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Evidence-Based Strategies for the Prevention of Workplace Violence Against Health Care Workers: Creating an Educational Toolkit

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**Evidence-Based Strategies for the Prevention of Workplace Violence Against Health Care
Workers: Creating an Educational Toolkit**

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Abstract

Background: Violence in healthcare is a growing problem. Health care workers are being physically and psychologically assaulted by patients and their families. This is particularly a problem in emergency departments, psychiatric units, waiting rooms and geriatric facilities.

Purpose: This project focused on the creation of an educational toolkit for the prevention of violence against healthcare workers.

Methods: This quality improvement project used Kotter's 8-step change model to guide the evaluation of a toolkit incorporating evidence-based nonviolent crisis prevention strategies with Crisis Prevention Institute's top 10 de-escalation tips. The project was implemented at a psychiatric hospital in Illinois. Healthcare workers reviewed the educational material in the toolkit. Questionnaire were used to collect data using the Confidence in Coping with Patient Aggression Instrument pre- and post-education. Descriptive statistics were used to analyze the data.

Results: Eleven healthcare workers participated. The mean score from the questionnaire was higher post-education (Mean= 27.52, SD= 3.32) compared to pre-education (Mean=22.83, SD=4.31). Additionally, there was an estimated 9% decrease in violence post educational intervention.

Conclusion: An educational toolkit has shown some promising results in increasing self-perceived confidence in coping with/managing patient aggression and reducing violence against healthcare workers.

Keywords: workplace violence, healthcare workers, violence prevention program

Introduction

Violence against healthcare workers is pervasive and entrenched in our healthcare system such that many consider it a part of the job (Blando et al., 2015; Locke, 2018). Across the globe, many healthcare workers have been kicked by patients, spat on, sexually assaulted, smeared with feces and urine to mention but a few yet they continue to perform their duties. Apart from the service industry, there is no other sector of the economy where this kind of treatment is tolerated and even expected. The consequences of workplace violence against healthcare workers include increase in medical errors, reduced quality of patient care, high rates of stress, decreased job satisfaction, absenteeism, and more injury claims (d'Ettorre & Pellicani, 2017; Gillespie et al., 2013). The incidence of violence is prevalent in emergency departments, psychiatric units, geriatric units and waiting rooms (Ferri et al., 2016; Llor-Esteban et al., 2017).

Background

Violence against healthcare workers is a global problem which is grossly under-reported; about 8% to 38% of healthcare workers experience physical violence during their career (World Health Organization [WHO], (n.d.)). In a multi-country case study conducted by WHO, it was discovered that more than half of responding healthcare workers had been victims of violence in the past year (WHO, 2002). It is estimated that 70% to 80% of assaults are not reported (Nelson, 2014). In the United States alone, 75% of an estimated 25,000 workplace assaults reported yearly occur in healthcare and social service settings (Occupational Safety and Health Administration [OSHA], 2015); healthcare workers have a 20% higher risk of workplace violence compared to their counterparts in other sectors (Harrell, 2011). Over 70% of serious physical attacks against healthcare workers are perpetrated by patients (Semeah et al., 2019).

Workplace violence has been defined as “violent acts, including threats of

assaults and physical assaults that are directed toward persons at work or on duty” (OSHA, 2015, p. 2). There are four types of workplace violence identified simply as type 1, type 2, type 3, and type 4 (The National Institute for Occupational Safety and Health [NIOSH], 2016). Type 1 violence is such that the perpetrator has no lawful relationship with the organization, or the employees and a crime is committed during the violent act; this is a less common form of violence in healthcare facilities (NIOSH, 2016). An example of Type 1 violence is the injury of a pharmacist during an armed robbery in a pharmacy. Type 2 violence is perpetrated by patients, visitors, clients, and family members on healthcare workers. It is the most common form of violence in healthcare, especially in emergency departments, psychiatric units, waiting rooms and geriatric settings (NIOSH, 2016). An example of Type 2 violence includes patients and families verbally and physically assaulting healthcare workers while doing their job. Type 3 violence (also known as lateral violence or horizontal violence) occurs between coworkers and involves bullying, verbal, and emotional abuse (NIOSH, 2016). An example of Type 3 violence includes a group of nurses bullying a new hire. Type 4 violence is perpetrated by individuals who have a personal relationship with the worker outside of work and brings personal disputes to the work setting (NIOSH, 2016); an example includes the verbal harassment of an employee by her boyfriend while at work.

Problem Statement

In the United States, the problem of violence against healthcare workers is indicated by 75% of an estimated 25,000 workplace assaults reported yearly occurred in healthcare and social service settings (OSHA, 2015) with healthcare workers having a 20% higher risk of workplace violence compared to their counterparts in other sectors (Harrell, 2011). This results in increased medical errors, reduced quality of patient care, high rates of stress, decreased job satisfaction,

absenteeism, more injury claims (d'Ettorre & Pellicani, 2017). Therefore, the purpose of the proposed project was to mitigate the problem of type 2 violence through the implementation of an evidence-based workplace violence prevention program.

Organizational “Gap” Analysis of Project

The quality improvement project was implemented in a psychiatric hospital located in Illinois. On several occasions, healthcare workers in this hospital have been punched, kicked, spat on, and even smeared with feces. Staff members unfortunately have taken this as part of the job. The organizational culture in this hospital is such that fosters compassion for patients from top management to all members of the workforce. This is very commendable; however, this same level of compassion and passionate sacrifice must also be extended to healthcare workers who have given so much of themselves to ensure the safety and overall wellbeing of their patients so much so that they may be at risk of compassion fatigue (Cetrano et al., 2017).

Review of the Literature

Articles were sought from the following data bases: ScienceDirect, Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycINFO, Science Citation Index, PubMed, Directory of Open Access Journals and Social Sciences Citation Index. The following keywords were used and combined together for the literature search: workplace violence, violence against healthcare workers, type 2 violence, violence against nurses, violence against physicians, violence against doctors, violence in healthcare, workplace violence in healthcare, workplace violence evidenced-based interventions, strategies for prevention of workplace violence, workplace violence prevention in healthcare, OSHA workplace violence guidelines, types of workplace violence, patient to worker violence, violence against health workers, violence

prevention programs, Veteran affairs workplace violence prevention program. The exclusion criteria were as follows: (1) studies on lateral violence or worker-on-worker violence (2) studies not regarding healthcare workers or healthcare facilities (3) studies not written in English (4) studies on intimate partner violence, domestic violence, child abuse or elder abuse (5) studies from the 1990s (6) studies that were not full texts. Inclusion criteria is as follows: (1) studies on type 2 violence (2) studies with evidence-based interventions for prevention of workplace violence in healthcare (3) studies with OSHA guidelines for prevention of violence in healthcare (4) studies with workplace violence prevention programs. Search results with full text, which were original research and had evidence-based interventions for workplace violence in healthcare were selected and rated using John Hopkins Evidence-Based Rating Scale (see Appendix H). The strength and quality of evidence of articles used was also outlined (see Appendix I). A search of the databases using the phrase “workplace violence prevention” yielded the following results: CINAHL Complete (376), PubMed (1027), PsycINFO (22), ScienceDirect (2194), Science Citation Index (291), Directory of Open Access Journals (63) and Social Sciences Citation Index (386). After removing duplicates and articles which are not relevant, the final number of articles is as follows: CINAHL Complete (3), PubMed (5), PsycINFO (3), ScienceDirect (5), Science Citation Index (3), Directory of Open Access Journals (3) and Social Sciences Citation Index (1).

