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Violence Against Nurses

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MSN, Walden University, 2012

BSN, University of Illinois, 2006

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Workplace violence against nurses causes stress, job dissatisfaction, injury, and financial burden. The purpose of this project was to examine training for nurses on violence, risk factors and on reporting workplace violence. The practice-focused question was designed to examine the effectiveness of educating nurses regarding violent patients and how to report episodes of violence. Benner's novice to expert theory guided the skill acquisition training of a convenience sample of 25 Midwestern medical nurses. The nurses participated by completing a survey prior to and following a violence simulation. A qualitative design was used with the 25 nurse participants who completed the pre-and post-simulation education surveys to assess for increased knowledge. Data were manually tabulated by coding responses into categories. Categorical themes of risk factors related to violence included environment, behavior, and illness-related; and themes related to interventions to prevent violence included awareness, education, communication, de-escalation, and calming. Overall results indicated that nurses saw the importance of reporting all injuries and violence to supervisors. The project makes a meaningful contribution to nursing practice by informing nurses how to report violence and injury from violence, and by informing administrators of the need for education in the recognition of risk factors for violence. The positive social change impact of this study for nurses is increased awareness that violence is not acceptable, and that a healthy work environment benefits nurses and promotes a safer healthcare work environment for patients and visitors to the healthcare setting.

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Section 1: Introduction

Introduction

Episodes of violence occur daily in healthcare settings. The Bureau of Labor Statistics (2015) reported an increase of violence-related workplace injuries accounting for 15.6 incidents per 10,000 workers in hospitals. The dictionary definition of violence is physical force to harm someone or damage property, a fervent feeling or expression, and undue alteration of words (Violence, 2014). The Violence Prevention Alliance (VPA), a subgroup of the World Health Organization, defines violence as "the intentional use of physical force or power, threatened or actual, against another person that either results in or has a high likelihood of resulting in injury, death, or psychological harm" (2016, para 2). While the two definitions are similar, the VPA gives violence a more intentional meaning. The Occupational Safety and Health Administration (OSHA) provides a third level of meaning for the term, defining violence in its relevance to healthcare. OSHA's (2015) definition indicates that violence in healthcare occurs when patients or clients verbally or physically threaten staff in their workplace. I used OSHA's definition for this project. Nurses, who represent the largest percentage of healthcare workers, may be targeted victims of intentional violence in the healthcare setting.

Although episodes of violence occur every day in the healthcare setting, reports may never be published; and violence is historically underreported. The Emergency Nurses Association (2016) suggested that underreporting occurs because of the tedious process of reporting, unclear policies, beliefs it would not make a difference or help, perceptions by staff members they may be penalized, and the belief that violence is part

of the job. A nurse may excuse an aggressive patient if the patient is ill and the attack is not considered intentional (Wolf, Delao & Perhats, 2014). This feeling comes from an ethical duty to not harm patients.

Healthy People 2020 objective OHS-6 promotes reduction in work related assaults, and suggests that the focus should be on preventing violence in the workplace (Occupational Safety and Health, 2016). In this project, I addressed nursing education to raise awareness and increase knowledge of prevention strategies related to aggressive patient situations. I explored the prevention and interventions related to violence against nurses. Section 1 includes the problem statement, and discussions of the purpose, nature, and significance of the doctoral project.

Problem Statement

Episodes of violence occur daily in healthcare settings. OSHA (2015) categorize serious violent injuries as those that require days off work for an injured person. Health care workers had 7.8 cases of serious workplace violence per 10,000 full-time employees, whereas construction and manufacturing had considerably less, with only two cases per 10,000 (OSHA, 2015). According to the employee injury report at my study site, the local health system had 49 injuries per 3100 employees for fiscal year 2015-2016.

While nurses accept that violence or threats are a part of the culture of the job, nurses should not tolerate violence of any sort (Wolf, Delao & Perhats, 2014). In its position statement on workplace incivility, bullying, and workplace violence, the American Nurses Association calls for a "culture of civility and kindness" (2015, p. 4). Physical and verbal assaults cause stress, job dissatisfaction, injury, and financial burden,

which contribute to stress, burnout, and high turnover rates (Speroni, Fitch, Dawson, Dugan & Atherton, 2014).

The Bureau of Labor Statistics (2015) reported workplace injuries related to violence at 15.6 incidents per 10,000 workers in hospitals. This statistic demonstrates the amount of workplace violence, yet Stokowski (2014) found that number may be underreported, as many nurses seem to only report serious events to their employers. OSHA statistics include direct physical assaults, written or verbal threats, physical or verbal harassment, and homicide (2015).

I conducted an evidence-based project at a health system where nurses' experiences with violence reflect the level of violence reported by the Bureau of Labor Statistics (2015). The health system has a documented history of violence against its nurses. In personal conversations with me, staff members expressed the idea that they were unprepared to recognize or respond to violent patients and clients. According to the employee injury report provided by the organization where this project took place, 21 injuries related to combative patients occurred in 2013; however, in 2014 the number reported had more than doubled to 45 injuries. Employee injuries, related to combative patients, increased to 49 during 2015.

Purpose

Hospitals are required to record and report occupational injury details to the Bureau of Labor Statistics and OSHA (OSHA Recordkeeping Rule, 2001). These statistics, as well as information from research studies, demonstrate the injuries related to assault from patients to healthcare workers. A review by Piquero, Piquero, Craig, and

Clipper (2013) cites at least 15 studies that discuss the prevalence of workplace violence in healthcare. Some of those studies are cited throughout this project, including a nursing specific study in Minnesota. The increase in injury episodes at this Midwestern hospital demonstrates a gap in knowledge regarding aggressive clients. The local hospital's violence rates are reflective of those around the Midwest (Arnetz et al., 2017).

The purpose of this doctoral project was to examine the gap in knowledge at a Midwestern hospital. I examined violence prevention standards at this hospital and current policies and procedures regarding violent episodes. I focused on educating nurses regarding signs of potential aggressive behavior and the mechanisms for tracking episodes. This violence prevention education assisted nurses to recognize risk factors to diffuse violence before it causes harm, while the tracking assisted leaders in plans of continued violence prevention principles.

Nature of the Doctoral Project

The practice setting for this doctoral project is a health system in the Midwest. In 2015, a nurse educator investigated the increased incidence of acts of physical and verbal assault from patients against nurses and nurse aides. In personal communication with me, the educator reported healthcare workers' injuries from patient violence increased from 21 to 45 incidents in one year. The nurse educator attributed the increase of assaults to the staff being unfamiliar with risk factors. She analyzed strategies to keep patients and staff safe during violent episodes. The educator surveyed her nurse coworkers before and after standardized de-escalation education. The nurse educator's medical unit implemented a visual cue of placing a green magnet on the door jamb of patients who

met STAMP criteria of risk for violence, as well as a buddy system for known risky situations. The STAMP violence risk assessment tool indicators include staring, tone of voice, anxiety, mumbling, and pacing (Kim, Ideker, & Todicheeney-Mannes, 2012). In a study on a medical unit in California, researchers used the same components of the STAMP tool and components from the ABRAT (Aggressive behavior risk assessment tool) and found that the risk assessment tool is valid for identifying potential violent patients on a medical unit (Kim, Ideker, & Todicheeney-Mannes, 2012). The local nurse educator presented information during a "lunch & learn" education event at the hospital. In this DNP project, I have built upon that previous project from 2015. For the DNP project, I showed a video recorded patient violence simulation scenario. Nurses completed an initial survey questionnaire prior to the presentation of a simulation of a violent episode, and again after the presentation.

