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Impact of a Healthcare Workplace Violence Prevention Module on Staff Knowledge

Michelle Leigh Arroyo
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Michelle Leigh Arroyo

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

Review Committee
Dr. Joanne Minnick, Committee Chairperson, Nursing Faculty
Dr. Mary Catherine Garner, Committee Member, Nursing Faculty
Dr. Sue Bell, University Reviewer, Nursing Faculty

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Abstract

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The healthcare sector experiences violence 4 times as much as any other civilian domain,including law enforcement and corrections facilities. The clinical practice problem addressed in this project was the lack of adequate healthcare workplace violence (HWV) prevention in a not-for-profit community hospital. The purpose of this project increase awareness of HWV prevention through the use of an education module. Rogers' diffusion of innovation model served as the foundation for analysis of scores from pre- and post-education tests. The practice-focused question asked if a module on HWV prevention based on current clinical practice guidelines and peer-reviewed literature would improve staff members' knowledge on workplace violence. A staff education project was designed to address the practice problem. The research design was an anonymous pre- and posttest for score comparison to analyze data by noting changes in the proportion of correct answers. Nursing professionals (N = 14) participated in the education module and pre- and posttests. The percent of correct answers to 18 knowledge-related questions increased from 82% on the pretest to 91% on the posttest. The facility elected to expand the project to a more comprehensive program and requested additional modules to broaden understanding of and sustain HWV prevention strategies. These efforts will enact positive social change for healthcare staff by promoting a culture that embraces a safe work environment, increases staff knowledge on HWV prevention, decreases HWV, and is supported by organizational systems.

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Dedication

It is my honor to dedicate this work to my family. My late father instilled a love of learning as a life-long pursuit. My parents always encouraged me to continually seek knowledge. My beloved husband has walked in tandem with me in this academic journey. He along with our children and parents are my biggest cheerleaders. Thank you for the village of support to all. Robert, there is no one else with whom I could imagine traversing this journey, I love, honor, and cherish you always; Gerrick, my sweet son, your kind and loving spirit gives me such gladness; Madison, darling baby girl, I adore your generous and helpful heart; Julia, your selflessness and sacrifice made all of this possible, I love you and am eternally grateful; Stephanie, having a sister who is also a friend provides endless pride, love, and care, thank you; and to my parents: David Berry, thank you for fostering my desire to learn, I miss you so much, but I'll always be your Angel; Jeanette Berry, your kindness and love motivates me to strive for my best self; Marian Clark, your steadfast love and devotion inspires me always; Dan Clark, you are a welcome and stalwart port in any storm, thank you for your love, your wit, and your care. Jill Berry, I honor all you have done for my father and for us girls. You have a kind soul and welcoming heart. I love you all.

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Table of Contents

List of Figures

Section 1: Nature of the Project

Introduction

According to the Occupational Safety and Health Administration (OSHA; 2016), workplace violence in healthcare settings represents the largest sector of civilian workplace violence. Gallant-Brown (2008) categorized violence across four types: (a) acts committed by individuals unrelated to the setting who enter the facility to commit the crime; (b) customers (in this case, patients or visitors) who commit acts against employees of the site; (c) acts committed by current or former employees; and (d) interpersonal violence done in the healthcare setting. For this project, violence included unwanted physical contact that often causes bodily injury but also might result in psychological harm. These incidences result in loss of workdays and pay, possible hospitalization or at least evaluation by a medical professional, and residual psychological trauma or stress (Gillespie, Bresler, Gates, & Succop, 2013; Walton & Rogers, 2017).

Despite this prevalence, healthcare workplace violence (HWV) is underreported and often erroneously considered part of the job (Arnetz et al., 2015; Hester, Harrelson, & Mongo, 2016; Stempniak, 2017). OSHA (2015b) admitted there is lack of any standard to prevent workplace violence but specified that an employer has a responsibility to its workers to promote a safe working environment, mitigating potential harm or recognized hazards. Other organizations, such as the American Association of Occupational Health Nurses, Association of Occupational Health Professionals in Healthcare, National Institute for Occupational Safety and Health (NIOSH), and The Joint Commission,

promote a culture of safety and urge regulating bodies to enforce a policy of zero tolerance when it comes to HWV (Evans, 2017). However, there is not yet a standard approach or stated requirement.

Ramacciati, Ceccagnoli, Addey, Lumini, and Rasero (2016) recommended strategies for interventions toward the goal of improving safety from violence in the healthcare environment. Of the many tactics used, education was a core concept, often coupled with various practical elements, such as active shooter drills, self-defense or de-escalation techniques, and policy changes (Copeland & Henry, 2018; Ramacciati et al., 2016; Sederstrom, 2016). Sederstrom (2016) highlighted the need for risk assessment and management as well as hands-on practice with simulation. Delivery of services as a nurse is more productive and efficient when nurses feel safe (Copeland & Henry, 2018; Sederstrom, 2016). Unmitigated safety issues stemming from the experience of HWV are documented sparsely throughout literature but affect nurses' lives and patient care (Hassankhani, Parizad, Gacki-Smith, Rahmani, & Mohammadi, 2018).

Awareness of HWV is more prevalent across the United States (Emergency Nurses Association [ENA], 2011; Evans, 2018). With increased attention to OSHA's focus on HWV, a not-for-profit community hospital in the southeastern United States endeavored to address concerns through the creation of the HWV team to develop a prevention program. The community hospital documented a dramatic rise in the incidence of combativeness from patients and visitors in 2011. A swift intervention of adding one-on-one monitoring for at-risk patients resulted in a decrease in reported violence by the following year. However, by 2015, combative attacks again increased.

The purpose of this doctoral project was to create, administer, and evaluate the HWV prevention module for nursing staff in new-hire orientation. Improving prevention strategies through training could impact morale and wellness, creating positive social change from within. Education on perceptions and defensive actions for safety has the potential to alleviate unnecessary stress, allowing nurses to focus on their work instead of fear or feeling unprepared to manage a potential assault.

Problem Statement

In the community hospital, reported combative attacks with violent behavior include slapping, punching with a fist, hitting with an object, kicking, or a twisting of the affected person's arm or hand. The rising trend in incidence was concerning and bore scrutiny, indicating that additional training and education was needed (see Arbury, Zankowski, Lipscomb, & Hodgson, 2017; OSHA, 2015b, 2016). While the site is committed to the prevention of HWV, as in other hospitals nationwide, there is a perception of little organizational support or concern before, during, or after a violent incident (see Christie, 2015; Wolf, Delao, & Perhats, 2014).

Nationally, there is a trend in nursing that reports nurses perceive violent behavior as expected or that it is part of the job (Copeland & Henry, 2018; Hester et al., 2016; Locke, Bromley, & Federspiel, 2018; NIOSH, 2013). However, researchers have suggested that managers recognize the significance of the problem and constraints at the organizational level contributing to its occurrence; lack of adequate training, appropriate environmental and risk assessment, financial limitations, and acuity of patients are among several significant barriers (Baby, Swain, & Gale, 2016). The problem for the project site

hospital is the need for comprehensive HWV prevention training with subsequent evaluation of its impact.

OSHA (2015b) recommended that workplace violence prevention strategies need to include a site-specific risk assessment, a demonstration of commitment from management and organizational leaders, stakeholder participation, safety and health training, as well as quality assurance with recordkeeping and program evaluation. Leadership within the project site hospital, including the director of occupational health and safety, initiated a committee to evaluate the current baseline perception of workplace violence incidence, approach to reporting, and effectiveness of training. My work on this project aligned with their goals and will become part of their program when implementing the HWV prevention program hospital-wide.

Prevention strategies work in part by increasing emotional intelligence (Littlejohn, 2012). Current education in this facility includes a 1-day offering describing psycho-education contributing to behavior and the use of therapeutic communication to manage or deflect potential violence. After the didactic presentation, a brief hands-on demonstration occurs with the practice of de-escalation techniques meant to protect both the staff member and the assailant from worsening injury or violence. Simulation improves a participant's ability to respond effectively to violence (Sanner-Stiehr, 2017). This class is offered frequently throughout the year but is not required. Staff who take the course receive a certificate of completion, which is a document that states the knowledge and skills need renewal annually.

The staff development team sought factors leading to low turnout and determined that staff members could attend training if unit staffing allowed and managerial approval was obtained. Because of those constraints, many nurses at this hospital have not completed the available course. At the time of this writing, there was no facility documentation available measuring the program's effectiveness or impact on HWV incidence. However, the project team desired the use of a staff survey created in collaboration with this project for a baseline measurement.

With this doctoral project, I aimed to pilot a different approach to the topic of HWV during new hire nursing staff orientation with subsequent evaluation. A comparison of tests administered before and after the education module were used to determine any change in the level of adoption and perception of knowledge. When the results of the pilot program proved successful, the education module transitioned to be a portion of a training initiative for the entire hospital as part of a strategy to prevent HWV and its sequelae. Nursing practice in this facility will exemplify a safer environment for healthcare workers and provide an improved culture of safety that other entities can model.

Purpose Statement

The purpose of this doctoral project was to create, administer, and evaluate an education module on HWV prevention. Intended outcomes included better awareness of the incidence and occurrence of HWV, prevention strategies to reduce these, and de-escalation techniques should any acts of aggression present. The healthcare sector

experiences violence 4 times as much as any other civilian domain, including law enforcement and corrections facilities (OSHA, 2016).

As such, the gap in practice is understood to include the following attributes: (a) a lack of any standardized measures to enforce, monitor, or manage HWV; (b) a limited definition of workplace violence; and (c) inconsistent or ineffective education to prepare staff for prevention of HWV (Evans, 2017). With this project, I aimed to answer the following practice-focused question: Will a module on HWV prevention based on current clinical practice guidelines and recommendations improve staff's knowledge on workplace violence? Among reviewed literature, it is evident that the lack of preparation correlates to increased incidence of HWV, leading to awareness of sequelae from an assault, including physical and psychological effects (Copeland & Henry, 2018). Reported elements are acute and posttraumatic stress disorders, increased anxiety and fear, or loss of satisfaction with their job or role leading to loss of confidence in fulfilling a nursing vocation (Gates, Gillespie, & Succop, 2011; Hassankhani et al., 2018; Wolf et al., 2014).

Through this project, I aimed to address an industry-wide lack of standard measures for HWV prevention at this hospital. More pointedly, a focus existed on showing improvement in HWV incidence with the use of an evidence-based prevention strategy as stated above for the community hospital. The objective remained setting an example for the geographical area by increasing knowledge attainment and skill acquisition. With a more comprehensive module for training on HWV prevention and strategies, nurses should report improved knowledge, skills, and competency to utilize

de-escalation techniques. Statistics have shown that successful programs lead to a decrease in incidence and severity of assaults, and as a result, nursing staff feel safer and provide more efficient care (Copeland & Henry, 2018). These efforts provided a foundational matrix upon which to implement a hospital-wide intervention within a year accompanied by ongoing improvement and outcome evaluation.

Nature of the Doctoral Project

This project was an educational intervention to address the issue of prevention of HWV. While literature indicates the breadth of workplace violence in many settings, for this project, only HWV in hospital settings was considered (see OSHA, 2015; Papa & Venella, 2013). The information I gathered provided a foundation from which to generate an approach then generalize to other settings as appropriate. Articles and websites from credible, evidence-based resources provided current data. PubMed, CINAHL, and MEDLINE Plus provided access to query articles, and websites supporting workplace violence prevention, such as OSHA, Centers for Disease Control (CDC), and ENA, offered industry recommendations.

In general, for any facility seeking to create HWV prevention programs, components must gain support from the organization and be developed on a case-by-case basis. Arbury et al. (2017) described how a one-size-fits-all approach to HWV prevention yields less success because environmental risks vary from site to site. To elaborate, as recommended by OSHA (2015b), the first step before program development is to perform a risk assessment so that components contributing to worsening safety issues are addressed or included in safety training. Another element required is organizational and

administrative support. Stakeholders of any given institution should have input into which method to implement.

Ultimately, gaining stakeholder input and buy-in improves the reception and implementation of safety health and training (Arbury et al., 2017; Arnetz et al., 2015). A site-specific risk assessment with key players' insight informs a better, evidence-based approach (Minnesota Department of Health [MDH], 2014; OSHA, 2015a, 2016). Arnetz et al. (2015) suggested that participants in the development include employees, managers, and even patients in an advisory capacity. In another study, a convergent group of staff and management enacted participatory action research with focus groups to discuss, implement, and evaluate strategies (Gates et al., 2011). To show relevance and effectiveness as well as measure the impact of training, recommendations include quality assurance utilizing comprehensive recordkeeping (MDH, 2014; OSHA, 2015a, 2016).

The hosting hospital for this doctoral project formed a team for HWV prevention to follow the previously named steps. My role as a scholar-practitioner included development, implementation, and evaluation of the education module and its effectiveness. The developed PowerPoint presentation served as the medium to educate on types of workplace violence. Topics included risks for occurrence, discussion of therapeutic communication, methods for the diffusion of possible volatile circumstances, and measures to follow when encountering violence. A hands-on exhibition with return demonstration showcased how to safely deflect and disengage an assailant. A comparison of pre- and posttest results from before and after the education module gauged the impact of teaching and attainment of knowledge, skills, and abilities.