Workplace Violence Prevention Program

The implementation of a workplace violence prevention program in healthcare facilities has shown some promising results in reducing rates of assaults on healthcare workers (Arnetz et al, 2017; Hill et al., 2015; Hodgson & Drummond, 2011; Isaak et al., 2018; Peek-Asa et al., 2009; Touzet et al., 2019). A particularly promising study was the one conducted by Arnetz and

colleagues which had a sample size of 2,863 subjects and utilized a randomized, controlled intervention with a mixed-methods approach. Implementation of a workplace violence prevention program comprised development of standardized reports of workplace violence, use of hazard risk ratio to prioritize hospital units for intervention, and administrative controls such as. It was reported that incidence of violent events was significantly lower in the intervention group compared to control group six months post intervention. The risk for violence-related injury was also lower in the intervention group as compared to the control group (Arnetz et al., 2017). Workplace violence prevention programs have also increased staff awareness of the problem and confidence in managing patient aggression (Al-Ali et al., 2016). Reduction in incidents of workplace violence requires a multifaceted approach (Davey et al., 2020).

Code Response Team

The use of a code green response team (CGRT) comprising a security personnel, charge nurse, physician, and primary nurse in a Pennsylvania hospital for de-escalating potentially violent events showed an 85% success rate with a subsequent 11% reduction in the use of patient restraints compared to the previous year (Dilman, 2015). This approach could be compared to the implementation of an intervention called SAFE (Spot a threat, Assess the risk, formulate a plan, and Evaluate the outcome) response. This evidence-based intervention included online training for clinicians and a clinical debriefing which was developed, evaluated, and implemented from 2012 to 2016. It comprised 1,866 survey respondents including nurses, physicians, social workers, and other healthcare workers from a large urban teaching hospital. The SAFE response is such that when a staff member spots a threat involving a patient or visitor, the SAFE response is activated and the patient's provider, nursing leadership and security are notified to respond to

the situation and even consults are paged for additional support if needed; the study revealed a 40% injury reduction rate among nursing staff (Lakatos et al., 2019).

De-escalation Training

Since workplace violence prevention program must be tailored to meet the needs of each facility, crisis prevention intervention/de-escalation training should be the primary component of the program as it has shown to be beneficial in decreasing incidence of violence (Wakefield, 2014) and increasing staff confidence in managing potentially violent situations (Baig et al., 2018; Guay et al., 2016). Limitations of the Wakefield study includes the fact that the study was limited to the emergency department and patient population was not standardized in terms of acuity etc. (Wakefield, 2014). Workplace violence against healthcare workers is on the increase and can be mitigated by implementing evidence-based strategies such as workplace violence prevention programs. These programs have shown some promising results and must be tailored to meet the unique needs of each facility.

Evidence Based Practice: Verification of Chosen Option

This DNP project was conducted because a review of the literature revealed that violence prevention programs have shown promising results in reducing and preventing violence against healthcare workers.

Theoretical Framework or Evidence Based Practice Model

Kotter's 8-step change model was used as a conceptual framework for implementing workplace violence prevention program to prevent or reduce violence against healthcare workers (see Appendix B). This model comprised 8 steps namely: (a) create urgency (b) form a powerful coalition (c) create a vision for change (d) communicate the vision (e) empower action (f) create

quick wins (g) build on the change and do not let up (h) make change stick (Aziz, 2017; Lv & Zhang, 2017). Kotter's 8-step change model would be applied to this proposal to implement a workplace violence prevention program in the following ways:

- *Create urgency:* It is common knowledge that it is the norm for individuals and organizations to resist change (Aziz, 2017); however, in a bid to bring about change in the current status quo (i.e., violence against healthcare workers), a sense of urgency was created by showing the data and statistics on violence against healthcare workers and its impact on workers as well as on organizations.
- *Form a powerful coalition:* The formation of a powerful coalition is an integral part of this model because without the involvement of stakeholders who are passionate and committed to the change project, it will not work. In view of this, the DNP student collaborated with nurses, therapists, and mental health associates on the unit as they are motivated to stop violence against healthcare workers. Furthermore, in a bid to form a formidable coalition, some members of the management team were identified to be drivers of this change project.
- *Create a vision for change:* It is imperative to create a vision for change because without a vision for the future, the momentum created at the very beginning will be lost. Hence, the vision for this proposal is "a workplace free of violence against healthcare workers".
- *Communicate the vision:* The DNP student communicated this vision or idealized picture of the future to stakeholders involved in this project at every given encounter and at every point in the project because effective leaders must be effective communicators (Baumann, 2019).

- *Empower action:* To ensure the success of this proposal, staff members were empowered to overcome obstacles. Training was one way of empowering employees while retaining their commitment to the organization as employee training has a positive correlation with organizational commitment (Hanaysha, 2016). To ensure commitment to this proposal, which is aimed at reducing violence against healthcare workers, stakeholders needing a refresher course on non-violent crisis intervention were provided a refresher course as identified. The organization trains every employee upon hire in non-violent crisis prevention and a refresher course is offered annually.
- *Create quick wins:* During this proposal, stakeholders were notified of quick wins such as when there is a successful de-escalation of a potentially violent situation between healthcare workers, patients, and their families. These quick wins helped to spur to action and motivate everyone who was involved in this project.
- *Build on the change and do not let up:* Kotter was of the view that projects fail when victory is declared too soon (Aziz, 2017). In view of this, staff members were encouraged to continue to utilize skills obtained and reinforced in the violent prevention program.
- *Make change stick:* To ensure a sustainable change, data showing reduction in violence against healthcare workers or increase in staff confidence in de-escalating a potentially violent situation was be made available to project participants. Success of the project was communicated at the completion of the project. Change(s) to practice will further be carried out through changes to unit policies and procedures.