Simulation has been shown to help participants develop cognitive and critical thinking skills in a safe, collaborative environment (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014). While I have located many studies on simulation, and many related to violence, I have not found a specific study that addresses a violence simulation for nurse education. The method of education evaluation I used for this project included both cognitive and critical thinking improvements. The project analysis included formative evaluation. Evaluation was performed prior to and following the simulation demonstration. I completed analysis of the participants' pre- and post-education scores to determine if the simulation increased the nurses' knowledge of prevention strategies. I used the simulation debriefing to assess knowledge acquisition—specifically nurses'

knowledge of and ability to state risk factors leading to violent behavior and how to file an incident report. The evaluation included an assessment of my performance in leading the simulation. Future summative evaluation of the annual injury reports was not within the scope of this project, but is a recommendation for the health system to track.

Significance

Violence is four times more common in healthcare settings than in other work places. Patients are perpetrators of at least 80% of the incidences of workplace violence, while another 12% is related to customers or other clients (OSHA, 2015). Illness, the stress of being sick, the feeling of helplessness, deterioration of status, mental illness, financial concerns, and substance abuse are possible causes of hostility from patients and clients (Wassell, 2009). Nurses need to recognize risks and be aware of the environment for their safety and the safety of patients and coworkers. I used a simulation scenario program to demonstrate possible threats to nurses in a safe environment. While a quiz can test knowledge, researchers can use simulation with debriefing to assess performance and offer feedback (Rudolph et al., 2016). The project I implemented on a medical unit has transferability to other units within the health system. Participation in this simulation and study positively impacts nurses within this facility, as well as nurses outside this facility.

National organizations have made statements that support campaigns against violence in the healthcare setting. The Robert Wood Johnson Foundation and the Institute for Healthcare Improvement have developed a joint project called Transforming Care at the Bedside (2016). Transforming Care at the Bedside (TCAB) is a process that encourages bedside nurses or frontline workers to initiate safety and quality measures,

which improve work conditions and patient care. The American Organization of Nurse Executives (AONE) and the Emergency Nurses Association (ENA) have also collaborated to develop steps to reduce violence in the workplace. The AONE Guiding Principles for Mitigating Violence (2014) include five primary focus areas, the fourth of which is on education and training on workplace violence. This evidence indicates national support that may help build awareness and reduction of violence locally after this project is complete.

These national initiatives align the strategic plan of the Midwestern health system, which is to reduce serious safety events by ensuring higher levels of learning. The simulation environment decreases orientation time and staff turnover while increasing nursing competency and confidence (Beyea, Slattery & von Reyn, 2010). Simulation develops cognitive, motor, and critical thinking skills in a safe, collaborative environment (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014). Simulation technology provides opportunities for replication of potentially adverse patient situations to educate nurses, thus improving their self-efficacy. The standardized simulation depicting patient violence was developed for nurses, but could potentially apply to the entire patient care team of providers, therapists, and nursing assistants.

Summary

Violence is four times more common in healthcare settings than in other work settings. The perpetrators of violence are primarily patients, while another 12% are customers or other clients (OSHA, 2015). Nurses need to be aware of the environment for their own safety as well as the safety of patients and coworkers. Nurses also need to

know the policies and procedures related to violence at their facility. The violence simulation I used in this project allows the nurse to learn in a safe environment, to recognize situations that lead to verbal and physical assault, and to learn appropriate reporting techniques.

Section 2: Background and Context

Introduction

Workplace violence occurs at astonishing rates in healthcare settings (BLS, 2015). Healthcare workers, especially nurses who have direct patient contact, lack the knowledge and skills to adequately recognize potential violence and assaultive behaviors (OSHA, 2015). I designed this doctoral project to educate medical unit nurses at a Midwestern hospital about violence prevention. In the project, I used simulation to demonstrate aggressive, abusive, and even violent patients. Simulation provides a safe training environment to educate nurses about the signs of potential assault (Oh, Jeon, & Koh, 2015). My mission for this DNP project was to investigate current policies in order to better understand the causes of the episodes of violence in the health system and use that information to inform a training intervention.

In Section 2, I address models and theories used for this project. Specifically, I explain behaviors and environments related to potentially unsafe situations, and discuss designing and evaluating interventions to prevent or minimize those situations. In this section, I also discuss the relevance that this topic of violence prevention and awareness has for nursing practice in general, at the local level, and for me.

Concepts, Models, and Theories

Simulations are used in healthcare to represent multiple types of events, situations, and learning experience with a specific purpose for each type of simulation (Lateef, 2010). Simulation techniques enhance training by allowing reproduction of behaviors and techniques (Lateef, 2010). It provides opportunities for assessment,

education, and research in a safe environment while allowing learning to transcend into real life (Society for Simulation in Healthcare, 2015). Learning occurs as a task is repeatedly performed using the same tools and actions as in the real environment (Lateef, 2010). The nurse/student has the ability to achieve competency by practicing on a coworker, a mannequin, or even a computer. The act of repeated safe practice in a pretend environment allows the nurse to gain knowledge and skills.

As nurses learn and perform clinical skills, they transition to enhanced clinical judgment, the process of understanding problems and concerns of patients (Benner, Tanner & Chesla, 2009). Benner's novice to expert theory guided this project. Benner's theory holds that as nurses acquire skills, they will require fewer cues (1984). Faculty at the University of Maryland, Baltimore School of Nursing (UMB SON), developed a simulation protocol applying Benner's concepts. These faculty members proposed that as skills and knowledge are gained, learners advance through proficiency levels (Larew, Lessans, Spunt, Foster, & Covington, 2006). The students (N =190) participated in a standardized and reproducible simulation to lead learners to recognize cues and problem solve. The proficiency levels for Benner's middle range theory include novice, advanced beginner, competent, proficient, and expert (McEwen & Wills, 2014). As nurses gain more confidence in their experience, they will need fewer cues and advance through the levels. Critical thinking is a crucial skill for nurses caring for clients who potentially may be violent or aggressive. A critique of the UMB SON live simulation was that it was time intensive. Thus, in my project, I used a video-recorded simulation of a standardized patient to ensure validity and brevity.

