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### Workplace Violence Interventions: A Benchmark Project

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**Workplace Violence Interventions: A Benchmark Project**

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NURS 5382: Capstone

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## Executive Summary

Workplace violence incidence rates are increasing in the medical field. The staff in the emergency department (ED) is especially prone to these workplace violence events due to patients arriving in such unpredictable states. Unfortunately, many hospitals and departments do not have a systematic approach to deal with workplace violence. This brings up a major safety concern for nurses.

Sadly, the majority of ED nurses report experiencing some type of workplace violence. As a result, workplace violence has a significant impact on a nurse's stress and productivity. Gates et al. (2011) gathered survey data from ED nurses. From those that responded to the survey, 37% demonstrated decreased performance after a workplace violence event and 94% reported at least one stress-related symptom after the event (Gates et al., 2011, p. 62). These findings suggest that even though ED nurses are able to continue working after a violent event, they may have trouble remaining focused, both cognitively and emotionally (Gates et al., 2011, p. 63). This study illuminates how detrimental workplace violence events can be to ED nurses.

Workplace violence is also a major stressor on medical professionals (Gates et al., 2011), whether they are anticipating a patient becoming violent or dealing with the aftermath of being verbally or physically assaulted. The aftermath of a workplace violence incident on a nurse lasts long after the incident, sometimes causing the nurse to experience PTSD from that event. Unfortunately, workplace violence incidents have led some nurses to change jobs or completely leave the profession (Edwards et al, 2014, p. 653). While Parkland Health & Hospital System has a current protocol in place regarding workplace violence, they do not have a systematic educational program in place covering workplace violence. The plan for this project is to

implement educational modules over workplace violence with the goal to reduce the total number of workplace violence incidents in the emergency department.

### **Rationale for Project**

The Nursing Code of Ethics discusses a nurse's responsibility and commitment to a patient (ANA, 2015). However, when a patient is threatening and is violent towards a nurse, the nurse's life is on the line, making it difficult for the nurse to adhere to the Code of Ethics. Violence against health care professionals is a profound problem in EDs worldwide. Alarming, most medical staff members report experiencing some type of workplace violence, whether that is verbal, physical, or sexual violence. The former director of the Parkland ED sent out a survey to the ED staff regarding workplace violence. Out of 145 participants that completed this survey, 121 participants reported that they had personally experienced a workplace violence event. This survey data illuminates that a change is warranted within the department. As an aspiring Family Nurse Practitioner (FNP), this safety concern for nurses led to the formation of the PICOT question: In emergency department nurses (P), how does the implementation of workplace violence interventions (I) compared with current practices (C) reduce the number of workplace violence incidents (O) in a 3-month period (T)? Emergency departments should consider a proactive approach by implementing a prevention-focused educational program (Gillespie et al., 2014). This program would make the nurse more aware of subtle behaviors that signal that a patient is becoming violent. Hopefully, educating and uplifting ED nurses and preparing them to be as safe as possible with violent patients and their families will not only increase their job satisfaction and work productivity, but will also benefit their patients through them becoming empowered to provide the best patient care possible.

## Literature Synthesis

During a review of literature, many articles discussed the importance of implementing workplace violence interventions in the hope to decrease workplace violence events. The interventions reviewed ranged from assessing nurses' perceptions of safety to assessing how workplace violence incidents affect nurses' overall productivity and job satisfaction to implementing educational programs and preventative measures to decrease workplace violence events. According to the evidence, workplace violence interventions decrease the overall number of workplace violence incidents.

First, it is important to assess nurses' perception of safety before implementing any other interventions. Burchill et al. (2018) evaluated the Personal Workplace Safety Instrument for Emergency Nurses (PWSI-EN) to measure an emergency nurse's perception of safety from workplace violence. Through statistical analysis, this study revealed that "hospital type, organizational confidence, and fear for patient safety were significant predictors of greater perceptions of safety" from workplace violence (Burchill et al., 2018, p. 97). By first addressing the complex issue of workplace violence perception, organizations are more likely to have nurses who are highly engaged and delivering high quality care (Burchill et al., 2018, p. 101). For this benchmark project, a perception of safety survey will be sent out to the staff prior to them completing the pre-test and educational modules.

Consequently, a workplace violence incident not only affects a nurse's perception of safety, but also creates anxiety. Edwards et al. (2014) discussed how anxiety is related to aggression in the workplace, identified different types of aggression that nurses encounter, and highlighted the groups of nurses who are at the greatest risk of workplace violence (Edwards et al., 2014, p. 658). The demographic groups at a greater risk of being exposed to workplace

violence include nurses who are younger and less experienced, male nurses, and night shift and weekend shift nurses (Edwards et al., 2014, p. 656). Verbal abuse is the most common type of aggression encountered (Edwards et al., 2014, p. 656). By highlighting the most vulnerable group of nurses and the most common types of aggression encountered, special accommodations can be included in an education program to prepare those who are most vulnerable.

Consequently, as a result of anxiety, nurses can often experience feelings of anger. Kalbali et al. (2018) explored how anger management training can help control how nurses perceive violence and aggression. The results of this study revealed that anger management programs “had a positive impact on the reduction of perceived aggression and physical and sexual violence” of ED nurses (Kalbali et al., 2018, p. 92). For the sake of this benchmark project, the workplace violence educational modules will tie in aspects of anger management.

Most importantly, it is essential to implement a workplace violence educational program, which will be the primary focus of this benchmark project. Gillespie et al. (2014) compared educational programs that provide solely online content with educational programs that provide a hybrid of both online and classroom-based content. This study measured whether nurses retained the information learned in each setting. The outcome of this study illustrated that the probability that learning outcomes will be achieved is increased when using hybrid modalities (Gillespie et al., 2014, p. 472). In another study by Casey (2020), a hybrid program was made available to participants over a six week course, beginning with the completion of a pre-test, followed by the education, then concluding with a post-test. Completion of the hybrid education program resulted in increased confidence and positive attitudes regarding management of patient aggression (Casey, 2019, p. 12). For the sake of this project, the focus will be on the online content with recommendations to include hybrid aspects in the future.



