Workplace Violence: An Urgent Call for Integrated Staff Education in Acute Care Hospitals

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Workplace Violence:
An Urgent Call for Integrated Staff Education in Acute Care Hospitals

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A Final Paper
Presented in Partial Fulfillment of the Requirements for the Degree of
Doctor of Nursing Practice, Executive Leadership

EL-DNP Committee

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Abstract

**Problem:** Type II workplace violence (WPV) in acute care hospital settings has become an epidemic of costly proportions in the United States. Regulatory mandates and healthcare accreditation standards increasingly require healthcare employers to provide a safe and healthy healing environment for patients and a safe work environment for staff. Implementation of a comprehensive WPV prevention program depends largely on organizational culture, participation and commitment from key stakeholders, and readiness for change.

**Context:** The patient-clinician relationship has drawn urgent attention, as healthcare organizations around the world implement key components of WPV prevention programs. The clinical management of patient aggression in non-emergency department and non-behavioral health settings (e.g., medical-surgical, telemetry, and step-down acute care units) has presented a unique knowledge gap for healthcare staff not traditionally trained to provide care for patients who present with aggression and/or behavioral crises.

**Interventions:** The project interventions focused on quantitative and qualitative evidence to develop, implement, and evaluate an integrated WPV prevention staff education course, to improve staff knowledge about WPV prevention and improve staff attitudes about managing care for aggressive patients. The course integrated organizational policies and protocols for violence risk assessment and behavioral emergency response codes.

**Outcome Measures:** Outcomes were measured by pre- and post-intervention surveys, data analyses, staff education evaluation forms, and anecdotal findings from participant feedback. The outcomes measured showed an improvement in staff knowledge (29.4%, n = 8) and attitudes (14.7%, n = 8) after the WPV prevention education course. The project was successfully implemented in a major healthcare care system in San Diego, California, and provided valuable
guidance in the development of integrated frontline nursing education as part of a comprehensive WPV prevention program.

Keywords: violence, workplace violence, workplace violence prevention program, crisis intervention, behavioral distress, nursing, psychiatric nursing, nursing leadership, mental health, behavioral health, healthcare
Acknowledgments and Dedication

I would like to express my profound gratitude to the University of San Francisco faculty, staff, and fellow alumni for cultivating an environment of nursing innovation, academic excellence, and cultural diversity throughout my graduate and doctoral studies. My USF experience has enriched my growth as a nurse executive, innovator, scholar, and healer. A very special thank you to my Doctor of Nursing Practice Committee: Dr. Sara Horton-Deutsch for her deliberate encouragement to do authentic healing work of the heart, and Dr. Elena Capella for her nursing leadership expertise and steadfast support of my professional development. Thank you to Dean Maggie Baker and Dr. K.T. Waxman for their dynamic, transformative leadership throughout my USF experience. A heartfelt thank you to my esteemed colleagues in EL-DNP Cohort 10 Class of 2020 – I will forever treasure the memories of our intensive teaching weekends, city adventures, heart-to-heart connections, and supporting each other in our growth as nurse leaders while surviving a global pandemic. By the grace of God, we did it!

This work is dedicated to my family and friends who have witnessed, encouraged, and supported my unrelenting dedication to the nursing profession. It is also dedicated to my nursing family – all the registered nurses, nurse leaders, directors, educators, mentors, and healthcare staff with whom I have had the honor to work including my DNP project preceptor, stakeholders, and participants. Last but never least, this work is dedicated to the courageous frontline healthcare workers around the world who face the increasingly stark reality of workplace violence yet remain enthusiastically committed to compassionate care of their patients and quality improvement in their work environments. You are unsung heroes and one of the driving forces behind my life’s best work. May your minds be inspired; your bodies, rested; your hearts, healed; and your souls, brave. God bless you, always.
Section II: Introduction

Problem Description

Workplace violence (WPV) in healthcare settings has become a serious epidemic in the United States. The Occupational Safety and Health Administration (OSHA, 2018a) defines WPV as “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide” (para. 2). In all occupational industries, nearly two million American workers are victims of WPV each year, while many more cases go unreported (OSHA, 2018a). Even if no physical injury occurs, threats, abuse, intimidation, hostility, harassment, and other forms of verbal violence cause significant psychological trauma and can potentially escalate to physical violence. From 2002 to 2013, the rate of serious WPV incidents (those requiring days off for an injured worker to recover) was more than four times greater in healthcare than in private industries and accounted for nearly as many serious violent injuries as all other industries combined (OSHA, 2018b).

While the definition of WPV is quite broad and includes criminal acts committed by external parties (i.e., a disgruntled former employee or a mass casualty incident) and incidents of lateral violence or incivility (i.e., bullying among co-workers), this project addresses WPV only in the context of the clinician relationship with patients, family members, and visitors in acute care hospital settings, which is classified as type II WPV by the Centers for Disease Control and Prevention (CDC, 2013). According to the Bureau of Labor Statistics, patients are the largest source of violence in healthcare (OSHA, 2018b). In 2013, patient interactions caused 80% of reported serious violent incidents of healthcare work injuries resulting in time away from work (OSHA, 2018b).
The ubiquity of WPV and its profound ripple effects on healthcare staff cannot be understated. As part of the American Nurses Association’s (ANA, 2014) “Healthy Nurse, Healthy Nation Challenge,” a 2014 health risk appraisal surveyed 3,765 registered nurses (RNs) and nursing students. Twenty-one percent of respondents reported being physically assaulted, and over 50% of respondents stated they were verbally abused in a 12-month period. In 2013, the most common causes of violent physical injuries resulting in days away from work across several healthcare occupations were hitting, kicking, beating, and/or shoving (ANA, 2014).

Healthcare organizations are challenged to address type II WPV, as the problem has grown beyond emergency department (ED) and behavioral health (BH) settings to other acute care hospital units, where healthcare staff generally do not possess the training and skillsets to assess and treat behaviorally aggressive patients. Special attention should be given to patient populations that commonly present with comorbidities that compound the potential for violence in a variety of acute care hospital settings. According to Langås, Malt, and Opjordsmoen (2011), patients with comorbid psychiatric and substance abuse, as compared to those with a single disorder, run a higher risk of delayed diagnosis, more severe psychopathological symptoms, less compliance with treatment, less therapeutic treatment, more impaired social functioning, increased ED admissions, higher prevalence of physical comorbidity, and suicidal ideation. These patients are also more likely to suffer from unemployment and homelessness and perpetuate violent or criminal behavior. Poor outcomes for these patients are especially alarming and call for more urgent substantial research on patients with comorbidities.

In addition to comorbid psychiatric and substance abuse disorders, there are varying risks for violence (e.g., potential harm to self and/or others) in patients who may exhibit aggression or behavioral challenges, including those suffering from homelessness (Deck & Platt, 2015);
dementia and Alzheimer’s disease (Alzheimer’s Society, 2019); neurological disorders, including traumatic brain injury and seizure disorders (Lane, Kjome, & Moeller, 2011); intellectual and developmental disabilities (Antonacci, Manuel, & Davis, 2008); and forensic disorders associated with criminal behavior. Increasing U.S. media reports have exposed tragic self- and other-directed violence as the result of psychosocial disorders, e.g., lateral violence or bullying and social isolation (Ireland & Power, 2004). Lastly, trauma victims who have survived traumatic events and major life stressors, e.g., domestic violence, death of a loved one, loss of employment, and natural disaster, also have the potential to perpetrate aggression due to inadequate coping mechanisms (Taft et al., 2009). An organization must be prepared to address the needs of this highly variable, often marginalized, patient population who require integrated assessment and treatment in a variety of acute care settings.

Available Knowledge

The articles included in this literature review support the implementation of a comprehensive, integrated WPV staff education course for non-BH and non-ED healthcare staff to effectively manage patient aggression in acute care hospitals. The patient, intervention, comparison, outcome, and time (PICOT) question was: For adult patients in non-BH and non-ED acute care settings (e.g., medical-surgical/telemetry/step-down units) who exhibit aggression toward clinical staff, does integrated staff education and training for crisis prevention and intervention, instead of maintaining the status quo with limited or voluntary staff education for those units, improve staff knowledge and attitudes about managing the care of aggressive patients? The timeframe to evaluate the PICOT question was June 2020 to September 2020 (three months post-implementation).
A search of CINAHL, PubMed (MEDLINE), DynaMed, PsycINFO, Agency for Healthcare Research and Quality (AHRQ) reports, and Google Scholar databases was conducted using the following search terms: crisis, emergency, work*, violence, education*, staff, hospital ‘or’ acute care, and psychiatr* or behavior*. Search parameters for all databases included articles with these search terms in the titles, abstracts, and/or major subject headings that were international, peer-reviewed, research articles, published in English in academic journals, with publication dates ranging from 2003 to 2018. The search was narrowed to 13 articles that were chosen from major subheadings of crisis prevention and crisis intervention, and from nursing, medical, psychiatric, and environmental safety journals. Peer-reviewed quantitative, qualitative, integrated reviews, systemic reviews, and scope review articles were validated by utilizing the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool (see Appendix A). All publications were found to be relevant and timely to the topic and were selected to create an Evaluation and Synthesis Table for Evidence-Based Literature Review (see Appendix B).

The PICOT strategy yielded a variety of evidence-based practice (EBP) publications on WPV staff education in hospital settings. While the strategy yielded very limited quantitative research, there was a plethora of qualitative research, including synthesis reviews that used a culmination of emerging evidence in WPV prevention programs. The evidence also indicates that quasi-experimental, pre-post intervention studies aim to evaluate the effect of education on staff knowledge and attitudes about WPV. This finding suggests staff education and training for the clinical management of patient aggression is an area of emerging research strongly driven by non-randomized, frontline interventions that may or may not decrease WPV incidence.
WPV prevention education, specifically designed for non-BH and non-ED healthcare staff, is limited; therefore, transferability to other acute care units is an area ripe for quality improvement (QI). Specifically, limitations include a lack of WPV prevention protocols (i.e., process map or flowchart) and frontline QI tools (i.e., violence risk assessment [VRA] screening tools) for comorbid patients outside of the ED and the inpatient BH settings for which there is very little research (Joint Commission [JC], 2018).

The review of evidence included a randomized control trial (RCT), a systematic review of RCTs, four quasi-experimental studies, three comparative studies, a scoping review, a thematic analysis, and two expert reviews of clinical practice guidelines. While the effectiveness of WPV staff education and its key components, holistically and individually, will require substantial research over time, an integrated review of the evidence shows initial results are promising. Current evidence suggests that several WPV prevention program components, such as policy, protocol, structured VRA, staff education, interdisciplinary team communication, documentation (e.g., incident reporting), and environmental surveillance, result in varying effects on staff knowledge and attitudes about managing care for aggressive patients and, overall, on WPV incidence.

Arnetz et al. (2017) conducted a cluster RCT of 15,000 healthcare workers in 41 units at seven hospitals in the Midwestern United States. Participants were randomized into intervention (n = 21) and control (n = 20) groups. To reduce the bias of skewed data from staff underreporting of WPV incidents, the researchers compared self-reporting staff questionnaires to the hospital system’s electronic incident reporting tool, which indicated a similar rate of underreporting (88%) in both intervention and control units. Supervisors on intervention units received unit-level WPV data to facilitate the development of a WPV prevention action plan or
protocol. The protocol included a VRA screening tool via an adapted checklist for staff to identify violence risk factors and evidence-based administrative, behavioral, and environmental strategies. Administrative strategies included a mandatory structured incident reporting tool, more immediate expert consultation and intervention by a multidisciplinary team (i.e., psychiatry and security), and monthly WPV prevention meetings with the safety and security committees. Behavioral strategies included staff education about de-escalation techniques and team-building. Environmental strategies included panic alarms installed on intervention units and more frequent rounding by security. No interventions were conducted on control units. Measured outcomes were rates of WPV incidence and healthcare worker injuries across study groups over a five-year period. At six- and 24-months post-intervention, WPV incidence was significantly lower on intervention units compared with control units (incident rate ratio [IRR] 0.48, 95% confidence interval [CI] 0.29 to 0.80; and IRR 0.37, 95% CI 0.17 to 0.83, respectively). Arnetz et al. concluded that data-driven interventions, including protocol, VRA, staff education, and interdisciplinary team communication, effectively decrease risks of type II WPV and associated worker injuries.

Kynoch, Wu, and Chang (2011) conducted a systematic review of 10 RCTs internationally published between 1992 and 2006, all of which evaluated the effectiveness of interventions for preventing and managing aggressive patients in acute hospital settings. The researchers identified types of aggression as verbal abuse, nonverbal abuse, physical violence, threatening behaviors, and assault. All the studies evaluated one or more interventions to prevent or mitigate violence, including administration of as needed or PRN medications, mechanical restraint, and seclusion; clinician behaviors, such as verbal de-escalation techniques, body language, recognition, and prevention strategies; environmental surveillance; limit-setting for
patients; and decreasing nurse-to-patient staffing ratio. The primary outcome measured was patient aggression. Secondary outcomes included staff injuries, staff confidence, staff knowledge and attitudes, staff skill level, stress/anxiety levels among staff, patient injuries, and early recognition of aggressive behaviors. Kynoch et al. concluded there was evidence to support using staff education to improve knowledge and attitudes in managing aggressive patients, and using chemical and mechanical restraints to reduce the risk of harm to patients and staff.

Morphet, Griffiths, Beattie, Velasquez Reyes, and Innes (2018) conducted a scoping review of 20 articles that evaluated the effectiveness of key interventions of WPV prevention programs to prevent and manage WPV incidence perpetrated by patients in healthcare settings. Scoping reviews, versus systematic reviews, that address specific research questions are helpful to map the broad range of research activity of an emerging topic that has not been extensively reviewed (Pham et al., 2014). Morphet et al. concluded that several interventions reduced WPV incidence, including a structured VRA screening tool; staff education consisting of early recognition of violence risk factors, communication and de-escalation techniques, and evasive self-defense; interdisciplinary behavioral rapid response teams (BRRTs); and increased visibility via environmental surveillance (transparent panels/windows in treatment areas to reduce access to weapons, adequate lighting, and cameras). In contrast, incident reporting and post-incident debriefing increased WPV incidence due to increased staff awareness (Morphet et al., 2018). More scoping reviews would be beneficial to help evaluate the individual and holistic effects of key components of WPV prevention programs.

Casteel et al. (2009) conducted a comparative study to evaluate changes in WPV incidence in acute care hospitals in California and New Jersey before and after the enactment of
state legislative policy. The California Hospital Safety and Security Act of 1995 requires acute care hospitals to develop comprehensive WPV prevention plans using OSHA’s regulatory Guidelines for Security and Safety of Health Care and Community Service Workers. Casteel et al. compared pre- and post-enactment employee assault rates in California ($n = 116$) EDs and psychiatric units with those in New Jersey ($n = 50$), where statewide WPV regulations did not exist at the time of the study. Assault rates in California hospitals were compared between a three-year pre-enactment period (1993 to 1995) and a six-year post-enactment period (1996 to 2001) using New Jersey hospitals as a control. Assault rates among ED staff decreased by 48% in California post-enactment, compared with ED staff assault rates in New Jersey ($IRR = 0.52, 95\% CI = 0.31, 0.90$). BH units at for-profit hospitals ($IRR = 0.41, 95\% CI = 0.19, 0.85$) and hospitals located in smaller communities ($IRR = 0.44, 95\% CI = 0.21, 0.92$) also experienced decreased assault rates post-enactment (Casteel et al., 2009).

Peek-Asa et al. (2007, 2009) conducted similar comparative studies of ED and BH units/facilities in California and New Jersey pre- and post-legislation that mandated comprehensive WPV prevention programs in California, but not in New Jersey, at the time of comparison. In both studies, Peek-Asa et al. concluded that there are gaps in legislative and regulatory compliance that should be addressed via a comprehensive, integrated approach to coordinate the components of policy, protocol, staff education, security, and environmental strategies. Sustainability is more likely with multidisciplinary and representative input from the staff and management and the enforcement of current OSHA guidelines. Other approaches, such as licensing and accreditation requirements through agencies such as JC and Centers for Medicare and Medicaid Services (CMS), stronger evidence to bolster emerging best practices, and visible engagement by leadership are also important considerations.
Particularly regarding staff education, Peek-Asa et al. (2007) noted it is common for hospitals to use existing packaged WPV prevention training programs, which do not include information about the organization’s specific policies, protocols, and potential risk factors. Hospitals also fail to include many employees in the required training (e.g., physicians and non-ED/non-BH staff). Nearly half of the education programs are one hour or less, which is insufficient to cover all the necessary material. Integrating legislative policy and regulatory compliance into staff education strategies may help develop comprehensive WPV prevention programs that increase patient and staff safety (Peek-Asa et al., 2007).

Some of the most promising research regarding WPV staff education focuses on the effectiveness of interdisciplinary team communication during behavioral crises. Wong, Wing, Weiss, and Gang (2015) conducted a quasi-experimental study of 162 ED staff members that measured the effect of structured simulation-based training on staff attitudes about managing patient aggression. The staff education focused on early communication, formal roles and responsibilities of each team member, de-escalation strategies, and structured debriefing. Wong et al. (2015) measured staff attitudes using the Management of Aggression and Violence Attitude Scale, which is validated and reliable in ED and BH settings. The researchers found that simulation-based training significantly improved staff attitudes about patient factors ($p < 0.0001$), staff factors ($p < 0.002$), and situational factors ($p < 0.001$); however, change in staff attitudes toward the actual management of patient aggression was not statistically significant ($p = 0.542$). Simulation-based training also encourages interdisciplinary teamwork due to its inherent ability to promote peer-to-peer interaction in a realistic but safe environment. Wong et al. (2018) conducted a thematic analysis of 57 interdisciplinary frontline employees at two hospitals, which
found that simulation-based training improved team cooperation and learning during behavioral emergencies.

Other research on WPV staff education focused on staff awareness, knowledge, and competence in recognizing violence risk factors and utilizing effective intervention strategies. Adams, Knowles, Irons, Roddy, and Ashworth (2017) conducted a quasi-experimental study of 48 WPV incidents initiated by 21 patients on two adult medical units at an academic hospital in Australia. Data were gathered from incident reports made by direct care workers \((n = 65)\), including nurses, nurse assistants, and patient care assistants. Questionnaires were distributed before and after staff education, administrated by a clinical expert, and included strategies to prevent and manage WPV incidents. Components of the staff education included early recognition of signs and symptoms of potential violence, staff using a buddy system when entering the aggressive patient’s room and using safety precautions on the unit, and consistent hand-off reports at shift change. Post-intervention, staff knowledge increased significantly \((p = 0.001, CI = 0.256-0.542)\), the use of verbal de-escalation techniques increased significantly \((p = 0.011)\), and the overall frequency of WPV incidents decreased from 30 to 17 (Adams et al., 2017).

Price and Baker (2012), in a thematic synthesis review of 11 international articles, also found that de-escalation techniques are a set of therapeutic interventions frequently used to prevent behavioral crises. Several interventions related broadly to staff competencies regarding WPV prevention, including establishing trust and therapeutic rapport with the aggressive patient, maintaining personal control and self-awareness, and verbal and nonverbal de-escalation skills. Other interventions related to the process of WPV intervention included ensuring safe conditions for de-escalation and two sub-themes: autonomy confirming interventions and limit-setting or
authoritative interventions (Price & Baker, 2012). De-escalation techniques are an example of a complex intervention that has been overlooked by nursing education initiatives. It is often assumed that staff can perform these techniques in clinical practice.

Gillespie, Gates, and Mentzel (2012) performed a quasi-experimental pre-post intervention study using a variety of educational methods for managing aggressive patients. The researchers evaluated the learning outcomes of 315 frontline employees from three EDs. Unit 1 – Unit 3 received only web-based education. Unit 4 received a hybrid of web-based then classroom-based education to apply web-based learning. Significant knowledge attainment was noted for both the web-based and hybrid cohorts ($p < 0.001$). There was no significant difference in knowledge attainment between employees who completed the web-based learning only and employees who completed the hybrid education ($p = 0.136$). The results of this study support utilizing web-based and classroom-based education as adjuncts to simulation-based training to create cost-effective continuing education opportunities for staff (Gillespie et al., 2012).

McPhaul et al. (2008) conducted a retrospective expert review of 10 psychiatric and addiction treatment facilities that underwent environmental audits to determine risk factors for type II WPV. Results were grouped by the impact on access control, the ability to observe patients (natural surveillance), patient and worker safety (territoriality), and activity support. Findings suggested that if environmental flaws in these areas were corrected, staff, patient, and visitor safety and security would improve, which ultimately would reduce the fear and unpredictability of WPV events. McPhaul et al. noted that the Prevention through Design initiative from the National Institute for Occupational Safety and Health (NIOSH) sparked healthcare leaders to develop innovative solutions to creating healing environments. The science
of evidence-based design shows promise of improved patient outcomes associated with natural light, nature views, noise reduction, and temperature control. An integration of occupational safety and holistic healing designs, coupled with security technology, may support comprehensive environmental surveillance that augments WPV prevention programs (McPhaul et al., 2008).

McPhaul, London, and Lipscomb (2013), in an expert review of clinical practice guidelines, examined emerging trends of healthcare organizations that were committed to developing WPV prevention programs. The article sets nursing leadership at the forefront of generating facility-level EBP to build a framework for developing comprehensive prevention programs. The framework used state mandates, OSHA’s Guidelines for Prevention of Workplace Violence in Health and Social Services, and JC’s Environment of Care accreditation standards to promote safety culture. This framework allows organizations to customize their cost-effective strategies in VRA and mitigation, staff education, documentation and record-keeping, and periodic evaluation of the effectiveness of components of the program (McPhaul et al., 2013).