Simulation education may be a strategy to stimulate critical thinking and decision making skills (Abe, Kawahara, Yamashina & Tsuboi, 2013). Some studies have shown that simulation does increase written test score and skill performance (Yuan, Williams, Fang, & Ye, 2012) (Cook et al., 2011). A systematic review of 26 trials showed that simulation increased mean scores knowledge (by 0.53 points) and skill (by 1.15 points; Yuan, Williams, Fang, & Ye, 2012). Yuan, Williams, Fang, and Ye (2012) found that some researchers using high fidelity simulation reported that nursing students made more errors when the simulation did not have standardization, such as using a checklist or time limit, but the repetition and feedback did enhance skill and knowledge.

Authors from the Mayo Clinic performed a systematic review and meta-analysis of 609 studies comparing technology-enhanced simulation to no intervention (Cook et al., 2011). Technology, as defined by the Mayo Clinic researchers, included simulators, mannequins, animals, and even human cadavers. The researchers found diversity in date of publication, type of simulation, and learning experience. The earliest study was from 1969, and the most recent was published after 2008. Most were set in simulation centers. The methods and outcome measures varied, as did the topics. The Mayo Clinic researchers' analysis showed that technology-enhanced simulation does show improved knowledge (95% CI, 1.04-1.35; P<.001) and skills (95% CI, 1.03-1.16; P<.001; Cook et al., 2011).

The inclusion of simulation in nursing education contributes to nurses' knowledge, skills, safety, and confidence (Norman, 2012). Norman, Dore, and Grierson (2012) found that the type of simulation (high-fidelity versus low fidelity) has no

specificity on skill acquisition. In a systematic review of 17 studies, Norman (2012) identified outcomes that include knowledge and skills, safety, communication, clinical judgment, satisfaction, confidence, and clinical evaluation. A single study focusing on novice nurses during orientation showed that simulation increased competency and confidence (Beyea, Slattery, & von Reyn, 2010). The novice nurses experienced simulations with mannequins and standardized patients, which were specific to their clinical setting with themes of quality improvement, communication, collaboration, and safety. Beyea, Slattery, and von Reyn (2010) found that the participants reported more favorable learning based on the type of the simulation design and reflective feedback. The novice nurses reported an increase in confidence, competence and readiness for practice while the facility reported that the length of orientation and nursing job turnover rate decreased.

A theoretical framework guides a researcher in assessing the problem, etiology, extent, and social value (Kettner, Moroney, & Martin, 2008). I used Patricia Benner's novice to expert theory as the framework for this project to understand how nurses acquire knowledge through experiencing situations.

The Kirkpatrick model guided the evaluation of the training program. The four levels of the Kirkpatrick model include: reaction, which measures how the participants felt about the training; learning, which measures participants' knowledge; behavior, which assesses if the knowledge is transferred to work; and results, which focus on the outcome of the program (Abdulghani et al., 2014). Kirkpatrick designed the evaluation model to be used for training programs. In this training program for nurses, I used the

reaction level to assess the nurse reaction to the delivery of education, and the learning level, to assess participants' learning with a short quiz. The behavior level is used to assess changes in behavior when the nurse returns to the unit, and the results level is broader and is used to assess system or organizational change. Unusual occurrences or incident reports are the focus at the results level. The number of incident reports may increase as nurses recognize what is classified as violence and as they discover the ease of reporting. In this project, I used the first and second levels.

Relevance to Nursing Practice

Workplace violence occurs in all types of jobs, but occurs at a relatively high rate in healthcare (Bureau of Labor Statistics, 2015). A startling video was released from CNN showing a 68-year-old man attacking at least eight nurses at St. John's Hospital in Minnesota (Pereira, 2014). A nurse suffered a collapsed lung while another had her wrist broken. An administrator stated, "this happens all the time" (Pereira, 2014). Two nurses were stabbed in Tennessee by a patient, and a New York nurse was repeatedly kicked in the head suffering a severe brain injury (Sandler, 2015). In another incident, a nurse asked a man to change into a gown in the emergency department. He stated he was tired of waiting, took a gun from under his shirt and shot into the air (Kragie & Lezon, 2017). Art has imitated life in storylines for television dramas that have included patients assaulting nurses on shows such as "ER" and "Greys Anatomy."

Major organizations and government entities have issued statements and enacted laws regarding violence against healthcare workers. This issue has become such a problem that as many as 32 states have made it a felony to assault a healthcare worker

(Workplace Violence, 2016). Healthy People 2020 includes an objective (OHS-6) which promotes reduction in work-related assaults (Occupational Safety and Health, 2016). The National Institute for Occupational Safety and Health (NIOSH) has developed programs to research and analyze workplace violence, and to provide education and prevention (Occupational Violence, 2014). Programs such as these increase knowledge with cross-sector collaboration (Economics, 2012). There is a cost benefit and value to employers and society in relation to projects that prevent worker-injury-related assaults (Economics, 2012).

Local Background and Context

The medical unit that served as my study site is in a locally-owned Midwestern hospital. This hospital is part of a larger health system that has entities in two states. The city it serves has just over 102,000 residents, 80% of whom are Caucasian (Census Quick Facts, 2015). The overall crime rate is 47 per 1000, which is considered very high (Crime Rate, n.d.). The health system hired a research company to perform a community needs assessment, one section of which addressed violence. The data was collected from surveys and FBI statistics. As shown in the community assessment report (2015), there were 467.8 violent crimes per 100,000 people in 2012. The crimes included murder, manslaughter, rape, robbery, and aggravated assault. The research also showed that 16.3% respondents say they had been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner. The health system has partnered with the local hospitals in sponsoring the needs assessment so the community may identify issues of concern and commit resources to them. The needs assessment demonstrated that violence is an issue

in the community, while the assault and injury rates within the hospital indicate that violence is an issue that demands resources. While the health system's mission is to provide quality compassionate health services to all those in need, this does not include being assaulted while providing those services.

The local medical unit is like any other unit in a suburban hospital, in that violence and assault occurs. OSHA requires a log of injury incidents for all healthcare workers, and nurses represent 30% of all hospital workers (OSHA, 2015). In a personal communication with me, a nurse educator at this Midwestern hospital reported that she noticed an increase in injuries on the medical unit, and examined the situation related to the number of injuries from combative patients. She found that the incidence of injuries from combative patients more than doubled in one year.

In this DNP project, I included a simulation of violence, which was provided by the hospital. The simulation laboratory at the hospital is located on one-half of an entire floor of the hospital, and allows for all healthcare disciplines to collaborate for best practice. The simulation lab has both high- and low-fidelity mannequins. They make use of standardized patients in rooms set with a variety of themes. Standardized patients are people who portray a patient. One room is staged as a client's home for visiting nurses, while another is set as a negative airflow room for all disciplines. The simulation lab meets the needs of the healthcare organization regarding the education of its healthcare providers in a collaborative and safe environment.

Some states have criminal statutes for assaulting a healthcare worker. In the Midwest, Illinois law states it is a third degree felony to assault a healthcare worker.

