guideline to better understand workplace violence and report violent acts towards them, nurses will act expeditiously and effectively in instances of patient or family members acting out in violent or potentially violent ways toward staff and others. Such CPGs' professional and social significance resides in their potential to improve staff satisfaction, performance, productivity, workplace health, and well-being (Sheehan & Griffiths, 2011).

Recommendations

Evidence-based CPG development addresses the gap in practice for nurses regarding the scope and nature of workplace violence in the hospital setting. I tailored the guideline based on the review of the literature and best practices, Walden's Manual for Clinical Practice Guideline Development (Walden University, n.d.), as well as feedback from the content expert panelist. Before dissemination, modifications to the guideline were made. These included clarifying the health question addressed by the guideline, clarifying the target population identified, and clarifying the guideline development. Furthermore, the rigor of the development of the guideline, the procedures for updates, and references were added to the guideline as they were missing. In addition, the level of evidence was added to the sources in Appendix B.

Strengths and Limitations of the Project

Strengths were identified during the development of this project. To start, nurses will benefit from equipping themselves with a better understanding of the scope and nature of workplace violence and the reporting of such incidents. Other key stakeholders such as administrators, patients, families, and security officers at the potential hospital

site will benefit from these guidelines as well. These guidelines were developed for nurses in a hospital setting, but they are generalizable and may be implemented in other healthcare facilities. Lastly, having the expert panel review the guidelines and provide feedback using the AGREE II tool for scoring the CPG strengthened my project and allowed me to revise and refine the guidelines.

Section 5: Dissemination Plan

My focus in this project was developing a CPG for at-risk nurses to address workplace violence. The development and promotion of this guideline served three primary purposes: to support and advocate for victims of workplace violence in healthcare; to educate and guide staff nurses on the scope and nature of workplace violence and reporting such incidents; and to share the results and findings of this guideline with key stakeholders to keep nurses safe from violent workplace events. The dissemination plan will make nurses aware of hospital workers' attitudes toward reporting violent events, working with hospital management to encourage a nonpunitive culture that encourages reporting. Furthermore, I plan on sharing the guideline with hospital administration to disseminate to all nurses. The CPG will be presented at state and national conferences. I will also present the CPG to key stakeholders at the local level. The presentation of this guideline and its intended use for all nurses in hospital settings provides a knowledge base for clarifying what constitutes workplace violence and how to mitigate and report workplace violence incidents. I plan on using my platform as a scholar-practitioner to share the CPG and findings by publishing in a journal such as the journal of the ANA or *The Journal for Nurse Practitioners.*

Analysis of Self

As a Scholar-Practitioner

DNP Essential III addresses the role of DNP nurses as scholar-practitioners who use EBP to improve patient outcomes (ANA, 2006). Additionally, DNP Essential V addresses and speaks to healthcare advocacy and policy. Insights gained from this scholarly experience emphasize organizational leadership, healthcare advocacy, and the

scientific underpinnings of practice. My knowledge base increased concerning the importance of a systematic review of the literature. The quality of evidence clarifies the need for a particular action. I now have tremendous respect for evidence-based guidelines because I know what is involved in developing them. As an experienced acute care nurse practitioner and stakeholder in nursing, I see it as my obligation and duty to advocate for and improve the safety of nurses in hospital settings. As a victim of emotional workplace violence, I feel a deep sense of responsibility to advocate for nurses to prevent them from experiencing either physical or emotional workplace violence. In conclusion, staff nurses will use this evidence-based research, which is easy to follow, to equip themselves with an understanding of the scope and nature of workplace violence in hospital settings.

As a Project Manager

As the project leader, I have over 20 years of critical care experience working in a high-risk setting for workplace violence. Currently, I am a supervisor of a high-acuity medical group, which was beneficial in organizing and leading this project to its completion. During this DNP project, there were many challenges, but the most pressing one was being in this program and working the first wave during an unprecedented pandemic in New York City. Working 70-hour weeks trying to save lives, writing the project, and taking didactic classes at the height of the pandemic brought many time-management challenges. If I learned anything from this period, it was that nurses have incredible stamina, possess effective problem-solving skills, and are calm under pressure. Healthcare workers have all been traumatized by this pandemic, so this guideline is more important to me now. Nurses are dedicated to making sure that patients are safe from

harm, and these same nurses deserve to be safe as well. This scholarly project will help nurses act effectively when patients or families act violently toward staff or others.

