Workplace Violence in Emergency Departments: Addressing Barriers to Reporting Through Education

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Abstract

Background: Workplace violence (WPV) in emergency departments is a national health care concern. Nurses practicing in emergency departments are at greater risk for violence than other health care professionals. Published literature suggests that WPV is underreported because of inadequate understanding of its definition and associated reporting processes, which contributes to a lack of evidence-based interventions to reduce its frequency. ***Purpose:*** Consistent utilization of a reporting database can assist in identifying trends in emergency departments' violence occurrences and subsequent interventions, as reviewed by the organization's WPV Committee. WPV education was offered with the intent of improving reporting accuracy and promoting better understanding of WPV. The WPV Committee's lack of engagement was addressed. ***Methods:*** Emergency department employees and leaders were offered education on the definition and reporting process of WPV through a free continuing nursing education module. The WPV Committee was simultaneously tasked with updating policies and creating engagement strategies to reduce WPV. ***Evaluation:*** Reporting system effectiveness was measured by comparing the frequency of documented occasions of violence before and after an educational intervention. Continuing nursing education pre- and posttest score comparison via paired *t* test was used to gauge WPV and reporting process knowledge. The WPV Committee's participation was increased. ***Clinical Implications:*** Utilization of a consistent WPV definition and reporting process aided accuracy of incident reports, exemplifying a culture that supports reporting incidents. This practice can inform data-driven interventions, when funneled through the WPV Committee, to reduce WPV, and may contribute to a safer emergency department environment for employees.

Keywords: workplace violence, emergency department, definition, reporting, education

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Problem Identification and Significance

Workplace violence (WPV) in the healthcare setting is of international and national concern (Albashtawy, 2013; Beech & Leather, 2003; Park, Cho, & Hong, 2014) given that nurses are four times more likely to experience aggression than any other category of health care worker (Hopkins, Fetherston, & Morrison, 2014). WPV is defined as "any incident in which an individual is threatened, abused, or assaulted in the workplace or in circumstances involving the workplace" (Schub & March, 2016, p. 1). There has been an increase in violence occurring in U.S. hospitals; in 2012, there were two events per 100 beds. By 2015, there were 2.8 events per 100 beds (Wyatt, Anderson-Drevs, & Van Male, 2016), while in 2013, 80% of health care setting violence resulting from patient interaction (Van Den Bos, Creten, Davenport, & Roberts, 2017). In 2016, hospitals and health system spent $1.1 billion for security and training to prevent violence, and $429 million for staffing, insurance, and medical care due to violence against hospital employees (Van Den Bos et al., 2017).

Emergency department (ED) nurses are more often exposed to WPV as compared to those colleagues practicing in other departments, ranging from 46% (Gates, Gillespie, & Succop, 2011; Wyatt et al., 2016) to 82% (Phillips, 2016). Nurses in the front line of patient care, such as those in the ED, are considered high risk for WPV due to physical proximity to and complex needs of their patients (Albashtawy, 2013; Park et al., 2014) and visitors (Van Den Bos et al., 2017).

The Emergency Nurses Association (ENA) and Institute for Emergency Nursing Research (2011) *Emergency Department Violence Surveillance Study* findings support that

nurses experienced verbal abuse (53.4%), consisting of yelling or swearing, most frequently by the patient (92.3%), with 86.1% not filing a formal report. WPV underreporting is a compounding problem that affects hospital administration and lawmakers' abilities to intervene effectively on environmental, security, policy, patient care, and employee safety levels (Hester, Harrelson, & Mongo, 2016). Estimating WPV frequency is difficult due to unclear definition of WPV, inconsistent investigation methods, incident report variation, and underreporting (Lau, Magarey, & McCutcheon, 2004).

Workplace Violence: Agency State of Affairs

There were fewer employee incident reports documenting ED WPV events than there were security department reports, demonstrating underreporting by direct care staff. For the year 2016, Security reports for the ED resulted in 277 incidents of assault, combative patient, harassment, or threatening actions (Figure 1). In comparison, 2016 ED employee incident reports yielded only ten percent of that total, with 27 reports documented. The organization had campus-specific WPV policies, with subsequent variation and three of four lacking the definition of WPV. The organization's WPV Committee had less than fifty percent attendance of direct care staff at its quarterly meeting; this membership criterion is required by the state's *Violence in Health Care Facilities Act* (2007). Engagement is defined as "emotional involvement or commitment" (Merriam-Webster, n.d.).

The purpose of this quality improvement project included three goals to improve the WPV reporting program and process: 1) education of ED employees and leadership about WPV reporting barriers, definitions, and the associated reporting process; 2) integration of a single WPV definition across the organization's WPV policies; and, 3) improved direct care staff engagement and participation in the organization's WPV Committee.

PICO Question

What strategies increase ED employee reporting rates of WPV incidents?

- Population (P): ED employees and leadership.
- Intervention (I): strategies to increase WPV reporting.
- Comparison (C): current ED WPV incident reporting rate.
- Outcome (O): increased incident reports of ED WPV.

Literature Search Criteria

A review of literature was conducted using the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE/PubMed, PsycINFO, Cochrane's Library, Summons, and the ENA. The primary search terms used to generate evidence included *workplace violence*, *reporting*, *emergency department*, and *reporting*. Articles were included if they were: (a) written between 2004 and 2017, (b) written in English, (c) available in full text, and (d) studied on humans. There was no limitation of countries included in the search, outside of the *Summon* search (Table 1). Unpublished manuscripts and dissertations were excluded.

Table 1

Search Strategy: Terms, Databases, Limitations, Articles for Review

Search terms	**Database**	**Inclusions**	**Articles for Review**
((“workplace violence” [MeSH terms] OR (“workplace” [All Fields] AND violence [All Fields] OR “workplace violence” [All Fields] AND (“emergency service, hospital”)	CINAHL	Written after 2004; Written in English; Available in full text; studied in humans; published manuscripts; scholarly/peer reviewed and nursing	3
	PubMed		21
	PsycINFO		1
	Cochrane’s Library		0
	ENA		0
	Summon (initial)		439
	Summon (repeat)	Additional inclusion filters applied: prevention, United States, violence prevention AND control.	13

Evidence Appraisal

The quality of the retrieved studies is variable; studies’ methodologies and aims differ (see Appendix A). Strengths include use of comparative reports against employee self-report/perception; however, many studies were conducted in a single site or organization, limiting generalizability. Articles written more than 15 years previously were excluded due to the complex and changing nature of EDs and WPV characteristics.

Published findings across studies are inconsistent specific to the benefits of WPV educational programs. Results from the culmination of retrieved articles (Table of Evidence, Appendix A) suggest that there are many reasons for reporting or not reporting incidents of WPV. Inconsistencies and variabilities across studies contribute to the challenges of planning

interventions to reduce the frequency of violent events. Studies used differing methods, instruments, and processes so like-comparisons are not possible. In addition, international research supports that WPV is a global concern, but comparing American ED settings to foreign EDs is not useful given confounding variables that include local law, regulatory bodies, culture, patient types, ED characteristics, and ED leadership.

