
Theses and Dissertations

2018

Successful mitigation of workplace violence against emergency department nurses: what hospital leaders are doing to accelerate progress

Judith A. Mikalonis

Follow this and additional works at: <https://digitalcommons.pepperdine.edu/etd>

Recommended Citation

Mikalonis, Judith A., "Successful mitigation of workplace violence against emergency department nurses: what hospital leaders are doing to accelerate progress" (2018). *Theses and Dissertations*. 1022.
<https://digitalcommons.pepperdine.edu/etd/1022>

This Thesis is brought to you for free and open access by Pepperdine Digital Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Pepperdine Digital Commons. For more information, please contact bailey.berry@pepperdine.edu.

**SUCCESSFUL MITIGATION OF WORKPLACE VIOLENCE AGAINST
EMERGENCY DEPARTMENT NURSES: WHAT HOSPITAL LEADERS
ARE DOING TO ACCELERATE PROGRESS**

A Research Project

**Presented to the Faculty of
Pepperdine Graziadio Business School**

**In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Organization Development**

**by
Judith A. Mikalonis**

December 2018

This research project, completed by

JUDITH A. MIKALONIS

under the guidance of the Faculty Committee and approved by its members, has been submitted to and accepted by the faculty of Pepperdine Graziadio Business School in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE
IN ORGANIZATION DEVELOPMENT

Date: December 2018

Faculty Committee

Committee Chair, Gary Mangiofico, Ph.D.

Committee Member, Terri Egan, Ph.D.

Deryck van Rensburg, DBA, Dean
Pepperdine Graziadio Business School

Abstract

The purpose of this study was to explore and understand the successful prevention and mitigation of workplace violence (WPV) against nurses in the Emergency Department (ED), and to learn what multidisciplinary hospital leaders are doing to accelerate progress. Specifically, the research considers the strategies, policies and actions hospital leaders are using to prevent and mitigate WPV; the positive progress or outcomes that have been realized thus far; what these leaders have learned in the process, and what they aspire to achieve in the future. In the process of exploring why and how positive progress accelerated, it was found that hospital leaders experienced positive progress in WPV prevention and mitigation when their hospitals provided a WPV program utilizing these exemplary strategies: (a) collaborative multidisciplinary partnerships, (b) fully engaged executive support, and (c) operationalized data. It was interesting to note that as multidisciplinary partners and fully engaged executives collaborated, and supported their teams in the process of establishing these WPV initiatives, a culture of respect was catalyzed and WPV initiatives gained momentum. The details of this research highlight that operationalized data—WPV data put to use in a centralized, customized, evidence-based approach—appears to have functioned as a key accelerant of positive progress in WPV prevention and mitigation for these hospital leaders.

Keywords: Workplace Violence, Healthcare, Nurses, Emergency Department, Prevention and Mitigation, Organization Development

Table of Contents

Abstract	iii
List of Tables	vii
List of Figures	viii
 1. INTRODUCTION.....	 1
Nature and Scope of the Problem	2
Overall Impact.....	2
Workplace Violence Consequences for Nurses.....	2
Workplace Violence Consequences for Hospitals, Health Systems, and Patients.....	3
Frequency and Overall Impact.....	4
Turnover and Costs to Replace Nurses	4
Direct Costs.....	4
Defining Prevention and Mitigation	5
Significance of the Study	6
Purpose and Goals of the Study.....	6
Central Questions.....	6
 2. LITERATURE REVIEW	 8
Inclusion and Exclusion Criteria.....	8
Historical Context of the Literature	8
Discussion.....	9
Precipitating and Contributing Risk Factors	9
Occupational and Demographic Factors for Emergency Department Nurses.....	10
Environmental Factors.....	12
Physical and Operational Environmental Factors.....	12
Staff-Patient Interface Environmental Factors.....	13
Perpetrator Risk Factors	14
Physical violence	14
Nonphysical violence	15
Nonphysical Violence as a Risk Factor for Physical Violence	15
Cultural Contexts of Workplace Safety	17
Respect.....	17
Safety	18
Leadership and Workplace Safety	20
Prevention, Interventions, and Barriers to Implementation	21
Guidelines and Recommendations.....	21
Effectiveness and Sustainability	22
Barriers to Implementation	22
Differences by Region and Country.....	23
Summary.....	24
 3. METHODS	 26
Research Design.....	26

Participant Selection.....	27
Participants by Hospital Clinical Role and Expertise	27
Participant Hospitals.....	28
Participant Enrollment.....	29
Data Collection Procedures	29
Online Demographic Survey	29
Interviews	29
Data Analysis Procedures.....	30
Reliability and Validity	31
Summary.....	31
 4. FINDINGS.....	 32
Demographic Data	32
Qualitative Findings.....	35
Research Question 1: Strategies, Policies and Actions	36
Strategies used to prevent and mitigate workplace violence	36
Policies used to prevent and mitigate workplace violence	50
Actions to prevent and mitigate workplace violence	54
Summary	60
Research Question 2: Positive Progress and Outcomes	61
Progress evolution	61
Progress dynamics	63
Progress scenarios and outcomes	66
Research Question 3: Learnings and Future Aspirations	70
Learnings.....	70
Future aspirations	73
Chapter Summary.....	75
 5. DISCUSSION.....	 76
Interpretation of the Findings	76
Success Factors of Hospital Leaders Reporting Positive Progress	76
Exploring How and Why Positive Progress Accelerated	77
Key Findings.....	77
Employing Strategies to Prevent and Mitigate Workplace Violence.....	77
Catalyzing a Culture of Respect.....	80
Gaining Acceleration through Operationalized Data	82
Implications.....	82
Recommendations.....	83
Limitations.....	84
Areas for Future Research	85
Conclusions.....	85
References.....	87
Appendix A: Association of Nurse Executives Guiding Principles Mitigating Violence in the Workplace.....	93
Appendix B: Pre-Interview Online Survey Questions & Interview Questions	97

Appendix C: Interview Questions.....	99
--------------------------------------	----

List of Tables

Table	Page
1. Study Participants by Hospital Clinical Role/Expertise	28
2. Central Questions of the Study and Corresponding Interview Questions	30
3. Collaborative Partnership Types	37
4. Law Enforcement Collaborative Partnership Characteristics	41
5. Fully Engaged Executive Support Characteristics	44
6. Success Factors of Reporting Workplace Violence Data	47
7. Strategies, Policies and Actions Themes	61
8. Six Progress Scenario Examples Reported by Participants	67

List of Figures

Figure	Page
1. Hospital Leader Participants' Workplace Violence Prevention and Mitigation Roles	34
2. Participants by Hospital Type	35
3. Actions by Leaders to Detect and De-escalate Workplace Violence	55
4. Actions by Leaders to Train and Equip Staff.....	57
5. Actions that Leaders take for Staff Inclusion, Support and Recovery	59
6. Leaders in Collaboration: Fully Engaged Executives and Multidisciplinary Partnership	78
7. Operationalizing Data Process in Workplace Violence Prevention and Mitigation.....	79
8. Key Study Findings	81

Chapter 1

Introduction

Hospital Emergency Departments (EDs) are known for treating victims of violence. Paradoxically, ED workers are also vulnerable to *becoming* victims of violence while on the job, due to the costly and complex phenomenon known as workplace violence (WPV). From verbal violence such as yelling, cursing, harassment or threats of harm, to physical assaults such as punching, kicking, spitting, or stabbing, WPV is often perpetrated by patients against the very healthcare providers who are trying to help them (Kowalenko, Gates, Gillespie, Succop, & Mentzel, 2013; Speroni, Fitch, Dawson, Dugan & Atherton, 2014). Nurses, in particular, bear the brunt of both physical and nonphysical/verbal violence by patients and by visitors who accompany them, with ED nurses experiencing a relatively higher frequency of WPV than many other hospital nurses (Arnetz et al., 2015a; Gacki-Smith, Juarez, & Boyett, 2009; Gerberich et al., 2004, Kowalenko et al., 2013).

Another component of WPV experienced by nurses includes lateral violence—defined as bullying, verbal violence and incivility against workers by coworkers or managers. Lateral violence has been linked to the underreporting of WPV by workers, (Blando, Ridenour, Harley & Casteel, 2015; Gates, 2004; Gates, Gillespie, & Succop, 2011b; Pompeii et al., 2016), and identified as a precipitating factor for patient-perpetrated physical violence by patients (American Organization of Nurse Executives [AONE] & Emergency Nurses Association [ENA], 2015; Gacki-Smith et al., 2009; Lanza et al., 2006; Rowe & Sherlock, 2005). Studies also indicate that the effects of all types of WPV impact the potential safety and wellbeing of patients (Gates et al., 2011b; Rowe & Sherlock, 2005).

Nature and Scope of the Problem

WPV against nurses in hospital EDs is endemic, systemic, and occurs worldwide, reportedly increasing by 15% or more every year. Many consider it an epidemic (Spector, Zhou & Che, 2014). In fact, health care support occupations have an assault-injury rate nearly ten times the general sector—only law enforcement's assault-injury rate is higher (Kowalenko et al., 2013).

WPV refers to a broad spectrum of behaviors that result in a concern for personal safety (Papa & Venella, 2013), and is defined as “. . . any act or threat of physical assault, harassment, intimidation and other coercive behavior by patients, families, and visitors; WPV also includes lateral violence, or bullying, between colleagues" (AONE & ENA, 2015, p. 278).

Overall Impact

The overall impact of WPV includes: (a) acute stress, ongoing post-traumatic stress, as well as physical and emotional injuries to nurses; (b) increased costs for healthcare organizations; (c) the loss of experienced nurses during a growing nursing shortage, and; (d) potential negative consequences for patient care and patient safety (Gates et al., 2011b; Gillespie, Gates & Berry, 2013; Spector et al., 2014; Van De Bos, Creten, Davenport & Roberts, 2017).

Workplace Violence Consequences for Nurses

While all workers in healthcare systems are at risk of violence, workers in hospital EDs are at particularly high risk of such events, with nursing staff being 5 to 7 times more likely than other clinical staff to experience physical violence and acute stress following violent events (Gates et al., 2011b). The actual number of incidents is likely much higher due to underreporting that is related to the persistent perception that assaults

are part the job (Gates et al., 2011b; Pompeii et al., 2016; Wyatt, Anderson-Dreves, & Van Male, 2016).

Regarding personal impact on nurses, ninety-four percent of nurses in one study experienced at least one post-traumatic stress disorder symptom after a violent event, with 17% having scores high enough to be considered probable for PTSD (Kowalenko et al., 2013). Nurses also admitted that unless they are physically injured, they are often expected to return immediately to their work after being physically assaulted by a patient or visitor (ENA, 2010; Gates et al., 2011b; Lanza, Zeiss & Rierdan, 2006).

Nurses are also vulnerable to nonphysical, verbal violence by patients, and incivility and bullying instigated by hospital co-workers, managers and physicians. This type of violence can have a serious, ongoing negative impact on nurses, often resulting in even more severe consequences than that of physical violence (Gerberich et al., 2004). In one study, the occurrence of any type of nonphysical violence, regardless of whether it was perpetrated against nurses by coworkers or patients, increased the likelihood of physical violence by patients against nurses by 7X or more (Lanza et al., 2006). These findings indicate a level of complexity that suggests that patient-perpetrated violence is catalyzed or at least amplified by the presence of normative incivility in a hospital system's culture.

Workplace Violence Consequences for Hospitals, Health

Systems, and Patients

An increasing body of evidence (Gates et al., 2011b; Gillespie, Gates & Berry, 2013; Gillespie, Pekar, Byczkowski & Fisher, 2017; Speroni et al., 2014) argues that violence and stress in the ED substantially influences negative consequences for all workers, including nurses, and poses significant impacts for hospitals and healthcare

systems on overall productivity, and patient care—regardless of worker, workplace and community environmental factors.

Frequency and Overall Impact

In a 2015 report, the Occupational Safety & Health Administration (OSHA) stated that “. . . Healthcare workers experienced 7.8 cases of serious WPV injuries per 10,000 full-time equivalents (FTEs) in 2013. Other large sectors such as construction and manufacturing had fewer than two cases per 10,000 FTEs” (p. 1). WPV harms workers both physically and emotionally, and experiencing WPV makes it harder for them to do their jobs (OSHA, 2015). WPV also incurs significant impact on hospitals for overtime, higher turnover, workers’ compensation losses, absenteeism, temporary staffing, training costs, deterioration of productivity and morale, and additional infrastructure for employee safety (Van De Bos et al., 2017). The overall result of the trend toward increasing WPV was characterized by one study as an “unprecedented human capital challenge” for hospitals looking to attract and retain talented workers (Papa & Venella, 2013).

Turnover and Costs to Replace Nurses

Estimated ED nurse turnover is specifically reported at 19.1% of the total workforce per year, and if that a nurse leaves the workforce for any reason, the costs to replace a nurse can run between \$37,700 and \$58,000 per nurse. ED nurses are estimated to be even more costly to replace, due to specialized training and certifications (Nursing Solutions, 2016).

Direct Costs

A recent American Hospital Association study (Van De Bos et al., 2017) highlighted these in-facility WPV, prevention and preparedness-related costs:

- Hospitals and health systems spent an estimated \$428.5 million on WPV, including \$234.3 million for staff turnover, \$42.3 million in medical care and indemnity (lost wages for employee victims) and \$90.7 million in disability and absenteeism costs.
- \$1.1 billion were spent in security costs directly related to prevention or addressing violence on premises, to include an estimated \$175.1 million on healthcare staff training in 2016, and;
- An estimated cost of \$97.6 million was allocated to WPV prevention plan development.

Clearly, WPV against nurses represents a costly, complex problem that potentially impacts us all, and must be mitigated. But how? And by whom?

Recommendations by AONE, ENA, American Nurses Association and The Joint Commission indicate that action and accountability by leaders and policymakers to establish a hospital-wide culture of safety and respect is key to the mitigation of WPV. Furthermore, they assert that hospital leaders across multiple disciplines are ultimately responsible to forge the path (American Nurses Association, 2014; AONE & ENA, 2015; The Joint Commission, 2008, 2012, 2017). Researchers on the topic have likewise asserted the importance of leadership engagement and response (Blando, Ridenour, Harley & Casteel, 2015; Gacki-Smith et al., 2009; Gates et al., 2011b; Gerberich et al., 2004; McPhaul, London & Lipscomb, 2013).

Defining Prevention and Mitigation

For purposes of this study, *prevention* was defined as “taking measures against something possible or probable” (“Prevention,” 2018, para. 1). Mitigation is defined as a “sustained action to reduce or eliminate risk to people and property from hazards and their effects” (Haddow, Bullock, & Coppola, 2010, p. 67).

Significance of the Study

While these studies identify the factors, impact, and costs of WPV, two questions emerge for this researcher:

1. Identifying effective WPV interventions for sustainable change: What is the gap regarding the identification, documentation and implementation of comprehensive, effective WPV interventions in hospitals—at both the organizational and departmental levels? (Kowalenko et al., 2013; Ramaciatti, Ceccagnoli, Addey, Lumini & Rasero, 2016).
2. Accelerating positive progress: How are hospital leaders and their teams currently collaborating to respond to accelerate the mitigation of WPV, and what kind of success are they seeing?

Purpose and Goals of the Study

Organization development is uniquely suited to address this complex issue of mitigating WPV against nurses as an organizational problem. The purpose of this study was to explore and understand the successful prevention and mitigation of WPV against nurses in the ED, and to learn what hospital leaders are doing to accelerate progress. The goals of this study are to:

1. Dialogue with multidisciplinary hospital leaders to explore positive strategies, policies or actions taken within their hospital systems to successfully mitigate WPV against nurses in the ED;
2. Identify successful WPV mitigation strategies, approaches and processes, as well as “lessons learned” by these leaders, and;
3. Discover hospital leaders’ vision for the future of workplace safety for nurses in their hospital system.

Central Questions

Central questions of this study include:

1. What strategies, actions and policies are hospital leaders using to effectively prevent and mitigate WPV against nurses in the ED?
2. What positive progress or outcomes have been realized in WPV prevention and mitigation in the ED thus far?

3. What have these leaders learned in the process and what do they aspire to achieve in the future?

Chapter 2

Literature Review

The purpose of this study was to explore and understand the successful prevention and mitigation of WPV against nurses in the ED and to learn what hospital leaders are doing to accelerate progress. The purpose of this literature review is to examine relevant studies related to WPV affecting nurses in hospital EDs.

Inclusion and Exclusion Criteria

While WPV can and does happen to all types of healthcare workers, across a variety of healthcare settings (OSHA, 2015; Van De Bos et al., 2017), WPV studies chosen for review feature a primary focus on hospital EDs and ED Nurses. To further narrow the scope of this study, and because of differences in international healthcare systems, studies that focused on non-U.S. hospitals were excluded from review, other than one brief reference to establish the worldwide magnitude of WPV against nurses (Spector et al., 2014). That said, because WPV impacts the entire hospital and happens in the context of hospital culture (The Joint Commission, 2017) and, because effective WPV mitigation efforts must take hospital culture into consideration, relevant studies such as those on U.S. hospital safety culture were inherently more broadly focused on the hospital as a whole.

Historical Context of the Literature

Before 2010, the majority of studies on WPV in the ED primarily focused on defining varying types and degrees of violence and describing the magnitude, cost, and consequences of the problem. Addressing prevention and identifying solutions was much less of a focus. Even now, the overall quality and consistency of WPV studies are reportedly variable, and generalizability of results has been limited (Anderson, Fitzgerald

& Luck, 2010; Kowalenko et al., 2013). As one study described it, the strength of scientific evidence for WPV prevention strategies is “. . .well past the ‘emerging’ evidence stage, but has not achieved the “unequivocal” stage” (McPhaul, London & Lipscomb, 2013, p. 4). In terms of focus, studies in recent years have gradually shifted toward identifying the effectiveness of preventive measures as well as the barriers to implementing them (Blando et al., 2015); researching appropriate frameworks and applicability for WPV interventions (McPhaul et al., 2013); and establishing and highlighting a more definitive connection between WPV, hospital culture, and patient safety (Chassin & Loeb, 2013; Kowalenko et al., 2013; Lucian Leape Institute, 2013).

Discussion

For purposes of discussing the prominent, relevant themes found in the literature, this chapter is divided into four sections: (a) precipitating and contributing risk factors, (b) cultural contexts of workplace safety, (c) leadership and workplace safety, and (d) prevention, intervention and barriers to implementations. The magnitude, frequency, persistence and consequences of WPV against ED nurses referenced in the previous chapter also lend significance to this study.

Precipitating and Contributing Risk Factors

In support of the purpose of this study, it is helpful to explore and understand the primary precipitating and contributing risk factors for WPV in hospitals, and in the ED environment, in particular.

To help pave the way to a better understanding of the frequency and potential risk factors of work-related assaults on nurses, the Minnesota Nurses Study surveyed 6,300 Minnesota nurses who were selected randomly from the 1998 Minnesota state licensing database for Registered Nurses and Licensed Practical Nurses (Gerberich et al., 2004).

From its quantitative, multivariate, nested-control design to its broad sample size and comprehensive survey, this two-part, epidemiological study was ground-breaking on many levels. This landmark study is believed to be among the first to quantitatively establish the sheer magnitude of both physical and non-physical WPV against nurses, as well as identify potential risk (Gerberich et al., 2004, 2005). Limitations included potential biases due to retrospective self-report by participants, but numerous strategies were implemented to minimize these biases (Gerberich et al., 2004). As a result, this study provided an important foundational basis to justify ongoing analytical studies, and to enable the development of appropriate prevention and mitigation (Gerberich, 2004, 2005; McPhaul et al., 2013).

The specific occupational, demographic and environmental risk factors related to the rates of physical and nonphysical WPV experienced by nurses and identified in this study are described below. These factors are relevant to this researcher's study as they can help identify effective WPV interventions by understanding what is known so far about the population of nurses against whom violence is perpetrated, the rate of violence they are experiencing, and potential areas of increased risk for WPV against nurses in the ED.

Occupational and Demographic Factors for Emergency Department Nurses

As part of their study, Gerberich and colleagues (2004) identified high rates of both physical and nonphysical WPV in a population of Minnesota nurses, with increased rates for those working in a nursing home or long-term care facility, and for those working in settings such as intensive care, emergency, or psychiatric/behavioral departments. Increased rates of violence were also identified for those providing and supervising patient care, as well as those working with primarily geriatric patients. As

indicated in Chapter 1, subsequent studies substantiated these increased rates by setting and occupation factors, and identified EDs as one of the areas for highest risk of violence in a hospital setting (Gacki-Smith et al., 2009; Gates et al., 2011a; Gillespie et al., 2017; Ramacciati, Ceccagnoli, Addey & Giusti, 2014).