Rogers' DOI model served as the foundation for data evaluation by appraising the reaction to teaching, the extent of learning and behavior change, and the outcome of training (see Dearing, 2009; Pashaeypoor, Ashktorab, Rassouli, & Alavi-Majd, 2017). I anticipated that most participants' resulting scores would fall into categories of early and late majority adopters on Rogers' DOI model (see Section 4; see Rizan, Phee, Boardman, & Khera, 2017). In subsequent sections, I define these categories more fully. Scholars on the topic suggested that those with favorable attitudes accept a need for the evidence-based intervention and create a higher proportion of early adopters, also called opinion leaders (Mohammadi, Poursaberi, & Salahshoor, 2018). Delivering this education module on HWV prevention to a group of motivated nursing staff demonstrated a degree of impact with regards to knowledge and skills attainment, bridging the gap in practice reflected in literature as a result of too few prevention strategies, which often leads to an increase in the incidence of HWV.

Significance

Supported by OSHA's (2015b) standards for safe work environments, employers are tasked to uphold safe practices and prevent assault and injury. Despite the breadth of research that shows how protective strategies improve the incidence of HWV, the most often identified interventions includes prevention strategies in training and continued education (Gillespie, Gates, Miller, & Howard, 2010). The American Nurses Association (ANA) urged health care entities to develop programs and promote a zero-tolerance policy for HWV ("ANA Sets 'Zero Tolerance' Policy…," 2015). Meanwhile, some

experts have weighed in with different strategies, citing that zero-tolerance policies limit access to care (Paniagua, Bond, & Thompson, 2009).

The significance of this project lay in the creation of one strategic action to improve the culture of safety and potentially reduce the incidence of HWV. As research shows, there are a variety of methods or strategies; no one approach has proved more substantial than others (Gallant-Roman, 2008). However, guidelines and recommendations encourage organizations and health care staff to enact some change toward this objective (OSHA, 2015b, 2016). A goal of this project was to show the impact on a small scale and provide one standard strategy for the hospital to maintain. The knowledge gained from the module empowered staff to recognize potential threats, neutralize or de-escalate a situation to achieve ideal safety, and honor best practices in patient care.

Not only did the undertaking on this project contribute to a culture of safety for the pilot group, but in it I examined one evidence-based approach to improve nursing practice and added to the existing body of knowledge on prevention of HWV. The employment or modification of these results and strategies applies across the healthcare setting spectrum. When staff members feel safer, they are more content (Copeland & Henry, 2018; Sederstrom, 2016). Safe environments improve morale and empower healthcare workers and organizations (Gillespie, Gates, Miller, & Howard, 2010).

HWV is a global problem, and workers in many settings experience a form of violence or aggression. While the focus in this project was geared toward educating the nursing staff in a community hospital, the consideration could be expanded to other areas

of service delivery in future endeavors. The principles of risk assessment, stakeholder involvement, and training still apply and require adjustments based on setting and other contributing factors (American Association of Occupational Health Nurses, 2014). While the most common sites of HWV include the emergency department or psychiatric areas, emergency workers and first responders, such as paramedics, police, or firefighters, are exposed to such extremes as well (Boyle & McKenna, 2017; Drew, Tippett, & Devenish, 2018). Outpatient settings or even home health services bear evaluation and should apply the recommended strategies adjusted to fit their needs (Gross, Peek-Asa, Nocera, & Casteel, 2013).

As awareness for the issue of HWV increases and motivation to act rises, in this project, I encouraged participants and empowered staff to improve their knowledge within their immediate environment. The intention remains to add more modules and demonstrations in the future so other staff could benefit from a more comprehensive and extensive program. Additionally, the education pieces would be transferable to other agencies with modifications per facility need and risk assessment, creating a slow ripple, but definite forward momentum, of social change. Innovating programs to enact positive social impact improves the safety of staff and promotes best practices in patient care.

Motivated individuals promote social change when they feel compelled to interact and engage in efforts with legislators. Members of the senate and house may be less familiar with healthcare policies within organizations but are integral in promoting policy that affects healthcare. Some regulations to practice (i.e., advanced cardiac life support) for nurses and providers in critical care settings are standardized but not federally

regulated. HWV prevention mandates for annual or biannual competency are lacking. Unless legislation for standardized training or a specific rule is approved, whether locally or nationally, it is unlikely any type of training will be mandatory. However, the proposed house bills require some form of training for prevention (H.R. 1309, 116th Congress 2019; H. R. 5223, 115th Congress 2018; H.R. 7141, 115th Congress, 2018). As of this writing, there is a newly proposed bill in the 116th Congress to supersede the previous proposals but with the same intent and additional needs (H.R. 1309, 116th Congress 2019; Gonzalez, 2019a).

Summary

The overall problem of an increase in the incidence of HWV as defined in statistics (OSHA, 2016) prompted a reflective look at data regarding this community hospital's current incidence and prevalence of HWV. The limited and available training sessions were not mandatory as of the genesis of this project, and the impact of such training was either unmeasured or unavailable to compare rates before and after initiation. The purpose of this project was to deploy a comprehensive education module, administer a formative evaluation of knowledge gained, and implement new interventions. A long-term purpose outside of the scope of this project was to continue with a summative evaluation of learned behavior outcomes in the hope of reducing HWV incidence.

By delivering an education piece on HWV prevention to the nursing staff at a not-for-profit community hospital in the southeast United States aimed to improve their safety. The training strategies in the education for prevention were targeted to reduce the

incidence and prevalence of HWV by empowering nursing staff to recognize risks, enact therapeutic techniques to prevent violence, and implement de-escalation techniques. The PowerPoint educational presentation provided insight and a demonstration with return exhibition to increase knowledge attainment. I used Rogers' DOI model to capture a change in knowledge through staff tests administered before and after the education module. As skill acquisition proves successful, the expectation is to build upon the foundational pieces with reinforcement teaching opportunities and further study.

The context description follows with relation to my role in the project, to the organization where it takes place, and as a scholar-practitioner seeking to improve upon the problem of HWV. In Section 2, I also discuss the DOI model to illustrate learning and innovation adoption. Furthermore, I provide a literature review of existing research by experts in environmental workplace safety for healthcare to elaborate on the breadth of HWV. The definitions of commonly used terms are presented to clarify concepts described in this paper. Strategies previously employed to mitigate the stated problem of HWV are also described to identify the gaps currently present. To that end, in the next section, I explain how this project will address identified gaps. Legislation proposed were also briefly mentioned in Section 1 but will be explored more comprehensively in the following section.

Section 2: Background and Context

Introduction

HWV reflects increasing incidence, which demonstrates especially remarkable statistics considering the low rate of incident reporting (Arbury et al., 2017; OSHA, 2015b, 2016). This project aligned with the need to evaluate education towards HWV prevention strategies as well as to mitigate incidence and prevalence. Scholarly inquiry informed the education piece that imparted knowledge using evidence-based practice (EBP) and guidelines to answer the practice-focused question. Upon evaluation of the implemented education module, I identified and addressed any gaps in knowledge gained or practices utilized. Goals at that point included further creation of comprehensive strategies for HWV and opportunities to generate new evidence or evaluate programs based on current guidelines.

In this section, I discuss strategies suggested by OSHA and the ENA toolkits related to HWV to identify which were most appropriate for this participant population. Additionally, incorporating perspectives of key stakeholders helped to determine how best to utilize strategies for efficient and effective use. Through conducting a literature review the most current and relevant material for this specific setting and participant population as a foundation of current practice guidelines were identified.

The facility provided internal data reflecting an industry-wide statistical finding of an increase in incidence and prevalence of HWV (Arbury et al., 2017; OSHA, 2015b, 2016). Researchers have revealed how education on prevention strategies with simulation benefits organizations and the staff therein (Halm, 2017). I developed the practice-

focused question to ask whether a module on HWV prevention based on current clinical practice guidelines and recommendations improves staff's knowledge on workplace violence. With this question in mind, the purpose of this project was to develop, implement, and evaluate an education module on HWV on nursing staff in a small, not-for-profit community hospital in the southeastern United States.

In this section, I review theoretical underpinnings for the development, administration, and assessment of education programs as well as the relevance of the project to nursing practice. I further iterate the rationale for the selected models to justify their congruence to the purpose of this project. Additionally, I further describe my role from a scholar-practitioner lens.

Concepts, Models, and Theories

Theoretical Framework with Rationale

The selected domain for this scholarly project corresponds with staff education. The *Staff Education Manual for Doctoral Projects* details principles that include the objectives to utilize a framework with which to plan, develop, implement, and evaluate an educational program (Walden University, 2017). In the following subsections, I discuss foundational models for collaboration as well as evaluation of provided education and its impact on the selected audience. Through the guidance of Walden's *Staff Education Manual* (2017), this project aligns with the DNP Essentials I, II, III, V, and VI (American Association of Colleges of Nursing, 2006). The manual's instructions further iterated that the evaluation should be formative with ongoing assessment, which is ideal for an education module's planning and development. Inclusion of relevant personnel is

necessary to the process. In this case, the staff development team and HWV prevention committee collaborated with me and provided a means to apply the program and subsequent evaluation. The resulting answers on pre- and posttests provided necessary insight to address project objectives.

Advancing research and clinical practice through close collaboration model. As stated earlier, collaboration is an essential component of program development. The necessary inclusion and participation inform elements of the project. With stakeholder involvement, there is more likely to be buy-in to the process, along with more meaningful feedback (Arbury et al., 2017). With this project, I aimed to adjust organizational culture as well as improve the perceptions of and responses to an existing problem. The underlying support of program development relies on the use of existing evidence to inform best practices (Singleton, 2017). Of many existing models, I selected the advancing research and clinical practice through close collaboration (ARCC) model to provide structure and guide program development.

Melnyk et al. (2017) outlined factors influencing the process of program development, implementation, and evaluation to include organizational assessment for strength and weakness identification wherein developers troubleshoot any perceived barriers or challenges. Additionally, it is necessary to appoint a mentor or champion of the project by selecting key stakeholders for whom EBP holds priority (Singleton, 2017). Within this framework, behavior and attitudes are reconditioned to shape acceptance and synthesis of EBP (Melnyk et al., 2017). There are metrics available for use to evaluate variables affecting the degree of organizational change and the perception of presence,

usage, and strength of EBP of participants and stakeholders (Melnyk et al., 2017; Singleton, 2017).

Formative evaluation. Exploring various program appraisals led me to discard summative evaluations. McNabney et al. (2009) spoke to assessing education using surveys after each session with a summative evaluation at the conclusion of a teaching series. They imparted how summative evaluations are presented at the end as a summary and offer a full reflection of the process from the points of view of stakeholders and participants. This approach speaks to the purpose of a project or intervention and compares outcomes to previous data, specifically (Chambers, 1994).

However, a formative evaluation follows the process of the project as a continual assessment (Miake-Lye et al., 2011). In this method, there is a journal of implementation, including how developers approached the execution of education, and the degree of education attainment. If evaluations reveal under par results, documentation followed with identification of the pitfalls and what impeded or assisted the intervention. For an understanding of outcomes, researchers compare data from before and after intervention activation (Chambers, 1994). Miake-Lye et al. (2011) described the accomplishment of stakeholder involvement through the use of a mix of semistructured interviews and data mining of the electronic health record.

Chambers (1994) described formative evaluation as measuring the formation or process toward outcomes as well as how the project grows or improves over time. From the description of this epistemological evaluation, it would follow that the ARCC could fall under formative evaluation because the framework addresses barriers along the way,

identifying changes in direction or trajectory. Fortunately, this method also aligns well with Rogers' DOI, the conceptual framework for this project, which follows the adoption of knowledge toward the use of it or *innovation* (Mohammadi et al., 2018).

With the ARCC, promoting desired EBP behaviors is supported through the formative process, which establishes acquisition and demonstration of content learned (Melnyk et al., 2017). The progression goes from the innovator, early adopters (or opinion leaders), early and late majority, and then laggards (Mohammadi et al., 2018). Addressing how each participant responds to training and why allows for the education toward them to be modified to maximize the diffusion and EBP adoption, new behavior, and the subsequent results (Rizan et al., 2017).

Rogers' DOI. The imparting and attainment of knowledge were central to this project and its objectives. Through the provision of a PowerPoint presentation, I developed a module informed by current guidelines to deliver data intending to improve the awareness and mastery of HWV prevention strategies. I selected Rogers' DOI model to establish effectiveness in teaching newly hired nursing staff about HWV prevention strategies. DOI lays out a framework of knowledge acquisition outcomes stratifying the audience and their perception or retention of data across the domains of innovator, early adopter (or opinion leaders), early and late majority, and laggard (Rizan et al., 2017). Outcomes and effectiveness are evident and correlated to the engagement of the student as well as how quickly they adopt or reject the teaching or innovation (Mohammadi et al., 2018; Rizan et al., 2017).

The themes of DOI are knowledge, persuasion, decision, implementation, and confirmation (Pashaeypoor et al., 2017). The attainment of knowledge occurs from exposure to innovation, achieving comprehension. The recipient enters the persuasion stage upon forming perceptions of the benefits of given knowledge. Characteristics to be considered in this stratum are specifically the relative advantage, complexity, simplicity, and trialability of the innovation (see definitions for these terms later in this section; Mohammadi et al., 2018).