Summary

The development of this CPG has served as a time of self-reflection on my 30 years in the health field. It has also contributed to my personal growth while shedding light on a serious problem affecting the safety of nurses and other healthcare workers. Experiencing emotional or physical violence impacts the lives of the nurses and their well-being. Studies have shown that workplace violence can affect the quality of care delivered and patient care outcomes (ANA, 2021). In addition, it contributes to the development of psychological conditions such as low self-esteem and a reduction in job satisfaction and organizational commitment among nurses (ANA, 2021). My goal was to help nurses identify risk factors, apply learned strategies to mitigate violence, report workplace violence, and, most importantly, keep them safe from harm. The content expert reviewers played a crucial role in reviewing, analyzing, and suggesting strategies and recommendations for a successful CPG. The project's goal was met to develop a guideline to equip nurses with knowledge of the scope and nature of workplace violence in the hospital setting, strategies to mitigate it, and a plan to report it.

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Appendix A: AGREE II Tool Results From Expert Panel

Domain 1: Scope and Purpose (Items 1-3)

	Appraiser 1	Appraiser 2	Appraiser 3	Total
Item 1	7	6	7	20
Item 2	7	4	7	18
Item 3	7	4	7	18
Total	21	14	21	56

Domain 1 Score: 88%

Domain 2: Stakeholder Involvement (Items 4-6)

	Appraiser 1	Appraiser 2	Appraiser 3	Total
Item 4	4	x	7	11
Item 5	4	x	7	11
Item 6	7	2	7	16
Total	15	2	21	38

Domain 2 Score: 60%

Domain 3: Rigour of Development (Items 7-14)

	Appraiser 1	Appraiser 2	Appraiser 3	Total
Item 7	4	x	7	11
Item 8	4	x	7	11
Item 9	3	x	7	10
Item 10	5	x	7	12
Item 11	6	x	7	13
Item 12	4	x	7	11
Item 13	7	x	7	14
Item 14	3	1	7	11
Total	36	1	56	93

Domain 3 Score: 55%

Domain 4: Clarity of Presentation (Items 15-17)

	Appraiser 1	Appraiser 2	Appraiser 3	Total
Item 15	7	4	7	18
Item 16	7	2	7	16
Item 17	7	4	7	18
Total	21	10	21	52

Domain 4 Score: 83%

Domain 5: Applicability (Items

	Appraiser 1	Appraiser 2	Appraiser 3	Total
Item 18	6	1	7	14
Item 19	5	1	7	13
Item 20	6	1	7	14
Item 21	6	1	7	14
Total	23	4	28	55

Domain 5 Score: 65%

Domain 6: Editorial Independence (Items 22-23)

	Appraiser 1	Appraiser 2	Appraiser 3	Total
Items 22	7	x	7	14
Items 23	4	x	7	11
Total	11	x	14	25

Domain 6 Score: 59%

Overall Guideline Assessment

Rate the Overall Quality of this Guideline

Appraiser 1	Appraiser 2	Appraiser 3	Total
5	2	x	7

Overall Assessment Score: 33%

Expert Overall Recommendation

I would recommend this guideline for use:

	Appraiser 1	Appraiser 2	Appraiser 3
Yes			x
Yes, with modifications	x	x	
No			

Appendix B: Review of the Literature Using John Hopkins Nursing Evidence-Based Practice