After reviewing 14 articles on workplace violence, Rodrigues Pereira et al. (2019) came to the conclusion that when educational programs are implemented, workplace violence is significantly reduced. Another systematic review revealed the evidence that workplace violence interventions decrease the risk of workplace violence incidents occurring (Raveel & Schoenmakers, 2019). A study by Jeong and Lee (2020) emphasized that the workplace violence prevention program should focus on coping skills and communication. This study confirmed that the implementation of a workplace violence educational program was an effective intervention for “improving the ability to cope with violence” (Jeong & Lee, 2020). Lastly, Wilkes et al. (2010) created a 17-item violence assessment questionnaire that included cues and behaviors of patients who are becoming violent. While the focus of this benchmark project is to create educational modules, parts from this violence assessment questionnaire will be included in the educational modules as a way to educate the staff on cues that a patient might become violent. The synthesized evidence revealed that workplace violence interventions decrease the total number of workplace violence incidents.

### **Project Stakeholders**

The project team will be comprised of key stakeholders, including the ED management team, the director and associate directors of the ED, the VP of the ED, and the ED nurse educators. In addition to the described roles, several interprofessional roles will also need to be represented, including the ED physicians and the hospital’s police department. The physicians will need to be on the same page as the nurses and management team regarding the process of how to deal with violent patients. The educational program could eventually extend to the physicians. The police department will also need to be included on the decision-making to determine their safety role in workplace violence incidents. A collaborative force is necessary to

ensure the safety of the employees and patients. All of these interprofessional roles will be allies as they all strive to keep the ED staff safe. The director and VP of the ED, in collaboration with the management team, will provide ultimate approval for the project. The IT team will also be needed to assist in uploading the educational modules into Parkland Pathways, the main software that Parkland uses for virtual trainings and modules.

Most importantly, the frontline nurses will be the ones directly dealing with the patients for the longest duration of time. The frontline nurses will be the ones completing the educational modules over workplace violence. These frontline nurses will be valuable assets to the team, as most are determined to raise awareness about workplace violence and to decrease the number of incident reports related to workplace violence. A key way to include employees at Parkland would be to include the unit-based committee in this project. This committee serves as the employees' voice and the committee meets every other week; therefore, time is already allotted for these designated employees on this committee to collaborate innovatively with this project (Cianelli et al., 2016, p. 20). Including the frontline nurses in the process will hopefully empower them to whole-heartedly complete the educational modules and play a major role in this project.

### **Implementation Plan**

The initial plan was to implement workplace violence interventions, emphasizing on education, in the emergency department at Parkland Hospital in Dallas, Texas. This plan has been converted to a benchmark project due to the current pandemic and Covid-19 restrictions. However, this plan will be outlined as if the project was going to be implemented in real time.

### **Perception Survey**

Prior to implementing the educational modules, it is important to assess a nurse's perception of safety. Staff will be emailed a Survey Monkey, which will contain a survey regarding a nurse's perception of safety, stress, anxiety, and productivity in relation to workplace violence. Staff will have one week to complete this perception survey. These results will be shared with the ED management team in hopes that these results will inspire them to sustain this project in the future. The following questions are individualized to assess each participant's perception of safety and knowledge of workplace violence:

1. On a scale of 1-5, with 5 being the safest, how safe do you feel taking care of potentially violent patients?
2. On a scale of 1-5, with 5 being the most comfortable, how comfortable are you with the process to follow if a workplace violence incident occurs in your clinical area?
3. Have you ever been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence)? Yes or No. Please explain.
4. Have you ever had to take off of work after being involved in a workplace violence incident? Yes or No. Please explain.
5. If you have been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence), how do you feel your productivity was returning to work? Please explain.
6. If you have ever been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence), did you feel stressed or nervous encountering potentially violent patient after that event? Yes or No. Please explain.

7. If you have ever been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence), did you feel that you were properly educated or prepared prior to that event on how to act or respond to the patient or family member? Yes or No. Please explain.
8. If you have ever been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence), what do you wish you would've known prior to that event? Please explain.
9. If you have ever been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence), would you have handled that particular situation any differently? Yes or No. Please explain.
10. If you have ever been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence), did you complete a Safety Post? Yes or No. Please explain.
11. If you have ever been involved in a workplace violence incident (including verbal, physical, or inappropriate/sexual violence), did you file a police report? Yes or No. Please explain.

### **Pre-Test**

The second step of the implementation phase will be the pre-test. The participants will be emailed a Survey Monkey that includes the pre-test. The staff will have two weeks to complete this. The participants will complete the pre-test on workplace violence prior to completing the educational modules. The participants will also complete a post-test after completing the educational modules. The same questions will be used for both tests and the correct answers will not be revealed to the participants after completion of the pretest (Gillespie et al., 2014, p. 469).

The following sample questions should be included in both the pre-and post-tests with correct answers highlighted in yellow:

1. What is the ED worker's first priority when dealing with an escalating patient?
  - a. Resolve the situation as quickly as possible.
  - b. Remove the patient from the ED.
  - c. Increase your distance from the patient. (Correct answer)
  - d. Immediately call the police department.
2. What should the ED worker say or do when a patient shows signs of increasing escalation (i.e. derogatory name calling, cursing, etc) and additional help is needed from the coworkers standing nearby?
  - a. Use a firm voice and say, "Call the police department!"
  - b. Look at the patient and say, "You will not talk to me like that."
  - c. Document the event in the medical record.
  - d. Use a hand gesture to indicate help is needed. (Correct answer)
3. The doctor informed the mother of a 2-year-old critically ill patient that test results indicate the patient may have cancer. The mother becomes verbally and physically violent. After the violence stops, what intervention should be performed first?
  - a. Evict the mother from the ED.
  - b. Tell your coworkers about the violent event. (Correct answer)
  - c. Complete an incident/safety event report.
  - d. Expedite the patient's admission to the pediatric ICU.

*Questions 1-3 were formulated from Gillespie et al., 2014, p. 470.*

4. According to the Parkland policy on workplace violence, all of the following are true except:

- a. Staff member needs to avoid escalating a patient.
- b. Staff member needs to use the least amount of force necessary to restrain the patient/visitor or to stop the violence.
- c. Staff member needs to withdraw from the violent situation.
- d. Staff member needs to fight back and show the patient who is boss.