Navigating these domains leads to a decision wherein the learner chooses to incorporate or discard an innovation (Pashaeypoor et al, 2017). If the decision leads to the innovation, representing an ideal action or option, adoption occurs (Mohammadi et al., 2018). Another concept that impresses the learner to reject or adopt is the compatibility of the intervention with EBP goals of stakeholders. Implementation results from adoption and consolidation of learning. The student then seeks results of implementation to confirm the benefits of innovation application (Pashaeypoor et al., 2017).

Literature Review

Incidence and prevalence. Entities that compile data on healthcare or other workplace incidents include OSHA, ENA, ANA, NIOSH, and the Bureau of Labor Statistics, to name a few. Across current literature, sources contain data showing that nurses (and other ancillary healthcare workers) are subject to violence more often and more violent than law enforcement and correctional officers (Brophy, Keith, & Hurley, 2018). OSHA (2016) reaffirmed the significance of the problem in healthcare settings by stating, “assaults comprise 10–11% of workplace injuries involving days away from

work, as compared to 3% of injuries of all private-sector employees" (p. 2). Supporting data shows that at least half, if not more, of emergency department staff have experienced violence from patients and visitors (either or both physical and verbal) within the past year (Ashton, Morris, & Smith, 2018; Hassankhani et al., 2018; Papa & Venella, 2013).

Stene, Larson, Levy, and Dohlman (2015) argued that education on what constitutes HWV, how to report it, reporting tool development, and organizational support resulted in perceptions that fewer staff members expected violence or considered it as part of the job. Stene et al. demonstrated how providing education on the previously mentioned elements reduced the incidence of violence as well. Other ways to mitigate incidence and prevalence include strategies tailored to the location and patient population. Key factors toward success in these endeavors include organizational support and stakeholder participation, facility-centered risk assessment, quality in the form of threat prevention and control, and training with psychoeducation or simulation (Arbury et al., 2017; Papa & Venella, 2013; Ramacciati, Ceccagnoli, Addey, Lumini, & Rasero, 2018). More discussion on toolkits and strategies follows.

Perceptions of violence and its prevention. Among several studies, literature reviews, and analyses, trending themes related to healthcare workers' perceptions arise. A dominant component is a belief that HWV is part of the job (Arbury et al., 2017; Brophy et al., 2018; Hassankhani et al., 2018). This prevailing perception was found especially true in settings that previous research confirmed endures an even higher likelihood of violent assaults, such as psychiatry, emergency services, forensic settings, memory care, and geriatric-psychiatry wards (Brophy et al., 2018). Justification for the prevalence

among the settings correlates to the populations likely to patronize them (Hassankhani et al., 2018).

In these studies, stratification of risk factors listed items commonly related to chemical impairment or substance use, extreme pain, history of violent behavior, cognitive disorders, and known or unknown psychiatric conditions (Copeland & Henry, 2018; Solorzano Martinez, 2016). In addition to the expectation of HWV, many healthcare staff felt helpless to report assaults because the anticipated responses ranged from discouragement from reporting, black-listing at job sites or other repercussions, unwanted negative attention to the agency, and that to pursue reporting or legal action is futile (Hassankhani et al., 2018).

Christie (2015) highlighted staff's discernment of managerial support as lacking and that overall, they felt unsupported, unprotected, disenfranchised, and powerless. An unfortunate theme identified across available literature was the physical, emotional, and psychological sequelae of the trauma (Ashton et al., 2018; Gates et al., 2011). Of a long list, a few of the conditions likely experienced are anxiety, fear, depression, insomnia, prolonged physical pain, and threats to professional or social integrity (Hassankhani et al., 2018). With or without reporting the event or organizational support (i.e., before, during, or after), the stress responses identified from a neurobiological standpoint were overwhelming (Beattie, Innes, Griffiths, & Morphet, 2018).

The repetitive exposure to the high-stress situation or expectation of violence, whether directly or vicariously experienced, leads to heightened activation of the fight or flight response (Copeland & Henry, 2018). In turn, an individual's ability to self-regulate

executive functions, emotional response, and other behaviors are impaired leading to subpar decision making or performance (Beattie et al., 2018; Gillespie et al., 2013). The perspectives of front-line workers are the focus of the problem but improving the presenting issues through program development requires consideration of other stakeholders' views. Managers and organizations have also responded in studies to reveal a need to incorporate attributes specific to incidents, organization, and EBP into their education tools (Arnetz et al., 2015b).

Reporting statistics. As discussed previously, there is a discrepancy between the incidence and reporting of incidents. Reasons given by participants in one study revealed perceptions as described above (Arnetz, 2015b). Unfortunately, the lack of enough data for any given organization muddles any attempt to perform risk assessment, planning of programs to redress HWV, and implementation of effective interventions. Because of fear of retaliation, perception of disengagement from managers, or other valid beliefs, an option to report electronically encourages observance of contributing attributes to the event as well as the outcome. Furthermore, it empowers the victim and engages management (Arnetz, 2015a).

Organizational reports. Many agencies have position papers taking a stance against workplace violence through means of education and standardized guidelines. OSHA is a crucial proponent of workplace safety and offers an injury tracking application for reporting to the agency days missed from work, restricted work activity, or transfers (The Joint Commission [TJC], 2018). This system's use in reporting HWV incidence has yet to be explored more fully, or yet implemented. The ANA indicates a

zero-tolerance policy, as does the Association of Occupational Health Professionals in Healthcare (ANA, 2016; Evans, 2017). Among the ANA's recommendations to achieve safer and healthier work environments are the following: develop a violence prevention program with key stakeholders' input, provide a means for staff to engage support, encourage reporting without blame or repercussions.

The ENA is a significant contributor to the body of literature available and has worked for over a decade on various issues promoting safety for staff and patient care in the nation's emergency departments. Not only are they one of the organizations offering a toolkit for strategy (to be discussed next), they have a position statement touting a call for collaboration to establish HWV prevention programs (ENA, 2014). The American Organization of Nurse Executives (2014) agreed that prioritized guidelines are needed to reduce violence in the workplace. The closest organizational report that offers guidelines other than the ENA is OSHA (2015a). The basis of their broad guidelines along with education examples provided by the CDC and ENA inform the teaching module for this doctoral project.

OSHA (2015a) iterated what many researchers have shown to be effective: the provision of a "comprehensive workplace violence prevention program" which provides knowledge regarding signal elements found to relate directly to more successful rates of incidence reduction (p. 3). These elements are management commitment and employee participation, worksite analysis and hazard identification, hazard prevention and control, safety and health training, and recordkeeping and program evaluation (OSHA, 2015a).

Other literature echoes this mission along with steps to create strategies and utilize toolkits.

Toolkits and strategies. In reviewing the prevailing authorities on prevention strategies, most suggested similar approaches and themes. For the most part, strategies follow OSHA's recommendations as previously cited. For the intent of this project, the focus will be on the specific element of creating a comprehensive HWV prevention program and its evaluation. A combination of interventions should be created based on findings from the risk assessment and organizational evaluation once a commitment is garnered from the agency (Gillespie et al., 2010).

Arnetz et al. (2017) submitted that the comprehensive intervention implemented at the studied sites showed a significantly lower rate of incidence six months after the development and dissemination of an action plan for violence prevention. The comprehensive plan enacted in the Arnetz et al. study mirrors recommendations from OSHA (2015a) to have a reporting system in place and a risk assessment. In this case, the risk assessment included a hazard matrix that prioritized areas of most likely occurrence and the higher risk arenas were the focus. At the current facility where I implemented my project, there are already units selected as a higher priority due to the population served, frequency of reporting, and type of injuries sustained, especially when requiring time off.

In the Arnetz et al. (2017) intervention, organizational buy-in was assisted by including stakeholders and organization policymakers in walking rounds wherein administrators spoke to staff from the unit about the frequency, severity, and other characteristics of HWV experienced there. From those efforts, the action plan was created

and then implemented using an existing checklist. An example of such a checklist from the MDH (2014) asserts that vital elements are in place (again echoing OHSA's [2015a] recommendations). Additionally, elements exist to inquire of data post-incident to trouble-shoot actions taken toward prevention.

Education provided to each unit was tailored to its unique needs as identified by the risk evaluation. Primary objectives in such education should include items such as being able to identify potential for violence, de-escalation strategies, environmental risk assessment, self-defense (also called personal safety strategies), patient-specific risk assessments, and reporting of violent incidences. I shared recommendations for this project at the project's site to incorporate all these items while engaging the education piece.

Concepts of successful education modules from across the existing research discussed how to manage aggression, emotional intelligence, therapeutic communication, deflection strategies (physical and verbal), and the activation of critical response teams (Arnetz et al., 2017; Gallant-Roman, 2008; Gates et al., 2011; Halm, 2017; Littlejohn, 2012; Solorzano Martinez, 2016; Wong et al., 2015; Zicko et al., 2017). Simulation is often beneficial as it gives staff practical examples of deflection and self-defense techniques while also preserving the patient's safety (Sanner-Stiehr, 2017). It was also encouraged to include all staff, especially security, in conjunction with nursing and ancillary front-line workers (Schoenfisch & Pompeii, 2016).

An element not often explored is the impact that communication difficulties have on potentially violent situations. Individuals presenting for healthcare services with

limited English proficiency face challenges affecting many aspects of care and systems issues (Arroyo, 2019; Raynor, 2016). Individuals with language barriers already face healthcare disparities; added obstacles to therapeutic communication complicate the ability to diffuse or de-escalate a potentially volatile situation (Adepoju, Preston, & Gonzales, 2015). There is a need to explore further the specific aspect of language and communication challenges as it intersects with the prevention of HWV.

Legislative interventions. As of 2014, there are a variety of state laws in effect with concern for protecting healthcare workers in most states (On Labor, 2014). Only nine states have mandated programs for prevention (H.R. 7141, 115th Cong., 2018). Unfortunately, many states had legislation stalled at various stages of proposal or approval. For those with laws enacted, consistency was not evident regarding what constituted felony or misdemeanors, and what punishment follows. Moreover, in some states, including the state where this project occurred, it is only a felony if it is against a provider or is of a high and aggravated nature.

In seeking research related to state-enacted rules, Gooch (2017) presented regulations specific to California. State Bill 1299 for California expects the implementation of new procedures, incidences reported and acted upon, and support to be provided to affected individuals immediately and ongoing. Their keywords to distill the critical action plan covered prevention, planning, response, and recovery (Gooch, 2017). Interestingly, within their tasks were the same recommendations of OSHA (2015a). Data collected since the 2014 state codes lead to a call to action from national legislators to implement a standard, across the board. Seminal works that have supported the move for

national efforts include OSHA's reports as well as those of the ENA (Gurney, 2014; OSHA, 2015a). As of 2018, two proposed bills will mandate prevention modules and staff training for healthcare workers (H. R. 5223, 115th Cong., 2018; H.R. 7141, 115th Cong., 2018).

Definition of Terms

Compatibility: The "match, consistency, and appropriateness of EBP use for nursing work," reflecting aims and intent of the innovation (Mohammadi et al., 2018, p. 27).

Decision: The aspect and stage of DOI where the learner decides to adopt or reject the intervention (McMullen et al., 2015).

De-escalation: Verbal or physical techniques used to reduce agitation and aggression, a method to mitigate aggressors' violent behavior (Arnetz et al., 2017; Gates et al., 2011; Solorzano Martinez, 2016; Wong et al., 2015).

Early adopter: Second category under DOI that falls outside of one standard deviation from the mean; first group to accept and implement innovation after teaching from innovators (Mohammadi et al., 2018; Rizan et al., 2017).

Early majority: Third category under DOI that falls within one standard deviation of the mean; second group to accept and implement innovation after teaching from innovators (Mohammadi et al., 2018; Rizan et al., 2017).

Healthcare workplace violence: Physical or verbal threats of assault directed to workers on duty occurring in various healthcare sectors (Arbury et al., 2017).

Innovation/Innovator: Evidence-based knowledge to impart and implement/the facilitator of EBP innovation (Mohammadi et al., 2018; Rizan et al., 2017)

Knowledge: "Educational enrichment, new strategy for education," often based on existing evidence, awareness of EBP and its use (Mohammadi et al., 2018; Pashaeypoor et al., 2017, p. 205).

Laggard: Last category of five under DOI that falls outside two standard deviations from the mean; the last group to accept and implement innovation after teaching from innovators (Mohammadi et al., 2018; Rizan et al., 2017, p. 203).

Late majority: Fourth category under DOI that falls within one standard deviation of the mean; third group to accept and implement innovation after teaching from innovators (Mohammadi et al., 2018; Rizan et al., 2017).

Observability: "How observable the effects and outcomes of EBP adoption are to users and other individuals" (Mohammadi et al., 2018, p. 27).

Persuasion: "Internalization of education, improvement of motivation," the positive perception and attitude toward the innovation (Harting et al., 2009; Rizan et al., 2017, p. 203).

Relative advantage: A perception of innovation that is integral in the stages to achieve its adoption (Mohammadi et al., 2018).

Staff Education Manual, The Manual: Document from Walden University outlining objectives, guidelines, and format to complete the doctoral project under staff education (Walden University, 2017).