Statute 708.3A of the Iowa Code states that it is a Class D felony to commit an assault against or intend to inflict serious injury to a healthcare provider. It is a misdemeanor if that assault causes injury (Emergency Nurses Association, 2016).

Role of the DNP Student

My role in this project included educating nurses regarding signs of potential aggressive behavior and the mechanism for tracking episodes. This education increased nurses' awareness of violence toward them while improving safety. The project aligned with OSHA and CPI recommendations. OSHA (2015) recommends comprehensive workplace violence prevention, which includes agreement from managers and staff to become more knowledgeable about prevention strategies, risk identification, episode, and employee training. The security staff and the behavioral health unit staff at the Midwestern hospital are trained yearly in de-escalation techniques using a program purchased from Crisis Prevention Intervention (CPI). CPI recommends prevention and safe patient handling if a situation becomes physical. The OSHA report (2015) includes discussions of facilities that use the electronic medical record to track violence screenings each shift, facilities that access criminal records on all behavioral health admissions, facilities that have dimly lit serene rooms, and facilities that use duress alarms that have GPS capability within the hospital.

Relationship to and Motivation for the Topic

I had previously worked at this hospital on the behavioral health unit from 2012 to 2014, and as a cardiac nurse from 2001 to 2007. When I began my career as a psychiatric nurse, I was astounded by the amount of mental and physical nursing involved with

working with behavioral and mental health clients, as compared to critical cardiac patients. I attributed exhaustion to the need to be constantly aware of all aspects of these patients. The department required constant supervision and documentation of all patients. I realized that even though I had been a nurse for 12 years, I knew little about the demands of providing safety to patients, coworkers, and myself in a behaviorally or mentally unstable situation. If an experienced nurse needed to learn something new, then all nurses should be provided that same education.

I must admit that as I have researched the violence topic, I have found that I am guilty of the same belief of many nurses: that assault or violence is part of the job or to be expected in the nursing arena. The belief that violence was just "part of the job" resulted in my coworkers and me rarely filing incident reports. While working both cardiac and behavioral health, I was a victim of verbally abusive comments and physical assault from patients. I have also witnessed and been employed on a unit where nurses have been injured to the extent that they have been taken off duty. Unfortunately, a co-worker sustained a serious injury as a confused older 120-pound patient grabbed her thumb and it took two other nurses to pry him from her, which was extremely physically demanding. She was on restricted duty for months and was unable to care for patients in the capacity of a nurse. Another nurse was physically assaulted by a psychiatric patient who lunged at him from his bed. The verbal assaults have included a wife who threatened an oncology nurse, telling the nurse she better put oxygen on her husband or there would be consequences.

When I heard a nurse from the medical unit speak at a "lunch and learn," I was surprised to hear of so many situations of assault and injury to nurses on a general medical unit. I expected reports of violence in the behavioral health unit and even in the emergency department, but not a general medical unit. My concern with the amount of injuries related to patient violence throughout the hospital and throughout the country has led to my interest in developing the project.

I have incorporated safety in my role as nursing faculty in hopes that when the students become nurses, they are more prepared for situations that involve patient and staff safety. The students learn to recognize how it is easier and more cost effective to prevent an issue rather than treat it. This applies to the concepts of medication safety, illness and fall prevention, and de-escalation rather than reaction. I used narrative safety stories to discuss my work experience prior to allowing students into the clinical environment. I wanted nursing students to be aware of their behaviors and mannerisms, for example, how a patient may interpret something as insignificant as rolling their eyes or the tone of their voice. In this project, I have focused on providing education to current nurses at the Midwestern hospital to ensure a safe environment.

Role of the Project Team

The project team included the nurse educator who first presented this topic in 2014. She previously researched this topic when her unit had an increase of injuries from assaults by patients. The team also included the nurse educator who is responsible for simulation. She is considered the local simulation expert. A pre-recorded video simulation was provided by the hospital. It included a standardized patient representing

an assaultive patient. I have the knowledge and ability to administer pre- and post-surveys and evaluations from nurses who are being trained. In the project, I also considered the current hospital policy and procedures. The current policy manager of the hospital was consulted regarding policies.

Summary

Safety is a top priority for clients, their families, coworkers, and the healthcare provider. The project provided education in a safe simulated setting. Oh, Jeon, and Kohn (2015) found that using standardized patients positively affected knowledge acquisition, communication skills, self-efficacy, learning motivation, and clinical skill acquisition. Evidence supports the use of simulation in developing cognitive and critical thinking skills (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014). A violence policy plays an important role in protecting and supporting healthcare workers. Policies, such as zero tolerance policies, have been effective in helping reduce violence because they set the standard of responding to the first and every occurrence (Nachreiner, Gerberich, Ryan, & McGovern, 2007).

Section 3: Collection and Analysis of Evidence

Introduction

A Midwestern hospital has episodes of violence against nurses that are reflective of crime rates within the community. Nurses have been injured, yet some nurses still do not consider yelling, pinching, and hitting as violence. Violence is seen as part of their job. Currently, the hospital does not have a policy specifically addressing patient violence against healthcare workers. Violence is only reported when serious injury occurs. The purpose of the project was to educate nurses regarding definitions of what constitutes violence, steps for prevention, and the reporting of episodes of violence.

Section 3 includes the practice focused question, sources of evidence, and analysis and synthesis. In this section, I discuss the problem and evidence to support further analysis of violence against nurses.

Practice-focused Question

Healthcare workers experience episodes of workplace violence at a greater rate than many workers other occupations (OSHA, 2015). Injuries related to violence occur at a rate of 15.6 incidents per 10,000 healthcare workers (Bureau of Labor Statistics, 2015). The local hospital had 49 injuries per 3100 staff members in 2015. Nurses tend to accept assault from patients as part of the job, and report only serious events to their employers (Stokowski, 2014). This evidence-based project relates to the local hospital's nurses who are unprepared to recognize or respond to violent patients and clients. The local nurse educator reported to me, injuries related to combative patients increased for the third straight year in 2015. The increase in injuries indicates a gap in knowledge regarding

aggressive clients. I questioned how to improve the preparation of nurses to address violence from patients, visitors, and others in the hospital environment.

The purpose of this doctoral project was to examine the violence prevention standards at the local Midwestern hospital and improve knowledge regarding violence toward nurses while improving safety. To accomplish the project, I used a recorded standardized patient simulation demonstrating signs of potential aggressive patient behavior. I then educated nurses on what constitutes a reportable incident, and on how to report it. The education aligns with the goal of improving nurses' abilities to address violence events in healthcare.

Sources of Evidence

Sources of evidence must be credible, especially with a controversial topic like workplace violence in healthcare. The sources of evidence I used in this project addressed improving nurses' abilities to address violence incidents. These sources included books, publications from professional organizations, journals, media, and interviews. Professional organizations include the American Nurses Association, the American Organization of Nurse Executives, and the Emergency Nurses Association. Journals, media, and books are listed in the references. I interviewed the employee health nurse, an educator, and security personnel at the study site. These sources assisted in my examination of the violence prevention standards at the hospital. I used the previous research and information from professional organizations to develop this project. Collection and analysis of data from participants before and after the simulation provided evidence of the effectiveness of the education program.

