IMPROVING SAFETY OF NURSING STAFF:

CHALLENGES AND SOLUTIONS REGARDING SAFETY FOR NURSING

STAFF IN ACUTE CARE PSYCHIATRIC SETTINGS

by

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Abstract

Workplace violence is defined as an act of abuse, threatening behaviour, intimidation, or assault on a person in his or her place of employment. Unfortunately, such violence is a reality for nurses. These take the form of physical, verbal, and threating behaviours, and harassment. Violence, particularly verbal abuse, is so prevalent that it is often considered "part of the job" and can contribute to many negative professional and personal effects for nurses. Therefore, it is important to understand what influences an individual to become violent in order to suggest and support initiatives to decrease it.

A literature review and consultations with key stakeholders were conducted to gather relevant information regarding violence committed by patients and others visiting mental health care settings. Through data analysis, two relevant themes were revealed: reporting and interventions. Reporting incidents of workplace violence is important to track and quantify aggressive episodes, thus emphasizing its seriousness. Nurses may differ in the perception of what constitutes violence, underreport incidents, and feel a sense of futility when reported violence continues. In addition, cumbersome methods of reporting can be a hindrance to the reporting process. Six areas of potential interventions were identified to increase safety for nurses. These are staffing, de-escalation training, environmental considerations, addictions services, organizational support, and consequences. All findings were summarized in a document to be presented to the leadership of the Mental Health and Addictions program within the local health care authority. The goal is to offer recommendations to lead to a decrease in workplace aggression and increased safety for nurses in the acute care psychiatric setting.

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Improving Safety of Nursing Staff:

Challenges and Solutions Regarding Safety for Nursing Staff in Acute Care Psychiatric

Settings

Violence is an unfortunate reality in nursing (Bonner & McLaughlin, 2007;

Crilly, Chaboyer, & Creedy, 2004). Despite declarations of zero tolerance of aggression

in the workplace (Canadian Nurses Association [CNA], 2005), violence continues to

occur. Thirty-four percent of nurses report episodes of physical violence while 47% of

nurses report emotional abuse. These statistics vary dependent on the setting. Forty-seven

percent of nurses in the psychiatric setting report being physically assaulted, while 70%

of nurses in the psychiatric setting report emotional abuse by a patient (Shields &

Wilkins, 2009). Violence, particularly verbal abuse, is so prevalent that it is often

considered "part of the job" (Baby, Glue, & Carlyle, 2014; Jonker, Goossens, Steenhuis,

& Oud, 2008). With the continuance of violence despite the expressed goal of zero

tolerance, strategies to increase safety of nursing staff are important to examine.

Workplace violence incorporates multiple types of behaviours. The Canadian

Centre for Occupational Health and Safety (2012) describe five examples of workplace

behavior:

1. Physical attacks, such as hitting and pushing;

2. Verbal abuse, including swearing and insulting language;

3. Threatening behaviours, for example shaking fists, destroying property, and
   throwing objects;

4. Threats, both verbal or written, with an intent to cause harm; and

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5. Harassment, including behaviours such as words, gestures, or bullying, which

     demean, embarrass, humiliate, or cause alarm.

It is important to recognize that violence in the workplace can originate from patients,

families, visitors, coworkers, and other workplace colleagues (Howerton-Child &

Mentes, 2010). This practicum focused on violence perpetuated by consumers of

psychiatric services, namely patients, families, and visitors.

    There are numerous reports in the media describing workplace abuse against

nurses. Multiple media reports in recent years have described episodes of aggression

towards nurses, namely incidents resulting in nurses exposed to threats, being spat at,

called vulgar names, and experiencing cuts and bruises as well as severe trauma

necessitating surgery (Canadian Broadcasting Corporation [CBC] News, 2013; CBC

News, 2015; Greater Toronto Area [GTA] News, 2015; Yahoo News, 2014). In my own

experience, I have had a patient grab my arm, had several patients run towards me, had

items thrown at me, have been threatened with statements involving the use of legal

means or media if a patient or family member is in disagreement with medical advice

(such as a patient not being admitted to hospital, or provided with medications), and have

on multiple occasions, been called obscene names. While strategies have been put in

place to create a safer environment, the abuse continues. I question: Are there other

strategies available to increase nurse safety in psychiatric settings?

    In order to enact strategies to increase nurse safety, it is important to consider all

aspects related to violence in health care settings, such as; patient characteristics, the

environment in which patients and nurses interact, a nurse's personal traits and

perceptions, and organizational policies combine to influence aggression against nurses (Hahn, Muller, Hantikainen, Kok, Dassen, & Halfens, 2013; Jonker et al., 2008; Ramacciati, 2014; Zampieron, Galeazzo, Turra, & Buja, 2010). Thus, the examination of violence requires a multi-dimensional approach (Ramacciati, 2014). Workplace violence results in many negative effects for nurses, including work dissatisfaction, stress, fatigue, loss of confidence, increased apathy towards patients, strained personal relationships, and financial hardships (Baby et al., 2014; Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013; Zampieron et al., 2010). Whatever the cause, addressing workplace violence is important for nurses, as well as patients and health care in general.

Goals and Objectives

The goals of this practicum are to (1) identify factors related to aggression in acute care psychiatric settings and (2) identify solutions to increase safety of nursing staff in psychiatric acute care settings.

There are 4 objectives:

1. Identify applicable research questions and appropriate resources to address the problem of workplace violence against nurses by utilizing personal clinical knowledge and experience.
2. Critique, interpret, and synthesize research literature to understand evidence based findings regarding aggression towards nurses.
3. Identify challenges and potential solutions regarding workplace violence by collaborating with a variety of healthcare professionals.

4. Develop a policy paper for senior administration in the Mental Health and Addictions program detailing results of reducing workplace violence.