Trialability: "Revolves around the extent to which EBP is trialable for a nurse," "can be experimented with," and "the ability to test an innovation" (Harting et al., 2009, p. 223; McMullen et al., p. 5; Mohammadi et al., p. 27; Rosen & Goodson, 2013).

Relevance to Nursing Practice

Achieving social change is possible through the exploration of factors to reduce healthcare workplace violence and its effect on clinical staff. Improving educational options available to staff enhances the work environment and patient satisfaction or outcomes. The insight gained will serve as a medium to enhance professional growth, educational standards, and expand the body of knowledge in the promotion of safer work environments. Additional studies might benefit from this exploration to further delve into complications of HWV, its prevention, and managing any sequelae experienced by individuals or the organizations affected.

In the American Association of the Colleges of Nursing's *Essentials of Doctoral Education for Advanced Nursing Practice* (2006), practice-focused education is encouraged. Scholarship in practice is attained using scientific underpinnings to utilize existing evidence and synthesize it for an education module for HWV prevention (Essential I). Additionally, the scholar-practitioner engages with organizational and systems leadership to improve practice and systems thinking by engaging stakeholders to take an active part in the risk assessment and prevention strategy process, empowering systems dynamics and intersystem functioning (Essential II). Most adeptly for this project, I am not creating new knowledge but evaluating the implementation of strategies

based on existing knowledge. In doing so, I demonstrate competency in leadership to translate research into practice and evaluate it (Essential III).

Internal policy and advocacy efforts initiated by this doctoral project were encouraged (Essential V). Further implications to nursing practice lie in advocacy and negotiating processes which develop policy at various levels, both locally and nationally. There is, indeed, interprofessional collaboration to bring this program to fruition at the host site (Essential VI). I play an essential role in the project team and promote dialog and momentum regarding this necessary teaching.

Fiscal responsibility is supported through this avenue of advocacy as there are costs associated with loss of working hours for victims, and injuries such as physical, mental, or emotional (Gates et al., 2011). Potential absenteeism or employee turnover likely proceed from these unfortunate events. Another resulting burden to the agency and its personnel is the need for time off from work to recuperate, or for legal and judicial pursuits (Hassankhani et al., 2017). Additionally, assessment continues from organizations revealing how penalties and citations show little evidence in attempts to mitigate incidence or prevalence to HWV (Gonzalez, 2019b).

The predefined prevalence of HWV and the need for a culture of safety wherein staff can care for patients to provide better outcomes underlie the imperative to create a response to the problem. To reinforce the statement, missives from OSHA, NIOSH, and the ANA implore agencies and organizations to mandate training, create zero-tolerance policies regarding HWV, and enforce these. The onus to comply rests in collaborators such as myself and the project team at the host site. If the requirement to create a safer

environment were not enough, the cost-benefit to prevent loss of workdays and impaired resources such as injured staff is far more a burden than that of program development, implementation, and evaluation (Wax, Pinette, & Cartin, 2016). Specific budget constraints are explored in later sections.

Standards endorsed by OSHA (2015a) are transparent with regards to general requirements and recommendations. Organizations must concede that HWV is a problem needing to be addressed and then mitigate identified issues by performing a risk assessment. With this in hand, a program can be developed to redress identified issues and pitfalls. Reporting must be enabled to empower victims of incidents to document occurrences. The provision of support for individuals with ongoing surveillance for any untoward sequelae is necessary. A reporting system enables incidence tracking to identify trends but also to evaluate the effectiveness of the previous steps.

Across literature, education has proven invaluable, reducing incidence as well as severity (Arnetz et al., 2017; Gallant-Roman, 2008; Gates et al., 2011; Halm, 2017; Littlejohn, 2012; Solorzano Martinez, 2016; Wong et al., 2015; Zicko et al., 2017). A variety of means can be employed to teach the targeted audience, as determined by key stakeholder input, hazard assessment, and staff input. To specifically address the gap in practice, suggested checklists keep program implementers on track of the tasks to complete, which, in turn, identify contributing attributes not recognized in previous steps. The process must evolve as new information surfaces. Facilitation of adaptations improves when there is adequate organizational support and collaboration.

This doctoral project addressed the gap in practice, specifically identified as the need for education (see MDH, 2014). The checklist used by MDH (2014) divides aspects of the violence prevention strategy into the initialism of SAFE. The *S* regards Safety Coordination, or the assembly of a violence prevention team whose task is to oversee the prioritization of prevention, the development of staff education, and a plan to engage staff, develop documentation approaches, and other surveillance and maintenance of this ongoing mission. The initial *A* denotes accurate and concurrent reporting and specifies types of data collection recommended to ensure appropriate processes to capture timely data. Detail of each incident should be recorded to assist in stratifying types of violence, severity incurred, and other elements as described in toolkits (such as OSHA's or the ENA's).

Of course, the next letter is *F*, which highlights the necessity for the Facility to maintain a safe culture and be accountable. Clear communication regarding risk screening accomplishes this step and leads to placement of processes for support and protection. Defining expectations of staff is required and includes attributes of violence and what should occur in the unfortunate and likely event it transpires. Answers to questions of how to report and to whom must be readily available, in advance when possible, to offer a proactive response instead of the circumstance where a victim has limited resources available when the time is at hand.

For this project, the letter *E* was of most importance as it explicitly addresses the need and development of staff education. HWV prevention education modules are more

effectual when minimum standards are expressed, including the following (MDH, 2014, pp. 1-4):

- Identifying situations with potential for violence,
- De-escalation strategies,
- Environmental risk assessments,
- Personal safety strategies,
- Conducting patient-specific risk assessments, and
- Reporting of violent incidences.

Merely having these elements is not enough without an evaluation and ongoing interventions tied to risks and root cause analyses. Continual support from administration and the HWV prevention program team are requisites to successful programs and maintenance of reduced incidence and prevalence. The goal of this project was to initiate the education program, evaluate its effectiveness, and modify if necessary, to improve its impact. Postproject research and program development will continue as I build upon the experiences gained throughout this endeavor.

Local Background and Context

HWV holds a higher percentage in incidence when compared to other civilian sectors where violence occurs (OSHA, 2015a). The hospital is aware of this statistic and gathered a team to address the problem. In collaboration with the project team, the determination found that the existing education and simulation is not well attended. Additionally, for those engaged in this process, little to no information regarding the effectiveness of knowledge or its practical application resulted. What was not currently

known is how this education is retained or reinforced, how the lessons and concepts are practiced and applied, and what is its impact on workplace violence. I enacted the education module with permission from the hospital's staff development office and their committee on HWV prevention.

The goal was to liaise with staff development, but more specifically, the HWV prevention program team. Additionally, I delivered in person the education module via a PowerPoint presentation developed for this project in conjunction with the team. The project team played an integral role as stakeholders in the process and outcomes. They provided feedback on materials as recommended in the *Manual* (Walden University, 2017). Participants' knowledge was gauged with the administration of tests both before and after the education presentation to answer the practice-focused question of whether a module on HWV prevention based on current clinical practice guidelines and recommendations would improve staff's knowledge on workplace violence.

Fortunately, work on this doctoral project coincided with the mission of the host hospital as they have recently formed the HWV prevention program team. The completion of a previous organizational assessment identified opportunities for improvement. There was minimal data about the incidence and prevalence of HWV in this facility as there had not been a specific reporting tool provided. The creation of an organizational reporting tool is part of the team's current mission but was secondary to this project.

However, there was an available graphic from the host site that identified a peak of incidences as reported to the employee health committee. Within the evidence

revealed, a pattern emerged of violence toward frontline staff that included punching, hitting with an open fist, kicking, or spitting. After the initial recording of this data, the hospital instituted changes to include a voluntary day-long session to learn therapeutic communication and responding with emotional intelligence. Additionally, there was a day-long self-defense or de-escalation component. Other strategies employed at that time were one-on-one observation for identified psychiatric patients with a potential for violence, cameras on psychiatric hold areas, and only specific staff with the requisite but limited training were permitted to work in these areas.

There was a decrease in incidence, initially, from over an average of two incidences a month in 2011, to an average of fewer than one a month the following year. However, in subsequent years there were intermittent peaks up to a monthly average of 1.67 in 2014, down to fewer than 1 in 2015 and back up to just over 1 in 2016. I have no data for the subsequent 2 years because that information was not made available. This almost 200-bed community hospital in a southeastern state hosts a demographic of mixed-payer sources. Additionally, as a potential for violence is proportionate to psychiatric or other behavioral health patients served, it bears scrutiny that the area is underserved for adequate mental health services.

As the hospital serves Medicare and Medicaid patients (as well as self-pay and commercial insurance), accreditation is required to be compliant with Centers for Medicare and Medicaid Services (2016) rules. Det Norske Veritas Healthcare, Inc. accredits the host hospital. While patient safety is a metric utilized toward accreditation requirements, there is not a specific category for staff safety, although a feasible

argument dictates that patient safety is better assured when staff safety is in place. With increasing attention on healthcare workplace safety and the call to make prevention programs mandatory, the evolution of the prevention program at this institution is timely.

Role of the DNP Student

As a DNP student, I fulfilled my primary role for this project in developing the teaching piece with input from the hospital's project team utilizing EBP guidelines from seminal works such as that of OSHA (2015a). The recommendations included in those guidelines inform the process to achieve better practices. The objective remained to provide the means by which nursing staff will improve their knowledge of prevention strategies by understanding types of HWV, contributing factors to these, be able to recognize potentially aggressive individuals or situations, and be able to state, or even demonstrate, methods to prevent harm to self or aggressor through de-escalation techniques.

My scholastic pursuit of information to support the development of the education module informed the project team. Furthermore, the literature provided information to support the development of other elements currently in progress unrelated to this project. As the objectives are separately convergent upon the desire to reduce incidence and prevalence of HWV, my work as innovator and teacher to disseminate the program and evaluate its effectiveness benefits the team's mission. Likewise, they implemented other elements as stratified in the OSHA (2015a) report and through the MDH (2014) checklist to ensure adherence to existing data that shows correlation with reduction in incidence, severity, and prevalence of HWV.

The cohort of participants includes the audience of newly hired nursing staff during onboarding training as they underwent a day of hospital orientation. Outside of my role as educator, I have no contact or authority over them. They also, during this time, participated in staff tests before and after the education module, which measured their reaction, learning, behavior, and outcomes. Measured results matched expectations in that their knowledge level increased enough to change behaviors and improve outcomes.

As a registered nurse for many years before advanced practice, I worked in the emergency department, where HWV is more likely to occur. I have been victim to a visitor shoving me as well as in other instances kicked and spat upon. Former colleagues of mine in separate instances were assaulted quite severely with one undergoing several sessions of occupational therapy for a traumatic brain injury. The other was strangled so gravely that he would have died had medics not realized his circumstance and intervened. The resulting sequelae for them personally and professionally underlined systems issues regarding lack of appropriate processes in place to prevent HWV, to report it, and to receive ongoing support.

News reports periodically highlight the more horrific incidents such as the brutalization of two nurses in Geneva, Illinois, in 2017 (NBC Chicago, 2017). This specific event drew the attention of a dedicated nurse in Maryland who began a movement using social media that evolved into The Silent No More Foundation whose mission is to support healthcare workers before, during, and after a workplace assault. I have been a part of this organization as a volunteer since its inception. I realized I could utilize my motivation to create meaningful social change, leading me to conceive this

project. I hope to build upon this work after its completion and further advocate for healthcare workplace safety.

Personal disclosure. My work with the project is separate from any for the Silent No More Foundation; I gain no monetary compensation for my involvement with the hospital's objectives as the work I contribute is unpaid. I am motivated and biased for the effectiveness of the education module with the altruistic goal of improving the culture of safety for peers, colleagues, and patients. I always regarded my profession as one to be revered and respected, but personal and vicarious experiences allow me to recognize and emphatically believe that violence should not be a part of the job. I will not accept that this contextual norm should remain and attest to continue efforts toward the promotion of a culture of safety against HWV through education, advocacy, and support.

Role of the Project Team

The host hospital has a program development team initiated separately from this doctoral project and has welcomed my input, encouraging me to create and implement the education module. The lead of this team is part of a more extensive department dedicated to the safety of staff, patients, and visitors. She is a master's educated, advanced practice nurse, and demonstrates motivation toward a goal of instituting actionable plans with both short and long-term goals. As part of her role, she leads biweekly meetings to discuss risk assessment. The discourse leads to suggestions and collaboration for interventions and innovations to address items identified in the risk assessment.

Measures are being enacted to provide reporting means and screening processes to stratify potential threats of HWV. My role on this team, as pertinent to this project, was the creation, implementation, and evaluation of an education module. I continue to bring to this collaboration evidence from literature reviews showing how prevention strategies decrease incidence and prevalence. These data coupled with the risk assessment information supplied enough background and context to frame the problem and pose the practice-focused question.

Members included on this team were a clinical performance improvement specialist, the director of the emergency department, the director and head nurse of the units housing psychiatric holds, the head of security, the director of emergency management and environmental compliance, and other stakeholders and interested parties. The collective intelligence and experience these members bring to the discussion are invaluable to their mission and for the support of my doctoral project. I consulted with the team lead about the education module development. Staff development and the HWV prevention committee assisted in coordinating the date of new-hire orientation for the module and pre- and posttest administration. Staff development and the security department offered a hands-on simulation of de-escalation techniques.