Goals, Objectives, and Expected Outcomes

Goal	Objective(s)	Expected Outcome(s)
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To create and evaluate an evidenced based educational toolkit for the prevention of type 2 violence against healthcare workers.	Participants will complete pre-intervention questionnaire to determine baseline confidence levels and post-intervention questionnaire and survey to determine post intervention confidence level.	60% of target providers will complete pre-intervention and post-intervention questionnaire, while 40% of participants will complete feedback on materials.
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Methods

This quality improvement project translated the current research evidence regarding the effectiveness of an educational intervention designed to prevent workplace violence to one clinical setting. The education equipped healthcare workers with the requisite skills and knowledge required to prevent and / or deescalate a violent situation. The hospital currently certifies all employees in non-violent crisis intervention (CPI) during orientation. The DNP student built upon and leveraged this training by incorporating it as an aspect of the educational toolkit. Based on a review of the literature, nonviolent crisis intervention/de-escalation training has shown promises in reducing violence against healthcare workers, but these programs must be customized to meet the needs and challenges of the facility.

Project Site and Population

The project was implemented at a psychiatric hospital in Illinois. The stakeholders for this quality improvement project included the nurses, advanced practice nurses, therapists, psychologists, physicians, mental health associates, supervisors, house keepers, facilities

management, and management staff/leadership team. There are about 25 therapists, 10 psychiatrists, 7 medical doctors, 6 advanced practice nurses, 26 mental health associates, 12 registered nurses and 4 psychologists. About 60% of healthcare providers are White, 30% are Black, and 10% are Asian; ages range from 20 years to 65 years; about 80% are females and 20% are males. The hospital has an average length of stay of 14.78 days. It serves patients across Illinois and neighboring states with patients travelling across state lines for medication management due to the shortage of psychiatric providers and facilities. The facility has several inpatient units, a drug treatment/rehabilitation unit, a partial hospitalization program as well as an outpatient clinic which serves patients across the lifespan from pediatric patients to older adults.

Measurement Instruments

Data was collected using the Confidence in Coping with Patient Aggression Instrument (CCPAI) (see Appendix D); permission was granted to use the instrument (see Appendix C). The purpose of the instrument is to measure confidence in coping with patient aggression. The CCPA consists of ten questions, which use an 11-point Likert scale. Example of questions include, how comfortable are you in working with an aggressive patient? Responses ranged from very uncomfortable to very comfortable, very poor to very good, very ineffective to very effective, very unable to very able etc. This instrument was found to be reliable ($\alpha = 0.96$) (Guay, Goncalves & Boyer, 2016) with a high degree of internal precision and consistency; the linear sum of Items 1 through 10, for which lower and higher totals represented lesser and greater confidence, respectively (possible range of 10 – 110) had a standard error of about 1.5 (Thackrey, 1987).

Implementation and Data Collection

The DNP student developed the educational toolkit by reviewing the literature and incorporating evidence-based nonviolent crisis prevention strategies with CPI's top 10 de-escalation tips. The DNP student posted physical flyers containing the topic and purpose of the project at employee time clocks, break rooms, bulletin boards and nursing stations. The poster provided staff with information about the project and how to participate. Staff were invited to contact the DNP student via the phone or email (listed in the flyer) if they had any questions or would like more information about the project goals and procedures. The poster specified that participation was voluntary, and that responses were strictly confidential. The flyer also contained information about a \$10 Amazon gift card which would be given to the first 25 participants.

Educational packets on the use of nonviolent crisis intervention and other de-escalation strategies to prevent type 2 violence (see Appendix K) were placed in labeled containers in nursing stations, and staff break rooms, across the hospital for review by healthcare workers at their convenience. A sign was placed in front of the packets directing participants on how to review the packet. Participants were asked to complete the CCPAI prior to reviewing the educational packet, and another CCPAI to be completed after reviewing the packet. Participants were asked to drop off their completed survey and questionnaire in a designated drop box conveniently located in the hospital. The DNP student protected participants and data by making sure that oral consents were obtained from participants prior to reviewing the educational packet, goals and procedure were explained in detail, survey and questionnaire were dropped off at a lock box conveniently located in the hospital by participants after reviewing the educational packet. Survey and questionnaire responses were anonymous, and data stored in the lock box was only accessible to the DNP student and project mentor.

Additionally, in the educational packet, participants were required to provide sociodemographic and occupational information (see Appendix F) and the DNP student placed a post card asking if the participants were willing to provide feedback about the educational materials reviewed. If yes, the participant took one of the business cards in the packet and contacted the DNP student to arrange a short (10 min) telephone interview/feedback on materials (Appendix E). Three participants contacted the DNP student, and he took notes during the interview for the purpose of updating and improving the educational packet (see Table 3). CPI verbal escalation continuum posters were also placed across the hospital as reminders (see Appendix J).

Data Analysis

Analysis used IBM SPSS Statistics (Version 25) analytics software. Data was entered, and coded, and missing data noted. Descriptive statistics were presented as mean and standard deviation.

Results

The QI project was implemented in two units in a psychiatric hospital. There were 11 participants comprising 5 mental health associates (MHA), 2 registered nurses (RN) and 4 therapists; there were 7 females and 4 males, 4 participants were between 20 and 30 years, 3 participants were between 30 and 40 years, 2 participants were between 40 and 50 years and the remaining 2 participants were between 50 and 60 years; 6 of them had over 5 years of experience on the job while the remaining 5 had less than 5 years of experience on the job; 6 participants identified as Black and 5 identified as White; 9 participants answered “Yes” to the question “Have you ever experienced type 2 (client on worker) violence?” while the remaining 2

answered “No” (see Table 1). The project was implemented over a 4-month period from October 2020 to January 2021 (see Appendix G). The overall self-perceived mean score of the CCPAI was higher post-intervention (Mean= 27.52, SD= 3.32) compared to pre-intervention (Mean=22.83, SD=4.31) (see Table 2) indicating improvement in their confidence in coping with patient aggression. There was a relationship between years of experience and confidence in coping with patient aggression because participants with 5 or more years of experience had greater confidence in coping with patient aggression when compared to their counterparts with fewer than 5 years of experience (60% and 40% respectively) (see Fig. 1). Data from the two units showed that violence against healthcare workers reduced by about 9% one month after the educational intervention (see Table 4).

Table 1

Participants’ Sociodemographic and Occupational Characteristics (n =11)

<i>Variables</i>	<i>n (%)</i>
<i>Job title</i>	
Mental Health Associate	5 (45.5)
Registered Nurse	2 (18.2)
Therapist	4 (36.4)
<i>Gender</i>	
Female	7 (63.6)
Male	4 (36.4)

<i>Age</i>	
20 – 30	4 (36.4)
30 - 40	3 (27.2)
40 – 50	2 (18.2)
50 – 60	2 (18.2)
<i>Years of Experience</i>	
≥ 5	6 (54.6)
< 5	5 (45.4)
<i>Race</i>	
Asian	1 (9)
Black	6 (54.6)
Hispanic	2 (18.2)
White	2 (18.2)
<i>Have you ever experienced type 2 (client on worker) violence?</i>	
Yes	9 (81.8)
No	2 (18.2)

Table 2.

