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Staff Education Using a Workplace Violence Reduction Bundle

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Executive Summary: Staff Education Project
Staff Education Using a Workplace Violence Reduction Bundle
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Summary

This Doctor of Nursing Practice (DNP) quality improvement staff education project addressed workplace violence (WPV) affecting medical-surgical nurses. Workplace violence is a persistent problem that increases risk for staff injury and psychological distress, contributes to burnout, and can compromise a safe care environment for patients and staff. The project examined whether a structured education program on a Workplace Violence Reduction Bundle, emphasizing the use of the Broset Violence Checklist (BVC) and evidence-based de-escalation strategies, would improve nurses' knowledge about de-escalation strategies. The project was informed by current evidence and relevant guidelines and involved medical-surgical nursing staff. Major products included staff education materials, a pre- and post-knowledge assessment tool, and a program evaluation survey. Analytical strategies included comparing pre- and postintervention knowledge test outcomes and summarizing program evaluation responses using descriptive statistics. Findings showed mixed item-level changes in knowledge scores, identifying specific content areas requiring reinforcement. Program evaluation responses reflected strong acceptability and perceived usefulness. Recommendations include targeted reteaching and strengthened assessment and reinforcement strategies in future quality improvement cycles. Implications for nursing practice include supporting early risk identification and de-escalation to promote staff safety. Advancing physically and psychologically safe workplaces and equitable support for staff disproportionately affected by WPV has potential to strengthen staff well-being and sustain safer clinical environments.

Background

WPV is a persistent safety and workforce problem in inpatient settings. WPV remains a significant concern for medical-surgical nurses who care for patients experiencing pain, delirium, withdrawal, and acute psychosocial distress. Exposure to patient aggression contributes to physical injury risk, psychological strain, emotional exhaustion, decreased job satisfaction, and nursing turnover, which can destabilize staffing and threaten a safe care environment (Gedik et al., 2023). Despite the prevalence of WPV, nurses frequently report a need for additional training to recognize early warning signs of escalation and apply evidence-based, noncoercive strategies before behaviors intensify. Addressing this practice gap supports safe, therapeutic care delivery and aligns with professional expectations for maintaining staff and patient safety.

Project Question and Purpose

The project question was the following: Among medical-surgical nursing staff exposed to aggressive patient behaviors, did education on a Workplace Violence Reduction Bundle increase staff knowledge and self-reported preparedness to address workplace violence? The purpose of this project was to evaluate whether a structured staff education program on the Workplace Violence Reduction Bundle improved medical-surgical nurses' knowledge of WPV risk recognition and evidence-based de-escalation strategies.

Evidence Supporting the Practice Change

Evidence supported multicomponent approaches to WPV prevention in health care settings, particularly interventions that combine staff education with structured processes for early risk recognition, reporting, and response. A systematic review by

Somani et al. (2021) found that multicomponent programs, including education, policy or process changes, environmental strategies, and reporting systems, demonstrate promise for WPV prevention. Quasi-experimental studies also supported structured prevention approaches that strengthen staff preparedness and promote standardized response practices (Cai et al., 2023). In addition, the BVC has demonstrated predictive utility for identifying patients at increased risk of aggressive behaviors, supporting its use as a brief, standardized risk recognition tool within clinical workflows (Hvidhjelm & Holst, 2025). Collectively, this evidence supported the implementation of an education-focused bundle to strengthen early identification and de-escalation skills and to promote a safer work environment.

Staff Education Project Development

The project was implemented on an inpatient medical-surgical unit in an acute-care hospital. Participants were registered nurses who provided direct patient care on the unit and were the primary end users of the Workplace Violence Reduction Bundle education and BVC workflow. These nurses routinely managed patients with pain, delirium, withdrawal, and psychosocial stressors, which can contribute to escalating behaviors and increased risk for WPV. Participation was voluntary. No patient-level data were collected or used. Nurses who did not provide direct patient care (e.g., those in administrative roles) were excluded; agency nurses were also excluded due to variable assignment patterns and limited access to unit-based education. The unit was selected because staff, at the time of the current study, frequently encountered early indicators of escalation during routine care, making it an appropriate setting to evaluate changes in staff knowledge and self-reported preparedness.

Intervention Description and Delivery

The project was implemented on an inpatient medical-surgical unit in an acute-care hospital. Participants were registered nurses who provided direct patient care on the unit and were the primary end users of the Workplace Violence Reduction Bundle education and BVC workflow. These nurses routinely managed patients with pain, delirium, withdrawal, and psychosocial stressors, which can contribute to escalating behaviors and increased risk for WPV. Participation was voluntary. No patient-level data were collected or used. Nurses who did not provide direct patient care (e.g., those in administrative roles) were excluded; agency nurses were also excluded due to variable assignment patterns and limited access to unit-based education. The unit was selected not only because staff frequently encountered early escalation indicators during routine care, making it an appropriate setting to evaluate changes in staff knowledge and self-reported preparedness, but also because it aligned with the strategic leadership priorities. By choosing this unit, I aimed to support the organization's broader goal of enhancing patient and staff safety on units with the highest risk of WPV, thereby portraying the project as a deliberate, system-level change rather than an isolated pilot.