Published findings revealed inconsistent rates of incident reporting, from 18% (Kvas & Seljak, 2014) to 74% (Stene, Larson, Levy, & Dohlman, 2015). Bias was identified as a limitation in many of the studies (Arnetz, Hamblin, Ager, Luborsky et al., 2015; Findorff, McGovern, Wall, & Gerberich, 2005; Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014; Taylor & Rew, 2010). Instruments were often researcher developed with limited validity testing, thereby reducing transferability (Arnetz et al., 2014; Blando, Ridenour, Hartley, & Casteel, 2015; Campbell, Burg, & Gammonley, 2015; Ferns, 2012). Articles were screened to assess for relevance toward WPV, reporting barriers, and EDs. Use of standardized, pre-specified inclusion criteria, such as ensuring the outcome of interest (reporting WPV), clinical setting (ED), and preferred study design (those with stronger levels of evidence) contributed to determining articles to incorporate in the Table of Evidence (Institute of Medicine, 2011).

Reporting Workplace Violence Incidents

Records of violent incidents that had occurred in the ED were incomplete in 66% of incident forms, suggesting the process did not prioritize reporting (Ferns, 2012). Campbell et al.'s (2015) review of studies that used measurement scales to describe incidents of violence concluded that there is a lack of standardized WPV measures and tracking mechanisms that subsequently contribute to inconsistent reporting that compromises understanding of the magnitude of WPV and hinder the development of research-based interventions and evaluations.

Barriers to reporting. Nurses' reasons for not reporting WPV incidents in the ED included lack of injury, expectation that violence was part of the job, inconvenient reporting processes, beliefs that nothing would change by reporting, and lack of time and knowledge of the reporting system (Copeland & Henry, 2017; Kvas & Seljak, 2014; Pich, Hazelton, Sundin, & Kable, 2010). Educating employees regarding the importance of reporting occasions of WPV through the employee incident process is necessary to ensure follow through (Copeland & Henry, 2017). Acts of violence viewed as "mild" should also be reported (Kvas & Seljak, 2014). Questionnaire-based survey results have demonstrated that employees have discussed acts of violence with coworkers so peer support in conjunction with knowledge about reporting procedures and policies may yield increased reporting (Kvas & Seljak, 2014). In addition, a supportive management response to reports of violence can empower employees to report (Pich et al., 2010; Stene et al., 2015).

Impact of workplace violence. There is significant literature regarding the impact of WPV on nurses, their work performance, and on the organization. Nurses experience various responses to WPV including physical injury, psychological symptoms such as affected sleep, flashbacks, resentment, sadness, frustration, worry, irritability, vulnerability, and propensity toward posttraumatic stress disorder symptoms (Chapman, Perry, Styles, & Combs, 2009; Gates et al., 2011; Kvas & Seljak, 2014; Pich et al., 2010).

Nurses who experience WPV have work performance affected by turnover, absenteeism, medical and psychological needs, workman's compensation, job discontent, reduced morale (Gates et al., 2011; Van Den Bos et al., 2017), burnout, greater numbers of errors, and increased workload for peers (Chapman et al., 2009). Patient care is adversely impacted by WPV with a demonstrated increase in physical restraint usage and negative interference in the therapeutic

nurse–patient relationship (Chapman et al., 2009) as well as an increased use of pharmaceutical restraints (Pich et al., 2010). Organizations are also impacted by WPV with documented effects that include absenteeism, altered workloads, morale, resignations, employee engagement/job satisfaction (Chapman et al., 2009; Kvas & Seljak, 2014).

Workplace Violence Definition

Researchers identified inconsistent WPV definitions as problematic (Kvas & Seljak, 2014; Nikathil, Olaussen, Gocentas, Symons, & Mitra, 2017) and complicated by chronically consistent underreporting (Arnetz et al., 2014). In a sample questionnaire survey, Kvas and Seljak (2014) described WPV incident underreporting as related to nurses' belief that nothing would change or resulting from a previous negative experience with reporting. Most victims of violence (52 to 78%) who did not complete a report felt nothing would be gained by reporting or a previous negative experience after reporting violence. Study findings were limited by self-assessment relying on recall and a low response rate (Kvas & Seljak, 2014). In comparison, Arnetz, Hamblin, Ager, Luborsky et al. (2015) published study identified an 88% WPV underreporting rate.

WPV interventions may include policy changes (Albashtawy, 2013), maintenance of a multidisciplinary team utilizing evidence-based appraisal and management techniques, and ongoing program evaluation analysis (Wyatt et al., 2016). Understanding barriers to reporting WPV will guide focused efforts toward creating a successful WPV prevention program (Wyatt et al., 2016).

Project Methodology

This quality improvement initiative addressed three components of the current WPV program: 1). increased knowledge of ED employees and leadership about the institutionally

approved definition of WPV and the appropriate reporting process; 2). inclusion of the institutionally approved definition within the policy and consistent policy parameters; and 3). improved WPV Committee attendance by direct care staff. Leadership support to report WPV (Stene et al., 2015), as evidenced by requesting managers and directors complete the continuing nursing education (CNE) module, was intended to increase employee and management consistency in practice. New Jersey regulations specified fifty percent membership of direct care employee participation requirements on the Workplace Violence Committee (Violence Prevention in Health Care Facilities Act, 2007) with the intention to facilitate structural empowerment (Blando et al., 2015). This criterion was included to protect the health care worker by necessitating their attendance. A representative of management or their designee oversees the committee, with responsibility to supervise all aspects of the program.

Setting

The setting for the project was a rurally situated, 753-bed healthcare organization comprised of four EDs located in southern New Jersey. Volumes at these EDs vary from 8,658 (Bridgeton); 11,096 (Elmer); 38,150 (Vineland), 27,514 (Woodbury) for the 6 months in 2017. Two of these EDs have attached crisis centers, resulting in frequent behavioral health and substance abuse presentations.

Baseline Workplace Violence System

Reporting, data collection, and policies. The organization's current electronic incident reporting system for WPV events, *Midas*, was designed to capture employee work-related injuries. This system does not require reporting of non-injurious WPV outcomes. There were data collection gaps in the incident report (need to include additional option for "gender" of assailant and "verbal" as a type of violence). A review of active organizational policies

demonstrated a lack of definition of WPV. In addition, the organization had four WPV policies, which contributed to inconsistency and variation.

Workplace Violence Committee. New Jersey state regulations require fifty percent of WPV Committee members to be direct healthcare employees. Attendance of direct care employees to WPV Committee meetings was less than required in 2016 and continued to be insufficient in 2017. Lack of engagement, as measured by attendance and number of meetings, suggests a deficient investment in remedying WPV (Figure 7), while contributing to inadequate communication and unmet regulatory expectations. These criteria are specified toward the possibility of reducing and mitigating the effects of violence in health care settings through employer-based violence prevention programs (Workplace Violence in Health Care Facilities Act, 2007). Implementing effective interventions based on the organization's reportable data and identifying measurable outcomes against which WPV improvements was evaluated were part of the long-term plan toward WPV prevention.

Workplace Violence Project Implications

ED employees and leadership were offered education regarding the definition of WPV and the importance of and process for incident reporting in order to reduce reporting barriers. Barriers identified by research have included unclear reporting policies (Edward, Ousey, Warelow, & Lui, 2014), lack of physical injury, absence of or difficult formal reporting systems (Hogarth, Beattie, & Morphet, 2016), and deficient WPV definition (Lau et al., 2004). The WPV Committee updated WPV policies by providing a consistent definition of WPV, prioritized attendance and engagement interventions, and reported outcomes of WPV reports and evidence-based interventions to employees.

