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Workplace Violence in Emergency Departments, Education and De-Escalation Training: A Benchmark Study

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Workplace Violence in Emergency Departments, Education and De-Escalation Training:

A Benchmark Study

A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

In the School of Nursing

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by

Summer Block

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Contents

Acknowledgments

I want to take a moment and acknowledge all of those who helped me through graduate school and most importantly helping me through writing this capstone paper. First, I want to thank Jesus Christ. Without the love and peace, I receive from Jesus I would have never had the strength to do this. Next, I would like to thank my husband, Tim Block. He is always my biggest cheerleader; he listens to me when I am feeling overwhelmed or discouraged and reminds me, I can do it. Without his love and support I know I would have never finished this. Next, I would like to thank my mother, Sherri Dague. From a young age I watched my mother dress in her white uniform and head off to work at the hospital with a smile. As I grew up, I watched how her uniform changed, but she never did. She never grew tired of helping people and you never saw frustration in her about her job. She has always been an amazing role model, or Mary Poppins as we call her in my house. She is the strongest woman I know, and I couldn't be prouder to have followed in her footsteps to become a nurse. I am the first of her children to receive a master's degree and I couldn't have done it without her loving words when I call her frustrated or upset. There have been many tearful calls to my mother over the years and she stays calm and loving, offering great advice. Thank you, mom. Finally, I would like to thank Dr. Greer. I had the pleasure of being a student multiple semesters with Dr. Greer as my professor. Although all the instructors have been supportive and amazing to work with, Dr. Greer has stood out to me. She encouraged me when I received new medical diagnoses and was too tired to continue. She showed me grace and was kind, caring and understanding when I struggled with the workload of school. She advised me on this paper, educated me on research and proper writing. Dr. Greer has made a significant impact on my life, and I will never forget the kindness, knowledge and love she showed me.

Executive Summary

Most people do not go to work and fear being assaulted or harassed daily. However, for emergency nurses in this county that is exactly what it has come to. Up to 96% of emergency department nurses state they have been verbally abused. This entails name calling, verbal threats, being shouted at and being sworn at. Anywhere from 25% to 60% of these nurses have had to face physical assaults while on the job. (Al-Aadi, 2020; Copeland & Henry, 2017; Grinberg, 2022; Li et al., 2019; McDermid et al., 2019). Physical assaults can include being spit on, slapped, punched, kicked, choked, objects thrown at them and even knives pulled on them (Grinberg, 2022 & Copeland & Henry, 2017). Per U.S. Bureau of Labor Statistics (2020), healthcare workers make up 73% of non-fatal workplace injuries due to violence. “Data shows American health care workers now suffer more nonfatal injuries from workplace violence than workers in any other profession, including law enforcement” (Boone, 2023). Al-Qadi (2020) stated, “This behavior has become so commonplace that it has become accepted as a standard occupational hazard of working in the ED”.

This country is facing a nursing shortage and emergency nurses are leaving the specialty or nursing all together because of the extreme amount of violence they face daily. Emergency nurses are highly skilled and trained and are an integral part of emergency services to a community. With a high rate of turnover in emergency nurses, we are facing a significant issue with the ability to safely care for emergency patients. Unless interventions are put into place to protect our nurses, things will only worsen and more nurses will be injury either emotionally, mentally, or physically.

It is imperative that hospitals acknowledge this epidemic of violence and work to put a stop to it. This paper will discuss what emergency nurses are facing daily as well as the negative impacts it has on the nurses. It will also discuss the research behind the best intervention which is

verbal de-escalation and self-defense training for all emergency department employees. These skills will help emergency staff de-escalate patients and family and hopefully prevent an assault from every happening. By providing this training to staff, they will be safer, happier in their work, take better care of patients and stay in the specialty thus decreasing the nursing shortage.

Rationale for the Project

Workplace violence (WPV) is present in many industries; however, according to Knull et al. (2019) the healthcare industry has a rate 3.5 times that of others. Within healthcare, emergency department (ED) nurses have the highest rates of verbal abuse, physical assaults, and threats of violence than other nursing units (Al-Qadi, 2020). On average, 25% of ED nurses experience physical assaults and 50% experience verbal abuse and threats (Al-Qadi). Although this number is startling, there is a significant issue with under reporting of these events by nurses (Recsky et al., 2023). Due to this the actual number of violent events seen by these nurses is unknown.