(Correct answer)

5. True or false: Every staff member has the obligation to immediately report the violent threat or situation to their supervisor and the Parkland police department, even if no injuries occurred. True (correct answer)

6. An employee who has experienced physical workplace violence has the option to take up to \_\_\_ days off.

- a. 1
- b. 5 (Correct answer)
- c. 7
- d. 10

*Questions 4-6 were formulated from Parkland policy SYS.HR.009 Workplace Violence (Parkland Health & Hospital System, 2019).*

7. All of the following are predictive cues that a patient might become violent except:

- a. Threat of harm
- b. Name calling

- c. Clenched fists
- d. Not looking at a staff member when they're talking (Correct answer)
- e. Tense posture
- f. Resisting medical care
- g. Increase in volume (speech)
- h. Confusion and disorientation

*Question 7 was formulated from Wilkes et al., 2010, p. 77.*

8. What type of abuse tends to be the most frequently encountered in health care?

- a. Verbal abuse (Correct answer)
- b. Physical abuse
- c. Sexual abuse
- d. None of the above

*Question 8 was formulated from Edwards et al., 2014, p. 656.*

Include additional questions such as the definition of aggressive behaviors and violence as well as nonverbal and verbal skills for anger management (Kalbali et al., 2018). Note: can create other questions as needed based on educational module content.

### **Educational Module Content**

The third step of the implementation phase will be the completion of the educational modules. These educational modules will be uploaded into every participant's Parkland Pathways (with the assistance of the IT team) and the participants will have three weeks to complete these modules. The software will allow the staff to pause the modules and complete at a later time if needed. Reminder emails will be periodically sent to staff. The management team

will also be instructed to remind the staff to complete the modules during the daily/nightly shift huddles.

The following teaching points should be included in the educational modules:

- Module 1- includes topics covering workplace violence prevention including effective communication with patients and visitors, risk assessment, and environmental safety (Gillespie et al., 2014, p. 469).
  - Include predictive cues that a patient might become violent (Wilkes et al., 2010, p. 77) as well as risk factors that could lead to a patient becoming violent (Ming et al., 2019, p. 7) and (Raveel & Schoenmakers, 2019, p. 17).
  - Include topics such as basic definitions of violence and aggressive behaviors, verbal/nonverbal skills to manage anger, communication tips, and appropriate vs. non-appropriate behaviors on how to manage anger (Kalbali et al., 2018, p. 91).
  - Include tips on how to predict/prevent workplace violence (Ming et al., 2019, p. 3).
  - Include breakaway skills for physical violence and communication skills for verbal abuse (Ming et al., 2019, p. 3).
- Module 2- focuses on a coordinated team approach to safely manage workplace violence (Gillespie et al., 2014, p. 469).
  - Include education on how to incorporate a team approach, including other nursing staff, leadership, and Parkland police department.



- Module 3- includes topics covering post-incident response including the care for the injured/victimized worker (Gillespie et al., 2014, p. 469).
  - Review current Parkland policy regarding workplace violence and how to complete an incident report (Parkland Health & Hospital System, 2019)
  - Include coping mechanisms (Ming et al., 2019, p. 3) and (Jeong & Lee, 2020).

### **Post-Test**

The fourth step of the implementation phase will be the completion of the post-test after completing the educational modules. The participants will be emailed a Survey Monkey that includes the post-test. The staff will have two weeks to complete the post-test. The same questions will be used in the post-test as the pre-test. In addition to the post-test, the participants will be sent a follow-up evaluation of the educational modules, which will be further discussed in the evaluation section of this paper. This follow-up evaluation will be sent in a separate email, but on the same day as the post-test.

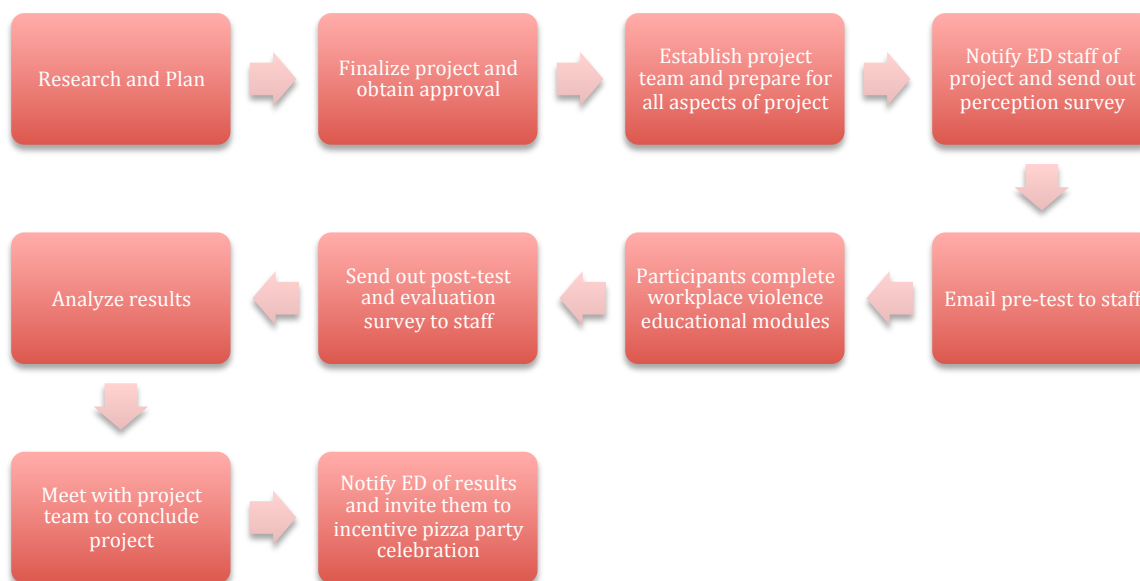
### **Project Timetable/Flowchart**

The initial steps of this project were completed in previous courses over the past semesters, specifically during Translational Science I taken Spring 2019, Translational Science II taken Fall 2019, and Organizational and Systems Leadership taking Spring 2020. The following is a projected timeline, however, this is a benchmark project due to Covid-19 restrictions.