The goal of the hospital with this project was to have the education module available for Summer of 2019, to achieve university and hospital institutional review board (IRB) approval, address doctoral committee and project team feedback, and to administer the education module and pre- and posttests. I relegated team member responsibilities to the lead for her feedback on the module and coordination of staff

orientation for the delivery of the presentation. Within the subsequent quarter year, I shared the tests' evaluation with the project team, discussed any trends, and addressed if needed. Resulting discourse from the initial reports follows in sections 4 and 5 of this document as partial fulfillment of a doctorate in nursing practice.

Summary

Through enacting this doctoral project, I shared a vision to demonstrate how an education module on HWV prevention improves knowledge of the nursing staff. Demonstrating collaboration and leadership engendered social change by promoting a culture of safety, improving the perception of HWV, and subsequently leading to better service delivery and patient outcomes. I addressed the known gap in practice through following guidelines based on existing data that shows remarkable effectiveness and a decrease in incidence and prevalence of HWV. Results of the module's implementation inform further education strategies for employment at the host site with the same goals in mind.

In the following section I further define planning for the project, its development, implementation, and evaluation. Additionally, the project aligned with the practice-focused question and overall purpose. As it relates to analyzing staff tests after the education module, a description of existing tools strengthened the choice of metric and its usage for this purpose. The theoretical underpinning justifies the type of evaluation of knowledge retained from the use of a staff education module to improve the perception of retained instruction and adoption of new behaviors leading to better outcomes in the prevention of HWV.

Section 3: Collection and Analysis of Evidence

Introduction

A not-for-profit community hospital with over 200 beds demonstrated a need for intervention to prevent HWV because there was an upward trend to incidence and prevalence. While this local phenomenon was concerning, labor statistics echoed the same tendency showing that workplace violence occurs more often in healthcare settings than in any other civilian sector (OSHA, 2016). However, researchers have reported promising data that implementing a variety of prevention strategies based on site-specific needs and risk assessments will decrease the rate of occurrence (Solorzano Martinez, 2016).

In this section, I discuss the practice-focused question, define sources of evidence, and outline the methods used for data analysis and synthesis. I continue by sharing existing research showing evidence that promoting the prevention of HWV through education as part of a more extensive program with multiple elements will effectively address the problem of HWV. Ethical considerations are addressed below to include how protections were achieved and maintained.

Practice-Focused Question

Healthcare workers undergo more assaults than reported; researchers have identified the quantity of incidence, while already higher in this arena than others, is mostly underreported (Papa & Venella, 2013; Stene et al., 2015). Higher incidence demonstrates a clear need for intervention. HWV hinders safe practices and ultimately affects service delivery (Copeland & Henry, 2018). Resulting complications for victims

of HWV include lost days of work; chronic physical, psychological, and emotional conditions; and for some, an inability to return to their same role, if resuming work is desired or possible (Hassankhani et al., 2018).

The project site's existing prevention plan provided an opportunity for improvement, which evolved into the formation of the HWV prevention program team. As an integral team member, I developed and implemented an education module as part of a larger plan. The objective included evaluating the audience of newly hired nursing staff with a test before and after an education module to answer the following practice-focused question: Will a module on HWV prevention based on current clinical practice guidelines and recommendations improve staff's knowledge on workplace violence?

Sources of Evidence

Throughout this document, I provide a discussion around the topic of HWV within the context of a southeastern community hospital. Various settings endure similar statistics as identified in several case studies and other research (see OSHA, 2015b; Papa & Venella, 2013). I proposed that the exercise of developing an education module using EBP would be transferable and generalizable to other venues of healthcare, such as skilled or long-term facilities, outpatient settings, prehospital care, and even home health domains. Stated EBP data emerged through scholastic searches utilizing credible, EBP sources including articles retrieved from the PubMed, CINAHL, ProQuest, and MEDLINE Plus databases using query terms denoting healthcare workplace violence, its incidence, prevalence, prevention, and results of strategies implemented. Industry leaders

and stakeholders, such as OSHA, CDC, and ENA, also provided reliable and valid guidelines, information, and methods.

Many of the identified data come from industry specialists, as stated, whose missions included improving worker safety. Progress identified in previous studies related to the purpose of this project in that organizations, such as the ENA, American Organization of Nurse Executives (now called American Organization for Nursing Leadership), OSHA, and NIOSH, aim to improve healthcare service delivery through safer work practices. In the case of HWV, research showed that a multifocused approach should include agency support and buy-in, systems evaluation for hazard assessment, development and implementation of a site-specific staff education module with prevention strategies, a reporting system in place, and continued record-keeping for tracking trends and mitigating any issues identified through continued assessment (OSHA, 2015a).

The education module I developed for this project (see Appendix A) debuted during the orientation phase of newly hired nursing staff along with a test given both before and after the education module. Through the use of this test, I evaluated a baseline understanding of HWV, its statistics and prevention, and other strategies. The effectiveness of education measured reaction, learning, behavior, and outcomes using Rogers' DOI with a second test after teaching concluded. The approach was essential to evaluate the implementation of EBP as a core component of doctoral nursing practice and scholarly pursuit. This evaluation allowed me to answer the practice-focused question

and furthermore provided a means with which to build further EBP implementation and evaluation or continue research.

A scholar-practitioner is beholden to explore academic repositories and other validated libraries for appropriate sources of evidence. To that end, I accessed the university library and its databases, including PubMed, CINAHL ProQuest, and MEDLINE Plus, using the following search terms in a variety of combinations: *healthcare workplace violence, prevention, incidence, strategy(ies), education, guidelines, evaluation,* and *perception*. Of the many results, anything with data on incidence, prevalence, or outcomes published before 2013 was set aside and used only for comparison if necessary.

A review of emerging literature assisted me in identifying themes, stratifying recommendations, and informing the education module development. If only a title and abstract were available, Google Scholar supported further searches for the full article. As demonstrated throughout this document, much of the cited sources occurred from the same information resulting after multiple iterations and combinations of the search terms, lending credibility to exhausting the available sources of usable information.

I obtained statistics about the project site's incidence, prevalence, and results of previous interventions from the safety committee and the resulting HWV prevention team. These were necessary to mention as they identified the immediate problem and aligned the practice-focused question, purpose, and nature of the project. Incident reports filed through staff report of injury after an HWV occurrence were collected by employee health and relayed to risk management.

Operational departments were made aware of the trend captured after 2011 when data were compiled and tracked over 5 years. There are limitations to the data available because reporting methods for HWV were not encouraged or made widely accessible. I received an invitation to the HWV prevention committee and its subcommittee of the HWV prevention program team, which permitted me access to requisite data. As attention to the problem has been more acute thanks to industry calls to action (e.g., the ANA's calls for "zero-tolerance" policies, etc.), the hospital is taking a closer look at safety and what pitfalls exist so that measures can be enacted to alleviate the problem.

The number of participants attending the education session was 14, which yielded enough information to address how the staff education module impacted their knowledge of prevention strategies and answer the practice-focused question. These tests were coded to avoid any identifying material to maintain participant confidentiality. To create the test for this project, I used a previously modified ENA tool as discussed by Stene et al. (2015) that was supplemented with frequently asked questions as described by OSHA requirements (see Payne, 2017). The tool's modifier granted permission to use it through e-mail contact (Stene et al., 2015; See Appendix D). In the pretest administered before the education module, I used narrative and Likert-type questions to gather their perceptions of experienced violence and contextualize their preexisting knowledge (see Appendix B).

Ethical Considerations

I informed participants of the purpose and topic of the project as well as what their role was. Subsequently, I obtained their consent prior to their participation and any

follow-up interactions. In subsequent sections I elaborate on the consent process and ethical considerations. Before proceeding with the pretest and education, I shared with participants that the topic of HWV poses exposure to potentially triggering concepts. Information for the project site's employee assistance program was made available and its use was left to the discretion of participants.

The intended population received assurances that their participation was voluntary and that data resulting from their tests would remain confidential and free of information that would identify them to others. Potential elements of concern included employers, financial or academic institutions, or other entities. Participants were permitted to withdraw their participation from the project at any time without any penalty.

Analysis and Synthesis

As stated, hospital personnel encouraged my coordination with staff development and the workplace violence prevention committee to provide a PowerPoint presentation to newly hired nursing staff. This education module was a supplement to the existing (i.e., optional) prevention training class offered annually. After receiving IRB approval (approval number 06-18-19-0482663), I presented the education module to nursing staff on hospital grounds with a pre- and posttest before and after the module to gauge knowledge gained. Class participants took the tests only after providing informed consent. The selection of participants was purposeful in that they were required to participate in education offered during their orientation, their presence was convenient, and the hospital has a mission to improve education on workplace violence prevention.

Tests for this pilot class were taken on paper without participant names listed, and only numbered with matching identifiers for pre- and posttest comparison. I viewed the results through the lens of DOI to interpret how knowledgeable nursing staff members are regarding the promotion of safety and preventing HWV (see Mohammadi et al., 2018). Data were coded and analyzed to identify emerging themes. I used a matrix to separate data by themes and demographic information for identification of any trends. Participants' information will be kept secured privately for a period of no fewer than 5 years as required by Walden University.

Summary

In this section, I juxtaposed the problem statement with the purpose of this project to show alignment with the practice-focused question of whether a module on HWV prevention based on current clinical practice guidelines and recommendations improved staff's knowledge on workplace violence. Frequently used terms were defined to facilitate understanding and frame the context of this project. While HWV occurs in many settings, as appropriate for the work herein, the sources of evidence were pertinent to the project site's population and service delivery. The analysis of resulting evidence after implementing the education module provided data with which to improve teaching prevention strategies to the project site staff.

An exhaustive literature review that reached saturation on the topic informed me and provided the foundation of knowledge used to create the staff education module. The limited baseline data from the hospital provided me with an impetus to seek more information. Subsequently, evidence confirmed that more education was required to

improve the incidence, prevalence, and severity of HWV as well as the reporting of incidents by providing improved strategies to that end. The latter aspect of this problem continues to be developed by the project team but separate from the purpose of this project. Ultimately, I described the selected participant pool as a purposive and convenient sampling upon which to pilot the education with the goal that the hospital will build upon the module and expand the piece more comprehensively.

To measure the results of this pilot, nursing staff took a test before and after the education module with the initial test including contextual data to categorize their experience in the field and exposure to HWV. Each participant's privacy and other ethical considerations were described. After attaining IRB approval from both Walden University and the hospital project site, I implemented and evaluated the education module. In section 4 I reveal my findings and recommendations, their implications, and what unexpected outcomes resulted. Additionally, contributions from the doctoral project team are described. It is necessary to note my perceptions of the strengths and limitations from this endeavor, and I outline methods to mitigate these for extension and further research.

Section 4: Findings and Recommendations

Introduction

Increased incidence of HWV nationwide served as background data for this doctoral project, which focused on similar data on a smaller scale at a 200-bed not-for-profit, community hospital. By developing an education piece addressing HWV prevention, I sought to mitigate this problem and address a gap in practice, which was identified as a lack of a standard approach to HWV education, prevention, and strategy. Pre- and posttest results were used to measure the nurses' change in understanding to determine whether this up-to-date education module on HWV prevention improved staff knowledge. I planned, developed, and implemented the module used as education to newly hired nursing staff to satisfy the purpose of this project.

The sources of evidence that I used to create the education module included available research and literature from industry specialists, such as the ENA, OSHA, NIOSH, and CDC. Locally, internal data were provided by the project site hospital to help understand the magnitude of the need for HWV prevention training. I utilized Rogers' DOI model to interpret and categorize the resultant data from the pre- and posttests. Information from a needs assessment provided contextual data and demographics regarding the nursing staff's previous exposure to workplace violence, previous training, and postincidence experiences. The themes identified from participant responses provided a platform for additional scrutiny and subject for this project.

Findings and Implications

All respondents participated in both pre- and posttests. The average score from the 18-item questionnaire administered before teaching was 82%, while afterward, it was 91%. Figure 1 shows a graph of the score comparison.

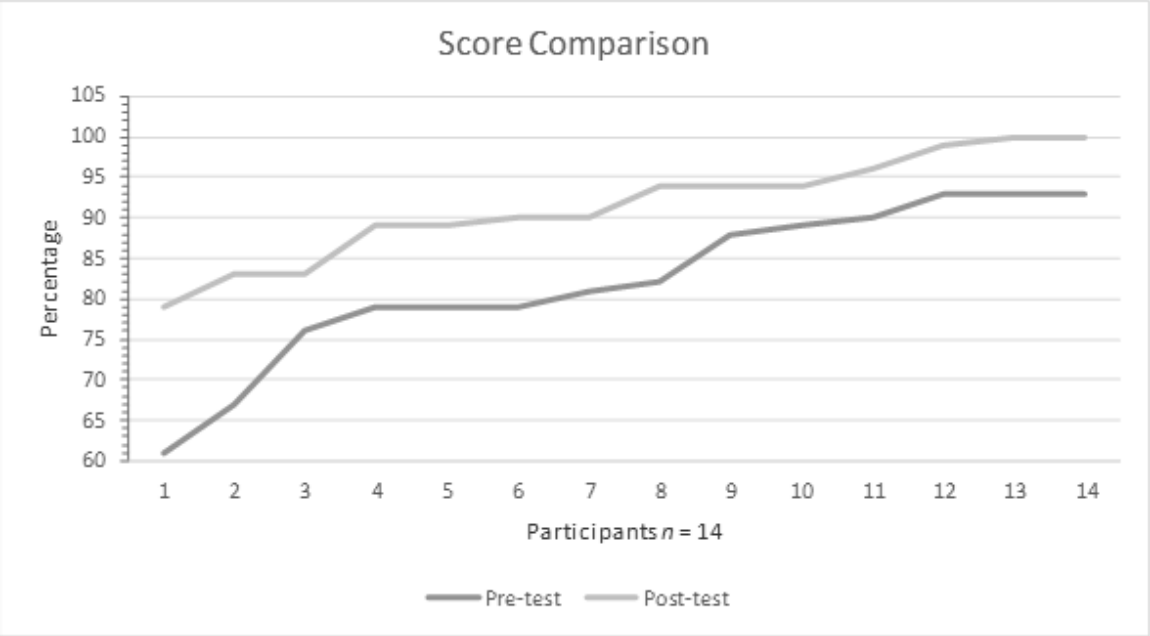

Figure 1. Pretest (i.e., the darker line) shows initial results, and posttest (i.e., the lighter line) shows results after education.