Importance of this Project

Violence in healthcare interferes with the quality of patient care delivered and affects the dignity and self-worth of health care employees (Burchill, 2015). The adverse implications of WPV on nurses include non-adherence to safety legislation in relation to health care employees, employee morale, sickness, absence, recruitment, fiscal measures (Beech & Leather, 2003), as well as affecting nurses' job performance and nursing care (Albashtawy, 2013; Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2012; Chapman et al., 2009; Gates et al., 2011; Shaw, 2015; Taylor & Rew, 2010).

The WPV Committee is responsible to develop evidence-based practice interventions in order to reduce WPV in the ED. In order to determine the frequency and trends of incidents, there needs to be a robust reporting database of WPV. Reliance on the incident reporting data source (*Midas*), is troubling related to concern of underreporting. Measurement of intervention effectiveness is unreliable if reporting of incidents is inaccurate. Nurses should consider the value of reporting WPV toward communicating their right to personal safety in the work environment (ENA, 2015).

Overall Project Goal

The goal of the project is to establish a standardized system of reporting that supports evidence-based interventions to reduce occasions of WPV in the systems' EDs.

Workplace violence reporting and education. This project's first goal was to provide education to ED employees and leadership on the definition of WPV and incident reporting process through a free CNE module. Education about the new WPV definition and reporting requirement was intended to increase reporting rates during a one-month pilot data collection period to demonstrate improved knowledge about the reporting process.

Standardization of workplace violence definition and institutional policy. The project's second goal of WPV definition integration into policy was to create one comprehensive, process-oriented, and network-wide policy. Variation existed between the four campus-specific policies, which contributed to inconsistencies in understanding the definition of WPV and the process of how to report it.

Improvement of workplace violence committee direct care staff representation and engagement. The project's third goal of increasing direct care staff representation and engagement to the Workplace Violence Committee was driven by New Jersey regulations requiring fifty percent of attendees "be health care workers who provide direct patient care or otherwise have

contact with patients" (Workplace Violence in Health Care Facilities Act, 2007, pg.2). Direct care staff should be selected by the bargaining agents, but are not required to have expertise in WPV. The remaining committee members should possess experience, expertise, or responsibility relevant to violence prevention (Violence in Health Care Facilities Act, 2007). The committee had leadership representation from Behavioral Health, Security, Risk, Human Resources, Employee and Occupational Health, as well as direct care staff from Laboratory, ED, Security, Pediatrics, and Medical-Surgical (Tables 2 and 3).

WPV event reviews were to be conducted by the WPV Committee to ensure evaluation of violence trends, through use of a trained multidisciplinary team, as indicated above. This process aligned with the organization's high reliability organization standards by deferring to expertise and maintaining a relentless focus on safety and consistent reporting.

Methods/Implementation

Workplace Violence Reporting Education

ED employees and leadership were informed of the WPV CNE module through multiple modalities, including electronic communication, employee meeting agendas, and departmental educators. The education department offered the WPV CNE module to all ED employees and ED leadership, permitting the ability to track the number of employees who completed the module. Employees were advised to review and complete this non-mandatory module through the organization's web-based education program, *Healthstream* with supportive strategies toward implementation.

The WPV CNE module addressed WPV definitions from the Occupational Safety and Health Administration, a review of the electronic reporting system, and the function and process of the WPV Committee regarding review of WPV reports. Pre-and posttests were provided online, including both multiple choice and yes/no questions. The pretest was assigned prior to the WPV CNE module; the posttest and evaluation were offered immediately following completion of the module. The pre- and posttest results were calculated with a paired *t* test in order to assess employee understanding related to the module's content. Testing results were de-identified for the writer; evaluation results were anonymous. The CNE module was not mandatory but a free offering from the organization's education center.

Workplace Violence Committee

Efforts to increase WPV Committee attendance included emailed invitations and reminders, and offering remote participation through a conference number and second meeting location. Results of reporting outcomes were shared with ED employees and leadership through the WPV Committee, completing the communication loop by promoting protocol and follow

through (Pich et al., 2010). The WPV reporting system was used to obtain WPV reporting incidents, thereby influencing opportunities and policies toward appropriate intervention (Anderson, Fitzgerald, & Luck, 2010). WPV reports were discussed at the network's quarterly WPV Committee meetings.

Project Design

This was a quality assurance/quality improvement project. It entailed endorsement by Quality, Nursing, ED leadership, Education, Occupational Health, and the Institutional Review Board coordinator. The organization's definition of a quality improvement includes assessing process, system, or program with an established set of standards to seek knowledge directly related to participants, minimal risks, to compare and improve the current process, system, or program, while maintaining inter-organizational integrity. The project only involved employees from the organization's four EDs. Project design included:

1. Education of ED employees and leadership about the institutionally adopted WPV definition and incident reporting processes (Tables 4 and 5). Improved incident reporting content with *Midas* related to enhancements (Appendix C).
2. Revision of WPV policies to reflect uniform WPV definition and consistent, singular policy across the institution; approved and endorsed by WPV Committee.
3. Increased direct healthcare staff attendance to WPV Committee meetings of 50% overall attendance; improved scheduled meeting adherence.

Measurement Tools

The project used the existing reporting tool, *Midas* (employee incident reporting electronic submission form) to enter incidents of WPV. This process has been in place for over four years. Incident reports were monitored and reviewed by Employee Health and Occupational

Health, and supported by Information Systems. These reports were integrated into the WPV Committee data, and refined by campus, location, employee type, and month, offering perspectives and highlights in order to determine the impact of WPV education. The *Midas* report was enhanced by adding "other" gender and "verbal" violence as options (see Appendix C). Attendance at the WPV Committee meetings was tracked to determine direct healthcare staff participation as required by state healthcare regulations.

The Protection of Human Participants

Informed consent was not obtained from employees, as CNE completion was not mandatory. Data reports (including testing results, evaluations, and incident reports) were de-identified with no personal or employee information accessed by this writer.

Procedures

Workplace Violence Education

The ED employees and leadership WPV CNE education opportunity was communicated through the organization's established methods, including email, fliers in the employee break room, daily huddles, and within the *Healthstream* catalogue. In addition, the organization's Magnet-recognized and high reliability organization culture was utilized to imbed the education and reporting process to employees. This education was shared between all four ED's concurrently, with an expectation of ED employees and leadership to review and familiarize themselves with the WPV definition and reporting process.

Workplace Violence Committee

Invitations to and reminders of future meetings were sent to WPV Committee members, comprised of Security, nursing leadership, Employee and Occupational Health, and direct care employees (Table 6).

Data Collection and Analysis

Workplace Violence Education

Twenty unique ED employees from a possible pool of 315 employees completed the CNE during the one-month data collection period. During the data collection period, employees were advised of the CNE module by five separate emails, posted fliers, daily huddles, staff meeting, and networking. Eighteen participating employees successfully completed the posttest. Likert-style evaluation data were collected (Figures 2 through 6).

Workplace Violence Reports

De-identified reports of WPV reports were monitored for four weeks to assess for impact and reporting volumes. This data was included in the WPV Committee agenda and minutes, with quarterly feedback to ED employees and leadership of reporting results and engagement. Anonymous results of the CNE module scores were reviewed to assess the impact of learning about WPV definition and reporting process.