Overview of Methods

In order to embark on this practicum project, a clear plan and timetable was proposed, and a practicum proposal was submitted, based upon personal interest in safety concerns for nurses in the psychiatric setting. Upon approval of the proposal, goals and objectives were established. A literature search was undertaken to uncover evidence based information pertaining to issues surrounding workplace violence and safety concerns of nurses. Then, in order to gain a fuller understanding of the issues, key stakeholders within a health care authority were identified and consulted, with the aid of a questionnaire, to gather further insight and knowledge. Current policies within the organization related to workplace violence were reviewed. Contact was also initiated with an external mental health agency to gather additional material that would contribute to a fuller understanding of nurse related aggression and safety. All information was critically analyzed and reviewed in order to reveal factors that contribute to aggression towards nurses in the psychiatric setting. As well, suggested methods to decrease patient and visitor initiated aggression towards psychiatric nurses is offered. A review of findings from this practicum project will be offered in the form of a document to the leadership of the local health care authority.

Literature Review

A search of the literature was conducted to gather existing evidence based on best practice regarding nurse related workplace violence. The databases CINAHL and PubMED were searched to disclose information relevant to the topic of nurse safety. The following search terms were utilized: "nursing", "violence", "psychiatric", "mental illness", "emergency", and "safety". CINAHL revealed a total of 439 articles. While PubMED revealed 2790 articles, by adding the search term "staff safety", this result was reduced to a more manageable 197 articles. A review of these articles resulted in 123 chosen for further examination. From these articles, 18 were critiqued for inclusion in the literature summary tables (Appendix B). A summary of the entire literature review can be found in Appendix A.

A review of the literature determined support for both the anecdotal evidence detailed in the media and the direct personal work experience; that violence directed towards nurses, and psychiatric nurses in particular, is real. A majority of researchers showed that aggression exists in the nurses' workplace, with 40% to 86% nurse reporting incidents of aggression (Atawneh, Zahid, Al-Sahlawi, Shahid, & Al-Farrah, 2003; Crilly et al., 2004; Hahn et al., 2013; Jonker et al., 2008; Rose, 1997; Zampieron et al., 2010). Interestingly, in the article by Jonker et al. (2008), while there were 181 incidents of aggression reported in one year, a majority of mental health nurses reported to never or rarely being confronted with aggression. This finding leads one to wonder if the perceptions of mental health nurses as to what is actually aggression may influence if an aggressive incident is reported. Thus, differences in nurses' perceptions may account for the wide range of reported incidents of aggression. As well, research evidence shows

there is much more non-physical, or verbal, aggression than physical violence (Crilly et al., 2004; Gerberich, Church, McGovern, Hansen, Nachreiner, Geisser, Ryan, Mongin, & Watt, 2004; Spector, Zhou, & Che, 2014; Stone, McMillan, Hazelton, & Clayton, 2011; Zampieron et al., 2010). While physical aggression and the resultant injuries are of major concern, verbal aggression itself cannot be discounted, as there are definite negative ramifications for nursing staff experiencing such abuse (Stone et al., 2011). Therefore, interventions in the workplace to counter aggression should recognize and address all forms of workplace violence, including verbal aggression.

The cause of workplace violence was explored in the literature. There were multiple factors noted, which could be summarized in four distinct categories; patient characteristics, staff characteristics, environmental factors, and organizational factors. Therefore, workplace violence can be viewed as a multi-dimensional issue (Ramacciati, 2014), often involving an interaction of several or all factors.

Patient Characteristics

Patients with certain characteristics appear regularly in psychiatric units and are more prone to exhibit violent tendencies than others. Patients with a psychiatric illness (Crilly et al., 2004; Duxbury & Whittington, 2005; Gerberich et al., 2004; James, Madeley, & Dove, 2006; Stone et al., 2011; Tam, Engelsmann, & Fugere, 1996; Zampieron et al., 2010), who are under the influence of alcohol or illegal substances (Crilly et al., 2004; James et al., 2006), or who exhibit demanding, attention seeking behaviours (Crilly et al., 2004) are more likely to become violent in a hospital setting. With a high number of such high risk patients attending psychiatric units, it is important

to have extra and specific safety protocols in place to protect staff and others in these areas.

Other more common traits were identified through the literature review as showing a relationship with increased aggression. Men (Gerberich et al., 2004; Hahn et al., 2013; James et al., 2006; Stone et al., 2011; Williamson, Lauricella, Browning, Tierney, Chen, Joseph, Sharrock, Trauer, & Hamilton, 2013; Zampieron et al., 2010) tend to show more physical forms of aggression compared to females (Williamson et al., 2013). In addition, being either elderly (Gerberich et al., 2004; Hahn et al., 2013; Williamson et al., 2013), perhaps due to cognitive issues, or between the ages of 16 and 30 years (James et al., 2006) increases the risk. Other traits include living in poverty (James et al., 2006), and being single, of aboriginal descent, or a war veteran (Williamson et al., 2013). Whatever the reason for certain groups to be at higher risk for aggression, be it decreased quality of life, low levels of social supports, having poor coping skills, being a member of a known disadvantaged group, or having a possible history of trauma, the fact remains that some people are higher risk for aggression.

Staff Characteristics

The characteristics of staff must also be considered in any discussion regarding workplace violence. The literature revealed discrepant results surrounding incidences of aggression in relation to staff members' years of experience (Crilly et al., 2004; Hahn et al., 2013; Jonker et al., 2008) and gender (Crilly et al., 2004; Gerberich et al., 2004). These varied results may stem from differing perceptions of violence by staff members, which consequentially affects reporting. This argument is supported by Hahn et al.

(2013), who indicated that staff with training in de-escalation had more frequent reports of patient violence than staff with less training. Is this increased reporting due to staff members actually perceiving patient actions as aggressive due to education in violent behaviours, whereas, without this education, aggression may have been perceived differently? In fact, one study recognized that "factors associated with nurses' perceptions of safety were not strongly associated with actual rates of violence" (Blando et al., 2013, p. 496). With the recognized problem of underreporting of aggression (James et al., 2006; Spector et al, 2014; Stone et al., 2011; Tam et al., 1996; Williamson et al., 2013; Zampieron et al., 2010), a focus on how staff characteristics and perceptions influence perception would lead to a greater understanding of workplace violence.