Comparison of Pre- and Post-intervention Confidence in Coping with Patient Aggression Scores

	Mean	N	Standard deviation
Pre-education	22.83	11	4.31
Post-education	27.52	11	3.32

Table 3.*Interview: Feedback on Materials*

Questions	1st Participant	2nd Participant	3rd Participant
Did you find the packet helpful?	Yes	Yes	Yes, the packet refreshed my memory on the overall topic.
Would you apply any of the information in your current position?	Yes	Yes	Yes, I would. This information is helpful on a day-to-day basis
Was the content well organized and easy to follow?	Yes	Yes	Yes, it was
What did you like the most about the packet?	I liked the de-escalation tips, especially tip #5. I like to validate people's feelings to	Instructions were clear. Step by step.	I liked how specific and detailed everything was.

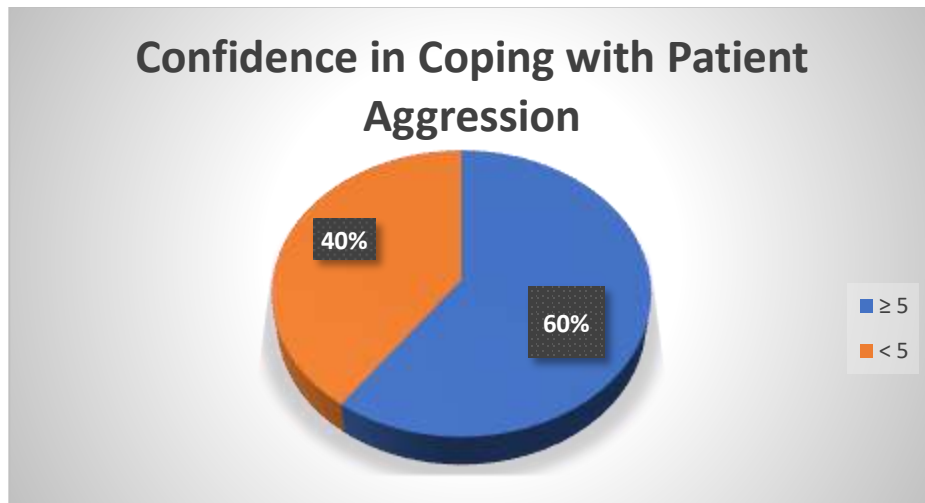
	show that you care/understand.		
How would you rate this packet overall on a scale of 1 - 10?	6	8	10
What would you change about the packet?	Include visual of CPI technique for physical aggression	Keep this packet	N/A – The packet entailed the right amount of information
Would you recommend this packet to a friend or colleague?	Yes	Yes	Yes

Table 4.*Incidence of Type 2 Violence Pre- and Post-education*

Variable	1 Month Pre-education	1 Month Post-education
Incidence of type 2 violence	13	12
Rate of reduction/increase	---	(-) 9%

Figure 1

Percentage of Confidence in Coping with Patient Aggression by Years of Experience



Discussion

The quality improvement project included the creation of an educational toolkit and measured the toolkit effectiveness in increasing staff confidence in coping with patient aggression and preventing type 2 violence against healthcare workers. Staff confidence in managing patient aggression improved after reviewing the educational packet, consistent with results of similar projects using the same instrument. The 9% decrease in type 2 violence 1 month post educational intervention was encouraging but there was no definite evidence to suggest that this was directly because of the educational toolkit. The sample size was limited due to the COVID-19 pandemic.

The educational toolkit was well received by study participants and continues to serve as a concise refresher packet for nonviolent verbal de-escalation training. The facility welcomed the packet but due to the COVID-19 pandemic and the resultant staffing shortage, the facility was

focused on other priorities at the time but indicated that recommendations would be adopted at a future date.

Setting Facilitators and Barriers

Resources and facilitators of this quality improvement project included a preceptor who was both proficient and compassionate, passionate members of the interdisciplinary healthcare team such as nurses, advanced practice nurses, therapists, psychologists, physicians, mental health associates, as well as other members of staff including housekeeping staff, facility management staff and security. These staff members, particularly the healthcare workers, were yearning for a change in the status quo because they wanted to be safe, while keeping the patients safe. A primary facilitator was the fact that management had already invested in basic training for all staff members during orientation in nonviolent crisis intervention (CPI). The leadership team encourages activities which will reduce violence against any staff member. This served as an additional facilitator to the project.

A major barrier to the implementation of the project was the COVID-19 pandemic, because due to it only 44% of the projected participants were recruited for the project and the entire project had to be overhauled in terms of provision of in-person education/presentation due to social distancing guidelines to accommodate restrictions imposed by the Centers for Disease and Prevention (CDC) and the municipality. Since COVID-19 was responsible for staffing shortages and possible staff burnout, the toolkit was presented in manner which would not appear monotonous to participants considering that participants would review the packet/toolkit at their leisure. Other barriers to implementation of this project included management's hesitancy to see a potential surge in incident reports created by healthcare workers due to greater awareness of workplace violence as well as the reluctance of healthcare workers to complete

incident reports for fear of retaliation by management. Another barrier was the readiness of management to provide the required personal protective equipment (PPE) for healthcare workers, especially the equipment needed when dealing with individuals who smear feces and other bodily fluids, raising significant concerns for disease transmission and sanitation. This was a significant concern as the need for PPE was already high during the COVID-19 pandemic. These barriers were addressed by assuring management that the benefits of the project such as reduction in staff turnover and payment of workers' compensation outweighs the costs since management had already invested in some training of staff on CPI. Management was also reassured that the training offered to staff was utilized in the prevention of type 2 violence.

Strengths and Weaknesses

Strengths of the project include a mean increase in confidence in coping with patient aggression scores and 9% decrease in type 2 violence post educational intervention. Other strengths include diversity of participants' years of experience, age group and race. A major weakness of the project was the small participants' size. Another weakness was the fact that there was no way of knowing if the participants followed the instructions for reviewing the educational packet. So, some participants could have potentially completed the pre and post CCPI without taking the time to review the packet.

Nursing Implication

Type 2 violence could be significantly reduced if toolkits such as this are adopted as part of the training modules in healthcare facilities across the country. With a reduction in type 2 violence, this could potentially lead to higher staff retention and lower staff burnout. This could

also potentially improve patient outcomes since type 2 violence has been associated to not only decreased job satisfaction but also poor patient outcomes.