Reasons for not reporting incidents of WPV included fear of retaliation, lack of knowledge to report, not believing anything would change, and lack of awareness that verbal abuse constituted WPV. However, comments also included feeling nothing had changed, and feeling blame for reporting. Three unique ED employees volunteered their names to be part of the WPV Committee, which were shared with the committee chairperson of inclusion on the committee.

Volume of weekly reports and frequency of WPV incident reports were compared to volume of reports prior to education module implementation. Content of incident reports did not display improved quality of incident detail based on the educational module. Continued WPV

educational opportunities, policy promotion, and reporting enhancements will be utilized to affect increased reporting of WPV.

Workplace Violence Committee

Attendance to WPV Committee meeting increased from three direct care staff at the September 2017 meeting to seven direct care staff at the February 2018 meeting, with representation by medical, ED, behavioral health pediatrics, security, and laboratory staff. This was achieved in part by engagement with and recruitment by current members, solicitation through the CNE offering, leadership support, and labor relations meetings. Eight members were able to participate through offering a second meeting location and a call-in option (Figure 7).

Outcomes

CNE pre- and post-test results demonstrated an improvement in knowledge regarding WPV definition, barriers of and examples of WPV (Figure 5). A post hoc two tailed paired t test yielded a statistically significant difference in pretest and posttest scores ($t = -3.8$, $p = 0.001$). A retrospective power analysis generated a 91 percent power calculation. This small sample size of 20 demonstrated improved understanding of WPV definition and the reporting process following the educational intervention.

CNE evaluation exemplified the benefits of the CNE (Figure 4) and experience with reporting (Figure 5). Full leadership and management support was pivotal, as employees report lack of support from hospital/ED management as contributing to inadequate reporting (Mennella & March, 2017). Figure 8 demonstrates ED WPV incident reports by quarter from the third quarter of 2016 to February 13, 2018.

WPV reports were reviewed by a multidisciplinary team (Arnetz et al., 2017; Wyatt et al., 2016) including Security, Employee Health, Risk, Patient Relations, and Occupational Health.

Effective policies and procedures on preventing, reporting, and managing WPV in the ED are essential from all participants and management to sanction a culture of safety (Stene et al., 2015). Methods of engagement to the WPV Committee included offering an option to call in, as well as a second meeting location (Tables 7 and 8; Figure 7).

Strengths

Strengths to this project included enhanced education for employees regarding WPV in the ED, education of the reporting method to collect and communicate WPV events, and utilization of the WPV Committee to provide effective WPV prevention interventions. CNE evaluations revealed increased employee-level understanding of WPV reporting. Evaluation of data was monitored through WPV Committee in order to maintain established processes and procedures. Active communication and recruitment strategies focused on increasing WPV Committee engagement resulted in an improved attendance rate from 33% percent (third quarter of 2017) to 39% (first quarter of 2018) of direct care staff. All four campuses had representation at the WPV Committee meeting. Explanations behind purposeful reporting of all episodes of WPV were maintained through utilization of the current reporting mechanism, and included the value and impact of reporting.

This project has demonstrated potential beyond its original objectives, as the employee annual educational requirements have been updated, a subcommittee regarding national and network-level WPV claims has garnered leadership attention, and counseling and emotional interventions will be prioritized to reduce posttraumatic stress disorder symptoms following an incident of WPV. ED WPV incident reporting was trending toward a 100% increase from the fourth quarter of 2017 to the first quarter of 2018.

Limitations

Limitations of this project included limited number of low participation rate. A sample size of 20 employees out of a possible 315 resulted in a seven percent participation rate. In addition, the lack of ED WPV reporting during the data collection period did not change. Changes to the WPV Committee chairperson resulted in transitional and scheduling delays, yet an opportunity to evolve the committee. Opportunities to increase CNE module completion include mandating the module as an orientation or annual requirement for staff and WPV committee members. Appointment of WPV Committee membership based on WPV incidents, bargaining agent assignment, or expertise may also encourage attendance. Threats to internal validity that may exist include offering the test/retest in a short window of time (cuing the participants of questions and answers) and the low participation rate that may not represent the ED employee target population.

Future Implications

Employees are directed to report violence in their work environment in order to share their experience and work toward development of evidence based practice intervention and a safe work setting. Mandating workplace violence reporting requirements of all staff would progress toward high reliability organization efforts. Use of debriefing to evaluate incidents of violence Development of an expert WPV Committee membership appointment would aid evidence-based practice applications, as well as create a system of evaluating the effectiveness of these interventions.

Summary

ED employees can understand employee safety concerns through utilization of data-driven quantified risk information in order to implement WPV interventions (Shaw, 2015).

Aligning educational content with the culture of the setting and needs of employees is vital (Papa & Venella, 2013) to addressing and reducing WPV. Due to the complex nature surrounding the factors contributing to WPV, applicable evidence based interventions are necessary. Use of data driven WPV reports to guide interventions is a fundamental strategy toward reduction and prevention. Utilization of an established WPV committee to guide interventions contributes to a consistent process of determining effectiveness.

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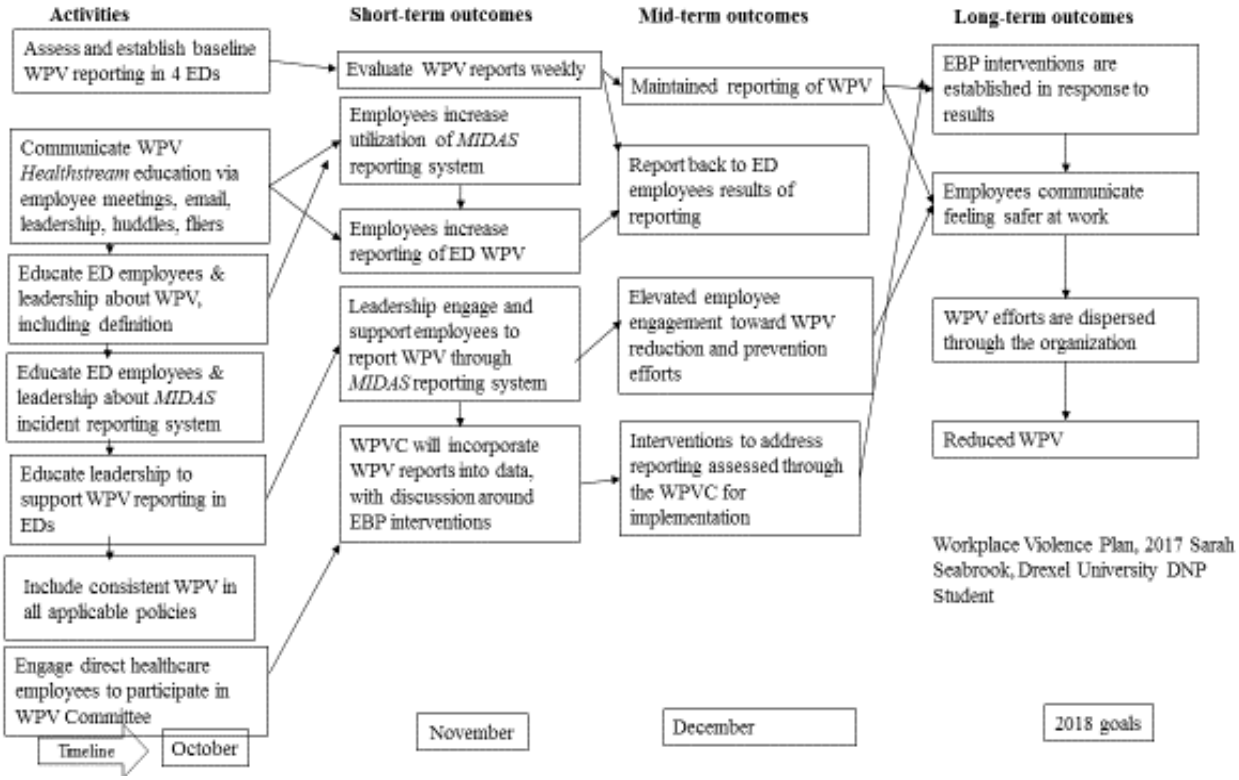
Appendix A: Table of Evidence