Environmental Factors

The nature of the environment in which patients and staff encounter each other contribute to workplace violence. Certain hospital units, such as psychiatry, emergency departments, nursing homes, long term care facilities, geriatric units, and locked units have higher numbers of aggressive incidents due to the types of patients present (Chen, Hwu, Kung, Chiu, & Wang, 2008; Gerberich et al., 2004; Hahn et al., 2013; Hesketh, Duncan, Estabrooks, Reimer, Giovannetti, Hyndman, & Acorn, 2003; Jonker et al., 2008; Spector et al, 2014; Tam et al., 1996). The presence of visitors can also increase aggression levels (Blando et al., 2013). Specific factors such as small spaces, overcrowding, and an unpleasant physical decor (Angland, Dowling, & Casey, 2014; Lau, Magarey, & McCutcheon, 2004) creates a non-therapeutic environment, particularly where a mix of patients with different psychiatric symptoms such as psychosis, paranoia,

or difficulty coping are located; it is not surprising that there is an increased risk of aggression under such conditions. Lengthy wait times in emergency departments are also associated with increased aggression (Angland et al., 2014; Crilly et al., 2004; James et al., 2006). In such areas, the presence of safety equipment such as cameras and panic buttons and secgurity guards specially trained in de-escalation techniques (Angland et al., 2014; Blando et al., 2013; Crilly et al., 2004) have been noted to contribute to perceived increased safety.

Organizational Factors

There are numerous organizational factors which contribute to the rate of workplace violence. Complex workloads, understaffing, and diminished resources negatively influence the work environment in such areas as education and training of staff, wait times, and resource availability (Gerberich et al., 2004; Hesketh et al., 2003). These are areas which are noted to influence aggression. Underreporting, as previously identified, might also occur due to lack of support and direction by management (Atawneh et al., 2003; Hesketh et al., 2003; Rose, 1997) or the time commitment involved to complete paperwork (Hesketh et al., 2003). Areas in which senior management might influence staff safety include: providing clear and supported guidelines when dealing with aggressive incidents (such as outlining the reporting of aggression); taking legal action against patients demonstrating aggression; conducting post-incident debriefing; creating and implementing policies concerning individuals who repeatedly demonstrate aggression; monitoring aggression levels of individuals within care facilities; and providing updates to staff (Baby et al., 2014; Gerberich et al., 2004;

James et al., 2006). Such support would have a positive influence on staff, as it is important for front-line nurses to feel that security is important to senior management (Blando et al., 2013). Increased education, support of research to study and improve safety, and involvement of front-line nurses in making decisions concerning safety (Baby et al., 2014; Blando et al., 2013) are other ways in which an organization can contribute to increasing the safety of staff.

Theoretical Framework – General Aggression Model

The General Aggression Model (GAM) is an integrative framework that incorporates several mini-theories on aggression (Anderson & Bushman, 2002). It is used to offer insight into aggressive behavior and to aid in the development of appropriate interventions. The authors have utilized the theory in studies on aggressive thoughts and behaviours related to violent song lyrics and video games (Anderson & Carnagey, 2003; Anderson & Dill, 2000). GAM focuses on the person in the situation or episode. The three main foci are inputs, routes, and outcomes.

1. The inputs focus on two factors: person factors (such as traits, gender, beliefs, and values) and situational factors (such as provocation, frustration, pain, and drugs).
2. There are three routes: cognition, affect, and arousal, which are interconnected.
3. The outcome involves appraisal, resulting in either thoughtful or impulsive action.

GAM incorporates aspects of the person's personality, past, and future expectations. When using GAM as a guideline for workplace violence, the patient's traits, such as age, psychiatric diagnosis, and presence of substance use are incorporated as a person factor.

The situational factors, such as wait times, and interaction with nursing staff are included as the second input. The routes of cognition, affect, and arousal detail the reality of how the patient accepts and analyses the inputs. Finally, as a result of an appraisal of the inputs and routes, the outcome will result in either a non-violent situation or a violent outburst.

A nurse could apply GAM to a workplace incident involving aggression. The nurse would assess the personal traits of the patient, as well as the environment in which a situation is occurring. By understanding that a patient's reaction is influenced by such characteristics, the nurse might be able to change a factor in a situation, such as moving a patient to a quiet area, in order to alter the effect. Thus, the output would be changed from, for example, one of increasing thoughts of anger to a decrease in agitation. In another example, a nurse might recognize that the route by which information is received may be altered. In a patient experiencing auditory hallucinations, for example, cognitive ability is affected such that the patient's perception of a situation is far different from reality. By understanding that cognitive changes might result in violence, interventions may be enacted to provide a safe, nurturing environment to the patient, which could produce an output of decreased risk. Both situations provide examples using GAM, where potentially aggressive situations are deescalated and workplace violence is avoided. GAM, therefore, provides a model by which patient aggression can be studied, and interventions can be conceived.

Consultations

An important step to achieve an understanding of patient perpetuated violence and, subsequently, to offer solutions for controlling such violence, is to undertake consultations with key stakeholders in order to gain information on the individual professional opinions and concerns related to the issue. The literature review revealed that workplace violence is multi-dimensional (Ramacciati, 2014) and incorporates multiple aspects, such as patient characteristics, the environment in which patients and nurses interact, nurses' own personal traits and perceptions, and organizational policies (Hahn et al., 2013; Jonker et al., 2008; Ramacciati, 2014; Zampieron et al., 2010). Therefore, it is imperative to consult with individuals who are involved in the workplace at multiple levels (such as direct care, managerial, policy development, and workplace quality and safety levels) in order to gather and to evaluate the viewpoints and expectations which influence how workplace violence is experienced and perceived.

The consultation process consisted of several steps. First, a list of objectives was established to guide the process. Next, key stakeholders were identified as participants, based on specific workplace roles involving either direct or indirect involvement in areas of psychiatric health care where workplace violence could occur. A questionnaire was then created in consultation with the practicum supervisor to collect relevant information. Data were collected, keeping in mind important aspects such as consent, privacy, data management, and data analysis. Finally, results of the consultation process were analyzed and summarized in tabular form. The consultation project was reviewed during this process to determine if ethics approval was required according to standards set by Memorial University. It was determined that this project involved quality improvement

and therefore ethics approval was not required. Please see Appendix D for the entire consultation report.

In addition to the consultations with key stakeholders, two Quality and Safety experts were interviewed to discuss incident reporting. These experts were located at two health care institutions: the regional health authority, and Centre for Addiction and Mental Health (CAMH), Toronto, ON. The regional health authority was included in this process due to the author's employment association with this institution. CAMH was included since it is the largest mental health and addictions teaching hospital in Canada and a world leader in research into mental health and addictions.

