Assessing the Perceived Prevalence and Reporting Practices of Type II Workplace Violence
in the BIDMC Emergency Department

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Capstone Manuscript

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Abstract

Problem: Workplace violence (WPV) is a recognized safety concern in Emergency Departments nationally. Type II WPV is an act or threat of violence (verbal, physical, stalking, harassment) from a patient or family member, towards an employee. Violence in the Emergency Care setting is a significant occupational risk for clinicians and is recognized in some states as a violent crime. To understand the problem, events must be reported. The purpose of this practice inquiry project was to measure the clinicians experience and likelihood to report events before and after a series of interventions.

Significance: Upon reviewing the voluntarily reported WPV data at the Beth Israel Deaconess Medical Center (BIDMC), reporting in the Emergency Department (ED) was low compared to other areas in the medical center. ED environments are especially vulnerable to violence due to stress, wait times, and medical factors for patients.

Methods: In order to better appreciate the actual prevalence of Type II WPV a survey was offered to all clinicians in the BIDMC ED. The survey was voluntary and contained both quantitative and qualitative questions sent to all clinicians and unlicensed staff in the ED at BIDMC. A series of interventions were implemented and the same group was resurveyed to measure change. The interventions included the implementation of a violence response team, standardizing a quality assurance multidisciplinary review of all WPV cases, violence prevention rounds with social work to engage in conversations, and educational enhancements.

Findings: The initial survey resulted in a 68% response rate. Of those who responded, 41% were nurses. ED staff and physicians reported that over their past seven shifts, 53% of respondents experienced or witnessed verbal/emotional violence and 24% of respondents
experienced or witnessed physical violence. Of the 139 respondents who reported that they had witnessed or experienced one or more types of violence within their past 7 shifts, only 17% had reported it in the voluntary reporting system. Reasons for not reporting in order of rank included: (1) 85% replied “it’s part of the job”, (2) 61% replied they did not expect anyone to do anything about it, (3) 56% replied it was due to the patient condition (demented or ill), and (4) 42% replied they did not have time. The pre-survey served as an assessment tool as well as educational information as it helped to inform clinicians about what constitutes violence and let the respondents know that the data we received would be utilized to help inform the resources that are needed to create a safer environment for staff and patients. Following the interventions, a post-survey was conducted and although some of the results did not shift greatly, the comments from the respondents validated the focus of this project as important to staff, patients and visitor safety.

Keywords: emergency nurse, workplace violence, type II violence, emergency department violence, violence prevention culture, and workplace violence interventions.
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Dedication

I would like to dedicate this project to those closest to me, my family. To my mother, a master’s prepared, prior nursing faculty member in the schools of nursing at Georgetown University and Boston University, and to my father, an accomplished orthopedic surgeon. Your influence on my career has been incredibly meaningful. The motivation for learning and caring for others that you both have instilled in me, contributes to who I am today. To my siblings, nieces and nephews who have supported me along this rewarding journey, your motivation, encouragement, and love displayed throughout this journey is forever appreciated.
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Chapter One

Introduction and Background

Workplace Violence (WPV) is a significant occupational hazard in health care and those who work in the Emergency Department (ED) are especially at risk ("Emergency Nurses Association," 2010). Researchers have found that the majority of physical violence against health care professionals is Type II Workplace Violence, where the victim is a healthcare worker and the perpetrator is a patient or visitor. (MacLean et al., 2009). The focus of this project was the clinicians’ perception and experience with type II workplace violence in the Emergency Department (ED) at Boston’s Beth Israel Deaconess Medical Center (BIDMC) and the pattern of reporting events. According to a survey study by the Emergency Nurses Association (ENA), 54.5% out of 6,504 emergency nurses reported experiencing violence within the past week from a patient or a visitor (Wolf, Delao, & Perhats, 2014). Frequently, these acts of violence towards staff went unreported, as many reported feeling that it was just “part of the job”.

The expansiveness of this problem has been highlighted on a greater scale over the past ten years ("Emergency Nurses Association", 2010). WPV is now a national focus at Emergency Nursing and Medicine Conferences both in the United States as well as internationally. This survey conducted in the Emergency Department (ED) at BIDMC demonstrated results equivalent to the ENA results. The incident rate of WPV is 3.8 times higher in the healthcare industry than any other industry with ED’s recognized as “highly vulnerable” ("Bureau of Labor Statistics," 2012) due to the populations served; the
stress of an unexpected visit for a patient/family, and the increase in volume of patients with psychiatric illnesses and substance use disorders. (Hahn et al., 2013).

The overall thematic in research related to WPV is suggesting an acceptance due to the very nature of the job (working in an emergency department setting), and the types of patients who utilize ED’s (Lagerwey, 2010). Many nurses reported experiencing violence as a part of their work day when working with a patient population with substance abuse disorders, mental health illness, dementia, and those with high emotions due to personal stress (Katrinli, Atabay, Gunay, & Cangarli, 2010). Understanding the prevalence, the perception of nurses, as well as the patterns and reasons for underreporting, may help to provide a targeted response plan and allow leaders to offer better supports to improve the health and safety of our staff (Katrinli et al., 2010).

The need to better understand the experience of Type II WPV in the ED and implementing effective responses has been identified in the literature as necessary to protect the health and well-being of clinicians in high risk settings such as the ED. At this point, the research has demonstrated that measuring the prevalence and severity of the problem may be challenging in certain settings or institutions, due to acceptance and tolerance. (Lagerwey, 2010).

In 2016, BIDMC began working to identify where Type II WPV occurred, as well as to evaluate whether there were opportunities for improvement. The initial assessments indicated that the reporting patterns did not seem to match what we were hearing from our staff about their day to day lived experiences. In the figure below, the increase in incidence of Type 2 WPV events from quarter to quarter is demonstrates the upward trend.
After examining the trend from fiscal year 2016 quarter by quarter, understanding the location of these events was critical to identify where interventions to mitigate risk should be deployed and to know where more information was needed. In the table 1 below, the locations of events reported in 2016 is displayed. The opportunity to study areas with low reporting, yet suspected higher incidences, was the catalyst for this project.

**Table 1: Location of Events BIDMC FY16**

<table>
<thead>
<tr>
<th>Location</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>44</td>
<td>8%</td>
</tr>
<tr>
<td>Patient Room (Floor)</td>
<td>387</td>
<td>77%</td>
</tr>
<tr>
<td>Psychiatric Unit</td>
<td>52</td>
<td>11%</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>16</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>517</td>
<td>100%</td>
</tr>
</tbody>
</table>

The objectives of the BIDMC ED 2016 pre-survey were to quantify the prevalence of Type II WPV and identify risk factors; to understand reporting practices, and to assess how well-prepared staff felt to handle potential violence. The objectives of the 2017 post survey
were the same as the 2016 objectives, with an additional focus to measure the effectiveness of recent improvement initiatives that had been implemented in the intervening year in the ED. The pre-survey explored the reported incidence of Type 2 WPV by the clinical teams as reported by activity in their last seven worked shifts, as a baseline measure. The survey also elicited the reasons why incidences were not reported. These pre and post surveys of the ED staff has provided a platform for understanding of perceptions and experiences, as well as identified needs for improvement and opportunities for further study.

BIDMC has been attentive and focused on employee safety with a keen lens on workplace violence under the direction of the department of Healthcare Quality, BIDMC tracks the rates of reported events and patterns of events – including types and locations of events within the hospital setting. There is a hospital committee structure that determines strategy, policy, and education, in response to the overall trends of WPV and associated employee injuries. Reduction in Type 2 WPV was identified as a priority in the BIDMC Annual Operating Plan in 2016 and 2017 as one of the focused areas to enhance employee safety. It was noted in the fall of 2016 that the BIDMC ED had very low reporting rates in the voluntary safety reporting tool while at the same time a high number of events were being verbally reported to the unit leadership. Due to this discrepancy this project was designed to understand the perception and experience of the clinical teams with regards to workplace violence, as well as to better appreciate the reasons for not reporting events, so that targeted improvement interventions could be implemented.

Of note, in the fall of 2016, the organization was also embarking on internal campaigns focused on employee safety at the BIDMC. A consulting firm was hired to
conduct a safety assessment that included an evaluation of physical infrastructure, environment, staffing patterns, and resources devoted to employee safety. The consultants evaluated entry points to the medical center and existing security systems and personnel, as well as the staff culture with regards to granting access to care areas and clinics. While this project focused on the direct interventions in one unit (BIDMC ED) with a measured response from clinicians in that environment, it is important to note that the larger campaign is a possible contributing factor to the overall broader institutional aim to improve the safety of our staff.

The ED clinicians (nurses, doctors, and technicians) were surveyed about their experiences either as a witness to, or victim of, Type II Workplace Violence (WPV) in the fall of 2016 and then re-surveyed in the fall of 2017 following several interventions aimed at improving workplace safety and reducing WPV. In the survey it is explained that Type II WPV is defined as violence committed by patients/visitors against an employee. This includes behaviors and conduct that create anxiety, fear, or distrust in the workplace and is inclusive of, but not limited to, homicide, physical battery, physical assault, stalking, threats, harassment, bullying, emotional abuse, and intimidation. (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). Data from this initial survey was used to develop targeted interventions over a series of months. The survey was repeated in 2017 with same group to evaluate the potential impact of the interventions.

The pre-survey in the fall of 2016 explored the current experiences of clinicians as well as assessed the pattern of reporting events in the ED at BIDMC. This served as an assessment to drive a targeted plan of interventions implemented in the spring of 2017. The
same team of clinicians was resurveyed with the same survey tool in the fall of 2017. Following the second survey, there were identified opportunities for further study in an effort to improve experience and perception of the work environment, safety, and ability to provide excellent patient care.

There were no published studies in the literature highlighting best practices to impact and influence the feeling that WPV is a “part of the job” or that evaluate the lack of reporting because “there is nothing that can be done” – two of the drivers identified in this inquiry as influencing reporting. The aim of this project was to assist BIDMC in better understanding the reasons for the under reporting of WPV events and the impact this trend has on employee safety. As we looked in to this mismatch, we learned from our staff that the lack of reporting was partly because many expressed that they believed that this was an inherent risk of working in the ED and that by accepting to work in this environment, one accepts the associated risk of exposure to violence. Therefore, the assumption is one of an underlying acceptance by clinical staff with regards to violence in the BIDMC ED.

**Purpose**

The purpose of this practice inquiry project was to better understand the experience and the reporting practice of WPV in the ED at BIDMC. The intent was to then to improve the practice environment in the ED at BIDMC by introducing a multi-pronged approach of interventions to support to move away from the prevailing feeling that violence is “part of the job” and that clinicians don’t expect that improvements will result in response to reported events. On the pre-survey it was demonstrated that violence was very common as evidenced by the fact that the violence was experienced by the majority of BIDMC
ED nurses filling out the survey (over 95%). It was also clear that the underreporting was driven by, in order of rank, (1) “it’s part of the job” with 84% response, (2) “didn’t expect a response” with 62% response, (3) “due to the patient condition” (intoxicated, dementia for example) with 54% response, and (4) “didn’t have time” with 42% response. The purpose of this project was to influence the first two drivers through quality improvement interventions. By promoting and implementing operational interventions in the BIDMC ED environment, that were responsive to type II WPV in an organized, supportive, consistent manner, we hoped to show support for and improve the safety and the well-being of the staff in the ED at BIDMC.