Citation	Main finding	Research method	Strengths of study	Weaknesses	Level of evidence
Arnetz, J. E., Hamblin, L., Russell, J., Upfal, M. J., Luborsky, M., Janisse, J., & Essenmacher, L. (2017). Preventing patient-to-worker violence in hospitals: Outcome of a randomized controlled intervention. *Journal of Occupational and Environmental Medicine*, *59*(1), 18–27.	By comparing individual hospital workers' self-reports of violence via questionnaire and via the hospital system's electronic incident reports, researchers found an underreporting rate of 88%.	The study was designed as a randomized, controlled intervention and utilized a mixed-methods approach.	A major strength of this study is the randomized controlled design and the large sample size, which encompassed over 2800 employees in 41 work units across seven hospitals. In addition, the study made use of developed, evidence-based elements, including the Hazard Risk Matrix, the worksite walkthrough, and the worksite checklist for identifying risk factors and preventive strategies for workplace violence.	A weakness of this study was despite its multiple sites, it took place within a single hospital system in a single geographic area of Midwestern United States. The results may not be generalizable to other hospital systems. Another weakness was that none of the walkthroughs in this study were conducted during nighttime hours and suggestions for violence prevention measures does not included the viewpoints of unit staff working night shifts. Lastly, contamination between intervention and control sites cannot be ruled out since several of the intervention and control units were in the same hospitals.	A
Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y., Chang, Y., Yang, Y., Yang, T., Chen, Y., Song, F., & Lu, Z. (2019). Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. *Occupational and environmental medicine*, *76*(12), 927–937. https://doi.org/10.1136/oemed-2019-105849	The highest rates of physical violence and sexual harassment against healthcare workers were found in Australia, England, Ireland, USA, Canada and New Zealand, and the lowest rates were found in Europe. A possible explanation was that abuse cases were under-reported in European countries. A 2014 Medscape Ethics report indicated that European doctors were twice as likely to not report suspected domestic violence than their US counterparts, and this tendency to under-report may carry over to their own experiences of WPV.	This meta-analysis was conducted following the checklist of the Meta-Analysis of Observational Studies in Epidemiology guidelines for the design, analysis, and interpretation.	The strength of this study was that the meta-analysis included 253 studies with larger sample sizes. It systematically summarized evidence on the prevalence and predictors of WPV towards all healthcare professionals (including physicians, nurses, and other healthcare staff). This study also investigated the prevalence and predictors of WPV against healthcare professionals around the world.	A weakness was the prevalence of workplace bullying may have been underestimated. Many reasons for under-reporting WPV included absence due to injury or time lost, time-consuming incident reporting procedures, inadequate supervisory or coworker support, fear of reprisal or blame for reporting, or a belief that reporting violent cases will not lead to any positive changes. Under-reporting results in underestimation of the extent of the problem.	A

Arnetz, J.E., Hamblin, L., & Ager, J. (2015). Underreporting of workplace violence: Comparison of self-report and actual documentation of hospital incidents. *Workplace Health & Safety, 63,* 200-210. doi:10.1177/2165079915574684	A greater proportion of questionnaire respondents (62%) self-reported an incident of WPV in the previous 12 months, compared with 12% who documented the incident via the electronic reporting system. In addition, a greater proportion of reporters had been injured or lost time from work because of a violent event, compared with under reporters; these two factors were associated with a higher likelihood of reporting in the electronic system.	Employees assigned to all 42 hospital units (N = 2,010) were asked by the researchers to participate in a questionnaire survey regarding their exposure to WPV and knowledge of the WPV reporting system.	This is the first study to examine underreporting of WPV incidents among health care workers by comparing individual questionnaire responses (self-report) regarding WPV experiences with actual incident documentation.	One limitation to this survey was that it was conducted in a single hospital system in one geographic area of the United States, so results may not be generalizable. The response rate on the questionnaire was low (22%). In addition, the questionnaire items related to experience of violence were retrospective and recall bias may have affected the results.	B
Li, P., Xing, K., Qiao, H., Qiao, H., Fang, H. Ma, H., Jiao, M., Hao, Y., Li, H., Liang, L., Gao, L., Kang, Z., Cui, Y., Sun, H., Wu, Q., & Li, M. (2018). Psychological violence against general practitioners and nurses in Chinese township hospitals: incidence and implications. *Health Quality Life Outcomes* 16, (117) https://doi.org/10.1186/s12955-018-0940-9	Many respondents in our study reported no procedures for reporting violence in their workplace existed when there were such procedures; many only reported incidents of physical violence.	A retrospective cross-sectional survey of township hospitals general practitioners and general nurses was conducted in Heilongjiang Province, China. Descriptive analyses and binary logistic regression analyses were used to estimate the prevalence and the risk factors of psychological violence.	The questionnaire was developed through a literature review and by modifying a questionnaire developed by a joint program of the International Labour Office (ILO), International Council of Nurses, WHO, and Public Services International.	Due to time constraints and resource restrictions, the study was limited to 90 purposively selected township hospitals in a single province in China, therefore, the study is not generalizable to all of China. In addition, the study was retrospective, and the data may be subject to recall bias.	B