Published Outcomes and Research

The PICO (population, intervention, comparison, and outcome) analysis of research model clarified the questions, which assisted in my discovery and review of literature. As I review the literature, I kept the following question in mind: Would the comparison of pretest and posttest scores demonstrate an improvement in knowledge of violence against nurses who attend simulation education?

I used EBSCO host, CINAHL, MEDLINE, and Science Direct databases to search for keywords such as *violence, assault, simulation, workplace violence, safety,* and *violence policy*. Full text, recently published (2007 to present) literature was included, while older articles and those not published in English were excluded. While not all sources I found are included and cited in this document, the search led me to education, nursing, public health, occupational health, and preventative medicine journals. The following organizations provided current standards of practice and suggested future practice guidelines: American Nurses Association, Emergency Nurses Association, American Organization of Nurse Executives, OSHA, and NIOSHA.

Archival and Operational Data

The doctoral project involved analysis of the organization's operational data regarding the number of employees injured as result of assault from patients. This de-identified data did not contain names or descriptions of the incidents, only the number of injuries from patients who were violent per fiscal year. I was provided a report of the data that is currently collected by the employee health nurses when a nurse files an unusual occurrence or incident report. I did not have access to that database and obtained all

information from the employee health nurses. Injury details are directly reported from the person injured or assaulted. The injury data is relevant, providing justification for tracking in relation to the practice problem in this project. Limitations inherent in the data include lack of full completion of the electronic report.

Evidence Generated for the Doctoral Project

I gathered evidence from medical unit nurses via a qualitative pre-and post-test questionnaire developed for the project. There are approximately 50 nurses on the medical unit at the local Midwestern hospital, and 25 participated. The survey was given on paper due to lack of available computers. Assessment included open-ended questions including: What is violence? What are risk factors that may lead to violence? What are interventions to prevent violence? and How do you report violence at this hospital? Nurses provided information rating their level of knowledge related to violence against nurses prior to a simulation and again following the simulation.

The ethical considerations were minimal regarding the protection of participants because the nurses simply observed a simulation and completed a questionnaire. The person portraying the patient in the recorded simulation is a nurse. This person was familiar with situations with patients, each portion was dramatized, and the person was not harmed. I have worked closely with my preceptor and the medical nurses on many projects, which has allowed for the development relationships with participants and the manager. The incentive for nurses to participate was their desire to reduce injuries to them or their coworkers.

Analysis and Synthesis

The lean process is a specific method to create a more efficient and safer process (Hakim, 2014). The local hospital models lean from the Toyota Production System, and bases its process of transforming waste into value on Womack and Jones' *Lean Thinking* (2003). Lean principles can be used for almost anything: planning a trip, arranging a move, and organizing a DNP project. I used the principles to organize the project utilizing the structured A3 road map and communication tool from lean. An A3 is named for the size of paper, an 11x17 single sheet. It is set up into nine sections or steps. Each step guides the user through a systematic approach to problem-solving. The A3 road map involves observations of workflow and standard work of those closest to the process. As I proceeded through the phases of the project, the A3 became more defined. A completed A3 was not within the scope of this DNP project because employee injury reports are constantly being collected. The A3 did help me organize the DNP project and process for reducing injuries from patient violence.

The hospital tracks injuries related to violence against healthcare workers from patients using a database accessed by the employee health nurses. The employee health nurse provided me the number of injuries to nurses from patients from previous years. Data did not include any names of nurses or patients involved in the incidents, nor what the injury was. The expected outcome would be to include the violence education in nursing orientation, thus reducing injuries in future years.

In addition, I conducted a content analysis using qualitative data from the open-ended questions to extract themes. Using these themes, I then compared the frequency of

themes which indicated that the nurses' knowledge was enhanced as a result of the training. The survey asked how to report violence and how to report an injury. I documented findings in a spreadsheet that contained each response coded with unique identifiers; no personal identification was requested of each participant. I coded and counted responses to see if themes emerged differently before and after the training, as evidence of learning.

Participants in the class were asked to evaluate the class. The questionnaire included questions related to my presentation. For example: Was the content presented in a way to help you learn? Was the instructor well prepared? Did the instructor make it possible to increase your knowledge and understanding of the subject? What were the instructor's strengths? and What would you suggest to improve the instructor's presentation? The first three questions were rated on a scale from 1 to 5, and the last two questions were free-text responses.

Summary

The key points in Section 3 have included further descriptions of the practice focused question, sources of evidence, analysis, and synthesis. The sources of evidence and analysis of pre- and post-simulation data provided support for my project regarding the need for future education related to violence against nurses.

Section 4: Findings and Recommendations

Introduction

The local Midwestern hospital that was the subject of this DNP project had an increase in the number of injuries to nurses from patients 3 years in a row. There is a gap in practice related to nurses' preparedness in addressing patient-to-nurse violence. I questioned the hospital violence prevention standards that should protect nurses while they are doing their job. In this doctoral project, I sought to assess if nurses gained knowledge of violence risk factors and violent prevention strategies.

The sources of evidence I used included professional journals, professional organizations, and nurses from the local hospital. The hospital is required to keep statistics which are obtained from the employee injury reports. The data are reported to multiple entities: OSHA, the Bureau of Labor Statistics, and Press Ganey NDNQI. National organizations, such as the Emergency Nurse Association, use that data when developing statements or programs related to the protection of workers.

Findings and Implications

With IRB approval 05-19-17-0241539, I began engaging nurses. The nurses were surveyed twice with the following questions:

- What is violence?
- What are the risk factors that may lead to violence?
- What are interventions to prevent violence?
- How do you report violence at this hospital?
- How do you report injury at this hospital?

A simulated violence scenario was shown and discussed using a PowerPoint format. I then distributed the post survey using the same questions. I promised that I would report findings from analysis and synthesis of the data regarding improvement in knowledge regarding recognition of risk factors for violence.

Question 1 addressed the definition of violence. Responses provided by the nurse participants indicated a shift in the pattern before and after the violence scenario. Before the training, responses that emerged relating to a definition of violence included harm (76%) and aggression (20%). After the education, responses provided included harm (96%) and aggression (4%). The common harm response referred to any action that caused harm to someone, while the common aggression response included physical attack. It is significant that nurses learned that violence is not only severe physical assault.

In Question 2, I asked about the risk factors for violence. Responses provided by nurses included themes of environment, behavior, and illness. Of the 25 nurses who participated in the project, 17 stated "environment" in their initial answer, while only 11 chose "environment" in the post survey. The initial response of "behavior" was reported by 13 of 25 nurses, while the post survey revealed 11 who stated "behavior" as one of their answers. The post survey response of "illness" increased from 6 to 12 answers. The responses that contributed to the theme of illness included physical and mental illnesses. Before the training, the emerging themes included patient's behavior and environment. After the training the emergent themes demonstrated the nurses' recognition that physical and mental illness affect violence too.