Author/date	Sample characteristic/ setting	Methodology	Independent variable(s)	Outcomes being investigated and approach to measurement	Results	Limitations
Findorff, McGovern, Wall, & Gerberich, 2005	WPV, healthcare	Cross-sectional	Individual and employment characteristics	Reporting WPV, relationship between characteristics of violent event	Most reports made verbally to leadership	Moderate response, recall & selection bias,
Pich, Hazelton, Sundin, & Kable, 2010	WPV, ED	Literature review	Nurses (ED)	Patient-related violence, review of literature	Identified reporting barriers, patient factors	Included settings outside of ED
Taylor & Rew, 2010	WPV, ED	Literature review	ED staff	Incident rates of WPV & effects on staff, review of literature	No consistent definition used, characteristics identified	Excludes older studies, one author is ED RN
Arnetz et al., 2014	WPV, hospital	Qualitative with content analysis	Patient to worker violent incidents recorded in database	Catalysts and circumstances of incidents, qualitative analysis	Reporting required if injury resulted, allowed 72 hours to report	Underreporting; focused on injury and not behaviors; limited to one hospital
Gillespie, Gates & Kowalenko, 2014	WPV, ED	Quasi-experimental intervention	Comparison ED, no intervention	WPV intervention implementation, ANOVA to compare intervention against comparison ED's	60% did not complete report, need engagement to reduce WPV	No randomization; reporting bias; increased awareness affects reporting, controls did not see changes
Kvas & Seljak, 2014	WPV, nursing	Questionnaire	Nurses	Nurses actions following WPV, reasons for not reporting; sample survey	Limited reporting due to belief nothing will be done	Inconsistent definition, self-assessment, low response rate
Arnetz et al., 2015	WPV, hospital	Questionnaire	Health care workers in hospitals	WPV and underreporting self-report vs. actual reports	88% underreport	Single system, recall bias, low response rate
Blando, Ridenour, Hartley & Casteel, 2015	WPV, hospital	Qualitative, focus groups	WPV programs in hospitals	Barriers to effective WPV programs, literature review and focus groups	Varied perception of violence; lack of management accountability	No randomization, unionized participants

Stene, Larson, Levy & Dohlman, 2015	WPV, ED	Quality improvement	WPV in ED	Education of ED staff on WPV, reporting tool quality improvement: survey, education, reporting tool	Assessed knowledge gaps, provided education, secured leadership support	Pre/post surveys not linked by participant; one location; convenience sample
Campbell, Burg, & Gammonley, 2015	WPV, healthcare	Systematic review	Health care providers	Review of instruments to measure and report incidents of WPV; literature review	Lack of standardized measures and reporting	Mostly researcher developed tools
Hogarth, Beattie, & Morphet, 2016	WPV, ED	Qualitative, focus groups	Nurses in EDs	Nurses' attitudes to reporting WPV focus groups with thematic analysis	Nurses do not use formal reporting system; report to self-protect	Self-selected small sample
Nikathil, Olaussen, Gocentas, Symons, & Mitra, 2017	WPV, ED	Systematic review & meta-analysis	WPV in ED	WPV in ED, drug/alcohol involvement, systematic review, pooled incidence of WPV	Drug/alcohol accounted for 50% of WPV incidents	Drug/alcohol accounted for 50% of WPV incidents

Note. ED = emergency department; WPV = workplace violence.

Appendix B: Workplace Violence Plan



Appendix C: *Midas* Employee Incident Report

(Inspira Health Network's Electronic Reporting System)

Workplace Violence

Assailant- gender (drop down) Male Female Other

Needed to call: (drop down) Security, Police, Nursing Supervisor, Code grey

Assailant- (drop down) patient, visitor, or staff?

Injury is a result of restraining patient. (radio button) Yes No

Assailant- (drop down) armed or unarmed

Assailant- predisposing factors (drop down): confused, dissatisfied with care, gang related, grief reaction, history of violence, intoxicated, mental disorder, wait time

Type of violence: (drop down) financial, physical, sexual verbal

Length of time between arrival and incident of violence (free text)

Debriefing take place? (radio button) Yes No

Has the employee had CPI training? (radio button) Yes No

Onset of behavior (free text)

Option to initiate report with f/u from supervisor or manager (free text)

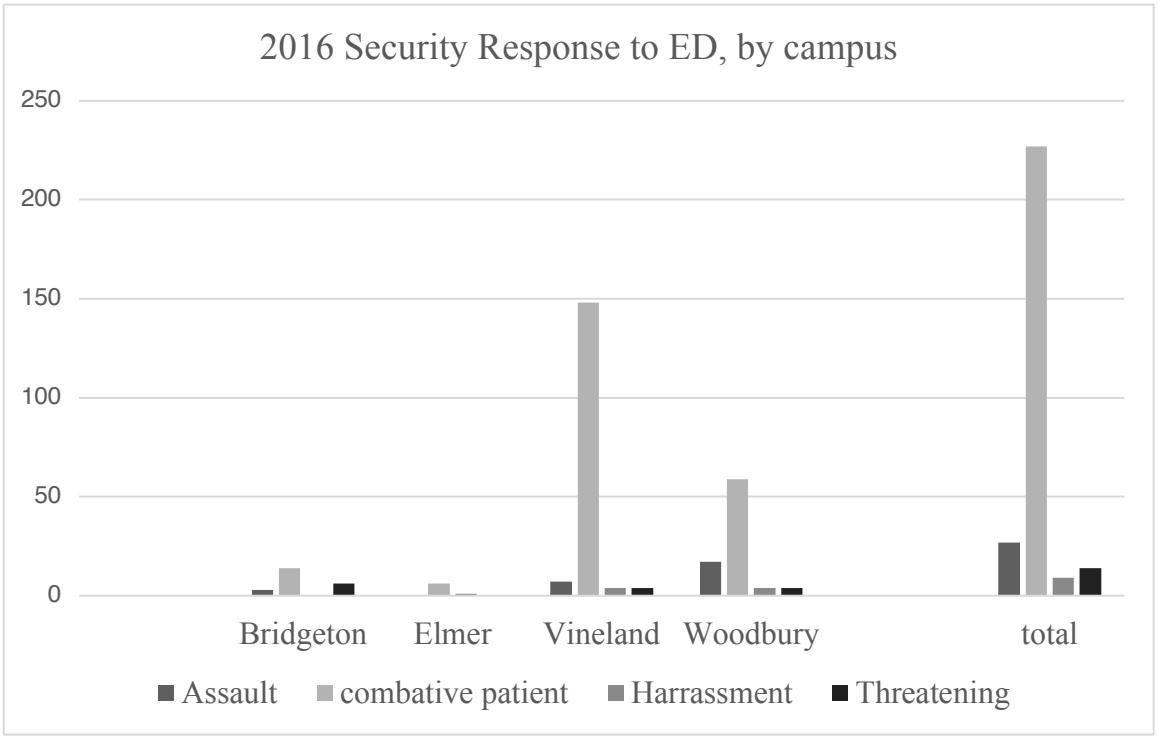


Figure 1. 2016 Security reports to the ED, by campus.