Hogarth, K.M., Beattie, J., Morphet, J. (2016). Nurses' attitudes towards the reporting of violence in the emergency department. *Australas Emergency Nursing Journal, 19*(2), 75-81, 10.1016/j.aenj.2015.03.006	Emergency nurses report violence but they use informal methods rather than the formal mandated reporting system RiskMan. In addition, nurse's attitudes to reporting influenced their decision to report. This study also discovered that participants were unclear about what the processes were, if a violent incident was reported.	The research method was a phenomenological approach where two focus groups were conducted at a tertiary emergency department. The data were audio-recorded, transcribed verbatim, and analyzed using thematic analysis.	The phenomenological approach taken provided new data from experienced emergency nurses in one large metropolitan ED, resulting in new insights into the underreporting of violence in the ED.	The weakness of this study was in the sample size so it may be considered too small for transferability of findings.	B
Rosenthal, L.J, Byerly, A, Taylor, A.D., Martinovich, Z. (2018). Impact and prevalence of physical and verbal violence toward healthcare workers. *Psychosomatics*, 59(6), 584-590.	Workplace violence and the abuse of healthcare workers are prevalent and impact employee engagement and posttraumatic spectrum symptoms.	An online cross-sectional survey was sent to healthcare workers to assess the prevalence, location, and type of violence by patients or families.	There were consistent results, definitive conclusions with reasonably consistent recommendations based on a comprehensive literature review. In addition, there was a sufficient sample size for the survey, and there was no reported conflict of interest.	The results of this survey may have response bias as those nurses or healthcare workers affected by violence may have been more likely to respond to a survey invitation on that topic. It also was done at a single, urban, academic hospital, and results could have been influenced by factors at this site and not others.	B
ALbashtawy, M., Al-Azzam, M., Rawashda, A., Batiha, A., Bashaireh, I., & Sulaiman, M. (2015). Workplace violence toward emergency department staff in Jordanian hospitals, *Journal of Nursing Research, 23*(1), 75-81 doi: 10.1097/jnr.0000000000000075	Physical and verbal violence is a serious problem in the ED. Participants cited a lack of policies concerning physical and verbal violence in the workplace.	A cross-sectional study was conducted among the staff of emergency departments at multiple Jordanian hospitals over a 3-month period.	The results are consistent, a sufficient sample size, and consistent recommendations were made based on comprehensive review of the literature.	One of the limitations of this study was the questionnaire lacked standardization to be a more reliable tool. The data-gathering was subject to recall and other biases.	A

Arnetz, J.E., Hamblin, L., & Ager, J. (2015). Underreporting of workplace violence: Comparison of self-report and actual documentation of hospital incidents. *Workplace Health & Safety, 63,* 200-210. https://doi.org/10.1177/2165079915574684	A greater proportion of questionnaire respondents (62%) self-reported an incident of WPV in the previous 12 months, compared with 12% who documented the incident via the electronic reporting system. In addition, a greater proportion of reporters had been injured or lost time from work because of a violent event, compared with under reporters; these two factors were associated with a higher likelihood of reporting in the electronic system.	Employees assigned to all 42 hospital units (N = 2,010) were asked by the researchers to participate in a questionnaire survey regarding their exposure to WPV and knowledge of the WPV reporting system.	This is the first study to examine underreporting of WPV incidents among health care workers by comparing individual questionnaire responses (self-report) regarding WPV experiences with actual incident documentation.	One limitation to this survey was that it was conducted in a single hospital system in one geographic area of the United States, so results may not be generalizable. The response rate on the questionnaire was low (22%). In addition, the questionnaire items related to experience of violence were retrospective and recall bias may have affected the results.	B
Li, P., Xing, K., Qiao, H., Qiao, H., Fang, H. Ma, H., Jiao, M., Hao, Y., Li, H., Liang, L., Gao, L., Kang, Z., Cui, Y., Sun, H., Wu, Q., & Li, M. (2018). Psychological violence against general practitioners and nurses in Chinese township hospitals: incidence and implications. *Health Quality Life Outcomes* 16, **(**117) https://doi.org/10.1186/s12955-018-0940-9	Many respondents in our study reported no procedures for reporting violence in their workplace existed when there were such procedures; many only reported incidents of physical violence.	A retrospective cross-sectional survey of township hospitals general practitioners and general nurses was conducted in Heilongjiang Province, China. Descriptive analyses and binary logistic regression analyses were used to estimate the prevalence and the risk factors of psychological violence.	The questionnaire was developed through a literature review and by modifying a questionnaire developed by a joint program of the International Labour Office (ILO), International Council of Nurses, WHO, and Public Services International.	Due to time constraints and resource restrictions, the study was limited to 90 purposively selected township hospitals in a single province in China, therefore, the study is not generalizable to all of China. In addition, the study was retrospective, and the data may be subject to recall bias.	B