Future Considerations

After the COVID-19 pandemic, when the social distancing guidelines and pandemic related restrictions are lifted, there is a need to develop a more robust toolkit which will involve offering in-person and virtual training sessions to mitigate possible COVID-induced apathy.

Ethical Considerations/Protection of Human Subjects

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP Project (Appendix A). A letter of support was received from the clinical site. The DNP student ensured that there are no identifiers in the responses and participant data was protected. There were no risks to participants. All electronic files surrounding the project was password protected and only accessible by the DNP student, mentor, and program chair.

Cost-Benefit Analysis/Budget

The costs for this project include cost of educational packets, while materials include Amazon gift cards and brochures.

Costs: Education & Training:

Educational packet $\$25 \times 5 = \125

Questionnaire and survey = \$50

Total for Education & training: \$175

Materials

Amazon gift cards $\$10 \times 11 = \110

Total Expenses: \$285

Estimated Cost Savings:

Cost of annual workplace violence charges for about 2.1% of nurses who reported injuries was \$94,156 (Speroni et al., 2014).

Estimated Benefits and Value:

At an estimated cost of \$285, the benefit of this project far outweighs any potential cost because the estimated cost of turnover for a full-time equivalent nurse is \$36,657 (Kurnat-Thoma et al., 2017) which is just one out of several other costs for which violence against healthcare workers is the major driver.

The DNP student was responsible for the total cost of \$285. As part of the cost of project implementation, there was no direct cost to the facility because nonviolent crisis intervention (CPI) training was provided to all employees upon orientation by the facility. Personal protective equipment was available on the unit for healthcare workers in close contact with patients who smear feces and bodily fluids.

Timeline

Over a 3-month period, all data was collected by the DNP student. The intervention was implemented as follows:

- November: Eligible participants were recruited, and pre- and post-intervention questionnaire was completed.

- December and January: Educational packets were reviewed by participants; pre- and post-intervention questionnaire and survey were collected, and data was analyzed.

Conclusion

Workplace violence against healthcare workers is a rising epidemic, which must be mitigated by adopting evidence-based strategies such as this educational toolkit. All stakeholders must work together to ensure the success of these strategies and ultimately the wellbeing and safety of staff members. Further research with high evidence levels and strength is required to address gaps in practice and to ascertain the effectiveness of other evidence-based strategies. Violence prevention programs have shown some promising results and must be tailored to meet the unique needs of each facility. The benefit of implementing a violent prevention program outweighs the cost in terms of human capital and financial resources.

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Appendix A

UMass IRB Letter of Approval

UMassAmherst

Human Research Protection Office

Mass Venture Center
100 Venture Way, Suite 116
Hadley, MA 01035
Telephone: 413-545-3428

Memorandum – Not Human Subjects Research Determination**Date:** November 10, 2020**To:** Chibuzor Anyanwu, College of Nursing**Project Title:** *Evidence-Based Strategies for the Prevention of Workplace Violence Against Health Care Workers; Creating an Educational Toolkit***HRPO Determination Number:** 20-229

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination based on the information provided to our office:

- ☐ The proposed project does not involve research that obtains information about living individuals [45 CFR 46.102(f)].
- ☐ The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information [45 CFR 46.102(f)(1), (2)].
- ☒ The proposed project does not meet the definition of human subject research under federal regulations [45 CFR 46.102(d)].

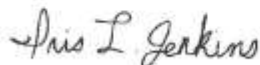
Submission of an Application to UMass Amherst IRB is not required.

Note: This determination applies only to the activities described in the submission. If there are changes to the activities described in this submission, please submit a new determination form to the HRPO prior to initiating any changes. ***Researchers should NOT include contact information for the UMass Amherst IRB on any project materials.***

A project determined as “Not Human Subjects Research,” must still be conducted ethically. The UMass Amherst HRPO strongly expects project personnel to:

- treat participants with respect at all times
- ensure project participation is voluntary and confidentiality is maintained (when applicable)
- minimize any risks associated with participation in the project
- conduct the project in compliance with all applicable federal, state, and local regulations as well as UMass Amherst Policies and procedures which may include obtaining approval of your activities from other institutions or entities.

Please do not hesitate to call us at 413-545-3428 or email humansubjects@ora.umass.edu if you have any questions.



Iris L. Jenkins, Assistant Director
Human Research Protection Office

Appendix B**Kotter's 8-Step Change Model**

*Adapted from Dr John Kotter's 8 Step Process for leading change
<http://www.kotterinternational.com/our-principles/changesteps/changesteps>*

Appendix C**Limited Permission to use “Clinician Confidence in Coping with Patient Aggression” scale**

You are hereby granted limited permission to use my

“Clinician Confidence in Coping with Patient Aggression” scale

subject to the following conditions:

This scale is to be used **for research purposes only**, pending further validation.

This scale must **not be altered**.

The **wording of each item must not be changed**.

The **11-point anchored response scale must not be changed**
(e.g., different number of scale points, omission or alteration of anchors).

To ensure fidelity, any non-English language translation must first be translated from English to non-English and then **independently back-translated** from non-English language back to English.

You forward to me a copy of your research results.

By using this instrument you agree to these conditions.

Limited permission to use this scale is automatically withdrawn if you do not meet each of these conditions.

note: this instrument is designed to yield **a single overall score** (sum of individual item values) - analysis of individual items alone will truncate reliability.

There is no fee for use of this instrument.

I attach a copy of this instrument for your reference.

Please confirm by return email your acceptance of the conditions above.

Very truly yours

Michael “Misha” Thackrey PhD

Professor of Psychology California State University Fresno

Charter Fellow, Association for Psychological Science

Appendix D**Confidence in Coping with Patient Aggression Instrument (Thackrey 1987)**

Below is a list of questions on dealing with patient aggression. Please read each question carefully and respond by circling a number on the scale.