All responding stakeholders agreed that workplace violence involves multiple types of actions, including physical and verbal abuse, threatening language and behaviours, and harassment, as noted in the literature (Canadian Centre of Occupational Health and Safety, 2012). As well, most of the respondents reported that the number of aggressive episodes occurring in the workplace had increased over time, with one respondent stating "Working … for years changed from isolated incidents of aggression to daily occurrences and even multiple incidents in a shift". This observation is in contrast to information received from the expert at CAMH, who indicated CAMH experienced a small but not significant increase in workplace aggression over time (CAMH representative (F.A.D.), personal communication, March 10, 2016). Three specific areas were explored in the consultations, namely, methods to report aggression, reasons for underreporting, and suggestions of useful interventions, all which will be explored in the following sections.

Methods to Report Aggression

Several methods of reporting were mentioned by key stakeholders. All respondents indicated that episodes of aggression are reported by the Clinical Safety Reporting System (CSRS), the official reporting system within the regional health authority to report adverse events. The purpose of this computerized reporting system is to report any event involving patients or visitors that results or has the potential to result in harm. CSRS is deemed to be a method to report workplace violence, including non-physical violence, and is indeed being utilized for this purpose, yet it is acknowledged that underreporting happens (regional health authority representative (T.M.), personal communication, March 1, 2016).

Another method to report aggression indicated by consultants was through documentation in patients' charts. Based on personal experience, I believe that more of the different types of aggression (namely verbal abuse, threatening behaviours, verbal threats, and harassment) would be officially reported using this method than by any other reporting means. However, a review of patients' charts is a cumbersome, inefficient means to report and track workplace violence. An audit of charts specifically to highlight incidents of abusive behaviour would be of interest to compare chart reporting to CSRS reporting.

The use of employee incident reports (which are primarily used for physical forms of aggression resulting in harm), notifying police, and alerting management or the on-call physician were other methods of notification cited by key stakeholders. Overall, while there are multiple methods by which reporting should occur, under-reporting, particularly

of non-physical violent behaviours, is happening.

Reasons for Underreporting

A majority of key stakeholders suspected that an underreporting of aggression occurred which, as one respondent indicated, is not unusual in many workplaces. There were multiple reasons identified by the key stakeholders for underreporting. They conveyed a belief that aggression is part of the mental state of the patient, is not deliberate and therefore can be excused. One participant stated that "all behaviour tends to be contributed to the mental state of clients, even alcohol intoxication". Four participants stated that underreporting could be due to the belief that aggression is part of the job, or an "accepted aspect of psychiatric nursing". One key stakeholder commented that, with aggression being "almost a daily occurrence", "it tends to become the new normal".

Most participants indicated another reason for underreporting was the feeling or belief that reporting incidents would not result in change or meaningful action to decrease workplace violence. One participant indicated that when no feedback is given to staff after a report is filed, the report itself may be seen as meaningless. Staff need to believe that the report warranted attention. In addition, one participant stated that the lack of consequences to the aggressor could be a reason not to report, thus acknowledging a sense of futility when nothing results from making a report. As one participant described: "a big portion of underreporting is the lack of support … and the feeling that nothing will be changed". The removal of extra pay for working in what was previously identified as high risk areas for violence led stakeholders to believe that workplace violence was not

considered a priority by administration. As well, minimizing the use of code white being called for the potential for, rather than actual, aggression was also mentioned by consultants as lack of organizational support.

Four participants mentioned that differentiation between types of aggression affected reporting, since some types of aggression (i.e. physical) would be reported, while other, non-physical types of aggression may not. This leads to incomplete and inaccurate reporting. Other reasons given by key stakeholders for underreporting are lack of time and not knowing how to complete the reporting process.

Interventions to Improve Safety

All responding participants indicated that the presence of security guards with, as one participant added, specialization in de-escalation techniques, was a useful intervention to improve safety. The desire to have police present with patients who are at a high risk for aggression was mentioned by several participants as a means to improve safety. There was no mention as to how police presence would increase safety, however their very presence may act as a deterrent to the initiation of violence. In addition, they could also be able to provide a physical support if a violent incident were to occur. A majority of participants stated that improvements to the environment would help increase safety levels. Improved wait times in the psychiatric emergency setting, more activities for patients, and the presence of peer support could also assist in decreasing the risk of aggression. According to the consultations and also based on personal experience, the lack of smoking privileges is a huge cause of workplace aggression by patients in the psychiatric setting, thus increased attention to nicotine replacement as well as further

research into this issue is an important consideration to minimize this risk.

All consultants stated that improved training on de-escalation techniques for staff would be a useful intervention to improve safety. Most stakeholders referenced the need for appropriate staffing as a means to improve safety. While, almost half of the stakeholders indicated that an increase in nursing staff would improve safety, one participant disagreed, saying that an increase in the number of security guards instead of extra clinical personnel would result in an improvement. Experience level, including having an experienced charge nurse with an increased role in the operation of the unit, was mentioned as useful when considering staffing. As well, staff mix was mentioned, in particular concerning the gender of staff, with one respondent indicating that some patients respond better to either male or female staff members.

Respondents also indicated that an increased focus on staff safety by health care institutions would contribute to increased overall safety. One respondent said that the existence of a workplace safety team, made up of staff and management, would be an organizational means to include staff in improving safety in the workplace. Other participants mentioned the importance of reinforcing consequences of acts of aggression, which would highlight the health care institution's low tolerance to aggression. Methods by which patients could be held accountable for deliberate acts of aggression were not offered in this consultation.

Two psychiatric nurses reported that much of the aggression observed was attributed to an increase in the use and availability of street drugs. Thus, many patients present to the psychiatric assessment unit (PAU) under the influence of drugs, seeking

more drugs, or going through withdrawal from substances. In order to emphasize the purpose of medication delivery in PAU to patients, the unit should clearly state that no narcotics or methadone will be prescribed or administered to patients saying they are in need of such medications. Additionally, an increase in Addictions Services for such patients would offer them the actual assistance that is applicable to their situation, rather than leaving them with little option but to seek out help or drugs at local emergency departments.