The effects of WPV have obvious risks of physical injuries. According to Grindberg et al. (2022) nurses who have witnessed or endured violence can experience reduced job satisfaction, stress, anxiety and depression, Post Traumatic Stress Disorder (PTSD), lack of self-care, reduced quality care for patients and all these issues can lead to burnout. On average 17.2 % of nurses change jobs every year compared to 19% of ED nurses leaving their job within two years secondary to WPV (Al-Qadi, 2020).

The healthcare industry is already facing a nursing shortage. According to McDermid et al. (2019) the high turnover rate seen in ED's contributes to longer wait times, increases of the overcrowding that is already occurring, low patient satisfaction scores, diversion of ambulances to care further away and decreases the ability of patients to receiving evidence-based care due to lack of trained and skilled nurses. Due to this the PICO question used for this benchmark study is: In emergency nurses (P), how do violent work environments (I) compared to less violent work environments (C) affect rates of burnout. The intervention that has the most success in decreasing WPV in ED's is that of verbal de-escalation and self-defense training.

Literature Synthesis

A literature review was conducted to evaluate the prevalence of workplace violence in emergency departments and how this prevalence has an impact on burnout and turnover. Major databases were searched. These databases included Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane library and PubMed. The date ranges were from 2010 to 2023. In the initial searches, the keywords used were "*nurse*" and "*workplace violence*", both with Boolean search mode. This initial search resulted in 685 articles. The search was narrowed by using keywords "*Emergency Nurse*" and "*workplace violence*" with Boolean search mode. This secondary search resulted in 127 articles. The third and final narrowing of search topics, included keywords of "*emergency nurse*" and "*workplace violence*" and "*burnout*," all with Boolean search mode. This final search resulted in nine articles. After reviewing the articles, three of these articles were selected for this review. The author then went back to the search that presented 127 articles and began to review and select articles that pertained to the topic and PICO question of "In emergency nurses (P), how do violent work environments (I) compared to less violent work environments (C) affect rates of burnout. In conclusion of the literature search, twelve articles were selected for review.

No disagreement was found within the literature regarding workplace violence, specifically against emergency department nurses. However, the rates of physical and verbal abuse varied among authors. The rates of physical abuse towards emergency nurses in the previous 12 months varied from 25% up to 60% and the rate of verbal abuse varied from 50% up to 96% of nurses. Verbal threats were at approximately 70% and sexual harassment was reported at 4% (Al-Aadi, 2020; Copeland & Henry, 2017; Grinberg, 2022; Li et al., 2019; McDermid et al., 2019).

All articles were also in agreement on the variables that lead to workplace violence in the emergency department setting. These included overcrowding of the emergency department, long wait times, delays in care, overworked staff causing a lack of communication with patients and families, high stress levels of patients and their families, high levels of aggression in society today, high levels of substance abuse and mental illness, lack of security and lack of nurse training in verbal de-escalation or self-defense (Al-Aadi, 2020; Copeland & Henry, 2017; Grinberg, 2022; Li et al., 2019; McDermid et al., 2019).

When a nurse is verbally attacked or physically assaulted, it can cause the nurse to be fearful, have anxiety about work, feel nervous and feel demoralized. It can cause significant psychological strain and mental exhaustion (Li et al., 2019). This can also lead to a feeling of powerlessness. Some nurses reported painful memories, intrusive thoughts, sleep disturbances, irritability, anger, loss of concentration, nightmares and even diagnosis of Post Traumatic Stress Disorder (PTSD). The fallout from these feelings among the victims of violence is that they may experience a lack of empathy towards future patients, have decreased job satisfaction and this can eventually turn to burnout. Of nurses who suffered either verbal or physical abuse at work, 82% suffered medium to high levels of burnout (Al-Aadi, 2020; Copeland & Henry, 2017; Grinberg, 2022; Li et al., 2019; McDermid et al., 2019).