<b>Major Project Steps</b>	<b>Projected Timeline*</b>
Research and plan	Previous Semesters (January 2019)- Current
Finalize project and obtain approval from director	Prior to start of Spring 2021 semester
Establish project team and meet with team to discuss project timeline, goals, participants (establish inclusion/exclusion criteria),	Week of January 11, 2021

implementation, and evaluation of project	
Notify ED staff of project- discuss at day shift and night shift team huddles every day of this week; send out perception survey and allow one week to complete	February 1, 2021
Email pre-test to staff: allow two weeks to complete	February 8, 2021
Upload education into Parkland modules- allow three weeks to complete and implement into their practice	February 22, 2021
Remind and encourage staff to complete modules	Weeks of March 1 to March 8, 2021
Email post-test and evaluation survey to staff: allow two weeks to complete	March 22, 2021
Meet with project team to analyze pre and post test results	Week of April 5, 2021
Meet with project team for final thoughts and conclude project- refine nursing process and practice; thank project team, celebrate success	Week of April 12, 2021
Notify ED of pre- and post-test results; thank them for their participation and invite them to an incentive pizza party celebration	Week of April 19, 2021

\*Timeline unable to be followed in this semester due to Covid-19.



This proposed project plan is provided as an outline for implementing workplace violence interventions at Parkland Hospital to help decrease workplace violence incidents. While this

project cannot be implemented this semester due to Covid-19, the goal would be that this project could be delivered to the Parkland ED management team to implement in the future at some point.

### **Data Collection Methods & Planned Evaluation**

The aim of this project is to reduce the number of workplace violence incidents in the Emergency Department. The evaluation plan of an evidence-based project is essential in order to analyze the impact of the implemented practice (Brewer & Alexandrov, 2015). An evaluation plan should be viewed as an influential tool to measure the impact of evidence-based change (Brewer & Alexandrov, 2015). The main question to guide the evaluation plan for this project is: Did the implementation of workplace violence interventions reduce the number of workplace violence incidents?

The pre-test and post-test results will serve as the outcome measurements needed to determine if this project was successful. The mean scores of the pre-test and post-test results will serve as the main outcome measurement. A *t*-test will be used to compare the mean pre-test score to the mean post-test score. However, prior to doing so, it would be important to confirm that the data is normally distributed (“The t tests,” n.d.). If the data is somehow not distributed normally, a nonparametric test, such as the Wilcoxon Rank Sum Test, can be used (Polit & Beck, 2017, p. 748). The outcome of implementing workplace violence educational modules will be considered worth continuing if the mean score of the post-test is higher than the pre-test and if the *t*-test discovers a statistically significant difference between the pre-test and post-test results. The hope is that the participants would retain the information learned during the educational modules and implement this into their nursing practice.

In addition to the post-test, a short evaluation survey created through Survey Monkey will also be emailed to the staff to acquire feedback from the participants (see Appendix A). This follow-up evaluation will be sent in a separate email, but on the same day as the post-test. The staff will have two weeks to submit this evaluation. This evaluation survey will serve as a guide for the management team to adjust the program as needed. Some of the perception survey questions will be scaled using the Likert scale to measure items, such as median, and determine trends in the scores. Likert scales are commonly used to assess feedback and assessment after educational interventions are implemented (Sullivan & Artino, 2013).

The inclusion criteria for this project consist of any emergency department nurse that completes all of the following within the designated timeframe: pre-test, educational modules, and post-test. The participation in this project will be highly encouraged, but not required; therefore, the project participants will be considered a convenience sample. Descriptive statistics will be used to summarize the participant demographic data using percentages, means, and standard deviations.

It is also important to track attrition of the participants. Attrition bias accounts for participants lost during a study and is important to consider as this can influence the final outcomes (Nunan et al., 2018). In this case, some staff might drop out due to forgetting to complete a certain part of the project or simply they ran out of time or were not interested. It will be important to send reminder emails to the staff and remind them during shift huddle to complete each aspect of the project by the determined due date. Cronbach's alpha can be used to assess the internal consistency and validity of a scale or test (Tavakol & Dennick, 2011). It's essential to evaluate the reliability and validity of a measurement tool (Tavakol & Dennick,

2011). The perception survey and evaluation survey will also include a few questions that will allow participants to provide a narrative response.

If this were an implementation project, other data would need to be collected, such as the number of workplace violence incident reports submitted before and after the implementation of this project. This data would be obtained from the IT team and the director of the ED. The comparison of the number of incident reports before and after the implementation of this project would supplement the evaluation portion of the project.

After the post-test results are collected and analyzed, the results will be shared with the project team. The project team would ideally determine how the change project could be adjusted to maximize benefits. The project team will continue to collaborate with the key stakeholders in order to sustain this project in the future. These evaluation results would hopefully illuminate how the change project impacted the ED. Optimistically, the project can be implemented in its entirety sometime in the future.

### **Cost/Benefit Discussion**

There should not be many costs associated with bringing this change to the emergency department, as the majority of the needed resources are electronic and already available to Parkland. There would be no additional cost for using Survey Monkey and emailing staff members. There would be no additional cost for uploading the educational modules into Parkland Pathways. All of the identified stakeholders are employed by Parkland and will not be an additional cost for this project. Project team meetings will be coordinated to be held during times that all of the stakeholders are able to meet while on shift. All of the project team documents could be uploaded into SharePoint to minimize the use of paper. The only anticipated cost at this point would be an incentive pizza party to thank the staff and project team for

participating. There are roughly 80 staff members staffed per shift, but every staff member who completes the pre-test, educational modules, and post-test would be invited as well as the entire project team. To be safe, 30 large pizzas would be ordered to feed around 100 staff members. On average, a large pizza costs around \$8, therefore, the allotted cost for 30 large pizzas would be \$270 (\$240 before tax and any additional fees). This incentive would hopefully encourage the staff members to participate in this project.

The cost to implement these workplace violence educational modules is low, but the potential benefits are high. It would be important to remind the stakeholders that the current Parkland policy regarding workplace violence states that employees who have experienced a physical workplace violence event have the option to take up to five days off of work, with the first three days being paid as workplace violence, therefore, not using any of the employee's PTO (Parkland Health & Hospital System, 2019). Ideally, the stakeholders would realize that decreasing the amount of workplace violence events would save the hospital money. Hopefully, that alone would motivate them to approve this project.

### **Overall Discussion/Potential Results**

Implementing a new project during an already stressful time would not get the best results. Therefore, this project has been converted to a benchmark project to avoid adding more stress of learning something new amongst the stresses and burnout associated with the pandemic. This benchmark project will ideally be implemented when the impact of Covid-19 on the emergency department has lessened.