In Question 3, I asked about interventions that have the potential to prevent violence. Themes included awareness, communication, de-escalation, and calming. Prior to the violence scenario, responses provided by nurses included themes of awareness and communication. After the education, responses provided included themes of calming and de-escalation. The responses related to calming increased from zero to 65%. The theme of de-escalation that originally had two responses increased to seven. The responses that contributed to the theme of calming included placing patients away from noisy call lights, speaking in calm voice, and turning down the lights.

In Question 4, I asked nurses about how to report violence. Prior to the violence scenario, responses provided by the nurse participants included themes of reporting to security personnel, supervisors, law enforcement officers, and of making an unusual occurrence report. After the education, responses provided indicated that nurses would also file an unusual occurrence report. The overwhelming theme of reporting demonstrates the importance of the nurse supervisor to have knowledge regarding policy and procedures when receiving reports of violence.

In Question 5, I asked how to report injury. Before the training, the themes related to reporting injury included reporting to a supervisor. The emerging theme, after the education, indicated that nurses would also file an unusual occurrence report. This shows the need for further education for all nurses because they need to file two reports: an injury report and an unusual occurrence report.

The potential impact of a smaller sample size is less power. Power is the ability for the study to detect relationships but not reach saturation of data (Grove, Burns, &

Gray, 2013). The implication of a smaller sample size may deter the organization or health system from supporting further violence education if they were basing their decision solely on the results of this survey. Adoption of the DNP project may impact individual nurses and all healthcare workers at the local hospital. Potential implications that demonstrate positive social change include increased awareness of risk factors related to potential violence and knowledge regarding resources and how to report an episode. A probable workplace violence policy has been discussed for the organization.

The employee injury rates following this DNP project have yet to be compiled by employee health nurses. An incident is investigated as injuries are reported. The data is submitted after investigation of each injury. The potential decrease of injuries that may be in that report is not within the scope of this DNP project.

The A3 lean tool was useful in the development of the DNP project. The Midwestern hospital uses this tool throughout the health system for organization of process flows (see Figure 1). It is then able to refer to the tool when evaluating the achievement of goals. In this DNP project, I provided violence education to nurses. The health system will continue to track the data and refer back to the process outlined in the lean tool if any modifications are needed.

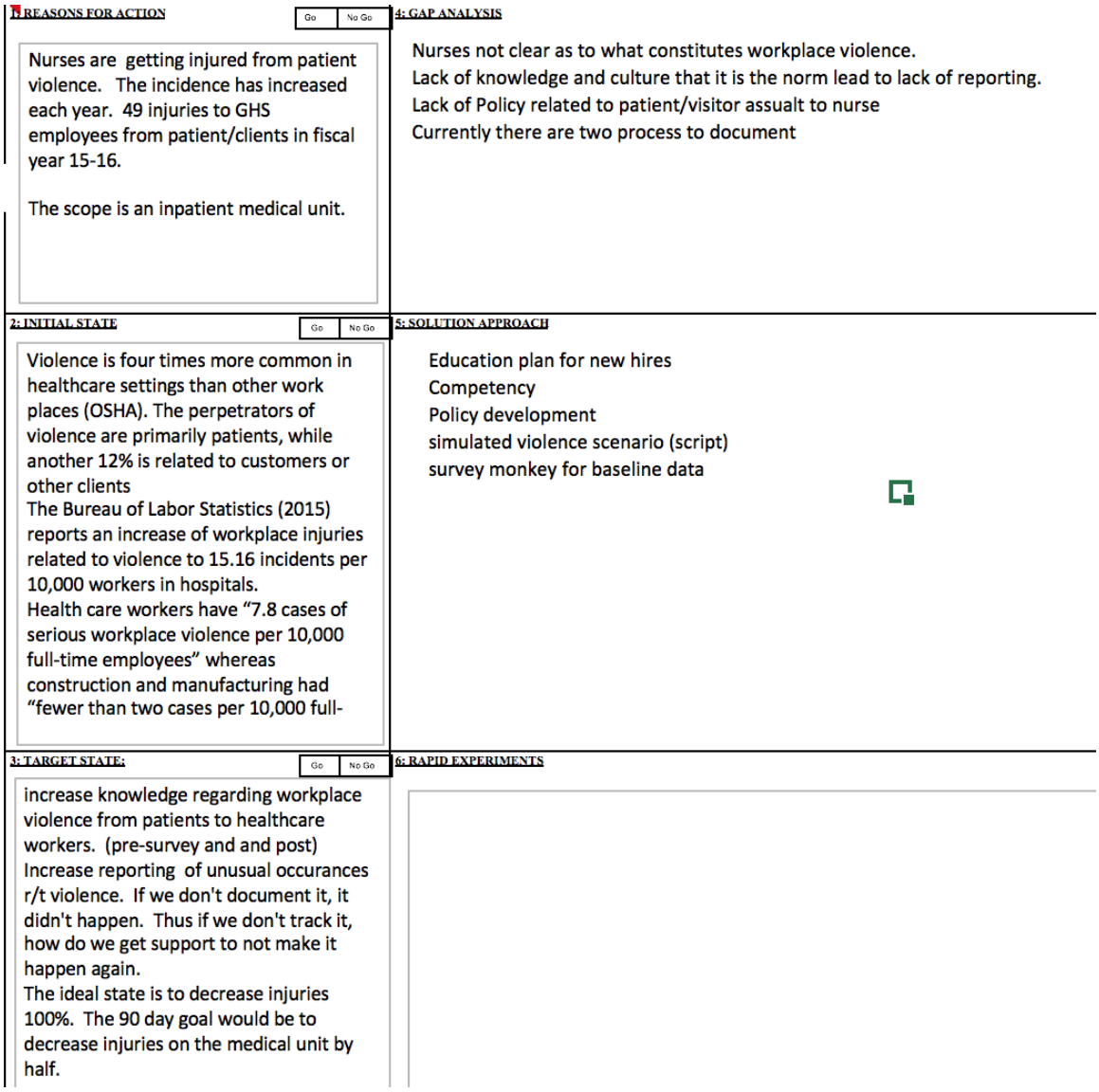

Figure 1. The A3 lean tool.

Recommendations

Nurses are victims of violence, as demonstrated by the number of injury reports each fiscal year at the local hospital. My recommended solution, which potentially addresses the gap-in-practice of nurses being victims of violence, includes continuation of the education to all nurses. The director of nursing education has already asked that I

continue to present education during nursing orientation and the nurse residency program each month. A strong workplace violence policy demonstrates to nurses that the administration supports and stands by them.