1. How comfortable are you in working with an aggressive patient?
Very Uncomfortable 1 2 3 4 5 6 7 8 9 10 11 **Very Comfortable**
2. How good is your present level of training for handling psychological aggression?
Very Poor 1 2 3 4 5 6 7 8 9 10 11 **Very Good**
3. How able are you to intervene physically with an aggressive patient?
Very Unable 1 2 3 4 5 6 7 8 9 10 11 **Very Able**
4. How self-assured do you feel in the presence of an aggressive patient?
Not Very Self-Assured 1 2 3 4 5 6 7 8 9 10 11 **Very Self-Assured**
5. How able are you to intervene psychologically with an aggressive patient?
Very Unable 1 2 3 4 5 6 7 8 9 10 11 **Very Able**
6. How good is your present level of training for handling physical aggression?
Very Poor 1 2 3 4 5 6 7 8 9 10 11 **Very Good**
7. How safe do you feel around an aggressive patient?
Very Unsafe 1 2 3 4 5 6 7 8 9 10 11 **Very Safe**
8. How effective are the techniques that you know for dealing with aggression?
Very Ineffective 1 2 3 4 5 6 7 8 9 10 11 **Very Effective**
9. How able are you to meet the needs of an aggressive patient?
Very Unable 1 2 3 4 5 6 7 8 9 10 11 **Very Able**
10. How able are you to protect yourself physically from an aggressive patient?
Very Unable 1 2 3 4 5 6 7 8 9 10 11 **Very Able**

Appendix E

Evidence-Based Strategies for the Prevention of Workplace Violence Against Health Care

Workers: An Educational Intervention

Feedback on Materials

1. Did you find the packet helpful?
2. Would you apply any of the information in your current position?
3. Was the content well organized and easy to follow?
4. What did you like the most about the packet?
5. How would you rate this packet overall on a scale of 1 - 10?
6. What would you change about the packet?
7. Would you recommend this packet to a friend or colleague?

Appendix F**Participant's Sociodemographic and Occupational Characteristics**

1. What is your current job title?
2. What is your gender?
3. How old are you?
4. How many years of experience do you have on the job?
5. What is your race?
6. Have you ever experienced type 2 (client on worker) violence?

Appendix G

DNP Project Timeline

Task	Nov	Dec	Jan	Feb	March	April
Recruitment of eligible participants	X	X				
Pre-intervention questionnaire	X	X	X			
Review of Educational Packet on prevention of workplace violence	X	X	X			
Post-intervention questionnaire and survey	X	X	X			
Data analysis				X		
Final Project write up.				X	X	X
Dissemination of results to facility/unit				X		

Appendix H

JHNEBP EVIDENCE RATING SCALES

STRENGTH of the Evidence		
Level I		Experimental study/randomized controlled trial (RCT) or meta analysis of RCT
Level II		Quasi-experimental study
Level III		Non-experimental study, qualitative study, or meta-synthesis.
Level IV		Opinion of nationally recognized experts based on research evidence or expert consensus panel (systematic review, clinical practice guidelines)
Level V		Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience)

QUALITY of the Evidence		
A High	Research	consistent results with sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.
	Summative reviews	well-defined, reproducible search strategies; consistent results with sufficient numbers of well defined studies; criteria-based evaluation of overall scientific strength and quality of included studies; definitive conclusions.
	Organizational	well-defined methods using a rigorous approach; consistent results with sufficient sample size; use of reliable and valid measures
	Expert Opinion	expertise is clearly evident
B Good	Research	reasonably consistent results, sufficient sample size, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence
	Summative reviews	reasonably thorough and appropriate search; reasonably consistent results with sufficient numbers of well defined studies; evaluation of strengths and limitations of included studies; fairly definitive conclusions.
	Organizational	Well-defined methods; reasonably consistent results with sufficient numbers; use of reliable and valid measures; reasonably consistent recommendations
	Expert Opinion	expertise appears to be credible.
C Low quality or major flaws	Research	little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn
	Summative reviews	undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results; conclusions cannot be drawn
	Organizational	Undefined, or poorly defined methods; insufficient sample size; inconsistent results; undefined, poorly defined or measures that lack adequate reliability or validity
	Expert Opinion	expertise is not discernable or is dubious.

*A study rated an A would be of high quality, whereas, a study rated a C would have major flaws that raise serious questions about the believability of the findings and should be automatically eliminated from consideration.

Newhouse R, Dearholt S, Poe S, Pugh LC, White K. The Johns Hopkins Nursing Evidence-based Practice Rating Scale. 2005. Baltimore, MD, The Johns Hopkins Hospital; Johns Hopkins University School of Nursing.

Appendix I**Strength and Quality of Evidence of Articles Used for Review of Literature**

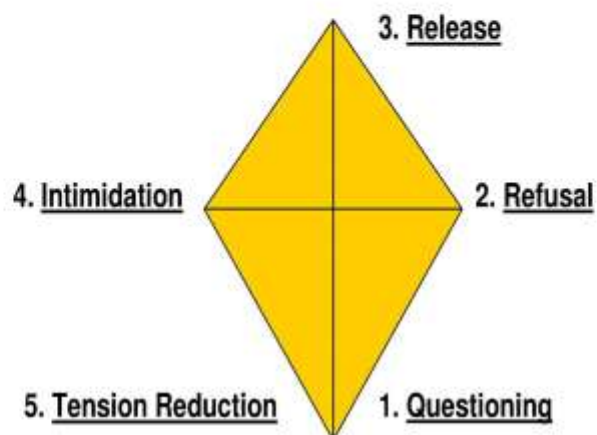
Article	Type of Article	Strength of Evidence	Quality of Evidence
Al-Ali, N. M., Al Faouri, I., & Al-Niarat, T. F. (2016). The impact of training program on nurses' attitudes toward workplace violence in Jordan. <i>Applied Nursing Research</i> , 30, 83-89.	Qualitative study	Level III	B
Arnetz, J. E., Hamblin, L., Russel J., Upfal, M. J., Luborsky, M., Janisse, J., & Essenmacher, L. (2017). Preventing patient-to-worker violence in hospitals: Outcome of a randomized controlled intervention. <i>Journal of Occupational and Environmental Medicine</i> , 59(1), 18–27. doi:10.1097/JOM.0000000000000909.	Randomized control trial	Level I	B
Baig, L., Tanzil, S., Shaikh, S., Hashmi, I., Khan, M. A., Polkowski, M. (2018). Effectiveness of training on de-escalation of violence and management of aggressive behavior faced by health care providers in a public sector hospital of Karachi. <i>Pakistan Journal of Medical Sciences</i> , 34(2), 294-299.	Quasi-experimental	Level II	B
Davey, K., Ravishankar, V., Mehta, N., Ahluwalia, T., Blanchard, J., Smith, J., & Douglass, K. (2020). A qualitative study of workplace violence among healthcare providers in emergency departments in india. <i>International Journal of Emergency Medicine</i> , 13(1), 33. https://doi.org/10.1186/s12245-020-00290-0	Qualitative study	Level III	B
Dilman, Y. (2015). EB72 code green for workplace violence. <i>Critical Care Nurse</i> , 35, e34-e35.	Quality improvement	Level V	B
Guay, S., Goncalves, J., & Boyer, R. (2016). Evaluation of an education and training program to prevent and manage patients' violence in a mental health setting: A pretest-posttest intervention study. <i>Healthcare</i> , 4(3), 49.	Qualitative study	Level III	B
Hill, A. K., Lind, M. A., Tucker, D., Nelly, P., Daraiseh, N. (2015). Measurable results: Reducing staff injuries on a specialty psychiatric unit for patients with developmental	Qualitative study	Level III	B