In this case, I assigned numerical values to each participant anonymously (1 through 14) to show change. A mostly upward trend indicated some degree of knowledge attainment. On closer inspection and comparison, I used a bar graph on individual scores to identify some areas where participants continue to need education (see Figure 2). The darker bars show the initial scores juxtaposed with the lighter bar representing training and changed measure of knowledge.

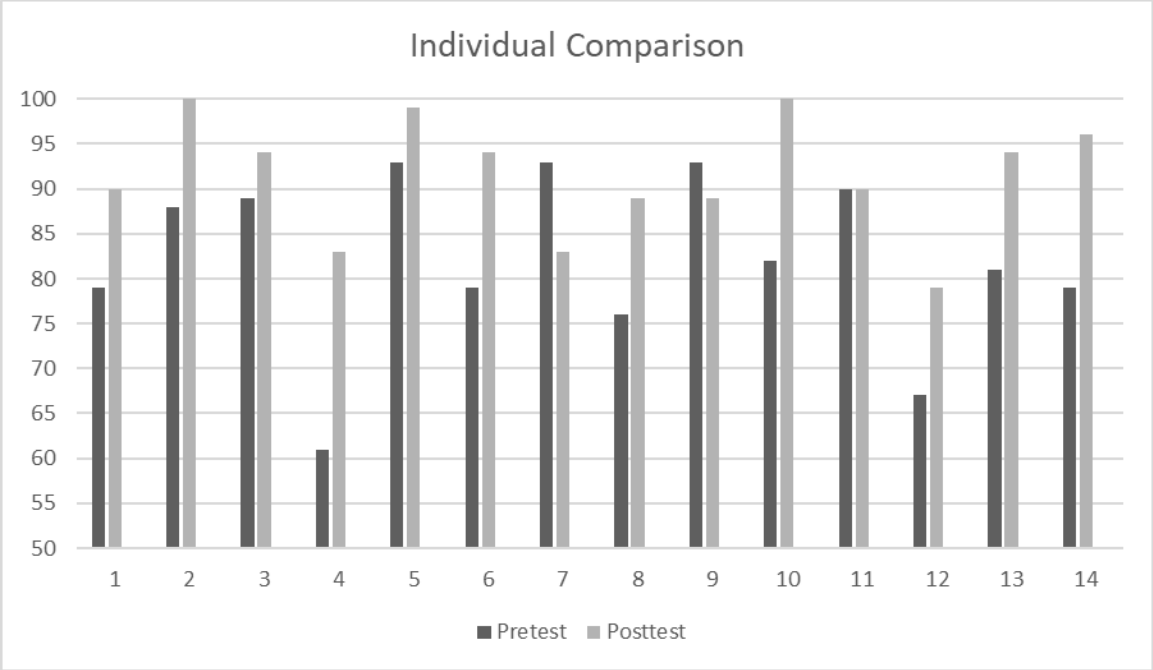

Figure 2. Individual comparison of pretest and posttest scores.

Unanticipated Outcomes

Future training sessions will incorporate revised questions supplemented with oral delivery for the pre- and posttest administration. The group completed these pre- and posttests independently within a brief amount of time (i.e., 20 minutes) before and after education delivery. Another unexpected result was the valuable inclusion of discussion during teaching. A beneficial dialogue occurred between participating members that provided insight into their exposure to workplace violence as well as effective and ineffective prevention strategies. Allowing for proactive conversation prolonged the presentation but had a positive effect on group dynamics.

Staff development demonstrated satisfaction with the process and inclusion of the new hires' opinions. Subsequently, they requested I repeat the presentation monthly with all new-hire orientation. However, time constraints limited the depth of information

discussed in the education module. The class size proved beneficial for discussion and module delivery, yielding a slightly larger participant pool than expected.

Implications

My analysis of the results from this project revealed a need for continued implementation of prevention strategies and education. The doctoral project team appreciated the data discovered in this pilot program and modified questions to better assess the requested data. Separate from the work of this project, the doctoral project team invited a limited sample of clinical and nonclinical staff to take the revised baseline test anonymously. The team intends to modify the test again after troubleshooting before organizational adoption.

Interestingly, this second sampling mirrored results of my pilot tests, indicating the same areas of need. Therefore, I recommend a systems approach to reach stakeholders and enact change through more education. In this case, a systems approach looks at various groupings in the organization, including patient, staff, educators, and administration. This mirrors other disciplines' use of systems theory (e.g., education or social sciences; Kearney, Leung, Joyce, Ollis, & Green, 2016).

An organization-wide assessment test for further context and background information will allow for a focus on departments requiring priority when rolling out teaching that occurs outside of the now-planned monthly offering during new-hire orientation. The internally offered education will be more comprehensive with an emphasis on unit-based risk assessments as identified through the pre- and posttests. One-

on-one training for practical application with de-escalation techniques for physical altercations will be promoted through secondary means.

Researchers previously identified several themes complicating the implementation of such programs (Purtle, Rich, Fein, James, & Corbin, 2015). Narrative data from this project echoes perceptions found within these themes including challenges to reporting, thoughts that little results from initiating reports, and other institutional factors promoting customer service rather than safe environments (Blando, Ridenour, Hartley, & Casteel, 2014). Primary implications from that work iterated in this project include recommendations to encourage reporting by promoting a supportive culture. This environment, in turn, empowers staff to engage in proactive measures as well as prevention and debriefing after an incident of violence in any form.

Positive Social Change

Workplace violence (of all types, including lateral violence) contributes to a disproportionate cost to employers for workers' injuries and days of lost work (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). Factors resulting in negative financial impacts and human resource deficits include the increased cost of healthcare or worker's compensation fees, legal and security costs after the fact, a higher rate of employee attrition or absenteeism, and decreased morale or productivity (American Association of Occupational Health Nurses, 2014). The staggering cost of HWV was reported as $4.2 billion annually as of 2008, meaning that as incidence rises, so too does the financial strain (Gallant-Roman, 2008; Speroni et al., 2014). Furthermore, after an injury or

assault, indirect financial burdens and biopsychosocial sequelae outweigh initial costs of prevention (National Safety Council, 2013).

Conversely, estimates of preventative expenses range from $5.50 per employee in some reports, also expressed elsewhere within budgets as $280 million for emergency preparedness, prevention programs, and staff training (Papa & Venella, 2013; Wray, 2018). From viewing the archival data and existing literature, preventing HWV through appropriate strategies not only improves expenditures financially but reduces negative impacts to human resources. In doing so, healthcare environments are more efficient, conducive to a proactive culture, and endorse positive social change (Beattie et al., 2018).

In this project I introduced concepts that allow for the initiation of behaviors toward positive social change within the organization and participating individuals. There is potential to generalize this process with forward momentum as I have now been tasked to continue the project within the hospital. Not only will each batch of new-hire participants gain meaningful education based on existing evidence, but their engagement leads by example. Through their further demonstration of said techniques and the eventual hospital-wide training, an expectation exists of reduced HWV incidence. Through these means, “the Hawthorne effect” leads to active engagement and improving the perception of an organization by its employees (Blando et al., 2014, p. 6).

To that end, the facility initiated a compliance program as an incentive. Interestingly, the stakeholders in that endeavor are administrators who acted separately from the HWV committee and the doctoral project team. Administrators recognize me as an agent of change from this project due to the momentum gained. The process proved

fruitful in that the need exists to continue developing additional education modules to build a more comprehensive prevention strategy. Further needs stated include developing and implementing subsequent phases wherein data are more adequately reported and analyzed. Social change is evident in that system processes now respond to the same benefits and goals.

Additionally, I continue with the commission of advocacy for victims of HWV in that while education and prevention strategies prove to have a beneficial impact, incidents persist, but hopefully on a lesser scale. Currently, my state is one of three without enhanced penalties for perpetrators of workplace violence in healthcare (South Carolina Hospital Association, n.d.). Often, the accused will plead down from a felony charge or have the case dismissed altogether due to mitigating circumstances (e.g., mental health), according to a private conversation with a state senator. Victims endure the resulting disappointment and demotivating factors, such as lack of enforced prosecution, which perpetuates the cycle of declining to report (Beattie et al., 2018; Christie, 2015).

In advocating for enforced penalties and policies regarding assailants, I continue to communicate with legislators to support H.R. 1309, for which there are no sponsors from my state. The data from this project and subsequent program initiation will show first-hand statistics on the improvement of awareness, prevention knowledge gain, and reduction of harm. The goal is to show how the program pays for itself by reducing the staggering cost of HWV, affected employees' loss of days worked, and other protracted problems resulting from such trauma.

Recommendations

Solutions to the Gap in Practice

The project site hospital invited me to continue with the education piece by providing comprehensive modules and additional units of exploration of HWV prevention strategies. The doctoral project team enlisted my help to update existing policies to incorporate better practices that are in line with findings and evidence from current literature and industry recommendations. In efforts to reinforce the pilot program education, the team plans to open the revised baseline test to all employees and add the module as part of annual competency training. The doctoral project team wishes to continue efforts and elicit more data for better planning and evaluation. Narrative results, along with the Likert-type responses, will inform future iterations of this education. Tailoring training and prevention strategies requires such an assessment, which improves the quality of product delivered as well as results gained (OSHA, 2015a; 2016).

The gap in practice addressed with this project was multifactorial, leading to a need for change in organizational culture and service delivery. Solutions included reinforcement of education with annual competency check-offs, accountability initiatives from the organization's administrative team, and further statistical inquiry into this facility's incidence of HWV as well as how this project and its teaching affect HWV prevalence. The tools utilized for this project will be fine-tuned based on team feedback.

Secondary Products

Two elements discussed within the education developed in this project require further development and implementation. The first is a hands-on, self-defense, practical

component that allows for the prevention of harm to the potential aggressor and the target. While one program is in place currently concerning this element, the team agreed that a better offering is available. To accomplish this task, the team proposed enlisting a different agency or mandating the current course.

As discussed in the first section, the offered self-defense course is poorly attended and is only voluntary. Secondly, providing an improved postincident response demonstrates organizational support by compassionately providing a biopsychosocial assessment and treatment plan for those exposed to HWV. Debriefing forms an essential component in meeting the needs of any postincident response. The formation of a debriefing team and subsequent policy require insight gained from this project and knowledge from existing research. Affiliated agencies, such as county emergency medical services and law enforcement, already engage in such strategies. The HWV team and doctoral project team suggest enlisting their expertise as well as EBPs in the next phase of program development.

Evaluation Procedures in Future Planning

Expanding the tests and teaching piece to the entirety of the hospital staff provides better data to the project team. For that purpose, the metrics will remain the same as in the pilot program. In future endeavors with secondary products (self-defense and debriefing policies, implementation, and evaluation), the proposed tools include measuring components related to incidence and its change, participant perception of the practical elements and their benefit (e.g., self-defense), and validated inventories for

acute and post-traumatic stress disorders such as those available from the Substance Abuse and Mental Health Services Administration (2019).

Contribution of the Doctoral Project Team

Process Summary

A parent committee for policy formation regarding staff and patient safety included members that formed the subsequent subcommittee. The occupational health and safety officer, an advanced practice nurse with specialized training in occupational health, headed the subcommittee and we collaborated to form the doctoral project team which aligned personal and project goals. At my first collaboration with her, we outlined a multiphased plan to evaluate a baseline of knowledge and target a pilot group for education with subsequent assessment of content learned.

As we delved into literature to inform the education piece, further data suggested and informed practices necessary for additional phases (hospital roll-out then debriefing and follow-up support), as described in the previous pages. We determined that biweekly meetings would be held to scrutinize a toolkit, checklist, and existing surveys, or tests to modify in the formulation for elements utilized herein. This preparation proved fruitful as the hospital hosted an organizational safety fair with booths for various concepts, including workplace violence. Separate from this project, that opportunity provided practical insight for myself and the team as to the dire need for education.

After that event, the focus on information that the pilot education piece would cover was refined and solidified. The team approved the piece as submitted for hospital IRB approval. Pending its endorsement, the project team offered feedback on the pre- and

posttests I modified to capture the most data and target information important for this organization. After reaching a consensus and the hospital finalized its consent for the project to proceed, I submitted the data for university IRB approval. The team's role at this point was to discuss timing for pilot administration.