The questions to be answered by the practice inquiry project are as follows:

1. What was the influence of a Violence Response Team Interventions (ED Physician, Public Safety, Nursing Leadership, Psychiatric Physician, and Social Work) following an event of type II WPV on clinicians reporting events?

2. What was the influence of a Violence Prevention Rounds on increased reporting of WPV events regarding “didn’t expect a response”?

The specific aims of the project were focused on increasing the staff and physician reporting of Type II WPV. Based on the BIDMC ED survey conducted in the fall of 2016, staff reported that in only 17% of all incidents would they report the event. The drivers for not reporting are noted above. With specific interventions to respond to violence, the specific aim was to have greater reporting of incidence of violence. Increased reporting, that truly reflected the staff experiences, would provide a greater opportunity to customize education and training programs for the employees and physicians; as well as to promote a
healthier work environment where clinicians won’t expect to be harmed, physically or verbally, in the practice setting. With greater reporting, there would be an opportunity to review all events through a root cause analysis, identifying opportunities for all teams to work collaboratively and to assure safe care standards are consistently met. Training for all team members would then have the potential to be standardized.

**Significance**

The significance of the problem of Type 2 WPV is of great impact to clinicians working in ED’s across the county. The lack of standardized measurement and reporting of events impacts improvement efforts as data is scarce (Gacki-Smith et al., 2009). As many healthcare organizations do not have institutional policies around response to Type II WPV, a perception may be that it is an accepted occupational hazard (May & Grubbs, 2002). As a noted vulnerable setting, for ED staff it is imperative that we train and support staff in areas where they may experience violence towards them from patients or family members. Research has demonstrated that the majority of physical violence against health care professionals is Type II Workplace Violence, where the victim is a healthcare worker and the perpetrator is a patient or visitor (Gacki-Smith et al., 2009). This known occupational hazard also poses a potential risk for future recruitment and retention of ED Staff.

Emergency departments are vulnerable to violence due to the high stress nature of the environment, which may be escalated by long wait times, lack of privacy, and tension of family members coping with their loved ones’ medical complaint. ("US Department of
Justice, Federal Bureau of Investigation," 2004). Studies continue to show high rates of experience in Emergency Departments when measured; however low rates of reporting have made resulted in under appreciation of the problem (Hahn et al., 2013). A key factor in feeling safe at work is institutional support as defined as having training/education, appropriate staffing levels, addressing environment concerns, and the support of leadership (administration, physician, and nursing) in the aftermath of an incident. (Kindly, Petersen, & Parkhurst, 2005). Examining the reasons behind not reporting violence in the ED at BIDMC leads to the opportunity to understand the reporting patterns and impact the experience for employees as well as patients and their family members.

Assaults in the ED are serious problems and interventions are critically needed. (Hahn et al., 2013) The relevance of addressing this problem is an important aspect to promoting a culture of safety for employees, as well as other patients and visitors. The relevance of addressing this problem may produce a practice change for clinicians where there is potential for a more united plan of care for patients who exhibit potential for violence either due to their medical condition or their level of stress during the emergency room visit.

This practice inquiry project has the potential to influence policy decisions at both local and national levels. This is a local and national area of study regarding the experience with WPV in ED’s, however there is opportunity to study interventions and impacts. In some states, it is a felony to commit a crime of violence against a healthcare worker. In Massachusetts, according to CH 265, “Whoever commits an assault or assault and battery on an emergency medical technician, an ambulance operator, or an ambulance attendant, while said technician, operator or attendant is treating or transporting, in the line of duty, a person,
shall be punished by imprisonment in the house of correction for not less than ninety days nor more than two and one-half years, or by a fine of not less than five hundred nor more than five thousand dollars, or both.” (“Criminal Laws,” 2013). This does not currently apply to health care workers in hospitals or clinics; however this issue is currently up for discussion in the Massachusetts legislature. Additionally, HB 1508 states: “An Act to authorize the arrest for assault and battery on a public employee” was referred to the judiciary committee in 2013 and is slated to go again this fall in Massachusetts to include nursing as part of this definition. In some states such as Utah, the law increases the penalty for attacking a health care provider or emergency medical service worker from a class A misdemeanor to a third-degree felony if the person acts "intentionally or knowingly" and causes "substantial bodily injury" in the course of the worker's duties.” (Chen, May 31, 2016, para. 9).

Chapter Two

Literature Review

The literature review focused on staff perceptions and reported experiences of workplace violence; evaluations of a sample of violence prevention programs; and literature on the culture of tolerance in healthcare, in order to provide a framework for this project. The search engines used for this literature review include the Web of Science and CINAHL. The key word search includes emergency nurse, workplace violence, type II violence, emergency department violence, violence prevention culture, perception, nurse-patient relations, and workplace violence interventions. The literature search demonstrated that over the past six years there has been an increase in study in this area of workplace violence in high risk settings such as ED’s and Psychiatric areas (Gacki-Smith et al.,
The focus of the Gacki-Smith study is aimed at emergency nurses and emergency residents in collecting personal experiences, as well as the desire for organizational involvement in safety and solutions.

The Gacki-Smith (2009) study was conducted using qualitative descriptive exploratory design and consisted of 46 narratives submitted by ED Nurses describing violence at work. Overall the nurses felt violence was endemic to their workplace and contributed to the understanding of cultural tolerance and perhaps underreporting of events. There were some limitations within the study such as nurses self-identifying who reported a traumatic experience in the workplace. Association among experience, education, and violent events were not demonstrated as demographic information was not collected in this study which is a further limitation. (Gacki-Smith et al., 2009).

In the ENA study (2012) supported the need for more research aimed at understanding the experience of violence, the perceptions of violence and the methods to decrease violence in the workplace. This study found that 54.5% of 6,504 emergency nurses experienced physical violence and/or verbal abuse from patients and visitors during the week. This ENA study (2012) propelled this topic into ED’s across the country. In the literature, it is a common belief that incidence is higher than what is reported, thus a spotlight was focused in 2012 by the ENA (Emergency Nurses Association) with regards to WPV with specific examination of ED settings to further understand this epidemic. Other studies have demonstrated that organizational commitment to a definition of workplace violence and a declaration of tolerance (or better stated as “Zero Tolerance”) is critical for front line providers reporting violence (Hahn et al., 2013). This study was a cross sectional
retrospective study completed in 2007 which investigated experiences with workplace violence in hospital settings in Switzerland. Data was collected via questionnaire with 2495 participants who identified as health professionals (nurses, physical therapists, nursing assistants, and occupational assistants). The conclusion of the study suggested that training can change the perceptions of and recognition of violence in the workplace setting. Training was found to create a high sensitivity to violence and influenced the perception of participants feeling of safety. Those with training reported organizational support recognizing this as a problem and responding to support their employees. (Hahn et al., 2013).

The impact of not adopting an organizational stance on violence, in addition to a perceived tolerance due to a lack of formal education, recognition, and response, further enforces the culture of acceptance of violence as an inevitable consequence of care ("American Association of Critical Care Nurses," 2004). Consequently, in the Renker (2015) study, nurses reported feeling that the lack of formal education on how to respond to violence and how to prevent violence, was putting them at risk in ED’s. Additionally, nurses reported that there was a lack of organizational recognition of violence in the workplace as part of the nurses’ job in "high risk areas" such as emergency departments and psychiatric floors (Renker, Scribner, & Huff, 2015).

In the Katrinli (2010) study, how nurses perceive violence (specifically bullying) in the workplace was explored by utilizing a survey method to reach 500 nurses over two weeks. The response rate was 46.4%, or 232 nurses. Some limitations included that the participants were all female and focused on peer to peer interactions, not specifically type II
workplace violence. Additionally, it was limited to Turkey thus some cultural considerations may be necessary. The results demonstrated the harm from violence can impact the physical and psychological well-being of victims as well as demonstrate the perpetrators’ need for power over situations they may have little control in.

The Anderson (2010) study demonstrated that there were training programs and educational classes that provided a foundation for conflict resolution, de-escalation techniques, and physical protection for safety (Anderson, Fitzgerald, & Luck, 2010). As occupational violence has strong negative effects on job satisfaction and retention, the Anderson (2010) study found interventions to support reduction of violence against ED Nurses must be aimed at environmental, policy, practice, and training. The study stops short of advising on which programs or methods, however does conclude single interventions often fail as the scope of the work is multifactorial. In the Gillespie (2013) study, staff reported a perceived positive influence of support from their organization based on the training they have been provided in regards to workplace violence (Gillespie, Gates, Mentzel, Al-Natour, & Kowalenko, 2013). The study surveyed ED nurses about their training and found that singular intervention models were not effective. The overwhelming response was the organizational support felt when workplace violence was being addressed broadly throughout the organization. Ultimately, this study recommended a multipronged approach to addressing violence in the workplace including a focus on team communication as well as training and education to support staff comfort in their response.

In the Gerditz study, the attitudes and feelings of nurses improved following a series of rapid training programs for emergency department staff (Gerditz et al., 2013). Gerditz
found that a rapid response team approach provided insight into a program or intervention which serves as a support to nursing as well as other clinicians. In the Kelley (2014) study, research on rapid response teams demonstrated benefit of preparing staff for what they can expect in the form of support. Should an event occur, staff are trained in the rapid response team intervention, management and follow up in the Kelley (2014) study. This study focused on the importance of reflection of an incident, identifying strategies to defuse violence, and focused work on identifying risk (Kelley, 2014). These are key safety measures for nurses in emergency departments (Calow, Lewis, Showen, & Hall, 2016).

A deep review of literature highlighted these three areas of study conducted in the past six years. They include a (1) research focus on the personal experience and individual perception of violence, (2) research relative to training programs implemented, and (3) team response to violence. The methods of research that are reviewed in this document, include survey studies, data base reviews, longitudinal designs, qualitative designs, quantitative designs, and finally, mixed methods. In reviewing the literature, cross sectional survey studies are looking at multiple site outcomes to examine the incidence of violence experienced in an effort to give context to the greater problem identified (Schnapp et al., 2016). Retrospective data-based reviews were examined to understand the rate of associated injuries related to workplace violence, amongst a large group of hospital employed nurses, in an effort to scope the problem for this research (Speroni et al., 2014). The Speroni study found over the course of a year, 76% of nurses in this study (N=762) reported verbal or physical abuse by patients and or family members of patients. The ED nurses in this study reported that the perpetrators were primarily white male patients aged 26-35 years who were
influenced by drugs and/or alcohol. The annual workplace violence cost of the 2.1% of nurses reporting physical injury was $94,156. (Speroni et al., 2014).

Several longitudinal studies evaluated naturally occurring groups over an identified time frame (Yang, Spector, Chang, Gallant-Roman, & Powell, 2012). In the Yang study, a two-wave longitudinal design with a 6-month interval, organizational violence prevention climates were specifically studies to predict the nurses chance of being exposed to physical violence over six months. The results suggested that reducing organizational pressures against workplace violence prevention will help decrease the chance of nurses’ exposure to physical violence. As violence has strong implications for health, well-being and safety, this study emphasizes how improving violence prevention programs and culture can benefit the health and safety of the nursing staff (Yang et al., 2012).