Contribution of the Doctoral Project Team

I worked with a team that included two nurse educators. One previously worked on making her unit safer, and the other is responsible for the simulation lab. I consulted the policy manager regarding current violence policies. The educators and policy manager served primarily as consultants during the project process, but the simulation educator has taken ownership of continuing the education started in this project. She has a role in nursing orientation for the health system. The policy manager has discussed a stronger violence against healthcare worker policy. Policies are evaluated on a yearly basis, and this policy is not yet due for review.

Strengths and Limitations of the Project

A strength for nurses participating in violence education is increased awareness that violence is not acceptable, and that a healthy work environment benefits nurses in the Midwestern hospital. An unanticipated limitation during the project process occurred in that the medical unit was closing at one hospital and relocating to another within the health system. Nurses on the medical unit were mandated to work thus limiting nurses who volunteered as subjects.

Summary

This project on violence against nurses included medical nurses volunteering to take a survey prior to and following a viewing of a violence simulation. Nurses learned

about risk factors for violence and how to report violence and injury. Responses from the surveys indicated that participants gained new knowledge after the simulation and debriefing. The concept of violence education has since been adopted by the education department as part of nursing orientation and has influenced consideration for a stronger workplace violence policy.

Section 5: Dissemination Plan

Introduction

In this final section, I describe my plan to disseminate this work to the Midwestern hospital experiencing violence against nurses. Nurses are applying this newly gained knowledge in their day-to-day activities, while hospital administrators may use the outcome data to develop a policy that makes a strong statement regarding violence from patients. Communication of results included a poster presentation at the healthcare organization leadership development day and a PowerPoint presentation at the hospital safety day, with a panel discussion that includes multiple disciplines. The audience at these two venues would include people ranging from the CEO to CNAs. Violence prevention is an appropriate discussion for everyone employed at the health system, but especially for direct care providers.

As I have discussed this DNP project topic, I have discovered that many in the hospital are surprised that patient to caregiver violence occurs. I had someone say that maybe we should not report the little things, only the big things that really cause injuries. Failure to report each problem is consistent with a theory developed in 1969 by psychologist Philip Zimbardo (Wilson & Kelling, 1982). Zimbardo (1969) suggested ignoring the small things such as a broken window leads to larger problems such as all the windows in the neighborhood being broken. Healthcare workers know the importance of preventative care, but we need also to recognize the importance of addressing “broken windows”; we need to address every episode of violence against nurses.

Analysis of Self

The journey to obtaining a DNP has provided me many opportunities for growth in knowledge and skills as a professional nurse. Prior to starting the DNP program, I thought that I was well educated and up to date. I belonged to and was active in my state nursing association and my local Sigma Theta Tau chapter. I read a variety of nursing and healthcare journals. The Walden DNP class work, project development, and practicum experiences have improved my nursing practice and my development as a scholar practitioner, and has influenced my professional goals.

The practicum and project experiences led me to change how I organize my work. A practicum with a lean specialist showed me how the healthcare organization uses lean principles for patient care areas as well as business areas. My DNP project provided me with an opportunity to collaborate with educators, nurses, employee health nurses, the policy department, and the human resources department. I have been fortunate to work with preceptors who are energetic, intelligent, patient, and wise. The interactions have allowed me to develop those positive traits that I admire and appreciate in those preceptors. Patience and wisdom are interpersonal skills that benefit all interactions whether it be a nurse, a business partner, or a patient.

As I continue my journey as a nurse, the enhanced knowledge, and skills I have obtained in the DNP program make me consider and reconsider long-term professional goals. When I began this journey, I was teaching at an associate degree community college nursing program and loved it. I changed positions and now work at the hospital. My practicum experience allowed me to see how energetic and alive I felt at the hospital.

I do miss the students and the awesome feeling I experienced when I saw them achieve success. My plan includes continuing this path of working at a hospital, which provides daily learning and advancement of knowledge and skills. I would also like to teach again, perhaps online or even clinically for the college where I previously taught.

Summary

Prevention of violence against nurses is significant. The simulation education program related to risk factors for violence and reporting of violence allowed nurses to participate in the prevention of violence. My educational and exciting journey as a DNP student came to an end with concluding the doctoral project. My journey as a lifelong learner never ends.

References

Abdulghani, H. M., Shaik, S. A., Khamis, N., Al-Drees, A. A., Irshad, M., Khalil, M. S., . . . Isnani, A. (2014). Research methodology workshops evaluation using the Kirkpatrick's model: Translating theory into practice. *Medical Teacher,* 36S24. doi:10.3109/0142159X.2014.886012

Abe, Y., Kawahara, C., Yamashina, A., & Tsuboi, R. (2013). Repeated scenario simulation to improve competency in critical care: A new approach for nursing education. *American Journal of Critical Care, 22*(1), 33-40. doi:10.4037 /ajcc2013229

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements.* Silver Spring, MD: Nursesbooks.org.

Arnetz, J., Janisse, J., Hamblin, L., Russell, J., Essenmacher, L., Upfal, M. & Luborsky, M. (2017). Preventing patient-to-worker violence in hospitals: Outcome of a randomized controlled intervention. *Journal of Occupational & Environmental Medicine, 59*(1), 18-27. dx.doi.org/10.1097/JOM.0000000000000909

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley.

Benner, P., Tanner, C.A., & Chesla, C.A. (2009). *Expertise in nursing practice: Caring, clinical judgment, and ethics.* (2nd ed). New York: Springer.

Beyea, S. C., Slattery, M. J., & von Reyn, L. J. (2010). Outcomes of a simulation-based nurse residency program. *Clinical Simulation in Nursing, 6*(5), e169-e175. http;://dx.doi.org/10.1016/j.ecns.2010.01.005

Bureau of Labor Statistics. (2015). Number of nonfatal occupational injuries and illness involving days away from work per 10,000 full time workers by industry and selected events or exposures leading to illness or injury, private sector. Retrieved from http://www.bls.gov/news.release/pdf/osh2.pdf

Census Quick Facts. (2015). Retrieved from the US Census Bureau at http://www.census.gov/quickfacts/table/PST045215/1919000

Community Needs Assessment. (2015). Retrieved from https://www.scottcountyiowa.com/health/community-assessments

Cook, D., Hatala, R., Brydges, R., Zendejas, B., Szostek, J., Wang, A., . . . Hamstra, S. (2011). Technology-enhanced simulation for health professions education: A systematic review and meta-analysis. *JAMA*, 306(9), 978-988. http://dx.doi.org/:10.1001 /jama.2011.1234

Crime Rate. (n.d.). Retrieved from https://www.neighborhoodscout.com/ia/davenport /crime/

Economics. (2012). Retrieved from the Centers for Disease Control and Prevention at http://www.cdc.gov/niosh/programs/econ/emerging.html

Emergency Nurses Association. (2016). Workplace violence prevention course. Retrieved from http://ena.org/education#online

Feda, D. M., Gerberich, S. G., Ryan, A. D., Nachreiner, N. M., & McGovern, P. M. (2010). Written violence policies and risk of physical assault against Minnesota educators. *Journal of Public Health Policy*, *31*, 461-477. http://dx.doi.org/10.1057/jphp.2010.32

Guiding Principles. (2014). Retrieved from http://www.aone.org/resources/mitigating-workplace-violence.pdf

Grove, S., Burns, N. & Gray, J. (2013). *The practice of nursing research: Appraisal, synthesis, and generation of evidence (*7th ed.). St. Louis, MO: Saunders Elsevier.