Appendix C: Clinical Practice Guidelines Addendum

Practice Guidelines for Assessing and Reporting Workplace Violence against Nurses

Definition of Workplace Violence:

Workplace violence refers to situations in which nurses are harassed, threatened, or assaulted on their job.

Problem Statement:

Workplace violence in healthcare is disruptive in delivering quality nursing care. It has a negative impact on the hospital setting. Workplace violence is an under-reported epidemic devastating the healthcare industry. It leads to injuries and illnesses resulting in decreased productivity and increased absenteeism in many healthcare settings. Workplace violence should not be considered the norm, nor should it be considered part of the job.

Having a guideline available with the steps to assess, apply learned strategies to mitigate workplace violence and report patient and family behavior considered abusive improves direct care giver response and reporting. There needs to be preventive measures after a violent incident occurs. An ideal workplace environment should have a convenient easy to use system for reporting specific workplace violence incidences to help determine future actions to prevent recurrences. This will lead to any positive change. Nurses need access to clear guidelines, managerial support, and encouragement to report.

This CPG to report violent acts help nurses act effectively in cases of patients or families acting out violently towards staff or others. The significance of these guidelines for the entire nursing profession is an improvement of staff satisfaction, performance, productivity, workplace health, and well-being.

Practice Focused Question:

Will the development of a nursing CPG for nurses in a hospital setting for identifying risk factors of workplace violence, identifying strategies to mitigate violence, and educating nurses on how to report workplace violence provide an effective tool for nurses to have a better understanding of the scope and nature of violence in the workplace?

Purpose:

The purpose of these guidelines is to help nurses in hospital settings better comprehend the scope and nature of violence in the workplace. In addition, the nurses will learn to identify risk factors, apply learned strategies to mitigate violence, and report workplace violence.

Learning Objectives:

- Nurses will learn how to identify risk factors of workplace violence in the hospital setting.

- To mitigate violence, nurses will learn how to recognize behavioral warning signs of individuals at risk for violent, erratic behavior.

- Nurses will learn to identify resources available in the hospital setting to report workplace violence and support injured nurses.

Stakeholder Involvement:

Promoting and using a CPG at the point of care represents a final translation hurdle to move evidence-based research into practice. The users and stakeholders of this CPG are nurses, physicians, patients, ancillary staff, and security officers.

Guideline Utilization and Implications:

Workplace violence in hospitals is a serious global occupational health problem (Chaiwuth et al., 2020). Nurses are at a high risk of experiencing violence aimed toward them by patients (de la Fuente & Schoenfisch, 2019). In addition, nurses and other providers are more likely to suffer an aggressive act than any other profession (Papa & Venella, 2013). However, staff nurses do not understand what constitutes workplace violence, and they are unsure how to report these incidents. These clinical practice guidelines serve as a resource for providing information on recognizing workplace violence and reporting it.