In looking at current interventions in response to the identified problem, many mixed-method approaches were reviewed which lends itself the opportunity of study. The ability to pre-survey prior to training and then follow up with a post-survey after training, allows for a rich intake to gain more qualitative data. (Gerditz et al., 2013). In the Gerditz study, 471 nurses completed a pre-test and post-test to determine if an educational program aimed at de-escalation techniques would influence staff attitudes regarding prevention and early management of patient aggression. The conclusion was limited in identifying changes in staff attitudes following the training, and therefore calling for greater work to quantify the impact of training on practice. Specifically, greater study focused on attitudes about the use of restraints in the emergency setting to understand decision making about restraining practices was thought to be necessary. There is limited data regarding pre-intervention and
post-intervention study in the research. Even with limitations, this study provides support that there is no finding to demonstrate impact on perception or experience with violence following this training (Gerditz et al., 2013).

In the qualitative descriptive exploratory design study led by Lisa Wolf, the findings are consistent with the literature citing environmental acceptance (expecting violence in the ED setting) and lack of cue recognition (by nurses) from patients prior to violent episodes, were indicative of cultural acceptance of violence in the ED setting. Additionally, this study cited the need for training of ED nursing in cue recognition of patient and/or family behaviors to study the impact in the future (Wolf et al., 2014). It is this cultural acceptance that may produce a decrease in reporting, thus a lack of response by hospital leadership as the problem may not be truly recognized.

Gaps and Opportunities

Many studies included mention of surveys or narrative responses to questions, yet none of the studies reviewed had produced a validated tool to assess the experience and/or perception of violence in the work place. The literature search produced a lot of studies that are longitudinal or retrospective under the assumption of nurses’ low reporting, or a failure to report, and that influence on the true experience of workplace violence remains a basis for more research. The research reviewed highlighted organizational deficiencies within this topic area without guidance from the research on best practices. A problem of under reporting and cultural acceptance has been identified in the studies reviewed as noted. There is a great need for both qualitative and quantitative research study to understand the impact of experience of workplace violence, implementation of rapid response teams, targeted
educational programs and organizational commitment. This study adds value to this topic area with demonstration of impact of an intervention over a short span of time, on the culture of acceptance for one emergency department.

Chapter Three

Theoretical Model

The most commonly used paradigm in the field of injury prevention, both physical and mental, is the Haddon Matrix (Haddon, 1999). This model was developed by William Haddon in 1970 and examines how environmental attributes and human factors relate. (Haddon, 1999) The ten items commonly referred to as “Haddon’s Strategies” introduce ways to prevent injury during the pre-event, event, and post-event stages. In the pre-event phase, preventing the existence of the agent, preventing the release from the agent, separating the agent from the host, and providing protection from the host are four pillars of this stage. With regards to WPV, the agent is the violence, and the host is the healthcare provider.

The second stage of this model is the event. In this phase it is critical to minimize the amount of agent present, control the pattern or release of the agent, control interactions between the agent and host, and finally to work to increase the resilience of the host. It is during this event stage that many of the interventions of this study were introduced and each intervention relates directly to these steps in this phase. Controlling the response to an event, the interactions between a patient and the clinician, and supporting that clinician to guide the care as best as possible is a phase of this study’s response to WPV and relates directly to these strategies.
The final stage of this model is the post event. It is here where a rapid treatment response for the host and rehabilitation for the host is contained. The post event of a WPV incident is focused on the health and wellbeing of the clinician in a similar fashion.

**Setting**

The practice setting where the project was implemented is in the Emergency Department at BIDMC. This is a level one trauma center that sees approximately 58,000 patients per year. This setting has seen a growing population of patients with mental illness as well as a growing population of patients with substance use disorders which has impacted the experience of WPV for all clinicians. Additionally, with great capacity constraints, and longer wait times in the department, staff was experiencing upset and angry family members who are already stressed with their loved ones’ condition. All of these elements can add to the experience of verbal / emotional / physical abuse providers report experiencing. The footprint of the department is circular with public safety stationed in the psychiatric zone (rooms noted as 24-28 in yellow) and the triage entry point (noted with a “T: in light blue).

Figure 2: Schematic of BIDMC ED 2016-2017
**Study Participants**

The participants for this process improvement project were clinicians employed by BIDMC ED as well as the Emergency Medicine Attending Physician group and the Emergency Residency Program from the Harvard Medical Faculty Physician (HMFP) group. This selected group represented approximately 250 clinicians including nursing, technicians, attending physicians and residents. Additionally, there was approximately 50 unlicensed staff including the registration and unit coordinator team and the ED Assistants (patient observers). All employees and physicians work either full time, part time, or per diem. The range of experience in this department varies from under one year to forty-four years. For the pre-survey, the respondents’ role and number of years working in the BIDMC ED is displayed in Graph 4.

Figure 3: Positions and Years Working at BIDMC ED
Method and Design

The design of the process improvement project involves a pre-survey of the ED staff at BIDMC, a quality improvement initiative, and a post-survey. The IRB approved (Appendix A) survey titled “Assessing the perceived prevalence and reporting practices of Type II Workplace Violence in the BIDMC Emergency Department” was conducted in the fall of 2016 to assess the perception, occurrence, and reporting practices of workplace violence in this specific department. The Emergency Department staff and physicians at BIDMC ED received an email (Appendix B) describing the study and a link to an online twelve-question anonymous survey. The participation was voluntary. The platform for the survey was Survey Monkey and there was no identifiable information or PHI that was collected from participants. The survey allowed respondents to skip any question they did not want to answer. At the end of the survey, participants were also given the option to withdraw from the survey. The Healthcare Quality Department at BIDMC utilized their premium level account through Survey Monkey which stored the data safely and securely. The co-investigator (project manager from Healthcare Quality at BIDMC) is the only person who had direct access to the data (Appendix C).

The goal was to use the information gained by surveying the employees and physicians in the ED at BIDMC, to help to answer these primary questions: the frequency in which they are experiencing or witnessing acts of violence, how well prepared they feel they are to manage patients and families in violent situations, and the barriers to reporting events. When the clinicians’ received the email through their work email account, they received the survey link and description of the process improvement. It is at this point that the individual consented to participate in this research study simply by following the link.
goal of making the survey accessible was important in our methodology thus this platform allows clinicians to take the survey from any setting of the subjects choosing. There was no verbal or in-person collection of the survey question data. Any individually identifiable information (gender, position, and years in service) was inputted on a voluntary basis and was only used in the study of the characteristics of the sample.

It was determined that the setting for the intervention was to be the ED at BIDMC which serves approximately 58,000 patient visits annually. The timing of this work was fortunate as the organization had prioritized employee safety and violence prevention as key goals in the medical centers annual operating plan for 2017. There were other organizational activities going on around the medical center such as an awareness campaigns for safety, public safety interventions to limit access to the buildings during certain after business hours, and a “see something, say something” campaign. By executing the pre-survey at this time, it was a theme that was likely on the forefront of participants minds with a heavy awareness about the organizations desire to understand the experience from those working in a highly vulnerable area with regards to WPV.

The inclusion criteria for this study were all staff who worked in the ED at BIDMC in the fall of 2016 and in the fall of 2017. The survey was emailed to all nurses, technicians, residents, attending physicians, patient information specialists, and ED assistants. The specific aim of the study was to look at nurse reporting of WPV as they are the primary reporter of incidents in the department. As this was voluntary, those excluding themselves were on a self-selected basis. The survey was sent to 250 people in both the pre and post intervention survey.
The sampling method was based on the roles selected when filling out the survey. A benefit of this method is the ability to compare nurse response to questions as compared to technicians or attending physicians’ which was relevant in the findings. Recruitment was conducted through standard department communication with acknowledgement that a survey was taking place and what the study was focused on. All people received the survey via their medical center email and could answer all questions or skip questions as they voluntarily decided. Over a three-week timeframe, all staff and physician teams received the introduction email with two additional email reminders about the survey and the end date to participate. This was the process for both the pre-survey and the post-survey. The initial email was from the project manager in health care quality and the reminders were from both the nursing director of the ED as well as the physician co-lead. Engagement from this team was critical in participation of all team. Therefore having collaborative leadership from a nursing leader as well as a physician leader was deemed critical to highlight the importance of this work and the goal of participation. However, it is important to note this was not required, as recruitment was passive.

**Data Collection**

This practice inquiry project involved both qualitative and quantitative study through survey questions with scale rankings as well as open ended questions able to be organized thematically. The data collection for this study was set on the Survey Monkey platform. There were twelve questions in which to study. The survey used a five-point scale and focused on overall experience as well as within the past seven shifts. The open-ended responses were grouped by themes for analysis.
Analysis

The analysis was done using pre and post survey questions to measure response of interventions. This was broken down into stages by first looking at the quantitative data and comparing pre and post results, followed by the qualitative data in the questions that were open ended for comments. The proposed presentation of the data is in table and grid format for larger audiences and a tracking board in the department for the staff.

As part of this analysis, data gathered is part of the violence reporting dashboard used in the medical center to raise awareness, direct resources such as public safety and social work, and offers the benefit of learning from other areas (such as the locked psychiatric unit) some best practices as well as share best practices.

Ethical Considerations

As this was a voluntary survey, generally there was no risk to participants who took part in the survey, pre or post intervention. There was no intent to examine individual responses thus the platform chosen to keep all respondents anonymous in the survey itself. The mechanism to ensure this was the assignment of the “owner” of the data as someone outside of the department leadership. The data “owner” was a project manager from the department of healthcare quality to ensure local management teams did not have the ability to sort by respondents and truly maintained the integrity of the data. Participants were told what the survey was intended for, that their participation was valuable yet voluntary, that they would remain anonymous and could participate fully or partially in the survey questions, and that all data would be presented to them after an analysis of the results.
Chapter Four

Interventions – Four Prong Approach

Goals of Interventions

The interventions in this process improvement had a couple of overarching goals. First, there was a goal to increase reporting to ensure the appropriate opportunities for training with the goal of excellence in patient care. Second, there was an aim to move the culture from a culture of accepting WPV as “part of the job” to a culture where events are reported, taken seriously, and collaboratively a team makes a safety plan for the patient and the staff. Third, there was an opportunity to look at how teams (nursing, physician, and psychiatry) together manage challenging patients. And finally, a goal standardize reporting for all levels of WPV both within the care team, as well as in the voluntary safety reporting system to better understand the experience. The interventions deliberately focused on what happens before and after an event including: reviewing cases to work to identify opportunities for improvement, discussions to elevate the topic and surface additional thoughts while supporting staff in the aftermath of an event, and finally a focus on training and preparation for this vulnerable environment.

Violence Response Team

One of the implemented interventions in response to the pre-survey data was to create a Violence Response Team consisting of interdisciplinary team members from nursing, physician, social work and public safety to debrief the event with the clinician(s) involved, assess whether the clinician(s) are capable to continue to work, discuss patient care goals and make a collaborative plan including setting boundaries of communication. In addition, this group could help inform decisions on operational improvements such as public safety
standby on a patient or medication delivery. In the ED at BIDMC, a standardized team huddle existed for when a patient is being admitted. It is called a “STOP” where the team reviews (s) significant events, (t) therapies (such as antibiotics or IV fluids), (o) oxygen requirements, and (p) plan. This standardized pause has resulted in a decrease in team miscommunications about treatment plans as well as provided opportunity for a team to review anything new prior to the patient leaving the ED. This intervention has been modified with regards to WPV events has been implemented with a similar structure, with a standard response, involving a multidisciplinary team, and producing an executed review of the event or anticipated event for action planning with a focus on safety and patient care.