By comparison, another study yielded more specific, contrasting data regarding the occupational, demographic and environmental risk factors for WPV. Kowalenko et al. (2013) found that while no occupation was immune from WPV, there were significant occupational differences regarding the *impact* of violent events. Nurses experiencing a violent event (assaults or physical threats) suffered from significantly more acute stress than physicians, and felt less safe than physicians, likely due to earlier contact with patients and spending more extended time with patients than physicians typically do. Other findings: there was no significant difference in the rate of violent events for men or women in any ED-related occupation, and being older and more seasoned in one's occupation also had no influence.

Likewise, for the Kowalenko et al. (2013) study, there were no statistical differences in the rates of violent events at any of the hospital types—suburban ED workers experienced similar rates of WPV as those at urban and level 1 trauma hospitals. There were also no statistically significant differences in violent events based on age, time of day, or hours worked per week. In summary, this study concluded, in part, that while Registered Nurses are more likely to be assaulted than other ED workers, no one working in the ED is immune to violence perpetrated by patients, regardless of the hospital setting. Understanding that everyone in any ED is at risk of WPV is an important consideration on many levels: (a) to avoid a false sense of security, (b) to help assess the

effectiveness of current WPV interventions, and (c) to better design more sustainable preventive processes for the future.

These contrasting, detailed findings by Kowalenko et al. (2013) may be explained by a number of important differences in study design. This study examined WPV related to multiple ED occupations in a variety of types of hospital settings, and included six hospitals in two states, Minnesota and Ohio. Whereas earlier studies focused on retrospective accounts, and introduced potential recall bias by asking respondents to recall the details of a violent event that may have happened 6-to-12 months prior, Kowalenko and colleagues assert that their quantitative study was the first to examine the incidence and consequences of WPV in EDs on a repeated, *monthly* basis over a 9-month period. While not without limitations, this longitudinal, repeated measures design helped offset potential recall bias due to self-reporting.

Environmental Factors

Given the dynamic nature of a hospital ED, it is important to consider what it is about the ED setting that increases the risk for WPV against ED nurses. Findings indicated that the 24/7 accessibility of the ED, staffing issues, and the inherently stressful characteristics of emergency medical situations are just a few of many WPV risk factors related to the ED environment (Kowalenko et al., 2013; Renker et al., 2015).

Physical and Operational Environmental Factors

Physical and operational factors that influence the resulting workplace/healthcare environment and define the way the ED is structured and operated appear to influence the frequency and impact of WPV, though not all studies agree to the extent.

From the perspective of ED nurses surveyed in one study (Renker et al., 2015), external environmental risk factors for WPV included the location of the facility, and a

high local violent crime rate. This contrasts with the finding of Kowalenko et al. (2013), which indicated that the type of specific hospital setting was not identified as a statistically significant risk factor for WPV in the ED. Other mentions of external environmental factors included multiple, unguarded entries into the unit, a lack of bulletproof glass at the main entrance to protect from gunfire, and isolated patient and treatment areas in the ED (Lenaghan, Cirrincione, & Henrich, 2018; Renker et al., 2015).

Internal physical/operational risk factors identified included the 24-hour accessibility of EDs, and the lack of adequately trained, armed or visible security guards, (Renker et al., 2015), along with crowding, lack of privacy, high patient volume, holding/boarding patients in need of behavioral health care, prolonged wait times for patients and visitors, and lack of an enforced visitor policy (Gacki-Smith et al., 2009).

Understanding these environmental risk factors informs and shapes the strategies, policies and actions related to WPV prevention and mitigation, and is relevant to this study.

Staff-Patient Interface Environmental Factors

Factors such as the pain, stress, and tension associated with an ED visit contribute to the highly stressful ED environment and potentially impact the staff-patient interface (The National Institute for Occupational Safety and Health, 2002). For the sake of clarity, these environmental factors are being discussed separately from specific WPV perpetrator factors.

A study by Gacki-Smith et al. (2009), which was the first national study of emergency nurses' experiences and perceptions of WPV, surveyed 3465 Registered Nurses who were members of the ENA. Findings from the Gacki-Smith et al. study were consistent with other literature that identified patient pain and discomfort as potential risk

factors for WPV in the ED, especially when combined with the tension, anger and stress of patients, family members and visitors in a highly stressful ED environment. Unsafe staffing levels, and not providing enough information to patients were also identified as risk factors for WPV, along with patient/visitor misconceptions of staff behavior, to include perceptions of staff as uncaring (Gacki-Smith et al., 2009; Wolf, Perhats, Delao, Clark, & Moon, 2017).

Regardless of the context, these findings regarding environmental risk factors represent multiple layers of complexity that hospitals must consider and contend with when considering sustainable ways to mitigate WPV against their ED nurses (The National Institute for Occupational Safety and Health, 2002).

Perpetrator Risk Factors

Who is perpetrating WPV against nurses in the ED, and what risk factors contribute to a higher rate of violence? Identifying the answers to these questions lies at the heart of preventing and mitigating WPV against ED nurses.

Physical violence. Perpetrators of physical WPV against nurses in earlier studies were frequently described as being male patients/clients, most often 66 years of age or older, who were impaired as a result of disease, behavioral health, or substance abuse (Gacki-Smith et al., 2009; Gerberich et al., 2004; Ideker, Todicheeney-Mannes & Kim, 2011). A more recent study (Kowalenko et al., 2013) corroborated the impairment factors of substance abuse and behavioral health, and further indicated that two-thirds of physical threats are more likely to be perpetrated by younger men, between 30 and 49 years of age. That said, the perpetrator risk factors associated with physical assaults were more evenly distributed, with 52% being perpetrated by men, and nearly half by assailants between the ages of 30 and 59 years. Women perpetrated 48% of the physical assaults,

dispelling the myth that men are responsible for the vast majority of physical assaults. That said, male perpetrators of assault, specifically, were significantly more likely to elicit acute stress that impacted a nurse's ability to: (a) handle and manage their workload; (b) provide safe and competent care, and (c) support and communicate with co-workers. These findings indicate a potentially significant impact on nurses with regard to patient care, and, ultimately—patient safety (Gates et al., 2011a; Kowalenko et al., 2013).

Nonphysical violence. When it comes to nonphysical violence against ED nurses, such as verbal abuse and threats, bullying, and incivility, studies found that ED workers are both perpetrators, and victims. Perpetrators of nonphysical violence were consistently identified as both patients/visitors, and coworkers, such as supervisors, physicians, and other employees (Gerberich et al., 2005; Gillespie et al., 2013; Lanza et al., 2006). These findings suggest that interventions designed to sustainably mitigate WPV should consider (a) the interlinking contexts of nonphysical and physical violence and (b) the risk factors for WPV associated with both types of potential perpetrators (Lanza et al., 2006). To further underscore the importance of this phenomena, we will also explore nonphysical violence as a risk factor—in and of itself—for physical violence against ED workers, to include nurses.

Nonphysical Violence as a Risk Factor for Physical Violence

A landmark quantitative study by Lanza et al. (2006), focused on the extent to which nonphysical violence is a risk factor for physical violence against workers in a healthcare setting. For purposes of the study, the word violence was defined as “. . . the commission of acts intended, or likely to threaten or harm an individual; or, the omission of acts needed to protect an individual from threat or harm” (p. 400).

As mentioned in the previous chapter, the Lanza et al. (2006) study yielded a strong odds ratio that workers who had experienced non-physical violence were 7.17 times more likely to experience physical violence than those who had not. They found that, “. . . physical violence rarely occurred in the absence of nonphysical violence” (p. 401). These findings suggest that targeting an initial reduction of nonphysical violence may reduce physical violence against nurses in the ED. Reduction of nonphysical violence is also an end in itself, as it impacts everyone in the hospital or ED setting, and has disruptive personal and workplace effects. Even mildly aggressive verbal incidents can have significant impact when experienced repeatedly (Findorff, McGovern, & Sinclair, 2005; Gerberich et al., 2004; Lanza et al., 2006).

Interestingly, results of the Lanza et al. (2006) study also demonstrated that staff-perpetrated nonphysical violence seemed to be related to *both* patient-perpetrated physical violence as well as staff-perpetrated violence. In other words, despite different individuals perpetrating these two forms of violence, it seems that when rates of nonphysical violence are higher, it follows that the risk of physical violence will be elevated, as well. These findings suggest the possibility of the systemic creation of a culture of disrespect that is cultivated by the tolerance of nonphysical violence in complex healthcare settings. More recent studies corroborate this suggestion, and thought leaders in the field of workplace safety & patient safety assert, that a culture of disrespect in a hospital has a negative impact on workplace safety, is conducive to the emergence of WPV, and has serious implications for patient safety, as well (Chassin & Loeb, 2013; Lucian Leape Institute, 2013).

Cultural Contexts of Workplace Safety

In support of this study's purpose, it is important to consider the impact of hospital culture on the effectiveness and sustainability of WPV interventions. This section of the literature review includes select studies and perspectives from the complementary discipline of patient safety.

Two important cultural contexts discussed in the literature relevant to the emergence and the prevention and mitigation of WPV in the ED include a culture of respect, and a culture of safety, or, safety culture. A culture of respect is, for all intents and purposes, a subset of safety culture, but this researcher is highlighting a culture of respect separately due to the previously established correlation between incivility, disrespect and the emergence of violence in the ED (Chassin & Loeb, 2013; Lanza et al., 2006; Lucian Leape Institute, 2013).

Respect

According to the Lucian Leape Institute (2013), the protection of the physical, psychological, and emotional safety of the workforce is a precondition to workplace safety, and ultimately, patient safety. Respect is also a precursor of WPV prevention and mitigation. Studies have correlated the safety of employees and patients and have demonstrated how the climate of an organization impacts the health of workers (Chassin & Loeb, 2013). Therefore, creating a culture of mutual respect within the hospital system must be a top priority when it comes to establishing a safe and supportive work environment that will help sustain preventive and interventional efforts to mitigate WPV in the ED (Oppel & Mohr, 2018).

As mentioned in the previous chapter, in many health care organizations, staff are routinely treated with disrespect. Emotional abuse, bullying, and even threats of physical

assault and learning by humiliation are “virtually normative” in the health care workplace (Blando et al., 2015; Gates, 2004; Gates et al., 2011a; Pompeii et al., 2016).

One study indicates that 77% of nurses and other clinical-care providers work with some who are condescending, insulting or rude, and that 33% percent work with a few who are verbally abusive—who yell, shout, swear or call names. For many, the treatment is frequent and longstanding (AACCN & VitalSmarts, 2005). That said, in another study, the most common behaviors perceived as intimidating were not the overtly abusive type of acts such as throwing objects or using profane language. Instead, impatience with questions, the failure to return phone calls or pages, and the use of condescending language topped the list (Chassin & Loeb, 2013). These behaviors not only create a culture of fear and intimidation that erode one’s sense of enjoyment and meaningfulness at work (Lucian Leape Institute, 2013), but they also increase the risks for patient harm and WPV (Ariza-Montes, 2013; Gates et al., 2011a; Rowe & Sherlock, 2005).

For purposes of this researcher’s study, a culture rooted in widespread disrespect will serve as a significant barrier to any preventive or interventional measures a hospital takes against WPV in the ED (Chassin & Loeb, 2013; The Joint Commission, 2017; Leape et al., 2012). Therefore, for some hospitals, recognizing and addressing the issues of disrespect and incivility might be the ideal place to start. For others, the best start might be identifying the good health of their current culture as a foundation upon which to build a strong program of WPV prevention.

Safety

Safety culture has been defined as “how safety happens on a sustainable basis” (The Joint Commission, 2012, p. 1), “what an organization is and does in the pursuit of

safety” (The Joint Commission, 2017, p. 7), and “core values and behaviors resulting from a collective and sustained commitment by organizational leadership, managers and health care workers to emphasize safety over competing goals” (American Nurses Association, 2016, p. 5). Based on these definitions, safety culture is imminently relevant to this researcher’s effort to explore and understand the strategies, actions and policies that cross-functional leaders intend to take to prevent and mitigate WPV, both now, and in the future.

So, how do nurses and other workers in the ED define and conceptualize an overall work safety climate in which they feel safe, supported and equipped to perform their best on behalf of patients? One study (McPhaul, London & Lipscomb, 2013) identified these specific staff perceptions as key to safety climate and culture:

1. The perception of management’s commitment to WPV prevention;
2. The extent to which employees are consulted on violence prevention;
3. That others on the team, including management, care about safety;
4. That management’s commitment impacts violence outcomes in a positive way.

In other words, hospital team members such as ED nurses measure an organization’s commitment to safety culture and WPV prevention by what leaders actually do, rather than what they say they do.

Other indicators of a strong safety culture as defined by The Joint Commission (2017) include (a) individuals within the organization who treat each other and their patients with dignity and respect, (b) staff who are productive, engaged, learning, collaborative, and (c) staff who share perceptions of the importance of safety.

As part of its mission to protect public health, The Joint Commission addresses WPV under their Environment of Care standard. Notably, The Joint Commission has

begun to approach WPV and its recommendations regarding potential WPV interventions in a more integrative way. In the latest publication of findings from The Joint Commission's most recent Safety Culture Project, worker safety and workplace safety are explicitly addressed in the context of patient safety and safety culture (The Joint Commission, 2012). This is because they assert that patient safety can't be achieved apart from worker/workplace safety and many of the lessons learned about patient safety and safety culture can be applied to keeping healthcare workers safe (Campione & Famolaro, 2018; The Joint Commission, 2012). The bottom line is that the implications of integrated, culture-focused interventions as a sustainable way to mitigate WPV are profound.

Leadership and Workplace Safety

Changing the status quo requires more than research, science, and the development of protocols. It requires leadership commitment, vision, and the will to make the right choices (Chassin & Loeb, 2013; Papa & Venella, 2013).

In the context of WPV in the ED, the first priority of hospital leaders is to be accountable for effective care while protecting the safety of patients, visitors and ED workers, such as nurses (Campione & Famolaro, 2018; The Joint Commission, 2017). Ultimately, the responsibility of creating a safety culture and/or culture of respect falls on the leaders, because they are the ones to set the tone and initiate the processes that will lead to change. Their job is to prevent disrespectful behavior by eliminating its causes (Campione & Famolaro, 2018; Leape et al., 2012). To that end, the Lucian Leape Institute put forth five major tasks for the hospital CEO with regard to cultivating a culture of respect (Leape et al., 2012).

1. To motivate and inspire by creating awareness, and a sense of urgency about the problem of disrespectful behavior;
2. To establish preconditions for a culture of respect by enabling every worker to feel he or she is appreciated, treated with respect, and has the support he or she needs to do his or her job;
3. To lead the establishment of policies regarding disrespectful behavior. Mutual respect, regardless of rank, role, or status, must be the explicit expectation;
4. To facilitate frontline worker engagement by addressing the systemic causes of disrespectful behavior, such as hierarchical systems of control;
5. To create a learning environment for residents and students by declaring and enforcing a zero-tolerance policy for confirmed, egregious, disrespectful or abusive behavior (Leape et al., 2012).

The CEO's responsibility is to support these activities, remove barriers to achieving them, and maintain a sense of urgency and progress toward the stated mission (Campione & Famolaro, 2018; Leape et al., 2012). Addressing such core issues can only help inform the sustainability of WPV mitigation prevention and practices in hospital EDs.

Prevention, Interventions, and Barriers to Implementation

Current approaches to the prevention and intervention of WPV are informed by the guiding principles and five focus areas established by the AONE and ENA at their Day of Dialogue in 2014 (AONE & ENA, 2015).

Guidelines and Recommendations

AONE and ENA (2015; see Appendix A) jointly developed eight guiding principles for mitigating WPV in the ED. Five focus areas concurrently developed to accompany the eight guidelines include: encouraging respectful communication and behavior, establishing a zero-tolerance policy, ensuring ownership and accountability, offering training and education on WPV, and creating outcome metrics of the program's success.

Effectiveness and Sustainability

When it comes to evaluating the effectiveness and sustainability of strategies for intervention and prevention of WPV, the few studies that have attempted to evaluate the effectiveness of interventions have shown weak evidence to date (Ramacciati et al., 2016). Further research is needed to identify effective training content, best practices, and appropriate security measures (Gillespie et al., 2014; Ramacciati et al., 2016). The complexity of the phenomena and the strong interrelations between factors suggest that the problem of WPV in the workplace may require multiple strategies based on multidimensional analysis, (Gillespie et al., 2014), or, as mentioned previously, a more culture-oriented approach (Chassin & Loeb, 2013).

Barriers to Implementation

Despite researchers' best efforts to design compelling studies and analyses of WPV interventions, barriers often arise in the process of actually implementing these interventions (Blando et al., 2015). Seven themes emerged in this study, most of which have been mentioned previously in this chapter: lack of action on management's behalf, despite reporting; varying perceptions of violence; bullying; profit-driven management models; lack of management accountability; focus on customer service; and weak social service and law enforcement approaches to mentally ill patients (Blando et al., 2015).

One well-known barrier to effective implementation of WPV programs that is not specifically listed above is the underreporting of violent events. Reporting of WPV by ED nurses is essential, yet the implementation of reporting (Gacki-Smith et al., 2009) can be complicated. Without reporting, it is more difficult to identify trends and problem areas within the hospital (Gallant-Roman, 2008). One study found that only 57% of physical violence and 40% of nonphysical violence is reported, and of these reports,

approximately 86% are simply verbal reports to supervisors (Findorff et al., 2005).

Barriers to reporting included:

- Concern that reporting ED violent incidents might have a negative effect on customer service scores;
- Fear of retaliation from ED management, hospital administration, nursing staff, or physicians for reporting ED violent incidents;
- Ambiguous ED violence reporting policies, resulting in failure of staff to report ED violent incidents;
- The perception that reporting ED violent incidents is a sign of incompetence or weakness;
- The attitude that violence comes with the job; and
- Lack of support from administration/ management (Manton, 2015).

For reporting of WPV in the ED setting to be effective, it is recommended that it be easy for victims to use, that the ED worker is protected from retaliation or other repercussions, and that management responds immediately (Leape et al., 2012).

Another barrier not previously highlighted is the perception that the intense focus of hospitals on ‘customer service’ or ‘patient satisfaction’ often results in the focus that ‘the customer is always right.’ This mindset is perceived by some to result in more permissiveness by healthcare providers toward perpetrators about unacceptable behavior, and can also impact whether or not action is taken against an abusive patient or family member (Blando et al., 2015; Manton, 2015).

Differences by Region and Country

Researchers also caution that although violence exposure is universal, there are regional and country differences in the incidence rates and sources of violence. Thus, interventions should be tailored to the particular violence issues in a particular setting and geographic location. Violence prevention programs need to be comprehensive and deal

with patients, their families and friends, and staff members, including nurses and physicians. Only by addressing all types and sources of violence can the workplace become a safer environment (Spector et al., 2014). Awareness of these potential barriers is helpful in the context of exploring and understanding the strategies, policies and actions related to WPV prevention and intervention programs.

Summary

What does the research tell us about ways to achieve the sustainable mitigation of WPV in the ED and the positive progress and outcomes so far? It is evident that WPV is a clear and present danger to the safety of ED nurses across the country and around the world, and that the risk factors that precipitate and contribute to WPV in the ED are dynamic, complex and numerous. The literature is filled with data about the incidence and prevalence of WPV, perceptions of risk factors for WPV, and the perpetrators of WPV. Less is known about specific, successful interventions required to prevent and mitigate WPV on a sustainable basis.

This literature review has explored a wide array of studies: those that consider the risk factors associated with WPV; studies about culture contexts for workplace safety, as well as the role of leadership in workplace safety, and finally, those focused on prevention, interventions & barriers to implementation.

Anchored within current research, the quest of this study is to explore and understand the successful prevention and mitigation of WPV against nurses in the ED, and to learn what hospital leaders are doing to accelerate progress. The remaining chapters continue this exploration. This study fills in the gaps left by previous research in three ways: First, this study builds upon and leverages the Joint Commission's safety culture research by attempting to engage hospitals already focused on safety culture-

related projects and/or process improvements, or High Reliability Organization designation.