The hope is that the project participants would retain the information learned during the educational modules and that the post-test mean score would be higher than the pre-test mean score. While the goal is to get the best results the first time, it might take a few approaches and

tweaking of the original plan in order to find the best solution. It is important for this project team to think “proactively instead of reactively” (Cianelli et al., 2016, p. 6). Innovative leaders should “consider changes before adverse events require them” (Cianelli et al., 2016, p. 6).

Anticipated barriers include time, poor attitudes, lack of staff involvement, and economic restrictions (Hockenberry et al., 2015, p. 206). Often times, people do not respond well to change. However, engaging staff in some of the decision-making could help minimize some of these barriers (Hockenberry et al., 2015, p. 203). Any innovative effort should begin with employee feedback and the most valuable asset to an innovative movement is the employees (Cianelli et al., 2016, p. 13-14). It’ll be important to include the employees in every step of this project, from the planning to the implementation to the evaluation. The frontline nurses will be the ones performing the actual steps of this project so it is crucial to have them engaged in every step. While it’s important to have buy-in from the key stakeholders, it is just as important for leaders to identify employees “who will be key players in the organization’s innovation efforts” as well as employee’s who are naturally creative and able to help problem-solve (Cianelli et al., 2016, p. 17-18). While this project was not able to implemented at this time, it’s important to consider factors that could support or hinder the projected success.

### **Recommendations**

It is recommended that this project be implemented whenever Covid-19 restrictions are lifted. The ED management team could also consider implementing case studies and simulation aspects in the future to make this initiative more of a hybrid program. A study by Ming et al. (2019) revealed that simulation education within a workplace violence education program “significantly improved the workplace violence perception and confidence among nursing staffs in coping with aggression events.” Another study by Bordignon and Monteiro (2019) agreed

that simulation training could be a helpful resource to guide medical professionals to deal with certain situations of workplace violence.

It is also recommended to include the frontline staff and management team throughout the entire process of the project. If the staff members feel like their voice matters, they will be more likely to stay engaged throughout the implementation of the project as well as in the future. Another way to ensure this project is sustained is by encouraging the management team to add these workplace violence educational modules to the new-employee orientation modules as well as create annual “reminder” modules for the already-established staff members. The management team can adjust the modules to best fit the department needs at any given time. One way they can do this is by keeping track of workplace violence events to see if there’s anything that should be modified within the modules. The management team could also offer this project to nurses as their promotion project to promote from the role of RNI to RNII. In addition to the educational modules that the staff will be completing, those interested in participating could also go around to staff members and teach them certain points and have them sign a binder for participation. Peers tend to learn well from each other.

The goal is that this project would be sustainable when it can actually be implemented. Sustainability “begins with the early adoption of a program and continues after implementation” (Breen, 2015, p. 4). It is important to recognize what revisions might be needed in order to maximize the outcome of this project. This project can be sustainable while still being adjusted to fit the current needs of the department.

### **Conclusion**

The research gathered in this project illustrates how workplace violence in the ED is detrimental to the well being of ED nurses. With the added stresses of Covid-19 and the PTSD



that some nurses are experiencing from this pandemic, it'll be more important than ever to focus on decreasing workplace violence incidents. Optimistically, the implementation of these educational modules would lead to decreased workplace violence incidents in the ED. In conclusion, the synthesized evidence supports the implementation of workplace violence interventions in order to decrease the number of workplace incidents.

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### Appendix A: Evaluation Survey

Please Share Your Feedback					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The perception survey was easy to access and complete.					
The pre-test was easy to access and complete.					
The post-test was easy to access and complete.					
The educational modules were easy to access and complete.					
After the completion of the educational modules, I feel more confident in dealing with a potentially violent patient.					
The length of the educational modules was adequate for the learning material.					
The overall program was satisfactory.					
Your ideas to improve the educational modules:					

## Appendix B: Evidence Evaluation Table

**PICOT Question:** In emergency department nurses (P), how does the implementation of workplace violence interventions (I) compared with current practices (C) reduce the number of workplace violence incidents (O) in a 3-month period (T)?

**PICOT Question Type** (Circle): **Intervention** Etiology Diagnosis or Diagnostic Test  
Prognosis/Prediction Meaning

### Caveats

- 1) The **only studies** you should put in these tables are the ones that **you know answer your question** after you have done rapid critical appraisal (i.e., the keeper studies)
- 2) Include APA reference
- 3) Use abbreviations & create **a legend** for readers & yourself
- 4) Keep your descriptions brief – there should be **NO complete sentences**
- 5) This evaluation is for the purpose of knowing your studies to synthesize.

Place your APA Reference here (Use correct APA reference format including the hanging indentation):

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Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
Author, Year, Title	Theoretical basis for study Qualitative Tradition		Number, Characteristics, Attrition rate & why?	Independent variables (e.g., IV1 = IV2 =)  Dependent variables (e.g., DV = ) Do not need to put IV & DV in Legend	What scales were used to measure the outcome variables (e.g., name of scale, author, reliability info [e.g., Cronbach alphas])	What stats were used to answer the clinical question (i.e., all stats do not need to be put into the table)	Statistical findings or qualitative findings (i.e., for every statistical test you have in the data analysis column, you should have a finding)	<ul style="list-style-type: none"> <li>Strengths and limitations of the study</li> <li>Risk or harm if study intervention or findings implemented</li> <li>Feasibility of use in your practice</li> <li>Remember: level of evidence (See PICOT handout) + quality of evidence = strength of evidence &amp; confidence to act</li> <li>Use the USPSTF grading schema <a href="http://www.ahr">http://www.ahr</a></li> </ul>