This intervention required a practice change adopted by all team members in the ED. It was a challenge initially; however, it has become a welcomed opportunity for improvement in managing WPV cases with a more standardized, unified approach. The goal of coming together to make a care plan was a simple concept, used in clinical situations, yet not a practice used in episodes of WPV and it was a newer practice to adopt for our public safety team. What was identified, is that clinicians are very strong when it comes to managing medical problems as a team, yet in regards to violence and setting boundaries with a verbally abusive patient or expectations with challenging patients and families, it was more complex for a team to come together, with an identified leader to set a plan in place to protect the clinicians, patient, and others in the environment. Often it is because of this perceived break in teams that violence escalates (Anderson et al., 2010) and therefore teamwork remains a critical aspect of staff safety and best practice. Brining a team together was a key element in the intervention.
Quality Assurance Multidisciplinary Review

Emergency Medicine has strength in quality assurance (QA) and case review at BIDMC however the cases reviewed have historically involved physical care and management of a patient. An intervention added after our pre-survey was an initiative to review all cases that resulted in WPV event in the ED. This review is multidisciplinary and involves dissecting a case and seeking opportunity for earlier interventions or improved communication and collaboration. In many of the cases we found a need for earlier consultation with psychiatry, as well as delays in getting orders for medications that may have assisted in managing behavior. We also found cases where breakdown in team communication created delay and frustration for the patient and later resulted in a type II WPV episode.

Following the violence response team debrief, a case is entered in to a system that alerts the QA team to an event for review. In addition to real time huddles with standardized reporting and planning, a review of all cases went through the multidisciplinary quality assurance committee in an effort to ensure we managed the cases medically as best we could as well as recognize any accommodation for those cases where clinicians did extraordinary things for patient care and / or staff safety. Learnings are brought forth to the daily huddles in the department led by the resource/charge nurse. These huddles occur at all shift changes and offer brief updates on the department as well as on learnings to teams can gain education and updates prior to starting their shift. These huddles have also been an opportunity to talk about cases and what went well so there is an opportunity to learn every day from these events. It was also important to continuously share to begin to shift the culture to one of reporting and expecting follow up on all events. Similarly, to how medical cases are shared
and reported for learning and accommodation, the new implementation of sharing WPV events following the QA process, demonstrates the focus on safety and culturally begins to imbed in the daily work with a highlight of importance.

**Violence Prevention Rounds**

Another intervention implemented after the pre-survey data was examined, was the development and implementation of Violence Prevention Rounds, facilitated by a Social Worker from the division of the Center for Violence Prevention and Recovery, a department within our Social Work Division. The forum was designed as a voluntary session, held monthly within the department during work hours. Additional staff and leadership would support patient care to facilitate staff attendance and the time of day was deliberate to engage the greatest number of participants. The topics were chosen by the clinicians and physicians in the ED and the discussions have been open and supportive. Occasionally the discussion centered on a specific patient or a common scenario and other times it was a broad discussion regarding staff expressing their experience. This intervention was modeled after the existing monthly "Ethics Rounds" led by the nurse ethicist at BIDMC and held in the ED.

This intervention needed to be led by the nursing directors to facilitate the staffing levels and organize time of day to be most successful with attendance and participation. The sessions were voluntary and noted very quickly to be greatly attended. This validated the pre-survey data of a shared experience and the desire to engage in discussions to support clinical teams.
Educational Enhancements

A review of the current state of education following the pre-survey served as a guide for changes during the implementation phase. At the time of the pre-survey, all nurses were required to take a full course called Management of Aggressive Behavior (MOAB) in addition to online training during their orientation to the ED. MOAB is a full day didactic course which is specifically geared towards clinicians and public safety staff who work in ED’s and Psychiatric facilities. The course content focusing teaching on skills to recognize, reduce, manage, and respond to violent or aggressive situations with patients’ in highly vulnerable areas.

The unlicensed teams, ED technicians, ED Assistants and Registration staff did not receive formal training during their orientation to the department as the focus was more “on the job” exposure. The residency program as well as the attending physicians also did not receive any formal training in this fashion and in the pre-survey these differences were evident. For example, the nursing staff reported feeling somewhat trained or very well trained when dealing the acute intoxication, acutely agitated patients, and acutely psychotic patients at a higher rate than either the residents or the unlicensed personnel. Greater than half of unlicensed staff felt not well trained when working with acutely psychotic patients and only one third of unlicensed staff felt somewhat trained when working with agitated visitors.

As part of the interventions, all of the Residents were assigned an online version of the MOAB training. This method of training was selected by the physician leadership as it was a training that would expose them to the content over the course of one hour and could be easily assigned and completed in this short time window of study. Additionally, all of the
unlicensed teams received online training tutorials with similar content. The limitation in enrolling all in the same training to measure impact was due to inability to gain class spaces and integrate into the schedules of over 250 people in a short time frame of study. The online programs were chosen as a substitute due to time, operations, and class ability. After the pre-survey, and prior to the re-survey, eleven technicians, fourteen residents, six attending physicians, and seven “other” (patient observers and registration) completed the one hour online training. Although this was a small percentage from each team, it represented thirty-eight people out of eighty-three non-nurse respondents from the pre-survey who completed this voluntary training, or approximately 46% of the non-nurse respondents.

**Hospital Initiatives**

It is important to note that overlapping with the timeframe of this department specific interventions was an internal hospital wide safety awareness campaign with ongoing initiatives focused on event reporting, event response, training and education, and access control. The event reporting aspect was aimed at simplifying the form in the reporting systems to increase use through the internal portal. Leaders also began working on a “Threat Response Team” in a collaborative effort with public safety, emergency management and senior leaders to develop an algorithm for threat evaluation. From an education and training perspective, a great focus was placed on training platforms on line for all employees of the medical center to promote annual “Safety / Security” messages to all staff. In conjunction with this work, a new policy was drafted regarding workplace violence including standard of care. And finally, access control was a major focus of the hospital initiatives adding visitor management equipment, enhanced access control to the campus, and deactivating the access
of terminated card holders within twenty-four hours. All of these interventions were publicized on the internal portal and discussed in staff meetings during the time of the pre-survey and re-survey.

Chapter Five

Findings and Results

Response Demographics

The scope of the experience with Type 2 WPV was evaluated with a survey that was conducted in September of 2016 at the BIDMC ED. This pre-intervention survey was sent to 250 people with a resulting response rate of 68% (169 individuals). Of the respondents, 68% were female and 32% were male; 39% were nurses, 29% doctors, 15% ED technicians, 15% other (patient registration, patient observers, and unit coordinators), and 2% were Patient Liaisons. The years of experience of respondents were highest in the 1-4 years at 34%, with the second highest 10+ years at 25%. Following that, less than one year comprised 21% of respondents and 5-10 years comprised 20% of respondents. The post-intervention survey was sent in 2017 to 250 people with a response of 135 or 54%. Of the respondents, 60% were female and 40% were male; 31% were nurses, 41% doctors, 19% ED technicians, 8% other (patient registration, patient observers, and unit coordinators), and 1% Patient Liaison. The years of experience of respondents were highest in the 1-4 years range at 42%, with the second highest respondents in the 5-10 years at 21%. Following that, 18% responded from the 10+ years demographic and 17% represented <1 year.
Experience and Frequency
In the pre-intervention survey, when asked whether the staff had experienced WPV over the past seven shifts, 37% answered “yes” to witnessing or experiencing physical violence, 82% answered yes to witnessing or experiencing verbal / emotional violence, 17% answered yes to witnessing or experiencing contamination, 15% answered “yes” to witnessing or experiencing sexual assault (includes sexual harassment), and 3% answered “yes” to witnessing or experiencing stalking (social media).

In the post-intervention survey, when asked whether the staff had experienced WPV over the last seven shifts, 41% answered “yes” to being witness to or victim of physical violence, 81% answered “yes” to being witness or victim to verbal / emotional violence, 16% answered “yes” being witness or experiencing contamination, 12% answered “yes” to being witness or experiencing sexual assault (includes sexual harassment), and 3% answered “yes” to stalking (social media).

Figure 4: 2016 and 2017 Experience

There was no significant difference between the pre and post intervention survey in the experience of witnessed or experienced violence in the past seven shifts. The frequency of experienced or witnessed WPV in the last 7 shifts remained high pre and post...
interventions without any significant change over time. As it is not possible to control the population coming to seek care in an emergency department, the study also looked at prevalence, reporting, and preparedness. All respondents were asked about frequency of violence with the scale noted in the figure below. It is also evident, between 2016 and 2017, the frequency of violence had not significantly changed nor had the frequency of type of violence shifted.

Figure 5: Reported Frequency of Violence

Breaking down the types of experienced and witnessed Type II WPV helped to describe the prevalence of certain types of WPV. The data further suggested that different
provider groups may be disproportionately affected by particular types of violence. For example, as compared to physicians, nurses and technicians appeared to witness / experience more physical violence and sexual assault. Compared to technicians, nurses and physicians appeared to witness / experience more intentional contamination. Verbal abuse was consistently high (80+ %) across all three groups.

Figure 6: Reported Incidents of Violence by Role

![Graph showing reported incidents of violence by role in 2016 and 2017 surveys.]

- **2016 Survey**
  - Physical Violence: 55%
  - Verbal/Emotional Violence: 41%
  - Contamination: 55%
  - Sexual Assault: 48%
  - Stalking: 24%

- **2017 Survey**
  - Physical Violence: 46%
  - Verbal/Emotional Violence: 32%
  - Contamination: 48%
  - Sexual Assault: 38%
The relative frequency of violence by each role is noted in the figure below. This is the frequency of witnessing or experiencing the different types of violence relative to the total n of the respondents in each group.

Figure 7: Relative Frequency of Violence by Role

- **Nurses**
  - Physical Violence
  - Verbal/Emotional Violence
  - Contamination
  - Sexual Assault
  - Stalking

- **Doctors**
  - Physical Violence
  - Verbal/Emotional Violence
  - Contamination
  - Sexual Assault
  - Stalking

- **Technicians**
  - Physical Violence
  - Verbal/Emotional Violence
  - Contamination
  - Sexual Assault
  - Stalking

*Roles with top three highest overall frequency of violence shown.

- Data suggest that different provider groups may be disproportionately affected by particular types of violence. For example:
  - Compared to doctors, nurses and technicians appear to witness/experience more physical violence and sexual assault.
  - Compared to technicians, nurses and doctors appear to witness/experience more intentional contamination.
  - Verbal abuse was consistently high (80%+) across all 3 groups.

**Reporting**

The study also evaluated the reporting rates by role. In the pre-survey, of the 139 respondents who said they witnessed or experienced one or more type of violence within their last 7 shifts, only 17% said they had formally reported it. The reporting rate for nurses who said they witnessed or experienced one or more type of violence with in their last 7 shifts, was 16%. In the post-survey, of the 135 respondents who stated they witnessed or experienced one or more type of violence within their last seven shifts, only 12% reported it.
The next series of figures and tables presents each discipline with their reporting for each category of Type II WPV.