As time passed, plans moved forward in discussion only as to how to approach the results once available. Other concepts considered included outlets for hospital-wide roll-out. Subsequent phases plan to incorporate better reporting platforms, administration buy-in, post incident training and support, and the practical matters related to self-defense demonstration. The staff development department, while not a part of the project team, were integral in providing the time and venue for the pilot education delivery.

Project Team Roles

I provided a repository of research to the project team as a representative of Walden University. The occupational health and safety officer presided over the biweekly meetings along with other key members of hospital staff. She and I directed the conversation and enlisted other members from the parent committee for their areas of specialty to inform project development. Interdisciplinary departments represented by leaders of their units engendered front-line knowledge to inform changes necessary to meet their needs. Security, employee health, laboratory, the emergency department, the psychiatric monitoring unit, risk management, and even information technology each had at least one participant on this subcommittee.

Extending the Project

I plan to continue my participation with the subcommittee and now with members of hospital administration to reinforce the education provided, develop the next phases of education and evaluation, and to support the organization in its initiative in safety and accountability. Meetings are planned to determine the approach and implementation after an evaluation of hospital-wide tests is complete. Moreover, there is a mutual goal for me and the occupational health and safety officer to research the matter and submit our results to industry publications. As the project is deemed successful and meets the hospital's needs, I have a personal goal to reach out to other regional agencies with proposals of similar projects that might benefit them.

Strengths and Limitations of the Project

In the development of the education piece and its implementation, I utilized identified strategies from literature to support and strengthen the program. The data provided insight and guidance. Its usefulness proved to be requisite in providing adequate prevention strategies against HWV. A limitation of the project is the scope and manner of application. As it is only a pilot program as of this writing, the size of the participant group was small. However, because of the rigors applied in formulating the module and its evaluation, it is undoubtedly generalizable to the whole hospital setting. This strength will prove valuable in the next phases of the program as it comes to fruition.

I was pleased to receive positive feedback from the institution, encouraging me to expand the program and persist in its education delivery. The agency's stakeholders remain keen to pursue this topic and improve organizational statistics. As this project not

only meets my goals as outlined in the first sections, it coincides with objectives the hospital strives to accomplish and sustain. Limitations of the project notably include organizational culture. As research hints, and the narrative results of this project shows, there is an uphill battle to alter perceptions of potential progress.

Certain aspects of this project revealed a limitation in that culturally sensitive and appropriate service delivery needs further exploration. In teaching communication skills to this project's participant population, much dialog regarding therapeutic communication and emotional intelligence ensued. However, other system challenges exist within many healthcare settings when engaging individuals of limited English proficiency (Arroyo, 2019). When a communication barrier exists, it becomes increasingly challenging to provide culturally competent care (Attard et al, 2015; Brisset et al., 2014). In the setting of communication challenges, and with the potential for health care workplace violence, lack of culturally competent care hinders the ability to deescalate or mitigate a volatile situation.

As such, recommendations for future projects include expanding the scope of this one with additional modules for a more in-depth and comprehensive product and a holistic approach. Further study is needed pertinent to system challenges with workplace violence, language barriers, and incidence of violence in the setting of limited English proficiency. Expanding the scope as previously described aims to evaluate the system impact from the implementation of prevention strategies.

Additionally, through the continued effort, new areas to assess and intervene are revealed. The hospital has accepted the mission from the state hospital association to

maintain safer work environments through addressing incidence of workplace violence. Because of their goals, exploration to quantify the longitudinal benefit of the prevention program implementation bears additional commitment in conjunction with my work and that of the doctoral project team as we move forward.

Section 5: Dissemination Plan

Organizationally, the goal is to report the resulting data of this project after a hospital-wide roll-out to the state hospital association. An incentive exists when reporting these data in organizational and industry specialist venues. On a smaller scale, the hospital provides speaking opportunities through Grand Rounds, which is a platform wherein education is provided to any clinical and nonclinical staff wishing to attend. My peers offered me encouragement to present my findings in this forum, stimulate conversation, and raise awareness of the unmitigated issue. Highlighting the need for all hospital personnel has the potential of increasing their desire to learn and, therefore, initiating the necessary changes from within.

Armola, Brandeburg, and Tucker (2010) posited that nursing grand rounds is an option to present case studies or other evidence and findings to impact practice. Furthermore, the researchers offered advice on the development of the grand round format for the institution, stating that this forum can be used to present shared governance results, case studies, literature reviews, expert speakers, and more. Finding a way to use this venue to present the results of my collaboration with the hospital for my project is now an objective.

Several members of the doctoral project team hold memberships with professional organizations within the realms of occupational health and safety, the state hospital association, and the International Association for Healthcare Security and Safety. The group's cultivation of the project creates a fundamental piece appropriate for presentation in any one of those settings in a conference. This platform affords me networking

opportunities, including the potential to attend conferences at some point. The enthusiasm and response from the healthcare community as it relates to supporting healthcare workers before, during, and after a workplace assault has been humbling.

Analysis of Self

Practitioner

In reviewing several education programs for HWV prevention, I gained knowledge to improve my situational awareness through emotional intelligence. In the delivery of patient care and with interactions among peers and colleagues, I strive to maintain strategies learned therein. I am even more aware of what nonverbal cues or contributing factors exist so that I practice proactively to not only protect myself and the patient or visitors nearby but to lead by example.

Staff members recognize contributions from the prevention program and seek measures to improve their practice. Networking allows me to introduce other methods of self-defense, with goals of reducing harm to the potential aggressor and facilitating safe escape for the healthcare worker. Having my experience validated in these measures endorses that the path I choose as a scholar-practitioner is a valid and worthwhile cause.

Scholar

The knowledge I attained through this doctoral project reinforced my commitment to scholarly growth. Integral to life-long learning, I desire to share with others and demonstrate competencies effecting change and developing solutions to critical matters. My efforts in this DNP project have culminated in the ability to critically evaluate

existing evidence, synthesize it for comprehension, and utilize the data toward better service delivery.

Subsequently, optimal outcomes result for stakeholders and, ultimately, patient care. Taking gradual and methodical steps for program development proved invaluable in bringing this staff education project to fruition. Utilizing the practical knowledge gained regarding a leadership role as a scholar-practitioner, I will further the mission of education and HWV prevention.

My efforts began with this project have evolved into a more considerable endeavor, but other needs remain. Through my comprehension of program development, I foresee an ability to take on the mantle of educator and consultant as my expertise grows. I strive to continue demonstrating these skills with the integration of EBP. The idea of possible opportunities intrigues me, and I welcome the path forged through education and attainment of a terminal degree.

Project Manager

Throughout my career, leadership has been an elusive prospect and a role I never intentionally sought with any goal other than sharing what knowledge and experience revealed. When the doctoral journey and passion for a topic merged, the steps that seemed tedious or difficult suddenly flowed easily when I applied my logic and ability. My confidence to lead others with similar goals has dramatically increased. This effort bolstered my reserve and motivated me to advocate and enact change. Creating this project by simplifying it to its basic steps mirrors the nursing process.

Similar to the scientific method, the initial step assesses needs or problems, then diagnoses items for change or intervention. Subsequently, planning the program utilizes identified stakeholders' input and existing evidence. Finally, the project manager delivers and implements the proposed program, culminating in an evaluation. These steps illustrate the foundation from which my career grew and how it shall proceed.

Completing the doctoral project transpired efficiently after all key pieces aligned. Solutions presented themselves via a plethora of literature, the imminent need for prevention strategies at the project site, and from the mission and goals of the project team. The valuable insight I gained over the course of this process includes practical knowledge of this type of undertaking. Troubleshooting and formative evaluation seem less daunting after performing the requisite steps.

Summary

The purpose of this doctoral project was to answer the practice-focused question as to whether an education piece on HWV prevention would improve the knowledge of the nursing staff. The identified gap in practice of the lack of a standard HWV prevention program creates a work environment with an increased incidence of healthcare worker assault in all its various forms. While researchers have suggested that implementation of prevention programs diminish the occurrence of HWV, less data are available that indicates the optimum measures taken to ensure compliance or reduced rates. From poring through numerous research and industry recommendations, I found that a consensus existed around the idea of systematically approaching each agency with a site-specific risk assessment and identifying environmental factors unique to its operations.

From this initial phase, a baseline assessment of staff also informed the project team of education needs. Subsequently, I delivered the pilot education program to an audience of newly hired nursing staff after which the change in knowledge revealed a positive correlation. Further work is needed to open this program to the whole hospital, but initial results are optimistic. Based on emerging information, I propose dedication to this pursuit with an initiative to improve the format of test delivery to better capture intended data and inform further program development.

Ultimately, the mission remains to ensure that organizational culture endorses a zero-tolerance policy toward HWV. Therefore, I commit to continued education on better measures to improve workplace safety. It is necessary to promote therapeutic alignment through emotional intelligence, understanding of the different types of HWV, and how to recognize risks or red flags. Teaching individuals how to deflect harm if an assault occurs while still protecting the aggressor holds importance. HWV is too often perceived as part of the job. Through education and practical application of prevention strategies, improved knowledge can lead to a proactive culture and social change.

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Appendix A: Healthcare Workplace Violence Prevention PowerPoint

HEALTHCARE WORKPLACE VIOLENCE PREVENTION

MICHELLE LEIGH ARROYO, MSN, APRN, FNP-BC

WALDEN UNIVERSITY

OBJECTIVES

The learner will be able to:

- Define and identify four types of workplace violence
- Understand extent of problem for healthcare staff
- Recognize risks of violence and identify warnings preceding potential violence
- Employ therapeutic techniques for de-escalation
- Be familiar with defensive techniques to prevent harm to self and/or assailant
- Locate avenues to report incidents and seek follow-up support

VIOLENCE IS NOT PART OF THE JOB

OSHA AND CAL/OSHA, 2013

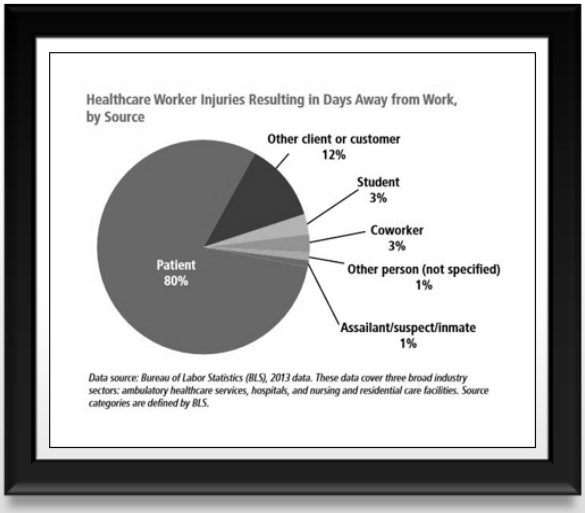
DEFINITION ACCORDING TO OSHA (2016)

- Any act or threat of violence that occurs at the worksite
- Does not include lawful acts of self-defense or defense of others
- HWV has a high likelihood of resulting in injury, psychological trauma, or stress with or without physical injury
- Might involve the use of dangerous weapons, with or without an injury

TYPES OF WORKPLACE VIOLENCE

- Criminal intent
- Customer/Client
- Worker-on-Worker
- Domestic Violence

NIOSH, 2016



INCIDENCE AND PREVALENCE

- The highest prevalence of workplace violence occurs in healthcare settings (OSHA, 2016).
- Often, the violence is more severe than that experienced by police or prison guards (Brophy, Keith, & Hurley, 2018
- Research confirms a higher likelihood of violent assaults in areas such as psychiatry, emergency, forensic settings, or memory-care/geri-psych wards (Brophy, Keith, & Hurley, 2018).