Second, this study highlights positive progress made with regard to preventing and mitigating WPV in the ED and gathers the perspectives of key leaders to identify positive progress WPV mitigation and prevention. The goal: to help accelerate the progress of WPV mitigation for nurses by leveraging the complexity of the problem.

Third, this study focuses on the strategies, actions, and policies of multidisciplinary hospital leaders and influencers. Most studies in this researcher's literature review surveyed staff nurses, PCAs and other ED clinicians, with an occasional focus on nursing leaders. My approach focused instead on interviewing a wider variety of clinical leaders, hospital policymakers, leaders in the area of workplace safety, patient safety, and quality, as well as nurse leaders and nurse executives.

This study additionally contributes to the body of research knowledge in three ways, as it (a) highlights the real-life strategies, policies, and actions of multidisciplinary hospital leaders as they collaboratively make progress in the prevention and mitigation of WPV in the ED; (b) explores the operationalization of WPV-related data in the context of WPV prevention and mitigation; and (c) proposes operationalized WPV data as an accelerant in the progress of successful WPV mitigation efforts.

Chapter 3

Methods

The purpose of this study was to explore and understand the successful prevention and mitigation of WPV against nurses in the ED, and to learn what hospital leaders are doing to accelerate progress. This chapter supports the research purpose by describing the research design, participant selection, data collection procedures, and process for analyzing the data. Three research questions were examined:

1. What strategies, policies and actions are hospital leaders using to prevent and mitigate WPV against nurses in the ED?
2. What positive progress or outcomes have been realized in WPV prevention and mitigation in the ED thus far?
3. What have hospital leaders learned in the process of WPV prevention and mitigation efforts, and what do they aspire to achieve in the future?

Research Design

This study was initiated with an extensive review of hospital WPV prevention and mitigation studies that appeared in the research literature. Approval to conduct the study was obtained through Pepperdine University's Institutional Review Board on May 11, 2018.

The research design for this study used a qualitative, composite study of exemplary practices and interventions utilized by multidisciplinary leaders in a target population of hospitals. Data were collected through semi-structured interviews. Qualitative design is particularly appropriate for studies such as this one, designs that are focused on questions involving situation-specific phenomena, or the influence of physical and social context and processes on specific events and activities (Creswell, 2014).

Participant Selection

Participants for this study were recruited through what is described by Maxwell (2013) as purposeful selection. To gain particular information that is relevant to this study, it was necessary to engage in deliberate selection of specific types of exemplary multidisciplinary leaders from hospitals who are (a) already strategically focused on workplace safety and WPV prevention in the ED and (b) whose roles are reflective of a hospital WPV prevention and mitigation task force or committee. Purposeful selection best enabled the researcher to answer the proposed research questions (Creswell, 2014). To gain access to these particular individuals, it was also necessary to engage in snowball sampling, which means to engage participants through referrals. Sources of relevant referrals included:

- The researcher's personal and professional network in healthcare, and beyond;
- Leaders and influencers within the WPV professional research community;
- Leaders within professional associations and advocacy groups for nurses and emergency nurses who are also focused on promoting successful WPV prevention and mitigation, such as AONE and ENA.

Participants by Hospital Clinical Role and Expertise

Interviews for the study were conducted with 20 multidisciplinary hospital leaders from ten different hospitals based in ten different states across the USA.

To provide context for validity, Table 1 indicates the hospital clinical role and expertise of the 20 participants. A few job role/titles were generalized slightly in cases where the researcher felt that the specificity of the title may compromise the confidentiality of the participants' identity. Two leaders have two titles each, so the number of titles/roles listed below total more than 20.

Table 1***Study Participants by Hospital Clinical Role/Expertise***

Participants by Hospital Clinical Role and Expertise	<i>n</i>
Chief Nursing Officer	1
Physician Medical Director of ED	1
Director of ED Nursing	1
ED Nurse Managers: 1 Senior, 3 Midlevel, 1 Assistant	5
Inpatient Charge Nurse Managers	2
Behavioral Health Nurse Administrator/Interventionists	2
Security Leaders: 2 Directors, 1 Manager	3
Patient Safety Specialist	1
Quality Leaders: 1 Director, 1 Manager	2
Education Leaders: 1 Director, 1 Manager	2
Information Technology Director	1
Hospital Ancillary Services Manager	1
Total	22

Note. Twenty-two titles are listed because two leaders each have two titles.

Participant Hospitals

In keeping with the literature review findings regarding WPV, all types and sizes of hospitals were considered, including hospitals already strategically focused on The Joint Commission Safety Culture initiative or those who have established a commitment of becoming a High Reliability Organization.

This researcher originally proposed that leaders from hospitals who have participated in The Joint Commission's Safety Culture initiatives or have committed to becoming a High Reliability Organization may be more primed, and ready to discuss exemplary progress toward sustainable WPV mitigation in the ED (The Joint Commission, 2017). Recruitment included these hospital systems, though not exclusively.

No hospital leaders who participated in the Joint Commission Safety Culture Initiative responded to recruitment efforts. That said, four WPV prevention leaders from

one hospital committed to becoming a High Reliability Organization did participate and were included in the study. The findings from their interviews, along with the general characteristics of all participant hospitals are covered in Chapter 4.

Participant Enrollment

To enroll participants, the researcher directly contacted, and networked with and through hospital leaders, influencers and WPV researchers known personally to her, as well as those not previously known to her, who had been identified through the literature review. Next, she asked recipients who responded to forward the emailed request to any other possible participants who qualified and may have been interested. Finally, she posted the request on appropriate online research-related sites such as ResearchGate.

Data Collection Procedures

Online Demographic Survey

In addition to providing a downloadable document explaining the study, a link to a brief, pre-interview online survey (see Appendix B) was given to screen the participants, and to capture basic demographic information such as age, gender, length of tenure, type of hospital, area of responsibility/expertise, and specific involvement in WPV mitigation and prevention. Verbatim narrative responses to the interview questions (see Appendix C) and any additional data provided by interviewees regarding the results of WPV prevention and mitigation efforts also were gathered. All screened participants met the criteria and were enrolled. Only one screened participant did not meet the criteria.

Interviews

An individual, semi-structured, 60-minute interview was conducted with each of the 20 multidisciplinary hospital leaders who participated in this study. Interviews were conducted over a 3-month period in the summer of 2018. Sixteen of the 20 phone

interviews were audio-recorded and transcribed to enable more accurate, reliable data analysis post-interview. Typewritten notes were taken for the remaining four participants, as they declined to be audio-recorded. Paraphrased transcripts were immediately prepared after these interviews. Table 2 presents the central study questions and corresponding interview questions, which were informed by this literature review.

Table 2

Central Questions of the Study and Corresponding Interview Questions

Central Study Questions	Corresponding Interview Questions
What strategies, policies and actions are hospital leaders using to prevent and mitigate workplace violence against nurses in the ED?	3, 4, 5, 6
What positive progress or outcomes have been realized in WPV prevention and mitigation in the ED thus far?	1, 2, 8, 10
What have hospital leaders learned in the process, and what do they aspire to achieve in the future?	7, 9

Data Analysis Procedures

Data analysis was informed by the literature review and included the following steps:

1. **Review and De-identify Recordings.** Initial steps included de-identifying, and naming each data file with a pseudonym that indicated gender/job discipline/healthcare facility code for later analysis.
2. **Transcribe and Import Transcripts into Qualitative Analysis Software.** The researcher listened to, transcribed, proofed, and then imported the transcripts into the *Audiotranskription F5 Transcribe/F4 Analyse* brand qualitative transcription/ analysis software. The researcher used the software as a digital, structured way to code the data and compare responses.
3. **Summarized Findings, Conclusions & Implications.** Finally, summarized findings were exported, conclusions extrapolated and implications noted.
4. **Demographic Data.** Demographic data were summarized and presented in tables, figures and text based on the information reported by participants. This data includes participant age range, gender, length of time in current role, area of professional responsibility/expertise, type and size of hospital, and specific involvement in WPV mitigation and prevention. It is reviewed in Chapter 4.

Reliability and Validity

To ensure reliability, the researcher has (a) documented as many steps of the procedures as possible, (b) checked the transcripts against the recordings for accuracy, (c) compared data to the codes multiple times, (d) compared findings to existing literature, and (e) discussed findings with her faculty advisor and other subject matter experts (Creswell, 2014).

To ensure construct validity and to provide a rich grounding for and test of the study conclusions, the study findings were conveyed using rich, “thick” data in the participants’ words with an aim to “. . . transport readers to the setting and give the discussion an element of shared experiences through detailed descriptions” (Maxwell, 2013). Qualitative data for this study were gathered using intensive 60-minute, semi-structured phone interviews. These were transcribed by the researcher.

Summary

As previously discussed, the literature review established that minimal data exists regarding WPV studies with multidisciplinary leader participants. Additionally, minimal data exists on studies that examine specific, successful interventions required to effectively prevent and mitigate WPV on a sustainable basis, especially in comparison to the scope of the problem. This study seeks to help fill this gap in the research. This chapter describes the method for exploring and understanding the strategies, policies and actions that have helped exemplary hospital leaders accelerate progress toward the mitigation and prevention of WPV against nurses in the ED. Chapter 4 details the findings.

Chapter 4

Findings

The purpose of this study was to explore and understand the successful prevention and mitigation of WPV against nurses, and to learn what hospital leaders are doing to accelerate progress. This study centers around three central research questions:

1. What strategies, policies and actions are hospital leaders using to prevent and mitigate WPV against nurses in the ED?
2. What positive progress or outcomes have been realized in WPV prevention and mitigation in the ED thus far?
3. What have hospital leaders learned in the process of WPV prevention and mitigation efforts, and what do they aspire to achieve in the future?

This chapter presents the findings of the study and describes the data collection results and data analysis. The first section presents demographic data gathered using a 10-question, online, anonymous survey. The second section presents qualitative findings gathered during 60-minute phone interviews with study participants. The chapter ends with a summary.

Demographic Data

Before their phone interviews, participants completed a brief, 10-question anonymous online survey via Survey Monkey to screen for baseline participation criteria and to capture demographic data. Additional demographic data were identified during phone interviews.

All 20 participants affirmed that the scope of their responsibilities included influencing the strategies, policies and actions related to WPV prevention and workplace safety for nurses of at least one ED. This was a primary baseline requirement for

participation, along with a minimum tenure of 6 months in their current leadership role and current WPV prevention and mitigation roles.

Participants were 55% Female ($n=11$) and 45% Male ($n=9$), ranging in age from 29-59 years, including 30% participants aged 29-39 years ($n=6$); 35% aged 39-49 years ($n=7$), and 35% aged 49-59 years ($n=7$). Participants' tenure in their current professional leadership position ranged from 1 year to 30 years, with a median of 12.5 years across all 20 participants. Because interviewing hospital leaders was an important goal of this study, the tenure indicated here was based on participants' tenure in their current professional *leadership* position, not their career tenure.

Participants' tenure in their current WPV prevention role (which differs from their professional position tenure) ranged from 1 year to 20 years, with a median of 6.7 years across all participants. Formal WPV prevention team/committee participation is just one way that participants gain experience in and/or influence WPV prevention and mitigation. Other areas of participation included: (a) monitoring and reporting WPV event data; (b) interfacing with other multidisciplinary leaders regarding WPV; (c) supporting and guiding staff before, during, and after WPV events; (d) designing and implementing WPV prevention strategies, actions and/or policies, and (e) participating in senior level workplace safety decisions.

Study participants' roles in WPV prevention and mitigation span a wide range, and participants were instructed to choose all roles that applied, or to write in their role if they didn't see it offered as a choice. Other roles written in included Quality, Ancillary Staff Safety, Staff Safety, Research and, Educator. All 20 participants chose more than one area of focus (see Figure 1).



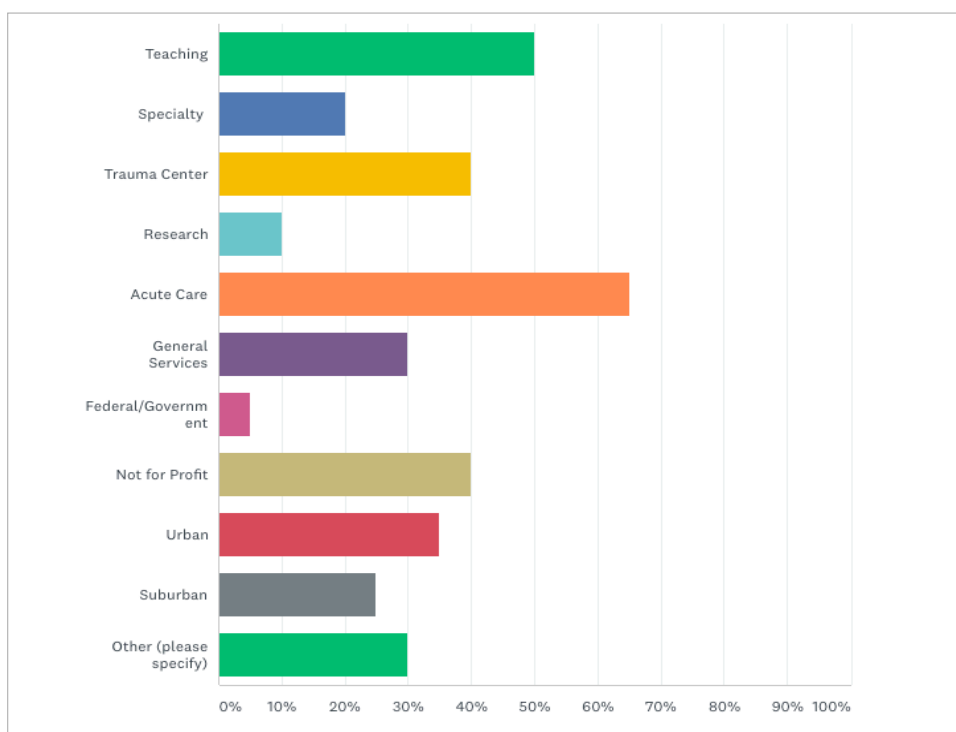
***Other:** Quality; Chair of WPV Team; Ancillary Staff; Staff Safety; Research; Educator

Figure 1

Hospital Leader Participants' Workplace Violence Prevention and Mitigation Roles

Hospitals of all sizes were included: medium and large hospitals, at 40% each, respectively, and small hospitals at 20% each. Nine ($n=9$) participants indicated that they supervise WPV prevention for multi-hospital systems ranging in size from 3-to 30+ hospitals, respectively. The remainder of participants ($n=11$) work at individual hospitals.

Participants were instructed to indicate all descriptors that they felt applied to their hospital or hospital system and to write in additional descriptors as desired. All 20 participants chose multiple descriptors. Some participants wrote in other hospital descriptors, including Level II Trauma Center; Regional; Community; Primary Stroke Center; Rural, and Multi-Hospital Systems (see Figure 2).



*Other: Level II Trauma Center; Regional; Community; Primary Stroke Center; Rural; Multi-Hospital Systems

Figure 2

Participants by Hospital Type

Of the 20 hospital leader participants, 85% of participants ($n=17$) identified having nursing experience, with ($n=9$) currently in a nursing role, and ($n=8$) with experience in a nursing role. Of the ($n=17$) participants with nursing experience, ($n=11$) participants reported specializing in ED nursing at some point in their careers, ($n=4$) reported specializing in behavioral health nursing, and ($n=2$) reported specializing in critical care/ICU nursing experience.

Qualitative Findings

This section of the chapter reports the findings of the qualitative interview analysis. These findings supported the three central research questions:

1. What strategies, policies and actions are hospital leaders using to prevent and mitigate WPV against nurses in the ED?
2. What positive progress or outcomes have been realized in the process of WPV prevention and mitigation thus far?
3. What have hospital leaders learned in the process of WPV prevention and mitigation efforts, and what do they aspire to achieve in the future?

In support of central research question number one, participants were asked to discuss the **strategies, policies and actions** that hospital leaders are using to prevent and mitigate WPV. Participant responses were coded for key concepts related to each of the three areas. The analysis of related findings begins first with strategies, followed by policies, and finally, actions.

Research Question 1: Strategies, Policies and Actions

Strategies used to prevent and mitigate workplace violence. Participants were asked to discuss strategies used by leaders at their hospital to successfully prevent and mitigate WPV. *Strategy* is defined in this study as “a method or plan chosen to bring about a desired future” (“Strategy,” 2018, para. 1). Three strategy themes were most commonly reported by participants: collaborative multidisciplinary partnerships (n=20), fully engaged executive support (n=18), and operationalized data (n=17). These themes are described in detail in the following sections.

Collaborative multidisciplinary partnerships. All participants mentioned this strategy as being particularly impactful when it came to evolving an approach to the prevention and mitigation of WPV across a variety of different contexts. The Collaborative Multidisciplinary Partnerships theme refers to the mention by participants of collaborating through multidisciplinary partnerships to prevent and mitigate WPV.

Four types of partnerships emerged from this dataset, and were assigned the subtheme of collaborative partnerships (see Table 3).

Table 3

Collaborative Partnership Types

Collaborative Partnerships	<i>n</i>
Security + Clinicians	17
Security + Behavioral Health + Clinicians	15
Law Enforcement + Clinicians	13
Multidisciplinary Workplace Violence Prevention Team	17

N=20

Security collaborative partnerships. Specific findings regarding both types of Security Collaborative Partnerships (with and without behavioral health involvement) were categorized into the three main subthemes: interventional WPV prevention and mitigation (*n*=17), shared strategic leadership (*n*=13), and inclusion in direct care/inpatient WPV prevention (*n*=9). The following sections describe these subthemes in detail.

Interventional workplace violence prevention and mitigation. Of all of the interventional efforts that this study's participants used to mitigate WPV in the hospital, Behavioral Emergency Response Teams (BERTs) are among the most dramatic, strategic, and collaborative. BERTs are focused on the skilled de-escalation of disruptive behavior using a multidisciplinary management approach. Based on the findings, the BERTs established at four of this study's participating hospital systems are an innovation that emerged out of necessity, as described in this quote from a participant:

Our Behavioral Emergency Response Team was started in order to respond to challenging patients throughout the hospital. The belief initially was that they were primarily psychiatric patients on other floors that were outstripping the staff's ability to manage them, despite training. Our non-ED staff typically only encountered aggressive patients every 6-to-12 months, which is not often enough to develop competency.

According to participants, hospital systems mentioning hospital-wide BERT teams in this study are large (400 beds+), offer behavioral health services, and feature multidisciplinary WPV prevention teams. While the specific number and scope of BERT members varied per team, participants described them similarly:

Our BERT Team has one behavioral health [Registered Nurse], who acts as the team lead, one psychiatrist, four security officers, and a critical care trained nurse. The critical care nurses are there to ascertain whether or not the etiology of aggression might be medical in nature. The psychiatrist is there to work with the physician to make medication recommendations if that's indicated. We all respond within five minutes of the call, do a huddle with the primary team—the nurse, and physician—and get some quick background on what's going on, and take action from there.

Variations on this model have included the “Family and Visitors BERT”, which addresses WPV related to family members or visitors, and a smaller “ED BERT” or “Mini BERT” comprised of ED staff and security only (no behavioral health staff). An example of an “ED BERT” is described below by an ED nursing leader participant:

In the past, our Security guards would be posted at entrances, and make rounds, but didn't get involved. Now when there is a behavioral alert, we come together as an ER team, all disciplines, and do a pre-huddle and post-debrief. For the pre-huddle, we explain the situation, the problem, and we decide who does what, as in, this guard will take this limb, this guard will take that one. One person, usually the nurse, talks to the patient. The goal is to be clear on roles, show a united front, keep everybody safe. Afterward we debrief on how it went, and file a report.

In some cases, participants were surprised by the data gathered as a result of the BERTs. A behavioral health leader participant responded in the following way:

It is interesting—as we began responding with our BERT throughout the hospital, we realized that the single greatest etiology for these behavioral episodes was actually hyperactive delirium, which is a medical issue that sometimes shows up

for older post-surgical patients who have had anesthesia. This data was fed back to our Committee, who is also seeking to address this. Basically, to address this we have to try to manage delirium before it begins, rather than after, so that's something we are working on.