Discussion

Violence, as evidenced by both the literature and key stakeholders, occurs in the inpatient psychiatric setting. In fact, many consultants noted there has been an increase in aggression in the acute care setting over the years. Not surprisingly, there is a wide-ranging cost for workplace violence. Work dissatisfaction, stress, fear, increased apathy towards patients, and strained personal relationships (Baby et al., 2014; Blando et al., 2013; Hamden & Hamra, 2015; Zampieron et al., 2010) are just several of the damaging effects experienced by nurses. The health care system itself also suffers negative consequences, including work absenteeism and other financial costs (Edward, Ousey, Warelow, & Lui, 2014; Greenlund, 2011). These facts affirm that workplace violence is a serious problem for nurses and for health care. However, what is uncertain is the level of urgency felt amongst those affected by workplace violence, namely nurses and other healthcare providers, in addition to those in management and administration who create and direct policies to protect staff, to initiate interventions that result in positive change. Based on the evidence reviewed, I argue that the matter of workplace violence is a

serious concern to all within healthcare. Therefore, a serious analysis of the topic is required to determine what needs to be done to reduce the risk of aggression and to increase safety.

The literature and all stakeholders agree that workplace violence encompasses a wide variety of actions including physical attacks, verbal abuse, threatening behaviours, threats, and harassment. Based on the information-gathering conducted thus far, it is necessary to establish specific facets of workplace aggression that require further scrutiny. It is important to know how much violence is happening. Without this knowledge, there would be no way to know if there is a decrease in violence once interventions are introduced. However, research and consultations have established that under reporting is prevalent. Thus, interventions to increase reporting must be explored. Furthermore, appropriate interventions to address violence must be examined. Such interventions must be guided by the factors that cause workplace aggression. By understanding the complex interaction of factors, appropriate interventions can be determined and enacted to decrease workplace violence and improve safety. What follows is an examination of these facets in relation to the important questions and challenges that were revealed by the literature search and consultations.

Reporting

The underreporting of workplace violence is acknowledged as commonplace (James et al., 2006; Spector et al, 2014; Stone et al., 2011; Tam et al., 1996; Williamson et al., 2013; Zampieron et al., 2010). This is a serious concern because, without accurate data revealing the true weight of the issue, the overall problem of workplace aggression

will be minimized. This, in turn, affects how organizations confront workplace violence. When analyzing the results of the literature search and the consultations, two main themes for underreporting were revealed; perception and futility. The perception of nurses regarding what actually constitutes aggression, and if some forms of aggression are excusable, determines if an incident which is formally defined as aggressive is actually reported. Equally important is the sense of futility that some nurses have. Nurses who believe, based upon prior experiences, that reporting will not result in change will likely regard reporting as an ineffective mechanism to improve safety. In addition to these themes, the mechanism to report incidents must be known, available, and time-efficient for the reporter to use.

Perception.

Individual perceptions are difficult to qualify as they are composed of a combination of our own experiences and values in all aspects of our lives. Thus, what is seen as violent by one individual (for example name-calling) might be seen as expected or tolerable behavior by someone else. Nurses with many years of experience working in psychiatry may have normalized violence in the workplace; after all, if it is occurring with frequency, then it could be viewed as regular behavior for the unit (Chen et al., 2008; Jonker et al., 2008) or, as one consultant stated, "part of the job". Nurses who have not experienced high levels of violence in the workplace or in their personal lives would likely perceive the same amount of violence as more unacceptable. One reason why violent behaviours are considered normal in psychiatry is due to the nature of psychiatric illness (Crilly et al., 2004; Duxbury & Whittington, 2005; Gerberich et al., 2004; James

et al., 2006; Stone et al., 2011; Tam et al., 1996; Zampieron et al., 2010). Often times

patients experiencing an acute crisis may have an altered sense of reality and thus act in

an aggressive manner; it is not how this patient would actually behave if he or she was

thinking coherently, but is a consequence of the illness.

Education on what actually constitutes aggression would help affect nurses'

perceptions of workplace aggression. What should be emphasized is that violence is an

action. It is not a judgement of the person completing the act of violence. Therefore, for

example, a 90 year old woman with dementia attempting to kick a nurse is just as much

an act of workplace violence as a 20 year old male patient who is uttering threats to harm

staff if he does not get the narcotics he is seeking. Whatever the source, the act itself is a

risk to safety and should be reported. Additionally, I believe that education should focus

on the broad definition of workplace violence, which includes many types of nonphysical

actions. Nurses should be informed that behavious such as name calling are considered

examples of workplace violence, even though this behaviour may be encountered

multiple times during a shift. Not only do such aggressive actions have the potential to

cause harm for the nurse, but such actions may agitate or frighten other patients, or may

further escalate into physical violence. Only by reporting all incidences of aggression can

the organization receive a true picture of workplace violence faced by nurses.

Futility.

When a nurse reports aggression and nothing is seen to be done, the act of

reporting seems pointless. According to the consultations and the literature (Baby et al.,

2014; Gerberich et al., 2004; James et al., 2006), nursing staff often express a sense of

futility and disengagement when there are no observed consequences to violent behaviour in the workplace. As one consultant stated "a big portion of underreporting is the lack of support felt from administration and the feeling that nothing will be changed". Therefore, why bother to report?

Post-incident debriefing and updates on investigations into aggressive incidents are important as they are one means to show nurses that workplace safety is important to the administration (Baby et al., 2014; Gerberich et al., 2004; James et al., 2006). There are policies in place requiring reporting and follow-up after an incident; these policies must be adhered to for nurses to know that the reporting process is working. Actual involvement by direct care nursing staff in the decision making process to formulate such policies is another suggestion to ensure effective safety initiatives (Baby et al., 2014).

The literature details little consequences for patients who exhibit violence. Flagging charts of and assigning two caregivers to patients who are involved in multiple violent episodes are two methods mentioned to acknowledge violent patients (Gerberich et al., 2004; Zampieron et al., 2010). While the use of the legal system to report workplace violence is mentioned, support by management and administration for this method is questioned by the literature (Baby et al., 2014) and the consultants. As a result, clear policies that address outcomes for violent patients, taking into account the patient's mental competence at the time of the incident, would provide concrete guidance and support to nursing staff regarding safety in the workplace.

Method to report.