The intervention involved a structured education program for staff on the Workplace Violence Reduction Bundle. Core components included basic skills training on WPV risk factors, antecedents of dangerous behaviors, strategies for applying the BVC, and evidence-based de-escalation methods (see Mitra et al., 2024). To evaluate the effectiveness of these educational components, I used specific assessment tools. WPV risk factors and antecedents were measured through knowledge quizzes before and after the intervention. Strategies for applying the BVC were evaluated by the correct and

consistent use in simulated scenarios. Evidence-based de-escalation methods were assessed via role-playing exercises in which staff demonstrated techniques effectively. The BVC training tool is provided in Appendix A. Staff received the training through a formal PowerPoint presentation, which included an application-focused discussion and case-based examples, ensuring that the training content aligned with organizational safety standards and unit expectations.

Evidence Collection and Analysis

Data collection techniques included a preintervention knowledge test, a postintervention knowledge test, and a post session program evaluation survey. The pretest and posttest instruments (see Appendix B) assessed nurses' knowledge of WPV concepts, early recognition of escalating behaviors, appropriate use of the BVC, and core de-escalation principles (see Recsky et al., 2023). The program evaluation survey (see Appendix C) assessed nurses' perceptions of training relevance, clarity, and usefulness using the Likert-type scale.

Evaluation Process and Ethical Considerations

The evaluation was assessed by its capacity to determine whether the educational intervention for staff delivered via a PowerPoint presentation (see Appendix D) achieved its intended objectives of enhancing knowledge. Pre- and posttest data were compared to evaluate the changes resulting from the educational offering (see Davis et al., 2021). This project adhered to the Walden University Doctoral Project Ethics Pledge. Evaluation was voluntary, no patient or participant identifiers were used, and the activity was conducted as a quality improvement initiative to strengthen education and practice.

Results

Registered nurses participated in the education program. Twenty-one staff completed the post session program evaluation survey ($N = 21$). For the knowledge outcome, participants used unique anonymous identifiers to link pre- and posttests; 10 matched pre- and postknowledge assessments were available for analysis ($n = 10$ pairs) (see Table 1). Descriptive statistics were used to summarize knowledge outcomes and item-level performance.

Table 1

Staff Education Knowledge Test Participation

Measure	Pre (n)	Post (n)
10-item Knowledge Test Completed	10	10

Mean knowledge scores remained similar across time points, with a pretest mean of 3.50 ($SD = 0.85$) and a posttest mean of 3.20 ($SD = 0.79$) reflecting a slight absolute decrease of 0.30 points, or 8.6%, on a 10-point scale (see Table 2).

Table 2

Knowledge Outcomes (10 Items): Descriptive Comparison of Pre- vs Postintervention Scores

Statistic	Pre ($n = 10$)	Post ($n = 10$)	Absolute change (post–pre)	Percentage change
Mean (SD) score, out of 10	3.50 (0.85)	3.20 (0.79)	-0.30	-8.6%
Median	3.50	3.00	-	-
Range	2 to 5	2 to 4	-	-

Score distributions were comparable, and most participants scored 3 or 4 on both assessments. The percentage of Score 2 increased from 10% preintervention to 20% postintervention, and no participants scored 5 on the posttest (see Table 3).

Table 3

Score Frequencies (Knowledge Total Score Distribution)

Total score (out of 10)	Pre <i>n</i> (%)	Post <i>n</i> (%)
2	1 (10%)	2 (20%)
3	4 (40%)	4 (40%)
4	4 (40%)	4 (40%)
5	1 (10%)	0 (0%)

Item-level analysis showed mixed trends. Performance improved on Item 2 (80% to 100%, an increase of 20 percentage points). Performance declined on Item 3 (80% to 50%, a 30-percentage-point decrease) and on Item 5 (30% to 20%, a 10-percentage-point decrease). Several items showed no change, including persistent incorrect performance on Items 1, 7, 9, and 10 (0% correct pre and post), highlighting specific content areas for targeted reinforcement in future education cycles (see Table 4).