Shared strategic leadership. Thirteen out of the 19 participants (86%) who have security on-site described security leaders as being invited into a more central, shared leadership role in WPV prevention and mitigation strategy. The nature of this role was described by one participant as “. . . both an ongoing evolution and a significant shift from the past when security was perceived as an outsider and functioned primarily at a tactical level.” A security leader had this to say about his partnership with the CNO:

Along with the CNO, I really took a strategic approach from the safety/security side. We looked at everything, all the elements, whatever we knew about at the time that were impacting the staff and our hospital that were making us vulnerable to WPV. I said, ‘Here are our recommendations of ways to improve it from the security perspective. Then we put that input together with the input from all other areas, and came up with a program.

A CNO leader summed up her partnership with the Security Director like this:

I think the reason our efforts worked as well and as quickly as they did is because we really saw ourselves as equal partners in it. And that we *owned* it equally. I wasn't going to him and saying ‘Oh my gosh, you need to fix this.’ And he wasn't looking back at me and saying ‘This isn't my problem, this is your nurses' problem.’ We were saying this is OUR problem and we need to work together. I think a lot of very well-meaning people could easily sit back and say ‘We just need more security.’ That's not the answer.

Inclusion in direct care/inpatient workplace violence prevention. Nine participants mentioned that at their hospitals, security guards also closely collaborate with clinicians and behavioral health on a regular basis to prevent and mitigate WPV in more of a direct care inpatient environment, such as the Trauma Unit, versus just the ED or the Behavioral Health Units. For example, specific security guards are assigned to a particular inpatient unit instead of rotating, random assignments, and some do rounds together with Behavioral Health on high-risk-for-violence patients. One leader said:

Including security in our plans and in our huddles certainly makes for better teamwork all around. For patients flagged at high-risk of violence, we provide Security with a “need-to-know” level of report regarding a particular patient so that when they have to intervene, they have some medical context and are equipped to be calmer in addressing patient behavior. Security also helps us with one-on-one consults as needed.

Regarding the overall impact of collaborating with security, a nursing leader said this:

Increasing our collaboration with Security has improved safety more than anything. Now we work together with Security in our planning and on our Workplace Safety Committee. Guards have been matched to units, the scheduling is more consistent, and Security rounds are more consistent. We all know what to expect. Trust has increased immensely.

That said, according to this study’s participants, a 24/7 level of security protection and collaboration can take time to establish, and requires an investment of resources. One ED nursing leader offered this caveat:

Keep in mind; these initiatives were very institution-dependent on increasing our security presence in the EDs. We put in a proposal and had to get additional FTEs. Now we have 24/7 security in the ED and in the waiting room—but that took four YEARS, and that took resources.

Interestingly, 50% ($n=10$) of participants mentioned that their facility now hires security guards as regular employees (versus rotating contractors) with an express purpose of training security (a) to facilitate the more hands-on, inclusive involvement mentioned above in accordance with the hospital’s policies and (b) to mitigate potential legal concerns and exercise more control over how a hands-on approach to security is carried out.

Law enforcement partnerships. Thirteen out of 20 participants (65%) explicitly mentioned collaboration with law enforcement as an approach to prevent/mitigate WPV. Table 4 shows the characteristics of these Law Enforcement Collaborative Partnerships.

Table 4***Law Enforcement Collaborative Partnership Characteristics***

Law Enforcement Collaborative Partnerships	<i>n</i>
On-call back-up support as needed for WPV in the ED	13
Paid off-duty officers in emergency department	10
Ongoing consultative support	9
Police substation in emergency department	4

N=20

On-call back-up support from community law enforcement as needed for WPV, was the most prevalent Law Enforcement Collaborative Partnership discussed by participants. Thirteen participants (65%) mentioned that they perceived that requests for help from the ED or inpatient units are now taken more seriously by law enforcement than in the past, and, that their requests elicit a more rapid response than before. As two different ED nurse leader participants at two different hospitals described it:

About four years ago we did initially have pushback from the police when we called for help. I work in a large inner-city department, and not in the greatest of areas, and because there weren't always visible injuries I don't know if they thought, 'Oh this isn't that important. That person was drunk.' We eventually resolved it by partnering more closely, and, I think because our state law changed to make assaulting a nurse a felony.

I had an incident with a patient about 20 years ago—I can still remember what room this guy was in. He was telling me, 'I'm going to kill you.' I called hospital security and the police—but until I actually went down to the police station myself, they dismissed me and said, 'Oh, he's not going to do anything.' That would never happen nowadays.

In addition to the paid off-duty police presence and police substation found in EDs (see Table 4), nine participants (45%) discussed ongoing, consultative partnering with local law enforcement. A WPV prevention team lead said:

Our relationship with local law enforcement became even more important as we started pressing charges against patients for behaving so poorly. We have a few jails in the area and they often bring a guard or two when a patient is admitted. We started by just having conversations. Officers sharing their wealth of knowledge really helped our staff.

Other examples of law enforcement consultative support specified by participants included (a) classroom training for nurses, (b) WPV simulation training, (c) advice on staying safe while working with forensic patients in EDs and inpatient units, and (d) assisting individual nurses by helping them file charges when they have been assaulted.

Multidisciplinary workplace violence prevention teams. The final finding in the Collaborative Partnership subtheme includes Multidisciplinary WPV Prevention Teams—also known as workplace safety teams or committees. These teams were discussed by 17 participants (85%) and were characterized as:

1. Central hubs of planning and ongoing monitoring of WPV prevention and mitigation efforts for their hospital and/or hospital system.
2. Multidisciplinary in nature, comprised of stakeholders / leaders from all across the hospital, such as Chief Nurse Executive, Senior Nursing Directors and Leaders, Behavioral Health, Emergency Medical Directors, Security, Facilities, Clinical Education, Emergency Medicine, Patient Safety, and other subject matter experts.
3. Varying in size based on the size of the hospital and/or hospital system. Team size ranged from 4 members, all the way up to 87 members.

Of the 17 participants who mentioned having a Multidisciplinary WPV Prevention Team at their hospital, 76% ($n=13$) served as an active member or leader of a formal hospital multidisciplinary WPV prevention team, with teams ranging in size from 4 to 87 members. Of the 13 study participants, nine participate on hospital system teams (3-to-30+ hospitals per systems), four participate on single-hospital teams and six are Chairs or Co-Chairs of their respective teams. Five of the seven participants who reported not being on a hospital level WPV Prevention Team did report actively participating in

WPV prevention efforts and committees in their state's American Nurses Association or ENA.

One WPV prevention team lead participant described how her team evolved into a committee that catalyzed WPV prevention at her hospital:

About 8 years ago, we formed a task force to look at patient care quality. Then we noticed pockets of violence here and there. We had two PCAs who were injured, two nurses in the float pool who were assaulted, plus two on the medical units within a short period of time. So, we did an analysis and saw all the potential gaps in our system, and realized this level of violence was not a one-time thing. We evolved quite quickly into a committee, and have been working on WPV prevention ever since.

Another team lead participant described the task focus of his team like this:

We developed a group dedicated to ongoing monitoring WPV and workplace safety. Their task is to monitor, review and make recommendations on any violent event, or anything they felt impacted our workplace safety and exposed us to violence. They collect the data and see the reports—they go over debriefs of events, recommend ways to improve, and coordinate training when necessary so that staff can benefit from what we learn, and be more proactive and preventive.

In addition to multiple disciplines, one WPV prevention team lead mentioned including members at all levels of the organization—including frontline employees:

The dynamic of our team is as diverse as you can get. There's everyone across the board, from staff nurses to HR. Members from each of 3 hospitals. Social workers. New employees going through orientation. Members from outpatient ambulatory centers. We also have an Employee council where employees meet and give input. And yes, we invite employees to attend our Workplace Safety meeting and air their concerns. Getting everyone talking gives us an opportunity to look at multiple sides of the same conversation and constantly reevaluate our process.

Fully engaged executive support. Fully Engaged Executive Support is the second Strategy of our Top 3 Strategies that support the first central question of this study. Fully Engaged Executive Support was discussed by 90% (n=18) participants during interviews. One participant said this:

There is no program that will be successful unless it is supported from the very top of the organization. Staff need to know that their safety is at the top of our goals, and to see that leaders are involved. Our CEO was extremely engaged with our staff at various levels to ensure they felt safe, with great emphasis on constant evaluation, and keeping things safe for staff, patients and visitors

Table 5 highlights the characteristics of Fully Engaged Executive Support as discussed by 18 out of 20 participants during interviews.

Table 5

Fully Engaged Executive Support Characteristics

Fully Engaged Executive Support Characteristics	<i>n</i>
Models and enforces a culture of civility and respect	18
Regularly communicates workplace violence safety as a priority at all levels of organization	15
Supports workplace violence prevention team initiatives	14
Actively includes frontline staff and invites input on workplace violence	9

N=20

Four additional findings, each reported by one participant each, are below. The theme is presented first, followed by a description in the participant's words:

- We should not believe or say that violence goes with the job: We as senior leaders have to take a stance that violence of any kind is absolutely not okay, while fully recognizing that it may still happen. We as a nursing department should not believe or say that violence goes with the job. When we say no it doesn't, and we do everything we can to put mitigating forces in place to keep it to a minimum, that goes a long way.
- We have to back up our support with action from the get-go: It is really important for our people to know that their leaders support them. When they believe that we will take action on what they say they tell us the truth about why things are happening the way they are, in a way that we won't get through more formal mechanisms, quantitative studies or incident reports.
- Implicit and explicit support obviously contribute to the success: In addition to providing the budget consideration for additional nurses, our initiative has been featured and promoted by leadership in a lot of

prominent ways throughout the organization. Implicit and explicit support from leadership obviously contribute to the success.

- If violence does occur, they take immediate action: Senior leaders set the tone. In our teaching hospital, we marry a culture of transparency with our High Reliability Organization practice of encouraging people to report. Our senior leaders make a point of making sure people know that violence of any kind, to include incivility or unprofessionalism will not be tolerated. If violence does occur, they take immediate action.

Operationalized data. The operationalized data theme refers to participants' mention of their WPV team putting WPV data to use as a strategy to prevent and mitigate WPV. This is the third of the top 3 strategies that supports the first central question of this study, which is to explore the strategies, policies and actions hospital leaders are using to prevent and mitigate WPV.

Operationalized data is not yet a workplace violence prevention norm. It is important to note that this strategy emerged from the data and was not found in the initial literature review. To understand why such a key strategy was not apparent in the literature, this researcher did a subsequent review on this topic and discovered that while reporting violent events is required, a customized, evidence-based approach utilizing operationalized data is considered exemplary (The Joint Commission, 2018). Unfortunately, the use of operationalized data is not yet the norm in the mitigation and prevention of WPV. This is due, in part, to a lack of systematic monitoring of violent events and practical and sustainable data collection systems at most hospitals (Arnetz et al., 2011; Arnetz et al., 2015b).

That said, in this study, participants indicated that putting WPV data to use—or operationalizing WPV data—was a highly critical, first step to understanding the depth, breadth, and impact of WPV at their facilities. As this CNO participant recalls:

When we first started out eight years ago, we had no centralized source of data about WPV. So, I asked security and our Workers Comp department to compile and consolidate their data on workplace injuries as a result of violence. We had 44 incidents where staff received significant injuries from being assaulted—fractures, concussions, lacerations needing sutures—pretty profound injuries that resulted in a significant amount of missed time. Once she saw the data, our President was compelled to make changes. Data was key—and getting injured staff to report violence was the first step.

According to this study's participants, in order for WPV data to be operationalized—or, systematically put to use—WPV-relevant data across the hospital must first be consistently reported and tracked in a centralized way. For this data to be made actionable and accessible, multidisciplinary leaders work together to analyze and synthesize WPV-related data from multiple siloed departments of the hospital, and make it accessible to the WPV prevention team, who work together to understand and interpret what that data means in the context of WPV and to integrate it into action plans. Characteristics of this approach utilized by seven (70%) of 10 hospital teams represented and reported by 17 (85%) of the participants are as follows:

- Report WPV data
- Monitor WPV data
- Analyze and synthesize WPV data
- Access WPV data
- Integrate WPV data into action plans

Report workplace violence data. All 17 participants who mentioned

Operationalizing WPV Data also discussed the success factors of reporting WPV, which are listed in Table 6.

Table 6

Success Factors of Reporting Workplace Violence Data

Success Factors of Reporting Workplace Violence Data	<i>n</i>
Knows that someone cares and is paying attention	15
Nurses <u>and</u> Leaders model that workplace violence is not “part of the job”.	15
A clear definition of workplace violence + what to report	12
Easy-to-use, centralized reporting / behavioral risk alert system.	12
Understand how and why to report workplace violence	9
Inclusion of frontline staff in workplace violence policymaking	9
Open door policy or access to direct supervisor	6
Knowing what will happen to the report afterward	5
State has a law against clinician assault; supports to press charges	5

N=20

Five additional findings, each reported by one participant each, are below. The theme is presented first, followed by a description in the participant’s words:

We don’t have to take verbal or physical abuse from anyone: We still have to work with the nurses to report it, but things have changed. It is no longer like, ‘Well, you work in an ED and violence is going to happen to you and you have to accept it.’ When my staff come to me I tell them, ‘No, we don’t have to take verbal or physical abuse from anyone—a patient, or a physician. Report it!’

Supporting to report and to file charges is very effective: Assaulting a nurse is a felony where I live. The only thing I believe is helpful in preventing violence in the ER is supporting staff to report violence, being transparent about what happens with the reporting and, supporting them to press charges.

Reporting is the evidence to gain support for what we need: Part of how we encouraged reporting was being very transparent and letting staff know that the data from their reporting is the evidence required to get executive support and funding for extra security, and other things we need.

For reporting to happen, it absolutely must be easy and convenient to use: To make it easy, we push out icon links for reporting to every computer in the org, including the nurses' workstation on wheels. We also include a link to our WPV website in every email signature so they can easily click to learn about prevention, training, and how to register for classes. We remind them: violence prevention is not an isolated incident, it is a comprehensive effort.

Staff need to hear what happens after they report: I know in years past, as a bedside nurse, that if I filed an incident report, I felt like it went to the 'black hole of incident reports' because there was never any follow-through. Staff need to know that somebody is paying attention, the reports are being looked at and reviewed, and, that somebody is taking action. They need to hear and understand what happens afterward. It is on us leaders to close that loop.

Monitor workplace violence data. Seventeen participants (85%) were part of (n=7) out of 10 hospital WPV Teams that monitor and review the data produced by WPV reports, with the ongoing monitoring of violent event reports typically performed by their WPV prevention committee, or team. As one leader explains:

One of our WPV prevention committee's explicit tasks is to monitor, review and make recommendations on any violent event, or anything else they feel impacts our workplace safety. They collect the data and review the reports, they go over debriefs of violent events and consider the best way to recommend improvement or coordinate training when necessary so that staff can benefit from what we learn, and we can all be proactive .

Analyze and synthesize workplace violence data. In the context of facilitating the Operationalized Data strategy across an entire hospital system, 17 participants (85%) were part of (n=7) hospital teams that analyzed and synthesized WPV data. One participant said:

We realized that to develop an action plan, our data on WPV had to be real time, correlated, choreographed and monitored so we could see the patterns between specific hospitals, etc. That way, we can track and trend and see whether it was verbal aggression, physical aggression or, what type of violent event occurred.

A WPV Team Lead participant discussed the prioritization of different data:

To justify the cost of our workplace safety training, we pulled our own actuarial data on violent incidents reported in our facilities, and prioritized regarding frequency of occurrence and lethality, and then matched our data up against an

ENA study that was about 3 years old. We found that there was very strong alignment between our internal data, and the ENA study.

A technology leader participant had this to say about tracking trends in WPV:

We look for trends, and evaluate accordingly. If there are a lot of one particular kind of event in a specific department, we compare the events to the procedure being performed. For instance, if we see reports of patient agitation, and a lot of kicks being reported, we look for patterns in the type of procedure, process, or a clue of a way to proactively avoid or prevent violence by changing how the procedure is done.

Access workplace violence data. Seventeen participants (85%) were part of seven hospital teams that access different segments of WPV data via monthly subcommittee report-outs at their WPV prevention team meetings. A subset of 10 participants reported that a digital dashboard interface or WPV website provides online access to WPV data.

As one participant put it:

What good are plans and processes without being able to build analytics that mitigate workplace violence and better all of your programs? We bring workplace violence to the forefront using the website as an interface to make resources readily available. We publicize awareness of the website and other resources from the employee to leaders monitoring violent events.

Integrate workplace violence data. Finally, one last characteristic of the Operationalized Data strategy includes integrating data into action plans that inform decision-making and help engage senior executives with WPV prevention and mitigation. For example, one hospital leader participant reported discovering a wider scope of WPV across the hospital than first believed:

We learned, as we built out more integrated analytics, that the ED is an entry point for violence—and that the violent patient doesn't just stay in the ED. Percentage-wise, we see that there are often larger issues with violent events in other units, like Trauma, or the ICU.

Another participant said this:

Many times, as our executive team are listening to the data analysis we bring, I see a light bulb go on for them. Abstract concepts become more concrete. Suddenly we know which policies to make, and which actions to take. Workplace

violence data offered in the context of our hospital's organizational goals drive the implementation of plans and processes that close the gaps between our execs, and our 'boots on the ground' staff.

Seventeen participants (85%) were part of the seven hospital teams (70%) that integrate WPV data into action plans.

Policies used to prevent and mitigate workplace violence. In support of central question one, participants were asked to discuss Policies used by leaders at their hospital to prevent and mitigate WPV. The word "Policy" in this context is defined as, "A definite course or method of action selected . . . in light of given conditions to guide and determine present and future decisions" ("Policy," 2018, para. 1). Three policy-related themes were most commonly reported by participants: systemwide central wpv policies / zero tolerance (n=20), professional code of conduct policies (n=17), and environment of care/ zero weapons policies (n=10). These themes are described in detail in the following sections.

Systemwide central workplace violence policies and zero tolerance. In response to being asked to describe the policies they used to prevent and mitigate WPV, all participants mentioned a Systemwide Central WPV policy and described it as an essential foundation for defining, reporting and monitoring WPV data. A security leader and information technology leader said this:

The first thing we tackled was our policy on WPV. Without it, it was impossible for us to discern what was a violent event, or not an event. This is where we started. It included all of the protocols and a position statement.

We developed a comprehensive WPV policy and a plan specifically tailored to our hospital system and our clinics, which is a part of our state-required illness and injury prevention plan. There are specific ED policies included within the addenda.

A patient safety leader agreed that a comprehensive policy was essential, and yet described his hospital system as “being in a state of transition” on WPV policy:

One of the barriers to making progress is that we don’t have a strong WPV policy—we don’t really have a clear definition of what is a violent event. That makes it hard to recognize, respond, and support our caregivers after violence occurs. Due to recent violent events, our executive leaders finally came along and said we should be doing a better job. We can no longer be ad hoc, we really need to look at this from a systems level and support it that way.

According to participants, a central component of a Systemwide WPV Policy is a position statement detailing what actions will and won’t be tolerated in a healthcare setting. Since the zero tolerance policy recommended in the ENA guidelines (see Appendix A) is well known—participants in this study were specifically asked to discuss zero tolerance policy as a starting point for discussing WPV Policies in general.

Although all participants discussed zero tolerance and agreed that their hospital’s position is that WPV is not acceptable, the term *zero tolerance* elicited a variety of responses. Here’s what one nursing leader and one security leader had to say:

We went with a zero tolerance policy. We said, “Our policy is every employee has a right to come to work without being assaulted or attacked.” That’s one of the first policies we codified and developed.

Our policy is zero tolerance for WPV—violence is not accepted. We support and encourage our staff to press charges if assaulted, and we support them to come off the schedule to go to court if necessary.

Two other participants expressed the same policy elements, without the Zero Tolerance name, and one participant also mentioned the medical screening required of hospitals by Federal law:

We don’t have an officially named ‘Zero Tolerance’ policy but we have communicated with staff that we won’t tolerate verbally abusive or physically abusive patients. We will do a medical screening and if we think the patient is safe to leave we will escort them out and not let them stay and abuse staff.

We called our policy ‘Zero Violence’. Our signage says we are a nonviolent environment and violence is not acceptable in our facility.

Two different WPV team leader participants at the same hospital had this to say about the progression of zero tolerance policies at their hospital over time:

We HAD a ‘Zero Tolerance’ policy before. We have a ‘Workplace Violence Prevention’ policy now. We started off as zero tolerance and staff really latched onto that. But what we struggled with is if we have a patient who's violent that can't leave, how do we have a Zero Tolerance policy?