A synthesis of the literature revealed that several WPV prevention program components, such as legislative policy and regulations (Casteel et al., 2009; Peek-Asa et al., 2007, 2009) and organizational protocol (Arnetz et al., 2017; Kynoch et al., 2011; Morphet et al., 2018), with a structured VRA (Arnetz et al., 2017; Morphet et al., 2018), have varying degrees of effectiveness for decreasing WPV incidence. Integrated simulation-based and hybrid staff education, with a focus on interdisciplinary team communication, shows significant correlation to the improvement of staff knowledge and attitudes about managing care for aggressive patients (Adams et al., 2017; Casteel et al., 2009; Gillespie et al., 2012; Kynoch et al., 2011; Morphet et
al., 2018; Peek-Asa et al., 2007, 2009; Price and Baker, 2012; Wong et al., 2015, 2018). Lastly, documentation including incident reporting (Arnetz et al., 2017; McPhaul et al., 2013) and environmental surveillance (Arnetz et al., 2017; Morphet et al., 2018) are congruent with federal/state regulatory recommendations and accreditation standards to mitigate risks and evaluate outcomes of WPV prevention interventions. All of these components, individually and synergistically, should be considered when developing and implementing WPV prevention staff education.

WPV prevention and intervention are emerging healthcare topics that will require further and intensive research to expand upon standards of EBP. Healthcare organizations must seek the culmination of evidence-based initiatives that drive system-wide solutions to develop and implement a comprehensive WPV prevention program. This QI project relied on additional sources related to emerging standards of practice for facility-specific implementation.

**Rationale**

The improvement themes for the project were based on the Institute for Healthcare Improvement’s (IHI) Quadruple Aim model for healthcare system improvement, which encompasses (a) enhancing patient experience, (b) improving population health, (c) reducing costs, and (d) improving the work-life of healthcare providers, including clinicians and staff (Bodenheimer & Sinsky, 2014). Despite the valid argument that customer satisfaction measures and EBP accomplish the first three aims, this improvement model is widely accepted as the new cornerstone for QI initiatives because the fourth aim is only achievable with major buy-in from staff and organization-wide support.

The fourth aim was a major driver of the project, as WPV continues to take a physical, mental, and financial toll on healthcare workers. According to a survey of 20,000 RNs
conducted by AMN Healthcare (2019), 41% of RNs reported being victims of WPV; another 27% say they have witnessed WPV. There are increasingly alarming media reports of nurses and healthcare workers being verbally abused and physically assaulted at work, which additionally may take a reputational toll on an organization. To set clear standards for how healthcare systems should protect their workers, professional nursing organizations, such as the ANA (2015), the Emergency Nurses Association (2019), the American Psychiatric Nurses Association (2008), and the American Organization of Nurse Leaders (2014), advocate for the implementation and/or evaluation of zero tolerance WPV policies. These guidelines are designed for organizational leadership to publicize expectations and standards of behavioral conduct to provide safe, therapeutic, healing environments for patients and staff. While criminal prosecution of patients, family members, or visitors who commit intentional acts of WPV on healthcare staff may be controversial, 35 states have now established or increased penalties for assault of healthcare workers (ANA, 2019a). Healthcare workers and organizations face crucial conversations, while WPV victims often undergo difficult recoveries from traumas associated with WPV.

**Framework**

The progression of this QI project was guided by project milestones according to Lippitt’s phases of change theory (Lippitt, Watson, & Westley, 1958; see Appendix C). This theoretical framework is a seven-step process that mimics the key steps of the nursing process (assessment, diagnosis, planning, implementation, and evaluation). The framework was useful in guiding the QI team’s work throughout each phase of the project, starting from conceptualizing the problem of WPV, to the planning and implementation of evidence-based remedies, and ending with the evaluation of interventions to inform best practices. Lippitt’s theory served as a
reminder to emphasize the importance of both EBP and meaningful engagement with project stakeholders and participants.

**Specific Aim**

This project’s specific aim was to implement a WPV prevention staff education program to improve staff knowledge about WPV prevention by 20% and to improve staff attitudes about managing care for aggressive patients by 20% in the non-ED and non-BH microsystems within three months post-implementation. The project’s financial goals were at least a 30% budget capital reduction for staff education costs, with at least a 25% return on investment (ROI).
Section III: Methods

Context

A medium-sized healthcare system in Southern California, comprised of two acute care hospitals, was utilized for this project. The clinical microsystems included a surgical intensive care unit (SICU) and a progressive care step-down unit (PCU). The microsystems were comprised of charge nurses (CNs) and RNs. The staff care for a wide demographic of adult patients with diagnoses requiring cardiac and hemodynamic monitoring. The targeted subpopulation of patients with the highest risk for WPV included those with substance abuse, homelessness, mental health disturbances (untreated, undiagnosed, and/or non-compliance with treatment regimen), dementia, and alcohol withdrawal requiring the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) protocol.

A stakeholder analysis was performed to determine which departments and individuals would be impacted by the QI initiative (see Appendix D). The key stakeholders responsible for project work were the manager of the WPV prevention program, the Threat Assessment and Management (TAM) committee, nursing management, frontline staff (i.e., charge nurses and RNs), clinical education staff, security personnel, and the Risk Management and/or the Quality Assurance Performance Improvement (QAPI) team. Stakeholders were invited to participate in the project interventions and provided opportunities to share transparent feedback, suggestions, and lessons learned. Organizational commitment to change was rooted in interprofessional collaboration and meeting the needs of constituents throughout the QI project.

Emerging Trends in WPV Prevention Programs

Ten states, including California, Connecticut, Illinois, Maine, Maryland, Minnesota, New Jersey, New York, and Oregon, have enacted laws that require WPV prevention programs in
public acute care hospitals; Washington State is mandated only to report WPV incidents. Facilities in these states have published WPV prevention program templates, which cumulatively and over time have the potential to set national trends and standards of best practice. While focusing only on one component of a WPV program is an oversimplification of the problem, focusing on all components at once is not feasible nor cost-effective. The evidence supports a multipronged approach to the development and implementation of a comprehensive WPV prevention program. To that end, this QI project will utilize a replicable approach similar to the Oregon Association of Hospitals and Health Systems (OAHHS, 2019) WPV Program Suggested Sequence of Activities Chart (see Appendix E), in conjunction with emerging best practices, to inform the development and implementation of an integrated WPV prevention staff education course. The OAHHS toolkit is endorsed by JC (2019), the Emergency Nurses Association, the Oregon Chapter of the American College of Emergency Physicians, the Oregon Nurses Association, the Northwest Organization of Nurse Leaders, and several other state and local healthcare professional entities.

The OAHHS (2019) WPV prevention toolkit was chosen to replicate because it is a step-by-step systems approach to organize program implementation based on key components, including policy (legislative and regulatory); accreditation standards; a behavioral emergency (e.g., code gray) response protocol, including a VRA screening tool and an algorithm for interdisciplinary team communication; staff education and training; and documentation. The steps are not always sequential and are often interdependent; therefore, a continuous quality improvement (CQI) approach is necessary to concurrently develop, implement, evaluate, and enhance processes. Ideally, staff educational strategies should be customized to an organization’s current policies and protocols. They should consider factors such as culture,
environment, the complexity of the patient population, facility size, resources available, and the barriers and gaps identified in microsystems. In summary, the OAHHS toolkit helped continually assess gaps and evaluate strategies of a comprehensive WPV prevention program that guided the development of staff education and training.

Policy development is guided by the General Duty Clause of the Occupational Safety and Health Act of 1970 and OSHA’s (2016) Five Core Building Blocks of a Workplace Violence Prevention Program (see Appendix F). For regulatory compliance, organizations should consult the U.S. House of Representatives Bill No. 1309 (H.R. 1309; see Appendix G) titled the Workplace Violence Prevention for Health Care and Social Service Workers Act (2019), which passed in the House on November 21, 2019 (U.S. Library of Congress, 2019). If the bill is enacted into law, it will give OSHA the authority to enforce its current guidelines outlined in the Five Core Building Blocks. Organizations should also consult California Senate Bill No. 1299 (SB-1299; see Appendix H) based on the California Occupational Safety and Health Act of 1973 and enforced by the California OSHA (Cal/OSHA), which makes WPV prevention programs mandatory in acute care hospitals and violations of specified provisions of the bill a crime (State of California, 2018). Regulations on WPV prevention programs should be closely monitored and considered in organizational policies to mitigate not only safety but also legal liability from all interested parties.

Accreditation standards are driven by JC’s Requirements Relevant to Physical and Verbal Violence Against Health Care Workers (see Appendix I), which require healthcare facilities to develop and maintain a written plan outlining how the institution provides for the security of patients, staff, and visitors. Institutions are also required to conduct VRAs, provide strategies for preventing instances of violence, and establish a response plan that is enacted when an incident
occurs (JC, 2012). Ideally, these practices will streamline organizational and clinical resources in response to behavioral emergencies to promote optimal outcomes. Lastly, documentation is driven by OSHA’s recordkeeping guidelines, including an internal sentinel event report; OSHA forms 300, 300A, and 301 for workplace incident and injury reporting; employee health forms; and workers’ compensation reports (OSHA, 2016). Incident reporting (or the lack thereof) is crucial to whether or not an organization can conduct meaningful root cause analyses to inform quality improvement and to ensure those changes occur in a transparent, non-punitive culture of safety.

**Interventions**

Organizational and microsystem assessments revealed there was a system-wide need for proper assessment and treatment of patients who present with behavioral issues, regardless of their setting or unit assignment within the hospital. Instead of evidence-based behavioral emergency policy and protocol, current organizational practices relied upon frontline clinician judgment to seek consultation from the attending physician and the security team who respond to multiple acute care units to assess aggressive patients who are often diagnosed with comorbidities. This process was somewhat arbitrary and potentially drained advanced practice, security, and nursing management resources and diverted attention from truly high-risk patients who needed immediate preventative or de-escalation interventions. While experienced clinical judgment and expert opinions are invaluable resources within a healthcare organization, there was no structured algorithm that set clear expectations from staff when managing patient aggression and behavioral crises. This was particularly true for non-ED and non-BH healthcare staff, who are not traditionally trained to manage patient aggression in comorbid and special patient populations who exhibit aggression.
The healthcare system utilized the widely adopted Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention course, which focuses on healthcare staff interaction with aggressive patients. The course offers educational instruction, along with an interactive component for verbal, paraverbal, nonverbal, and physical de-escalation and intervention tactics (CPI, 2018). It also addresses psychological and physiological responses that will minimize the potential harm of disruptive and aggressive behavior. The CPI course has become a standard of practice for nursing education, mostly for ED and BH staff due to a higher incidence of aggressive patients treated on those units. However, offering the full eight-hour CPI course for other acute care hospital units (i.e., medical-surgical, telemetry, and other step-down units) is not a cost-effective option due to the higher number of healthcare staff on those units and because staff in those settings do not have the experience, education, or skills to manage behavioral crises with a focus on patient-centered, trauma-informed care. The solution was to develop a less costly, more concise, integrated staff education and training course beyond mere crisis containment in the management of patient aggression.

**Gap Analysis**

In a review of the JC Sentinel Event Database from 2004 to 2009, the following contributing causal factors regarding type II WPV events in healthcare organizations were identified most frequently.

- *Leadership:* Noted in 62% of the events, most notable problems in policy and procedure development and implementation.
- *Human resources-related factors:* Noted in 60% of the events, such as the increased need for staff education and competency assessment processes.
• **Assessment:** Noted in 58% of the events, particularly in the areas of flawed patient observation protocols, inadequate assessment tools, and lack of psychiatric assessment.

• **Communication failure:** Noted in 53% of the events among staff, patients, and families.

• **Physical environment:** Noted in 36% of the events in terms of deficiencies in general environmental safety and security practices.

• **Problems in care planning:** Information management and patient education were causal factors identified less frequently (JC, 2010).

A gap analysis (see Appendix J) and root cause analysis via a fishbone diagram (see Appendix K) were performed based on stated JC (2010) WPV causation factors and the organization’s September 2019 Nursing Needs Assessment, which polled all healthcare workers, including 494 frontline nursing staff (CNs, RNs, licensed vocational nurses [LVNs], and certified nursing assistants [CNAs]). Frontline staff were surveyed about their knowledge and attitudes about organizational policy and protocol for WPV events, interdisciplinary team communication during a behavioral crisis, professional and managerial support, personal safety (e.g., de-escalation strategies), documentation (e.g., incident reporting), and organizational culture surrounding the issue of WPV. The gap analysis and root cause analysis identified QI opportunities for staff education and training initiatives within the scope of the project.

**Gantt Chart**

From the onset of the project, it was crucial to develop a detailed plan or project charter to guide the proposed changes and to engage in effective communication with all key
stakeholders (see Appendix L). A Gantt chart was created to outline the project timeline, track progress, and achieve the goals of the project (see Appendix M).

In September 2019, a key informant interview with the manager of the Workplace Violence Prevention Program was conducted to assess the current state of policy, protocol, and EBP, which revealed the organization is in the development stage of a comprehensive program and seeking to meet the demands of the September 2019 Nursing Needs Assessment. By March 2020, additional key informant interviews were conducted with nursing leadership to secure sponsorship and support sustainability and with frontline staff to gather qualitative and participant demographic data on the intervention units. Despite several delays and modifications related to the COVID-19 pandemic (see Section V: Limitations), stakeholders remained engaged and committed to the project implementation.

In June 2020, the project manager scheduled and implemented four virtual, one-hour integrated staff education sessions (see Appendix N) via the teleconferencing tool Zoom, in line with social distancing and infection control protocols set in response to the pandemic. The course included EBP for early recognition of WPV risk factors, signs, symptoms, trauma-informed care for special patient populations, and basic WPV prevention and intervention techniques, and emphasized the importance of debriefing and documentation via incident reporting for QI purposes (American Society for Healthcare Risk Management, 2018; Canadian Center for Occupational Health & Safety, 2018; CPI, 2016, 2017, 2018; JC, 2010, 2012, 2018; NIOSH, 2006; OSHA, 2016). Utilizing additional knowledge gained by applying the OAHHS toolkit that informed the gap analysis, the staff education sessions integrated existing organizational policy and protocol, including a safety precaution for violent patients (a green triangle with an exclamation point) and the corresponding documentation in the electronic health
record (EHR) initiated by the primary RN and approved by the unit nurse manager. Note: The safety precaution is *not* a VRA screening tool that utilized structured assessment to differentiate varying risk levels for violence from aggressive patients. The interactive components of the course emphasized the importance of interdisciplinary communication via the AHRQ TeamSTEPPS I PASS (the) BATON model (see Appendix O) and allowed for open-ended participant discussion and feedback with implications of the COVID-19 pandemic.

Also, in June 2020, pre-intervention surveys were administered to the participants on intervention units to gather baseline data about their knowledge about WPV prevention and attitudes toward aggressive patients (see Appendix P). Immediately after the staff education sessions, post-intervention surveys were administered to measure the effect of the interventions on staff knowledge and attitudes, and staff education evaluation surveys were administered to evaluate the education course (see Appendix P and Appendix Q). Further review of the interventions as they relate to project outcomes are discussed in the Measures section.

Secondary interventions ran concurrently to the project implementation and were based on the OAHHS WPV prevention toolkit recommendations. Secondary interventions included recommendations for the development/revision of WPV policy in compliance with current federal/state regulations and accreditation standards, development/revision of WPV prevention protocol in line with current EBP, and development/implementation of a VRA screening tool. Concurrent recommendations also included that of a BRRT, consisting of the patient’s primary RN, the healthcare professional who has the strongest therapeutic rapport with the patient (physician, physiatrist and/or APRN), a BH/ED clinician, a TAT or CPI expert, a charge nurse, a nursing supervisor, and security personnel. This CQI process allowed for project modifications to address any additional gaps identified and remedied unanticipated barriers to implementation.
**Work Breakdown Structure**

To organize and group the work completed throughout the project timeline, a work breakdown structure (WBS) was created to designate the roles and responsibilities of the QI team throughout the project timeline (see Appendix R). According to Martinelli and Milosevic (2016), a WBS is an outcome-oriented organization of project components that defines the total scope of the project. When presented in a graphical format, the WBS is useful to visualize, identify, and estimate all of the work of the project. A driver diagram was created to plan all components of the improvement process (see Appendix S). This method helped to create a clear vision and communication of the project goals to key stakeholders.

**Responsibility/Communication Plan**

A communication/responsibility matrix was designed to keep stakeholders advised of the project status, updates, and objectives (see Appendix T). This communication plan designated the QI team’s roles and responsibilities, and how and when the QI team communicated about project activities. The project manager created a transparent line of communication to share best practices, request feedback on proposed changes, and promised to communicate results to all parties. Interprofessional communication is a crucial component of the QI initiative and for the ongoing development of the WPV prevention program.

**SWOT Analysis**

A strengths, weaknesses, opportunities, and threats (SWOT) analysis was conducted to examine the organizational and microsystem strengths and weaknesses, opportunities for growth and improvement, and any threats to the success of the project (see Appendix U). Key organizational strengths included the potential to increase patient and staff safety by improving staff knowledge and attitudes about managing care for aggressive patients. A shared governance
model of evidence-based project management is well-known for increasing multidisciplinary engagement in the QI process. Key environmental opportunities included anticipating state/federal regulations and accreditation standards that will drive parameters for policy and protocol development and, therefore, the implementation of staff education and training initiatives. Key organizational weaknesses included the cost of education and increased investment in managerial resources to commit to change sustainability. Lack of incident reporting and lack of cultural transparency may have hindered accurate gathering of data and utilizing performance measures. Lastly, key external threats to the project included increased societal violence, increased access to weapons and firearms, barriers created by the COVID-19 pandemic, and strained mental health resources that make it difficult to isolate WPV incidents related to healthcare settings.

Budget, Cost-Benefit Analysis, and Return on Investment

A budget, cost-benefit analysis, and ROI analysis were conducted to determine the value of financially tangible components of the project’s most cost-effective interventions (see Appendix V). Primary budget costs were calculated for the first year of implementation for an acute care hospital unit with 68 staff members, including 52 RNs and 14 CNAs. Budget line items included staff education and training costs (average $60/hour per staff member) for a one-hour virtual WPV prevention and intervention course ($4,080); annual code gray simulation drills/scenarios (one hour) to prevent skills fade ($4,080); annual computer module (one hour) for WPV awareness and interventions ($4,080); technology for computer training module based on average e-learning designer costs ($1,000); instructor or clinical educator adjusted salary and certification costs based on hours dedicated to research, education design, and training implementation ($3,100); room/unit signage, magnets/markers for whiteboards, and stickers for
patient charts ($200); and organizational, administrative, and interdisciplinary costs for ongoing evaluation of interventions ($2,500). The total estimated first-year budget equaled $19,040.

The benefits of implementing a WPV prevention program with integrated staff education were mostly measured by cost savings and avoidance costs associated with maintaining the status quo or ineffective interventions. WPV incidents are low-frequency, high-risk events, with the potential to bankrupt an organization and ruin its public reputation. OSHA (2018c) estimates, 500,000 U.S. employees have 1,175,100 lost work-days each year, amounting to $55 million in lost wages and billions of dollars in employer costs annually, due to WPV. Direct injury costs are associated with workers’ compensation claims, including medical bills and indemnity for lost wages, overtime for other employees to cover absent employees, training and onboarding new employees to replace absent employees, patient and staff litigation/settlement costs, increased staff turnover, and property damage (OAHHS, 2019). Indirect costs, often variable and immeasurable, are associated with poor patient outcomes; diversion of leadership, risk management, and other resources for WPV investigations; diminished public image; decreased productivity; and decreased morale, with profound professional, physical, and psychological damage for healthcare staff (U.S. Department of Labor, 2018). The estimated ROI equals 60.4% but may be highly variable based on quality outcomes related to simulation-based learning versus a virtual delivery platform. The actual ROI is also difficult to ascertain due to the unpredictability of WPV events and the variability of associated costs.

**Cost-Effectiveness Analysis**

As stated, the current standard of practice for WPV prevention staff education is an eight-hour CPI course, which is mostly offered to ED and BH units as mandatory competency requirements. For other acute care hospital units (i.e., medical-surgical, telemetry, step-down
CPI may not be cost-effective due to the higher number of healthcare staff on those units and because staff in those settings do not have the clinical experience, education, or skills to manage behavioral crises with a focus on patient-centered, trauma-informed care. The current estimated staff education budget (see Appendix W) was calculated for an acute care hospital unit with 68 FTEs, including 52 RNs and 14 CNAs. Budget line items included annual education and training costs per staff member ($1400 per participant) for a 8-hour CPI course ($95,200); annual instructor or clinical educator adjusted salary and certification costs based on hours dedicated to research, education design, and training implementation ($6,200); training and unit materials, such as paper, printer ink, and binders ($1,000); and organizational, administrative, and interdisciplinary costs for ongoing evaluation of interventions ($5,000). The total estimated current staff education budget equaled $107,400. When comparing current staff education costs to those of the project interventions, there was an 82.3% reduction in budget capital costs.