Sources of Evidence and Search Criteria:

This DNP project's sources include a systematic review of the literature grading system using the Johns Hopkins Nursing Evidence-based model and expert panel feedback to validate the content using the Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument. The literature review includes resources obtained

from databases: PubMed, CINHAL, Medline, Science Direct, Sage Journals, OVID, Wiley online library, and ProQuest dissertations and theses global**.**

Strengths and Limitations of Body of Evidence:

Strengths: In a 2016 Bureau of Labor Statistics survey of nonfatal injuries, the healthcare industry had an incident rate of 14.3 per 10,000 full-time workers for injury caused by another person, where the national rate is 1.7 for all other industries (Bureau of Labor Statistics, 2017). Therefore, many sources exist regarding this global occupational hazard.

Limitations: Despite the prevalence of workplace violence, there lacks a standardized guideline on how to assess and report workplace violence across all healthcare settings.

Link between recommendations and the supporting evidence:

Spector et al. (2014) reviewed 136 articles involving 151,347 nurses from 160 samples and discovered that the overall violence exposure rates were 36.4% for physical violence and 66.9% for nonphysical violence. Despite the high prevalence of workplace violent acts and aggression towards nurses, under-reporting is a worldwide phenomenon in the nursing profession (Song et al., 2021). Causes of underreporting are multifactorial and have not been earnestly studied (Song et al., 2021). For example, a survey in Slovenia reported that nurses report violent incidents in formal written form ranging from only 6.5% (verbal abuse) to only 10.9% (physical violence) (Kvas & Seljak, 2014). Some foreign studies have offered explanations for under-reporting. For example, nurses perceive the aggressive behavior as unintentional related to the patient's mental status, or they feel reluctant to report an incident they feel has had a mild impact on them. The

most significant reasons for under-reporting are that nurses believe workplace violence is the norm and part of the job and are unsure what constitutes workplace violence. Another common reason is that nurses believe no preventative measures after the violent incident occurs and reporting the incident would not lead to any positive change (Song et al., 2021). Other barriers to reporting workplace violence are a lack of clear guidelines, nurses' ideas of time-consuming reporting procedures, lack of managerial support, fear of blame, fear of losing one's job, and no encouragement to report (Song et al., 2021). This guideline will serve as a tool to help nurses better comprehend the scope and nature of violence in the workplace and how to report it.

External Review:

The guidelines will be assessed by multiple expert appraisers with experience in developing guidelines and workplace violence.

Advice and/or Tools on How the Recommendations can be put into Practice:

The Clinical Practice Guidelines can be introduced into the healthcare setting through various entry points. An assessment of these guidelines may be conducted by hospital administrators, a guideline-review committee, risk management, or other committees responsible for evaluating current practices and policies of the healthcare system.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6717691/

The Updating Process of Clinical Practice Guidelines.

1. Identify new relevant evidence via literature review, collecting opinions for experts, external review, or alerts.

2. Assessment of the need for an update, whether new evidence alters the current clinical practice guidelines, whether new evidence is not yet included; expert judgment; or producing continuous evidence summaries.
3. Updating process through literature search, evidence selection, evidence synthesis, or assessment.
4. External review with a multidisciplinary sample not involved in developing or updating the clinical practice guidelines should be conducted.

Vernooij, R.W., Sanabria, A.J., Solà, I. *et al.* Guidance for updating clinical practice guidelines: a systematic review of methodological handbooks. *Implementation Sci* **9,** 3 (2014). https://doi.org/10.1186/1748-5908-9-3

Appendix D: Clinical Practice Guidelines

Nursing Clinical Practice Guideline Development for Assessing, Mitigating and Reporting Workplace Violence

Section 1

If you are unsure of the risk factors involved with workplace violence, read the below information then continue to the next section. If you are familiar, you may skip to the next section 2.

Patient, Client and Setting-Related Risk Factors

1. Working directly with people who have a known history of violence, abuse drugs, and gang members.
2. Transporting patients is a high-risk activity.
3. Working alone in a facility or in patients' homes.
4. Poor environmental design of the workplace.
5. Poorly lit corridors, rooms, and parking lots.
6. Lack of means of emergency communication.
7. Prevalence of firearms, knives and other weapons among patients and their families and friends.
8. Working in neighborhoods with high crime rates.

Organizational Risk Factors

1. Lack of facility policies and staff training for recognizing and managing escalating hostile behaviors from patients, or visitors, or staff.
2. Working when understaffed.
3. High volume turnover.
4. Inadequate security and mental health personnel on site.
5. Long waits for patients and overcrowded waiting rooms.
6. Perception that violence is tolerated, and victims will not be able to report the incident to the police.