Burnout among nurses can not only cause significant emotional, psychological, and physical distress to the nurse, but it can have a negative effect on our healthcare system. With more occurrences of burnout, especially in the emergency department, there is a correlation with intention to leave either the organization, the department or nursing in general. This can then lead to more vacancies in emergency departments which in turn lead to heavier workloads,

increase in poor communication with patients and the cycle circles back to the causes of violence against these nurses (Li et al., 2019).

Although the rates of violence against emergency nurses are astounding, there is still a significant issue with nurses reporting violent attacks. Some nurses state they do not report the incident if "no one was hurt," physically that is. Some have even come to the realization that violence is just a part of their jobs, and they must deal with it. Due to this lack of reporting, the occurrence of violence is much higher, meaning there is an even bigger problem than originally thought. This is not only a problem for emergency nurses and healthcare organizations, but it is a national problem that needs to be addressed. There needs to be a way to decrease the strain on patients and their families as well as nurses working on the floor. This includes training for nurses to identify signs of aggression early and to be able to defend themselves against an attack (Copeland & Henry, 2017; Grinberg, 2022; Li et al., 2019; McDermid et al., 2019).

Project Stakeholders

Stakeholders for this project range from the Chief Executive Officer (CEO) to the housekeeping staff of a hospital. The CEO, Chief Nursing Officer (CNO) and Chief Financial Officer (CFO) are stakeholders that make the final decisions on approval of the intervention as well as the financial cost of training staff. The CNO is ultimately responsible for all nurses in the hospital and will need to have buy in to the project and its outcomes for the CNO to approve anything that involves nursing.

This project will also require the Nursing Director of Emergency Services as well as the Director of Hospital Security. The Directors will be meeting with a team to help facilitate the training and education for staff as well as securing a location to hold the training. Next, the project will require front line staff to be major stakeholders in this project. The project is

ultimately about their safety and their training. It is important that they have a seat at the table to voice concerns or ask questions regarding the plan. Finally, representatives of all other departments. Because violence can be seen anywhere in a hospital, it is important that everyone within the hospital have some sort of training to mitigate violence. This project will not only help protect nurses, but patients, ancillary support staff and others within the hospital.

Implementation Plan

Due to the significant time needed to complete this plan implementation and evaluating effects, a benchmark study is proposed. The focus of this plan is to give in-depth education to emergency department employees on workplace violence, how to react to it, prevent it and how to keep themselves safe from a physical attack. The director of security for St. Luke's The Woodlands Hospital as well as the emergency services director are both certified in verbal de-escalation training as well as self-defense for healthcare workers through the Crisis Prevention Institute (CPI).

Each year every hospital employee is assigned online learning modules regarding workplace violence and violence prevention. Prior to this in person training, all emergency employees have already completed these yearly education modules online. The modules include what constitutes workplace violence, how to recognize it and what to do in given situations. It briefly covers what to do if there is an active shooter in the facility but does not cover much on verbal or physical assaults from active patients or their family members. Due to the lack of significant education regarding crisis management and self-defense in the online learning modules, this program is of the utmost importance. The security director and emergency services director will be facilitating this education and training.

Timetable/Flowchart

Due to the seriousness of this topic along with the significant negative fallout from the violence, there will be a rapid deployment of training to this emergency department. St. Luke's The Woodlands Hospital emergency department currently has 64 employees, 42 of which are registered nurses. The 64 employees will be separated by their manager into six groups of 10-11 employees for training. Each training session will be for a total of eight consecutive hours combining in-person education with role play simulation as well as hands-on self-defense training.

Week one will have an 8-hour session offered on Monday, Wednesday, and Friday. Week two will have an 8-hour session offered on Tuesday, Thursday, and Saturday. Again, the manager of the emergency department will be assigning groups of employees to specific training sessions. The 8-hour training sessions will be held in the education center on property. The first four hours will be an education session facilitated by either the security or emergency services director. They will instruct the employees on reasons why patients and visitors become violent, how to recognize signs of escalation including learning the crisis escalation path. They will be educated on how to recognize which stage of crisis the violent person is in and in turn they will be taught different options on how to properly handle each situation or phase a person may be in. After each section of education, there will be a role play or simulation aspect of training. This will be an interactive feature with all employees participating.