Figure 8: Reporting by Nurse Respondents

Figure 9: Reporting by Doctor Respondents
Figure 10: Reporting by Technician Respondents

![Graph showing reporting rates for different types of violence](chart.png)

Table 2: Comparative Reporting Rates by Role

### 2016 Survey

<table>
<thead>
<tr>
<th>Role</th>
<th>Witnessed / Experienced Violence</th>
<th>Reported Violence</th>
<th>Report Rate</th>
<th>Report Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>56</td>
<td>9</td>
<td>16%</td>
<td>4</td>
</tr>
<tr>
<td>Doctor</td>
<td>37</td>
<td>2</td>
<td>5%</td>
<td>5</td>
</tr>
<tr>
<td>Technician</td>
<td>20</td>
<td>5</td>
<td>25%</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>6</td>
<td>43%</td>
<td>1</td>
</tr>
<tr>
<td>Role not specified</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>3</td>
</tr>
<tr>
<td>Patient Liaison</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>6</td>
</tr>
</tbody>
</table>

### 2017 Survey

<table>
<thead>
<tr>
<th>Role</th>
<th>Witnessed / Experienced Violence</th>
<th>Reported Violence</th>
<th>Report Rate</th>
<th>Report Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>38</td>
<td>7</td>
<td>18%</td>
<td>2</td>
</tr>
<tr>
<td>Doctor</td>
<td>50</td>
<td>4</td>
<td>8%</td>
<td>4</td>
</tr>
<tr>
<td>Technician</td>
<td>23</td>
<td>3</td>
<td>13%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>1</td>
</tr>
<tr>
<td>Role not specified</td>
<td>13</td>
<td>0</td>
<td>0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient Liaison</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
It is important to note that in 2016, the Nurses had the highest in-group proportion that witnessed/experienced violence yet had the fourth highest rate of reporting events. Even though 56 nurses said they witnessed/experienced some type of violence, only 16% reported it. When the response of the physicians is examined, the reporting rate dropped to 5% despite the frequency of their experience. The staff members who were least involved in direct patient care (registration observers, and unit coordinators) were the most likely to report an incident in the 2016 pre-survey. In 2017, post interventions, there is a significant change where the physicians were the highest reporting group, in proportion, that witnessed or experienced violence yet were the lowest to report through the instructed methods. The response rate from physicians increase in the second survey with 50 respondents stating they experienced or witnessed events, only 8% of them reported it despite the rise in events. This group received education that was new in their training as noted in the intervention section.

When a WPV event was reported, 74% of the time it was reported to a supervisor or member of the leadership team (resource nurse, clinical advisor, nursing director, or ED RN/MD administrator on call). Few events were reported to public safety/security, 17%, and even fewer through the organization’s reporting tool for incidents, 4%.

Figure 11: Primary Reporting Method
Reasons for not reporting WPV

In both the 2016 and 2017 surveys, the four top responses were (as selected from a list of options):

1. “It is part of the job”
2. “Didn’t expect anyone to do anything about it”
3. “Patient condition – demented or ill” (“not their fault”)
4. “Did not have time during shift to report”

The interventions included the creation of a violence response teams and the center for Violence Prevention and Recovery staff forums were aimed at reducing the reason for not reporting. The goal was to instill in the department that WPV was not something an employee or physician needed to deal with in isolation and that there were supports in place for them. The trends with both data sets are below in the figure and show a strong consistency year over year when responding to questions about reporting.

Figure 12: Reason for Not Reporting WPV
Education

Respondents were asked how well trained they felt to recognize and diffuse aggressive behavior, dementia, acute trauma, acute psychotic and agitated patients, and acute intoxication. From 2016 through 2017 the level of feeling very well trained, somewhat trained and somewhat untrained, remained consistent despite interventions.

During the intervention stage, there was no new training introduced to nursing. However, the ED technicians, other unlicensed respondents, and the residency program did receive an optional one-hour online training focused on MOAB skills. More respondents signed up for training which occurred in the fall of 2017 in to the spring of 2018 however that cannot be appreciated in this survey due to the timing.

Figure 13: Recognition and Diffusion of WPV

<table>
<thead>
<tr>
<th></th>
<th>Somewhat or very untrained</th>
<th>Somewhat trained</th>
<th>Somewhat or very well-trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive behavior</td>
<td>29%</td>
<td>31%</td>
<td>40%</td>
</tr>
<tr>
<td>Chronic dementia/sundowning</td>
<td>11%</td>
<td>35%</td>
<td>54%</td>
</tr>
<tr>
<td>Acute trauma</td>
<td>10%</td>
<td>29%</td>
<td>61%</td>
</tr>
<tr>
<td>Acutely psychotic altered MS</td>
<td>11%</td>
<td>23%</td>
<td>66%</td>
</tr>
<tr>
<td>Acutely agitated normal MS</td>
<td>13%</td>
<td>26%</td>
<td>61%</td>
</tr>
<tr>
<td>Acute intoxication</td>
<td>6%</td>
<td>24%</td>
<td>70%</td>
</tr>
</tbody>
</table>
Greatest Risk Factors and Prevention Measures

After assessing the rates of WPV, prevalence, role differences in experience, reporting practices, reasons of not reporting, and differences pre and post interventions, respondents were given open ended questions. The first question was: “What do you see as the greatest risk factors of violence, including what daily activities put you at risk?” and the second was “What prevention measures do you believe could reduce violence or increase safety in the ED”?

2017 Survey

In response to the greatest risk factors free text question, the comments included wait times, staffing changes, workload, security presence and communication. Figure 14 highlights the themes in the 198 responses. The number on the bar graph represents how many respondents mentioned this risk factor when responding to the question.
This graph above combines the themes all of the comments from the pre and the post surveys of 2016 and 2017 as they overlapped tremendously. Risk factors remained consistent despite the interventions, as the department continued to struggle with long wait times and boarding times to be admitted, staffing variability and workload, and the overall behavior and condition of the patients seeking care. The interventions were not aimed to decrease these factors; however, they were aimed to mitigate and create an environment of support and proactive response. Some of the top risk factors from the 2016 pre-survey were high patient volumes, crowding, poor visitor monitoring, workload demands and long wait times. In the 2017 post survey, long wait times, workload, and security monitoring continued to prevail with additional feedback about patient frustrations escalating along with unrealistic expectations.

In response to the second question the following suggested measure to prevent WPV were solicited: increased security and education, additional communication, implementing
policies to limit visitors. The 200 responses were grouped thematically and are displayed in the graph below. All respondents from 2016 and 2017 are collated here as many themes remained consistent.

Figure 15: Prevention Measures to Reduce WPV from Respondents

The respondent’s feedback about prevention measures are aligned with respondent’s feedback about risk factors of WPV. The free text comments were placed in to themes noted in figure 15. The focus points range from increase safety event reporting, to restricted access for visitation, more education on prevention and de-escalation techniques, and a strong theme of communication improvements throughout both the pre and post survey. The respondents’ top strategies in the pre-survey for preventive measures for reducing WPV were in order of highest response: 1.) more security, 2.) restricted visitor policies, 3.) WPV training on prevention, 4.) increase safety event reporting, and 5.) alternative methods to call for help. Some of the top strategies in the post survey for preventive measures as received by
respondents in order of highest response are: 1.) patient education for zero tolerance for violent behavior, 2.) de-escalation training, 3.) increase security presence, 4.) communication and team work, and 5.) visitor management efforts.

Employee and Physician Feedback
One of the great learnings of this project is the feedback from respondents who participated and have demonstrated engagement in this important work. Although some of the metrics did not move as initially intended, the shift in conversation and feedback has been realized.

Some of the pre-survey comments included:

• “We need more security to help us”
• “There are multiple times I have felt unsafe in the department because of patients.”
• “There should be more training and we need to know our rights.”
• “More training for all teams is always welcomed as this is not going away.”

Some of the post survey comments included:

• “I feel we have a gotten a good handle on the response to physical violence in the department, but verbal and other forms of violence are seen in the department on a frequent basis and are still treated as “part of the job” by staff”.
• “Happy for the increased security 24 hours a day.”
• “Our leaders care and are working with us to help us to respond better.”
• “It is a daily battle of managing expectations and priority setting which may not be understood by patients/visitors. Being proactive and talking about this as a concern is the first step towards improvement.”
Chapter Six: Summary

Discussion and Implementation

The goal of the BIDMC ED 2016 pre-survey was to quantify the prevalence of Type II WPV and identify risk factors; to understand reporting practices, and to assess how well-prepared staff felt to handle potential violence. The objectives of the 2017 post survey were the same as the 2016 objectives, with an additional focus to measure the effectiveness of recent improvement initiatives that had been implemented in the intervening year in the ED. The environment of a level one trauma center ED is fast paced with diverse ranging patient populations and multiple clinical teams. This process improvement project aimed to better understand the staff experiences with type II WPV, as well as to understand the reasons for underreporting of events. The pre-intervention survey data helped to inform the development of interventions, with the goal of making improvements in the care of verbally aggressive and/or violent patient management and to improve employee safety.

Although some of the results from pre to post surveys did not shift greatly, the comments from the respondents validated the focus of this project as important to staff, patients and visitor safety. This was not surprising as the interventions were somewhat limited and the time between surveys may have been too close to detect any meaningful change. Interventions were implemented over six months prior to a resurvey. Some of the challenges getting them started related to workload in the department, ability to free staff to attend huddles and discussions with the center for violence, as well as some challenges making this a priority in their daily work with competing demands. As stated, this was a short timeframe to impact change and it is a suggestion that this study be repeated again in
the fall of 2018 with a continued focus on the ongoing interventions to measure impact over time. The findings in this study are very consistent with the literature as this is a newer area of study and it is recognized that it will take time to see benefit of the interventions due to the complex nature.

The majority of the physicians, nurses, and technicians in the BIDMC ED reported having been exposed to some form or type II WPV in the past seven shifts at time of survey. Most of the violent episodes were verbal / emotional, followed by physical violence, and then contamination. Contamination in this context is defined as the deliberate act to expose a health care provider to body fluids/matter such as urine, saliva, feces, or blood. There was no significant change in reporting patterns between the 2 surveys. Those that did report said that they did so primarily by talking to leadership in the department. The top reasons for not reporting remained that it was thought to be part of the job and despite interventions many felt that this is a known risk in the environment. Clinicians’ reported feeling inadequately trained to deal with a variety of medical conditions that have been associated with WPV.

Based on the pre-intervention survey data that the organization responded by increasing security presence with twenty-four hours a day fixed post officer in the triage (entrance) area. Previously, the security personnel in the triage area would often leave their post to respond to other calls in the medical center and return when the call was completed. This added change was thought to be a great support to all clinical teams.

Suggestions for future interventions include more focused training particularly aimed at improving communication strategies with patients and families. It was also a suggestion that this survey be repeated annually to measure changes as movement with this inquiry will
take time as supported by the literature as well as by the experience of this work. Continued study here is necessary to capture the impact of the improvements over a longer timeframe. It was sufficient to assess the current state and to identify additional opportunities for improvement.

It is critical local leadership support, drives and leads this work in order to fully engage teams. There was strong emergency physician engagement and the responses from the pre-intervention survey to the post did result in increased participation. The physician champion leading this effort has recently started to focus one month of mortality and morbidity rounds on the care of the violent patient in an effort to continue to execute interventions with different clinical teams in an effort to continue to improve the experience as a healthcare provider at BIDMC ED.