A cost-effectiveness analysis (CEA; see Appendix W) was conducted to determine the benefits of maintaining the status quo of current CPI staff education versus implementing the project interventions. For congruency, the benefits of each intervention were stagnated based on similar quality outcomes that may be immeasurable related to COVID-19-related barriers. The cost-benefit ratio (CBR) calculation is total benefits (revenues + cost savings) divided by total proposed costs of replicating the project interventions. The CBR of current staff education was 10.7, while the CBR for the proposed staff education was 60.4. The project interventions were less costly, more concise, and integrated within existing organizational policies and protocols specifically targeted for healthcare settings, unlike the current CPI staff education. Integration offers customizable solutions for the step-by-step development of a comprehensive WPV prevention program. Additionally, integration allows the organization to measure the feasibility
and cost-effectiveness of pilot interventions before rolling out organization-wide implementation.

Based on this financial modeling, the financial goals of the project of at least a 30% budget capital reduction for staff education costs with at least 25% ROI were exceeded. Alternative financial analyses would be indicated for post-pandemic WPV prevention staff education interventions, including in-person, simulation-based drills with the interdisciplinary care team.

**Study of the Interventions**

The IHI (2018) Family of Measures was utilized for the ongoing assessment of contextual elements that contributed to the successes, failures, efficiency, and costs of the project. The IHI model for measuring quality improvement relies upon setting a purpose to bring new knowledge into practice; using sequential, observable tests to measure change; stabilizing any biases from test to test; gathering *just enough* data to learn and complete another cycle of change; and using small tests of significant changes that accelerate the rate of improvement over a duration of time. The project manager was responsible for ensuring the completeness and accuracy of data upon each data point by following up with nurse managers and participants for the completion of surveys and evaluations. There were no notable de novo measures that deviated from the outcomes measure and evaluation plans (see Measures and Analysis), other than to acknowledge and share anecdotal findings from participant survey data about current organizational, clinical, and administrative practices, and open-ended participant feedback.
Measures

The effectiveness of interventions was measured utilizing the IHI (2018) Family of Measures, including:

1) A 30-question pre- and post-intervention survey, comprised of five demographic questions (Questions 1-5), five organizational (clinical and administrative) questions (Questions 6-10), ten multimodal knowledge-based questions (Questions 11-20), and 10 Likert scale attitude-based questions (Questions 21-30), was administrated to staff via SurveyMonkey before and after the integrated WPV prevention staff education course. The pre- and post-intervention surveys measured staff knowledge about WPV prevention and staff attitudes about managing care for aggressive patients. Currently, there are no nursing practice competency scales for WPV prevention skills except those designed for ED and BH staff, which are not validated measures for staff competencies on medical-surgical, telemetry, and step-down units. The knowledge-based questions in the pre/post surveys were developed from current evidence and standards of practice, as outlined in the literature review, while the attitude-based questions were modified from the Clinician Confidence in Coping with Patient Aggression instrument (Thackrey, 1987). Participants were asked to provide the last four digits of their telephone number as their participant ID number to protect anonymity and to eliminate potential bias.

2) Staff education evaluation forms, comprised of seven Likert scale items and two open-ended questions, were administered to staff via SurveyMonkey immediately after the integrated WPV prevention education course to measure the level of
participation, relevance/interest of the material, and teaching effectiveness for logistical feedback. All evaluations were anonymous.

3) Anecdotal findings of organizational, clinical, and administrative WPV prevention practices were obtained from the pre- and post-intervention surveys (Questions 6-10) and via open-ended feedback during the integrated WPV prevention staff education sessions. This allowed for staff interaction and for the project manager to gauge staff perceptions about WPV, aggressive patients, and leadership support in reporting WPV events in a culture of safety.

**Analysis**

Demographic data were secured in coordination with nursing management and, most pertinently, healthcare staff on the intervention units. The data included several data levels necessary to analyze primary and secondary outcomes according to the unique characteristics of the staff participants ($n = 8$; see Appendix X). Nominal data included job title (i.e., CN and RN) and hospital unit (i.e., SICU and PCU). Ordinal data included pre- and post-intervention test scores on a scale of 0% to 100%. Interval data included years of experience in current job role (0 - 1 years, 1 - 2 years, 2 - 5 years, and > 5 years); level of education (certificate [0 - 2 years]; diploma or ASN [2 - 12 years], undergraduate or BSN [12 - 16 years], graduate or MSN [> 16 years]); and pre- and post-intervention educational test scores on a scale of 0% to 100%. Ratio data were to include the number of WPV sentinel events across the organization and on each unit and the actual dollar costs associated with each WPV event; however, due to the COVID-19 pandemic barriers, these data were not available at the time of the project.

Statistical analysis was conducted via paired sample $t$-tests to compare pre- and post-intervention data to determine if there was a change in staff knowledge and attitudes. Pearson
statistical correlation tests were conducted to determine if there was a correlation between variables related to job title, years of experience, and level of education versus pre- and post-intervention test scores. This information will be useful for the organization to help determine the appropriate allocation of staff educational resources to support the sustainability of the project. Lastly, due to COVID-19 barriers, paired sample t-tests could not be conducted to determine if there was a correlation between the average of pre- and post-intervention test scores and pre- and post-intervention WPV sentinel events on corresponding intervention units. This information would have informed if there was a relationship between staff education and WPV incidence across respective units and, if available, associated cost savings.

**Ethical Considerations**

This QI project was conducted in strict adherence to research guidelines set by the Institutional Review Board and the Institutional Review Board for the Protection of Human Subjects at the University of San Francisco (USF). As defined by both entities, this project did not involve human subjects (living persons about whom the project manager obtained data through intervention or interaction or identifiable private information) or research as a systematic investigation designed to contribute to generalizable knowledge. A signed Statement of Non-Research Determination form, a Letter of Academic Support from the organization, and an executed affiliation agreement were secured before the commencement of project activities (see Appendix Y and Appendix Z).

While there were no conflicts of interest to be declared, WPV events often present competing ethical principles for practitioners caring for aggressive patients. The issue of safety gives priority to the ethical principle of beneficence, which means the healthcare team must commit actions that are good for the patient. However, the ethical principle of autonomy, to
respect personal freedoms and patient choice, is often of conflicting interest. Another ethical principle is respect for others, which is a legal, ethical principle guided by the federal Patient Self-Determination Act of 1991 that supports the patient’s right to determine the medical care he or she receives.

According to King and Gerard (2016), moral stress occurs when two ethical principles compete. For example, the primary goal in behavioral crisis intervention is to maintain physical and psychological patient and staff safety, while all actions taken are for the good of the patient, despite a profoundly complex set of conflicting ethical principles. Perhaps most importantly to the patient, their privacy, autonomy, and self-determination in the decision-making process are preserved. The healthcare team must make every effort to negotiate a contract for safety with the patient and, secondarily, respect and honor their wishes in the form of safe and reasonable compromise. The MORAL (massage, outline, resolve, act, and look back) model of ethical decision-making can be applied to foster quality, therapeutic outcomes for patients and staff while maintaining the integrity of ethical consideration. The model can be used to resolve ethical dilemmas and act by applying the best option for the patient’s plan of care. The healthcare team must massage the dilemma to identify and define the ethical issues; outline the options, making a list of pros and cons; resolve the dilemma by applying basic ethical principles to each option; act by applying the best option; and look back to evaluate processes, including the implementation of a plan of care.

The ANA (2019b) maintains, “There is a need for all nurses in all roles across all settings to commit to working toward creating work environments that support moral courage” (para. 1). ANA ethical standards offer guidance on moral courage to help frontline staff take action to do the right thing. Moral courage involves the willingness to speak out and do what is right in the
face of potential adverse outcomes. To that end, frontline participants involved in this project were given anonymity by providing the last four digits of their telephone numbers as their participant ID number on pre- and post-intervention surveys. Outcomes were measured and evaluated with de-identified participant data, which was meant to foster psychological safety and a culture of safety and transparency regarding the sometimes controversial topic of WPV. Advocating for WPV prevention solutions for both patients and staff requires moral courage and persistent dedication to professional and personal development, despite challenging environments. Additionally, applying the Jesuit value of caring for the whole person or *cura personalis*, caregivers create a healing environment that respects the patient’s intellectual, physical, and spiritual health (USF, 2019) and acknowledges the trauma of cultural and social injustices that should be handled with compassionate care in crisis.
Section IV: Results

As stated, the project’s specific aim was a 20% improvement in staff knowledge about WPV prevention and a 20% improvement in staff attitudes about managing care for aggressive patients through educational strategies in non-ED and non-BH microsystems within three months post-implementation. The project’s financial goals were at least a 30% budget capital reduction for staff education costs, with at least a 25% ROI. Staff knowledge was improved by 29.4%, which exceeded the project goals. Staff attitudes improved by 14.7%, which fell short of the project goals but was a notable improvement. While the financial goals of the project were impacted by the COVID-19 pandemic modifications, theoretically, the cost to implement the project as an organizational initiative presents significant cost savings and ROI compared to the current nursing education strategies. Overall, the project was well-received by all stakeholders and will further the development of the system-wide WPV prevention program.

The project was successfully implemented on the SICU and PCU microsystems in a medical center located in downtown San Diego, California. The only modifications to change strategies were related to barriers presented by the COVID-19 pandemic, and there were no unintended consequences or failures of the interventions. Appendix AA illustrates the data collected from the pre- and post-intervention surveys and represents all the project variables. Participants (n = 8) were evenly distributed between the SICU and PCU units, with four participants from each unit. Seven participants were RNs and one was a CN. Seven participants had at least five years of nursing experience, while education was varied among ASN/diploma, BSN, and MSN nurses represented in each intervention unit. The total mean increase from pre-to post-intervention survey scores was 19.2 and 8.0 score points for staff knowledge and attitudes, respectively. Outlier data from Participant 3 were excluded due to the participant’s
failure to complete the pre-intervention survey. Possible outlier data from Participant 1 was included because it had an ordinal value; however, it is unlikely that the participant started with a perfect attitude score, which may have been achieved by checking the most optimal answer choices for each attitude question.

Appendix BB shows the data and statistical analyses of the project outcomes. Using a paired sample t-test, where statistical significance equals $p \leq .05$, the staff education intervention did have a statistically significant impact on staff knowledge ($p = .02$); however, using the same measure, the intervention did not have a statistically significant impact on staff attitudes ($p = .1$). These findings suggest that staff knowledge about WPV prevention is more easily influenced by education than staff attitudes about aggressive patients. While these results may not be highly credible or replicable due to the sample size, de Winter (2013) maintains the paired sample t-test is a feasible test for small samples that meet certain raw data assumptions even if one or more of those assumptions are weak. Alternatively, Liang, Fu, and Wang (2019) suggest the use of a non-parametric test such as the Wilcoxon signed rank test for greater statistical power, however, there may be instances where both tests require raw data transformation and/or yield significant results.

Appendix CC illustrates the Pearson statistical correlations of all the variables in the project after excluding outlier data. Interestingly, the strongest positive correlation ($r(5) = .74$, $p = < .10$) was between pre- and post-intervention staff attitude scores. This finding reiterates the lack of statistical significance of the staff education impact on their attitudes while suggesting a change in attitude may be predicated by pre-existing perceptions about aggressive patients, whether those perceptions are positive or negative. Less significant findings included the strongest negative correlation ($r(5) = -.62$, $p = > .10$), which was found between post-knowledge
scores and the intervention unit, where SICU outperformed PCU. This finding, along with a similarly correlated finding between pre-intervention knowledge scores on the SICU unit \( (r(5) = -0.53, p > .10) \), may suggest a higher exposure to aggressive patients in SICU related to the demographics and clinical factors of that patient population. The findings may also suggest SICU staff’s experience influences their ability and/or willingness to assimilate knowledge about caring for these unique patients. This finding is reiterated by a mild, negative correlation \( (r(5) = -0.53, p > .10) \) between pre-knowledge scores and intervention units, where PCU performed lower than SICU. A mild, positive correlation was found between years of experience and both pre-attitude scores \( (r(5) = 0.53, p > .10) \) and post-attitude scores \( (r(5) = 0.53, p > .10) \), respectively. These findings, which are potentially unexpected benefits of the project, suggest that more experienced nurses may undergo a more positive shift in attitude about coping with aggressive patients after staff education than their less experienced counterparts. Lastly, a mild, negative correlation \( (r(5) = -0.54, p > .10) \) was found between pre-attitude scores and education level, suggesting less educated nurses start with a more positive perception about coping with aggressive patients. These results might be more significant and credible in post-pandemic projects with larger sample sizes.
Section V: Discussion

Summary

The project yielded key information specific to staff knowledge and attitudes that will inform ongoing nursing education as part of the organizational WPV prevention program. Nursing education should be integrated with current policies, protocols, incident reporting, documentation standards, and clinical and environmental best practices. The integration will ensure the organization develops and implements cost-effective solutions for the interdisciplinary team while evaluating ongoing opportunities for improvement in the management of behavioral emergencies.

Key Findings

Key findings related to staff knowledge and attitude outcomes are outlined in Appendix DD and Appendix EE, respectively. These findings were captured via the pre- and post-intervention survey scores and evaluated for positive or negative changes in staff knowledge (Questions 11-20) and attitudes (Questions 21-30), which determined the areas staff are doing well and areas for improvement. This information will be particularly useful for the guidance of ongoing nursing education development and implementation and, ideally, for simulation-based learning.

Regarding WPV prevention, the staff exhibited a positive change in knowledge for WPV risk factors (Question 11), WPV signs and symptoms (Question#12), and verbal de-escalation strategies (Question 13). These findings suggest staff can identify the potential for violence in aggressive patients, as well as intervene with verbal de-escalation strategies involving language in the form of direct communication. Areas for improvement in staff knowledge included paraverbal de-escalation strategies (Question 14), physical disengagement strategies (Question
16), and the importance of incident reporting, even if no one was injured (Question 20). These findings suggest staff need additional education and training about indirect forms of de-escalation strategies (i.e., tone of voice, body language, active listening, silence), physical disengagement that avoids harm to the patient and staff, and what types of WPV incidents should be reported if there were no physical injuries (i.e., verbal threats and abuse).

Regarding clinical competence in coping with aggressive patients, the staff exhibited a positive change in attitude about their ability to physically intervene with aggressive patients (Question 23), their perception about current training for patients who present with physical aggression (Question 26), and their perception of feeling safe around aggressive patients (Question 27). These findings suggest, as did the findings of staff knowledge, that staff can easily identify and manage interventions for physically aggressive patients (i.e., safety precautions, calling the security team, team communication). Areas for improvement in staff attitudes included their perception of their training for psychological aggression (Question 22), their perception of their ability to intervene with psychologically aggressive patients (Question 25), and their ability to meet the needs of aggressive patients (Question 29). Again, these findings echo the results of changes in staff knowledge, in that staff attitudes about aggressive patients largely depend upon a relationship founded in trust and rapport to meet the patient’s needs, which nurses outside of non-ED and non-BH settings may find more difficult without experience and/or education.

**Lessons Learned**

Lessons learned came from anecdotal findings related to current WPV prevention organizational, clinical, and administrative practices from pre- and post-intervention surveys (Questions 6-10) results (see Appendix FF). After the integrated WPV prevention education
course, most participants showed an overall increase in awareness about the organizational WPV prevention policy, i.e., the definition of WPV and what incidents should be reported on their respective units (Question 6); and the organizational protocol, i.e., who to call for assistance and how staff should respond to behavioral emergencies (Question 7). However, anything less than a 100% awareness of policy and protocol could put staff in dangerous situations with violent patients and could mean untold liability costs to the organization if staff are unaware of expectations about their roles and responsibilities during behavioral crises. Both before and after the staff education sessions, most participants were aware of the difference between structured risk assessments using a VRA tool or checklist (Question 8) versus random clinician judgment to activate safety precautions on their units (Question 9). This information is important for staff to understand that the use of a VRA tool would need to be validated in their respective settings and patient populations, and corresponding staff education and training would need to be conducted for proper use of the tool. Therefore, staff rely upon an interdisciplinary team approach for expert clinician judgment that activates safety precautions and guides evidence-based responses to behavioral crises. Lastly, after implementing the staff education course, participants reported less fear of blame or punishment by management associated with reporting WPV incidents (Question 10). This finding may suggest that nursing education for WPV prevention can increase trust and collaboration between frontline staff and leadership in a true culture of safety.

Additional lessons learned came from anecdotal findings from open-ended participant feedback provided during the staff education sessions (see Appendix GG). Due to the small size of the participant sample, these sessions were more intimate and collegiate than perhaps larger sessions would have been. This intimate environment may have allowed participants to connect with the project manager on a peer-to-peer level, which fostered open and honest disclosure
about their experiences with WPV, aggressive patients, and an opportunity to offer recommendations for organizational change.

The literature overwhelmingly supports that frontline staff make some of the most important contributions to the development and implementation of WPV prevention programs. The results of the staff education evaluation forms (Appendix HH) strongly indicate that ongoing nursing education should be a top priority for the organization. The majority of the participants found the integrated WPV staff education course to be of high-quality instruction, relevant to their jobs, well organized, and interesting. One-hundred percent of participants would recommend the course to others in their profession. Participants cited the most valuable parts of the course as the review of organizational policies and protocols, the I PASS the BATON method of team communication during behavioral crises, and various de-escalation strategies for aggressive patients. Several participants commented that the course was comprehensive enough, without any further recommendations other than in-person, simulation-based training and case scenarios without the social distancing barriers posed by the COVID-19 pandemic.

**Dissemination Plan for Nursing Education and Implications for Nursing Practice**

In August 2020, the dissemination plan for WPV prevention nursing education as part of a comprehensive WPV prevention program was shared with stakeholders, including the program manager and the TAM subcommittee partly comprised of nurse educators and frontline nursing staff, and shared separately with the other project stakeholders. Regarding continuous improvements in staff knowledge about WPV prevention, recommendations included a clear communication from leadership about policies and protocols with staff parameters and expectations, more simulation-based training, and the piloting of a structured VRA screening tool and a BRRT comprised of WPV experts and frontline champions. Regarding continuous
improvements in staff attitudes about coping with aggressive patients, recommendations included leadership emphasis on a culture of safety that encourages reporting and open collaboration about WPV incidents, which would foster an environment of peer support and nursing professional development. Future training should include an increased emphasis on the difference between mental health and behavioral health—that for any reason, anyone, anywhere, and at any time can experience behavioral distress that may result in violence. Adding these elements will further work toward eliminating the stigma of mental illness and educate nurses about special behavioral health patient populations and their unique needs for holistic, trauma-informed care.

The project outcomes have several implications for executive nursing practice and healthcare leadership. The most important aspect of improving staff knowledge and attitudes about WPV is organizational culture. Leadership must gain frontline clinicians’ trust through the transparency of policy and protocol and adequate representation of staff nurses in the change process. It is frontline nurses, physicians, and healthcare staff who generate EBP at the bedside that produces quality outcomes. The organization must prioritize WPV prevention as a matter of proactive change versus crisis management, which will further influence a culture of safety, where the staff is competent and confident in managing behavioral crises. When nursing and organizational leaders consult regulatory, accreditation, legal, and ethical standards in the development of a WPV prevention program, there are significant cost savings and ROI, including the public reputation. Lastly, nursing leaders have a moral obligation to protect and serve their nursing staff through caring professional development. This support may lessen the effects of physical and psychological trauma on nurses, which has wide-ranging implications for the entire nursing profession.
Interpretations

As stated, the statistical analyses showed that the WPV staff education intervention had a notable impact on the change in staff knowledge about WPV prevention and the change in staff attitudes about their clinical confidence in coping with aggressive patients. These results reflect the findings of other publications about improving staff knowledge; however, more research is needed to determine the causal influences on staff attitudes. A possible reason for this difference in anticipated versus observed outcome is that knowledge is readily changed with new information. In contrast, attitudes may be based on varying individual and environmental factors that encompass a deeper set of values, beliefs, and perceptions about aggressive patients. WPV incidents may involve physical and emotional trauma, which can activate staff responses based on fear instead of therapeutic care. Changes in attitudes may involve much deeper, caring work of the heart to enable nurses to approach patients in behavioral distress with the same compassionate mindfulness as they would for patients in medical distress.

The project outcomes followed Lippitt’s phases of change theory in the proper assessment, diagnosis, planning, implementation, and evaluation of interventions. Outcomes were also in line with the OAHHS WPV Program Suggested Sequence of Activities Chart related to nursing education development and implementation. That the healthcare organization, at the time of the project, was still in the development stage of a comprehensive program allowed for a multi-pronged approach to integrating existing policy and protocol with nursing education, with an emphasis on frontline interventions that will drive EBP (i.e., a VRA screening tool, team communication, and documentation). This continuous QI process builds upon small wins that are sustainable throughout the organization and will elevate staff performance and improve care outcomes.
Limitations

Barriers to implementation included a limited opportunity to provide education to all staff via simulation-based training due to the social distancing limitations of the COVID-19 pandemic. The participant size was significantly reduced by the inability to meet in person with staff on additional hospital units due to government infection control regulations and shutdowns. Efforts were made to include a wider participant pool; however, staffing constraints during the pandemic made increased, consistent participation difficult. A smaller participant pool lends to less generalizability about the outcomes of the project; however, it provides feasibility for a pilot program before the organization-wide rollout of nursing education initiatives.