The appropriate method to report aggression to gather accurate statistics on workplace violence should be clearly defined in the policies of the organization. The reporting method within this health authority is CSRS. While this system is readily available via computer, time constraints and complexity of the system may affect reporting consistency, thus measures should be taken by those who provide the program to ensure it is user friendly. Another factor is that nurses know that CSRS is a method to report all types of aggression. According to the consultations, they do; however, continuing education on what constitutes aggression should emphasize the importance of reporting of all types of workplace violence by this means. The addition of a prompt or reminder in CSRS itself, for example, a drop box on screen asking if this incident involves an episode of workplace violence (similar to what is available for falls and medication errors) might act as a reminder to nurses to report aggression using CSRS. With the acknowledgement that workplace violence occurs in health care and that it is under reported, any trigger to promote its importance and need for documentation during the reporting process itself could increase its appropriate use. In the very least, an increase in reporting would give the institution more accurate statistics that workplace violence is an important and urgent issue, and that it is a priority matter in health care.

Interventions

There are a multitude of factors which affect workplace aggression. The literature and consultants have identified many areas where changes can be made to reduce the risk of violence. These areas involve staffing matters, training in de-escalation, environmental changes, presence of appropriate resources, organizational support, and punishment and

consequences to perpetrators of violence.

Staffing.

Staffing is a factor that affects safety. All consultants, as well as the literature reviewed, support the presence of trained security guards as an effective means to positively influence a safe working environment. Security personnel are a visual deterrent to violence and, with the proper training and authority, would be able to act when workplace violence is escalating or occurring. Such actions can involve separating patients, reporting to nursing staff, or intervening when violence becomes physical. When the issue of nursing staff levels was considered, half of the key stakeholders indicated that an increase in nursing staff would lead to a decrease in violence. This is supported by the literature, which acknowledged that complex workloads and understaffing results in increased aggression (Gerberich et al., 2004; Hesketh et al., 2003). Understaffing of nursing staff could compromise the time available for nurses to implement therapeutic nursing interventions such as active listening, redirection, observation, re-assessment of needs (such as comfort or hunger), and timely medication intervention. In addition, improvements to wait times in emergency settings have a direct influence on patient mood and feelings of anger. On the other hand, other consultants did not see an increase in nursing staff as being a means to decrease violence and, instead, identified a greater reliance on security to achieve this goal. Staffing mix such as female : male staffing ratios and experience level were also noted during consultations as having the potential to influence workplace aggression. A review of the appropriate types and numbers of staff would assist in determining how an improvement in staffing would decrease workplace

violence.

Training in de-escalation.

Improved training on de-escalation techniques for staff was mentioned by all consultants as a way to improve safety. The literature also supports the importance of such training, as it results in increased awareness and reporting of aggression (Hahn et al., 2013). CAMH offers training in de-escalation techniques to staff, to be updated on an annual basis, with more regular training for areas with increased aggression (CAMH representative (F.A.D.), personal communication, March 10, 2016). A commitment by administration, the involvement of appropriate education professionals, and the availability of direct care staff are all necessary to ensure training would occur.

Environmental considerations.

The physical environment where patients are located influences aggression. Limited, cramped spaces in nursing units decreases options to re-locate patients if escalation in violence is noted. Privacy and confidentiality are also compromised by space constraints, which could negatively impact a patient's mood and behaviour. An improvement to the overall aesthetics of the space might also be an area of focus to decrease levels of aggression.

Resources related to addictions.

Symptoms of addiction are a cause for aggression, as noted by several stakeholders. Patients under the influence of alcohol or drugs, seeking drugs such as narcotics, or undergoing withdrawal are at increased risk of aggression (Crilly et al.,

2004; James et al., 2006). The presence of appropriate services, whether it is addictions

recovery centers, thorough and effective follow-up services, or support programs for

persons who are actively abusing substances, would be ideal in order to provide them

with more appropriate care. In addition, the amount of aggression related to patients not

being permitted to smoke within the Health Authority should be acknowledged and better

managed. Having clear guidelines, consistent reinforcement, and readily available

nicotine replacement would help in controlling this aggression. However, based on

personal observation, I believe that nurses will continue to encounter much workplace

aggression from both patients and their family members regarding the no smoking policy.

Organizational support.

An increased focus on staff safety by health care institutions was mentioned by

several key stakeholders as an important contribution to overall improved workplace

safety. The literature supports this viewpoint, reporting that such support would have a

positive influence on staff (Blando et al., 2013). There are many areas where

administration can have an effect, including providing clear and supported guidelines

regarding workplace violence and supplying a mechanism for nursing staff to manage

individuals who repeatedly demonstrate aggression. Support around sufficient staffing,

education, legal implications, inclusion of front-line staff in decision-making, and

providing updates to staff (Baby et al., 2014; Gerberich et al., 2004; James et al., 2006)

are areas where administration can show leadership to decrease workplace violence.

Punishment and consequences.

There are a number of questions regarding how patients should be treated after being aggressive with nursing staff. Should there be consequences to patients who exhibit violence towards nurses? What types of consequences? In addition, would the use of such consequences be an effective means to decrease violence? The answer to all these questions is not known. However, several key consultants expressed the importance to having consequences in response to acts of aggression and in showing low tolerance to aggression. The methods by which these actions could be effectively achieved were not offered. Involvement of legal action to more serious physical and threatening forms of workplace violence is one route to enact consequences to dangerous behaviours. However, not all acts of workplace violence are illegal. The literature review revealed that flagging a patient's chart when multiple episodes of aggression occur, and having extra staff present when known past perpetrators are present (Gerberich et al., 2004; Zampieron et al., 2010) are potential consequences to such behaviour. Perhaps flagging every chart when one incident of workplace violence is noted would be a useful protective measure. Further research, however, should be completed to determine if the use of consequences or punishment of patients who exhibit violent behaviour towards nursing staff will result in increased safety.

Policy Paper

A policy paper on the topic of nursing safety in psychiatric settings regarding workplace violence was developed for the administration of the Mental Health and Addictions Program. It serves as a summary of information gathered from the literature and the consultations conducted during this project. The document is located in Appendix

E. The following section details focus areas where action is recommended.

1. **Education and Training**

De-escalation training results in increased reporting of workplace violence (Hahn et al., 2013). In addition, such training was noted by all key stakeholders, as well as the literature (Blando et al., 2013), as an intervention that could improve safety. A commitment by administration to provide regular, repeated, up-dated, and appropriate de-escalation training to nursing staff could result in a decrease of workplace violence.