An employee from the group will be selected and given a scenario and instructions on how to act or behave. This may include swearing, yelling, name calling, and other threatening behaviors. It may also have the employee act out violent acts or threats that the other employees try to de-escalate with the skills they have learned. After each scenario simulation, there will be a

five minute debrief to discuss what was done well and to identify where further areas of education are needed. This in-person education and simulation session will last for four of the eight hours. The final four hours will be the hands-on portion of the training.

During the second four hours the director of security will instruct the staff in hands on self-defense techniques from the Crisis Prevention Institute (CPI) training guide. This education is meant to be a last resort and only if there is no other option to keep the patient or others safe from a violent attack in the hospital. Staff will learn how to release themselves and others from such things as hair grabs, choke holds, or arm grabs that can occur. These techniques are meant to be used in a manner that causes zero harm to the attacker.

Every emergency employee will go through this same 8-hour training session upon hire and then every six months (Gillam, 2014). The research suggests the best outcome to decrease workplace violence is if the education is approximately eight hours in length and repeated at least twice a year (Gillespie et al., 2014). The education department will track compliance and participation of all emergency employees to ensure they are well educated and equipped to handle these scary situations.

Data Collection Methods

Data collection for this project will be done through the Integrated Research Information Systems (IRIS) housed in the St. Luke's The Woodlands server. When there is any incident outside of normal operations, staff members are to enter an incident report into the IRIS system. Since staff are entering these incidents, it allows leadership the ability to track and trend specific incidents, such as workplace violence. Reports can be run collecting data on types of incidents, dates, time, and people involved. Data collection includes recording the volume of incident reports totals for a 6-month period. By using these reports, I will be able to compare the volume

of security calls and violent incidents that are occurring within the hospital. I will take the report data from the six months prior to implementation of the plan and then every month for one year following the start of the project.

Evaluation

St. Luke's the Woodlands hospital has been tracking security events in the emergency department since 2019 using their current Integrated Research Information Systems (IRIS). In 2019 the ED alone had 31 security events involving verbal or physical abuse. In 2020, there were 45 documented events of violence. During the heart of COVID season, the ED documented 49 violent events in 2021. Still during COVID in 2022, the ED documented 42 violent events. Finally, in 2023 the ED reported 30 violent events (D. Carni, personal communication, October 12, 2023)

The IRIS system is an incident reporting system that staff, physicians and leaders can use to document any type of situation out of the normal operations of the hospital. The use of this system allows for report building and the ability to track and trend types of incidents, where they occurred and details of events. We will continue to use this reporting system in the evaluation of effectiveness of the in person verbal de-escalation and self-defense training. Each month a report will be run on security events involving violence in the emergency department specifically. During the first two months after training, the incidence of events will increase. Although alarming, this is to be expected due to the history of underreporting. Now that staff are educated about the importance of reporting these events, more incidents will be documented in the system (Gillam, 2014).

The initial report will be run at 30 days post training and again at 60 days post training. In these first reports there will be an increase in violent events reported. The increase in reports will

be 40%-60% of the baseline level of reports (Gillam, 2014). All months following the first 60 days, there will be a marked decrease in violent events being reported in the IRIS system. This decrease will be up to 25-75% less than baseline reporting (Gillam, 2014).

Cost/Benefit Analysis

According to the National Safety Council Injury Facts, in 2021 it costs a facility approximately $43,080 for every injured employee. This price includes lost productivity due to lost workdays as well as medical costs. The cost to send a hospital employee to become a certified trainer in CPI nonviolent crisis intervention with advanced physical skills, is $5,649 per person (Crisis Prevention Institute, n.d.). Training will consist of eight hours per employee in the emergency department. There are currently 57 employees. The cost for education training for staff would be 456 hours per six months or 912 hours per year. The average pay rate for emergency department employees is $40 an hour. Taking the average wage of $40 an hour and multiplying that by 912 hours, gives us an estimated total of $36,480 in total costs to provide eight hours of education to every employee twice a year. Because two of our directors are already certified CPI trainers, we do not have the cost of $5, 649 per person to send leaders to become certified as an instructor. Although the cost per year is $36,489, it is still less than two employees being injured and the cost of that injury to the facility. It is in the facilities best interest to provide this training every six months to staff to mitigate the risk of employee harm and the financial stain each injury puts on the facility.