The plan to mitigate barriers included implementing a condensed, one-hour staff education course (compared to a full eight-hour CPI course), to not disrupt staffing or clinical care. Several sessions were offered to staff on intervention units due to staffing constraints and limited availabilities. The project manager maintained consistent and persistent stakeholder engagement to negotiate buy-in for new improvement opportunities and resources by communicating via email, text, and Zoom teleconferencing. These communication strategies helped mitigate pandemic barriers. Providing low-cost, high-impact alternatives to WPV prevention nursing education that focus on dual patient and staff safety will encourage executive and sponsor stakeholders to invest in the microsystem. Lastly, open communication that promotes transparency with all stakeholders, from executive leadership to frontline staff, will enlist and encourage unit champions to sustain visible momentum for change regardless of obstacles.
Conclusions

The project’s short-term progress will largely depend upon whether the organization can prioritize low-cost, high-demand, high-impact interventions and can do so with a sense of urgency and enthusiasm to sustain frontline participation. Long-term progress will result from the culmination of best practices for QI initiative components that drive organizational change. The organization must not delay priority interventions in anticipation of perfect solutions. Rather, as a Magnet-designated academic institution, the healthcare system must anticipate not only regulatory and accreditation standards but also consider innovative, novel approaches that advance nursing science and discovery. High-reliability organizations that embrace challenges as opportunities for improvement and share their successes and setbacks in a transparent safety culture level the playing field among organizations to go beyond merely what is legally required and do what is ethically right.

Sustainability is possible when all stakeholders align to support a common goal. There is no unequivocal scientific evidence for WPV prevention programs, and it is unlikely that interventions will rely on randomized controlled experiments. Consequently, frontline staff are perhaps the most qualified stakeholders to inform organizational leadership about local evidence generated at the facility level that will ultimately lead to full-scale implementation of a WPV program (McPhaul et al., 2013). The organization must invest in the microsystem, celebrate small wins, and replicate success until enough evidence creates a standard of practice that sustains the gain.

This QI initiative has broad implications for nurse leaders and their roles in QI, risk assessment, clinical care coordination, outcomes management, team leadership and interprofessional communication, transitions in care, and implementation of EBP (American
Association of Colleges of Nursing, 2013). Research on type II WPV is quickly expanding and increasingly focused on the assessment and treatment of BH patients in various healthcare settings. This population often falls through the cracks due to suboptimal mental health literacy and skills or fears and stigma from inexperienced, integrated health clinicians. Nurse leaders are uniquely poised to guide healthcare organizations in the development of comprehensive WPV prevention programs that address the special clinical and safety needs of this patient population to ensure they receive genuinely holistic care.
Section VII: References


doi:10.1037/0735-7028.18.1.57


Section VII: Appendices
Appendix A

**Johns Hopkins Nursing Research Evidence Appraisal Tool**

<table>
<thead>
<tr>
<th>Article Title:</th>
<th>Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s):</td>
<td>Publication Date:</td>
</tr>
<tr>
<td>Journal:</td>
<td></td>
</tr>
<tr>
<td>Setting:</td>
<td>Sample (Composition &amp; size):</td>
</tr>
<tr>
<td>Does this evidence address my EBP question?</td>
<td>□ Yes □ No Do not proceed with appraisal of this evidence</td>
</tr>
</tbody>
</table>

**Level of Evidence (Study Design)**

A. Is this a report of a single research study? *If No, go to B.*

1. Was there manipulation of an independent variable?
2. Was there a control group?
3. Were study participants randomly assigned to the intervention and control groups?

If Yes to all three, this is a Randomized Controlled Trial (RCT) or Experimental Study

   □ Yes □ No

If Yes to #1 and #2 and No to #3, OR Yes to #1 and No to #2 and #3, this is Quasi Experimental (some degree of investigator control, some manipulation of an independent variable, lacks random assignment to groups, may have a control group)

   □ Yes □ No

If No to #1, #2, and #3, this is Non-Experimental (no manipulation of independent variable, can be descriptive, comparative, or correlational, often uses secondary data) or Qualitative (exploratory in nature such as interviews or focus groups, a starting point for studies for which little research currently exists, has small sample sizes, may use results to design empirical studies)

   □ Yes □ No

NEXT, COMPLETE THE BOTTOM SECTION ON THE FOLLOWING PAGE, “STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION”
## B. Is this a summary of multiple research studies? If No, go to Non-Research Evidence Appraisal Form.

1. Does it employ a comprehensive search strategy and rigorous appraisal method (Systematic Review)? If No, use Non-Research Evidence Appraisal Tool; If Yes:
   a. Does it combine and analyze results from the studies to generate a new statistic (effect size)? (Systematic review with meta-analysis)
   b. Does it analyze and synthesize concepts from qualitative studies? (Systematic review with meta-synthesis)
   If Yes to either a or b, go to #2B below.

2. For Systematic Reviews and Systematic Reviews with meta-analysis or meta-synthesis:
   a. Are all studies included RCTs?
   b. Are the studies a combination of RCTs and quasi-experimental or quasi-experimental only?
   c. Are the studies a combination of RCTs, quasi-experimental and non-experimental or non-experimental only?
   d. Are any or all of the included studies qualitative?

### COMPLETE THE NEXT SECTION. “STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION”

### STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION:

---

NOW COMPLETE THE FOLLOWING PAGE, “QUALITY APPRAISAL OF RESEARCH STUDIES”, AND ASSIGN A QUALITY SCORE TO YOUR ARTICLE
## Johns Hopkins Nursing Evidence-Based Practice
### Appendix E: Research Evidence Appraisal Tool

#### Quality Appraisal of Research Studies

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the researcher identify what is known and not known about the problem and how the study will address any gaps in knowledge?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Was the purpose of the study clearly presented?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Was the literature review current (most sources within last 5 years or classic)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Was sample size sufficient based on study design and rationale?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If there is a control group:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Were the characteristics and/or demographics similar in both the control and intervention groups?</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>- If multiple settings were used, were the settings similar?</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>- Were all groups equally treated except for the intervention group(s)?</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>Are data collection methods described clearly?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Were the instruments reliable (Cronbach's α [alpha] &gt; 0.70)?</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>Was instrument validity discussed?</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>If surveys/questionnaires were used, was the response rate ≥ 25%?</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>Were the results presented clearly?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If tables were presented, was the narrative consistent with the table content?</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td>Were study limitations identified and addressed?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Were conclusions based on results?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

#### Quality Appraisal of Systematic Review with or without Meta-Analysis or Meta-Synthesis

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the purpose of the systematic review clearly stated?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Were reports comprehensive, with reproducible search strategy?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Key search terms stated</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Multiple databases searched and identified</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Inclusion and exclusion criteria stated</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Was there a flow diagram showing the number of studies eliminated at each level of review?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Were details of included studies presented (design, sample, methods, results, outcomes, strengths and limitations)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Were methods for appraising the strength of evidence (level and quality) described?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Were conclusions based on results?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Results were interpreted</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Conclusions flowed logically from the interpretation and systematic review question</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Did the systematic review include both a section addressing limitations and how they were addressed?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

#### Quality Rating Based on Quality Appraisal

**A** *High quality*: consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence.

**B** *Good quality*: reasonably consistent results; sufficient sample size for the study design; some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.

**C** *Low quality or major flaws*: little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn.
## Appendix B

### Evaluation and Synthesis Table for Conducting Evidence-Based Literature Review

<table>
<thead>
<tr>
<th>Citation</th>
<th>Design / Method / Conceptual Framework (if applicable)</th>
<th>Sample/Setting</th>
<th>Major Variable Studied and Definitions</th>
<th>Measurement of Major Variables</th>
<th>Findings of Data Analysis</th>
<th>Implication to Nursing Practice</th>
<th>JHNEBP Critical Appraisal Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams et al.</td>
<td>Quasi-experimental using linear regression</td>
<td>Results of 48 WPV incidents initiated by 21 patients. Data were collected from direct-care staff and from WPV incident reports on two adult medical units at an academic hospital in Australia.</td>
<td>Nurses, nurse assistants, and patient care assistants participated in staff education intervention ( n = 65 ) and completed a survey before and after the education, which included four main areas: patient assessment, planning, implementation, and post-incident debriefing. Staff completion rate was 77%.</td>
<td>Knowledge, confidence, and capability of frontline staff to prevent/manage WPV incidents pre- and post-intervention. Incident data measured the frequency and recurrence of WPV, and if patients met criteria for high violence risk.</td>
<td>After the educational intervention, staff knowledge increased significantly ( p=0.001, CI 0.256-0.542 ), the use of verbal de-escalation techniques increased significantly ( p=0.011, 1df ), and the incidence of WPV decreased.</td>
<td><strong>Education</strong> and training provided by clinical experts resulted in increased knowledge, greater use of verbal de-escalation, and less incidents. However, more education and training is required to improve the perceived staff competence to manage WPV incidents.</td>
<td>Level II: High quality</td>
</tr>
<tr>
<td>Arnetz et al.</td>
<td>RCT</td>
<td>15,000 healthcare workers in 41 units at seven hospitals were randomized into intervention ( n = 21 ) and control ( n = 20 ) groups.</td>
<td>Intervention units received unit-level WPV data to facilitate development of a WPV prevention protocol; no data were presented to control units. A hazard risk matrix was used to identify hospital units at increased risk for</td>
<td>Main outcomes were rates of WPV incidents and healthcare worker injuries across study groups over 5 years.</td>
<td>6-months post-intervention, WPV incidence was significantly lower on intervention units compared with controls (incident rate ratio [IRR] 0.48, 95% confidence interval [CI] 0.29 to 0.80). At 24 months, the risk for violence-related injury was lower on</td>
<td>Data-driven, workplace interventions are effective in decreasing risks type II WPV and associated injuries.</td>
<td>Level I: High quality</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Population</td>
<td>Intervention</td>
<td>Results</td>
<td>Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
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<td>---------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Casteel et al. (2009)</td>
<td>Comparative study</td>
<td>Comparison of pre- and post-initiative employee assault rates in California (n = 116) emergency departments and psychiatric units with those in New Jersey (n = 50), where statewide WPV initiatives did not exist at the time.</td>
<td>Changes in WPV incidence to hospital staff before and after enactment of the California Hospital Safety and Security Act in 1995. Poisson regression with generalized estimating equations was used to compare assault rates between a 3-year pre-enactment period (1993–1995) and a 6-year post-enactment period (1996–2001) using New Jersey hospitals as a temporal control.</td>
<td>Assault rates among ED staff decreased 48% in California post-enactment, compared with ED staff assault rates in New Jersey (rate ratio [RR] = 0.52, 95% confidence interval [CI]: 0.31, 0.90). ED employee assault rates decreased in smaller facilities (RR = 0.46, 95% CI: 0.21, 0.96) and for-profit-controlled hospitals (RR = 0.39, 95% CI: 0.19, 0.79) post-enactment. Among psychiatric units, for-profit-controlled hospitals (RR = 0.41, 95% CI: 0.19, 0.85) and hospitals located in smaller communities (RR = 0.44, 95% CI: 0.21, 0.92) experienced decreased assault rates post-enactment.</td>
<td>Workplace violence prevention legislation may be an effective method to increase safety to health care staff.</td>
<td>Level III: High quality</td>
<td></td>
</tr>
<tr>
<td>Gillespie et al. (2012)</td>
<td>Quasi-experimental</td>
<td>315 employees from 3 EDs. Units 1–3</td>
<td>Employee knowledge about the prevention, management. Units 1–3 received pre- and post-tests to A paired samples t tests reflected a significant increase in</td>
<td>A quality WPV staff education program can achieve</td>
<td>Level II: High quality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
received web-based education only. Unit 4 received a hybrid web-based & classroom-based education.

and recovery from workplace violence. measure their knowledge gained. Unit 4 was allowed to apply new knowledge learned during the web-based education. knowledge (p < 0.001). There was no significant difference in knowledge between employees in Units 1-3 and employees in Unit 4 (p = 0.136).

significant learning outcomes in ED settings. Web-based education may yield similar learning outcomes equal to that of a hybrid education program.

**Kynoch et al. (2011)**

Systematic review of RCTs

Major scholarly database review for published and unpublished studies from 1990 to 2007.

Quantitative studies

10 quantitative studies that evaluated the effectiveness of interventions for the management of aggressive patients of acute care settings.

Specific interventions may assist staff in managing aggressive patients in acute care settings, including: acute care nurse education and training in aggression management techniques, use of PRN medications to minimize harm to patients and staff, and the use of physical restraints.

This systematic review makes several recommendations for WPV prevention and intervention in acute care hospitals. However, there is a lack of high-quality research in the acute care settings; therefore, a huge area of opportunity for future research.

**McPhaul et al. (2013)**

Expert review of clinical practice guidelines

Healthcare organizations that are committed to implementing a WPV prevention program.

Key components of a comprehensive WPV prevention program includes leadership engagement, state regulations, federal worker safety policies, organizational protocols, environmental factors, facility security, documentation, staff education and training, and locally-generated best practices.

Framework that includes multipronged approach to WPV program implementation.

A well-defined framework for the implementation of a WPV prevention program allows healthcare organizations and individual facilities to address WPV by customizing their own strategies.

Frameworks are useful tools to guide EBP implementation of WPV prevention programs at the organizational and facility levels.

**Level I:** High quality

**Level IV:** High quality
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Method</th>
<th>Study Details</th>
<th>Results</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>McPhaul et al.</td>
<td>Retrospective expert</td>
<td>10 healthcare facilities underwent environmental audits to determine the</td>
<td>A retrospective record review was performed on environmental audits that were conducted by an architect in two</td>
<td>Healthcare organizations can positively impact the effectiveness of type II WPV interventions by including an environmental assessment with associated hazard controls.</td>
</tr>
<tr>
<td><strong>Peek-Asa et al. (2007)</strong></td>
<td><strong>Comparative study</strong></td>
<td><strong>Compared WPV programs in high-risk EDs among 116 hospitals in California and 50 hospitals in New Jersey.</strong></td>
<td><strong>WPV programs were scored on the components of staff education, policies and protocols, security measures, and environmental hazard control.</strong></td>
<td><strong>Data was collected through staff interviews, a facility walk-through of environmental hazards, and review of policies, protocols, and staff education materials.</strong></td>
</tr>
<tr>
<td><strong>Peek-Asa et al. (2009)</strong></td>
<td><strong>Comparative study</strong></td>
<td><strong>Compared WPV prevention programs in psychiatric units and facilities in California and New Jersey.</strong></td>
<td><strong>Various components of WPV programs, including policy and protocol, environmental, and security modifications.</strong></td>
<td><strong>Qualitative data collection through staff interviews, a facility walk-through of environmental hazards, and review of policies, protocols, and staff education materials.</strong></td>
</tr>
<tr>
<td><strong>Price &amp; Baker (2012)</strong></td>
<td><strong>Thematic synthesis literature review</strong></td>
<td><strong>11 international papers that offer de-escalation techniques for managing patient violence de-escalation themes.</strong></td>
<td><strong>Violence de-escalation themes.</strong></td>
<td><strong>Seven themes that emerged from data synthesis.</strong></td>
</tr>
</tbody>
</table>
### WORKPLACE VIOLENCE

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong et al. (2015)</td>
<td>Quasi-experimental</td>
<td>162 ED staff members completed an interdisciplinary staff education focusing on improving team communication and staff attitudes toward type II WPV using simulation-enhanced education for ED staff. The staff participation was &gt;95%, for a total of 106 paired surveys.</td>
<td>Staff attitudes towards patient aggression both at pre- and post-education.</td>
<td>Parameters for internal/patient factors, external/staff factors, and situational/interactional perspectives on patient aggression significantly improved ($p &lt; 0.0001$, $p &lt; 0.002$, $p &lt; 0.0001$ respectively). Change in staff attitudes toward management of patient aggression was insignificant ($p = 0.542$). Several quality improvement initiatives were successfully implemented.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A structured, simulation-enhanced, interdisciplinary protocol was successful in improving multiple facets of ED staff attitudes toward behavioral crises.</td>
</tr>
</tbody>
</table>
### Wong et al. (2018)

| Quasi-experimental with meta-synthesis | 57 total participants included ED residents and attending physicians, physician assistants, advanced practice registered nurses, ED nurses, technicians, and security staff at two hospital sites. | Teamwork in the management of agitated patients and the impact of a simulated interdisciplinary response to an aggressive patient in the ED. | KidSIM Questionnaire addressing teamwork and simulation-based learning attitudes pre- and post-simulation-based education. | KidSIM scores revealed significant improvements in attitudes toward relevance of simulation, interdisciplinary education, and situational awareness, as well as four of six elements pertaining to team member roles and responsibilities. | Simulation-based training may be effective to enhance teamwork in behavioral crises and to foster dual patient and staff safety | Level III: Good quality |
### Appendix C

#### Seven Phases of Lippitt’s Change Theory with Project Milestones

<table>
<thead>
<tr>
<th>Phases of Lippitt’s Change Theory</th>
<th>Project Milestone</th>
<th>Anticipated Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of the Problem</td>
<td>• Identification of EBP guidelines and measures</td>
<td>January 2019 – ongoing</td>
</tr>
<tr>
<td></td>
<td>• Gap analyses</td>
<td>Fall 2019</td>
</tr>
<tr>
<td></td>
<td>• Project charter</td>
<td>Fall 2019</td>
</tr>
<tr>
<td>Assessment of Motivation and Capacity for Change</td>
<td>• Organizational and microsystem Assessments</td>
<td>Fall 2019</td>
</tr>
<tr>
<td></td>
<td>• Stakeholder analysis and QI team building</td>
<td>Fall 2019 – ongoing</td>
</tr>
<tr>
<td>Assessment of Resources</td>
<td>• Assess current policy (regulatory compliance &amp; accreditation) and protocols (behavioral emergency process map, violence risk assessment (VRA) screening tool, front-line communication and EBP, documentation)</td>
<td>Fall 2019 – ongoing</td>
</tr>
<tr>
<td></td>
<td>• Budget</td>
<td>Fall 2019</td>
</tr>
<tr>
<td>Select Change Objectives</td>
<td>• Develop staff education and training materials and measures</td>
<td>Fall 2019 – Spring 2020</td>
</tr>
<tr>
<td>Choose Roles of Change Agents</td>
<td>• Work Breakdown Structure</td>
<td>Fall 2019</td>
</tr>
<tr>
<td>Maintenance of the Change</td>
<td>• Implement staff education and training</td>
<td>Summer 2020</td>
</tr>
<tr>
<td>Terminate the Helping Relationship</td>
<td>• Project evaluation and sustainability</td>
<td>Fall 2020</td>
</tr>
</tbody>
</table>

## Appendix D

### Stakeholder Analysis

<table>
<thead>
<tr>
<th>High Power</th>
<th>Keep Satisfied</th>
<th>Manage Closely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Executive Leadership</td>
<td>TAM / WPV Committee</td>
</tr>
<tr>
<td></td>
<td>Nursing Management</td>
<td>Nursing Administration</td>
</tr>
<tr>
<td></td>
<td>Nursing Education</td>
<td>Physicians</td>
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<td></td>
<td>Frontline staff</td>
<td>Quality Assurance and Performance</td>
</tr>
<tr>
<td></td>
<td>Security Personnel</td>
<td>Improvement (QAPI) Team</td>
</tr>
<tr>
<td></td>
<td>Unit Champions</td>
<td>Regulatory &amp; Accreditation Entities</td>
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<tr>
<td></td>
<td>Patients / Families / Visitors</td>
<td>Community</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Low Interest</th>
<th>Monitor</th>
<th>Keep Informed</th>
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<tbody>
<tr>
<td></td>
<td>Facility Management</td>
<td>Ancillary Staff</td>
</tr>
</tbody>
</table>

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Ancillary Staff
Information Technology
Employee Health
Labor Union
### Workplace Violence Toolkit – Tool ii

<table>
<thead>
<tr>
<th><strong>Workplace Violence (WPV) Program Development, Implementation &amp; Evaluation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suggested sequence of activities</strong></td>
</tr>
<tr>
<td><strong>Step 1</strong> Use WPV Toolkit and resources provided to review best practices for assessing risk of, control &amp; prevention of WPV, &amp; related regulations/legal responsibilities. Collect baseline incident/injury data (OSH 300 log; HCA log; Code Grey rpts; etc) &amp; associated workers comp costs related to WPV.*</td>
</tr>
<tr>
<td><strong>Step 2</strong> Analyze data to identify units/depts, &amp; employee groups with higher risk of exposure to WPV, &amp; the nature, severity, &amp; cost of WPV injuries. Begin to identify hazards/risks &amp; program elements that need to be addressed</td>
</tr>
<tr>
<td><strong>Step 3</strong> Enlist support of senior leadership to develop or enhance a WPV program</td>
</tr>
<tr>
<td><strong>Step 4</strong> Identify a WPV program champion; program/project coordinator; &amp; interdisciplinary WPV committee (include behavioral health experts as needed &amp; external resources e.g., local law enforcement)</td>
</tr>
<tr>
<td><strong>Step 5</strong> Educate committee about principles of WPV &amp; elements of successful programs; current evidence base; &amp; the proposed approach to addressing WPV at your facility &amp; function of the team</td>
</tr>
<tr>
<td><strong>Step 6</strong> Determine the scope of the issue &amp; program needs. Identify stakeholders. Assess organization's culture &amp; readiness for change. Review current policy/procedures. Conduct gap analysis, staff survey &amp; safety/security assessment</td>
</tr>
<tr>
<td><strong>Step 7</strong> Analyze all data collected &amp; prioritize hazards &amp; program needs. Start developing WPV program plan</td>
</tr>
<tr>
<td><strong>Step 8</strong> Formulate solutions to address control hazards or risks identified &amp; prioritized i.e., engineering controls (e.g., design of the physical environment &amp; access &amp; surveillance of the facility); administrative controls &amp; safe work practices (e.g., identification &amp; management of patient/visitors at risk of violence; incident response; reporting &amp; post incident management; security protocols; WPV zero tolerance policies); identify the need &amp; process for piloting any controls</td>
</tr>
<tr>
<td><strong>Step 9</strong> Develop a WPV communications plan; employee/stakeholder education &amp; training plan; &amp; zero tolerance WPV policy</td>
</tr>
<tr>
<td><strong>Step 10</strong> Complete the WPV program plan (what, how, who, cost, return on investment, timelines, measurement tools, etc.) &amp; program implementation plan</td>
</tr>
<tr>
<td><strong>Step 11</strong> Obtain approval of the WPV program plan; implementation approach; &amp; draft zero tolerance policy from senior leadership</td>
</tr>
<tr>
<td><strong>Step 12</strong> Finalize the WPV program plan; approach; &amp; policy per leadership input</td>
</tr>
<tr>
<td><strong>Step 13</strong> Implement the WPV program policy, plan &amp; hazard controls. Implement the WPV communications plan*** Educate &amp; train employees***</td>
</tr>
<tr>
<td><strong>Step 14</strong> Evaluate solutions &amp; processes (e.g., training &amp; communications) Evaluate program implementation process. Communicate outcomes/successes to all stakeholders</td>
</tr>
<tr>
<td><strong>Step 15</strong> Plan, implement &amp; standardize pilot processes to other units/locations (as applicable) Conduct proactive audits of units/departments to identify risk for WPV &amp; gaps in current policies &amp; practices Develop a process to integrate security/safety design principles into building remodel &amp; new construction facility wide</td>
</tr>
</tbody>
</table>

### Concurrent & Ongoing Activities

- Evaluation of program metrics & processes.
- Continuous improvement of program.
- Communication & marketing of program to stakeholders.
- Documentation & overall program management.
- Update program & project management plans periodically.
- Workers comp injury case management.