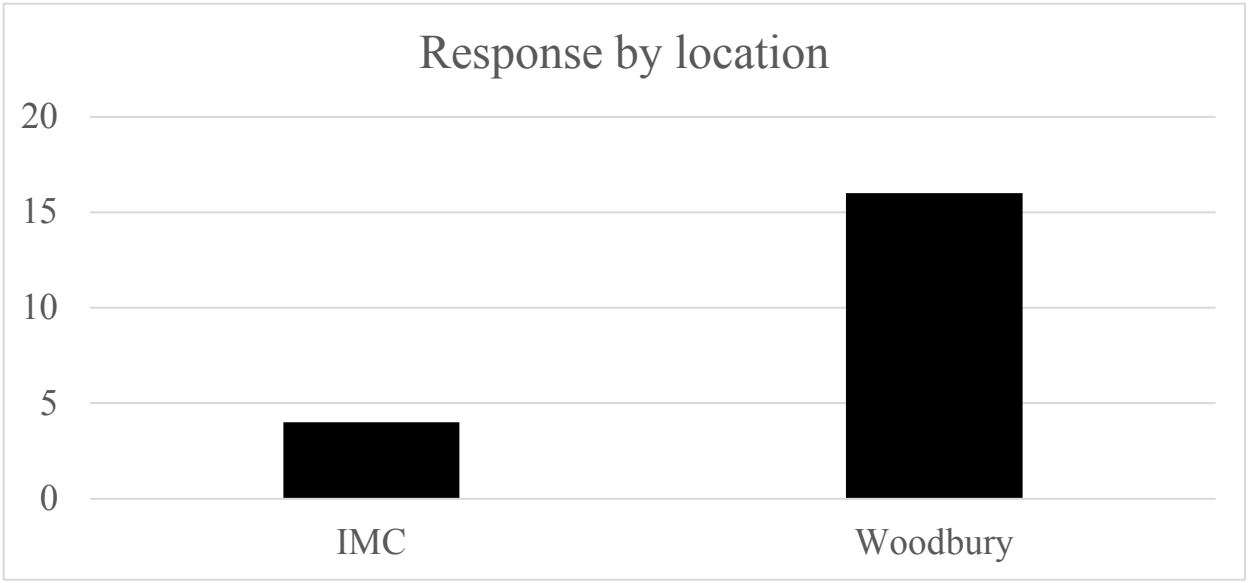


Figure 2. CNE Summary by location.

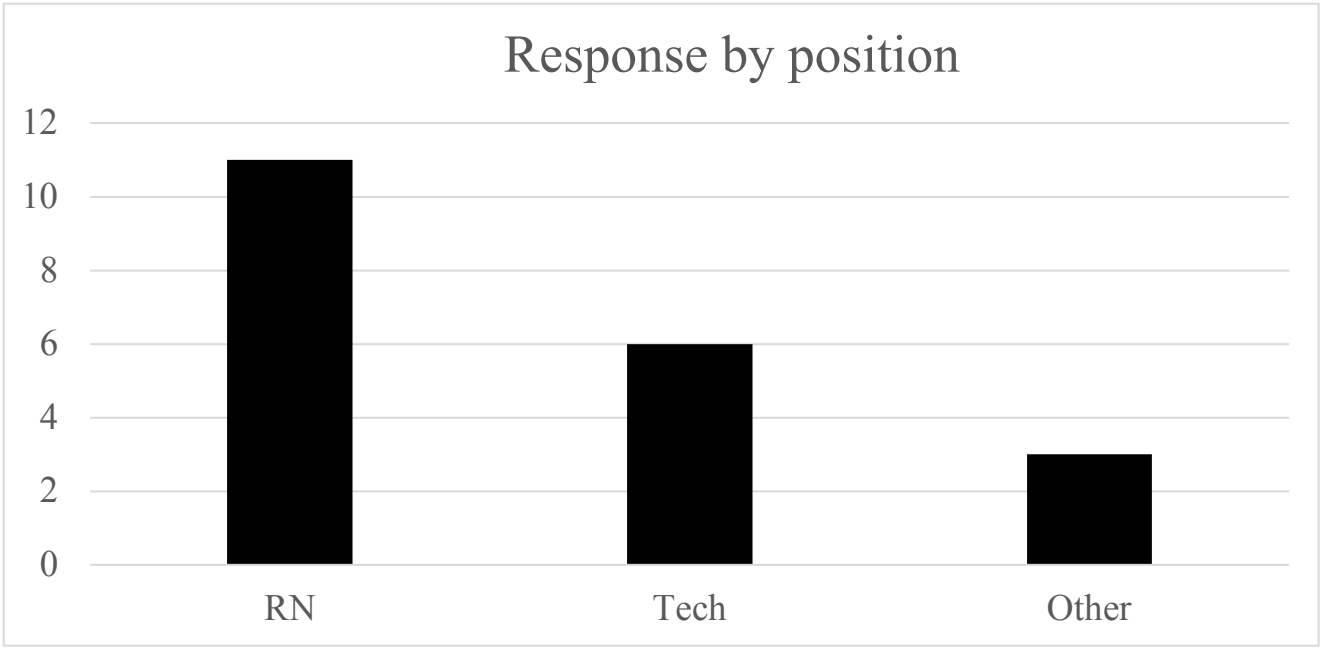


Figure 3. CNE summary by position.