Discussion of Results

Due to time constraints for this project, it was completed as a benchmark study. According to Gillespie et al., (2014), there was a 50% decrease in violent attacks the year following the proposed training schedule. This significant drop in attacks was only found in the

facilities who had high participation in the 8-hour courses, high engagement from leadership and staff as well recurrent training at a time at least 150 days from the initial training. Based on this observed improvement, and the estimation of highly engaged leadership and high participation, it is safe to estimate a 50% reduction in violent attacks at this facility following training. With the current rate of assaults ranging from 31-49 a year and an estimated 50% reduction in events the first year it will drop the rate to approximately 15-24 attacks per year's vs the 31-49. As training continues and the facility implements zero tolerance policy and increases security present we will expect this rate to drop even further.

Conclusions/Recommendations

With a society that has increases in medical illnesses as well as lack of insurance and the ability to find medical providers; more and more people use emergency rooms every year. This not only increases the risk of violence but of burnout of our healthcare workers themselves. It is a cyclical problem we face. As more healthcare workers leave the profession due to the violence they endure, more patients will have to wait longer for care and in turn increase their stress and likely to assault someone. It is imperative that more research is done on the subject to find other ways to train staff that has an even higher prevalence of decreasing attacks and in turn decreasing turnover of emergency department nurses.

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Appendix A

NURS 5382 Capstone Evidence Table

PICOT Question:
In emergency nurses (P), how do violent work environments (I) compared to less violent work environments (C) affect rates of burnout

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

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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 =)	What scales were used to measure the outcome variables (e.g., name of scale, author,	What stats were used to answer the clinical	Statistical findings or qualitative findings (i.e., for every statistical test you have in the data analysis column, you should have a finding)	• Strengths and limitations of the study • Risk or harm if study intervention or findings implemented. • Feasibility of use in your practice

				Dependent variables (e.g., DV =) Do not need to put IV & DV in Legend	**reliability info [e.g., Cronbach alphas])**	**question (i.e., all stats do not need to be put into the table)**		**• Remember: level of evidence (See PICOT handout) + quality of evidence = strength of evidence & confidence to act • Use the USPSTF grading schema http://www.ahrq.gov/clinic/3rduspstf/ratings.htm**
1. Al-Qadi, M. (2020). Nurses' perspectives of violence in emergency departments: A metasynthesis. *International Emergency Nursing*. https://doi.org/10.1016/j.jenj.2020.100905	Qualitative	Metasynthesis	N=119 Nurses in 6 Studies 272 studies initially identified; Duplicates removed=574 remaining 557 removed for exclusion criteria. 11 removed at full article exclusion Remaining = 6 articles	IV-Emergency Nurses, violence perpetrated against emergency nurse DV-Nurses perception of violence	Noblit and Hare's Meta ethnographic methodology and critical appraisal skills studies	Noblit and Hare's meta ethnographic methodology	63.9% -verbal abuse 11.9% -Physical abuse. 95% of all ED nurses will experience verbal abuse at some point in career. 50% threatened 62% sworn at	Level of evidence=6 Limitations: authors interpretation and exper. Author bias: Different countries Nurses' own perception Net benefit=moderate
2. Copeland, D., & Henry, M. (2017). Workplace violence and perceptions of safety among emergency	Qualitative	Cross-sectional design	N=147 (92 female, 55 males) Sent to 235 emergency	IV-emergency dept. staff, exposure to violence,	chi square test	SPSS v 24 software p<.05	88% had exposure to violence/6 months Verbal most prevalent Exposure to violence not limited to bedside staff	Level of evidence=6 Limitations: small sample size, only one facility, minimal variety in RN experience,