Zero Tolerance was very contradictive for staff and it created some issues. It caused some staff frustration, thinking that here you tout the Zero Tolerance policy, but here a patient sits who is beating on me every day for two weeks. We still tell staff that we don't want them to tolerate that type of behavior, but we don't go so strongly as to say that we're Zero Tolerance. And yet, staff still quote Zero Tolerance. The name really stuck with them.

Another complicating factor mentioned by participants is that there are a variety of types of WPV, and caregivers' tolerance for abuse varies. One security leader had this to say about enforcing Zero Tolerance in the face of verbal violence from a patient:

When it comes to Zero Tolerance, mitigating verbal abuse is a harder goal to reach because staff have different tolerances for different levels of abuse. Someone can take things personally, and another will feel intimidated. One staff member says, “You know what, the way they said that to me, I’m still shaking.” And the other staff says, “You know, I didn’t even pay no attention to that. That’s just a blowhard talking.”

When asked who decides “how much is too much” in WPV, another leader said:

It is subjective—if a staff person feels uncomfortable or threatened, they feel uncomfortable or threatened. We believe them. We encourage them to speak up and report it.

Professional code of conduct policies. Another category of WPV prevention policies mentioned by all 20 participants were Policies that specifically addressed lateral violence against coworkers, such as incivility, verbal violence, bullying, and/or sexual assault.

These responses were categorized within a theme of Professional Code of Conduct Policies. Professional Code of Conduct Policies are formal policies that codify what employee professionalism is and detail which actions are not acceptable.

According to 17 participants (85%), their hospitals have established a Professional Code of Conduct for all employees, with an emphasis on civility and respect. One senior nursing leader commented:

Respect starts at the top. Our senior leadership have made it emphatically clear that no sort of bias or violence against people will be accepted—whether it is nurse-on-nurse bullying or any lateral disruptive behavior by physicians. When it occurs, there is a rapid response by very senior leadership. For example, one time a physician was rude to a nurse, and our senior leaders made the physician publicly apologize to the nurse, in person.

An ED nursing leader had this to say about professional conduct policies:

I have a professionalism policy that I write nurses up against all the time. You just have to be that way. I can say all day, ‘Okay, everyone be nice to one another.’ Or, it works a lot better to have people be accountable to one another.

Another nursing leader emphasized looking out for new graduate hires:

When we hire new nurses, especially new grads, we emphasize that lateral violence is not anything they need to tolerate as a new employee. That old saying that ‘ED nurses eat their young’—we want that to go away. And it seems to be working.

Another participant’s hospital system very explicitly clarified an aligned stance on sexual harassment and sexual assault, complete with a robust reporting system.

Regarding this approach, this senior nursing leader shared the following:

Our hospital’s senior leaders and HR traveled throughout our campus and every hospital in our system to explicitly address workplace-related sexual harassment and sexual assault. They took the hospital attorney with them and made it clear that sexual harassment and sexual assault won’t be tolerated, it is very serious, and that anyone who is found guilty could lose their professional license, and their job.

Environment of care / zero weapons policies. Environment of Care Policies.

Findings from this study indicated that half the participants mentioned an Environment of Care policy that covered ongoing risk assessment and facility improvement, similar to the one described by this security leader:

We looked at our whole facility to see if the environment contributed to the violence—like, our waiting room, the layout of the ED, outside doors, who can gain access—do we have panic alarms, a way to check for weapons, metal detectors. We addressed environments that could result in too many people accumulating in one area, or staff being too isolated, or trapped, or frustrated because people feel they are waiting too long, or aren't being cared for properly, or being ignored.

Half the participants in this study also mentioned a Zero Weapons Policy, as indicated by this response:

We have signage at the entrance stating “No Weapons Allowed.” The expectation is that no matter where you go on our campus you will not bring any weapons in our building. In our ERs, we have metal detectors and X-ray machines that check for weapons. Depending on the legality of the weapon we find, we either hold it until the person is done, or call the police to engage as necessary. Either way, we don't allow them into our building.

All 10 participants use weapon detection tools, and indicated that they found value in them as a deterrent. One security director said:

Two components really help the Zero Weapons policy—signage about our policy, and the metal detector to measure compliance. The sooner that people can see the signage, the better. And you have to have the enforcement piece, because once someone finds out that you don't enforce your policy, they have less desire to comply with it.

In some cases, the evidence of a metal detection as a deterrent was found right outside the entrance to the ED, as indicated by this participant's response:

When we first rolled out the program you would see people come up to the door and see the metal detector and literally turn around, go away and then come back. We found knives and other weapons stashed in our bushes and around the corner. They seem to respect the fact that we let them know our policy. And most people seem to want to comply anyway

Actions to prevent and mitigate workplace violence. This section reports data related to Central Question 1—strategies, policies and actions that hospital leaders use to prevent and mitigate WPV against nurses. Participants were asked to discuss actions used by leaders at their hospital to successfully prevent and mitigate WPV. Actions highlighted in this section include those that had not already been covered in the

descriptions of the Strategies and Policies sections. The three most prevalent themes that emerged in the interview data regarding leaders' actions to prevent and mitigate WPV were: Detect and De-escalate WPV (n=20), train and equip staff (n=18) and staff support and recovery (n=15). These themes are discussed in the following sections.

Detect and de-escalate workplace violence. All 20 participants discussed the actions they took to detect and de-escalate agitated behavior. The Actions taken to detect and de-escalate WPV are highlighted in Figure 3 (Note: This data is in addition to data on de-escalation using BERT Teams, introduced earlier in this chapter.)

INITIATIVES	TACTICS
<p>DETECT + DE-ESCALATE Workplace Violence</p> <ul style="list-style-type: none"> ➤ 100% supported initiatives to proactively detect, assess and address Behavioral Health (BH) risks in the ED right away (n=20) ➤ 85% supported initiatives to develop and support vigilance and awareness for all staff—direct care, security <u>and</u> ancillary staff throughout the hospital (n=17) 	<ul style="list-style-type: none"> ➤ 85% tracked high-risk patients via behavioral “flag” or banner on Electronic Medical Record (EMR) (n=17) ➤ 50% provided Personal Workplace Violence alarms for individuals (n=10) ➤ 45% identified high-risk patients to ancillary staff using magnets on the hospital room door (n=9) ➤ 30% embedded Behavioral Health nurses and assistants in the ED (n=6)

Figure 3

Actions by Leaders to Detect and De-escalate Workplace Violence

According to 17 participants (85%), keys to help detect and de-escalate WPV are (a) creating awareness throughout the hospital of the risk and potential for violence and (b) equipping all staff to detect signs of violence and de-escalating appropriately. Five participants additionally stated:

An important part of de-escalation is not overreacting. We have to remember that we are here to care for people and to see if we can determine what's causing the agitation, and then take care of a lot of what's causing that aggressive behavior. In the past, if there was a situation bubbling up, the issue would go further or longer. Now we create communication that allows for earlier detection, alerts others to warning signs and engages more people in the process.

We embed Behavioral Health Nurses and Assistants in our EDs 24/7. Having Behavioral Health nurses here helps us detect escalation sooner. Their intuition for what's going on is much more attuned than the average bedside nurse or clinician who are more likely to be personally triggered by antisocial behavior or don't see the anger episodes coming. I can't overstate how specialized their expertise is in terms of preventing violence.

If I can't get a patient to de-escalate, I move them to a quieter area. The ER is super loud, and noisy and sometimes too stimulating, so if I can't get a patient to de-escalate I either move them to a quieter area, like our psych room. If I can't do that I try to move other patients away from the more agitated one, because anxiety is contagious.

We also wear a small personal, electronic alarm to call for help when needed. Five years ago, a staff member was assaulted and a patient got her in a headlock. Within 3 months, everyone was wearing this alarm that attaches to the name tag. If you need help, you just pull it, and throw it to set off a very loud alarm that is also tracked electronically and allows Security to pinpoint your location. It also makes other staff aware of an active threat in progress.

Our ER has a Psychiatric triage nurse. The Psychiatric Triage nurse knows the patients—the patients know the nurse. You can get patients in and admitted, or, in and out. We resource them from time to time—staff call and ask what's the best strategy with a patient, based on looking at their treatment plan. The ER has ten people who work that role, 24/7.

Train and equip staff. Eighteen participants (95%) discussed the actions they take to train and equip staff and prevent and mitigate WPV. Figure 4 highlights actions discussed by participants, categorized by action-related initiatives and tactics.

INITIATIVES	TACTICS
<p>TRAIN & EQUIP STAFF</p> <p>➤ 95% of 20 participants (n=18) supported initiatives to Train & Equip all healthcare system employees to detect, prevent & respond appropriately to WPV.</p>	<p>➤ 95% provided online, instructor-led and simulation-based education (n=18)</p> <p>➤ 85% evolved training over time with staff feedback and input, and centralized WPV data (n=17)</p> <p>➤ 65% provided Workplace Violence training to <u>all</u> employees at every level of the organization (n=13)</p> <p>➤ 50% created custom or semi-custom curricula aligned w/organization culture and strategy (n=10)</p>

Figure 4

Actions by Leaders to Train and Equip Staff

According to the 95% of participants that discussed WPV prevention training, the most basic level of training offered to all staff includes recognizing the warning signs of violence and how to de-escalate it. More intensive levels of training such as hands-on physical interventions are offered based on the staff member's role and their risk of violence. Specific training types mentioned included AVADE, Crisis Prevention Initiative training and Management of Aggressive Behavior training. Specific findings in participants' own words that support this theme are:

We have Workplace Violence Training for 100% of all staff: Everyone gets the computer-based training. The more they come in contact with patients, the more education they receive. Anyone who works in direct patient care gets our non-crisis intervention training. Our hospital invested in it right away, which was huge. Everybody in direct patient care got the self-defense and the de-escalation piece.

We assess and assign a level of violence risk that everyone can see on the EMR: We have a Behavioral Flag banner in our system, along with a 4-question Violence Risk Assessment to score the patient as high or low for risk of violence. The system assigns a level of risk that everyone can see, and we train staff on protocols of how to respond, based on specific behavior. Our nurses know the systems, know when to call, and that builds confidence, which makes them less likely to be injured.

It is a Team intervention, not a Security intervention: Because we all received the same training, and trained together, things went smoother when we had a violent event because we all spoke from the same playbook. It kept things from escalating because we knew who was expected to respond, who's in charge, and it allowed everyone to do their roles and be supportive, instead of competing for the lead.

We did a specialized training for ED nurses on positioning in the room: For example, we train nurses to always have your back to the door so you are not locked in on the opposite side of the bed. Or how reaching over a patient can compromise your safety and put you in a compromised position. We gave specifics on what to do if someone grabs you, grabs your hair, or tries to choke you.

Behavioral simulation of violent events is such a key education piece for us: We've done a behavioral simulation of a patient who's out of control, and a visitor who's out of control. This type of hands-on training is very, very important, and very impactful. Staff see for themselves the best way to de-escalate, to handle that situation—and what to do when the situation escalates—like putting people in restraints, if absolutely necessary.

Staff inclusion, support, and recovery. Nineteen participants (95%) discussed the actions they take for Staff Inclusion, Support and Recovery, in the context of WPV prevention and mitigation. Figure 5 highlights actions discussed by participants, categorized by initiatives and tactics.

INITIATIVES	TACTICS
<p>STAFF INCLUSION, SUPPORT & RECOVERY</p> <ul style="list-style-type: none"> ➤ 95% supported initiatives to remind staff that workplace violence isn't acceptable, and to report workplace violence of all types (<i>n</i>=19) ➤ 75% included frontline staff input in the design and evaluation of workplace violence initiatives (<i>n</i>=15) ➤ 50% described internal initiatives designed to mitigate Workplace Violence by supporting and empowering nurses in recovery from workplace violence events and assaults (<i>n</i>=10) 	<ul style="list-style-type: none"> ➤ 95% surveyed staff regarding safety and satisfaction on a regular basis (<i>n</i>=19) ➤ 90%* offered staff time off to press charges and/or attend court in response to WPV assault (<i>n</i>=18) ➤ 65% described specific Executive/Senior Leader support and response to violent events (<i>n</i>=13) ➤ 50% offered ongoing self-care & support resources such as support groups and Trauma-Informed Care (<i>n</i>=10) <p><i>*90% of participants are in states where patient assault of a nurse is a crime</i></p>

Figure 5

Actions that Leaders take for Staff Inclusion, Support and Recovery

In the context of the theme of Staff Inclusion, Support and Recovery, participants described initiatives and tactics to prevent WPV through staff support, and including staff as described in Figure 5. Initiatives and tactics to mitigate WPV by personally supporting the recovery of staff who experienced WPV trauma were also discussed. Specific findings in participants' own words that support this theme are:

Our initial work was just changing the mindset of staff: We tell our staff, when a patient's swinging and kicking, you don't have to try to control them. Walk away, don't get yourself hurt. You need to be there to take care of the next patient. So that was our initial work, was just changing the mindset of staff, that they don't have to stand there, they don't have to take it, they can set boundaries.

First, we listened to staff: We went to the emergency rooms of all of our hospitals at all different times of the day and night. We listened to the valets who parked cars; we listened to registrars, clinical staff, we listened to anyone who would talk

to us. Our only question was, ‘Tell us your experience with violence in your job here.’ We got an amazing amount of information from people.

The more input we get from the staff who are working with patients, the better: It is huge to get those who are doing the work to contribute input to our initiatives. Huge in the buy-in, and huge in the success, because then you know you are working on what’s important to everybody.

We created our de-escalation policy in conjunction with the staff: We also had them help teach it. In hospitals, we often try to do things quickly and sometimes make assumptions. It might seem to take too long to include everyone, but it actually works better because they are enfranchised and they own it.

Senior leaders who have seen us in action really respect our work: We have a managing provider who is a physician—he kept hearing BERT calls, so he came to a few BERT alerts and observed what we do, firsthand. Now that he has actually seen how hard people fight, and how long it might take to calm them down, he has new context for what we do. He supports us in a more informed, aligned way, and that has changed how he influences Workplace Violence policy.

Sometimes it is about taking care of the person after violence happens: It is not always about prevention; sometimes it is about taking care of the person after violence happens. It is about supporting them so that they can continue to work and we don’t lose them, so that they don’t decide that nursing isn’t for them anymore. We connect them to resources. We check in continuously. We say hey, are you still doing okay? Are you struggling with anything? How can we help?

Summary. In support of Central Research Question 1, participants were asked to discuss the strategies, policies and actions that hospital leaders are using to prevent and mitigate WPV. Qualitative findings were discussed and categorized based on three themes for each category (see Table 7). Qualitative findings in support of central research question number 2, which explores the positive progress or outcomes in WPV prevention and mitigation by hospital leaders will be explored in the next section of this chapter.

Table 7***Strategies, Policies and Actions Themes***

Top Strategies	Top Policies	Top Actions
<ul style="list-style-type: none"> • Collaborative Multidisciplinary Partnerships • Fully Engaged Executive Support • Operationalized WPV Data 	<ul style="list-style-type: none"> • Systemwide Central WPV Policies / Zero Tolerance • Professional Code of Conduct Policies • Environment of Care / Zero Weapons Policies 	<ul style="list-style-type: none"> • Detect + De-escalate WPV (BERTs and more) • Train & Equip Staff • Staff Inclusion, Support & Recovery

Research Question 2: Positive Progress and Outcomes

This section explores the qualitative findings that support the second central research question of this study: What positive progress or outcomes have been realized in WPV prevention and mitigation in the ED thus far? Participants were asked to discuss the positive progress and outcomes at their hospital in the context of WPV prevention and mitigation. The definition of progress for purposes of this study is “To proceed, or move forward; to develop to a higher, better or more advanced stage” (“Progress,” 2018, para. 1). Based on this definition, positive progress is largely subjective and relative to participants’ organizational goals, where they started, and how progress in WPV prevention and mitigation was being measured. Nineteen participants discussed progress, leading to three themes: progress evolution (n=19), progress dynamics (n=14), and progress and outcome scenarios (n=7). These themes are described in the following sections.

Progress evolution. Of the 95% of participants who discussed progress, all (n=19) recognized progress they had made, and the majority found it difficult to quantify

their progress. A theme of Evolution emerged from participant descriptions. Here is how an education leader summarized perspective on the progress made by his team:

The work is successful. It is constantly growing and the reach to our regional partners is expanding. We are accomplishing new and greater things all the time. It is energizing to have a group that includes a wide variety of perspectives and concerns. That's all part of our ongoing and evolving participation.

In his response, a WPV team member summarized his team's progress as "a constant evolution that requires constant evaluation."

How to measure the progress is a tough question. Describing the progress that we've made is hard to measure because over the eight years we've been doing this we've seen patients become increasingly more and more violent. You never achieve utopia. It takes a long time to move a system—it is a constant evolution that requires constant evaluation because the landscape is always changing.

A nursing leader had this to say about her WPV prevention program's progress:

It is really been an evolution. My original goal was to reduce workplace injuries to zero. It was that simple. I was mobilized by the fact that my nurses were being assaulted and that I was accountable to do something about it. We aren't at zero yet, so we haven't achieved it, but we have reduced injuries. We have made progress.

Despite their struggle to quantify progress, participants were able to describe the characteristics of positive progress evolution and outcomes over time. These characteristics, in participants' own words, are as follows:

- People not being cursed out and assaulted as much (95%)
- Greater staff awareness about WPV (95%)
- Improving our relationship with; collaborating more with security (95%)
- Everyone on our team is now trained in WPV de-escalation (95%)
- We now have a multidisciplinary WPV prevention team (85%)
- WPV reporting has increased (85%)
- More comfort in speaking up and denouncing disruptive behavior (85%)
- We now use patient-specific WPV alerts in our EMR (75%)

- We now have BERT teams and/or behavioral health partners (75%)

Progress dynamics. When asked to discuss positive progress and outcomes in support of central research question number two, participants described dynamics that impacted their progress. These dynamics are categorized into three themes: changing environment (n=15), hospital culture (n=14), and growth and capacity (n=10).

Changing environmental dynamics. When asked to discuss positive progress and outcomes, (n=15) 65% of participants said that working in an environment of constant change (a) made it difficult to ascertain progress with WPV initiatives; (b) influenced their ability to choose how to best prioritize their WPV prevention efforts and resources, and (c) helped them realize that preventing and mitigating WPV will be an ongoing effort. A WPV team lead / nursing leader participant described it like this:

We are always looking at our program and how to make it better, but I don't think we would ever reach a place of saying 'we have no workplace violence at all.' I don't think we'll ever get to that point because we will always be mitigating challenges to continue to try to improve since the world around us will always be changing.

Fifteen participants (65%) discussed drug addiction and the opioid crisis as a dynamic in their work environment. One participant said:

The opioid crisis has significantly changed the dynamics in patient behavior and patient care. There are so many opioid patients that come into our ED, and end up on our units, and different skill sets are needed. We also end up dealing with that patient a lot longer than in the past. Constant vigilance is necessary to ensure safety for everyone.

An ED nursing leader gave this example:

We now have a lot more issues with opioid overdoses. Friends bring them in, and drop the person off in front of the hospital. We find loaded weapons in the car, needles all over the place. Our safety teams partnered with security to develop education on that and now there's a security team that goes out to make sure it is safe for us to go out to the OD victim in the car. That represents progress for the better, and a change for the worse.

Sixteen participants (75%) cited the perceived increase of patients with behavioral health issues, many of whom are under-resourced. An ED nursing leader expressed this perspective:

In our community, patients are often walking around crazy with no place to go. They say they are suicidal, so we keep them, and as the drugs wear off they become violent and don't want to stay, but we can't let them leave because psych needs to clear them, and we don't have enough psych docs to cover. Or—sometimes patients are cleared to leave the ER but don't want to, because it is cold outside, and there's nowhere to go. Toggling between not enough and too much is a tough dynamic to deal with.

This WPV team leader noted that the dynamics of increased community violence often seem to outpace progress:

Progress? That's such a hard one to answer because I feel like we've done a ton of work and I do feel it is been beneficial. So much is better. The hard part is we've done this over eight years and in that eight years we have seen patients become increasingly more violent due to drugs, mental health, dementia. This change in our patient community and ongoing influx of violence often leaves us feeling like we are lagging behind.