**Study Limitations**

This study represented a beginning for the ED at BIDMC to understand the complexity of experience and perception of type II WPV in a high-risk area of the ED. The timing of the study presented some limitations. One limitation was the timing of interventions. The interventions were rolled out April 2017-September 2017, following a pre-intervention survey in the fall of 2016. The delay in the roll out was influenced by the need for leadership agreement on a planned intervention as well as engagement from physician and social work teams. The challenge of introducing new processes or focused work prior to the summer months is complex as well as the challenge of the short time frame to measure impact.
Plan for Dissemination

This project has been shared with the entire staff in the ED at BIDMC as well as the Emergency Medicine Attending and Residency groups. Organizationally, the data has been shared with various workplace violence committees and leadership groups that span the organization. In November of 2017, the pre and post data was presented as part of a larger presentation at a nursing seminar as well as a larger group of nurses from across the organization in the fall of 2017. Although some of the key metrics did not shift tremendously over this short timeframe, the implanted interventions continue and we plan to re-survey in the fall of 2018 to evaluate effectiveness over a longer time period. The organization has also launched a workplace safety campaign that compliments on a greater scale the intent of this work with regards to reporting, response, training, and tolerance. The positive image of this campaign is leading the way for employees to feel supported, receive clearly set standards and expectations for providers and clinicians, and highlight the importance of employee safety in the annual operating plan of 2017 at BIDMC. The key stakeholders include senior leaders, physician partners and departments of emergency medicine and psychiatry, emergency department nursing as well as the chief nursing officer, employee and occupational health system, public safety, social work, and all teams that work in the ED at BIDMC. This is ongoing work with research potential and a highly recognized benefit to the organization with the learnings of one departments experience as the goal evolves to reduce WPV organizationally.
References


Appendix A: IRB Simmons College and BIDMC

Simmons College
Institutional Review Board

Worksheet to determine if the project is research or performance improvement (aka Quality Improvement)

<table>
<thead>
<tr>
<th>Researcher's Name:</th>
<th>Kirsten Boyd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department/Program:</td>
<td>Doctorate of Nursing Practice</td>
</tr>
<tr>
<td>E-Mail:</td>
<td><a href="mailto:kboyd2@bidmc.harvard.edu">kboyd2@bidmc.harvard.edu</a></td>
</tr>
<tr>
<td>Phone:</td>
<td>617-754-2362</td>
</tr>
</tbody>
</table>

Project Title: Assessing the Perceived Prevalence and Reporting Practices of Type II Workplace Violence in the BIDMC Emergency Department

Is the project’s purpose SOLELY to evaluate whether putting research evidence into practice improves quality measures? No ☐ Yes ☐

Will the data you gather be sensitive in nature? (i.e. have the ability to cause emotional distress, potentially put someone in financial, legal, physical or other harm)? No ☐ Yes ☒ (please explain)

Do you intend the data that will be collected to be of widespread interest or usefulness to a larger audience than the subjects you collect data from, or widespread interest beyond your department? No ☐ Yes ☒ (please explain)

The pre/post survey with interventions will likely be transferable to other practice settings in addition to emergency departments. Workplace Violence is of large national concern in healthcare and interventions tested in this PI may be of widespread interest to a larger audience.

Will you be publishing or presenting the results outside of Simmons College? No ☐ Yes ☒ If yes: as a PI project or as a research study? PI

Will subjects to be used in the project come from a vulnerable population including minors under the age of 18, economically and/or educationally disadvantaged persons, prisoners, pregnant women, fetuses, the seriously ill, persons with mental disabilities, or incompetent individuals? No ☐ Yes ☒

PROJECT DESCRIPTION: Please attach the description of your PI/QI project to this form. Sufficient detail should be provided so that we can determine the level of risk involved as well as the purpose of the project.

Student Signature: Kirsten Boyd Date: 5/9/2017

Faculty/Staff Signature: AMY Date: 5/8/2017

Accepted ☒(not research) or Denied ☐ (this is research)

Next action to be taken: Submit separate IRB application.

Other action required:

Authorized Signature: Date: 6/7/17
Determination of Exemption

IRB Protocol #: 2016P000235

Principal Investigator: Patricia Polcari
Protocol Title: Assessing the Perceived Prevalence and Reporting Practice of Type II Workplace Violence in the BIDMC Emergency Department
Funding: None
Review Type: Exempt
IRB Determination Date: 09/08/2016
Notification Date: 09/14/2016

The Beth Israel Deaconess Medical Center Committee on Clinical Investigations has determined that the referenced application meets the criteria for exempt status under exempt category/categories 2.

When the CCI determines that a study is exempt continuing review and approval is not required. In some circumstances, modifications to exempt research disqualify the research from the exempt status. Modifications that could increase the risk level, alter the study design or population, or involve a change in PI must be submitted to the CCI for review and approval prior to implementation.

PLEASE NOTE:

You are reminded that you are required to follow the requirements described in the CCI Policy and Procedure Manual.

If there are any questions you may contact the Committee on Clinical Investigations (CCI) at 617-975-8511.
DETERMINATION OF HUMAN SUBJECT RESEARCH

All protocols involving both "research" or "clinical investigations" and "human subjects" must be reviewed and approved by the IRB before recruitment and data collection may start. The range of activities involving human participants at BIDMC comprises patient care, teaching and research; however, not all of these activities constitute human subject research. For example, training, education, quality improvement, and review of case reports are activities in which our faculty and staff are commonly engaged. However, for some activities it might be difficult to tell whether they qualify as human subject research. Furthermore, these activities may become research when an individual decides to take “accidental discoveries” and/or “innovative practices,” a step further and engage in a systematic investigation with the intent to contribute to generalizable knowledge.

Please refer to the CCI Policy Manual for further definition of human subject research.

If it unclear whether the activities in question meet the definition of “human subject research,” please complete the following questions and return the completed form as a Word document via email to Jessica Ripton, Director, CCI-IRB Operations at jripton@bidmc.harvard.edu for a determination.

PROVIDE A TITLE OF PROJECT

Workplace Violence Survey for the Emergency Department

WHO IS INVOLVED WITH THE PROJECT

<table>
<thead>
<tr>
<th>Name of individual leading the project:</th>
<th>Taj Qureshi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Healthcare Quality</td>
<td>Division: Patient Safety</td>
</tr>
<tr>
<td>Telephone: 617-975-9741</td>
<td>Pager:</td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
</tr>
</tbody>
</table>

Do you have other "collaborators" working on the project with you? If so, can you identify them at this time? Pat Folcarelli (HCQ); Meg Femino (Emergency Management); Chris Casey (Public Safety); Kirsten Boyd (Emergency Department); Scott Rollings (Emergency Department)

EVALUATION
Provide a brief description (one paragraph) of the purpose or goal of the project, the intent for conducting the project, and the procedures used to accomplish the purpose or goal:

Workplace Violence is a significant occupational hazard in health care and those who work in the Emergency Department are especially at risk. These events frequently go unreported so the severity of the issue is severely underestimated. The Workplace Violence Prevention Committee will be using a brief survey created through Survey Monkey to survey all BIDMC Emergency Department staff and providers (nurses, residents, MDs, NPs, PA’s, PCTs and Techs, etc.) on the perceived prevalence of workplace violence, and the reporting practices of such events. We will use definitions from the literature to educate them on the scope of events that are considered Workplace Violence. The survey will be anonymous and voluntary and will ask some or all of the following questions:

1. In your last six shifts, have you been witness to, or victim of, Type II Workplace Violence (as defined)?
2. In your last six shifts, have you experienced the following events? (select all that apply – physical assault, threats, stalking, etc.)
3. If you experienced Workplace Violence in your last six shifts, did you report the occurrence?
4. What was the primary way you reported it?
5. Why didn’t you report it?
6. What daily activities, if any, expose you to the greatest risk of violence?
7. To what degree are you concerned about being threatened or physically attacked by a patient/visitor while you are at work?

Does the project include testing the safety and efficacy of a drug or device in a human subject?  
[ ] Yes  [x] No

Do you intend that the information you learn from the project to be generalizable beyond BIDMC and BIDMC processes and practices? The intent is that the activity is undertaken to contribute to generalizable knowledge, not to provide immediate and continuous improvement and feedback in the local setting. Generalizable knowledge applies beyond a specific time and location.

[ ] Yes  [x] No

Will you collect data from living individuals through some type of intervention?  
[ ] Yes  [x] No

Will you interact in any way with a living individual?  
[ ] Yes  [x] No
If yes, describe:

Will you have access to individually identifiable information?  
[ ] Yes  [x] No
If yes, describe:
REVIEWER DETERMINATION – FOR CCI USE ONLY

☐ The activities described do not meet the definition of Human Subject Research.

☐ More information is required in order to determine if the activities meet the definition of Human Subject Research. Please provide the following information:

☐ This project meets the definition of human subject research and should be submitted to the CCI as:
  - An Exempt Application
  - An Expedited Application
  - A Full Board Application

(Provide link to CCI Website for forms and instructions when returning a determination: http://research.bidmc.harvard.edu/OST/CCI/CCIForms.asp)

Reviewer Name ___________________________ Date ___________________________

Signature ___________________________
EXEMPT RESEARCH APPLICATION

RESEARCH STAFF INFORMATION

A. PRINCIPAL INVESTIGATOR(P1)

Principal Investigator: Pat Folcarelli, RN, PhD

P.I.’s Chief of Department or Division (Assistant): Ken Sands, MD, MPH Chief Quality Officer and Senior Vice President, Health Care Quality

PI E-Mail Address: pflocare@bidmc.harvard.edu

NOTE: Please use the Research Staffing Form to indicate all the co-investigators/study staff members who will be participating in this study.

B1. TITLE OF PROPOSAL

Assessing the Perceived Prevalence and Reporting Practices of Type II Workplace Violence in the BIDMC Emergency Department

B2. SHORT TITLE (50 CHARACTERS – MUST CONTAIN KEYWORDS FOR IDENTIFYING PROTOCOL)

Workplace Violence in the Emergency Department

C. SPONSOR/FUNDING SOURCE

This section must be completed for all research studies, even if no funding is available. If no funding is available for the study, please provide an explanation as required in the first box below and then skip to the PURPOSE section. Complete the remainder of this section for all sponsored and/or funded research studies. For applications involving federal or foundation funding, Department of Health and Human Services (HHS) requires under regulation 45 CFR 46.103 (f) that each application or proposal for HHS-supported human subject research be reviewed and approved by the IRB. For OHRP, any discrepancies between the HHS/NIH application and the protocol submitted to the IRB must be resolved prior to the involvement of human subjects (May 31, 2010 memorandum). If sponsored and/or funding source changes, the PI must submit that information to the CCI with an amendment form for further review. See the CLINICAL TRIALS OFFICE section at the end of the application for required signatures verifying budget and/or contract status.

☐ No funding is available – provide reason and then skip to the section D1. titled PURPOSE. (If not funded, contact the Clinical Trials Office at (617) 734-4443 or CTO@bidmc.harvard.edu for possible review.

Please provide reason: This is work coming out of the Workplace Violence Committee as a part of quality improvement work for the Department of Healthcare Quality

☐ Yes, monetary and/or non-monetary funding (i.e., in kind): ☐ Industry ☐ Federal ☐ Foundation ☐ Free Drug or No Cost Loan of Device

(Please complete C6 thru C8 below—Complete C9 thru C6 for federal grants)

C2. FUNDING OR SUPPORTING INFORMATION (check the appropriate box)

☐ Industry initiated, and supported research

☐ Funding entity:

☐ Investigator initiated, externally supported research

☐ Funding entity:

☐ Investigator initiated, internally supported research

☐ Internal funding source:

C3. REVIEW/APPROVAL OF FUNDING AGREEMENT AND BUDGET
For both industry and internally funded research, as well as in-kind support such as free drug or no cost loan of device, the BIDMC Clinical Trials Office (x74443 or CTO@bidmc.harvard.edu) should review/approve the funding agreement and budget.

For all other externally funded research please contact the Research Administrator or Research Administrative Director for your department for review/approval of the funding agreement/application and budget. A list of research administrative personnel may be found at: https://research.bidmc.harvard.edu/Data/ResearchAdministrators.aspx

Which BIDMC research administrative office did you contact for review and approval of your funding agreement and budget?