Table 4

Item-Level Knowledge Performance: Percentage Correct Pre vs Post (With Change)

Item (Q#)	Correct answer	Pre correct <i>n</i> (%)	Post correct <i>n</i> (%)	Change (percentage) points
1	B	0 (0.0%)	0 (0.0%)	0.0
2	C	8 (80.0%)	10 (100.0%)	+20.0
3	B	8 (80.0%)	0 (0.0%)	-30.0
4	A	10 (100.0%)	10 (100.0%)	0.0
5	C	3 (30.0%)	2 (20.0%)	-10.0
6	C	1 (10.0%)	0 (0.0%)	-10.0
7	B	0 (0.0%)	0 (0.0%)	0.0
8	C	5 (50.0%)	5 (50.0%)	0.0
9	B	0 (0.0%)	0 (0.0%)	0.0
10	B	0 (0.0%)	0 (0.0%)	0.0

Program Evaluation

Program evaluation findings demonstrated strong acceptability and perceived usefulness of the educational intervention ($N = 21$). Across the 10 Likert-scale evaluation items (Q1 to Q10), 18 respondents (85.7%) selected *strongly agree*, and three respondents (14.3%) selected *agree*, resulting in 100% positive agreement for each item (see Tables 5 and 6). Staff feedback supported the feasibility of delivering the training and endorsed the clarity, relevance, and applicability of the content to clinical practice.

Table 5

Program Evaluation Results by Item (Q1 to Q10), Likert Frequency and Percentage (N = 21)

Item	Program evaluation item (abbrev.)	Strongly agree <i>n</i> (%)	Agree <i>n</i> (%)	Positive agreement (agree + strongly agree)
1	The speaker was clear	18 (85.7%)	3 (14.3%)	21 (100%)
2	Content relevant to practice	18 (85.7%)	3 (14.3%)	21 (100%)
3	Objectives stated and met	18 (85.7%)	3 (14.3%)	21 (100%)
4	Materials supported learning	18 (85.7%)	3 (14.3%)	21 (100%)
5	Gained new WPV knowledge	18 (85.7%)	3 (14.3%)	21 (100%)
6	More confident using BVC	18 (85.7%)	3 (14.3%)	21 (100%)
7	Identify escalation earlier	18 (85.7%)	3 (14.3%)	21 (100%)
8	Length/format appropriate	18 (85.7%)	3 (14.3%)	21 (100%)
9	Session met learning needs	18 (85.7%)	3 (14.3%)	21 (100%)
10	Recommendation to other staff	18 (85.7%)	3 (14.3%)	21 (100%)

Note. Ratings used a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*).

Items map to domains: Knowledge (Q5, Q7), Confidence (Q6), and Program Quality (Q1-Q4 and Q8-Q10).

Table 6

Program Evaluation Summary (N = 21)

Summary metric	Result
Strongly agree responses (overall pattern)	18/21 (85.7%)
Agree responses (overall pattern)	3/21 (14.3%)
Positive agreement (agree + strongly agree)	21/21 (100%)

Interpretation of Effectiveness and Magnitude of Change

In this DNP quality improvement project, descriptive findings indicated the intervention was feasible and highly acceptable, as reflected in program evaluation responses. Knowledge outcomes remained stable overall, with mixed changes at the item

level. These findings support continued educational intervention with targeted refinements, including strengthening instruction and reinforcement for items with persistent gaps, and reteaching content areas in which posttest performance declined. Given the small sample size and quality improvement design, results should be interpreted as performance and process feedback to guide iterative improvement rather than as evidence for broad generalization.

Limitations and Broader Significance

This project was implemented in a single unit with a small sample size, limiting generalizability. The evaluation period was brief, which did not allow for assessing long-term outcomes, such as sustained behavior change or trends in reported WPV events over time (see O'Brien et al., 2024). In addition, self-reported measures may have been influenced by response bias. Despite these limitations, WPV remains a widespread concern across health care settings. Structured education that strengthens early risk recognition and de-escalation skills can be adapted for other units and organizations and supports ongoing quality improvement efforts to promote staff safety and safer care environments.

Conclusions

Overall Impact and Recommendations

This DNP quality improvement staff education project demonstrated that training on the Workplace Violence Reduction Bundle was feasible to deliver and was strongly endorsed by staff, as evidenced by program evaluation findings. Knowledge outcomes were stable overall, with mixed item-level changes that identified specific content areas requiring reinforcement. Recommendations include targeted reteaching of persistent

knowledge gaps; reinforcement strategies such as brief huddles, job aids, and teach back; and continued leadership support to integrate violence prevention strategies into routine practice. Future evaluations should include longer follow-up and, if feasible, objective measures such as trends in reported WPV events and restraint use.

Implications for Nursing Practice and Social Change

The implications for nursing practice include strengthening early risk recognition and improving consistency in de-escalation decision making to support staff safety and safer care environments. Facilitating psychologically safe workplaces and equitable support for staff who may be disproportionately affected by WPV has the potential to positively impact diversity, equity, and inclusion and promote social change. Continued quality improvement efforts can strengthen staff well-being and sustain safer clinical environments.