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*Step 1 - If WPV injury/incidence data is not sufficient to identify the initial need to implement a program then the tools listed in Step 2 can be used to gather more data.

**Step 8 is an ongoing process as new WPV evidence base and security related technology is made available; and some controls may take time to implement due to feasibility etc.

***Steps 8, 13-15 Development of hazard controls, processes & program implementation activities may need to occur concurrently or in a different sequence depending on facility needs and resources.

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https://www.oahhhs.org/safety
Appendix F

Five Core Building Blocks of a Workplace Violence Prevention Program

1) Management commitment and employee participation: Managers communicate priority of WPV prevention, establish objectives, provide adequate resources and support, and appoint leaders with authority and knowledge to nourish change. Additionally, employees with direct patient care experience are ideally involved in all aspects of the program development and are encouraged to report WPV incidents and concerns without fear of retribution.

2) Worksite analysis and hazard identification: Procedures are established to continually identify workplace hazards and manage risks. While an initial worksite assessment is fundamental to setting safety guidelines, QI occurs after meticulous re-assessments and evaluations of WPV sentinel events to determine opportunities for improvement. These tasks should be centrally assigned to the Facility Management, Risk Management, and Quality Control departments who can collaborate to continually improve processes.

3) Hazard prevention and control: A written policy and protocol for WPV prevention and intervention should be implemented to eliminate or control WPV hazards while implementation progress is tracked for quality outcomes for patients and staff. The program should have clear goals and objectives readily available and communicated to all staff.

4) Safety and health training: All employees should have education and training on hazard recognition and control, and be advised of their roles and responsibilities during a WPV crisis according to policy and protocol.

5) Record keeping and program evaluation: Accurate documentation of injuries, illnesses, hazards, and specific details of WPV incidents will help determine the scope and severity of WPV, identify patterns, evaluate methods, identify knowledge and training gaps, and develop corrective action solutions for ongoing QI.

Appendix G

U.S. House of Representatives Bill H.R. 1309

Workplace Violence Prevention for Health Care and Social Service Workers Act

H. R. 1309

AN ACT

To direct the Secretary of Labor to issue an occupational safety and health standard that requires covered employers within the health care and social service industries to develop and implement a comprehensive workplace violence prevention plan, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Workplace Violence Prevention for Health Care and Social Service Workers Act”.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents.

TITLE I—WORKPLACE VIOLENCE PREVENTION STANDARD

Sec. 101. Workplace violence prevention standard.
Sec. 102. Scope and application.
Sec. 103. Requirements for workplace violence prevention standard.
Sec. 104. Rules of construction.
Sec. 105. Other definitions.

TITLE II—AMENDMENTS TO THE SOCIAL SECURITY ACT

Sec. 201. Application of the workplace violence prevention standard to certain facilities receiving Medicare funds.

TITLE I—WORKPLACE VIOLENCE PREVENTION STANDARD

SEC. 101. WORKPLACE VIOLENCE PREVENTION STANDARD.

(a) INTERIM FINAL STANDARD.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Labor shall promulgate an interim final standard on workplace violence prevention—

(A) to require certain employers in the health care and social service sectors, and certain employers in sectors that conduct activities similar to the activities in the health care and social service sectors, to develop and implement a comprehensive workplace violence prevention plan to protect health care workers, social service workers, and other personnel from workplace violence;

(B) that shall, at a minimum, be based on the Guidelines for Preventing Workplace Violence for Health care and Social Service Workers published by the Occupational Safety and Health Administration of the Department of Labor in 2015 and adhere to the requirements of this title; and

(C) that provides for a period determined appropriate by the Secretary, not to exceed 1 year, during which the Secretary shall prioritize technical assistance and advice consistent with section 21(d) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 670(d)) to employers subject to the standard with respect to compliance with the standard.
WORKPLACE VIOLENCE

(2) APPLICABILITY OF OTHER STATUTORY REQUIREMENTS.—The following shall not apply to the promulgation of the interim final standard under this subsection:
(A) The requirements applicable to occupational safety and health standards under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)).
(B) The requirements of chapters 5 and 6 of title 5, United States Code, and titles 2 and 42, United States Code.

(3) NOTICE AND COMMENT.—Notwithstanding paragraph (2)(B), the Secretary shall, prior to promulgating the interim final standard under this subsection, provide notice in the Federal Register of the interim final standard and a 30-day period for public comment.

(4) EFFECTIVE DATE OF INTERIM STANDARD.—The interim final standard shall—
(A) take effect on a date that is not later than 30 days after promulgation, except that such interim final standard may include a reasonable phase-in period for the implementation of required engineering controls that take effect after such date;
(B) be enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655(b)); and
(C) be in effect until the final standard described in subsection (b) becomes effective and enforceable.

(5) FAILURE TO PROMULGATE.—If an interim final standard described in paragraph (1) is not promulgated not later than 1 year of the date of enactment of this Act, the provisions of this title shall be in effect and enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act (29 U.S.C. 655(b)) until such provisions are superseded in whole by an interim final standard promulgated by the Secretary that meets the requirements of paragraph (1).

(b) FINAL STANDARD.—
(1) PROPOSED STANDARD.—Not later than 2 years after the date of enactment of this Act, the Secretary of Labor shall, pursuant to section 6 of the Occupational Safety and Health Act (29 U.S.C. 655), promulgate a proposed standard on workplace violence prevention—
(A) for the purposes described in subsection (a)(1)(A); and
(B) that shall include, at a minimum, the elements contained in the interim final standard promulgated under subsection (a).

(2) FINAL STANDARD.—Not later than 42 months after the date of enactment of this Act, the Secretary shall promulgate a final standard on such proposed standard that shall—
(A) provide no less protection than any workplace violence standard adopted by a State plan that has been approved by the Secretary under section 18 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 667); and
(B) be effective and enforceable in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act (29 U.S.C. 655(b)).

SEC. 102. SCOPE AND APPLICATION.
In this title:
(1) COVERED FACILITY.—
(A) IN GENERAL.—The term “covered facility” includes the following:
(i) Any hospital, including any specialty hospital, in-patient or outpatient setting, or clinic operating within a hospital license, or any setting that provides outpatient services.
(ii) Any residential treatment facility, including any nursing home, skilled nursing facility, hospice facility, and long-term care facility.
(iii) Any non-residential treatment or service setting.
(iv) Any medical treatment or social service setting or clinic at a correctional or detention facility.
(v) Any community care setting, including a community-based residential facility, group home, and mental health clinic.
(vi) Any psychiatric treatment facility.
(vii) Any drug abuse or substance use disorder treatment center.
(viii) Any independent freestanding emergency centers.
WORKPLACE VIOLENCE

(ix) Any facility described in clauses (i) through (viii) operated by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).
(x) Any other facility the Secretary determines should be covered under the standards promulgated under section 101.

(B) EXCLUSION.—The term “covered facility” does not include an office of a physician, dentist, podiatrist, or any other health practitioner that is not physically located within a covered facility described in clauses (i) through (x) of subparagraph (A).

(2) COVERED SERVICES.—

(A) IN GENERAL.—The term “covered service” includes the following services and operations:

(i) Any services and operations provided in any field work setting, including home health care, home-based hospice, and home-based social work.
(ii) Any emergency services and transport, including such services provided by firefighters and emergency responders.

(iii) Any services described in clauses (i) and (ii) performed by a Federal Government agency and required to comply with occupational safety and health standards pursuant to section 1960 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).
(iv) Any other services and operations the Secretary determines should be covered under the standards promulgated under section 101.

(B) EXCLUSION.—The term “covered service” does not include child day care services.

(3) COVERED EMPLOYER.—

(A) IN GENERAL.—The term “covered employer” includes a person (including a contractor, subcontractor, a temporary service firm, or an employee leasing entity) that employs an individual to work at a covered facility or to perform covered services.

(B) EXCLUSION.—The term “covered employer” does not include an individual who privately employs, in the individual’s residence, a person to perform covered services for the individual or a family member of the individual.

(4) COVERED EMPLOYEE.—The term “covered employee” includes an individual employed by a covered employer to work at a covered facility or to perform covered services.

SEC. 103. REQUIREMENTS FOR WORKPLACE VIOLENCE PREVENTION STANDARD.

Each standard described in section 101 shall include, at a minimum, the following requirements:

(1) WORKPLACE VIOLENCE PREVENTION PLAN.—Not later than 6 months after the date of promulgation of the interim final standard under section 101(a), a covered employer shall develop, implement, and maintain an effective written workplace violence prevention plan for covered employees at each covered facility and for covered employees performing a covered service on behalf of such employer, which meets the following:

(A) PLAN DEVELOPMENT.—Each Plan shall—

(i) be developed and implemented with the meaningful participation of direct care employees, other employees, and employee representatives, for all aspects of the Plan;
(ii) be tailored and specific to conditions and hazards for the covered facility or the covered service, including patient-specific risk factors and risk factors specific to each work area or unit; and
(iii) be suitable for the size, complexity, and type of operations at the covered facility or for the covered service, and remain in effect at all times.

(B) PLAN CONTENT.—Each Plan shall include procedures and methods for the following:

(i) Identification of the individual responsible for implementation of the Plan.
(ii) With respect to each work area and unit at the covered facility or while covered employees are performing the covered service, risk assessment and identification of workplace violence risks and hazards to employees exposed to such risks and hazards (including environmental risk factors and patient-specific risk factors), which shall be—

(I) informed by past violent incidents specific to such covered facility or such covered service; and
(II) conducted with, at a minimum—
(aa) direct care employees;
(bb) where applicable, the representatives of such employees; and
(cc) the employer.

(iii) Hazard prevention, engineering controls, or work practice controls to correct hazards, in a timely manner, applying industrial hygiene principles of the hierarchy of controls, which—
(I) may include security and alarm systems, adequate exit routes, monitoring systems, barrier protection, established areas for patients and clients, lighting, entry procedures, staffing and working in teams, and systems to identify and flag clients with a history of violence; and
(II) shall ensure that employers correct, in a timely manner, hazards identified in any violent incident investigation described in paragraph (2) and any annual report described in paragraph (5).

(iv) Reporting, incident response, and post-incident investigation procedures, including procedures—
(I) for employees to report workplace violence risks, hazards, and incidents;
(II) for employers to respond to reports of workplace violence;
(III) for employers to perform a post-incident investigation and debriefing of all reports of workplace violence with the participation of employees and their representatives;
(IV) to provide medical care or first aid to affected employees; and
(V) to provide employees with information about available trauma and related counseling.

(vi) Procedures for communicating with and training the covered employees on workplace violence hazards, threats, and work practice controls, the employer’s plan, and procedures for confronting, responding to, and reporting workplace violence threats, incidents, and concerns, and employee rights.

(vii) Procedures for—
(I) ensuring the coordination of risk assessment efforts, Plan development, and implementation of the Plan with other employers who have employees who work at the covered facility or who are performing the covered service; and
(II) determining which covered employer or covered employers shall be responsible for implementing and complying with the provisions of the standard applicable to the working conditions over which such employers have control.

(viii) Procedures for conducting the annual evaluation under paragraph (6).

(C) AVAILABILITY OF PLAN.—

(i) IN GENERAL.—Each Plan shall be—
(I) made available at all times to the covered employees who are covered under such Plan; and
(II) to the extent possible, emailed to each such employee upon completion of the employee’s annual training under paragraph (3)(A).

(ii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to serve in lieu of training or any other requirements under this Act.

(2) VIOLENT INCIDENT INVESTIGATION.—

(A) IN GENERAL.—As soon as practicable after a workplace violence incident, risk, or hazard of which a covered employer has knowledge, the employer shall conduct an investigation of such incident, risk, or hazard under which the employer shall—
(i) review the circumstances of the incident, risk, or hazard, and whether any controls or measures implemented pursuant to the Plan of the employer were effective; and
(ii) solicit input from involved employees, their representatives, and supervisors about the cause of the incident, risk, or hazard, and whether further corrective measures (including system-level factors) could have prevented the incident, risk, or hazard.

(B) DOCUMENTATION.—A covered employer shall document the findings, recommendations, and corrective measures taken for each investigation conducted under this paragraph.

(3) TRAINING AND EDUCATION.—With respect to the covered employees covered under a Plan of a covered employer, the employer shall provide training and education to such employees who may be exposed to workplace violence hazards and risks, which meet the following requirements:
(A) Annual training and education shall include information on the Plan, including identified workplace violence hazards, work practice control measures, reporting procedures, record keeping requirements, response procedures, anti-retaliation policies, and employee rights.

(B) Additional hazard recognition training shall be provided for supervisors and managers to ensure they—
   (i) can recognize high-risk situations; and
   (ii) do not assign employees to situations that predictably compromise the safety of such employees.

(C) Additional training shall be provided for each such covered employee whose job circumstances have changed, within a reasonable timeframe after such change.

(D) Additional training shall be provided for each such covered employee whose job circumstances require working with victims of torture, trafficking, or domestic violence.

(E) Applicable training shall be provided under this paragraph for each new covered employee prior to the employee’s job assignment.

(F) All training shall provide such employees opportunities to ask questions, give feedback on training, and request additional instruction, clarification, or other followup.

(G) All training shall be provided in-person and by an individual with knowledge of workplace violence prevention and of the Plan, except that any annual training described in subparagraph (A) provided to an employee after the first year such training is provided to such employee may be conducted by live video if in-person training is impracticable.

(H) All training shall be appropriate in content and vocabulary to the language, educational level, and literacy of such covered employees.

(4) RECORDKEEPING AND ACCESS TO PLAN RECORDS.—
   (A) IN GENERAL.—Each covered employer shall—
       (i) maintain for not less than 5 years—
           (I) records related to each Plan of the employer, including workplace violence risk and hazard assessments, and identification, evaluation, correction, and training procedures;
           (II) a violent incident log described in subparagraph (B) for recording all workplace violence incidents;
           and
       (ii) (I) make such records and logs available, upon request, to covered employees and their representatives for examination and copying in accordance with section 1910.1020 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), and in a manner consistent with HIPAA privacy regulations (defined in section 1180(b)(3) of the Social Security Act (42 U.S.C. 1320d–9(b)(3))) and part 2 of title 42, Code of Federal Regulations (as such part is in effect on the date of enactment of this Act); and
       (II) ensure that any such records and logs that may be copied, transmitted electronically, or otherwise removed from the employer’s control for purposes of this clause omit any element of personal identifying information sufficient to allow identification of any patient, resident, client, or other individual alleged to have committed a violent incident (including the individual’s name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals such individual’s identity).

   (B) VIOLENT INCIDENT LOG DESCRIPTION.—Each violent incident log shall—
       (i) be maintained by a covered employer for each covered facility controlled by the employer and for each covered service being performed by a covered employee on behalf of such employer;
       (ii) be based on a template developed by the Secretary not later than 1 year after the date of enactment of this Act;
       (iii) include, at a minimum, a description of—
           (I) the violent incident (including environmental risk factors present at the time of the incident);
           (II) the date, time, and location of the incident, and the names and job titles of involved employees;
           (III) the nature and extent of injuries to covered employees;
(IV) a classification of the perpetrator who committed the violence, including whether the perpetrator was—

(aa) a patient, client, resident, or customer of a covered employer;
(bb) a family or friend of a patient, client, resident, or customer of a covered employer;
(cc) a stranger;
(dd) a coworker, supervisor, or manager of a covered employee;
(ee) a partner, spouse, parent, or relative of a covered employee; or
(ff) any other appropriate classification;

(V) the type of violent incident (such as type 1 violence, type 2 violence, type 3 violence, or type 4 violence); and

(VI) how the incident was abated;

(iv) not later than 7 days after the employer learns of such incident, contain a record of each violent incident, which is updated to ensure completeness of such record;

(v) be maintained for not less than 5 years; and

(vi) in the case of a violent incident involving a privacy concern case, protect the identity of employees in a manner consistent with section 1904.29(b) of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act).

(C) ANNUAL SUMMARY.—

(i) COVERED EMPLOYERS.—Each covered employer shall prepare an annual summary of each violent incident log for the preceding calendar year that shall—

(I) with respect to each covered facility, and each covered service, for which such a log has been maintained, include the total number of violent incidents, the number of recordable injuries related to such incidents, and the total number of hours worked by the covered employees for such preceding year;

(II) be completed on a form provided by the Secretary;

(III) be posted for 3 months beginning February 1 of each year in a manner consistent with the requirements of section 1904 of title 29, Code of Federal Regulations (as such section is in effect on the date of enactment of this Act), relating to the posting of summaries of injury and illness logs;

(IV) be located in a conspicuous place or places where notices to employees are customarily posted; and

(V) not be altered, defaced, or covered by other material.

(ii) SECRETARY.—Not later than 1 year after the promulgation of the interim final standard under section 101(a), the Secretary shall make available a platform for the electronic submission of annual summaries required under this paragraph.

(5) ANNUAL REPORT.—Not later than February 15 of each year, each covered employer shall report to the Secretary, the frequency, quantity, and severity of workplace violence, and any incident response and post-incident investigation (including abatement measures) for the incidents set forth in the annual summary of the violent incident log described in paragraph (4)(C). Not later than May 15 of each year, the Secretary shall provide to Congress a report containing statistical data with respect to, and a summary of, reports submitted to the Secretary under this paragraph. The contents of the report of the Secretary shall not disclose any confidential information.

(6) ANNUAL EVALUATION.—Each covered employer shall conduct an annual written evaluation, conducted with the full, active participation of covered employees and employee representatives, of—

(A) the implementation and effectiveness of the Plan, including a review of the violent incident log; and

(B) compliance with training required by each standard described in section 101, and specified in the Plan.

(7) PLAN UPDATES.—Each covered employer shall incorporate changes to the Plan, in a manner consistent with paragraph (1)(A)(i) and based on findings from the most recent annual evaluation conducted under paragraph (6), as appropriate.

(8) ANTI-RETALIATION.—

(A) POLICY.—Each covered employer shall adopt a policy prohibiting any person (including an agent of the employer) from discriminating or retaliating against any employee for reporting, or seeking assistance
or intervention from, a workplace violence incident, threat, or concern to the employer, law enforcement, local emergency services, or a government agency, or participating in an incident investigation.

(B) PROHIBITION.—No covered employer shall discriminate or retaliate against any employee for—
(i) reporting a workplace violence incident, threat, or concern to, or seeking assistance or intervention with respect to such incident, threat, or concern from, the employer, law enforcement, local emergency services, or a local, State, or Federal government agency; or
(ii) exercising any other rights under this paragraph.

(C) ENFORCEMENT.—This paragraph shall be enforced in the same manner and to the same extent as any standard promulgated under section 6(b) of the Occupational Safety and Health Act (29 U.S.C. 655(b)).

SEC. 104. RULES OF CONSTRUCTION.
Notwithstanding section 18 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 667)—
(1) nothing in this title shall be construed to curtail or limit authority of the Secretary under any other provision of the law;
(2) the rights, privileges, or remedies of covered employees shall be in addition to the rights, privileges, or remedies provided under any Federal or State law, or any collective bargaining agreement;
(3) nothing in this Act shall be construed to limit or prevent health care workers, social service workers, and other personnel from reporting violent incidents to appropriate law enforcement; and
(4) nothing in this Act shall be construed to limit or diminish any protections in relevant Federal, State, or local law related to—
(A) domestic violence;
(B) stalking;
(C) dating violence; and
(D) sexual assault.