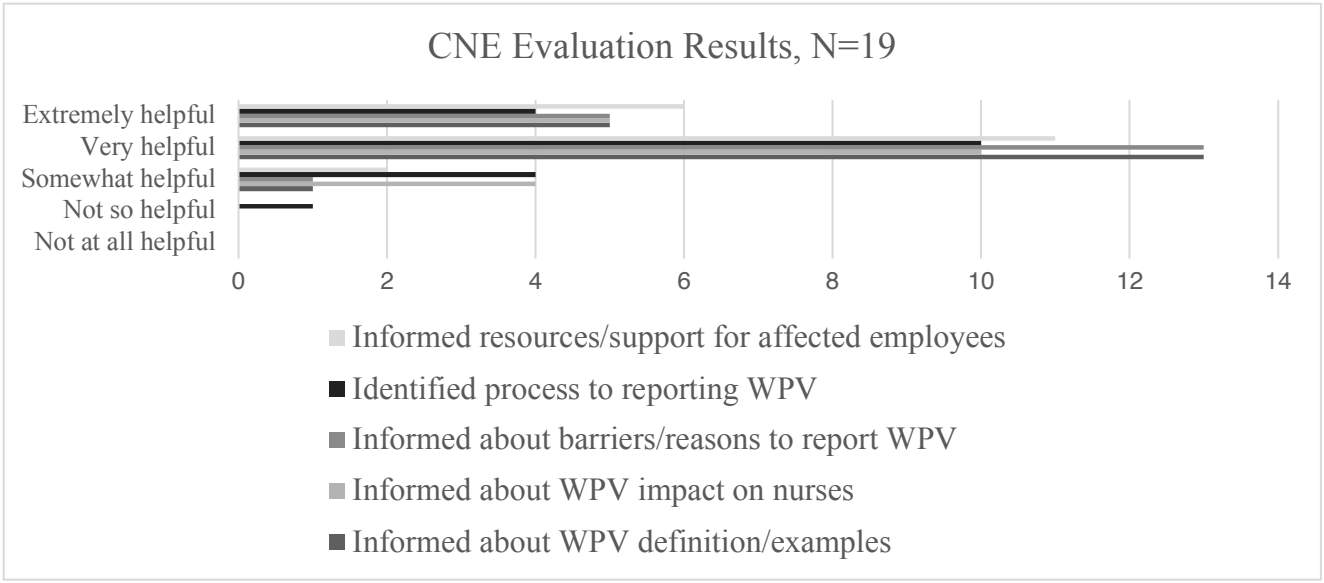


Figure 4. CNE Evaluation Results.

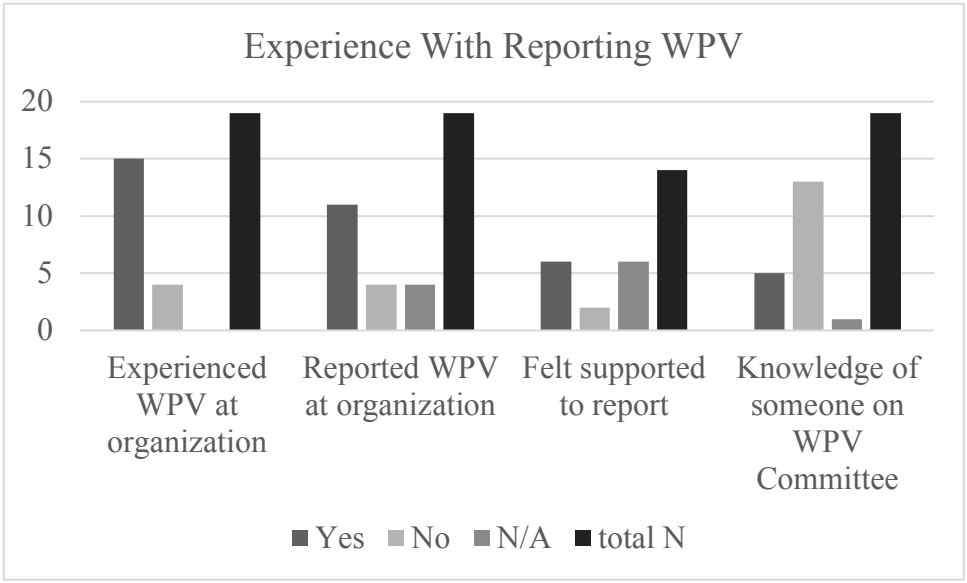


Figure 5. Experience with Reporting WPV.

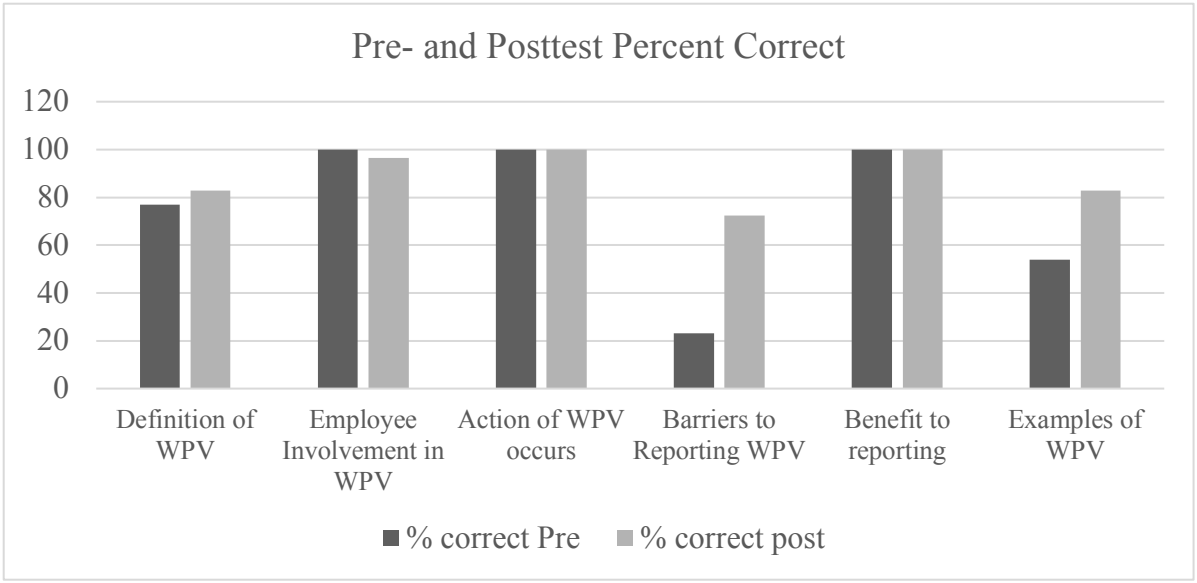


Figure 6. Pre- and posttest percent correct.

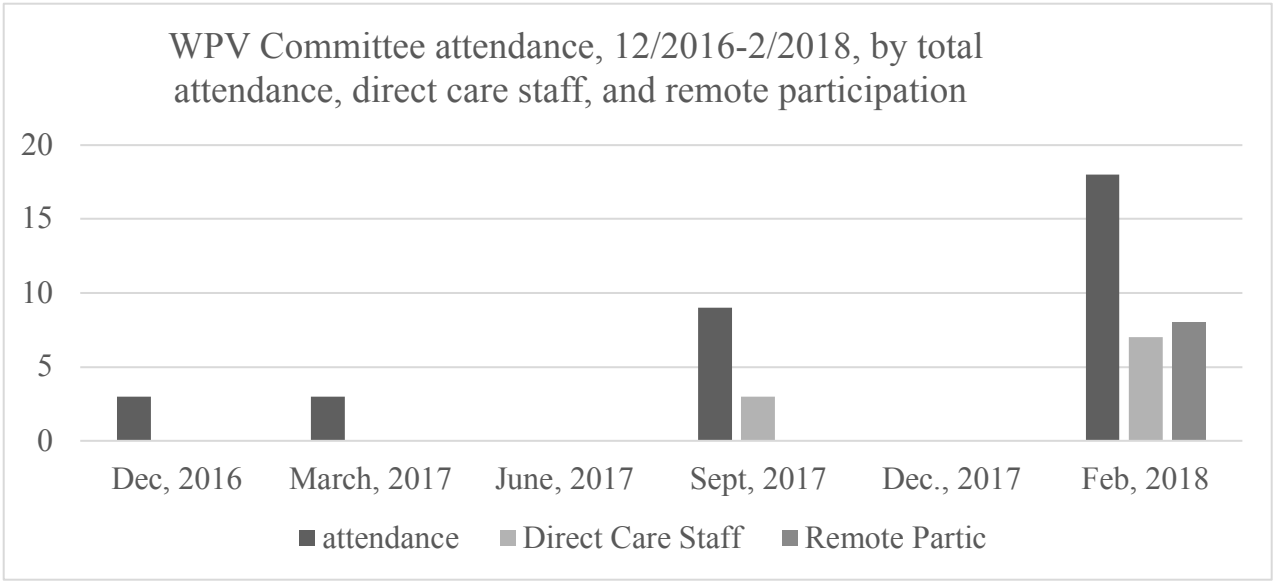


Figure 7. WPV Committee Attendance, 12/2016 through 2/2018, by total attendance, direct care staff, and remote participation.