								<a href="http://q.gov/clinic/3rduspstf/ratings.htm">q.gov/clinic/3rduspstf/ratings.htm</a>
Raveel & Schoenmakers, (2019). Interventions to prevent aggression against doctors: A systematic review.	No identified theory.	SR	<p>Databases searched: Pubmed, Embase, TRIP, Cochrane &amp; Psycharticle</p> <p>Search terms: aggression, violence, physician, doctor, workplace, prevent*, strategy*, intervent*, general practitioner, health care</p> <p>Abstracts published in English January 2000- April 2019</p> <p>Qual And Quant studies; SR</p> <p>44 studies included (15 quant, 15 qual, 7 SR, and 7 reviews)</p>	<p>IV: interventions to prevent aggression</p> <p>DV: decreased risk of WV</p>	Various used throughout the studies included in SR	Thematic analysis	Themes included studies reporting on interventions, pre-event preventive measures, violence prevention programs, risk assessment and risk control measures, interventions during the event, and post-incident measures	<p>Strengths: moderate evidence that a violence prevention program can decrease risk of WV</p> <p>Limitations: possible bias across studies d/t studies were mainly in English</p> <p>No risk/harm identified; no competing interest</p> <p>Very feasible as WV is high in the ED setting</p> <p>Level V evidence; moderate certainty</p> <p>QOE: good</p> <p>USPSTF: Grade B</p>
Bordignon & Monteiro, (2019). Use of simulation in training on violence in nursing practice.	No identified theory.	IR	<p>Search terms: “simulation technology,” “patient simulation,” “simulated patients,” “simulation training,” “high fidelity simulation training,”</p>	<p>IV: completion of simulation activities</p> <p>DV: better understanding of WV</p>	Various used throughout the studies included in integrative review	Thematic analysis	Themes included violence and simulation	<p>Strengths: showed that simulation effective in training to manage WV</p> <p>Limitations: review didn’t include every study on simulation; diversity of</p>



			<p>“workplace violence,” “lateral violence,” “horizontal violence,” “physical violence,” “physical abuse,” “verbal abuse,” “sexual harassment,” “bullying,” and “mobbing” Searched in CINAHL, MEDLINE, &amp; ProQuest Central databases on 03/07/18</p> <p>9 final studies included</p>					<p>proposals throughout studies No risk/harm identified; no competing interest</p> <p>Very feasible as WV is high in the ED setting</p> <p>Level V evidence; moderate certainty</p> <p>QOE: fair</p> <p>USPSTF: Grade C</p>
<p>Jeong &amp; Lee, (2020). The development and effectiveness of a clinical training violence prevention program for nursing students.</p>	<p>Kim’s Conceptual Framework</p>	<p>Quasi</p>	<p>N=22 in experimental group N=23 in control group Total N=45</p> <p>Senior nursing students @ K University in North Gyeongsang Province in South Korea; must have completed &gt;1 yr of clinical training and have experienced &gt;1 account of violence at their clinical center</p> <p>All females in their early 20s</p>	<p>IV: completion of WV prevention program</p> <p>DV: improved ability to cope with violence</p>	<p>The Counseling Self-Estimate (COSE) Inventory</p> <p>Self-Confidence in Coping with Patients’ Assault Scale</p> <p>SPSS/WIN 25.0</p>	<p>Mean</p> <p>Alpha (a)</p> <p>Cronbach’s alpha</p> <p>Chi-square</p> <p>Fisher’s exact test</p> <p>Repeated measures ANOVA</p>	<p>Mean age experimental group- 22.4 y/o; mean age control group- 24 y/o</p> <p>0.05</p> <p>0.76 in COSE Inventory; 0.74 in Coping with Patients’ Assault Scale</p> <p>See table 2 on p. 8</p> <p>See table 2 on p. 8</p> <p>See table 6 on p. 10</p>	<p>Strengths: this study revealed that the implemented violence prevention program seemed to be effective; had a control group</p> <p>Limitations: students unable to see the long-term effects of this study No risk/harm identified; no competing interest</p> <p>Very feasible as WV is high in the ED setting</p> <p>Level III evidence; moderate certainty</p> <p>QOE: good</p> <p>USPSTF: Grade</p>

						Mann-Whitney U-test	See table 2 on p. 8	B
						P-value	See table 2 on p. 8, table 3 on p. 9, and table 4 on p. 9	
						Kolmogorov-Smirnov test	See table 3 on p. 9	
						Bonferroni's method	See figures 3, 4, & 5 on p. 11	
Ming et al., (2019). Using simulation training to promote nurses' effective handling of workplace violence: A quasi-experimental study.	No identified theory.	Quasi	66 participants enrolled via convenience sampling in 3,000 bed medical center in Taipei, Taiwan (these participants were nursing staff who worked in emergency departments and med-surg wards)  Attrition rate not applicable.	IV: completion of simulation training  DV: nurses' perception and confidence against WV	SPSS for Windows V23.0  Cronbach's alpha  Perception of Aggression Scale	Pearson's <i>r</i>  Cronbach's alpha  Mean  SD  GEE	R=0.69 and 0.67 (questionnaire reliability)  0.92- to measure the reliability of the scale  Age and seniority  Age and seniority  Used to compare the pre- and post-test results	Strengths: results revealed that the intervention was significant Limitations: single-group No risk/harm identified; no competing interest  Very feasible as WV is high in the ED setting  Level III evidence; moderate certainty  QOE: good  USPSTF: Grade B
Kalbali et al., (2018). Impact of anger management training in controlling perceived violence and aggression of nurses in emergency	No identified theory.	Quant  Quasi	N= 112 ED nurses of educational healthcare centers in Gorgan, Iran  Control group= 56  Test group= 56 Attrition rate not	IV: completion of anger management training  DV: perceived violence and aggression of nurses in the ED	SPSS software (version 16-SPSS 16.0 Student Version for Windows Inc. SPSS©2009)	Cronbach's alpha  Paired t-test  Wilcoxon test	Reliability determined as 0.78, 0.76, 0.87, 0.80  See table 1 on p. 92  See table 3 on p. 93	Strengths: <i>P</i> = 0.05 was considered statistically significant. Limitations: subject selection from ED only; lacked using more valid clinical assessment

departments.			applicable.			<p>Mann-Whitney test</p> <p>P-value</p> <p>Mean &amp; SD</p> <p>Chi-square test</p> <p>Fisher's exact test</p>	<p>Used in SPSS software to analyze the data</p> <p>Set @ P&lt;0.05; P=0.007 in test group (significant difference), P=0.91 in control group (no change)</p> <p>“3.25± 3.02 and 28.58± 4.16, respectively, which indicated a lack of homogeneity between the study groups”</p> <p>See table 1 on p. 92</p> <p>See table 1 on p. 92</p>	<p>methods</p> <p>No risk/harm identified; no competing interest</p> <p>Very feasible as WV is high in the ED setting</p> <p>Level III evidence; moderate certainty</p> <p>QOE: good</p> <p>USPSTF: Grade B</p>
Rodrigues Pereira et al., (2019). Institutional strategies to prevent violence in nursing work: An integrative review.	No identified theory.	Integrative review	<p>Nurses were participants of all studies</p> <p>Selection of articles was conducted through LILACS, PubMed Central, Scopus, CINAHL, and WoS</p> <p>Initial sample was 252</p> <p>221 articles were excluded d/t</p>	<p>IV: measures to prevent nursing WV</p> <p>DV: prevention of nursing WV</p>	See charts 1 & 2 for the different scales used to measure each study	Thematic analysis	<p>Canada has the lowest levels of WV; verbal violence is the most common</p>	<p>Strengths: this study included exploring WV in the primary care setting</p> <p>Limitations: this study may have excluded some research that was in different languages outside the inclusion criteria</p> <p>No risk/harm identified; no competing interest</p>