SEC. 105. OTHER DEFINITIONS.
In this title:
(1) WORKPLACE VIOLENCE.—
(A) IN GENERAL.—The term “workplace violence” means any act of violence or threat of violence, without regard to intent, that occurs at a covered facility or while a covered employee performs a covered service.
(B) EXCLUSIONS.—The term “workplace violence” does not include lawful acts of self-defense or lawful acts of defense of others.
(C) INCLUSIONS.—The term “workplace violence” includes—
(i) the threat or use of physical force against a covered employee that results in or has a high likelihood of resulting in injury, psychological trauma, or stress, without regard to whether the covered employee sustains an injury, psychological trauma, or stress; and
(ii) an incident involving the threat or use of a firearm or a dangerous weapon, including the use of common objects as weapons, without regard to whether the employee sustains an injury, psychological trauma, or stress.

(2) TYPE 1 VIOLENCE.—The term “type 1 violence”—
(A) means workplace violence directed at a covered employee at a covered facility or while performing a covered service by an individual who has no legitimate business at the covered facility or with respect to such covered service; and
(B) includes violent acts by any individual who enters the covered facility or worksite where a covered service is being performed with the intent to commit a crime.

(3) TYPE 2 VIOLENCE.—The term “type 2 violence” means workplace violence directed at a covered employee by customers, clients, patients, students, inmates, or any individual for whom a covered facility provides services or for whom the employee performs covered services.

(4) TYPE 3 VIOLENCE.—The term “type 3 violence” means workplace violence directed at a covered employee by a present or former employee, supervisor, or manager.
(5) **TYPE 4 VIOLENCE.**—The term “type 4 violence” means workplace violence directed at a covered employee by an individual who is not an employee, but has or is known to have had a personal relationship with such employee, or with a customer, client, patient, student, inmate, or any individual for whom a covered facility provides services or for whom the employee performs covered services.

(6) **THREAT OF VIOLENCE.**—The term “threat of violence” means a statement or conduct that—

(A) causes an individual to fear for such individual’s safety because there is a reasonable possibility the individual might be physically injured; and

(B) serves no legitimate purpose.

(7) **ALARM.**—The term “alarm” means a mechanical, electrical, or electronic device that does not rely upon an employee’s vocalization in order to alert others.

(8) **DANGEROUS WEAPON.**—The term “dangerous weapon” means an instrument capable of inflicting death or serious bodily injury, without regard to whether such instrument was designed for that purpose.

(9) **ENGINEERING CONTROLS.**—

(A) **IN GENERAL.**—The term “engineering controls” means an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between a covered employee and the hazard.

(B) **INCLUSIONS.**—For purposes of reducing workplace violence hazards, the term “engineering controls” includes electronic access controls to employee occupied areas, weapon detectors (installed or handheld), enclosed workstations with shatter-resistant glass, deep service counters, separate rooms or areas for high-risk patients, locks on doors, removing access to or securing items that could be used as weapons, furniture affixed to the floor, opaque glass in patient rooms (which protects privacy, but allows the health care provider to see where the patient is before entering the room), closed-circuit television monitoring and video recording, sight-aids, and personal alarm devices.

(10) **ENVIRONMENTAL RISK FACTORS.**—

(A) **IN GENERAL.**—The term “environmental risk factors” means factors in the covered facility or area in which a covered service is performed that may contribute to the likelihood or severity of a workplace violence incident.

(B) **CLARIFICATION.**—Environmental risk factors may be associated with the specific task being performed or the work area, such as working in an isolated area, poor illumination or blocked visibility, and lack of physical barriers between individuals and persons at risk of committing workplace violence.

(11) **PATIENT-SPECIFIC RISK FACTORS.**—The term “patient-specific risk factors” means factors specific to a patient that may increase the likelihood or severity of a workplace violence incident, including—

(A) a patient’s treatment and medication status, and history of violence and use of drugs or alcohol; and

(B) any conditions or disease processes of the patient that may cause the patient to experience confusion or disorientation, be non-responsive to instruction, behave unpredictably, or engage in disruptive, threatening, or violent behavior.

(12) **SECRETARY.**—The term “Secretary” means the Secretary of Labor.

(13) **WORK PRACTICE CONTROLS.**—

(A) **IN GENERAL.**—The term “work practice controls” means procedures and rules that are used to effectively reduce workplace violence hazards.

(B) **INCLUSIONS.**—The term “work practice controls” includes—

(i) assigning and placing sufficient numbers of staff to reduce patient-specific Type 2 workplace violence hazards;

(ii) provision of dedicated and available safety personnel such as security guards;

(iii) employee training on workplace violence prevention methods and techniques to de-escalate and minimize violent behavior; and

(iv) employee training on procedures for response in the event of a workplace violence incident and for post-incident response.
TITLE II—AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 201. APPLICATION OF THE WORKPLACE VIOLENCE PREVENTION STANDARD TO CERTAIN FACILITIES RECEIVING MEDICARE FUNDS.

(a) IN GENERAL.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (X), by striking “and” at the end;

(B) in subparagraph (Y), by striking at the end the period and inserting “; and”; and

(C) by inserting after subparagraph (Y) the following new subparagraph:

“(Z) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act) and skilled nursing facilities that are not otherwise subject to such Act (or such a State occupational safety and health plan), to comply with the Workplace Violence Prevention Standard (as promulgated under section 101 of the Workplace Violence Prevention for Health Care and Social Service Workers Act).”;

and

(2) in subsection (b)(4)—

(A) in subparagraph (A), by inserting “and a hospital or skilled nursing facility that fails to comply with the requirement of subsection (a)(1)(Z) (relating to the Workplace Violence Prevention Standard)” after “Bloodborne Pathogens standard)”; and

(B) in subparagraph (B)—

(i) by striking “(a)(1)(U)” and inserting “(a)(1)(V)”;

and

(ii) by inserting “(or, in the case of a failure to comply with the requirement of subsection (a)(1)(Z), for a violation of the Workplace Violence Prevention standard referred to in such subsection by a hospital or skilled nursing facility, as applicable, that is subject to the provisions of such Act)” before the period at the end.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply beginning on the date that is 1 year after the date of issuance of the interim final standard on workplace violence prevention required under section 101.

Passed the House of Representatives November 21, 2019.

Attest:

Clerk.

116TH CONGRESS
1ST SESSION

H. R. 1309

AN ACT

To direct the Secretary of Labor to issue an occupational safety and health standard that requires covered employers within the health care and social service industries to develop and implement a comprehensive workplace violence prevention plan, and for other purposes.
Appendix H

California Senate Bill (SB) No. 1299

California Senate Bill (SB) No. 1299: Workplace violence prevention plans: Hospitals. An act to add Section 6401.8 to the Labor Code, relating to occupational safety and health.

[Approved by Governor September 29, 2014. Filed with Secretary of State on September 29, 2014.]

Existing law regulates the operation of health facilities, including hospitals.

The California Occupational Safety and Health Act of 1973 imposes safety responsibilities on employers and employees, including the requirement that an employer establish, implement, and maintain an effective injury prevention program, and makes specified violations of these provisions a crime.

This bill would require the Occupational Safety and Health Standards Board, no later than July 1, 2016, to adopt standards developed by the Division of Occupational Safety and Health that require specified types of hospitals, including a general acute care hospital or an acute psychiatric hospital, to adopt a workplace violence prevention plan as a part of the hospital’s injury and illness prevention plan to protect health care workers and other facility personnel from aggressive and violent behavior. The bill would require the standards to include prescribed requirements for a plan. The bill would require the division, by January 1, 2017, and annually thereafter, to post a report on its Internet Web site containing specified information regarding violent incidents at hospitals. The bill would exempt certain state-operated hospitals from these provisions.

Because this bill would expand the scope of a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Section 6401.8 is added to the Labor Code, to read:

(a) The standards board, no later than July 1, 2016, shall adopt standards developed by the division that require a hospital licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code, except as exempted by subdivision (d), to adopt a workplace violence prevention plan as a part of its injury and illness prevention plan to protect health care workers and other facility personnel from aggressive and violent behavior.
(b) The standards adopted pursuant to subdivision (a) shall include all of the following:

(1) A requirement that the workplace violence prevention plan be in effect at all times in all patient care units, including inpatient and outpatient settings and clinics on the hospital’s license.

(2) A definition of workplace violence that includes, but is not limited to, both of the following:

(A) The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

(B) An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

(3) A requirement that a workplace violence prevention plan include, but not be limited to, all of the following:

(A) Personnel education and training policies that require all health care workers who provide direct care to patients to, at least annually, receive education and training that is designed to provide an opportunity for interactive questions and answers with a person knowledgeable about the workplace violence prevention plan. The education and training shall cover topics that include, but are not limited to, the following topics:

(i) How to recognize potential for violence, and when and how to seek assistance to prevent or respond to violence.

(ii) How to report violent incidents to law enforcement.

(iii) Any resources available to employees for coping with incidents of violence, including, but not limited to, critical incident stress debriefing or employee assistance programs.

(B) A system for responding to, and investigating violent incidents and situations involving violence or the risk of violence.

(C) A system to, at least annually, assess and improve upon factors that may contribute to, or help prevent workplace violence, including, but not limited to, the following factors:

(i) Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence.

(ii) Sufficiency of security systems, including alarms, emergency response, and security personnel availability.
(iii) Job design, equipment, and facilities.

(iv) Security risks associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas.

(4) A requirement that all workplace violence prevention plans be developed in conjunction with affected employees, including their recognized collective bargaining agents, if any.

(5) A requirement that all temporary personnel be oriented to the workplace violence prevention plan.

(6) Provisions prohibiting hospitals from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.

(7) A requirement that hospitals document, and retain for a period of five years, a written record of any violent incident against a hospital employee, regardless of whether the employee sustains an injury, and regardless of whether the report is made by the employee who is the subject of the violent incident or any other employee.

(8) A requirement that a hospital report violent incidents to the division. If the incident results in injury, involves the use of a firearm or other dangerous weapon, or presents an urgent or emergent threat to the welfare, health, or safety of hospital personnel, the hospital shall report the incident to the division within 24 hours. All other incidents of violence shall be reported to the division within 72 hours.

(c) By January 1, 2017, and annually thereafter, the division, in a manner that protects patient and employee confidentiality, shall post a report on its Internet Web site containing information regarding violent incidents at hospitals, that includes, but is not limited to, the total number of reports, and which specific hospitals filed reports, pursuant to paragraph (8) of subdivision (b), the outcome of any related inspection or investigation, the citations levied against a hospital based on a violent incident, and recommendations of the division on the prevention of violent incidents at hospitals.

(d) This section shall not apply to a hospital operated by the State Department of State Hospitals, the State Department of Developmental Services, or the Department of Corrections and Rehabilitation.

(e) This section does not limit the authority of the standards board to adopt standards to protect employees from workplace violence. Nothing in this section shall be interpreted to preclude the standards board from adopting standards that require other employers, including, but not limited
to, employers exempted from this section by subdivision (d), to adopt plans to protect employees from workplace violence. Nothing in this section shall be interpreted to preclude the standards board from adopting standards that require an employer subject to this section, or any other employer, to adopt a workplace violence prevention plan that includes elements or requirements additional to, or broader in scope than, those described in this section.

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
Appendix I

The Joint Commission Requirements Relevant to Physical and Verbal Violence Against Health Care Workers

HOSPITALS

Environment of Care (EC)

**EC.01.01.01 Element of Performance (EP) 4**: The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital’s facilities.

**EC.01.01.01 EP 5**: The hospital has a written plan for managing the following: The security of everyone who enters the hospital’s facilities.

**EC.02.01.01 EP 1**: The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities.

Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

**EC.02.01.01 EP 3**: The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

**EC.02.01.01 EP 7**: The hospital identifies individuals entering its facilities. 

Note: The hospital determines which of those individuals require identification and how to do so.

**EC.02.01.01 EP 8**: The hospital controls access to and from areas it identifies as security sensitive.

**EC.04.01.01 EP 1**: The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
- Injuries to patients or others within the hospital’s facilities
- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others
- Security incidents involving patients, staff, or others within its facilities
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures
- Medical or laboratory equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors

Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.

Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.

**EC.04.01.01 EP 3**: Based on its process(es), the hospital reports and investigates the following: Injuries to patients or others in the hospital’s facilities.

**EC.04.01.01 EP 6**: Based on its process(es), the hospital reports and investigates the following: Security incidents involving patients, staff, or others within its facilities.

**EC.04.01.03 EP 2**: The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues.

**EC.04.01.05 EP 1**: The hospital takes action on the identified opportunities to resolve environmental safety issues.
Emergency Management (EM)

EM.01.01.01 EP 2: The hospital conducts a hazard vulnerability analysis (HVA) to identify potential emergencies within the organization and the community that could affect demand for the hospital’s services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented. (See also EM.03.01.01, EP 1; IC.01.06.01, EP 4)

Note 1: Hospitals have flexibility in creating either a single HVA that accurately reflects all sites of the hospital, or multiple HVAs. Some remote sites may be significantly different from the main site (for example, in terms of hazards, location, and population served); in such situations a separate HVA is appropriate.

Note 2: If the hospital identifies a surge in infectious patients as a potential emergency, this issue is addressed in the "Infection Prevention and Control" (IC) chapter.

EM.01.01.01 EP 3: The hospital, together with its community partners, prioritizes the potential emergencies identified in its hazard vulnerability analysis (HVA) and documents these priorities.

Note: The hospital determines which community partners are critical to helping define priorities in its HVA. Community partners may include other health care organizations, the public health department, vendors, community organizations, public safety and public works officials, representatives of local municipalities, and other government agencies.

EM.01.01.01 EP 4: The hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community’s capability to meet its needs. This communication and identification occur at the time of the hospital's annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1)

EM.01.01.01 EP 5: The hospital uses its hazard vulnerability analysis as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency).

Note: Mitigation, preparedness, response, and recovery are the four phases of emergency management. They occur over time: Mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

EM.01.01.01 EP 7: The hospital's incident command structure is integrated into and consistent with its community’s command structure.*

Note: The incident command structure used by the hospital should provide for a scalable response to different types of emergencies.

Footnote*: The National Incident Management System (NIMS) is one of many models for an incident command structure available to health care organizations. The NIMS provides guidelines for common functions and terminology to support clear communications and effective collaboration in an emergency situation. The NIMS is required of hospitals receiving certain federal funds for emergency preparedness.

EM.02.01.01 EP 2: The hospital develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. (See also EM.03.01.03, EP 5)

Note: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the hospital may experience. Response procedures could include the following:
- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the hospital to new patients
- Staged evacuation
- Total evacuation
**EM.02.02.01 EP 1:** The Emergency Operations Plan describes the following: How staff will be notified that emergency response procedures have been initiated.

**EM.02.02.01 EP 2:** The Emergency Operations Plan describes the following: How the hospital will communicate information and instructions to its staff and licensed independent practitioners during an emergency.

**EM.02.02.01 EP 3:** The Emergency Operations Plan describes the following: How the hospital will notify external authorities that emergency response measures have been initiated.

**EM.02.02.01 EP 4:** The Emergency Operations Plan describes the following: How the hospital will communicate with external authorities during an emergency.

**EM.02.02.01 EP 6:** The Emergency Operations Plan describes the following: How the hospital will communicate with the community or the media during an emergency.

**EM.02.02.01 EP 12:** The Emergency Operations Plan describes the following: How, and under what circumstances, the hospital will communicate information about patients to third parties (such as other health care organizations, the state health department, police, and the Federal Bureau of Investigation [FBI]).

**EM.02.02.05 EP 1:** The Emergency Operations Plan describes the following: The hospital’s arrangements for internal security and safety.

**EM.02.02.05 EP 2:** The Emergency Operations Plan describes the following: The roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency.

**EM.02.02.05 EP 3:** The Emergency Operations Plan describes the following: How the hospital will coordinate security activities with community security agencies (for example, police, sheriff, National Guard).

**EM.02.02.05 EP 7:** The Emergency Operations Plan describes the following: How the hospital will control entrance into and out of the health care facility during an emergency.

**EM.02.02.05 EP 8:** The Emergency Operations Plan describes the following: How the hospital will control the movement of individuals within the health care facility during an emergency.

**EM.02.02.05 EP 9:** The Emergency Operations Plan describes the following: The hospital's arrangements for controlling vehicles that access the health care facility during an emergency.

**EM.02.02.05 EP 10:** The hospital implements the components of its Emergency Operations Plan that require advance preparation to support security and safety during an emergency.

**EM.02.02.11 EP 7:** The hospital trains staff for their assigned emergency response roles.

**EM.02.02.11 EP 2:** The Emergency Operations Plan describes the following: How the hospital will manage the activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge.

**EM.02.02.11 EP 3:** The Emergency Operations Plan describes the following: How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services. (See also EM.02.02.03, EPs 9 and 10)

**EM.03.01.03 EP 2:** For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital’s two emergency response exercises includes an influx of simulated patients.

Note 1: Tabletop sessions, though useful, cannot serve for this portion of the exercise.

Note 2: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.

**EM.03.01.03 EP 10:** During emergency response exercises, the hospital monitors its management of the following: Staff roles and responsibilities.
Leadership (LD)

LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the hospital.
LD.04.01.01 EP 2: The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations.
LD.04.04.05: The hospital has an organization-wide, integrated patient safety program within its performance improvement activities.

Provision of Care, Treatment, and Services (PC)

PC.01.02.13 EP 6: Based on the patient’s age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
- A psychiatric evaluation
- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
- For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:
  Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4)
PC.03.05.03 EP 1: The hospital implements restraint or seclusion using safe techniques identified by the hospital’s policies and procedures in accordance with law and regulation.

Rights and Responsibilities of the Individual (RI)

RI.01.06.03 EP 1: The hospital determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:
The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion.

## Appendix J

### Gap Analysis

<table>
<thead>
<tr>
<th></th>
<th>Current State (FROM)</th>
<th>Desired Future State (TO)</th>
<th>GAPS</th>
<th>Remedies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy</strong></td>
<td>• Staff lacks awareness of what acts of patient aggression constitute workplace violence</td>
<td>• Staff aware of definition of WPV and what type of incident(s) to report</td>
<td>• Lack of clear policy and/or failure to enforce policy by leadership in a transparent culture of safety</td>
<td>• Educate staff on organizational definition of WPV, and when/how to report sentinel events without blame</td>
</tr>
<tr>
<td></td>
<td>• Staff lacks awareness of emergency response protocol or algorithm</td>
<td>• Staff aware of which patient encounters require escalation and who to contact for assistance</td>
<td>• Limited engagement by leadership to make protocol clear and visible to staff</td>
<td>• Educate staff on unit protocol and standards of practice for managing patient aggression</td>
</tr>
<tr>
<td></td>
<td>• Scrambled resources “as needed” with unclear roles and expectations</td>
<td>• Staff anticipate patient needs and communicate with interdisciplinary team in real time</td>
<td>• Limited emphasis on prevention versus crisis management</td>
<td>• Educate staff on the importance of team communication to relay crucial information about patient condition before, during, and after a crisis</td>
</tr>
<tr>
<td>Team Communication</td>
<td>• Staff unaware of signs and symptoms of potential behavioral crisis</td>
<td>• Staff can recognize potential risk for violence early to immediately intervene</td>
<td>• No cross-training of skills needed to prevent WPV incidents</td>
<td>• Educate staff on signs and symptoms of aggression and potential violence so that patient needs are met</td>
</tr>
<tr>
<td>Prevention</td>
<td>• Staff unaware of parameters for permissible intervention e.g. verbal, non-verbal, and physical de-escalation</td>
<td>• Staff is compliant with organizational policy and protocol for the use of verbal, non-verbal, and physical de-escalation interventions including manual, physical, and chemical restraints and seclusion, up to and including assistance from security and/or law enforcement</td>
<td>• Lack of awareness of policies and protocols that set expectations for staff intervention to prevent WPV</td>
<td>• Educate staff on policies and protocols for intervention, and caution against legal implications for the improper use of force</td>
</tr>
<tr>
<td>Intervention</td>
<td>• Staff unaware of parameters for permissible intervention e.g. verbal, non-verbal, and physical de-escalation</td>
<td>• Staff can recognize potential environmental hazards and/or triggers to aggressive behaviors</td>
<td>• Limited awareness of multifactorial contributors to violent behavior</td>
<td>• Educate staff, patients, and visitors about potential hazards and triggers in the environment and give patient informed choice to participate in their care plan e.g. controlling temperature, light, noise, and odors</td>
</tr>
<tr>
<td>Environment</td>
<td>• Staff unaware of environmental influences on patient care and potential triggers of aggression</td>
<td>• Staff can recognize potential environmental hazards and/or triggers to aggressive behaviors</td>
<td>• Lack of awareness about how underreporting deters quality improvement, increases stigma, and puts patients and staff at continued risk</td>
<td>• Educate staff about importance of timely and accurate documentation to improve safety and quality</td>
</tr>
<tr>
<td>Documentation (Incident Reporting)</td>
<td>• Staff is reluctant to report WPV incident for fear of blame or punishment</td>
<td>• Staff consistently and accurately report WPV incidents as defined by organizational policy</td>
<td>• Lack of awareness about how underreporting deters quality improvement, increases stigma, and puts patients and staff at continued risk</td>
<td>• Educate staff on use of Employee Assistance Program and fostering an environment of peer support</td>
</tr>
<tr>
<td>Culture</td>
<td>• Leadership is engaged but lacks transparency in setting the organizational mission and values about the topic of WPV</td>
<td>• Leadership has an open-door policy and offers support for staff who experience, witness, and/or report WPV incidents</td>
<td>• Lack of trust between staff and leadership for fear of blame or punishment</td>
<td>• Educate leadership about the impact of visible engagement and transparency to promote a culture of safety</td>
</tr>
</tbody>
</table>
Appendix K

Root Cause Analysis (Fishbone Diagram)
Appendix L
Project Charter

CHARTER FORM

Name: Nicole Bellisario MSN RNCN

Team Members: Dr. Sara Horton-Deutsch & Dr. Elena Capella

Project Title: Workplace Violence: An Urgent Call for Integrated Staff Education in Acute Care Hospitals

University/Organization Name: University of San Francisco

Health System Sponsor Name: University of California San Diego (UCSD) Health

What are we trying to accomplish?