Hospital culture dynamics. When asked to discuss positive progress and outcomes, 14 participants (60%) characterized the positive impact of Culture Dynamics on positive progress and outcomes as (a) no longer accepting violence as part of the job, (b) asking for what's needed to feel safe, (c) speaking out and stepping forward to call out lateral violence, and (d) executive leaders enforcing codes of conduct. Findings were as follows:

Our first work was to convince nurses that they don't have to get hit to do their job: We spent a ton of time just changing that part of culture and I feel like we've done great work with that. Our staff now know that you can walk out of the room, you can leave, you do not have to sit in that room and take that kind of behavior, and that's been huge.

We are not just brushing violence under the rug anymore as part of the job: There's a real difference in the workplace culture as a result of our efforts. People are speaking out and stepping forward in lateral violence, and patient and visitor violence—a definite culture shift in all facets. From the ENA, to The Joint

Commission, to OSHA—all of those cumulative efforts have put it in the front of people's minds.

You have to feel safe to do your job: Now, there is more of a culture of team and teamwork—of feeling cared for. Staff believes that leaders truly care about their safety in the work environment. When I hear from people that they feel there is an improved sense of their safety, that's when I start to feel that we are starting to have that culture change that we are looking for.

Our relationship with security is a culture change that has shown so much progress: When we do risk assessment reviews and ask staff about security, it is so fun to hear them say, 'Oh no, security's around all the time, every time I call, they're there.' You can hear in their voice and you can see on their face how much they appreciate knowing that security is a partner with them—especially after so much work.

In terms of civility and respect in our ED, it is now very positive, and collegial: I've been a nurse for 30 years, so I remember when doctors misbehaved and threw charts. That kind of behavior doesn't happen in our facility anymore. Our medical director has a zero policy for physician disruptive behavior. We recently had a physician who was out of control. Our medical director took him out of the situation. Our VP of nursing came down to talk to the nurse. That's positive progress.

Growth and capacity dynamics. When asked to discuss positive progress and outcomes, 50% of participants mentioned Growth & Capacity Dynamics, such as changes in organizational structure, growth, or changes in available time, attention, leadership, staffing resources and budget. An education leader described it this way:

We got 99.9% of our people trained. Great progress was made. But one of the biggest dynamics in complying with the workplace violence training legislation was that it had to be instructor-led training, on paid time. Getting that many people off and available to train, plus the sheer capacity mass of instructors, classrooms, and instructor-to-student ratios was daunting.

Another capacity dynamic discussed by a majority of participants was Time. Great progress takes time, as these three WPV team leads can attest:

We've made great progress, but review and approval takes time. Approval of each step can take a month. Our BERT took a **full year** to get done. The Universal Treatment Plan took over a year.

The main dynamic that I see in terms of progress is time. Time to get it all done in the day. WAIT time to get something built and operational—it can take months to

get something running and built into the system—APPROVAL time and process to get multiple committees to approve, plus getting information distributed and people trained.

We are totally committed to being there for our staff when they experience violence. Yet there's lag time involved in learning about an incident, we can't anticipate when violence will happen, and being supportive takes time.

Another nursing leader discussed the dynamic tension between Growth and Capacity in his ED:

Making progress and growing requires clear goals and time. It takes time to cement new things and integrate them into the culture. Then once you finish something you are off to something else. It is hard to get the behaviors we want and to make sure that the programs are sustained across time because change happens and you lose attention. Continuity over time is difficult. We have a lot of operational changes, and we all wear a lot of hats.

Progress scenarios and outcomes. In support of Central Research Question 2, participants were asked to discuss positive progress and outcomes. Nineteen participants (95%) reported they had access to data regarding progress, and eight participants (40%) were prepared to share more detailed data applied within the context of specific progress scenarios and outcomes. Table 8 presents five progress scenario examples from five different hospitals based on actual documented changes shared by the eight participants who represented them.

Table 8

Six Progress Scenario Examples Reported by Participants

Scenario	WPV Training and Reporting	Workplace Safety Progress	Summary
1: Year-Over-Year WPV Program Overall Progress	<ul style="list-style-type: none"> • Nine different components of workplace safety are reported every month—from assaults to de-escalated scenarios, to how many weapons were recovered, and where; the total of incident reports completed, etc. • Data is tracked as close as possible to real-time reporting. • The WPV prevention team meets monthly, and, among other things, reviews the most recent data, plus last month's data. • These data guide feedback and recommendations. • Goals are iteratively adjusted as a result. 	<p>Year-over-Year Progress, across a four-year time span:</p> <ul style="list-style-type: none"> • Total Injuries related to WPV were reduced by more than half. • Total Workers Compensation payments were reduced by more than half. 	<p>Year-over-Year, for the past 4 years, total injuries and total workers compensation payments have both been reduced by more than half. Violence increased slightly this year for the first time in four years. Staff were gathered to find out what they think is happening/what needs to change.</p> <p>Next Steps:</p> <ul style="list-style-type: none"> • Safety Groups were established in two emergency departments. • The Safety Group and key executives meet every two weeks to fast-track a plan around identifying and fixing emergent issues like an increase in violence. • The staff are owning the initiative this time, rather than administration.
2: De-Escalation / WPV Prevention Success	<ul style="list-style-type: none"> • Reports of violence are divided into five categories, with Level One being the least severe, to Level Five, which is most severe--indicates an assault with an outcome of missed work and required medical attention. 	<ul style="list-style-type: none"> • Even though the number of reported violent incidents have doubled, the number of Level Five incidents have remained the same. 	<ul style="list-style-type: none"> • Progress is successfully being made with both mitigation and prevention through a reduction of the overall lethality of reported violent events.
3: Reduction in the number of BERT Calls	<p>Hospital 1:</p> <ul style="list-style-type: none"> • Year 1: had about 1.2 BERTs per day. • Since individual treatment planning for violent patients started six months ago, experienced under one BERT call per day. 	<ul style="list-style-type: none"> • The number of repeat BERTs are decreased; also, staff are being educated on other resources and techniques that they can use with difficult patients. 	<p>The number of BERTs have been reduced significantly ahead of any curve we had envisioned. Still early to generalize results.</p>

Scenario	WPV Training and Reporting	Workplace Safety Progress	Summary
	<p>Hospital 2:</p> <ul style="list-style-type: none"> BERT calls total is the same, or reduced. Staff rate BERT calls as effective, 80% of the time. BERT calls rated at mid-level severity have dropped Use of violent restraints reduced from 20x per month to 4x per month 	<ul style="list-style-type: none"> Dramatic reduction in the use of violent restraints at Hospital 2. 	<p>The lethality of WPV patient-to-worker assaults appear to be de-escalated or lessened, based on the reduction in BERT calls at mid-level security, and the reduction in the use of violent restraints.</p>
4: WPV Training Compliance	<ul style="list-style-type: none"> Pulled and prioritized actuarial data for WPV reported in facilities and matched against ENA study—found a lot of alignment. Based on this data, a WPV plan and regulations were developed, with a heavy emphasis on de-escalation, plus active defense training for those who need it; created a three-tiered WPV training curriculum in compliance with new state laws. Training included all hospital employees from multiple states, even though not required by law to train in all states. Tier 1 Training: Awareness for all; Tier 2: De-escalation and self-defense for frontline caregivers; Tier 3: Defensive control tactics for employees at highest risk: ED, Behavioral Health, Security 	<ul style="list-style-type: none"> Success in compliance is due to high accountability. Training all employees with the same curriculum has created a common language and a level of awareness that is beginning to shift culture toward vigilance, and that it is okay to speak up. Several violent events occurred post-training and those involved indicated that they felt more prepared and less intimidated to respond to the WPV. Employees also indicated that the learnings are useful to prevent violence in life outside of work, as well. Trained master trainers who trained frontline instructors who trained 99.9% of tens of thousands of employees across multiple states in compliance with deadline. 	<ul style="list-style-type: none"> More time is needed to develop empirical data, but the infrastructure to measure it is in place. Early results are promising. Pulling together the right subject matter experts for comprehensive planning and collaboration and dealing with the logistics of training was daunting, but doable. Policies and training must be developed in conjunction with legal and the union to ensure compliance with the law and union agreements. The goal is to see a dramatic reduction in violent events. Reaching out to the outside local community to share awareness and learning and help to reduce violence outside the hospital as well.
5. WPV Data Dashboard	<p>Created a very robust reporting and analytics dashboard to process internally reported WPV data, and generate actionable reporting.</p>	<ul style="list-style-type: none"> Discussions and decisions of WPV Safety Council and hospital leaders are maximized. Training and curriculum are fresher and more relevant. 	<p>Access to actionable data helped align the perspectives of multidisciplinary leaders and facilitated the reporting of WPV data, and the operationalization of WPV data.</p>

Scenario	WPV Training and Reporting	Workplace Safety Progress	Summary
6. Trauma-Informed Care WPV Training	<p>A Trauma-Informed Care WPV Training Program</p> <ul style="list-style-type: none"> Based on the ACEs study, Trauma-Informed Care is being used in the context of a hospital Trauma unit to help everyone on that unit, from housekeepers to social workers and clinicians—to know more about the effects of early childhood trauma on people. <p>Training Program Components:</p> <ul style="list-style-type: none"> <i>Trauma-Informed Care Training</i> designed to create awareness for nurses around the impact of trauma on themselves and their patients; <i>Creating a Personal Safety Plan</i> of what to do, who to talk to when feeling anxious, overwhelmed, or dealing with a critical issue; and, <i>Keeping a Resiliency Journal</i>—a scrub-pocket-sized booklet where a nurse can privately self-score their internal stress as they transition between work, home, and other environments. The goal: (a) to acknowledge and experience feelings, not ignore them; (b) take responsibility for actions; and (c) plan how to shift mindsets, and transition between environments. <i>Peer Support Groups</i>—weekly groups that meet to talk and reflect. 	<p>Context:</p> <ul style="list-style-type: none"> The community surrounding this hospital is “off the charts” for the number of people who have experienced or are currently experiencing childhood trauma. <p>Purpose: To increase workplace safety by helping staff view the experience of patient agitation from the perspective of someone who has been through trauma, and adjust their perspective, and their response accordingly.</p> <p>Progress and Next Steps:</p> <ul style="list-style-type: none"> Trauma Staff report changing their approach to working with Trauma patients. Trauma Staff report engaging in self-care, and reflection to be more self-aware. Preliminary results: A significant increase in patient satisfaction scores; very positive feedback from staff on Trauma Unit about the impact of the program. 	<p>What’s New:</p> <ul style="list-style-type: none"> A new pilot program of WPV Training focused on in-depth, purposeful self-care effort focused on personal resiliency is being pilot-tested specifically with Trauma Nurses in the context of WPV. Promising preliminary progress has been noted. <p>Next Steps:</p> <ul style="list-style-type: none"> Measure results over a longer period of time and test for generalizability. Roll out to other areas of the hospital, such as the ED, as appropriate.

BERTs = Behavioral Emergency Response Teams WPV = workplace violence, ED = emergency department, ENA = Emergency Nurses Association

Research Question 3: Learnings and Future Aspirations

To explore Central Question 3, hospital leader participants were asked to identify what learned in the process of WPV prevention and mitigation efforts. Findings are described in the following sections.

Learnings. Eighteen participants responded, leading to three learning themes: Scope of WPV (n=7), shared awareness (n=6), and listening (n=7). These themes are described in the following sections.

Scope of workplace violence. Seven participants (35%) discussed what they learned about the sheer enormity of the scope and complexity of WPV, including some who characterized how they adapted their response to WPV as a result. A WPV team lead and nursing leader made these two comments:

I think we've learned how big this problem is. That you cannot use just one avenue to combat it, that you really have to approach it from all different angles. We worked on the EMR, we worked on the magnet on the door, we worked on the culture changes we needed to make. I mean it is like a, you know, seven-headed monster and you have to constantly be working on all of them to make a difference.

I am personally learning that there is more and more that we don't know. Violence in society is getting worse and worse. This project will not have an end and will have to continue to evolve to keep people safe. It is unfortunate that we in healthcare are here to make people feel better, and yet we are vulnerable to violence. We just keep working on it.

In response to her team's growing awareness of the broad scope of WPV in a hospital setting, a senior nursing leader had this to say about what she, and her team learned:

You really have to take a broad-based approach and look at everything, and not underestimate the scope and complexity of this problem. And culture. Culture has to change. Without culture change any success would be fleeting.

A technology leader participant said this:

We've learned that this work is a marathon, not a sprint. The moment I see people stop and say we did it all I will stop and worry that we have missed something and wonder what we still have to come up with. Threats will never stop. We must stay vigilant.

Shared awareness. When asked what they learned in the process of their WPV prevention and mitigation efforts, six participants (30%) discussed what they learned about developing a shared awareness of WPV with others, and what has changed, or what might need to change, as a result. A safety leader said:

I am learning that violence is a broad conversation that extends into real life and that you have to keep talking about it. The more you talk about it, the more aware people become. If you don't talk about what you are going to do when violence occurs, you won't be prepared to respond.

A senior ED nursing leader had this to say about socializing WPV initiatives:

I'm learning just how important it is to socialize this, so people can own it. Socializing workplace violence for me means that we talk about it in public forums over many months. We ask for suggestions, we make revisions, and then when it finally gets pushed out it goes out to a huge audience, we take action together. When policies were just on paper it didn't happen like that. Now it is centralized and much more verbalized.

Perspectives on the challenges and opportunities of shared awareness came through in these two comments by a senior nursing leader and behavioral health leader:

We've found that the most difficult thing about this process in a big, siloed hospital system is knowing what's going on. We wouldn't know a darn thing about what's happening if we didn't ask. Security can push out as much training as they like, but if we are going to act on it we have to know about it.

As a society, we are facing more violence and that gives leadership an opportunity of awareness that behavioral events are not necessarily a failure on the staff's response. The criticism used to be, 'Staff is not nice enough' when we've learned that the reality is, that guy is delirious—being nice is not going to help.

A WPV team lead had this to say about shared awareness with the public:

I've learned that a lot of people are **not** aware of the frequency with which violence happens in hospitals in our country. I feel that we need to raise that awareness. It is not "if" violence is going to happen, it is "when." People are stressed and angry and there's no one size fits all response to fix everything.

Listening. Seven hospital leader participants (35%) responded to the question of what they learned in the process of WPV prevention efforts by discussing the importance of listening to staff. Two senior ED nursing leaders had this to say:

We've found that the concept of listening and supporting your staff is ubiquitous—whether you work in a 10-Bed ER or in a big place like us. If you don't listen to your staff, you will continue to have poor outcomes.

After listening to my team, I'm now more aware than ever that staff DO care about patients who act out in violence. They want to provide care to the patient regardless, and to have a good outcome. *And* staff also want and need to be safe and to feel safe at work and to work in a safe environment.

A WPV team lead described the impact on her learning of a violent event at her hospital:

We had a shooting incident in our hospital—about 5 years after we had started our work. And it really changed how I thought about this process. We came in the night after the shooting, myself and our educator, and just listened to staff. And I realized that they need that. They need us to hear their stories. We all need it. We need to hear from the people at the front line who are doing this work day in and day out.

Additional findings. Five additional learnings, cited by one participant each, were identified in the data. The learning and corresponding participant comment for each are:

- Whatever your process or plan is, stay true to it! Be resolved: We had peaks and valleys as far as progress, and learned to be honest through the process. We created a process and we saw it through, no matter how painful the changes.
- The answer is not just, 'We need more Security: Nursing and Security have to own the problems and the solutions as equal partners—versus Security executing on Nursing's agenda—that made it work quickly for us.
- Making sure that people feel safe at work is everything: They've got to feel safe, and confident. You think you know that, then you see violence in action in real-time, and see that people naturally feel afraid, and alone, and tentative.
- Speed up progress by getting quick wins through Pilot test groups: When we have an idea that we think might be effective, but not the budget to do it on a large scale, we try first for success at the pilot group level, then build something bigger.

- CEO engagement is crucial at every level of the organization: We relayed what we learned to our CEO, and she personally brought it up to the hospital at large, what she learned, what she was going to do about it. She was fully engaged.

Future aspirations. Participants were asked what they aspire to achieve in the future in terms of WPV prevention and mitigation. For purposes of this study, Aspire is defined as, “To seek to attain or accomplish a particular goal” (“Aspire,” 2018, para. 1). Eighteen participants responded to this question, yielding three themes: zero injuries (n=6), continuous improvement (n=8), and align collective priorities (n=4). These are described in the following sections.

Zero injuries. Six participants (30%) discussed achieving a significantly reduced injury rate as a result of WPV, and a corresponding shift in the overall work environment. Two WPV team leads contributed these two responses:

Well the ‘achieve’ for me is that violence is just not happening at work. That there’s a level of respect for hospital staff where you don’t have to be assaulted or come to work worrying that you are going to be shot, beaten or cursed at—because that’s not a nice work environment.

Zero injuries would be ideal, though not likely. I would aspire to see instead, zero “Level 5” violent events that result in missed work. And, that everyone would feel safe, and be more aware and vigilant in the moment.

Continuous improvement. Of the 20 participants who were asked this question, eight participants (40%) discussed a variety of aspirations related to a theme of Continuous Improvement. One behavioral nursing leader had this to say:

I want to do better at quantifying the results of de-escalation, such as a decline in the severity of events, fewer events, etc. In the future, I’d like to better understand whether or not the severity of events is decreasing.

This WPV team lead aspires to achieve a sense of safety for all employees:

The ultimate would be to keep improving so that we can achieve a general consensus by all of our employees that they feel safe. On our surveys, that would

look like a 4 or a 5, with 5 being highest on a scale of 1 to 5. That's the ultimate goal.

One senior nursing leader aspires to consistency and awareness for her team:

What I would like to so see is that we would really have a consistent approach and not do 'one-off things.' That our security would communicate more, and that the policy-makers would talk more with those of us in the field, so we could each be more aware of what's happening for the other.

Align collective priorities. Four participants (25%) mentioned aspiring to rally a collective alignment around the prioritization of workplace safety. An ED senior physician leader and a CNO contributed these two comments:

I want to get our entire Senior Leadership Team on the same page, survey our staff about their safety, observe the current safety climate at work and see what other measures we can do to keep improving everyone's safety.

I would like to see workplace safety on the top of the agenda of every Chief Nursing Officer in the country. Every situation is different, but anytime we speak about this, those in the audience are very upset and angry, and bring up how this is a huge issue that is not being addressed in their facility. My answer is always the same: "Maybe that's true. But make it *yours*. Make it your agenda item and talk about it constantly. You can drive it."

Additional aspirations that emerged in the interviews and support the themes above are reflected in the following participant comments:

- Mitigate verbal abuse by patients more effectively by learning how to more clearly define what constitutes a verbal assault—especially since staff have different tolerances for verbal abuse.
- Use more stories in WPV education. People learn through stories, if they hear stories of incidents handled well, that might cue their life experiences for them.
- Reduce the lag time between when a violent event occurs, is reported through the system and when a manager knows about it, reaches out and touches base with staff.
- Continuously refine BERT service further. Improve these calls more proactively, to decrease assault rates, restraint rates, and employee burnout.
- Communicate more about WPV work to staff through charge nurse huddles.

- Execute on what has been learned through our systemwide employee survey, with a focus on lateral violence and a stronger leadership response.
- Decrease violence by better managing delirium patients long-term and increasing everybody's ability to prevent delirium and recognize who's at risk.
- That staff continue to feel that they can come to work and be supported in their role, despite the prospect of violence—and that we will address their concerns.
- Reduce crowding and violence in EDs by creating a Mental Health Urgent Care center and/or create an ED Care Coordinator role, or a Crisis Follow-up telehealth program to help assess patients more quickly, and help connect mental health patients to more appropriate resources.

Chapter Summary

This chapter reported the findings that emerged from the study and described the data collection results and data analysis. The first section presented demographic data gathered using a 10-question, online, anonymous survey. The second section presented qualitative findings gathered during 60-minute phone interviews with study participants.

Analysis of the qualitative study data corresponded to the three central questions of this study, which are:

1. What strategies, policies, and actions are hospital leaders using to effectively prevent and mitigate WPV against nurses in the ED?
2. What positive progress or outcomes have been realized in WPV prevention and mitigation in the ED thus far?
3. What have these leaders learned in the process and hope to achieve in the future?

The next chapter provides a discussion, including an interpretation of findings, implications, recommendations, limitations, and conclusions of the study results.