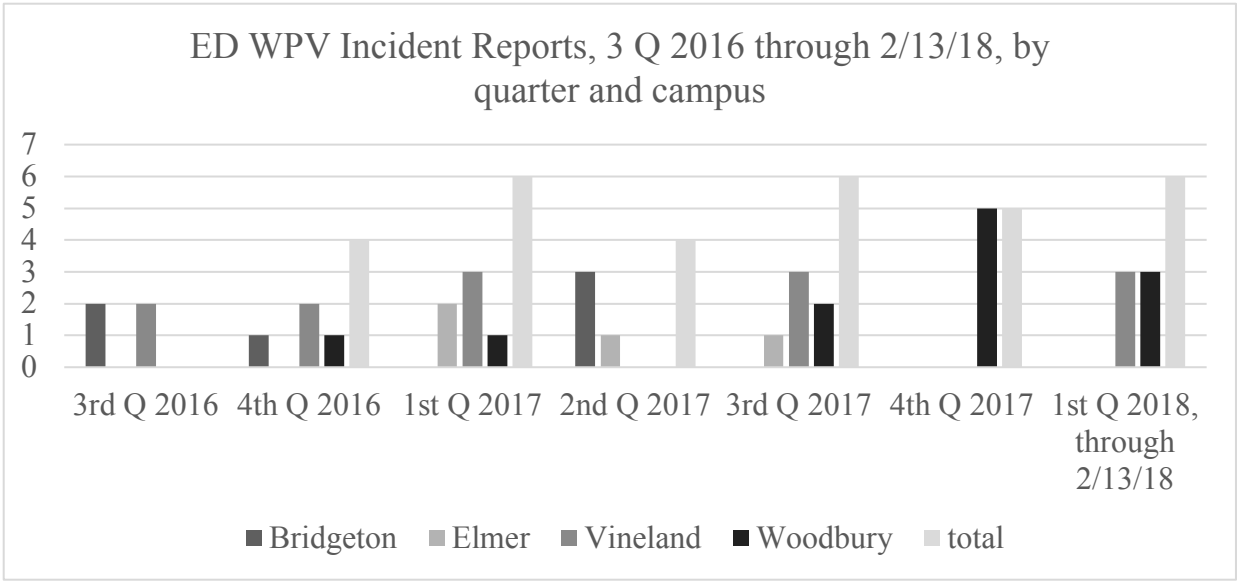


Figure 8. ED WPV Incident Reports, 3rd Q 2016 through 2/13/18, by quarter and campus.

Tables.

Table 2.

Workplace Violence Committee Members by department and number of members

Department	Number of members
Direct Care Staff	24
Security leadership	4
Supervisors	2
Behavioral Health leadership	2
Employee Health/Occupational Health	2
Care Coordination manager	1
ED Nursing leadership	1
Human Resources manager	1
Public Relations	1
Risk	1

Table 3.

WPV Committee Structure and Engagement Interventions

WPV Committee Structure	Engagement Interventions
New Committee Chair (Security Department) 10/1/2017	
	Emailed meeting invitation with attendance confirmation
	Emailed reminders of meetings
	Tracked meeting attendance by job position through meeting sign in
	Member wrote an article about WPV Committee in newsletter
	Emphasis on commitment to attendance
	Use of tele-conferencing to support remote attendance
	Use of a second meeting location for employee convenience

Table 4.

CNE Strategies and Implementation

Strategies	Implementation
Teaching strategy/method of education	CNE was offered on the organization's education platform (*Healthstream*), to support employee comfort with and expectation of available educational offerings.
Content delivery	Content was delivered through a PowerPoint presentation, authored by this writer as a DNP student. Organizational specifics (how to report in the system's incident reporting program- *Midas*- as well as internal and external programs offering support to those affected by WPV) was included to personalize CNE to employees
Communication	Communication of educational opportunity was shared through email, fliers, daily huddles, ED educators, staff meetings, and word of mouth.

Table 5.

Workplace Violence Continuing Nursing Education Objectives and Content

Objectives	Content
Objective	The participant will demonstrate knowledge of the definition of Workplace Violence (WPV), as per the Occupational Safety and Health Administration.
Objective	The participant will understand the barriers to and importance of reporting WPV.
Objective	The participant will demonstrate understanding of the organization's process for reporting WPV, and the functions of the WPV Committee.
Content	Content was determined by researched evidence of reporting barriers, including lack of a consistent definition, reasons and how to report, and the importance of the WPV Committee in creating change regarding WPV safety.

Table 6.

WPV Project Measurements and Timelines

Interventions	Measurements	Timelines
ED Employees & Leaders		
-WPV & incident reporting education	*Healthstream* completion report	Weekly x 4
-WPV & incident reporting knowledge	Pre- and posttest CNE results	Weekly x 4
-Increased WPV reporting	*Midas* ED WPV reports	Weekly x 4
-Support of WPV reporting	Employee Engagement Survey	18 months
WPV Committee		
-Engagement of direct care staff	Increased attendance	Quarterly
-Consistent WPV definition in policy	Policy review and approval	Quarterly
-Improved reporting content	Increased specificity of WPV reports	Quarterly
-Improved interventions	Reporting trends	Quarterly

Table 7.

WPV Program Gaps, Interventions, and Outcomes

WPV Program Gaps	Interventions	Outcomes
Incident report lacks "other" gender and "verbal" violence	Elements added to the incident report form	Enhanced report
WPV policy lacked incident reporting process	Included guidance of incident reporting process in policy	Updated guide for staff
WPV Policy- lacked WPV definition	Definition added to policy	Consistent definition/expectation
Different policy per campus	Integration of policies toward one comprehensive for network	Unified policy endorsed through WPV Committee

Table 8.

Project Goal, Objectives, and Outcomes

Project Goal	Objectives	Outcomes
Goal: Increase reporting of WPV in ED		Trending to increase by 100 percent by end of 1st quarter 2018
	Objective 1: Education of ED employees and leadership about the institutionally adopted WPV definition and incident reporting process.	Educated six percent of ED employees and leadership
	Objective 2: Revision of WPV policies to one uniform definition and policy.	Achieved at 2/2018 WPV Committee meeting
	Objective 3: Increase direct care staff WPV Committee engagement from September 2017 meeting to February 2018 meeting.	Not achieved; increased from 33 to 39 percent