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Appendix A: Broset Violence Checklist (Complete Tool)

Objective: 1 Broset Violence Checklist (BVC)

The 6 Behaviors

Behavior	Definition	Example
Confusion	Confusion	Confusion
Irritability	Irritability	Irritability
Boisterous	Boisterous	Boisterous
Verbal Threats	Verbal Threats	Verbal Threats
Physical Threats	Physical Threats	Physical Threats
Attacking Objects	Attacking Objects	Attacking Objects

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13

Objective: 1 Broset Violence Checklist (BVC)

Scoring and Thresholds

- Each item = 0 (absent) or 1 (present).
- Total = 0–6 points.
- Interpretation:
 - 0–1 = Low risk
 - 2 = Moderate risk (increased monitoring)
 - ≥3 = High risk → initiate safety measures and de-escalation strategies.

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14

Appendix B: Pre- and Posttest Knowledge Assessment (10 Items)

No names were collected; anonymous unique identifiers were used for pre- and post-matching.

Staff Education Program: Workplace Violence Reduction Bundle Pretest/Posttest

Thank you for participating in this Staff Education Project focusing on the Workplace Violence Reduction Bundle (WVRB).

Completion of this pretest/post-test will serve as your consent to participate in this educational program. For confidentiality, please do not put your name on this document. You will be provided a unique identifier to ensure that your pretest is associated with your posttest. Circle the correct answer.

Unique ID _____ Date _____

1. What is the primary purpose of the Broset Violence Checklist (BVC)?

- A. To document patient demographics
- B. To identify patients at risk for violent behavior within the next 24 hours
- C. To record patient medication compliance
- D. To monitor staff attendance

2. How many behaviors are assessed on the Broset Violence Checklist (BVC)?

- A. 3
- B. 5
- C. 6
- D. 8

3. A BVC score of 2 indicates what level of risk?

- A. No risk, continue routine observation
- B. Moderate risk — initiate prevention plan
- C. High risk — call security immediately
- D. Low risk — reassess in one week

4. Which of the following is an example of a de-escalation technique?

- A. Maintaining a calm tone and allowing personal space
- B. Standing over the patient to show authority.
- C. Speaking loudly to regain control
- D. Ignoring early warning signs of agitation

5. Which principle of Trauma-Informed Care (TIC) is most essential during a crisis?

- A. Focusing solely on patient compliance
- B. Prioritizing staff convenience
- C. Promoting safety, trust, and empowerment
- D. Using restraint immediately to ensure safety

6. What is the preferred first-line approach when a patient begins to escalate?

- A. Call for physical restraint assistance
- B. Leave the room immediately
- C. Attempt verbal de-escalation and assess the environment
- D. Administer medication without assessment

7. When should staff complete a post-event debriefing?

- A. Immediately after every shift
- B. Within 24 hours of a violent incident
- C. Only if the patient was injured
- D. After the next staff meeting

8. What is the primary goal of post-event debriefing?

- A. To identify who caused the incident
- B. To discipline staff members involved
- C. To promote learning, reflection, and recovery
- D. To report the incident to external agencies

9. Which of the following best describes a safe alternative to restraint?

- A. Ignoring patient requests
- B. Offering sensory items or quiet time
- C. Using multiple staff to contain the patient
- D. Forcing medication compliance

10. What is one expected outcome of implementing the Workplace Violence Reduction Bundle?

- A. Decreased staff confidence in managing aggression
- B. Improved staff knowledge and confidence in preventing workplace violence
- C. Increased use of restraints
- D. Reduced communication between teams.

Answer Key: 1=B, 2=C, 3=B, 4=A, 5=C, 6=C, 7=B, 8=C, 9=B, 10=B

Appendix C: Program Evaluation Tool

Response scale: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree

1. The speaker was clear.
2. The content was relevant to my practice.
3. The objectives were stated and met.
4. The materials supported my learning.
5. I gained new knowledge about workplace violence prevention.
6. I feel more confident using the Broset Violence Checklist (BVC).
7. I can identify escalation earlier after this session.
8. The length and format were appropriate.
9. The session met my learning needs.
10. I would recommend this education to other staff.

Appendix D: Staff Education PowerPoint Presentation (Outline)

Slide 1: Title and purpose of session

Slide 2: Why workplace violence prevention matters (staff safety and patient care)

Slide 3: Definitions and common drivers of escalation in medical-surgical settings

Slide 4: Workplace Violence Reduction Bundle overview and unit workflow

Slide 5: Broset Violence Checklist: items, scoring, and interpretation

Slide 6: When and how to use the BVC in routine care

Slide 7: Core de-escalation principles (tone, space, choices, validation)

Slide 8: Communication techniques and scripting examples

Slide 9: Team response: when to call for help and escalation pathways

Slide 10: Documentation and reporting expectations

Slide 11: Post-event support: debriefing, resources, and learning loops

Slide 12: Summary, key takeaways, and questions