Chapter 5

Discussion

The purpose of this study was to explore and understand the successful prevention and mitigation of WPV against nurses in the ED, and to learn what hospital leaders are doing to accelerate progress. Specifically:

1. What strategies, policies and actions are hospital leaders using to prevent and mitigate WPV against nurses in the ED?
2. What positive progress or outcomes have been realized in WPV prevention and mitigation in the ED thus far?
3. What have hospital leaders learned in the process, and what do they aspire to achieve in the future?

This chapter presents a discussion of the study results in the context of the larger body of research highlighted in Chapter 2. Interpretation of the findings, implications, recommendations, limitations, and suggestions for future research are also explored.

Interpretation of the Findings

Success Factors of Hospital Leaders Reporting Positive Progress

In support of the research purpose, findings in the previous chapter were first analyzed to explore the success factors of hospital leader participants who reported positive progress. Seventeen hospital leader participants (85%) were part of the seven hospital teams (70%) who reported experiencing positive progress in WPV prevention and mitigation. Specifically:

1. Each participated on teams that utilized all three of the strategies identified in this study (i.e., collaborative multidisciplinary partnerships, fully engaged executive leaders, operationalized data).
2. Fifteen leaders participated in a collaborative multidisciplinary partnership of some kind, either as part of their hospital's WPV prevention team, and/or as part of a BERT at their hospital.

3. Each indicated that fully engaged executives and collaborative multidisciplinary partnerships helped foster a hospital culture of respect and professionalism that they characterized as foundational to the progress of their WPV initiatives.
4. Each acknowledged that his or her overall positive progress was influenced by their awareness of WPV research highlighted in the literature, and their alignment with exemplary WPV practices and initiatives recommended by WPV mitigation experts. One of the most frequently mentioned WPV mitigation standards was that of the AONE Guiding Principles of WPV Mitigation in Appendix A (AONE & ENA, 2015).

Exploring How and Why Positive Progress Accelerated

Next, the findings were analyzed to better understand how and why the above-mentioned success factors resulted in progress and positive outcomes, with attention given to potential accelerants of progress.

Despite the limited scope of this study, it is interesting to note three key findings that support how and why positive progress in WPV prevention and mitigation may have accelerated for these particular participants. According to this study's findings:

1. Hospital leaders experienced positive progress in WPV prevention and mitigation when their hospitals provided a WPV program utilizing these exemplary strategies of collaborative multidisciplinary partnerships, fully engaged executives, and operationalized data.
2. In keeping with the literature, as multidisciplinary partners and fully engaged executives collaborated, and supported their teams in the process of establishing these WPV initiatives, a culture of respect was catalyzed and initiatives gained momentum.
3. Operationalized data appears to have functioned as a key accelerant of positive progress in WPV prevention and mitigation for these hospital leaders.

Key Findings

Employing Strategies to Prevent and Mitigate Workplace Violence

The first key finding is that hospital leaders experienced positive progress in WPV prevention and mitigation when their hospitals provided a WPV program utilizing

three exemplary strategies: collaborative multidisciplinary partnerships, fully engaged executives, and operationalized data.

Collaborative multidisciplinary partnerships and fully engaged executives.

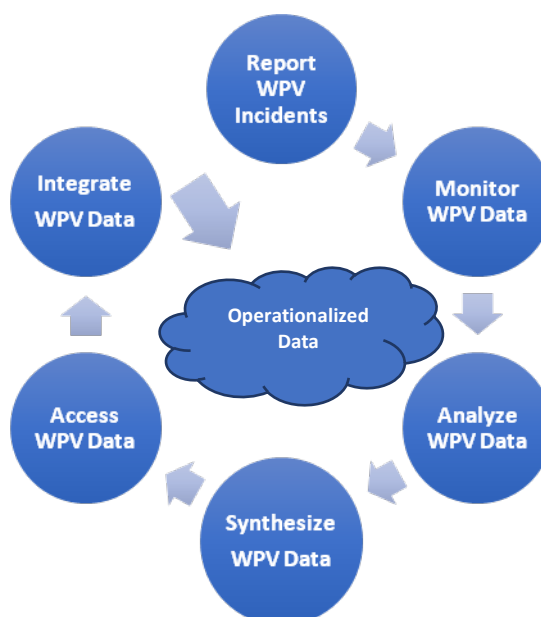
The importance of fully engaged executive leaders being supportive of WPV initiatives is found throughout the WPV literature (Chassin & Loeb, 2013; Leape et al., 2013; Papa & Venella, 2013) and was mentioned by all 20 participants. Collaboration among multidisciplinary leaders is also recommended as a WPV strategy and exemplary practice (AONE & ENA, 2015; The Joint Commission, 2017). The functions of fully engaged executives and collaborative, multidisciplinary partnerships are reviewed in Figure 6.

Fully Engaged Executives	Collaborative, Multidisciplinary Partnerships
<ul style="list-style-type: none"> ➤ “Executive level” usually refers to C-Level executives and Board Members, depending on the size of the hospital. ➤ Champion WPV initiatives, often participate on a WPV prevention team. ➤ Model, enact and enforce WPV policies, especially those related to civility, respect, and professionalism. ➤ Invite input from and include frontline staff and other relevant subject matter experts on WPV prevention-related issues. ➤ Create awareness and a sense of urgency about the problem of disrespectful and abusive behavior. ➤ Catalyze positive progress in WPV prevention and mitigation through aligned strategy and decision-making processes. 	<ul style="list-style-type: none"> ➤ Multidisciplinary Workplace Violence Prevention Teams: Central “hubs” that collectively coordinate, administer and manage the WPV prevention and mitigation initiatives across a hospital or hospital system, to include creating and enacting Strategies, Policies and Actions. ➤ Interventional Multidisciplinary Partnerships between clinicians, security, behavioral health, and, law enforcement (such as BERTs), focused primarily on WPV Interventions localized to the direct patient care level in the ED, or on inpatient units. ➤ Mid-Level to Senior Level Leaders involved in these Partnerships create and implement WPV initiatives, AND model the fully engaged leader behaviors that are described to the left.

Figure 6

Leaders in Collaboration: Fully Engaged Executives and Multidisciplinary Partnerships

Operationalized data. Operationalized data was characterized in Chapter 4 as centralized, actionable WPV data that hospital leaders systematically put to use to prevent and mitigate WPV, operationalized data represents the third strategy used by these hospital leaders, and a key emergent finding that was not noted in the literature review, even though it has just recently been advised by The Joint Commission (The Joint Commission, 2018). According to this study’s participants, their exemplary process of operationalizing data picks up where the reporting of WPV data leaves off (see Figure 7).



WPV = workplace violence

Figure 7

Operationalizing Data Process in Workplace Violence Prevention and Mitigation

Participants indicated that once WPV reporting became the norm in their hospital culture, the ability to operationalize reported WPV data was essential to the start-up, momentum and positive progress of WPV mitigation in their hospital. Operationalized

data in the WPV context helps create awareness, highlight opportunities, guide planning, map accountability, improve engagement, accelerate decisions, and activate learnings and aspirations.

Catalyzing a Culture of Respect

In the context of this study and its findings, a culture of respect is based on the explicit behaviors associated with the protection of the physical, psychological, and emotional safety of the workforce. All 20 participants mentioned the importance of respect and professionalism being modeled, codified and enforced by senior leaders at every level. The second key finding is that a culture of respect was catalyzed and WPV initiatives gained momentum as multidisciplinary partners and fully engaged executives collaborated and supported their teams in establishing WPV programs.

Fourteen participants (60%) specifically discussed that as a culture of respect in their hospital culture evolved and matured, the strategies, policies and actions being initiated by their multidisciplinary partnerships and fully engaged executives gained greater traction and support. For example, as the culture shifted, and WPV reporting became more of a norm, hospital leaders utilized operationalized data to gain momentum, and further accelerate positive progress and outcomes. These exemplary practices align with the literature on hospital safety culture, a culture of respect, and the AONE Guidelines (AONE & ENA, 2015; Chassin & Loeb, 2013; Leape et al., 2013). This study extends and builds upon these findings by illustrating the positive progress that participants gained when combining the two strategies in such multifaceted ways.

Gaining Acceleration through Operationalized Data

According to The Joint Commission's (2018) recommendations and this study's findings, operationalized data is a differentiator that sets the efforts of these participants

apart as exemplary. According to participants, operationalized data functioned as an accelerator of positive WPV progress that allowed them to better facilitate a customized, evidence-based approach to preventing and mitigating WPV. This finding extends the minimal amount of information found in the literature regarding operationalized data in a WPV context by illustrating multiple examples of positive progress resulting from the successful use of operationalized data to prevent and mitigate WPV. Figure 8 illustrates the combination of these three strategies as reported by this study's participants.

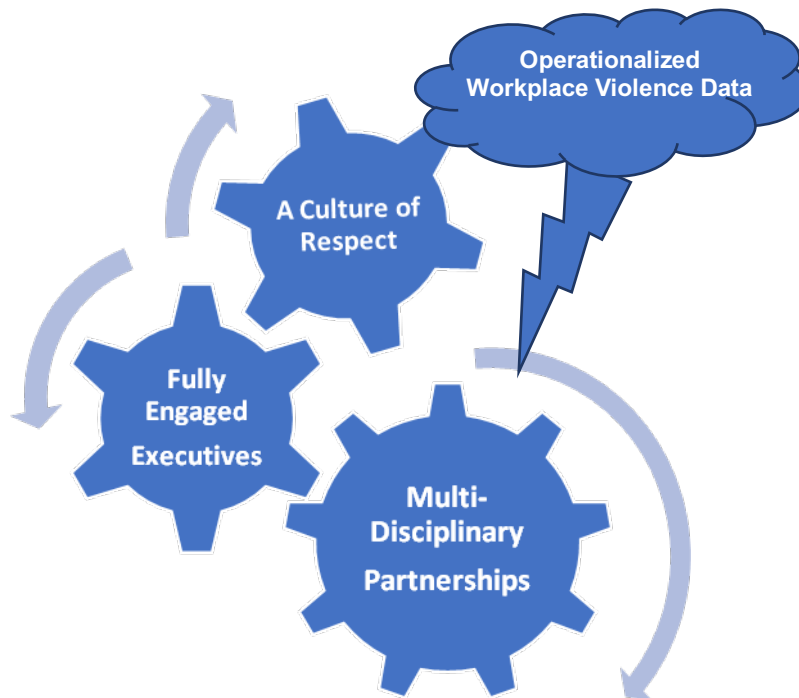


Figure 8

Key Study Findings

Implications

The findings of this research contributed deeper understanding about the collaboration of multidisciplinary hospital leaders to accelerate positive progress in the prevention and mitigation of WPV against nurses.

WPV is a systemic problem necessitating a systems approach across multiple disciplines. In the literature review conducted for this study, there were no research studies identified that focused on what hospital leaders are doing to mitigate WPV using a multidisciplinary approach successfully. There was also minimal mention in the literature of the operationalization of data in the context of WPV prevention and mitigation.

By bringing together the literature and the in-depth qualitative interview data from a sample of 20 multidisciplinary U.S. hospital leaders from 10 hospitals actively focused on WPV prevention and mitigation, this study was able to:

1. Identify findings that highlight the real-life strategies, policies, and actions of multidisciplinary hospital leaders as they collaboratively make progress in the prevention and mitigation of WPV in the ED;
2. Explore the operationalization of WPV-related data in the context of WPV prevention and mitigation; and,
3. Propose operationalized WPV data as an accelerant in the progress of successful WPV mitigation efforts.

The findings of this research have possible implications for consideration by hospital leaders focused on successfully preventing and mitigating WPV and organization development practitioners supporting or advising hospital leaders and their teams focused on successfully preventing and mitigate WPV. These implications are expressed below in the form of both challenges and opportunities.

In terms of challenges, WPV is a complex, far-reaching phenomenon that is multi-faceted, and ever-evolving within a dynamic environment of change that could potentially outpace the progress of a single hospital leader or hospital system trying to go it alone. Successful mitigation of WPV requires a sustainable approach driven by ongoing leadership, and guided by operationalized data. That said, operationalized data is a challenge to set up and establish for hospitals with limited resources or siloed data systems. Another challenge is that a culture of respect is a precondition to sustain success, and yet leaders are aware that a hospital culture can take a long time to shift, especially within a large, complex system like a hospital.

In terms of opportunities, when participants were asked about positive progress, they indicated that the landscape of WPV prevention and mitigation appears to be changing for the better, and hospital leaders who are committed to tackling the prevention and mitigation of WPV are poised to benefit from the learning of those who have gone before them. The findings of this study demonstrate that operationalized data can help accelerate positive progress for WPV prevention and mitigation, and that those hospital leaders who are further along in their experience are willing, prepared, and even eager to share their hard-won wisdom.

Recommendations

Five recommendations are offered based on the literature and in keeping with the findings of this study:

1. Hold a hard line on respect and professionalism. Participants repeatedly pointed out that no matter what size a hospital is, and what constraints a hospital has on resources, every leader can begin with modeling, codifying and enforcing professionalism and respect. 100% of participants discussed the importance of respect and professionalism as a baseline to WPV prevention. According to 17 participants (85%), their hospitals have established a

Professional Code of Conduct for all employees, with an emphasis on civility and respect.

2. Establish a clear, central systemwide policy on WPV. 100% of participants mentioned a systemwide central WPV policy and described it as an essential foundation for defining, reporting and monitoring WPV data. Based on this study's findings, it is recommended that hospitals looking for an initial starting point for WPV prevention and mitigation efforts begin by aligning with the AONE/ENA guidelines (Appendix A). Encouraging WPV reporting by taking into consideration the success factors of WPV reporting on page 59 of this study may also be helpful.
3. Collaborate through multidisciplinary partnerships. Ongoing multidisciplinary collaboration was perceived by all 20 participants as foundational to preventing and mitigating WPV. The systemic nature of WPV, and the need to track and respond to patients at a high risk for violence as they move through a hospital system were just a few of the reasons given to recommend a multidisciplinary partnership approach. Utilizing a WPV prevention team as a hub of WPV prevention and mitigation; and cultivating key interventional partnerships between clinicians, security and behavioral health (such as BERTs) are primary examples.
4. Include frontline hospital staff in all aspects of WPV research, policymaking and decision. The 10 hospital leaders in this study who have been a part of WPV prevention and mitigation efforts for 7 years or more *repeatedly* emphasized the importance and benefits of including frontline hospital staff in the process of initial WPV research, policymaking, decision-making and more, depending on the hospital. The advantages are many, resulting in accelerated positive progress and outcomes.
5. Operationalize the Data. Make WPV reporting a norm, and put data to use to inform and accelerate positive progress—for all the reasons stated in this study, and as recently recommended by The Joint Commission (2018).

Limitations

Given the limited focus and scope of this study, the findings cannot be generalized to other hospitals and hospital systems, and the small set of participants may not be representative of the entire population of multidisciplinary hospital leaders successfully preventing and mitigating WPV. Even so, this researcher believes that this multidisciplinary qualitative study has contributed toward understanding how to

accelerate positive progress in WPV prevention and mitigation, and that hospital leaders may gain helpful insight and encouragement in the process of reviewing these findings.

Areas for Future Research

Three suggestions for future research are offered based on this study and the review of the literature:

1. Operationalized data as an accelerant of progress for WPV prevention and mitigation initiatives.
2. How multidisciplinary teams might incorporate and consider the perspectives and experiences of patients and families who have witnessed or been perpetrators of patient-on-worker WPV; especially with a goal of reducing patient/family agitation and preventing verbal violence.
3. The impact of Trauma-Informed Care on WPV prevention and caregiver resiliency.

Conclusions

This study concludes with three conclusions and five suggestions.

1. The top three strategies used by these hospital leaders helped advance positive progress in the development and enactment of policies and actions (i.e., initiatives) to prevent and mitigate WPV.
2. As multidisciplinary partners and fully engaged executives collaborated and supported their teams in the process of establishing these WPV initiatives, a culture of respect was catalyzed and initiatives gained momentum.
3. Operationalized data appears to have functioned as a key accelerant of positive progress in WPV prevention and mitigation for these hospital leaders.

This researcher's study and the research in this area would suggest:

1. WPV is a complex, far-reaching phenomenon that is multi-faceted and evolving within a dynamic environment of change that could potentially outpace the progress of a single hospital system trying to go it alone.
2. The landscape of WPV prevention and mitigation is changing, and hospital leaders committed to tackling the prevention and mitigation of WPV can benefit by sharing their experiences, and learning from one another.

3. The multidisciplinary strategic approach outlined in this study demonstrates the power of collaboration and co-creation of hospital leaders energized and informed by actionable, relevant, operationalized data.
4. Like the participants of this study, hospital leaders and organization development practitioners alike can start right where they are by identifying what they do and don't know. They can accelerate progress by (a) spearheading WPV initiatives, (b) working toward operationalizing their data, and (c) collaborating with hospital leaders who are further along in their WPV prevention and mitigation efforts.
5. Multidisciplinary WPV teams might accelerate progress even further by including organization development practitioners in their efforts, whether internal or external, especially in these areas:
 - Strategy and facilitation of the large-scale, complex, ambiguous change process associated with WPV prevention and mitigation.
 - Strategy and facilitation of sustainable mitigation plans for leaders and staff impacted by violent events—addressed in the context of individual, team, environment and systems levels.
 - Support of WPV prevention and mitigation education initiatives, especially in the areas of lateral violence, civility, crucial conversations, culture change; and the behavioral changes associated with new policies.
 - Coaching and supporting multidisciplinary leaders, clinicians and their teams as they navigate the transition into interdisciplinary WPV team efforts and the implement WPV strategies, actions and policies over time.
 - Partnering in future action research efforts to help prevent and mitigate WPV.

References

- American Association of Critical Care Nurses (AACCN) & VitalSmarts. (2005). Silence kills: The seven crucial conversations for healthcare. Retrieved from: www.aacn.org/WD/Practice/Docs/PublicPolicy/SilenceKills.pdf
- American College of Healthcare Executives (ACHE) and NPSF Lucian Leape Institute. (2017). *Leading a culture of safety: A blueprint for success*. Chicago, IL: American College of Healthcare Executives.
- American Nurses Association. (2014). Workplace violence. Retrieved from nursingworld.org/workplaceviolence
- American Nurses Association. (2016). A culture of safety. Retrieved <http://community.ana.org/pages/cultureofsafety?ssopc=1>
- Anderson, L., Fitzgerald, M., & Luck, L. (2010). An integrative literature review of interventions to reduce violence against emergency department nurses. *Journal of Clinical Nursing*, 19(17-18), 20-30.
- Ariza-Montes A. (2013). Workplace bullying among healthcare workers. *International Journal of Environmental Research & Public Health*, 10(3), 121-131.
- Arnetz, J. E., Aranyos, D., Ager, J., & Upfal, M. J. (2011). Development and application of a population-based system for workplace violence surveillance in hospitals. *American Journal of Industrial Medicine*, 54(12), 925-34.
- Arnetz, J. E., Hamblin, L., Essenmacher, L., Upfal, M. J., Ager, J., & Luborsky, M. (2015a). Understanding patient-to-worker violence in hospitals: A qualitative analysis of documented incident reports. *Journal of Advanced Nursing*, 71(2), 338-348.
- Arnetz, J. E., Hamblin, L., Essenmacher, L., Upfal, M. J., Ager, J., & Luborsky, M. (2015b). Using database reports to reduce workplace violence: Perceptions of hospital stakeholders. *Work: A Journal of Prevention, Assessment, & Rehabilitation*, 51(1), 51-59.
- Aspire. (2018). In *Merriam-Webster.com*. Retrieved from <https://www.merriam-webster.com/dictionary/aspire>
- American Organization of Nurse Executives (AONE) and Emergency Nurses Association (ENA). (2015). AONE and ENA develop guiding principles on mitigating violence in the workplace. *Journal of Emergency Nursing*, 41(4), 278-280.