2. **Collaboration**

Nursing staff want to be involved in decisions affecting their safety (Baby et al., 2014; Blando et al., 2013). A feeling of futility occurs for nurses when workplace violence continuously occurs, despite reporting. Important issues affecting nurses could be introduced in a collaborative environment with management and administration so that specific concerns, such as staffing and environmental considerations, can be discussed in context with policies and financial issues. This would ensure that all viewpoints, not just that of administration, are involved in decision-making.

3. **Advocacy**

Aggressive behavior that results from patients who abuse substances is one cause of workplace violence (Crilly et al., 2004; James et al., 2006). Several consultants confirmed that patients who are under the influence of drugs, seeking more drugs, or going through withdrawal from substances are a source of aggression. Advocating for appropriate addictions services that are timely and available for those seeking help, as well as

supportive community support for active and recovering users, would be useful to supply the needed support for these patients.

4. Consultation

Sharing information between psychiatric institutions on issues regarding workplace violence is a means to improve safety for nurses. Therefore, initiating contact with similar institutes to gather and analyze data, explore best practice guidelines, and determine if interventions are adaptable to this health authority is a method that could potentially result in improvements.

5. Research

While this paper is the result of an extensive review of the literature and consultations with key stakeholders, there is an acknowledged lack of research on workplace violence (Baby et al., 2014). Therefore, continued research, collaborations, and evaluations of any issues associated with workplace violence (such as prevention, monitoring, and interventions) are encouraged to ensure that relevant, appropriate, and up-to-date measures are being taken to decrease workplace violence.

ANP Competencies

There are four Advanced Nursing Practice competencies as defined by the Canadian Nurses Association (2008): clinical, research, leadership, and consultation and collaboration. All competencies were demonstration during the completion of this practicum project.

Clinical Competencies

An advanced practice nurse provides a level of expertise in a specialized area of nursing. The examination of workplace aggression promotes an understanding of what is required to ensure a safe work environment in which nurses, patients, and other health care members work together to provide holistic care. The following examples detail the demonstration of the clinical competencies achieved with this practicum project.

- Intervention strategies, such as improved de-escalation training and the involvement of staff in administrative decision-making, were recommended as means by which workplace violence could be decreased.

- The complex nature of a number of factors, namely patient characteristics, staff traits, environmental concerns, and administrative process, were identified as contributors to workplace violence.

- A theoretical framework, the General Aggression Model (Anderson & Bushman, 2002), was discussed as a method of anticipation and guidance to lower the potential of workplace aggression, thus linking theory to nursing practice.

- Appropriate health care professionals were engaged in the consultation process to gather information to increase nursing staff safety.

- The results of the knowledge generated from the research for this practicum were summarized in the form of a document for the Mental Health and Addictions program at the regional health authority, to be used as a guide for potential interventions regarding reducing workplace violence.

Research Competencies

The Canadian Nurses Association (2008) states that "generating, synthesizing and using research evidence is central to advanced nursing practice" (p. 23). The process of completing the practicum involved significant demonstration of this competency and is detailed as follows.

- A significant concern within the nursing profession, namely workplace violence, was identified as an area requiring further examination.

- A literature review was conducted to gather data on existing research results on aspects related to workplace violence.

- Information from the literature review was analyzed and critiqued in order to determine evidence for best practice for improvements to nurse safety.

- A questionnaire was devised and applied to consultants to gather information on workplace violence.

- The need for ethical approval was considered using a screening tool.

- Dissemination of results from this research will proceed through a presentation, report, and position paper.

Leadership Competencies

Advanced practice nurses often act as change agents, involved in seeing new ways to practice in order to improve care and to positively influence health policy. Throughout this practicum project, safety concerns in a psychiatric setting were identified, and potential interventions were determined and suggested as means to improve safety for

nurses. The following list notes examples of the application of the leadership competency in the proposed practicum.

- The policy paper for administration is a means to advocate for interventions to improve safety in the psychiatric acute care setting.
- The results of this practicum encourage a culture that supports collaboration of all stakeholders in the area of workplace violence, including those at the management and administrative levels.
- The practicum report, position paper, and presentation are all means of informing colleagues and health care institutions of evidence based practice that would contribute to an increase in safety for nurses.

Consultation and Collaboration Competencies

Advanced practice nurses consult and collaborate with professionals in a variety of sectors. This competency was applied in the practicum, as seen in the following examples.

- Key stakeholders from a variety of disciplines (direct care, management, administration, professional practice consultants, and quality controls experts) were identified and contacted as collaborators to gather opinions on several aspect of workplace violence.
- Data from questionnaires used in consultations were synthesized and summarized to provide evidence concerning issues and interventions regarding improvements to nursing safety.

- Consultations were conducted with Quality and Risk professionals at the regional health authority and CAMH to discuss factors concerning workplace violence.

Conclusion

Workplace violence is a significant problem for nurses and for health care. Through the process of completing this practicum, much information was accumulated from various sources, analyzed, and summarized, thus providing suggestions which could ultimately decrease aggression and increase safety. By presenting these recommendations to administrators within the Mental Health and Addictions program, there exists the real potential that these recommendations will be adopted. Thus, the ultimate goal for this practicum, to gain a greater understanding of workplace violence in order to reduce workplace violence, would be achieved.

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Appendix A: Literature Review and Critical Appraisal

Literature Review and Critical Appraisal

Improving Safety of Nursing Staff:

Challenges and Solutions Regarding Safety for

Nursing Staff in Acute Care Psychiatric Settings

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Violence is an unfortunate reality in nursing (Bonner & McLaughlin, 2007; Crilly, Chaboyer, & Creedy, 2004). Despite declarations of zero tolerance of aggression in the workplace (Canadian Nurses Association [CNA], 2005), violence continues to occur. Thirty-four percent of nurses report episodes of physical violence while 47% of nurses report emotional abuse. These statistics vary dependent on the setting. Forty-seven percent of nurses in the psychiatric setting report being physically assaulted, while 70% of nurses in the psychiatric setting report emotional abuse by a patient (Shields & Wilkins, 2009). Violence, particularly verbal abuse, is so prevalent that it is often considered part of the job (Baby, Glue, & Carlyle, 2014; Jonker, Goossens, Steenhuis, & Oud, 2008). Thus, despite an expressed goal of zero tolerance, violence in the workplace continues. Therefore, it is important to examine strategies to increase safety of nursing staff.