			<p>failure to meet inclusion criteria; 16 articles were excluded as repeats.</p> <p>Final sample N= 14 articles</p> <p>Attrition rate not applicable</p>					<p>Very feasible as WV is high in the ED setting</p> <p>Level V evidence; moderate certainty</p> <p>QOE: good</p> <p>USPSTF: Grade B</p>
Casey, (2019). Management of aggressive patients: Results of an educational program for nurses in non-psychiatric settings.	Knowles' Adult Learning Theory	Descriptive/quant	<p>36 RNs and 5 LPNs work full time on the designated neuro unit</p> <p>N=23 (20 RNs + 3 LVNs)</p> <p>Attrition rate not applicable</p>	<p>IV: completion of educational program</p> <p>DV: change in confidence and attitudes of nurses towards workplace aggression</p>	<i>The Incidence of and Attitudes Toward Aggression in the Workplace</i> was used; this included a questionnaire and course evaluation	Means	See tables 1, 2, & 3 for pre and post test score means	<p>Strengths: overall increase in posttest scores</p> <p>Limitations: small sample; short amount of time provided for learning</p> <p>No risk/harm identified; no competing interest</p> <p>Very feasible as WV is high in the ED setting</p> <p>Level VI evidence; moderate certainty</p> <p>QOE: good</p> <p>USPSTF: Grade C</p>
Burchill et al., (2018). Psychometric testing of the personal workplace safety instrument for emergency nurses.	<p><u>Conceptual Framework</u></p> <p>Countermeasures (security, training, unit design)</p> <p>Pt-nurse interaction</p> <p>Hospital/judicial support</p>	<p>Quant</p> <p>Descriptive</p>	<p>N= 305 total ED RNs from 16 diff. hospitals</p> <p>N= 210 RNs from Magnet hospitals</p> <p>N= 95 RNs from non-Magnet hospitals</p> <p>Attrition rate not applicable</p>	<p>DV: ED RNs' perception of safety from WV</p> <p>IV: predictors of safety from workplace violence (PWSI-EN total score)</p>	<p>Cronbach alpha for the 23-item PWSI-EN: .912</p> <p>Subscale-to-total correlations</p> <p>Known-groups approach- used to examine instrument's ability to</p>	EFA	<p>63%- suggests the survey is valid</p> <p>.88 (exceeded the recommended threshold for acceptability)</p>	<p>Strengths: cronbach alpha of .912; EFA of 63% suggests the 23-item instrument is valid</p> <p>Limitations: sample only including RNs from hospitals in suburban or urban EDs</p>

	(reporting and f/u support)				<p>detect significant differences</p> <p>5-point Likert scale (strongly disagree to strongly agree)</p>	<p>Bartlett test of sphericity</p> <p>Pearson's correlation</p> <p>Exploratory varimax factor analysis</p> <p>Linear multiple regression model</p> <p>Bivariate statistics</p>	<p>Showed sufficient correlation</p> <p>2 items were low and not significant w/ <math>r=.09</math>, <math>p=.14</math> and <math>r=-.10</math>, <math>p=.068</math> (values on table S3)</p> <p>5 items didn't load w/ acceptable factor loadings (<math>&gt;.30</math>) on factors w/ Eigen values <math>&gt;1</math></p> <p>Used to examine PWSI-EN total score</p> <p>Between variables of the demographic survey and PWSI-EN total scores (variables associated w/ better perceptions of safety from PVV: practicing in a community hospital, greater confidence in one's</p>	<p>No risk/harm identified; no competing interest</p> <p>Very feasible as WV is high in the ED setting</p> <p>Level IV &amp; VI evidence; moderate certainty</p> <p>QOE: good</p> <p>USPSTF: Grade B</p>
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							<p>organization to maintain a safe work place, and more strongly disagreeing w/ “I am sometimes scaref for the safety of my patients”)</p> <p>Used to compare ordinal age and continuous experience measures (key predictors: years of EN experience, years of overall nursing experience, hospital type, and Magnet status of hospital)</p>	
Edwards et al., (2014). Nursing and aggression in the workplace: A systematic review.	No identified theory.	SR	<p>Any nurse who experienced anxiety r/t WV</p> <p>Databases searched: MEDLINE n=663 CINAHL n=463 PsycINFO n=417</p> <p>Total screened n=1542</p> <p>Excluded n=1406</p> <p>Assessed for eligibility n=137</p>	<p>IV: aggression in the workplace for nurses</p> <p>DV: occupational anxiety</p>	Critical Appraisal Skills Programme (CASP) research checklist	<p>Crosstabulation</p> <p>Thematic analysis</p>	<p>See table 1 on p. 656 of article</p> <p>Younger and less experienced nurses @ greater risk of violence</p> <p>Male nurses more likely to encounter physical WV</p> <p>Night</p>	<p>Strengths: the findings that were synthesized were not available prior to this study; identifies types of aggression encountered</p> <p>Limitations: only English publications used; no trial studies; small sample sizes; possible bias d/t self-report</p> <p>No risk/harm</p>