Hakim, H. (2014). Not just for cars: Lean methodology. *Nursing Management 45*(3). 39–43. http://dx.doi.org/10.1097 /01.NUMA.0000443942.06621.6e

Hayden, J.K., Smiley, R.A., Alexander, M., Kardong-Edgren, S., & Jeffries, P.R. (2014). The national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. *Journal of Nursing Regulation, 5*(2). 1-66.

Kettner, P. M., Moroney, R. M., & Martin, L. L. (2008). *Designing and managing programs: An effectiveness-based approach* (3rd ed.). Thousand Oaks, CA: Sage.

Kim, S. C., Ideker, K., & Todicheeney-Mannes, D. (2012). Usefulness of aggressive behaviour risk assessment tool for prospectively identifying violent patients in medical and surgical units. *Journal of advanced nursing*, *68*(2), 349-357. http://dx.doi.org/10.1111/j.1365-2648.2011.05744.x

Kragie, A. & Lezon, D. (2017). Impatient patient opens fire in Houston area ED. Retrieved from http://www.emsworld.com/news/12292119/impatient-patient-opens-fire-in-houston-area-ed

Larew, C., Lessans, S., Spunt, D., Foster, D., & Covington, B. (2006). Innovations in clinical simulation: application of Benner's theory in an interactive patients care

simulation. *Nursing Education Perspectives 27*(1), 16-21.

Lateef, F. (2010). Simulation-based learning: Just like the real thing. *Journal of Emergencies, Trauma and Shock, 3*(4), 348–352. http://dx.doi.org/10.4103/0974-2700.70743

McEwen, M., & Wills, E. (2014). *Theoretical basis for nursing* (4th ed.). Philadelphia, PA: Wolters Kluwer Health.

Nachreiner, N., Gerberich, S., Ryan, A., & McGovern, P. (2007). Minnesota nurses' study: Perceptions of violence and the work environment. *Industrial Health 45*, 672-678. http://dx.doi.org/10.2486/indhealth.45.672

Norman, J. (2012). Systematic review of the literature on simulation in nursing education. *ABNF Journal*, *23*(2), 24-28. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/22774355

Norman, G., Dore, K., & Grierson, L. (2012). The minimal relationship between simulation fidelity and transfer of learning. *Medical Education*, *46*(7), 636–647. http://dx.doi.org/10.1111/j.1365-2923.2012.04243.x

Occupational Safety and Health. (2016). Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/occupational-safety-and-health/objectives

Occupational Violence. (2014). Retrieved from the Centers for Disease Control and Prevention at http://www.cdc.gov/niosh/topics/violence/traumaviol_research.html#nurses

Oh, P., Jeon, K.D. & Koh, M.S. (2015). The effects of simulation-based learning using

standardized patients in nursing students: A meta-analysis. *Nurse Education Today 35*(5). http://dx.doi.org/10.1016/j.nedt.2015.01.019.

OSHA. (2015). Guidelines for preventing work-related violence in healthcare and social service workers. Retrieved from https://www.osha.gov/Publications/osha3148.pdf

OSHA Recordkeeping Rule (2001). Retrieved from https://www.osha.gov/OshDoc/data_RecordkeepingFacts/RKfactsheet1.pdf

Pereira, M. (2014, November 7). *Nurses attacked by rampaging patient* CNN. Retrieved http://www.cnn.com/videos/us/2014/11/07/newday-dnt-pereira-man-attacks-nurses.cnn

Rudolph, J. W., Palaganas, J., Fey, M. K., Morse, C. J., Onello, R., Dreifuerst, K. T., & Simon, R. (2016). A DASH to the top: Educator debriefing standards as a path to practice readiness for nursing students. *Clinical Simulation In Nursing*, *12*(9), 412-417. http://dx.doi.org/10.1016/j.ecns.2016.05.003

Sandler, M. (2015). Patient stabs two nurses at Knoxville, TN hospital. Retrieved from Modern Healthcare at http://www.modernhealthcare.com/article/20150914/NEWS/150919937

Society for Simulation in Healthcare (2015). Simulation. Retrieved from http://www.ssih.org/About-Simulation

Speroni, K. G., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. (2014). Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient

visitors. *Journal of Emergency Nursing 40*(3). 218–228. http://dx.doi.org/10.1016/j.jen.2013.05.014

Stokowski, L. (2014). Step Away from that nurse! Violence in healthcare continues unabated. Retrieved from Medscape at http://www.medscape.com/viewarticle/835015

Transforming Care at the Bedside. (2016). Retrieved from the Institute of Healthcare Improvement at http://www.ihi.org/Engage/Initiatives/Completed/TCAB/Pages/default.aspx

Violence. (2014). *Merriam-Webster Collegiate Dictionary* (11th ed.). Springfield, MA

Violence Prevention Alliance. (2016). Definition and typology of violence. Retrieved from http://www.who.int/violenceprevention/approach/definition/en/

Wassell, J., (2009). Workplace violence intervention effectiveness: A systematic literature review. *Safety Science*. 1049-1055. http://dx.doi.org/10.1016/j.ssci.2008.12.001

Wilson, J. & Kelling, G. (1982). Broken windows. Retrieved from The Atlantic at https://www.theatlantic.com/magazine/archive/1982/03/broken-windows/304465/

Wolf, L. A., Delao, A., & Perhats, C. (2014). Nothing changes, nobody cares: Understanding the experience of emergency nurses physically or verbally assaulted while providing care. *Journal of Emergency Nursing 40*(4). 305–310, http://dx.doi.org/10.1016/i.jen.2013.11.006.

Womack, J. P., & Jones, D. T. (2003). *Lean thinking: Banish waste and create wealth in your corporation.* New York: Free Press.

Workplace Violence. (2016). Retrieved from the American Nurses Association at http://nursingworld.org/workplaceviolence

Workplace Violence in Healthcare. (2015). Retrieved from the Occupational Safety and Health Administration (OSHA) at https://www.osha.gov/Publications/OSHA3826.pdf

Yuan, H., Williams, B., Fang, J., Ye, Q. (2012). A systematic review of selected evidence on improving knowledge and skills through high-fidelity simulation. *Nurse Education Today 32*, 294-298. http://dx.doi.org/10.1016/j.nedt.2011.07.010.

Zimbardo, P. G. (1969). The human choice: Individuation, reason, and order versus deindividuation, impulse, and chaos. In Nebraska symposium on motivation. University of Nebraska press.