Aim statement (How good? For whom? By when? 1-2 sentences):
The specific aim for this project is a 20% improvement in staff knowledge and attitudes about managing care for aggressive patients through educational strategies in non-ED and non-BH microsystems within 90 days post-implementation.

Problem to be addressed (Defines WHAT broadly; 2-3 sentences)
Type II workplace violence (patient versus staff) is responsible for 80% of workplace violence incidents in the healthcare industry. The project addresses the significant knowledge gap and misperceptions about aggressive patients for non-ED and non-BH healthcare staff not typically trained or educated about behavioral emergencies that may lead to workplace violence.

Reason for the effort (Defines WHY; 4-5 sentences)
Evidence-based integrated staff education addresses knowledge gaps and misperceptions about aggressive patients in order to prevent and mitigate WPV incidents.

Expected outcomes/benefits (Defines WHAT specifically, still not HOW; 3-4 sentences)
A 20% improvement in staff knowledge and attitudes about managing care for aggressive patients through educational strategies in non-ED and non-BH microsystems may decrease WPV incidence and, therefore, reduce injuries and costs associated with WPV.

How do we know that a change is an improvement?
(Identify outcome, process, and balancing measures; 4-5 sentences)
Outcomes will be measured by educational pre- and post-intervention surveys, staff education evaluation forms, staff surveys, and data analyses. The outcome measure is the change in staff knowledge and attitudes post-intervention of the education course.

What changes can we make that will lead to improvement?
(Initial changes, barriers, key stakeholders; 4-5 sentences)
Implement a revised 30-minute virtual staff education course on ICU and PCU units with a focus on EBP for early recognition of WPV risk factors, signs, symptoms, trauma informed care, and basic prevention and intervention techniques. Staff education will incorporate existing revised policy and protocol. The course will emphasize the importance of team communication with a focus on the code gray process map to list clear expectations of best practices, and clear roles and responsibilities for the healthcare team. The course will also emphasize the importance of incident reporting, documentation, and creating a supportive healing environment for patients and staff. Barriers may include COVID-19 pandemic restrictions and lack of engagement by management or participants. Key stakeholders include staff, frontline managers, nurse managers, nurse educators, physicians, nurses, and hospital leadership. The WPV committee–patient assessment feedback form (PBF), security, and facility staff, patients, families, visitors, and the community at large.

Read the following statement and check the box below before submitting this charter to the IHI Open School.

☐ I certify that my faculty advisor has reviewed and approved this charter.
## Appendix M

### Gantt Chart

<table>
<thead>
<tr>
<th>Project Milestones</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identification of WPV Prevention Program EBP Guidelines &amp; Measures</strong></td>
<td></td>
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<tr>
<td><strong>Literature Review</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Stakeholder Analysis &amp; QI Team Building</strong></td>
<td></td>
<td>2020</td>
</tr>
<tr>
<td><strong>Key Informant Interviews</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organizational &amp; Microsystem Needs Assessments</strong></td>
<td></td>
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<tr>
<td><strong>Assess Policy (regulatory compliance &amp; accreditation standards)</strong></td>
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<tr>
<td><strong>Assess Protocol (VRA screening tool, process map, front-line EBP, communication, documentation)</strong></td>
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<tr>
<td><strong>Gap Analysis</strong></td>
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<tr>
<td><strong>Gather demographic data for participants and intervention units</strong></td>
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<td><strong>Staff Pre-intervention Tests</strong></td>
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<tr>
<td><strong>Staff Education &amp; Training Course</strong></td>
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<td><strong>Staff Post-Intervention Tests</strong></td>
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<td><strong>Project Feedback &amp; Adjustments</strong></td>
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Appendix N

Integrated Workplace Violence Prevention Staff Education Course

Course Title: Workplace Violence: An Urgent Call for Integrated Staff Education in Acute Care Hospitals

Date: June 2020

Floor(s)/Unit(s)/Cohort(s): Hillcrest, SICU and PCU units (via teleconference)

Instructor: Nicole Bellisario MSN RN CNL (Email: neBellisario@usfca.edu)

Part I: Learners

I. Eligible Learners: All acute care CNs, RNs, LVNs, CNAs, nurse managers, and ancillary staff in Telemetry, Medical-Surgical, Step-Down units, and other hospital units in needs assessment.

II. Education Level: CNs, RNs, LVNs, CNAs, and ancillary staff involved in direct patient care. CNs, safety committee members, and/or unit champions should take lead on education initiatives on their respective units.

III. Developmental Level: Knowledge and skill acquisition through listening, observing, and return demonstration are required to master full competency from this training.

IV. Cultural Considerations: This course is considered an enhancement of practice for non-ED and non-BH unit staff to learn and master the principles of non-violent crisis prevention and intervention. This knowledge will improve both the quality of care delivered to patients and the safety of the work environment for staff.
Part II: Objectives

Upon the completion of the educational initiative, students will be able to master the following learning objectives:

1) List at least three risk factors for type II WPV
2) List at least three signs and symptoms of type II WPV
3) Recite two examples each of verbal, paraverbal, non-verbal, and physical intervention best practices
4) Recite the rationale for the TeamSTEPPS I PASS (the) BATON team communication acronym
5) Understand the importance of reporting and documenting WPV incidents in a non-punitive culture of safety that is supportive of staff and quality improvement
6) Demonstrate improvement in attitudes toward patients with behavioral emergencies through a better understanding of factors contributing to WPV
7) Feel an increased sense of confidence and security in handling violent patients thus leading to better patient outcomes
8) RNs should complete the NIOSH Workplace Violence Prevention Online Course for Nurses (www.cdc.gov/niosh/topics/violence/training_nurses.html)
9) RNs should also participate in a WPV simulation, skills fair or demonstration, and/or volunteer to take a Crisis Prevention Institute (CPI) course or equivalent

Total estimated time: 1 hour
Part III: Presentation

I. Perceptions about Patients in Behavioral Distress [5-minute visual, integrative exercise].
   A. Participants share thoughts and feelings about image of type II WPV
   B. CPI® Changing Perceptions, Changing Care [3-minute video].
      https://www.youtube.com/watch?v=UL5fBRe4Uo&list=PL7FBO42DE67C78544&index=2
   C. Mentally ill are more likely to be victims rather than perpetrators of violence

II. What is Workplace Violence? [PowerPoint Presentation]
   A. Definition
   B. Incidence and Prevalence
   C. Four Types of Workplace Violence
   D. Type II Workplace Violence
   E. Healthcare System Impact
   F. Best Practices: Early Recognition, De-Escalation, Team Communication, Documentation, Quality Improvement

III. Early Recognition [PowerPoint Presentation]
   A. Systemic Causes of Workplace Violence in Healthcare
   B. Risk Factors
   C. Signs and Symptoms

IV. Best Practices for Non-violent Crisis Prevention & Intervention [PowerPoint Presentation]
   A. Non-verbal Communication
      1. Proxemics
      2. Kinesics
      3. Haptics
   B. Paraverbal Communication
      1. Tone
      2. Volume
      3. Cadence
   C. Verbal Communication
      1. Limit Setting
      2. Empathetic Listening
   D. Physical Interventions
      1. Disengagement Skills

V. CPI® Top 10 Tips for De-Escalation [PowerPoint Presentation]
VI. Team Communication [PowerPoint Presentation]
   A. TeamSTEPPS → I.P.A.S.S. (the) B.A.T.O.N. Model
   B. Team Huddles
   C. Hand-off Reports
   D. Unit/Door Signage/Precautions
   E. White Boards
   F. Post-incident Debriefing

VII. Documentation [PowerPoint Presentation]
   A. Event Reporting System (ERS): iReport
   B. Electronic Health Record (EHR): EPIC
   C. Incident Report: For patient injuries (report to Compliance Department)
   D. Occupation and Environmental Medicine (Employee Health): For employee injuries

VIII. Quality Improvement [PowerPoint Presentation]
   A. Regulatory Compliance → Policies & Protocols
   B. Accreditation → Evidence-based Practice
   C. Risk Management → Ethical and Legal Duty of Care
   D. Quality Control → Process Review
   E. Education & Training → Professional Code of Conduct

IX. Question and Answer Session with Open Discussion for COVID-19 Implications

X. Post-Intervention Surveys and Staff Education Evaluation Forms (via SurveyMonkey)

XI. Continuing Education (CE) Credits (optional)
    Workplace Violence Prevention Online Course for Nurses (NIOSH)
    www.cdc.gov/niosh/topics/violence/training_nurses.html

XII. Additional Resources:

   Organizational P&P: Security Management Program and Workplace Violence Prevention Program
   The Ultimate CPI® Resource Pack

   CPI®'s Top 10 De-Escalation Tips

   Nursing Support: American Nurses Association #EndNurseAbuse, National Suicide Prevention Lifeline 1-800-273-8255
Appendix O

Team STEPPS – I PASS (the) BATON Model of Communication

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<thead>
<tr>
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<tr>
<td><strong>I</strong></td>
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<td><strong>P</strong></td>
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<td><strong>A</strong></td>
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<tr>
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<td><strong>Situation</strong></td>
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<td><strong>S</strong></td>
<td><strong>SAFETY Concerns</strong></td>
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<tr>
<td><strong>T</strong></td>
<td><strong>Background</strong></td>
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<tr>
<td><strong>E</strong></td>
<td><strong>Actions</strong></td>
</tr>
<tr>
<td><strong>H</strong></td>
<td><strong>Timing</strong></td>
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<tr>
<td><strong>E</strong></td>
<td><strong>Ownership</strong></td>
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<td><strong>N</strong></td>
<td><strong>Next</strong></td>
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</table>

<p>| | |</p>
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<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I</strong></td>
<td>Introduce yourself and your role/job (include patient)</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>Name, identifiers, age, sex, location</td>
</tr>
<tr>
<td><strong>A</strong></td>
<td>Present chief complaint, vital signs, symptoms, and diagnosis</td>
</tr>
<tr>
<td><strong>S</strong></td>
<td>Current status/circumstances, including code status, level of (un)certainty, recent changes, and response to treatment</td>
</tr>
<tr>
<td><strong>S</strong></td>
<td>Critical lab values/reports, socio-economic factors, allergies, and alerts (falls, isolation, etc.)</td>
</tr>
<tr>
<td><strong>T</strong></td>
<td>Co-morbidities, previous episodes, current medications, and family history</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>What actions were taken or are required? Provide brief rationale</td>
</tr>
<tr>
<td><strong>H</strong></td>
<td>Level of urgency and explicit timing and prioritization of actions</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>Who is responsible (person/team) including patient/family?</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>What will happen next? Anticipated changes? What is the plan? Are there contingency plans?</td>
</tr>
</tbody>
</table>

Appendix P

Pre- and Post-Intervention Surveys

Pre-/Post-Intervention Survey
Workplace Violence: An Urgent Call for Integrated Staff Education in Acute Care Hospitals

by
Nicole E. Bellisario, MSN, RN, CNL
EL-DNP Student ‘20
University of San Francisco

Staff Education Pre-/Post-Intervention Survey

Please answer the following questions about your knowledge and attitude about type II workplace violence (WPV) i.e. patient aggression against healthcare staff. Please be honest and answer questions as they pertain to your current role, unit, and organization. Thank you for your participation.

1. Provide your participant ID number (last 4 digits of your phone number).

Participant ID Number

2. What is your current job title?

○ CNA / Nurse's Aide
○ Charge Nurse
○ Staff LVN
○ HUSC
○ Staff RN

3. What is your current unit?

○ Medical-Surgical
○ Step Down
○ Telemetry
○ Surgical PCU
○ SICU

4. How many years of experience do you have in your current job title?

○ < 1 year
○ 1-2 years
○ 2-5 years
○ > 5 years
5. What is your level of education?

- CNA - Certification
- LVN/RN - Diploma or Associate of Science in Nursing (ASN)
- RN - Bachelor of Science in Nursing (BSN)
- Other healthcare license/certification
- RN - Master of Science in Nursing (MSN) or higher

6. Are you aware of your organizational Workplace Violence (WPV) Prevention policy including the definition of WPV and what types of incidents you should report on your unit?

- Yes
- No
- I'm not sure

7. Are you aware of your organizational Workplace Violence (WPV) Prevention protocol including who you should call and how you should respond to behavioral emergencies on your unit?

- Yes
- No
- I'm not sure

8. Does your unit utilize a violence risk assessment (VRA) tool or checklist to screen patients for the risk for violence?

- Yes
- No
- I'm not sure

9. Does your unit have safety precaution(s) for high-risk aggressive patients? (e.g. a sign outside the patient's room, a magnet on the communication whiteboard, a colored wristband, and/or a sticker on the paper chart). How are the safety precaution(s) determined?

- Yes, safety precautions are determined by nurse/clinician judgment
- Yes, safety precautions are determined by a violence risk assessment (VRA) screening tool
- No
- I'm not sure

10. I fear I will be blamed or punished by management if I report a workplace violence (WPV) incident.

- True
- False
11. What are some risk factors for workplace violence caused by combative patients? (Select all that apply)

- Working with patients who have a history of violence or who may be delirious or under the influence of drugs
- Lifting, moving, and transporting patients
- Working alone
- Poor environmental design with blocked vision or escape routes
- Poor lighting in hallways or exterior areas
- Lacks of means of emergency communication
- Presence of firearms
- Working in neighborhoods with high crime rates
- Lack of training and policies for staff
- Understaffing, especially during mealtimes and visitor hours
- High staff turnover
- Inadequate security staff
- Long wait times and overcrowded waiting room
- Unrestricted public access
- Perception that violence is tolerated and reporting incidence will have no effect

12. What are some signs and symptoms of workplace violence caused by combative patients? (Select all that apply)

- Any change in behavior (negative or positive)
- Sudden change in energy level
- Behavior intensity and frequency are disruptive to environment
- Disrespect of authority
- Argumentative
- Impulsive
- Restless / anxiety
- Verbal abuse
- Emotional outbursts
- Holds grudges
- Blames others
- Confusion / distraction
- Social isolation
- Poor hygiene
- Glaring or avoiding eye contact
- Violation of personal space
- Preoccupation with violence or weapons
- Recent life changes or trauma
- Irrational beliefs or ideas
- Hopelessness

13. Which of the following are example(s) of verbal de-escalation strategies? (Select all that apply)

- Provide positive reinforcement for good behavior e.g. saying "You did great today!"
- Give the patient a "high-five" when they are polite to staff
- Tell the patient staff will call the police if they do not calm down
- Express empathy by saying, "I understand you are upset. Tell me how I can help."
- Tell the patient that their aggressive behavior is inappropriate
14. Which of the following are example(s) of paraverbal de-escalation strategies? (Select all that apply)

☐ Stand squarely in front of the patient with an authoritative posture

☐ Use a calm tone of voice with a regular rate and cadence of speech

☐ Match the patient's volume and intensity of speech

☐ Use active listening and silence to allow for contemplation and reflection

☐ Be clear and concise when offering choices and explaining consequences

15. Which of the following are example(s) of non-verbal de-escalation strategies? (Select all that apply)

☐ Respect the patient's personal space and boundaries

☐ Make steady eye contact with the patient until they calm down

☐ Smile if the patient threatens you to show them you are not afraid

☐ Position yourself in a supportive manner that is both empathetic and protective

☐ Nod your head to show the patient you are listening to their concerns

16. Which of the following are example(s) of physical disengagement strategies? (Select all that apply)

☐ Shielding yourself from physical harm e.g. if the patient throws an object toward you, you block it and run for help

☐ Pushing the patient off of you and holding them down on the floor while staff calls for help

☐ Using martial arts tactics to defend yourself from a patient assault

☐ Placing yourself between a patient and another staff member who are engaged in a physical altercation

☐ Releasing yourself from the patient’s grip/hold then running away to get help

17. What is the rationale for the TeamSTEPPS I PASS (the) BATON acronym?

☐ To provide a hand-off report to the Charge Nurse so they can give report to the physician for your aggressive patient

☐ To update safety precautions on the unit communication whiteboard

☐ To enhance interdisciplinary team communication and collaboration on patient care when responding to an emergency code

☐ To post a notice for visitors not to agitate the aggressive patient

18. Establishing trust and a therapeutic rapport with a combative patient is an effective way to ensure their needs are met.

☐ True

☐ False
19. If a patient becomes increasingly combative, it is not ok to set limits to establish expectations of appropriate behavior, and to provide the patient with clear choices and consequences.

- True
- False

20. Reporting workplace violence events through the Event Reporting System (ERS) is important for quality improvement but if no one was hurt, there is no reason to report it.

- True
- False

21. How comfortable are you in working with an aggressive patient

- Very uncomfortable
- Uncomfortable
- Uncomfortable
- Uncomfortable
- Uncomfortable
- Comfortable
- Comfortable
- Comfortable
- Comfortable
- Very comfortable

22. How good is your present level of training for handling psychological aggression?

- Very poor
- Quite poor
- Poor
- Moderately poor
- Slightly poor
- Slightly good
- Mildly good
- Moderately good
- Quite good
- Very good

23. How able are you to intervene physically with an aggressive patient?

- Very unable
- Quite unable
- Moderately unable
- Mildly unable
- Slightly unable
- Slightly able
- Mildly able
- Moderately able
- Quite able
- Very able

24. How self-assured do you feel in the presence of an aggressive patient?

- Very unassured
- Quite unassured
- Moderately unassured
- Mildly unassured
- Slightly unassured
- Slightly assured
- Mildly assured
- Moderately assured
- Quite assured
- Very assured

25. How able are you to intervene psychologically with an aggressive patient?

- Very unable
- Quite unable
- Moderately unable
- Mildly unable
- Slightly unable
- Slighty able
- Mildly able
- Moderately able
- Quite able
- Very able
26. How good is your present level of training for handling physical aggression?