Clinical Trial Office (complete section C4.)
Research Administrator or
Research Administrative Director

C4. CLINICAL TRIALS OFFICE INFORMATION

☐ The contract and budget that support this research application are under review, and pending final approval.

☐ The contract and budget that support this research application have been reviewed and fully executed/approved.

☐ N/A (This research application is not supported by industry or internal funds).

Comments

C5. FUNDING OR SUPPORT DETAILS

List dollars requested/approved:

Describe any non-monetary support that will be provided (e.g., free medication, research drug, device, material gift):

This research study involves: ☐ one site only/BIDMC Locations ☐ multiple sites

For federal grants: Is BIDMC the awardee institution? ☐ Yes ☐ No

If No, who is the awardee institution?

If Yes, attach a completed, signed copy of the HHS/NIH application.

Note: The CCI cannot grant final approval until the grant application has been reviewed.

C6. DISCREPANCIES

Are there any discrepancies including administrative (e.g., title, Principal Investigator) or procedural between the CCI application and the HHS/NIH application? ☐ Yes ☐ No

If yes, specify and explain all differences:

C7. HHS/NIH APPLICATION DETAILS

Assigned HHS/NIH grant #:

Grant application submission date:

Grant application status: ☐ Funded ☐ Pending (priority score/percentile is "fundable")

D1. PURPOSE

Provide a brief description of the purpose of the study.
The purpose of this study is to assess the perception, occurrence, and reporting practices of Workplace Violence within the Emergency Department at BIDMC. This survey will serve as an education tool to inform staff of what constitutes violence, and the data we receive will help inform the resources that are needed to create a safer environment for staff and patients, such as a simplified reporting tool and a zero-tolerance policy for violence.

D.2. STUDY DESCRIPTION

Study description:

a. Describe background for the study and its purpose by including goals of the research in terms of relevance to human biology, disease processes, human behavior, organizational and educational processes. This should help elucidate the appropriate exemption category and delineate research activities from required activities that are routinely conducted and evaluated (for example, training and educational practices, quality improvement/quality assurance activities). Workplace violence is a major issue in the United States of America, even more so in the Healthcare Industry, leading to feelings of “anxiety, fear, and a climate of distrust in the workplace,” according to the Federal Bureau of Investigation’s Workplace Violence: Issues of Response. Previous research on this subject has shown that 100% of Emergency Department nurses surveyed experienced verbal assault and 82.1% of those same nurses had experienced physical assault in the previous year (May & Grubbs, 2002). Workplace Violence is highly underreported. The effects of Workplace Violence are far reaching and include decreased perceptions of safety, increased employee leave time, decreased employee satisfaction, and increased employee turnover, all of which may have effects on patient satisfaction and patient outcomes. Understanding the prevalence of Workplace Violence, current reporting practices, and barriers to increased reporting may lend itself to the development of recommendations for the mitigation of Workplace Violence.

b. Specific aims or hypotheses, if applicable.

Workplace Violence against emergency department staff and physicians is pervasive, severely underreported, and perceived as part of the job. Surveying the staff can help us answer these primary questions: the frequency in which they are experiencing or witnessing acts of violence, how well prepared they feel they are to manage patients and families in violent situations, and the barriers to reporting events.

c. Describe the study procedures and methods (make sure you distinguish between those procedures done solely for the research and those that will be done outside the research context.) Emergency Department staff and physicians at BIDMC will be supplied with an email describing the study and a link to an online, twelve-question, anonymous survey, which they will volunteer to participate in. We have chosen SurveyMonkey as the online platform as there is no identifiable information or PHI that will be collected from participants. The survey will allow for
Respondents to not respond to any question, and they can skip questions they prefer not to respond to. At the end of the survey, participants will be given an option to withdraw from the survey. Healthcare Quality has a premium-level account through SurveyMonkey which will store the data safely and securely. Lisa Buchbaum, Co-Investigator, will be the only one who will have direct access to the data, which will be deleted from SurveyMonkey following export to excel file on the drive and then deleted.

E. SUBJECT POPULATION

1. Describe how subjects will be identified or recruited.

   The subject population for this study are emergency department staff and emergency medicine physicians at BIDMC. All emergency department staff and physicians will receive an email describing the study with a link to an online twelve question survey. Staff will choose to self-enroll in the study by independently following the link to the online survey and completing it.

2. Describe any interactions you will have with subjects. You must describe a consent process whereby you will ensure that you have disclosed to subjects the following points:
   a. That the activities involve research
   b. The procedures to be performed
   c. That participation is voluntary
   d. Name and contact information for the investigator

   Provide a script for the verbal consent process

   By following the link below and completing the brief, 12-question, anonymous survey, you are consenting to participate in a research study to assess the prevalence of Type II workplace violence (patient to staff) in the Emergency Department. The intent of the survey is to assess the exposure to and perceptions of preparedness to manage and report acts of violence. Please note that participation is voluntary and confidential. If you have any questions, please contact the Primary Investigator, Pat Focarelli, RN at pfocarelli@bidmc.harvard.edu.

3. Describe how you will maintain the privacy interests of subjects (for example, you will, when appropriate, discuss the study or collect information from subjects in a location and/or in a manner that prevents others from knowing or hearing about the subjects' participation.

   The online survey is confidential and may be taken in any setting of the subjects choosing. No verbal or in person collection of information will occur.

4. Describe how subjects' data, specimens and/or records will be identified.

   All data and records are completely confidential and will not be associated with personal identification.

5. Describe how subjects’ individually identifiable information will be recorded ensuring that provisions are made to maintain the confidentiality of the data.

   Any individually identifiable information (limited to your gender, position, and years of service in this study) are voluntary and will be held in confidence, only to be used in
F. EXEMPTION CATEGORY DETERMINATION

MINIMAL RISK

Does this research project involve only minimal risk to human subjects:  ☐ Yes ☐ No
‘Minimal risk’ is defined as follows:

‘…the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.’

If No, the study does not qualify for exemption, nor does it qualify for expedited review and therefore a full application must be submitted for review by the convened committee.

If you answer Yes, please check any of the following activities that describe the research you are proposing and complete the appropriate sections as required. Note: Categories 1-5 cannot be FDA regulated:

☐ 1. Normal educational practices and settings
   Complete Question 1 below

☐ 2. Educational tests, surveys, interviews, or observations of public behavior
   Complete Question 2 below

☐ 3. Educational tests, surveys, interviews, or observations of public behavior not exempt under Category 2
   Complete Question 3 below

☐ 4. Existing data sets, documents, records and specimens (‘Existing’ means existing before the research is proposed to the IRB for exempt determination.)
   Complete Question 4 below

☐ 5. Public Service benefits/programs evaluation
   Complete Question 5 below

☐ 6. Taste and food quality evaluation
   Complete Question 6 below

QUESTION 1 – STANDARD EDUCATIONAL ASSESSMENTS (EXEMPTION CATEGORY 1)

Does this research involve evaluation of an instructional strategy that deviates from those commonly accepted or used in student, patient or staff training or education?  ☐ Yes ☐ No

If Yes, this research does not qualify as exempt.

A. Does this research involve randomizing subjects to different instructional methods?  ☐ Yes ☐ No

If Yes, this research does not qualify as exempt.

B. Does this research involve deception, or withholding information from subjects?  ☐ Yes ☐ No

If Yes, this research does not qualify as exempt.

‘If you answered yes to any of the questions above, the proposed research may be eligible for expedited review. Please review Part M before submitting a new application.

QUESTION 2 – EDUCATIONAL TESTS, SURVEYS, INTERVIEWS, OBSERVATION (EXEMPTION CATEGORY 2)

A. Will identifiers be recorded with or linked to (e.g. via a coding system) the data? Identifiers include name, address, zip code, all elements of dates for dates directly linked to an individual (birth date, admission date, discharge date, date of death, and all ages over 65), telephone number, fax number, e-mail address, social security number, medical record number, health plan beneficiary number, account number, license number, vehicle identifiers, device identifiers, Web Universal Resource Locators, Internet Protocol address numbers, finger or voice prints, full face photographs?  ☐ Yes ☐ No

Or
B. Does the content of the surveys, interviews, observations, etc. used for this study involve asking sensitive information that could place the subject at risk of criminal or civil liability, or negatively impact the subject’s financial standing, employability, insurability, professional standing or reputation should there be a breach of confidentiality?

☐ Yes ☐ No

If your answer is Yes to both, this research qualifies as neither exempt nor expedited.

"If you answered “Yes” only to question 2A, the proposed research may be eligible for exempt review.

"You must include a copy of all survey or assessment instruments, interview questions/guides, etc., for CCI review. If interacting directly with subjects to administer instruments, provide the CCI with a script that you will use to obtain consent.

C. Does the research involve survey procedures, interview procedures or observation of public behavior where the investigator participates in the activities being observed?

☐ Yes ☐ No

If Yes, this research does not qualify for exempt review.

QUESTION 3 – EDUCATIONAL TESTS, SURVEYS, INTERVIEWS, OR OBSERVATION OF PUBLIC BEHAVIOR THAT IS NOT EXEMPT UNDER CATEGORY 2. (EXEMPTION CATEGORY 3)

A. Does the conduct of this research involve appointed or elected public officials, or candidates for public office as research subjects?

☐ Yes ☐ No

If Yes, this research may qualify as exempt. Provide a complete description of the subject population in this application.

B. Does any Federal statute require without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter?

☐ Yes ☐ No

If Yes, this research may qualify as exempt.

QUESTION 4 – STUDY OF EXISTING DATA, DOCUMENTS, RECORDS, SPECIMENS (EXEMPTION CATEGORY 4)

A. Please answer the following questions if using data, documents or records:

☐ Not Applicable

1. Are these existing data, documents, records publicly available?

☐ Yes ☐ No

If Yes, this research may qualify as exempt.

2. Will information be recorded by the investigator in such a manner that the subjects cannot be identified directly or through identifiers linked to the subject? Identifiers include name, address, zip code, all elements of dates of birth, telephone number, tax number, e-mail address, social security number, medical record number, health plan beneficiary number, account number, license number, vehicle identifiers, device identifiers, Web Universal Resource Locators, Internet Protocol address numbers, finger or voice prints, full face photographs?

☐ Yes ☐ No

If Yes, this research may qualify as exempt.

3. Please complete the following information about records to be studied:

Number of records needed:
Data/records/document to be studied were collected during the following time period:
From: To:

Note that all records must exist at the time of submission of this application.

Will Psychiatric Records be Obtained? ☐ Yes ☐ No

If Yes, this research does not qualify as exempt. In accordance with Massachusetts state law, psychiatric records may only be reviewed upon receipt of express written consent to disclose from the subject.

Source of Data, Documents or Records:
☐ Hospital Medical Record ☐ Electronic Medical Record ☐ Educational Record
B. Please answer the following questions if using human specimens:

1. Are these existing specimens publicly available? □ Yes □ No
   If Yes, this research May qualify as exempt.
   Or

2. Will information be recorded by the investigator in such a manner that the subjects cannot be identified directly or through identifiers linked to the specimens? Identifiers include name, address, zip code, all elements of dates for dates directly linked to an individual (birth date, admission date, discharge date, date of death, and all ages over 15), telephone number, tax number, e-mail address, social security number, medical record number, health plan beneficiary number, account number, license number, vehicle identifiers, device identifiers, Web Universal Resource Locators, Internet Protocol address numbers, fingerprint or voice prints, full face photographs? □ Yes □ No

3. Please complete the following information about specimens to be studied:
   Number of specimens needed:
   Specimens to be studied were collected during the following time period: From: ___________ To: ___________
   Note that all specimens must exist at the time of submission of this application.
   Source of Specimens:
   □ BIDMC Pathology □ Other** (specify): ____________________________

**If using de-identified data or specimens for studies previously conducted, identify each of those studies, and describe the procedures by which identifiers were removed from the data/specimens.