department staff members: Experiences, expectations, tolerance, reporting, and recommendations. *Journal of Trauma Nursing*, *24*(2). https://doi.org/10.1097/JTN.0000000000000269			dept. staff members 52=RN 5=Psych RN, 28=MD/DO, 23=Rad tech, 9=PA, 5=secretary, 4=technician, 5=assessors and clerks	DV-Perceptions of safety			Staff are exposed frequently to violence Staff expect to be exposed to violence Perceive themselves as safe even when exposed to violence Do not often report violence	Net benefit=High
3. Gillespie, G., Gates, D., Kowalenko, T., Bresler, S., & Succop, P. (2014). Implementation of a comprehensive intervention to reduce physical assaults and threats in the emergency department. *Journal of Emergency Nursing*, *40*(6), 586-591.	Qualitative	Quasi-experimental	N=209 220 volunteers 213 met criteria 4 lost to attrition	IV-emergency nurse DV-environmental change, policy change, education, and training	Chi square analysis	N/A	Decrease in assault 0.17-0.13 ($p<.01$) Decrease in threats 0.49-0.37 ($p<.01$) N-179 (86%) threatened, assaulted once in 18mo. 1333 events reported monthly. 346 physical assaults 987 physical threats 832 violent events 252 physical assaults	Level of evidence=3 Limitations-did not allow randomization, participants first come, reporting bias, report fatigue Net benefit=High, B

https://dx.doi.org/10.1016/j.jen.2014.01.003								
4. Grinberg, K., Revach, C., & Lipsman, G. (2022). Violence in hospitals and burnout among nursing staff. *International Emergency Nursing*. https://doi.org/10.1016/j.jenj.2022.101230	Qualitative	Cross-sectional design	150 nurses 75 ER Nurses 75 inpatient nurses	IV- Perception of violence, exhaustion, workload DV-difference in ER vs other nurse and violence	Pearson correlation coefficient test	IBM SPSS Statistics V21.0	**ED RN:** Burnout-4.23 (±0.640) Physical violence 0.53 (±0.464) Verbal Violence 1.713 (±1.046) **Non-ER nurses:** Burnout-3.748 (±0.573) Physical Violence 0.246 (±0.488) Verbal Violence 0.8200 (±0.906)	Level of evidence=6 Limitations-n/a Net benefit=High, B
5.								

Krull, W., Gusenius, T., Germain, D., & Schnepper, L. (2019). Staff perception of interprofessional simulation for verbal de-escalation and restraint application to mitigate violent patient behaviors in the emergency department. *Journal of Emergency Nursing*, *45*(1). https://dx.doi.org/10.1016/j.jen.2018.07.001	Qualitative	Quality Improvement Project	98 ED Staff Provider:9 PCA-17 RN-52 Security- 11 LCSW-5 Coordinator-1	IV- Participation, DV-confidence, knowledge, preparedness	Cronbach α	Bowker's NLN simulation design scales	Knowledge-SD=26 to 6 Skills-SD=29 to 10 Abilities-SD=30 to 12 Confidence-SD 33 to 14 preparedness-SD=38 to 10	Level of evidence=6 Limitations-unequal size of the 4 disciplines in training Net benefit-High, A
6. Li, N., Zhang, L., Xiao, G., Chen, J., & Lu, Q. (2019). The relationship between workplace	Qualitative	Cross-sectional design	415 eligible, 401 returned, 385 questionnaires eligible	IV- WPV, JS, TI 1 DV-Job satisfaction,	Spearman's Pearsons correlation analysis	IBM SPSS 20.0	346 violence last year Verbal aattack-89.9%	Level of evidence=6 Limitations-selection bias, long time span between questionnaires

violence, job satisfaction and turnover intention in emergency nurses. *International Emergency Nursing*, 50-55. https://doi.org.10-1016/j.ienj.2019.02.001				perception of safety			Threats-70.6% physical violence-20.5% Sexual harassment-3.9%	Net benefit-Moderate, C
7. McDermid, F., Mannix, J., & Peters, K. (2019). Factors contributing to high turnover rates of emergency nurses: A review of the literature. *Australian Critical Care*, 390-396. https://doi.org/10.1016/j.aucc.2019.09.002	Meta Analysis	Review of Literature	92 initial articles Duplicates removed, N=76 Records screened and excluded. N=41 Full text exclusion N=21 Qualitative and mixed method studies N=16	IV-critical incidents, work environment, DV-stress, PTSD	Critical Appraisal skills programme (CASP)	Thematic analysis	Causes of burnout include workplace violence and aggression, critical incidents in workplace and work environment	Level of evidence=7 Limitations-n/a Net benefit-Moderate