disabilities. <i>Work</i> , 51, 99-111. doi: 10.3233/WOR-152014			
Hodgson, M. J., & Drummond, D. J. (2011). Assault rates and implementation of a workplace violence prevention program in the veterans health care administration. <i>Journal of Occupational and Environmental Medicine</i> , 53(5), 511-516. doi: 10.1097/JOM.0b013e31820d101e.	Non-experimental study	Level III	B
Isaak, V., Vashdi, D., & Steiner-Lavi, O. (2018). The long-term effects of a prevention program on the number of critical incidents and sick leave days. <i>International Journal of Mental Health Systems</i> , 12(71), 1-5.	Qualitative study	Level III	B
Lakatos, B. E., Mitchell, M. T., Askari, R., Etheredge, M. L., Hopcia, K., DeLisle, L... & Shellman, A. (2019). An interdisciplinary clinical approach for workplace violence prevention and injury reduction in the general hospital setting: s.a.f.e. response. <i>Journal of the American Psychiatric Nurses Association</i> , 25(4) 280–288.	Quality improvement	Level V	B
Peek-Asa, C., Casteel, C., Allareddy, V., Nocera, M., Goldmacher, S., Ohagan, E... & Harrison, R. (2009). Workplace violence prevention programs in psychiatric units and facilities. <i>Archives of Psychiatric Nursing</i> , 23(2), 166-176.	Qualitative study	Level III	B
Touzet, S., Occelli, P., Denis, A., Cornut, P., Fassier, J., Le Pogam, M... & Burillon, C. (2019). Impact of a comprehensive prevention programme aimed at reducing incivility and verbal violence against healthcare workers in a french ophthalmic emergency department: An interrupted time-series study. <i>BMJ Open</i> , 9(9), 1-10. doi: 10.1136/bmjopen-2019-031054	Non-experimental	Level III	B
Wakefield, G. S. (2014). Nonviolent crisis intervention training and the incidence of violent events in a large hospital emergency department: An observational quality improvement study. <i>Advanced Emergency Nursing Journal</i> , 36(2), 177-188.	Observational study	Level III	B

Appendix J

CPI Verbal Escalation Continuum Poster

The Verbal Escalation Continuum



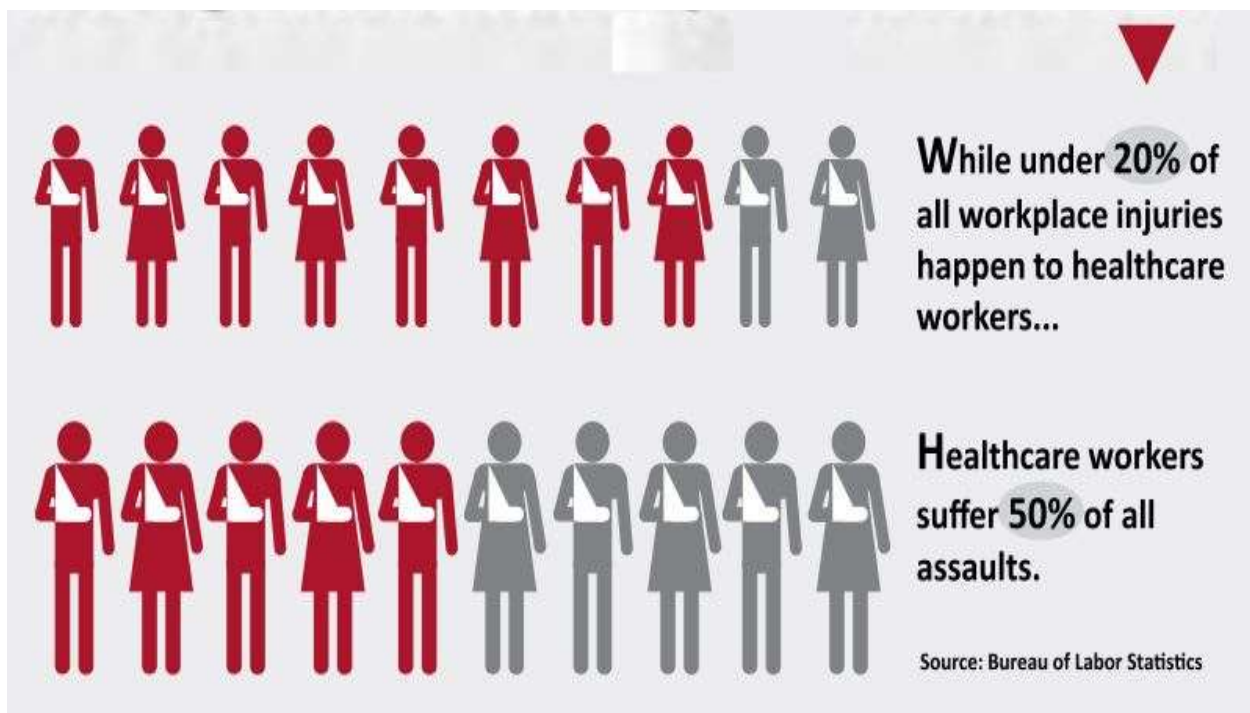
Approved Verbal Interventions

Questioning	Refusal	Release	Intimidation	Tension Reduction
<ul style="list-style-type: none"> • Give a rational response • Stick to the topic (redirect) • Ignore the challenge (not the person) • Set limits if patient (s) persists 	<ul style="list-style-type: none"> • Set clear, simple, reasonable and enforceable limits • State directives by starting with positive comment first • Allow patient time to process request/directive • End process with giving patient a choice and natural outcomes 	<ul style="list-style-type: none"> • Allow them to let off steam, if possible • Remove audience or acting out person from the area • When individual begins to quiet down, state directives that are non-threatening • Use understanding approach • Be prepared to enforce limits that were set 	<ul style="list-style-type: none"> • Seek assistance and wait for team to intervene if possible • Try to avoid individual intervention, as this is more likely to jeopardize the safety and welfare of both staff and acting out person 	<ul style="list-style-type: none"> • Establish Therapeutic Rapport • Reestablish positive communication with the patient (s)

Source: CPI: Nonviolent Crisis Intervention Training © Crisis Prevention Institute, Inc.

