Combating Workplace Violence: An Evidence-Based Initiative in Progress

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Significance

- Workplace violence (WPV) is considered one of the most dangerous hazards within healthcare occupations (BLS, 2014).
- Type II WPV (patient or visitor violence to staff members) is the most common violence in the healthcare (HC) industry.
- Lack of recognition of the true incidence and underreporting of verbal violence, which often precedes physical violence, may contribute to a false sense of security within a HC facility (HCF).
- Fully addressing the problem of WPV may be met with resistance thus, precipitating poor perceptions of support from HC employees.
- Type II WPV results in significant direct (compensation for lost work) and indirect costs (decreased staff satisfaction and retention) to a HCF.
- Professional organizations (ENA, AACN) have initiated recommendations to address the issue of WPV.
- Zero violence policies have become the industry recommendation for combating WPV in the HC industry.

PICOT

- Does the implementation of a multi-faceted WPV program (I) positively impact (O) the emergency department staff's (P) perception of support for a zero-violence environment (C) over an 8-week period of time (T)?

Review of Literature

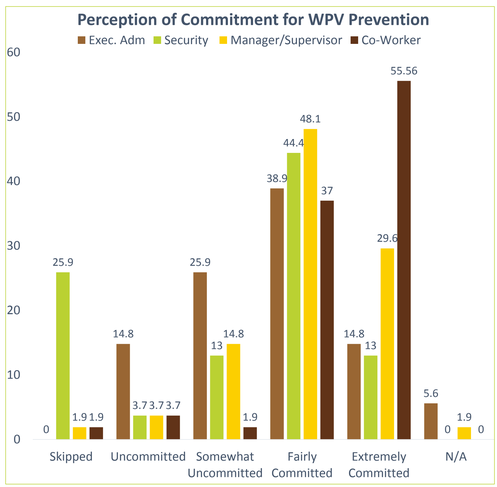
- Search terms: workplace violence, patient violence, patient aggression, patient assault, intervention, practice, policy, procedure
- Inclusion criteria: hospital setting, English, peer reviewed, scholarly, policy development, acute care hospital setting
- Exclusion criteria: interdepartmental conflict/incivility (Type III), restraint and/or seclusion for organic conditions (i.e., dementia), no policy or procedures included in the research.
- Quality appraisals were conducted using Johns Hopkins Evidence Appraisal Tools; 17 pieces of evidence included in final appraisal:
- 4 Level I (3 high quality JBI summaries & 1 CPG)
- 3 Level III (1 good quality case control & 2 high quality cohort)
- 4 Level IV (3 good quality LR & 1 high quality narrative review)
- 1 Level VI (1 good quality descriptive study)

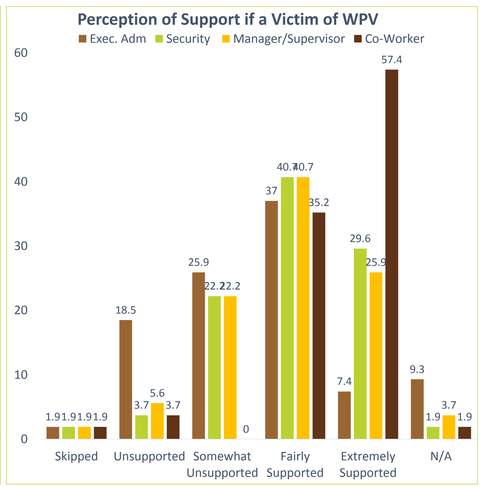
Database	CINAHL	Cochrane Library	Google Scholar	JBI	Medline	ProQuest	VHGN	Hand Search
Record	46	9	31	17	32	41	75	4
Articles accepted	6	3	7	5	5	6	4	2
Duplicate	3	2	4	3	3	4	2	0
Final accepted	3	0	3	2	2	2	3	2

Synthesis of Evidence

- Acknowledgement that WPV happens, is relevant to patient care, and is a priority for HCFs (AONE, 2014).
- Administrative and behavioral interventions are crucial to managing WPV (Anderson et al., 2010).
- Hospital and management with commitment to WPV are less likely to experience WPV (ENA, 2011; Gillespie et al. 2013; Tishler et al., 2013; Wassell, 2009).
- Facilities with an established zero tolerance policy had lowest risk (9.1%) when compared to those with a policy, but not zero tolerance (13.7%) and without a policy (18.3%) (ENA, 2011).
- Organizational changes/policy influenced staff behavior; instituting policy and improving a reporting form made reporting more meaningful for nurses (Anderson et al., 2010).
- **Best Practice Recommendations included the Following Approach:**
  - Shared Responsibility – whole organization approach; policy & procedure; employee surveys; physical environment protection; & accurate records (AONE, 2014; Chen, 2012; Heckeman et al., 2012; HFAP, 2015; JBI, 2016; Long, 2016; OSHA, 2015; Sachs & Jones, 2015; TJC, 2016)

Decision to Change Practice





- A recent incident of significant PV provided the initial impetus for practice change.
- The practice facility did not have a policy or procedure to address WPV.
- There were discrepancies in WPV reporting using current mechanism 34:1 (security call requests to online reporting) ratio.
- The facility's WPV employee survey, conducted in September, 2016 revealed that:
  - The ED had the highest reported occurrence of WPV and security request calls due to WPV.
  - The ED staff reported a poor perception of support from executive administration.
  - 14.81% of ED respondents (*N* = 54), indicated potential of leaving department in next 6 months due to WPV.
- The facility WPV employee survey also confirmed that there was a disproportionate amount of reported violence when compared to formal online reporting.

Implementation

- Multifaceted WPV Program
- Participants: ED staff
- Setting: Midwestern acute care hospital facility
- Design: Pre-/post-intervention comparison
- Tool(s): WPV Employee Surveys, Online Incident Reports, Security Request Calls
- Theoretical Framework: Kotter's Change Model
- EBP Model: Iowa Model of Evidence-Based Practice to Promote Quality Care
- Practice Change: Develop and implement an institutional zero violence environment policy & procedures
- Educational in-services conducted in December, 2016:
  - Definitions of WPV; comparison of types of WPV, review of policy, proper mechanism for online reporting
- Develop and post WPV signage in patient care areas
- Improve communication with local law enforcement, updated police hold forms

Evaluation of Change

- Primary outcome: Comparison of WPV Employee Surveys
- Secondary outcome: Comparison of online reports of WPV and security request calls for patient and/or visitor violence
- A 10-percentage point increase in ED staff who reported security and executive administration were "fairly" or "extremely" committed to WPV prevention was targeted as a measure of project success
- Additionally, enhanced WPV knowledge was anticipated to increase online reporting of WPV, resulting in a decreased ratio of security calls to WPV reports

Progress to Date

- Formation of WPV task force committee
- Evaluation of pre-implementation WPV employee survey
- Evaluation of pre-implementation online incident reports & security request calls for WPV within the ED setting
- Development and implementation of a zero violence environment policy & procedures
- Educational roll out to ED staff
- Development and implementation of hospital WPV signage placed in all departments
- Preparation of post-implementation WPV employee survey to be launched February 27, 2017
- Long-term plan for sustained organizational change

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