- Very poor
- Quite poor
- Moderately poor
- Mildly poor
- Slightly poor
- Slightly good
- Mildly good
- Moderately good
- Quite good
- Very good

27. How safe do you feel around an aggressive patient?

- Very unsafe
- Quite unsafe
- Moderately unsafe
- Mildly unsafe
- Slightly unsafe
- Slightly safe
- Mildly safe
- Moderately safe
- Quite safe
- Very safe

28. How effective are the techniques that you know for dealing with aggression?

- Very ineffective
- Quite ineffective
- Moderately ineffective
- Mildly ineffective
- Slightly ineffective
- Slightly effective
- Mildly effective
- Moderately effective
- Quite effective
- Very effective

29. How able are you to meet the needs of an aggressive patient?

- Very unable
- Quite unable
- Moderately unable
- Mildly unable
- Slightly unable
- Slightly able
- Mildly able
- Moderately able
- Quite able
- Very able

30. How able are you to protect yourself physically from an aggressive patient?

- Very unable
- Quite unable
- Moderately unable
- Mildly unable
- Slightly unable
- Slightly able
- Mildly able
- Moderately able
- Quite able
- Very able
Appendix Q

Staff Education Evaluation Form

Please complete the following survey based on the virtual course you attended on June 3, 2020 titled: Workplace Violence - An Urgent Call for Integrated Staff Education in Acute Care Hospitals

1. Please rate the following on a scale of 1-4:
   Excellent (4) Good (3) Fair (2) Poor (1)

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<th>1</th>
<th>2</th>
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<td>Quality of Instruction</td>
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<td>Relevance of Material</td>
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<td>Participation/Interactive</td>
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<td>Interest of Material</td>
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<tr>
<td>Overall Evaluation</td>
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2. Would you recommend this course to others in your profession?
   - Yes
   - No
   - I don't know

3. What was the most valuable part of this course?

4. Kindly share any recommendations for future courses.
Appendix R

Work Breakdown Structure

Quality Improvement Team

Lippitt's 7 Phases of Change Theory

1 Diagnose
- Executive Leadership
- Nursing Management
- Clinical Education
- Multidisciplinary Team / TAM Committee / Security Team
- Front-line Staff
- QAPI Team
- Patients / Families

2 Motivate
- Policy Legislation
- Unit Protocols
- Emerging Trends
- Code Grey Protocol
- VRA tools
- QI Processes & Measures
- Differential Populations

3 Resources
- Accreditation
- Best Practices
- Simulation
- Advanced Violence
- Competency Morale
- Data Collection
- Code of Conduct

4 Action
- Budget Org Culture
- Restraints, Seclusions, Sitter
- Web-based Classroom
- Risk Assessment
- Environmental Surveillance
- Expert Consultation
- Safety Precautions
- Team Communication
- Incident Reports
- EHR Documentation
- Trauma-Informed Care

5 Change
- Urgency
- Incident Reporting
- De-escalation Intervention
- Debriefing
- Early Recognition
- Intervention
- Unit Champions
- Communication
- Employee Health & Injury Data
- Holistic Care

6 Maintain
- Transparency
- Safety Culture
- Intervention
- Consultation
- Safety Precautions
- Team Communication
- Incident Reports
- EHR Documentation
- Trauma-Informed Care

7 Sustain
- Visible Engagement
- Incident Reporting
- De-escalation Intervention
- Consultation
- Safety Precautions
- Team Communication
- Incident Reports
- EHR Documentation
- Trauma-Informed Care

Decreased WPV Incidence
- ROI Culture Change
- Team Support
- Competence
- Targeted Assessment
- Increased Knowledge
- Quality Data
- Quality Outcomes

ROI Culture Change
- Caring & Coping Strategies
- Confidence
- Intervention Clear & Consistent Guidelines
- Therapeutic Outcomes
- Track Patterns & Trends
- Increased Satisfaction
Appendix S

Driver Diagram

**Primary Drivers**
- AIM
- Decreased Workplace Violence

**Secondary Drivers**
- Policies
- Protocols
- Evidence-based Practice
- Standards of Practice
- Nursing Standards
- Legal & Ethical Standards
- Incident Reporting Procedures
- Documentation
- Environmental Hazards
- Process Improvement
- Data Collection
- Simulation-based Training
- Evidenced-based Practice
- Prevention and De-escalation
- Organizational Readiness
- Zero Tolerance
- Urgency & Transparency

**Specific Ideas to Test or Change Concepts**
- Code Gray Policy Review / Revision
- Code Gray Protocol Review / Revision
- Violence Risk Assessment
- Multidisciplinary Consultation
- Trauma-Informed Care
- Dual Patient and Staff Safety
- Violence Risk Assessment
- ERS, EHR, Incident Reports
- Safety Precautions
- IHI Family of Measures
- PDSA, Staff Surveys, Evals
- Team Communication
- Risk factors, Signs, Symptoms
- Best Practices
- Leadership Support
- Fair Staff Representation
- Clear Expectations
- Open Door Policy
- Coping Strategies
## Appendix T

### Communication/Responsibility Matrix

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<th>Project Activity</th>
<th>Audience</th>
<th>Medium</th>
<th>Frequency</th>
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<tr>
<td>Policy Review &amp; Development</td>
<td>Executive Leadership, Director WPV Prevention Program</td>
<td>In-person / Email</td>
<td>Once monthly</td>
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<td>Protocol Review &amp; Development</td>
<td>Director WPV Prevention Program, TAT, Nursing Management, Front-line Staff</td>
<td>In-person, Staff Surveys via SurveyMonkey</td>
<td>Once monthly &amp; as needed</td>
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<td>Education &amp; Training</td>
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<td>In-person</td>
<td>Biweekly / as needed</td>
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<td>Feedback &amp; Adjustments</td>
<td>All QI Team</td>
<td>In-person / Email</td>
<td>As needed</td>
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Appendix U

SWOT Analysis

Strengths

- Increased patient and staff safety
- Better patient outcomes
- Staff & Patient satisfaction
- Evidence-based value
- Leadership support
- Shared governance
- Community trust

Weaknesses

- Cost of education, training, & materials; increased management resources
- Change requires sustained commitment
- Lack of existing policy & protocol, urgency, & transparency
- Lack of reporting

Opportunities

- Anticipate regulatory mandates
- Adhere to accreditation standards
- Utilize immediate, low cost, high impact tools
- Expert consultation
- Cost mitigation

Threats

- Increased violence in society
- Strained mental health services
- Lack of adequate or enforceable legislation
- Increased access to firearms and weapons
## Appendix V

### Budget, Cost-Benefit, and Return on Investment Analysis

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<td>$300,000</td>
</tr>
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<td>Staff Litigation / Settlements</td>
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<tr>
<td>Reduced Staff Turnover</td>
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<tr>
<td>Property Damage</td>
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<tr>
<td><strong>TOTAL COST SAVINGS</strong></td>
<td>≈ $1,150,000</td>
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<table>
<thead>
<tr>
<th>INDIRECT COST SAVINGS</th>
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<tr>
<td>Reduced Diversion of Resources</td>
<td>variable</td>
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<tr>
<td>Productivity Gains</td>
<td>variable</td>
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<tr>
<td>Increased Staff Morale</td>
<td>variable</td>
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<tr>
<td><strong>TOTAL COST AVOIDANCE</strong></td>
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| TOTAL BENEFITS                            | ≈ $1,150,000 |

Return on Investment: ≈ 60.4%
Appendix W

Cost-Effectiveness Analysis

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<thead>
<tr>
<th>COMPARATIVE COSTS</th>
<th>CURRENT STAFF EDUCATION</th>
<th>PROPOSED STAFF EDUCATION</th>
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<tbody>
<tr>
<td><strong>DIRECT COSTS (ESTIMATED)</strong></td>
<td><strong>ANNUAL</strong></td>
<td><strong>YEAR 1</strong></td>
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<tr>
<td>Staff Education and Training</td>
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<td>Annual Staff Simulation Drills</td>
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<td>Annual Computer Training Module</td>
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<td>Technology Training Development</td>
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Cost Effectiveness Analyses

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<th>Proposed Staff Education</th>
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<td>Cost-Benefit Ratio</td>
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82.3% Decrease in Budget Capital
Appendix X

Data Set

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<th>Staff Participant</th>
<th>Job Title</th>
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<td>PCU</td>
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<td>BSN</td>
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<td>PCU</td>
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<td>MSN</td>
</tr>
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<td>4</td>
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<td>PCU</td>
<td>2-5 years</td>
<td>MSN</td>
</tr>
<tr>
<td>5</td>
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<td>PCU</td>
<td>&gt;5 years</td>
<td>BSN</td>
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<td>&gt;5 years</td>
<td>ASN/Diploma</td>
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<td>7</td>
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<td>SICU</td>
<td>&gt;5 years</td>
<td>BSN</td>
</tr>
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<td>8</td>
<td>RN</td>
<td>SICU</td>
<td>&gt;5 years</td>
<td>MSN</td>
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Appendix Y

Signed Statement of Non-Research Determination Form

Doctor of Nursing Practice
Statement of Non-Research Determination (SOD) Form
The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

General Information

Last Name: Bellisario
First Name: Nicole
CWID Number:
Semester/Year: Fall 2019
Course Name & Number: NRS749E: Qualifying Project
Chairperson Name: Dr. Sara Horton-Deutsch
Advisor Name:

Project Description

1. Title of Project

Workplace Violence: An Urgent Call for Integrated Staff Education in Acute Care Hospitals

2. Brief Description of Project

Clearly state the purpose of the project and the problem statement in 250 words or less.

This is a quality improvement project that will address type II workplace violence (patient versus clinician) in acute care hospitals. The clinical management of patient aggression in non-Emergency Department (ED) and non-Behavioral Health (BH) settings (e.g. medical-surgical, telemetry, and step-down acute care units) has presented a unique knowledge gap for healthcare staff not traditionally trained to provide care for patients who present with aggression and/or behavioral crises. The student, serving as the project manager, will recommend the implementation of integrated staff education and training including: awareness of organizational policy and protocols for violence risk assessment (VRA) and emergency response codes; prevention and intervention techniques that are current standards of evidence-based practice: interdisciplinary team communication via huddles, hand-off reports, whiteboard communication, and unit signage; documentation of WPV sentinel events (e.g. incident reports); and visible engagement from organizational leadership in a transparent non-punitive culture of safety.

3. AIM Statement: What are you trying to accomplish?

- What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well-defined, and at a minimum describe the target population, the desired improvement, and the targeted timeframe.
- To improve (your process) from (baseline)% to (target)%, by (timeframe), among (your specific population)
Complete this statement:

- staff knowledge and improve attitudes about managing care for aggressive

To **increase** / decrease: __patients________________________ (process/outcome)

- lack of knowledge and awareness of organizational policy, protocol, violence risk

from: __assessment. environmental hazards, importance of documentation in a culture of safety________ (baseline %, rate, #, etc.)

to: __assessment. environmental hazards, importance of documentation in a culture of safety________ (goal/target %, rate, #, etc.)

by: __6 months post-implementation (August 2020)________________________ (date, 3 - 6-month timeframe)

in: __medical-surgical, telemetry, and step-down units________________________ (population impacted)


4 Brief Description of Intervention (150 words).

4a. How will this intervention be implemented?

- Where will you implement the project?
- Attach a letter from the agency with approval of your project.
- Who is the focus of the intervention?
- How will you inform stakeholders/participants about the project and the intervention?

This project will be implemented at **redacted** in San Diego, CA.

The focus of the project is education and training for clinical staff (charge nurses, RNs, LVNs, CNAs) on non-Emergency Department and non-Behavioral Health units (e.g. medical-surgical, telemetry, and step-down).

The project manager will engage with Executive Leadership, Nursing Management, the Threat Assessment Taskforce (TAT) / Workplace Violence Committee, Clinical Education, Risk Management, and front-line clinical staff to assess staff needs and knowledge gaps. The project manager will create buy-in from key stakeholders for the implementation of integrated staff education and training as part of a comprehensive WPV prevention program.
5. Outcome measurements: How will you know that a change is an improvement?
- Measurement over time is essential to QI. Measures can be outcome, process, or balancing measures. Baseline or benchmark data are needed to show improvement.
- Align your measure with your problem statement and aim.
- Try to define your measure as a numerator/denominator.
  - What is the reliability and validity of the measure? Provide any tools that you will use as appendices.
  - Describe how you will protect participant confidentiality.

Outcomes will be measured by educational pre- and post-intervention tests, staff education evaluation forms, staff surveys, data analyses, and an organizational culture assessment. These measures will evaluate the effectiveness of interventions to improve staff competency and attitudes for managing the care of aggressive patients; assess level of engagement and receptivity to change by key stakeholders; and determine organizational readiness to implement low cost, high impact items of a WPV prevention program without delay. Staff may participate anonymously with coded identification to track pre- and post-intervention data, and will be asked their permission for participation prior to commencement of project activities.
## DNP Statement of Determination

### Evidence-Based Change of Practice Project Checklist*

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

### Project Title:
Workplace Violence: An Urgent Call for Integrated Staff Education in Acute Care Hospitals

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.</td>
<td></td>
<td>X</td>
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<tr>
<td>The specific aim is to improve performance on a specific service or program and is a part of usual care. All participants will receive standard of care.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The project is not designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control. The project does not follow a protocol that overrides clinical decision-making.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does not develop paradigms or untested methods or new untested standards.</td>
<td></td>
<td>X</td>
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<tr>
<td>The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does not seek to test an intervention that is beyond current science and experience.</td>
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<td>X</td>
</tr>
<tr>
<td>The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.</td>
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</tr>
<tr>
<td>The project has no funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: “This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### Answer Key:
- If the answer to all of these items is “Yes”, the project can be considered an evidence-based activity that does not meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files.
- If the answer to any of these questions is “No”, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: [http://answers.hhs.gov/ohrp/categories/1569](http://answers.hhs.gov/ohrp/categories/1569)
DNP Statement of Determination
Evidence-Based Change of Practice Project Checklist Outcome
The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:
Workplace Violence: An Urgent Call for Integrated Staff Education in Acute Care Hospitals

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.
☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

Student
Last Name: Bellisario
First Name: Nicole
CWID Number:
Semester/Year: Fall 2019
Student Signature: 
Date: 11/22/19

Chairperson
Name: Dr. Sara Horton-Deutsch

Chairperson
Signature: Sara Horton-Deutsch
Date: 

DNP SOD Review
Committee
Member Name: 

DNP SOD Review
Committee
Member Signature: 
Date: 

University of San Francisco, School of Nursing and Health Professions
DNP Statement of Determination Form | Page 5
Appendix Z

Letter of Support from Organization

February 10, 2020

To the University of San Francisco, School of Nursing and Health Professions, Graduate Nursing Department,

Nicole Bellsario, MSN RN CNL, EL-DNP student with an expected graduation date in 2020 has been approved for DNP practicum hours related to her project entitled Workplace Violence: An urgent call for integrated staff education in acute care hospitals. For Spring/Summer/Fall 2020, we will provide 20-30 on-site hours during each semester.

For additional questions. Please contact me at [email protected]

Closing,
## Data Collection

<table>
<thead>
<tr>
<th>Staff Participant</th>
<th>Job Title Coded (Charge RN = 1, RN 2)</th>
<th>Unit Coded (SICU = 1, PCU = 2)</th>
<th>Years of Experience Coded (&lt;1 1, 1-2 = 2, 2-5 = 3, &gt;5 = 4)</th>
<th>Level of Education Coded (ASN/Diploma = 1, BSN = 2, MSN = 3)</th>
<th>Pre-Intervention Knowledge Score</th>
<th>Post-Intervention Knowledge Score</th>
<th>Pre-Intervention Attitude Score</th>
<th>Post-Intervention Attitude Score</th>
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**Key**
- **Low score**
- **High score**
- **increase**
- **decrease**
- **outliers**
Appendix BB

Data Analyses

Staff Knowledge

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<th>Workplace Violence Prevention</th>
<th>t-Test: Paired Two Sample for Means</th>
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*Outlier data without ordinal values are excluded

Staff Attitudes

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<th>Clinical Competence in Coping with Aggressive Patients</th>
<th>t-Test: Paired Two Sample for Means</th>
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*Outlier data without ordinal values are excluded
### Appendix CC

**Pearson Statistical Correlations**

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Appendix DD

Key Findings Related to Staff Knowledge

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<th>Knowledge Scores By Question</th>
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<td>% change</td>
<td></td>
<td></td>
<td></td>
<td>29.4%</td>
</tr>
</tbody>
</table>
Appendix EE

Key Findings Related to Staff Attitudes

<table>
<thead>
<tr>
<th>Attitude Scores By Question</th>
<th>Pre-Intervention Average</th>
<th>Post-Intervention Average</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 21</td>
<td>5.57</td>
<td>5.38</td>
<td>-0.19</td>
</tr>
<tr>
<td>Question 22</td>
<td>5.86</td>
<td>6.25</td>
<td>0.39</td>
</tr>
<tr>
<td>Question 23</td>
<td>4.71</td>
<td>6.88</td>
<td>2.17</td>
</tr>
<tr>
<td>Question 24</td>
<td>6.00</td>
<td>6.75</td>
<td>0.75</td>
</tr>
<tr>
<td>Question 25</td>
<td>6.29</td>
<td>6.25</td>
<td>-0.04</td>
</tr>
<tr>
<td>Question 26</td>
<td>4.86</td>
<td>6.63</td>
<td>1.77</td>
</tr>
<tr>
<td>Question 27</td>
<td>4.86</td>
<td>6.38</td>
<td>1.52</td>
</tr>
<tr>
<td>Question 28</td>
<td>5.57</td>
<td>6.13</td>
<td>0.56</td>
</tr>
<tr>
<td>Question 29</td>
<td>6.00</td>
<td>6.50</td>
<td>0.50</td>
</tr>
<tr>
<td>Question 30</td>
<td>5.43</td>
<td>6.13</td>
<td>0.70</td>
</tr>
<tr>
<td>Total Average</td>
<td>5.52</td>
<td>6.33</td>
<td>0.81</td>
</tr>
<tr>
<td>% change</td>
<td></td>
<td></td>
<td><strong>14.7%</strong></td>
</tr>
</tbody>
</table>

Key
- Doing well
- Needs improvement

- increase
- decrease
- outliers
Appendix FF

Anecdotal Findings Related to Current WPV Prevention Organizational, Clinical, and Administrative Practices

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>I'm not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q6 Are you aware of your organizational Workplace Violence (WPV) Prevention policy including the definition of WPV and what types of incidents you should report on your unit?</td>
<td>62.50%</td>
<td>12.50%</td>
<td>25.00%</td>
<td>8</td>
</tr>
<tr>
<td>Q7 Are you aware of your organizational Workplace Violence (WPV) Prevention protocol including who you should call and how you should respond to behavioral emergencies on your unit?</td>
<td>62.50%</td>
<td>12.50%</td>
<td>25.00%</td>
<td>8</td>
</tr>
<tr>
<td>Q8 Does your unit utilize a violence risk assessment (VRA) tool or checklist to screen patients for the risk for violence?</td>
<td>Yes</td>
<td>No</td>
<td>I'm not sure</td>
<td>Total</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes, safety precautions are determined by nurse/clinician judgment</td>
<td>62.50%</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Yes, safety precautions are determined by a violence risk assessment (VRA) screening tool</td>
<td>0.00%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I'm not sure</td>
<td>0.00%</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9 Does your unit have safety precaution(s) for high-risk aggressive patients? (e.g., a sign outside the patient’s room, a magnet on the communication whiteboard, a colored wristband, and/or a sticker on the paper chart). How are the safety precaution(s) determined?</td>
<td>Yes, safety precautions are determined by nurse/clinician judgment</td>
<td>62.50%</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Yes, safety precautions are determined by a violence risk assessment (VRA) screening tool</td>
<td>0.00%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I'm not sure</td>
<td>0.00%</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q10 I fear I will be blamed or punished by management if I report a workplace violence (WPV) incident.</td>
<td>True</td>
<td>False</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>True</td>
<td>12.50%</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>False</td>
<td>87.50%</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix GG

**Anecdotal Findings Related to Open-Ended Participant Feedback**

<table>
<thead>
<tr>
<th>Participant Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy clarification needed re: definition of WPV and which types of incidents to report via iReport</td>
</tr>
<tr>
<td>Protocol clarification needed re: safety precautions (green sign) and EPIC banner initiated by manager</td>
</tr>
<tr>
<td>Protocol clarification needed re: roles/responsibilities of security team, nursing staff, and management</td>
</tr>
<tr>
<td>More manager and physician support needed to initiate / approve safety precautions for violent patients</td>
</tr>
<tr>
<td>More physician education needed via MedStaffing re: initiating safety precautions for violent patients</td>
</tr>
<tr>
<td>Team communication could be improved about aggressive patients (i.e., whiteboards, huddles, hand-off reports, incident debriefings)</td>
</tr>
<tr>
<td>Patients should be aware of code of conduct expectations with management support</td>
</tr>
<tr>
<td>A behavioral rapid response team (BRRT) (i.e., WPV prevention champions/experts) and increased social worker presence on the units would be helpful for staff managing care for patients with high-risk for violence</td>
</tr>
<tr>
<td>Organization should emphasize location and use of peer support resources for staff physically and/or emotionally impacted by WPV events</td>
</tr>
<tr>
<td>More simulation-based trainings needed to refresh skills</td>
</tr>
<tr>
<td>More education about special behavioral health populations and trauma-informed care</td>
</tr>
</tbody>
</table>
Appendix HH

Results of Staff Education Evaluation Forms

Q1 Please rate the following on a scale of 1-4: Excellent (4) Good (3) Fair (2) Poor (1)

Answered: 8   Skipped: 0

Q2 Would you recommend this course to others in your profession?

Answered: 8   Skipped: 0
Q3 What was the most valuable part of this course?

<table>
<thead>
<tr>
<th>#</th>
<th>RESPONSES</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pass the baton</td>
<td>6/18/2020 4:38 PM</td>
</tr>
<tr>
<td>2</td>
<td>Review of safety in policies/plans</td>
<td>6/18/2020 12:33 PM</td>
</tr>
<tr>
<td>3</td>
<td>Showing the different techniques to handle aggressive, psychologically unstable patients/behavior</td>
<td>6/13/2020 11:12 AM</td>
</tr>
<tr>
<td>4</td>
<td>Na all good info</td>
<td>6/10/2020 8:32 PM</td>
</tr>
<tr>
<td>5</td>
<td>to learn about work place violent and how to prevent/deescalated in future</td>
<td>6/5/2020 6:43 PM</td>
</tr>
<tr>
<td>6</td>
<td>de-escalation tips</td>
<td>6/5/2020 4:14 PM</td>
</tr>
<tr>
<td>7</td>
<td>Everything on it is relevant</td>
<td>6/4/2020 1:46 PM</td>
</tr>
<tr>
<td>8</td>
<td>Techniques to use</td>
<td>6/3/2020 3:50 PM</td>
</tr>
</tbody>
</table>

Q4 Kindly share any recommendations for future courses.

<table>
<thead>
<tr>
<th>#</th>
<th>RESPONSES</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nada</td>
<td>6/18/2020 4:38 PM</td>
</tr>
<tr>
<td>2</td>
<td>Case study/Scenario examples would be beneficial in exploring this Further. Even if reviewed over zoom.</td>
<td>6/18/2020 12:33 PM</td>
</tr>
<tr>
<td>3</td>
<td>Would like for this course to be done in sim lab with ample amounts of examples, role play, scenarios to work through in the class. If not done in sim lab, even just providing examples and scenarios to really drive the techniques taught in this course home for us to better remember and draw upon it in the workplace.</td>
<td>6/13/2020 11:12 AM</td>
</tr>
<tr>
<td>4</td>
<td>Na</td>
<td>6/10/2020 8:32 PM</td>
</tr>
<tr>
<td>5</td>
<td>in person training will be great</td>
<td>6/5/2020 6:43 PM</td>
</tr>
<tr>
<td>6</td>
<td>Shorter pre-post assessment survey</td>
<td>6/5/2020 4:14 PM</td>
</tr>
<tr>
<td>7</td>
<td>None at the moment</td>
<td>6/4/2020 1:46 PM</td>
</tr>
<tr>
<td>8</td>
<td>I thought the class was informative. I would recommend more time to go over scenarios staff may encounter at work.</td>
<td>6/3/2020 3:50 PM</td>
</tr>
</tbody>
</table>