- Blando, J., Ridenour, M., Hartley, D., & Casteel, C. (2015). Barriers to effective implementation of programs for the prevention of workplace violence in hospitals. *OJIN: The Online Journal of Issues in Nursing*, 20(1). Retrieved from <http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-20-2015/No1-Jan-2015/Articles-Previous-Topics/Barriers-to-Programs-for-the-Prevention-of-Workplace-Violence.html>
- Campione, J., & Famolaro, T. (2018). Promising practices for improving hospital patient safety culture. *The Joint Commission Journal on Quality and Patient Safety*, 44(1), 23-32.
- Chassin, M. R., & Loeb, J. M. (2013). High-reliability health care: Getting there from here. *The Milbank Quarterly*, 91(3), 459–490.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.
- Emergency Nurses Association. (2010). More than half of emergency department nurses have been physically assaulted at work, new study finds. Retrieved from <http://www.ena.org/MEDIA/PRESSRELEASES/Pages/WorkPlaceViolence.aspx>
- Findorff, M. J., McGovern, P. M., & Sinclair, S. (2005). Work-related violence policy: A process evaluation. *AAOHN Journal*, 53(8), 360-369.
- Gacki-Smith, J., Juarez, A.M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. (2009). Violence against nurses working in US emergency departments. *Journal of Nursing Administration*, 39(7-8) 340-349.
- Gallant-Roman, M. (2008). Ensuring nurses' safety in violent workplaces. *AAOHN Journal*, 56(2), 51-52.
- Gates, D. M. (2004). The epidemic of violence against healthcare workers. *Occupational Environment Medicine*, 6(8), 49–650.
- Gates, D., Gillespie G., Kowalenko T., Succop P., Sanker M., & Farra S. (2011a). Occupational and demographic factors associated with violence in the emergency department. *Journal of Emergency Nursing*, 33(4), 303-313.
- Gates, D. M., Gillespie, G., & Succop, P. (2011b). Violence against nurses and its impact on stress and productivity, *Nursing Economics*, 29(20), 59-87.
- Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H., Nachreiner, N. M., Geisser, M. S., & Jurek, A. (2005). Risk factors for work-related assaults on nurses. *Epidemiology*, 16(5), 704-709.
- Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H., Nachreiner, N., Geisser, M., ... & Watt, G. (2004). An epidemiological study of the magnitude and consequences of work-related violence: the Minnesota nurses' study. *Occupational & Environmental Medicine*, 61, 495–503.

- Gillespie, G. L., Gates, D. M., Kowalenko, T., Bresler, S., & Succop, P. (2014). Implementation of a comprehensive intervention to reduce physical assaults and threats in the emergency department. *Journal of Emergency Nursing*, 40(6), 586-591.
- Gillespie, G. L., Gates, D. M., Mentzel, T., Al-Natour, A., Kowalenko, T., & Jordan, I. (2013). Evaluation of a comprehensive ED violence prevention program. *Journal of Emergency Nursing*, 39(1), 376-383.
- Gillespie, G. L., Gates, D., & Berry, P. (2013). Stressful incidents of physical violence against emergency nurses. *OJIN: The Online Journal of Issues in Nursing*, 18(1), 2.
- Gillespie, G. L., Pekar, B., Byczkowski, T. L., & Fisher, B. S. (2017). Worker, workplace, and community/environmental risk factors for workplace violence in emergency departments. *Archives of Environmental & Occupational Health*, 72(2), 79-86.
- Haddow, G., Bullock, J., & Coppola, D. (2010). *Introduction to emergency management*. Burlington, MA: Butterworth-Heinemann.
- Ideker, K., Todicheeney-Mannes, D., & Kim, S. C. (2011). A confirmatory study of Violence Risk Assessment Tool (M55) and demographic predictors of patient violence. *Journal of Advanced Nursing*, 67(11), 2455-2462.
- The Joint Commission. (2008, July 9). Sentinel Event Alert, Issue 40: Behaviors that undermine a culture of safety. Retrieved from https://www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety/
- The Joint Commission. (2012). *Improving patient and worker safety: Opportunities for synergy, collaboration and innovation*. Oakbrook Terrace, IL: The Joint Commission.
- The Joint Commission. (2017, March 1). Sentinel Event Alert 57: The essential role of leadership in developing a safety culture. Retrieved from https://www.jointcommission.org/sea_issue_57/
- The Joint Commission. (2018, April 16). Sentinel Event Alert 59: Physical and verbal violence against healthcare workers. Retrieved from https://www.jointcommission.org/sea_issue_59/
- Kowalenko, T., Gates, D., Gillespie, G. L., Succop, P., & Mentzel, T. (2013). Prospective study of violence against ED workers. *American Journal of Emergency Medicine*, 31(1), 197-205.

- Lanza M., Zeiss R., & Rierdan J. (2006). Non-physical violence a factor for physical violence in healthcare settings. *American Association of Occupational Health Nurses Journal*, 54(9), 397-402.
- Leape L. L., Shore M. F., Dienstag J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., & Healy, G. B. (2012). Perspective: A culture of respect, Parts 1 and 2: The nature and causes of disrespectful behavior by physicians. *Academic Medicine*, 87(7), 845-858.
- Lenaghan, P., Cirrincione, N. M., & Henrich, S. (2018). Preventing ED violence through design. *Journal of Emergency Nursing*, 44(1), 7-12.
- The Lucian Leape Institute. (2013). Through the eyes of the workforce: Creating joy, meaning and safer health care. Report of the Roundtable on Joy and Meaning in Work and Workforce Safety. National Safety Foundation.
- Manton, A. (2015). The issue of violence in the emergency setting. *Journal of Emergency Nursing*, 43(6), 495-496.
- Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage.
- McPhaul, K., London, M., & Lipscomb, J. (2013). A framework for translating workplace violence intervention research into evidence-based programs. *OJIN: The Online Journal of Issues in Nursing* 18(1), Manuscript 4. Retrieved from <http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/A-Framework-for-Evidence-Based-Programs.html>
- The National Institute for Occupational Safety and Health. (2002). Violence: occupational hazards in hospitals. Available at <http://www.cdc.gov/niosh/docs/2002-101/>
- Nursing Solutions, Inc. (2016). 2016 National healthcare retention & RN staffing report. Retrieved from <https://www.nsinursingsolutions.com/Fils/assets/library/retention-institute/NationalHealthcareRNRetentionReport2016.pdf>
- Occupational Safety & Health Administration (OSHA). (2015). Preventing workplace violence: A road map for healthcare facilities. Retrieved from <https://www.OSHA.gov/Publications/OSHA3827.pdf>
- Oppel, E., & Mohr, D. (2018). Paying it forward: The link between providers' civility climate, civility toward patients, and patient experience outcomes. *Healthcare Management Review*. doi: 10.1097/HMR.0000000000000209

- Papa, A., & Venella, J. (2013). Workplace violence in healthcare: Strategies for advocacy. *OJIN: The Online Journal of Issues in Nursing* 18(1), Manuscript 5. Retrieved from <http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Workplace-Violence-Strategies-for-Advocacy.html>
- Policy. (2018). In *Merriam-Webster.com*. Retrieved from www.merriam-webster.com/dictionary/policy
- Pompeii, L. A., Schoenfisch, A., Lipscomb, H. J., Dement, J. M., Smith, C. D., & Conway, S. H. (2016). Hospital workers bypass traditional occupational injury reporting systems when reporting patient and visitor perpetrated (type II) violence. *American Journal of Industrial Medicine*, 59(10), 853-865.
- Prevention. (2018). In *Merriam-Webster.com*. Retrieved from www.merriam-webster.com/dictionary/prevention
- Ramacciati N., Ceccagnoli A., Addey, B., & Giusti, G.D. (2014). Comment on: Nurses' perceptions of the factors which cause violence and aggression in the emergency department: A qualitative study. *International Emergency Nursing*, 22(3), 134–139.
- Ramacciati, N., Ceccagnoli, A., Addey, B., Lumini, E., & Rasero, L. (2016). Interventions to reduce the risk of violence toward emergency department staff: Current approaches. *Open Access Emergency Medicine: OAEM*, 8, 17–27.
- Renker, P. Scribner, S. & Huff, P (2015). Staff perspectives of violence in the emergency department: Appeals for consequences, collaboration, consistency. *Work*, 51(1), 5-18. doi: 10.3233/WOR-141893.
- Rowe, M. M., & Sherlock, H. (2005). Stress and verbal abuse in nursing: Do burned out nurses eat their young? *Journal of Nursing Management*, 13(3), 242-248.
- Spector, P. E., Zhou, Z. E., & Che, X. X. (2014). Nurse exposure to physical and nonphysical violence, bullying and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, 51(2), 74-84.
- Speroni, K. G., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. (2014). Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *Journal of Emergency Nursing*, 40(3), 218-228.
- Strategy. 2018. In *Merriam-Webster.com*. Retrieved from <https://www.merriam-webster.com/dictionary/strategy>
- Van Den Bos, J., Creten, N., Davenport, S., & Roberts, M. (2017). Cost of community violence to hospitals and health systems. Milliman Research Report for the American Hospital Association.

- Wolf, L., Perhats, C., Delao, A. M., Clark, P. R., & Moon, M. (2017). On the threshold of safety: A qualitative exploration of nurses' perceptions of factors involved in safe staffing levels in emergency departments. *Journal of Emergency Nursing*, 43(2), 150-157.
- Wyatt, R., Anderson-Dreves, K., & Van Male, L. M. (2016). Workplace violence in healthcare: A critical issue with a promising solution, *Journal of American Medical Association*, 316(10), 1037-1038.

Appendix A: American Organization of Nurse Executives Guiding Principles

Mitigating Violence in the Workplace

AONE GUIDING PRINCIPLES

MITIGATING VIOLENCE IN THE WORKPLACE



Introduction

Workplace violence is an increasingly recognized safety issue in the health care community. Workplace violence is generally defined as any act or threat of physical assault, harassment, intimidation and other coercive behavior. It also includes lateral violence, or bullying, between colleagues (e.g. nurse/nurse, doctor/nurse, etc.). In 2010, the Bureau of Labor Statistics data reported health care and social assistance workers were the victims of approximately 11,370 assaults by persons. While workplace violence against health care professionals can and does happen everywhere, the hospital emergency department is among the most vulnerable settings. According to a 2011 study by the Emergency Nurses Association (ENA), 54.5 percent out of 6,504 emergency nurses experienced physical violence and/or verbal abuse from a patient and/or visitor during the past week. The actual rate of incidences of violence is much higher as many incidents go unreported, due in part to the perception that assaults are "part of the job".

The American Organization of Nurse Executives (AONE) and ENA convened a *Day of Dialogue* to discuss how incidents of violence are currently addressed in hospitals, as well as the need to create an environment where health care professionals, patients and families feel safe. The outcome of the meeting was the development of guiding principles, as well as a tool kit, to assist nurse leaders in systematically addressing measures to decrease and control violence in the workplace. The focus of these resources is the hospital setting; additional work is needed to address workplace violence across the care continuum.

The guiding principles and priorities listed below are steps to systematically reduce lateral, as well as patient and family violence in the work place.

Guiding Principles

1. Recognition that violence can and does happen anywhere.
2. Healthy work environments promote positive patient outcomes.
3. All aspects of violence (patient, family and lateral) must be addressed.
4. A multidisciplinary team, including patients and families, is required to address workplace violence.
5. Everyone in the organization is accountable for upholding foundational behavior standards, regardless of position or discipline.
6. When members of the health care team identify an issue that contributes to violence in the workplace, they have an obligation to address it.
7. Intention, commitment and collaboration of nurses with other health care professionals at all levels are needed to create a culture shift.
8. Addressing workplace violence may increase the effectiveness of nursing practice and patient care.

Five Priority Focus Areas

1. *Foundational behaviors to make this framework work:*
 - Respectful communication, including active listening
 - Mutual respect demonstrated by all (i.e. members of the multidisciplinary team, patients, visitors and administrators)
 - Honesty, trust and beneficence
2. *Essential elements of a zero-tolerance framework:*
 - Top-down approach supported and observed by an organization's board and C-Suite
 - Enacted policy defining what actions will not be tolerated, as well as specific consequences for infractions to the policy
 - Policy is clearly understood and equally observed by every person in the organization (i.e. leadership, multidisciplinary team, staff, patients and families)
 - Lateral violence is prohibited, regardless of role or position of authority (i.e. the standard of behavior is the same for doctors, nurses, staff and administration)
3. *Essential elements to ensuring ownership and accountability:*
 - Personal accountability, meaning everyone in the organization is responsible for reporting and responding to incidents of violence
 - Zero-tolerance policy is developed with input from staff at every level in the organization, thus ensuring staff co-own the process and expectations
 - Universal standards of behavior are clearly defined and every person in the organization (including patients and families) is held equally accountable
 - Incidents of violence are reported immediately to persons of authority, through the chain of command, to ensure immediate enforcement of the zero-tolerance policy
4. *Essential elements of training and education on workplace violence :*
 - Organizational and personal readiness to learn
 - Readily available, evidence-based and organizationally-supported tools and interventions
 - Skilled/experienced facilitators who understand the audience and specific issues
 - Training on early recognition and de-escalation of potential violence in both individuals and environments
 - Health care specific case studies with simulations to demonstrate actions in situations of violence
5. *Outcome metrics of the program's success:*
 - Top ranked staff and patient safety scores
 - Incidence of harm from violent behavior decreases
 - Entire organization (staff) reports feeling "very safe" on the staff engagement survey
 - Patients and families report feeling safe in the health care setting
 - Staff feels comfortable reporting incidents and involving persons of authority
 - The organization reflects the following culture change indicators: employers are engaged, employees are satisfied and HCAHPS scores increase.

Participants in the Day of Dialogue on Mitigating Violence in the Workplace

- Karen Wray, MSN, RN-BC, NEA-BC, AONE board member
- Reynaldo Rivera, DNP, RN, NEA-BC, FAAN, AONE board member
- Erik Martin, MSN, RN, CNML, AONE board member
- Deena Brecher, MSN, RN, APRN, ACNS-BC, CEN, CPEN, ENA president
- JoAnn Lazarus, MSN, RN, CEN, ENA past-president
- Kathy Szumanski, MSN, RN, NE-BC, ENA chief nursing officer
- Lisa Wolf, PhD, RN, CEN, FAEN, ENA director of the Institute for Emergency Nursing Research
- Kris Powell, MSN, RN, CEN, NEA-BC, ENA member
- Sean Elwell, MSN, RN, EMT-B, ENA member
- Veronika Riley, director of American Hospital Association Workforce Center
- Pam Thompson, MS, RN, CENP, FAAN, AONE chief executive officer
- Susan Hohenhaus, LPD, RN, CEN, FAEN, ENA executive director
- Stacey Chappell, AONE sr. communications specialist – advocacy & special projects

About the American Organization of Nurse Executives

The American Organization of Nurse Executives (AONE) is the national professional organization for nurses who design, facilitate and manage care. With more than 8,500 members, AONE is the leading voice of nursing leadership in health care. Since 1967, the organization has provided leadership, professional development, advocacy and research to advance nursing practice and patient care, promote nursing leadership excellence and shape public policy for health care. AONE is a subsidiary of the American Hospital Association (AHA). For additional information, visit the AONE website at www.aone.org.

About the Emergency Nurses Association

The Emergency Nurses Association (ENA), which has more than 40,000 members worldwide, is the only professional nursing association dedicated to defining the future of emergency nursing and emergency care through advocacy, expertise, innovation and leadership. Founded in 1970, ENA develops and disseminates education and practice standards and guidelines, and affords consultation to both private and public entities regarding emergency nurses and their practice. Additional information is available at ENA's website, www.ena.org.

AONE GUIDING PRINCIPLES

MITIGATING VIOLENCE IN THE WORKPLACE

Resources

- Anderson, C. (2002). Workplace Violence: Are Some Nurses More Vulnerable? *Issues in Mental Health Nursing*, 23(4), 351-366.
- Emergency Nurses Association. (2011). *Emergency Department Violence Surveillance Study*. Des Plaines, IL.
- Gacki-Smith, J., Juarez, A. & Boyett, L. (2009). Violence against Nurses Working in US Emergency Departments. *Journal of Nursing Administration*, 39 (7/8), 340-349.
- Lipscomb, J., Silverstein, B., Slavin, T.J., Cody, E. & Jenkins, L. (2002). Perspectives on Legal Strategies to Prevent Workplace Violence. *Journal of Law, Medicine, & Ethics*. 30(3), 166-172.
- McPhaul, K. & Lipscomb, J. (2004). Workplace Violence in Health Care: Recognized but not Regulated. *Online Journal of Issues in Nursing*, 9 (3).
- National Institute for Occupational Safety and Health (NIOSH). Division of Safety Research. (2002). Violence: Occupational hazards in hospitals. Cincinnati, Ohio: U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, Division of Safety Research.
- Seifert, P.C. (2011). Reaping What We Sow: The Costs of Bullying. *AORN Journal*, 94(4), 326-328.
- United States Department of Labor. Occupational Safety & Health Administration. Safety and Health Topics. Workplace Violence. (2014). Available: www.osha.gov/SLTC/healthcarefacilities/violence.html
- Wolf, L.A., Delao, A.M., & Perhats, C. (2014). Nothing Changes, Nobody Cares: Understanding the Experience of Emergency Nurses Physically or Verbally Assaulted While Providing Care. *Journal of Emergency Nursing: JEN*. 40(4):305-310. doi: 10.1016/j.jen.2013.11.006.

Copyright 2014 by the American Organization of Nurse Executives. All rights reserved.

Appendix B: Pre-Interview Online Survey Questions & Interview Questions

Demographic Survey: Research Study on WPV

⊕ PAGE TITLE

* 1. What is your age range?

* 2. What is your gender?

- ☐ Male
☐ Female

* 3. What type of hospital do you work at? Select as many as apply.

- | | |
|---|---|
| <input type="checkbox"/> Teaching | <input type="checkbox"/> General Services |
| <input type="checkbox"/> Specialty | <input type="checkbox"/> Federal/Government |
| <input type="checkbox"/> Trauma Center | <input type="checkbox"/> Not for Profit |
| <input type="checkbox"/> Research | <input type="checkbox"/> Urban |
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> Suburban |
| <input type="checkbox"/> Other (please specify) | |

* 4. What is your professional role and/or area of clinical responsibility/expertise? (check as many as apply)

- ☐ Hospital Executive
☐ Physician
☐ Nursing
☐ Administrator
☐ Director / Manager
☐ Other (please specify)

* 5. How long have you worked in this role?

* 6. Does the scope of your responsibilities include influencing the strategies, policies, and actions related to workplace violence and workplace safety for nurses in the Emergency Department (ED)?

- ☐ Yes
☐ No
☐ Comment if desired (optional)

* 7. What is your specific involvement in Workplace Violence (WPV) mitigation?
(check as many as apply)

- ☐ Patient Safety
- ☐ Workplace Safety
- ☐ WPV Prevention/Mitigation
- ☐ Emergency Department
- ☐ Security
- ☐ Consultant
- ☐ Behavioral Health
- ☐ WPV Researcher
- ☐ Analyst
- ☐ Other (please specify)

* 8. How long have you been involved in this area of WPV Mitigation?

* 9. Are you currently participating as part of an organized WPV Prevention Team?

- ☐ Yes
- ☐ No
- ☐ If yes, how many participants are on your team?

* 10. What size is your hospital?

- ☐ Decline to state
- ☐ Small (less than 100 beds)
- ☐ Medium (100-499 beds)
- ☐ Large (500 or more beds)
- ☐ Other (please specify)

-Asterisk (*) indicates that participant must respond to question to complete survey
-Anonymous survey built using Survey Monkey.
-Electronic link provided to recipients via email.

Appendix C: Interview Questions

1. What has been your organizations' history regarding WPV, especially as it relates to WPV against nurses in the ED?
2. What precipitated the formation of this WPV prevention/mitigation effort? (The Joint Commission, 2012)
3. Help me understand the overall progress the hospital has made with regard to WPV prevention and mitigation. (The Joint Commission, 2012)
 - a. What did the team set out to accomplish? What did you accomplish?
 - b. What progress has been made? What was your role in the progress?
 - c. When did you feel best about your contribution?
4. Tell me about the strategies you and your team used to prevent and/or mitigate WPV in the ED. (Arnetz et al., 2015a)
5. What policies were enacted to clarify, support, or reinforce these strategies? For instance, did your hospital consider utilizing a zero-tolerance policy for WPV? (AONE & ENA, 2015) Why or why not? What have the results been so far?
6. What specific actions were taken? What interventions were designed or implemented? (Ramaciatti et al., 2016, Gillespie et al., 2014)
7. What factors or conditions contributed to the success of the effort? (Anderson et al., 2010)
8. What's your assessment of the impact of this effort? How was this measured? Can you share the specific data with me? (Gillespie et al., 2014)
9. What have you and/or the hospital leaders on your team learned in the process, and what do they aspire to achieve in the future? (ACHE & Lucian Leape Institute, 2017)
10. What difference if any, has been made in the workplace culture of your ED as a result of these efforts? (Chassin & Loeb, 2013).