Appendix K

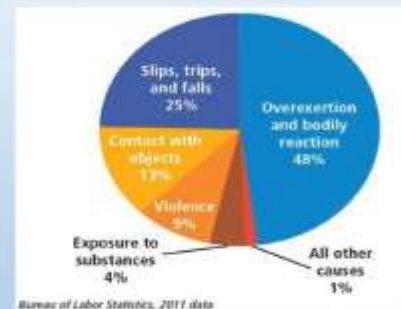
Educational Packet on Prevention of Violence Against Healthcare Workers



In the United States, the problem of violence against healthcare workers is indicated by 75% of an estimated 25,000 workplace assaults reported yearly occurred in healthcare and social service settings (OSHA, 2015) with healthcare workers having a 20% higher risk of workplace violence compared to their counterparts in other sectors (Harrell, 2011). This results in increased medical errors, reduced quality of patient care, high rates of stress, decreased job satisfaction, absenteeism, more injury claims (d'Ettorre & Pellicani, 2017). Therefore, the purpose of the proposed project is to mitigate the problem of type 2 violence through the implementation of an evidence-based workplace violence prevention program.

Prevalence of Workplace Violence in Healthcare

- Violence is more common source of injury in healthcare than in other industries (10-13% vs 3%)
 - Under 20% of all workplace violence injuries happen to healthcare workers, healthcare workers suffer 50% of all assaults (OSHA, 2015)



(OSHA, 2013)






CPI'S TOP 10

De-Escalation Tips

crisisprevention.com



CPI'S TOP 10 DE-ESCALATION TIPS

Can These Tips Help Me?

Whether at work or at home, you might deal with angry, hostile, or noncompliant behavior every day. Your response to defensive behavior is often the key to avoiding a physical confrontation with someone who has lost control of their behavior.

These 10 De-Escalation Tips will help you respond to difficult behavior in the safest, most effective way possible.

TIP 1

Be empathic and nonjudgmental.

When someone says or does something you perceive as weird or irrational, *try not to judge or discount their feelings*. Whether or not you think those feelings are justified, *they're real to the other person*. Pay attention to them.

Keep in mind that whatever the person is going through, it may be the most important thing in their life at the moment.

TIP 2

Respect personal space.

If possible, *stand 1.5 to three feet away* from a person who's escalating. Allowing personal space tends to *decrease a person's anxiety* and can help you *prevent acting-out behavior*.

If you must enter someone's personal space to provide care, explain your actions so the person feels less confused and frightened.

CPI'S TOP 10 DE-ESCALATION TIPS

TIP 3**Use nonthreatening nonverbals.**

The more a person loses control, *the less they hear your words*—and the more they react to your nonverbal communication. Be mindful of your *gestures, facial expressions, movements, and tone of voice*.

Keeping your tone and body language neutral will go a long way toward defusing a situation.

TIP 4**Avoid overreacting.**

Remain *calm, rational, and professional*. While you can't control the person's behavior, *how you respond to their behavior* will have a direct effect on whether the situation escalates or defuses.

Positive thoughts like "I can handle this" and "I know what to do" will help you maintain your own rationality and calm the person down.

TIP 5**Focus on feelings.**

Facts are important, but *how a person feels is the heart of the matter*. Yet some people have trouble identifying how they feel about what's happening to them.

Watch and listen carefully for the person's real message.

Try saying something like "That must be scary." Supportive words like these will let the person know that you understand what's happening—and you may get a positive response.

TIP 6**Ignore challenging questions.**

Answering challenging questions often results in a power struggle. When a person challenges your authority, *redirect their attention to the issue at hand*.

Ignore the challenge, but not the person. Bring their focus back to how you can work together to solve the problem.

CPI'S TOP 10 DE-ESCALATION TIPS

TIP 7**Set limits.**

If a person's behavior is belligerent, defensive, or disruptive, give them *clear, simple, and enforceable limits*. Offer concise and respectful choices and consequences.

A person who's upset may not be able to focus on everything you say. Be clear, speak simply, and offer the positive choice first.

TIP 8**Choose wisely what you insist upon.**

It's important to be thoughtful in deciding *which rules are negotiable and which are not*. For example, if a person doesn't want to shower in the morning, can you *allow them to choose* the time of day that feels best for them?

If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations.

TIP 9**Allow silence for reflection.**

We've all experienced awkward silences. While it may seem counterintuitive to let moments of silence occur, sometimes it's the best choice. It can *give a person a chance to reflect on what's happening*, and how he or she needs to proceed.

Believe it or not, silence can be a powerful communication tool.

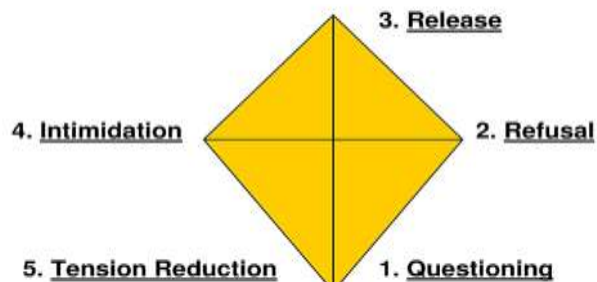
TIP 10**Allow time for decisions.**

When a person is upset, they may not be able to think clearly. Give them a few moments to *think through what you've said*.

A person's stress rises when they feel rushed. Allowing time brings calm.

➤ Visit crisisprevention.com to learn more.

The Verbal Escalation Continuum



Approved Verbal Interventions

Questioning	Refusal	Release	Intimidation	Tension Reduction
<ul style="list-style-type: none"> • Give a rational response • Stick to the topic (redirect) • Ignore the challenge (not the person) • Set limits if patient (s) persists 	<ul style="list-style-type: none"> • Set clear, simple, reasonable and enforceable limits • State directives by starting with positive comment first • Allow patient time to process request/directive • End process with giving patient a choice and natural outcomes 	<ul style="list-style-type: none"> • Allow them to let off steam, if possible • Remove audience or acting out person from the area • When individual begins to quiet down, state directives that are non-threatening • Use understanding approach • Be prepared to enforce limits that were set 	<ul style="list-style-type: none"> • Seek assistance and wait for team to intervene if possible • Try to avoid individual intervention, as this is more likely to jeopardize the safety and welfare of both staff and acting out person 	<ul style="list-style-type: none"> • Establish Therapeutic Rapport • Reestablish positive communication with the patient (s)

Source: CPI: Nonviolent Crisis Intervention Training © Crisis Prevention Institute, Inc.



At St. David's South Austin
Medical Center,



The ED serves more than

75,000



per year.



After implementing
Nonviolent Crisis Intervention®,



the ED saw a



23%

reduction in violent
incidents.*

**What can CPI training do for
YOUR facility?**



crisisprevention.com

*During the one-year period between November 2012 and October 2013. Data taken with permission from Dr. Sally Gillam's article, "Nonviolent Crisis Intervention Training and the Incidence of Violent Events in a Large Hospital Emergency Department," *Advanced Emergency Nursing Journal*.