8. Ramacciati, N., Ceccagnoli, A., Addey, B., Lumini, E. & Rasero, L. (2016). Interventions to reduce the risk of violence toward emergency department staff: Current approaches. *Open Access Emergency Medicine*, *9*, 17-27. https://dx.doi.org/10.2147/OAEM.S69976	Qualitative Study	N/A	51 initial papers 10 duplicates excluded. 25 excluded after reading abstract. 5 excluded after reading full text. One excluded no full text Final N=10	IV- Attacks, aggression, violence DV-approach to decrease violence	T tests	Haddon matrix	Strategies relevant, acceptable, feasible and comprehensive	Level of evidence=6 Limitations-n/a Net benefit-moderate, B
9. Recsky, C., Moynihan, M., Maranghi, G., Smith, O., Jenssen, E., Sanon, P., Provost, S., & Hamilton, C. (2023). Evidence-Based approaches to mitigate workplace	Meta Analysis	Rapid Review	Original articles 4070 Duplicates removed, non-full text removed, exclusions removed, N=21 individual studies N=3 Review	IV- Level of education, coordination of program DV-mitigate workplace violence	Cochrane rapid review methods	Joanna Briggs Institute tools	Multipronged approach better Less improved single approach	Level of evidence=1 Limitations-not generalizable in some situations, gray literature not reviewed. Net benefit-Moderate, C

violence from patients and visitors in emergency departments: A rapid review. *Journal of Emergency Nursing*, *49*(4). https://doi.org/10.1016/j.jen.2023.03.002								
10. Vrablik, M., Chipman, A., Rosenman, E., Simcox, N., Huynh, L., Moore, M., & Fernandez, R. (2019). Identification of processes that mediate the impact of workplace violence on emergency department healthcare workers in the USA: Results from a qualitative study. BMJ Open, Article e031781.	Qualitative	Phenomenological Approach	N=23 ED staff members, varied titles	IV- Perceptions, coping mechanisms, relationships DV-decrease violence=decrease burnout	Phenomenological approach Transactional Model of Stress and Coping	Initial content analysis	Correlation to workplace violence and burnout	Level of evidence=1 Limitations-selection bias, no race or ethnicity data Net benefit-moderate C

https://dx.doi.org/10.1136/bmjopen-2019-031781								
11. Wakefield Giliam, S. (2014). Nonviolent crisis intervention training and the incidence of violent events in a large hospital emergency department an observational quality improvement study. *Advanced Emergency Nursing Journal*, *36*(2), 177-188. https://dx.doi.org.org/10.1097/TME.0000000000000019	Qualitative	Quality Improvement Project	All ED staff (all titles)	IV- Cumulative % month of ED staff and how did NCI training DV-monthly frequency of code purple	Pearson's regression mode	Hawthorne Effect IBM SPSS statistical version 22	23% decrease in violent assault after training, but only if recent training done.	Level of evidence=6 Limitations-individual judgement of employee, no validation of code purple Net benefit-High, B
12. Wirth, T., Peters, C., Nienhaus, A., & Schablon, A.	Systematic Review	N/A	Initial=1174	IV- Intoxication, mental illness	n/a	Joanna Briggs Institute tools	Positive correlation between training/education and violence	Level of evidence=1 Limitations-

(2021). Interventions for workplace violence prevention in emergency departments: A systematic review. *International Journal of Environmental Research and Public Health*, *18*, 8459. https://doi.org/10.3390/ijerph18168459			Screening and duplicates excluded=1135 Full text with eligibility-final N=15	DV-summarize violence prevention programs				No gray literature Net benefit-moderate B

Legend:

SD=Strongly disagree with knowledge, skills ability, confidence and preparedness for violence and violence prevention
WPV-Work place violence

JS-Job satisfaction

TI 1-Turnover intention

NCI-Non-Violent Intervention

Appendix B

Flowchart