Note. OSHA (2016). Guidelines for preventing workplace violence for healthcare and social service workers. https://www.osha.gov/sites/default/files/publications/osha3148.pdf

Section 2

If you are unsure if your workplace environment is safe, monitor the following workplace analysis checklist below then continue to the next section. If you are familiar with what constitutes a safe environment, then you may skip to section 3.

1. Exit doors on the floors should only be opened from the inside to prevent unauthorized entry.
2. Have an internal phone system available to activate emergency assistance.
3. Make sure there is an alarm system or panic button in high-risk areas, and you know where they are.
4. Make sure there is good visibility of patients and visitors.
5. Arrange the patient areas to minimize stress, including minimizing noise.
6. Secure all drugs, equipment, and supplies.
7. Have access to a "safe room" to use during emergencies.
8. Make sure furniture in the room is arranged to prevent from becoming trapped.

Assess the Influence of Day to-Day Work Practices on Occurrences of Violence

1. Identification tags must be worn to enter the building.
2. Identify patients with a history of violence.
   a. Put contingency plans in place for these patients: restrict visitors and supervise their movement throughout the facility.
3. Have emergency phone numbers readily available.
4. Minimize waiting times for patients as to eliminate stress.
5. Do not enter seclusion rooms alone or work alone in emergency areas, particularly at night.

Section 3

If you are unsure what strategies nurses can take to make their workplace safer, then read the following guidelines and then continue to the next section. If you are aware, you may skip to section 4.

Dress for safety by removing anything from yourself that may be used as a weapon or grabbed by someone

- Long hair needs to be tucked away so that it can't be grabbed.
- Jewelry – avoid earrings or necklaces.
- Wear comfortable clothes as overly tight clothing may restrict movement.
- Avoid loose clothing or scarves that may get caught.
- Use breakaway safety cords or lanyards.

Be aware of your work environment

- Note exits and emergency phone numbers.
- Minimize confusion, background noises, and crowding as it can increase stress levels.
- Note mealtimes, shift changes, and transportation of patients as these are times of increased disruptive behaviors.

Section 4

If you are unaware of what violent behavior is preceded by warning signs, read the following cues that are considered indicators of possible violence then continue to the next section. If you understand what precedes violent behavior, then skip to section 5.

Verbal Cues

- Speaking loudly or yelling
- Swearing
- Threatening tone of voice

Non-verbal or Behavioral Cues

- Physical appearance (clothing and hygiene neglected)
- Arms held tight across chest
- Clenched fists
- Heavy breathing
- Pacing or agitation
- A terrified look signifying fear and high anxiety
- A fixed stare
- Aggressive or threatening posture
- Thrown objects
- Sudden changes in behavior
- Indications of drunkenness or substance abuse.

- If you don't feel safe, notify your direct supervisor and the security department to have them assess the situation. Read the next section.

- If you do not believe you are in danger, continue monitoring the situation, and escalate it to the security department or your supervisor if any changes in your initial assessment changes. You may skip to section 5.

Section 5

If you have been a victim of workplace violence

- File an incident report and participate willingly in employer investigative actions.
- Report any injuries to your supervisor and then get assessed through the Employee Health Office, Employee Assistance Program, or the Emergency Department.
- Seek counseling if experiencing trauma to alleviate any post-traumatic stress.
- Work with criminal justice authorities if legal action is called for.

** The order in which a nurse initiates these actions may depend upon the nature of the injury or trauma suffered.

- If you are afraid to report workplace violence out of fear of retaliation, or out of fear you will be discriminated against, then equip yourself with the following knowledge:

- Equip yourself with the understanding of the Federal Protections for Whistleblowers under the Occupational Safety Act: Nurses will not be discriminated against or retaliated against for filing any complaint about workplace violence.

  https://www.osha.gov/sites/default/files/publications/OSHA3638.pdf

- Be involved in the filing of the incident and be included in the process and feedback regarding the status of any anticipated actions.

  https://www.in.gov/dol/files/OSHA_Sample_Workplace_Violence_Incident_Report_Forms.pdf