TYPE II VIOLENCE STATISTICS

From Allen, 2018

IMPACT OF VIOLENCE ON HEALTHCARE WORKERS

Biophysical Manifestations (NIOSH, 2016)

- rapid heart beat, increased blood pressure
- hyperventilation, sweating
- rash or hives
- stomach pain, nausea, vomiting
- diarrhea, frequent urination
- chest pain
- involuntary shaking
- release of stress hormones
- decreased sleep

IMPACT OF VIOLENCE ON HEALTHCARE WORKERS

Emotional Manifestations (NIOSH, 2016)

- fear: of injury, loss of life, losing control, or of going crazy
- high anxiety: about what to do, how to escape, stopping the abuse
- shock/disbelief
- guilt, embarrassment, or shame
- fight-flight impulse toward self-protection
- post-trauma sequelae: e.g., nightmares, re-play of the frightening incident, crying

IMPACT OF VIOLENCE ON HEALTHCARE WORKERS

Cognitive Manifestations (NIOSH, 2016)

- inability to focus or concentrate
- interference in ones usual problem-solving ability

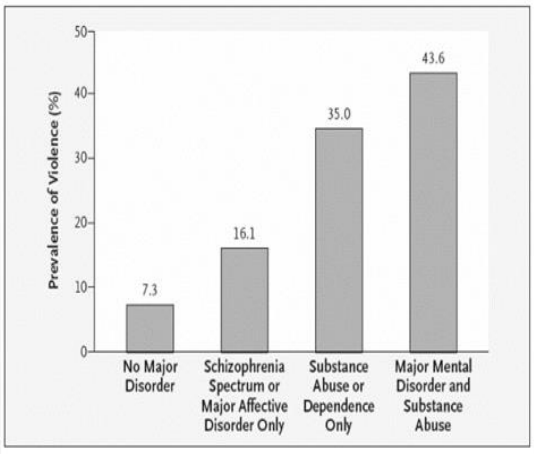
IMPACT OF VIOLENCE ON HEALTHCARE WORKERS

Behavioral Manifestations (NIOSH, 2016)

- cannot perform usual work demands
- becoming withdrawn
- crying easily
- lack of sleep
- avoiding usual social interaction
- losing temper easily - yelling, getting angry at family members, etc.
- acting impulsively
- driving hazardously as a result of anxiety and emotional upset

RISKS OF VIOLENCE

- Availability (e.g. nurses, medical staff, etc.; response of security)
- Staff inexperience, lack of knowledge about violence recognition & prevention
- Environmental factors
- Patient factors (e.g. pain, fear, medication reaction, delirium, mental health, history of violence)
- (Solorzano Martinez, 2016)



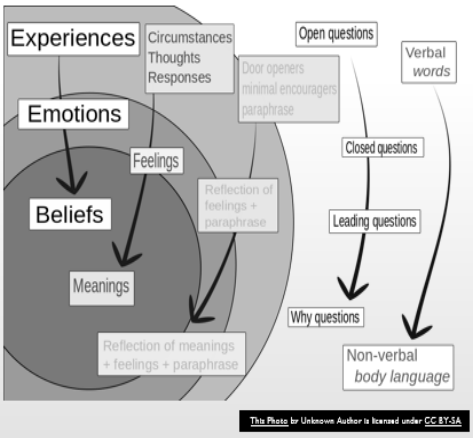
Lifetime Prevalence of Violent Behavior among Persons with or without Major Psychiatric Disorders and Substance Abuse.

BEHAVIORAL RED FLAGS & CONTRIBUTING FACTORS

- History of violence
- Communication issues from any source (staff, patient, family, etc.)
- Agitation
- Inconsistent behavior (reaction does not match situation)
- Incongruent verbal and non-verbal communication from potential assailant
- Raised voice
- Extended wait times/delay in service delivery
- Intense experiences/anticipatory grief or anger
- Graph from NIOSH, 2016

INTERVENTION STRATEGIES

- Empower staff through training with classroom work (didactic) and simulation (practical)
- Avoid crisis
- Verbal skills
- Non-verbal skills
- Setting limits
- Enlist help



THERAPEUTIC MANAGEMENT FOR DE-ESCALATION

- Emotional intelligence
- Congruence in verbal and non-verbal communication
- Consistency in expectations and service delivery
- Person-in-environment perspective; understand "where they are coming from."
- Environmental awareness, e.g. stimuli, other triggers controlled or reduced

SELF-DEFENSE

- When verbal de-escalation techniques do not work the need arises to minimize harm
- Be aware of surroundings, available exits
- Protect yourself, the aggressor, and other bystanders
- Call for help
- Use facility-sanctioned techniques (TherapeuticOptions™)

YOU HAVE A RIGHT TO REPORT

- Immediate Supervisor
- Nursing supervisor
- Seek evaluation in the ED and fill out SREO (through intranet/safety coach card)
- Risk management
- EAP (optional)

PREVENTION REDUCES INCIDENCE AND PREVALENCE
BE SAFE AND BE SILENT NO MORE

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Appendix B: Pretest

- **What are the most and/or least effective methods of controlling violence in the healthcare setting?**

  Most effective:

  Least effective:

- **What improvements could be made to how "high risk" patients (e.g., as suicidal, violent, or altered mental status patients) are handled?**

- **Rate how safe you feel from workplace violence in the healthcare setting overall as well as in each area of this hospital.**

	Not at all Safe									Extremely Safe
Overall level of safety in the Hospital	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
ED settings (waiting area, triage, trauma, minor visit area, regular exam rooms)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Inpatient units, rooms	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Critical Care areas	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Outpatient Services (lab, radiology, etc.)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Psychiatric holding (ED and CMU)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Surgical services (in- and out-patient)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

- **How long ago did you receive training on preventing and/or mitigating healthcare workplace violence?**

  Never.....①
  0-3 months .....②
  4-6 months .....③
  7-9 months .....④
  10-12 months .....⑤
  More than 12 months .⑥

- **If you have experienced workplace violence while working (at this facility or others), did you formally report the occurrence(s)?**

  No, I did not formally report the occurrence(s) ..... ①
  Yes, I formally reported some of the occurrences ..... ②
  Yes, I formally reported any occurrence of workplace violence ③

- **Have you been instructed to report physical or verbal abuse regardless of the level of severity or harm?**

  No.....①
  Yes .....②

- **How do you report workplace violence?**

- **If an incident of workplace violence occurs and is reported, what typically happens?**

- **Why do staff members not report workplace violence?**

- **From the actions listed below, indicate which of the following items you believe to constitute workplace violence. Additionally, indicate whether you have personally experienced any of the items.**

	I consider this action to be workplace violence		I have personally experienced this action while at work	
	Yes	No	Yes	No
Bitten	①	②	①	②
Called names	①	②	①	②
Hair pulled	①	②	①	②
Harassed with sexual language/innuendo	①	②	①	②
Hit (e.g., punched, slapped)	①	②	①	②
Hit by thrown objects	①	②	①	②
Kicked	①	②	①	②
Pinched	①	②	①	②
Pushed/shoved	①	②	①	②
Scratched	①	②	①	②
Sexually assaulted	①	②	①	②
Shot/shot at	①	②	①	②
Spit on/at	①	②	①	②
Stabbed	①	②	①	②
Sworn/cursed at	①	②	①	②
Threatened with physical harm	①	②	①	②
Verbally intimidated	①	②	①	②
Voided on/at	①	②	①	②
Yelled/shouted at	①	②	①	②
Other (describe):	①	②	①	②
Other (describe):	①	②	①	②
Other (describe):	①	②	①	②

- **How prepared do you feel to manage aggressive or violent behavior?**

Not at all Prepared — Completely Prepared

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

- **Do you feel that workplace violence from patients and/or visitors is simply a "part of the job" in healthcare settings?**

No.....①
Yes.....②

- **Do you feel that workplace violence has increased, remained the same or decreased over the past year?**

Increased.....①
Remained the same.....②
Decreased.....③

- **Please rate how effective our hospital's security personnel is in preventing violence against hospital staff in our organization.**

Not at all Effective — Extremely Effective

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

- **Please rate your perception of security response time in responding to violence against hospital staff:**

Slower than needed	Slower than expected	N/A	As Expected	Faster than expected
①	②	③	④	⑤

- **Please rate your perception of security presence in general for violence prevention:**

Not at all	Sometimes	Neutral	Most of the Time	Always
①	②	③	④	⑤

- **What types of violent situations do you feel most and/or least prepared to handle?**

Most prepared:

Least prepared:

- **What other suggestions do you have for improving how workplace violence is handled in this hospital (before, during, and after incidents occur)?**

1. Select all that apply from the following statements that reflect OSHA's definition of workplace violence
    a. Any act or threat of violence that occurs at the worksite.
    b. Does not include lawful acts of self-defense or defense of others.
    c. HWV has a high likelihood of resulting in injury, psychological trauma, or stress with or without physical injury.
    d. Might involve the use of dangerous weapons with or without an injury.
2. The following is an example of which type of healthcare workplace violence? A patient presents to the emergency department for antibiotics and pain medication. When the doctor does not prescribe what he seeks, he becomes belligerent and punches the nurse.
    a. Criminal Intent
    b. Customer/Client
    c. Negligence
    d. Malpractice
3. The following is an example of which type of healthcare workplace violence? Nurse A is responsible for the orientation of a newly hired staff member. She is frustrated at the lack of experience the orientee displays and posts a deprecating comment on social media, sharing it with coworkers. She also makes sure to avoid the orientee through the first few shifts expecting her to "sink or swim,' instead of answering questions or helping her learn.
    a. Employee Dispute
    b. Worker on Worker
    c. Hazing Ritual
    d. Domestic Violence
4. The following is an example of which type of healthcare workplace violence? Police apprehend a man armed with gasoline and a lighter after he snuck into an unsecured door and attempted to place several fires in stairwells of a community hospital. One wing sustained some damage and was evacuated. The rest of the hospital was secured before the blaze spread. He was neither a patient nor visitor.
    a. Security breach resulting in a felonious act
    b. DSM-5 classification # 312.33 Pyromania
    c. Failure of staff to execute safety protocols
    d. Criminal intent to harm hospital staff

5. The following is an example of which type of healthcare workplace violence? A staff member gets an urgent notice to an estranged spouse in the parking lot to discuss legal matters. The interaction escalates to a physical and verbal confrontation where the staff member receives injuries from the spouse. No one even knew they were having trouble.
    a. Anger management issues resulting in harm
    b. Domestic violence resulting from marital conflicts
    c. Failure to exercise de-escalation techniques
    d. Absence of legal representation when discussing legal matters
6. Out of the four types of workplace violence, acts from customers or clients are the most prevalent in healthcare workplace settings
    a. True
    b. False
7. In what setting does workplace violence occur the most?
    a. Law enforcement
    b. Detention and corrections
    c. Post office
    d. Healthcare
8. Out of the following biophysical systems, which ones are affected by the impact of violence on healthcare workers?
    a. Nervous and musculoskeletal systems
    b. Respiratory and cardiovascular systems
    c. Endocrine and gastrointestinal systems
    d. All of the above
9. Name the domains where types of symptoms of acute stress and post-traumatic stress symptoms may occur for victims of HWV.
    a. Biophysical and emotional
    b. Cognitive and behavioral
    c. Metaphysical and spiritual
    d. A & B

10. After a triage evaluation, a gentleman complaining of pain is asked to sit down and wait. While he initially complies, he becomes more restless and then agitated after waiting for a long period of time. He starts to yell at triage staff and pacing, waving his arms. Which red flags of potential violence were present?
    a. Failure to disclose pain in triage
    b. Pain and perception of prolonged waiting
    c. Raised voice and agitation
    d. All of the above
    e. B & C only
11. A patient with an addiction disorder is held on psychiatric commitment papers for a suicide attempt. Upon arrival to the observation unit, the patient is sad and withdrawn but has a history of self-harming behavior and violence toward others. Which red flags of potential violence were present?
    a. Substance use & mental health disorder
    b. Self-harm behavior & violence towards others
    c. Sad and withdrawn
    d. A&C only
    e. All of the above
12. An agitated adult patient with autism is brought to the emergency department. Additionally, the patient has limited English proficiency. The nurse recognizes the complex situation, employs communication through interpreters, and consistently follows through with expected care. The patient is triggered by overstimulation and is calmed when the nurse allows family to assist. This is an example of what technique?
    a. Common sense
    b. Good customer service
    c. Exceeding scope of practice
    d. Therapeutic de-escalation
13. Despite proactive communication and service delivery, a patient becomes aggressive. Responding staff are at risk of experiencing violent behavior from the patient. How do they protect themselves, the patient, and other people?
    a. Call for back up, restrain the patient, and wait
    b. Medicate the patient to calm down, document the incident in the chart
    c. Enlist help, keep self between exits and patient, use self-defense techniques to safely subdue and/or escape
    d. Ignore the patient until they calm down, post security at their door

14. Should you report incidents of workplace violence?
    a. Yes
    b. No
    c. Depends on the nature of the incident.
15. Of the following, what incidents should be reported? 1) Verbal harassment, 2) bullying, 3) stalking, 4) physical threats, and 5) physical injury
    a. 3, 4, and 5
    b. 1, 2, & 3
    c. 2 & 5
    d. none of the above
    e. all of the above
16. The hospital has a department tasked with developing, implementing, and following-up on workplace safety and incident reports.
    a. True
    b. False
17. Punitive or retaliatory action is forbidden against any employee who requests intervention as a result of a violent occurrence.
    a. True
    b. False
18. Avenues to exercise your right to report include which of the following:
    a. Immediate supervisor or nursing supervisor
    b. Completion of a Supervisors Report of Employee Occurrence (SREO)
    c. Discuss your experiences on social media
    d. A&B
    e. B&C
    f. All of the above

Appendix C: Posttest

1. Select all that apply from the following statements that reflect OSHA's definition of workplace violence
   a. Any act or threat of violence that occurs at the worksite.
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    c. Discuss your experiences on social media
    d. A&B
    e. B&C
    f. All of the above

Appendix D: Permission to Use and Modify ENA Tool

From an Email dated February 19, 2019:

Michelle,

Thank you for reaching out. This is the survey we used [attachment redacted]. We took the ENA tool and modified it to fit our unit. So some of it will not make sense as far as north, south etc….but you should be able to get the general idea of the questions we used.

Hope this helps.

Best of luck,
Julie

Julie A. Stene MHA/MSN, RN | Nurse Manager – East Tower 5 A/B - Medical Cardiac PCU | Department of Nursing | Instructor of Nursing | College of Medicine | East Tower 5-857 | Phone: 507-538-7934 | Pager: 127-92121 | stene.julie@mayo.edu
Mayo Clinic | 200 First Street SW | Rochester, MN 55905 | www.mayoclinic.org