QUESTION 5 – PUBLIC BENEFIT OR SERVICE PROGRAMS (EXEMPTION CATEGORY 5)
A. Does the research involve collecting sensitive information that could place the subject at risk of criminal or civil liability, or negatively impact the subject’s financial standing, employability, insurability, professional standing or reputation should there be a breach of confidentiality? □ Yes □ No
   If Yes, this research qualifies as neither exempt nor expedited.

QUESTION 6 – TASTE AND FOOD QUALITY EVALUATION (EXEMPTION CATEGORY 6)
A. Does the research proposed involve subjects consuming any type or volume of food that has potential risks such as additives or ingredients at or below a level found to be safe by an approved federal agency? □ Yes □ No
   If Yes, this research does not qualify as exempt.

G. USE OF DATA/RESULTS
Select all forms of disclosure:
□ Publication □ Other (describe)
□ Oral Presentation □ Commercial Entity (describe)

H. SIGNATURES and INVESTIGATOR STATEMENT
The investigator(s) certifies that:

- the information in this application is an accurate and complete presentation of all aspects and phases of the proposed research activities;
- The Committee on Clinical Investigations will be notified of any contemplated changes in the protocol regarding confidentiality of data that would affect applicability of the exemption.
Though exempt protocols do not require continuing review by the IRB, the investigator(s) understand that the Committee on Clinical Investigations has the right to ask for reports regarding the status of the research or may audit the research conducted under this exemption.

The principal investigator understands that by signing this Protocol application s/he is responsible for the conduct of the research protocol.

I have read and understand the above statement.

PRINCIPAL INVESTIGATOR SIGNATURE

DATE

EXEMPT CATEGORIES (45 CFR 46.101 b)

Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

Note: Categories 1-5 are not exempt under FDA regulations.

1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
   (i) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) Any disclosure of the human subjects’ responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, or reputation.

3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if (i) the human subjects are elected or appointed public officials or candidates for public office, or (ii) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

5) Research and demonstration projects which are conducted by or subject to the approval of Department or Agency heads, and which are designed to study, evaluate, or otherwise examine:
   (i) Public benefit or service programs; (ii) Procedures for obtaining benefits or services under those programs; (iii) Possible changes in or alternatives to those programs or procedures; or (iv) Possible changes in methods or levels of payment for benefits or services under those programs. **

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1 However, the exemptions at 45 CFR 46.101(b) do not apply to research involving prisoners, fetuses, pregnant women, or human in vitro fertilization, Subparts B and C. The exemption at 45 CFR 46.101(b)(2), for research involving survey or interview procedures or observation of public behavior, does not apply to research with children, Subpart D, except for research involving
observations of public behavior when the investigator(s) do not participate in the activities being observed.
Taste and food quality evaluation and consumer acceptance studies. (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture. This category is also exempt under FDA regulations.

******* DHHS has provided additional guidance for category #5:

The Office for Protection from Research Risks (OPRR) has determined that the following criteria (see 48 FR 9266-9270, March 4, 1983) must be satisfied to invoke the exemption for research and demonstration projects examining “public benefit or service programs” as specified under Department of Health and Human Services (HHS) regulations at 45 U.S. 461.10(b)(5):

1. The program under study must deliver a public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service (e.g., social, supportive, or nutrition services as provided under the Older Americans Act).

2. The research or demonstration project must be conducted pursuant to specific federal statutory authority.

3. There must be no statutory requirement that the project be reviewed by an Institutional Review Board (IRB).

4. The project must not involve significant physical invasions or intrusions upon the privacy of participants.

Institutions should consult with the HHS funding agency regarding the above conditions before invoking this exemption. In addition, it is extremely important that staff in all HHS agencies understand and respect the following principles, which are critical to the successful implementation of human subject protections under HHS regulations:

1. Institutions conducting (nonexempt) HHS-supported human subjects research must provide OPRR with an acceptable Assurance of Compliance with the human subjects regulations [45 CFR 46.103(a)]. Under the terms of such Assurances, it is typically the responsibility of the Institutional Review Board (IRB) or other designated institutional official(s), not the investigator, to determine whether research activities qualify for exemption. Institutions holding OPRR-approved Assurances generally require that all research involving human intervention/interaction or identifiable private information [45 CFR 46.102(f)(2)] be subjected to independent verification of exempt status.

2. Institutions may elect under their Assurance not to claim the exemptions provided in the regulations, choosing instead to require IRB review of all research involving human intervention/interaction or identifiable private information.

3. While HHS requires neither an Assurance nor a Certification of IRB Review [45 CFR 46.103(f)] for exempt research, institutional requirements regarding review of such research are, nevertheless, binding on investigators. It would be inappropriate for staff of any HHS agency to discourage potential awardees from submitting their activities for institutionally required IRB review.
Appendix B: Email Introduction to 2017 Survey

Dear Colleague/Staff Member,

Workplace Violence is a significant occupational hazard in health care and those who work in the Emergency Department are especially at risk. Research shows that the majority of physical violence against health care professionals is Type II Workplace Violence, where the victim is a health care worker and the perpetrator is a patient or visitor. Frequently, these acts of violence toward staff go unreported; therefore, the severity of this issue is severely underestimated, especially in the Emergency Department.

Last Fall, a brief, 12-question survey was conducted to assess the perceived prevalence of Type II Workplace Violence and the reporting practices of such events in the Emergency Department at BIDMC. Our goal is to once again capture this information so that your ideas on the potential for violence can assist BIDMC in gauging the effectiveness of recent improvement initiatives, as well as identifying or confirming the need for increased safety measures in the workplace for staff, physicians, patients, and families.

You are being asked to participate in the survey because you are currently staff members or physicians working in BIDMC’s Emergency Department. The survey will take less than 4 minutes to complete. By completing the survey, you are giving your consent to the researcher to use your responses for the research study, and the data we collect may be published. You will be asked to provide your gender, position, and length of employment in the Emergency Department at BIDMC, however these questions will only serve for demographics and are not mandatory to provide. It is important to note that the survey is designed to be anonymous and all responses are completely confidential and not associated with personal identification.

Your participation in the survey is entirely voluntary and you may choose to end your participation at any time. If you decide to withdraw from the survey at any time, your responses will be deleted.

Please follow the link HERE for the survey, or simply copy and paste https://www.surveymonkey.com/r/56NHNCL into your web browser.

The survey will close on Sunday, October 8 at 11:59pm.

If you have any questions or comments, please email or call me at 617-667-4204. You can also contact the Human Subject Protection Office (330 Brookline Avenue, Boston, MA 02215, 617-667-0469).
Thank you very much for taking the time to complete this questionnaire.

Sincerely,
Taj Qureshi, on behalf of Pat Folcarelli

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# Appendix C: Pre and Post Survey

## Introduction and Definitions

This is a brief survey and will take less than 5 minutes to complete.

**Introduction:** Workplace Violence is a significant occupational hazard in health care and those who work in the Emergency Department (ED) are especially at risk. At the same time, acts of violence towards staff go unreported; therefore, the severity of this issue is severely underestimated, especially in the ED. Those who work in the Emergency Department are especially at risk. The purpose of this survey is to assess the perceived prevalence of Type II Workplace Violence, and the reporting practices of such events in the ED at BIDMC using standardized definitions.

**Definitions from the literature:**

**Type II Workplace Violence** is violence committed by patients/visitors against an employee. This includes behaviors and conduct that create anxiety, fear, or distrust in the workplace and is inclusive of, but not limited to: homicide, physical battery, physical assault, stalking, threats, harassment, bullying, emotional abuse, and intimidation.

**Battery** includes hitting with body part, slapping, kicking, punching, pinching, scratching, biting, pulling hair, hitting with an object, throwing an object, spitting, beating, shooting, stabbing, squeezing and twisting. This includes intentional contamination of the employee with the patient’s bodily fluids including saliva, blood, urine, feces, and genital secretions.

**Assault** includes actions, statements, and written or nonverbal messages conveying threats of physical injury, which were serious enough to unsettle your mind. It includes expressions of intent to inflict pain, injury, or punishment. It includes attempted physical battery without contact, as described above.

**Sexual Assault** is any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Failing under the definition of sexual assault are sexual activities as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape.

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1. In your last six shifts, have you been witness to, or victim of, Type II Workplace Violence (as defined above)?
   - [ ] Yes
   - [ ] No
2. In your last six shifts, have you experienced the following events? (select all that apply)

<table>
<thead>
<tr>
<th>Event</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Battery</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Assault</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Contamination by a patient’s bodily fluids</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Harassed with sexual language/muendo</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sarcasm</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

3. If you experienced workplace violence in your last 12 shifts, did you report the occurrence(s)?
   - ☐ Yes
   - ☐ No

4. What is the primary way you reported it?
   - ☐ Supervisor or Leadership (i.e., Resource Nurse, Clinical Adviser, Director of Nursing, or Physician AOC)
   - ☐ Directly to Patient Relations or Risk Management
   - ☐ Incident report in the Patient Safety Reporting System (PSRS)
   - ☐ Public Safety or Security
   - ☐ Human Resources or Employee Relations
   - ☐ Social Work
   - ☐ I have not experienced workplace violence in my last 12 shifts
   - ☐ No, I did not report the occurrence(s)
   - ☐ Other (please specify)
5. Why didn’t you report it? (select all that apply)
   - [ ] It’s part of the job
   - [ ] Patient demented or ill (not their fault)
   - [ ] Unsure how to report incident
   - [ ] Unaware it was a crime
   - [ ] Didn’t expect anyone to do anything about it
   - [ ] Lack of supervisor support
   - [ ] Lack of security/police support
   - [ ] Didn’t have time during shift to report it
   - [ ] Didn’t want to get involved in legal process of pressing charges
   - [ ] Other, (please specify)

6. What daily activities, if any, expose you to the greatest risk of violence?

7. To what degree are you concerned about being threatened or physically attacked by a patient/visitor while you are at work?

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Not at all</th>
<th>Somewhat prepared</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. How well-trained do you feel that you can recognize aggressive escalation and diffuse it before physical violence occurs in patients/visitors with the following presentations?

<table>
<thead>
<tr>
<th>Acute intoxication</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a whole</td>
</tr>
</tbody>
</table>

   | Acutely agitated patients with normal mental status |
   | As a whole         |

   | Acutely psychotic patients (altered MS) |
   | As a whole         |

   | Acute trauma patients |
   | As a whole         |

   | Patients with chronic dementia/sundownering |
   | As a whole         |

<p>| Visitors with aggressive behavior |
| As a whole         |</p>
<table>
<thead>
<tr>
<th>9. Rate how safe you feel from workplace violence in the ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all safe</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

10. Is there anything else you would like to share about your experience in the ED related to workplace violence?

[ ]

11. Please select your position at BIDMC

[ ]

12. How long have you worked in the ED at BIDMC

- [ ] Less than a year
- [ ] 1-4 years
- [ ] 5-10 years
- [ ] More than 10 years