			(excluded n=53)  Studies in review n=84  Attrition rate not applicable				shift/weekend shift nurse @ greater risk of WV  Verbal abuse most common  Poor reporting of WV incidents	identified; no competing interest  Very feasible as WV is high in the ED setting.  Level V evidence; moderate certainty  QOE: fair  USPSTF: Grade C
Wilkes et al., (2010). Development of a violence tool in the emergency hospital setting.	No identified theory.	Quant/ Descriptive.  Delphi design: expert panel	Purposive sample- 23 experts (15 academics, 8 clinicians)  11 experts for rounds 1 and 2; 6 experts for round 3  Attrition rate: from sample to round 1: 47.8%; round 2 100%; round 3 54.5%	IV: none identified.  DV: none identified.	SPSS statistical software: used in round 1 of Delphi to analyze the results  Likert scale: used in rounds 2 and 3 of Delphi to rate the importance of each item (scale of 1 to 5...1 least important and 5 most important)	Mean  Standard deviation	Round 2: 17 cues had mean rating of >2.64 (items measured on scale of 1-5)  Round 3: all 17 cues had mean rating >2.33 (items measured on scale of 1-5)  Used in round 3 of Delphi to assess all of the 17 behavioral cues...see table 3 on p. 79 of the article for all 17 standard deviations of the items	Strengths: the tool created requires no prior knowledge of the patient's medical history; ideal size for expert panel of 11 experts  Limitations: as of 2010, the violence tool from this study still needed to be tested for effectiveness and internal validity  No risk/harm identified; no competing interests  Very feasible as WV is high in the ED setting.  Level VI evidence (descriptive); moderate certainty  QOE: fair  USPSTF: Grade C

<p>Gillespie et al., (2014). A workplace violence educational program: A repeated measures study.</p>	<p>No identified theory.</p>	<p>Quant. Quasi</p>	<p>Participants from EDs in Midwest US</p> <p>Pedi system w/ 2 EDs, comm-based ED, L1 pedi trauma center, L1 A/P ED/trauma center</p> <p>N=120 (F n=104, M n=16, W n=112, RN n=86)</p> <p>Attrition rate: 69.5%- total employees between all of the EDs was 394, 227 of those completed the training program, 143 of those enrolled in the study, 120 completed the study procedures</p>	<p>IV: completion of WV hybrid educational program</p> <p>DV: knowledge retention for employees who completed the program content</p>	<p>Repeated measures ANOVA</p> <p>20 question WV test w/ short demographic questionnaire-items reviewed by expert panel-questions leveled to test participants @ levels within Bloom's taxonomy of educational objectives</p>	<p>Repeated measures ANOVA and Wilk's A statistic</p> <p>Mean</p> <p>SD</p> <p>Alpha 0.05</p>	<p>Wilk's A = .390, <math>F(2, 118) = 26.554</math>, <math>p &lt; .001</math>, <math>n_2 = .310</math></p> <p>Mean test score for T1 58.5%, T2 61.8%, T3 66.8% (scores became higher over time)</p> <p>SD for T1 10.6, T2 10.1, T3 9.3</p> <p>Only a 5% chance that the hypothesis would be rejected</p>	<p>Strengths: achieved power &gt;95%; increase in post-test scores after completion of the hybrid program</p> <p>Limitations: attrition rate 69.5%</p> <p>No risk/harm identified; no competing interests</p> <p>Very feasible as WV is high in the ED setting.</p> <p>Level III Evidence; high certainty</p> <p>QOE: good</p> <p>USPSTF: Grade B</p>
<p>Gates et al., (2011). Violence against nurses and its impact on stress and productivity.</p>	<p>No identified theory.</p>	<p>Quant. CSD</p> <p>Descriptive, observational.</p>	<p>Randomized sample</p> <p>Survey sent to 3,000 nurses-members of ENA</p> <p>264 surveys returned</p> <p>230 surveys fully completed</p> <p>Return rate 8.8%</p> <p>14% M (n=32)</p> <p>86% F (n=198)</p> <p>91% - NHW</p> <p>9% Blacks/ AP islanders/ NA</p>	<p>IV: violence against nurses from patients and visitors</p> <p>DV: impact on nurses' stress and productivity and symptoms of PTSD</p>	<p>Impact of Events Scale-Revised: high IC (0.79-0.91) &amp; strong S/S (74.5/63.1)</p> <p>Healthcare Prod. Survey: IC 0.871-0.945; <math>r = 0.801</math>, <math>p &lt; 0.001</math></p> <p>Demo/occ survey</p>	<p>Descriptive and bivariate stats</p> <p>Mean</p> <p>Alpha level</p>	<p>Calculated using version 17 of the Stat Pkg for SS</p> <p>Mean total prod: -0.05; mean score of group for Impact of Event Scale-Revised: 18.67; Intrusion scale mean: 7.86</p> <p>0.05-powerful</p>	<p>Strengths: achieved power 85%; small response rate but findings still powerful</p> <p>Limitations: CSD; no cause and effect identified; no measurement of perceived severity; no examined relationship among severity/symptoms/productivity; self-reported data; response rate 8%</p> <p>No risk/harm identified; only</p>



			There was no attrition rate because there was no control group and no follow up.			Two-sided statistic	findings- only a 5% chance that the hypothesis would be rejected  Small to medium effect size: 0.20- indirect relationship btwn stress and work productivity	survey, no implementation  Very feasible as WV is high in the ED setting.  Level VI evidence; Moderate certainty  QOE: Fair  USPSTF: Grade C
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**Legend:****AP:** Asian-Pacific**A/P:** adult/pediatric**Comm:** community**CSD:** Cross Sectional Design**Demo/occ:** demographics/occupational**Diff:** different**ED:** Emergency Department**EN:** emergency nurse**ENA:** Emergency Nurses Association**F:** females**F/u:** follow-up**GEE:** Generalized Estimating Equations**IC:** internal consistency**IR:** Integrative review**L1:** level 1**Lit:** literature**M:** males**NA:** Native Americans**NHW:** Non-Hispanic Whites**Pedi:** pediatric**Prod:** productivity**Pt:** patient**PTSD:** Post-Traumatic Stress Disorder**QOE:** Quality of Evidence**Qual:** qualitative**Quant:** quantitative**Quasi:** Quasi-experimental**RN:** registered nurse**SD:** standard deviation**SR:** systematic review**S/S:** sensitivity/specificity**Stats:** statistics**Stat Pkg for SS:** Statistical Package for Social Sciences**T1:** test 1**T2:** test 2**T3:** test 3**W:** white**WV:** workplace violence\*\*\*Prompts for each column – **please do not repeat the headings, just provide the data**

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