In order to explore such strategies, it is important to define exactly what is workplace violence. According to the Canadian Centre for Occupational Health and Safety (2012), workplace violence incorporates multiple types of behaviours. The following list presents five examples of workplace behavior:

6. Physical attacks, such as hitting and pushing;

7. Verbal abuse, including swearing, and insulting language;

8. Threatening behaviours, for example shaking fists, destroying property, and throwing objects;

9. Threats, both verbal or written, with an intent to cause harm; and

10. Harassment, including behaviours such as words, gestures, or bullying, which demean, embarrass, humiliate, or cause alarm.

All the above examples of violence are common to nurses (Atawneh, Zahid, Al-Sahlawi, Shahid, & Al-Farrah, 2003; Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013; Chen, Hwu, Kung, Chiu, & Wang, 2008; Crilly et al., 2004; Hahn et al., 2013; James, Madeley, & Dove, 2006; Spector, Zhou, & Che, 2014; Stone, McMillan, Hazelton, & Clayton, 2011; Tam, Engelsmann, & Fugere, 1996; Zampieron, Galeazzo, Turra, & Buja, 2010). There are multiple questions as to how and why violence occurs, such as: What causes acts of aggression by patients? What are the contributing factors to workplace violence? Research into these questions contribute to an understanding of this trend and, ideally, give direction to nurses and healthcare leaders to enact policies and methods to increase nurse safety. With this in mind, the literature has been examined to delve into the topic of workplace violence. What follows is a detail of the literature search, a summary and critique of the available literature, and a discussion of the gaps in knowledge on the topic of violence towards nurses in the workplace. In addition, a theoretical framework to guide the proposed research will be discussed.

Searches

The databases CINAHL and PubMED were searched to reveal information relevant to the topic of nurse safety. The following search terms were utilized: "violence", "psychiatric", "mental illness", "emergency", and "safety". CINAHL revealed a total of 439 articles. While PubMED revealed 2790 articles, by adding the search term "staff safety", this result was reduced to a more manageable 197 articles. A review of these articles resulted in 123 articles chosen for further examination. From these articles, 19 were initially chosen to be used in the literature review. Fifteen articles are quantitative studies, two articles are qualitative studies, and two articles are reviews of the literature. One of the two reviews of the literature was a literature

review, which is not a critical analysis of the literature. Therefore, while the literature review is included in the discussion in this paper, it is excluded from the literature review tables.

Violence Against Nurses is Real

In order to probe the topic, it must be established that workplace violence does exist for nurses and that it is an issue. Multiple researchers have concluded that aggression exists in the work environment. Zampieron et al. (2010) found that 49.4% of nurses in Italian health institutions experienced aggression in the year previous. This result is similar to that found by Crilly et al. (2004), who reported that 50% of nurses in two emergency departments in Australia experienced aggression in the previous five months, and to the study by Rose (1997) where 40% of nurses in Ireland were assaulted in the year prior to the study. Another study that included multiple disciplines of health care professionals in a university general hospital in Switzerland showed a much higher result, with 85% of participants indicating violence throughout their entire careers (Hahn et al., 2013). Atawneh et al. (2003) found similar results, indicating that 86% of nurses experienced some type of violent incident at work. However, while there is much evidence from multiple studies that nurses experience workplace violence, an article by Jonker et al. (2008) contradicts this evidence by finding that a majority of nurses working in a mental health institution reported to never or rarely being confronted with aggression, despite experiencing 181 incidents of aggression per year. This finding leads one to wonder if the perceptions of mental health nurses are influenced by a general belief that aggression is a regular part of the job. Regardless, the consensus from the majority of studies indicates that a vast majority of health care employees, including nurses, will be exposed to workplace violence.

Research evidence shows there is much more non-physical, or verbal, aggression than physical violence (Stone et al., 2011). Results from studies vary from 4.8% to 36.4% of physical aggression, and 53% to 81.6% of verbal aggression (Crilly et al., 2004; Spector et al., 2014; Zampiron et al., 2010). Gerberich et al. (2004) indicated that there was a physical assault rate of 13.2 per 100, while the incidence rose to 38.8 per 100 for verbal assaults. Even the study by Jonker et al. (2008) indicated that 60% of confrontations with patients involved verbal aggression. While physical aggression and the resultant injuries are definitely a major concern, verbal aggression itself cannot be discounted, as there are definite negative ramifications for nursing staff experiencing such abuse (Stone et al., 2011).

What Causes Violence?

Workplace violence is a multi-dimensional issue (Ramacciati, 2014). As a result, violence must be examined from a number of vantage points in order to identify and understand all causal factors so that aggression in the workplace can be addressed. It is useful to view the causal factors of workplace violence in four distinct categories: patient characteristics, staff characteristics, environmental factors, and organizational factors. It is important to note, however, that each category does not exist in isolation; it is often an interaction of some or all factors that result in violence.

Patient Characteristics

Certain patients are more prone to exhibit violent tendencies than others. Patients with psychiatric illness may become violent in hospital settings (Crilly et al., 2004; Duxbury & Whittington, 2005; Gerberich et al., 2004; James et al., 2006; Stone et al., 2011; Tam et al., 1996; Zampieron et al., 2010), likely due to impaired cognition as a result of the nature of the illness

itself. As well, persons under the influence of alcohol or illegal substances show increased

aggression (Crilly et al., 2004; James et al., 2006), likely due to the resultant impairment in either

cognition or judgment. In an emergency room setting, patients exhibiting demanding, attention

seeking behaviours showed more violence (Crilly et al., 2004). While this behavior is often noted

by nurses, the violence is often not expected.

Gender is a factor, with male patients involved in more violent incidents than females

(Gerberich et al., 2004; Hahn et al., 2013; Stone et al., 2011; James et al., 2006; Williamson et

al., 2013; Zampieron et al., 2010). This result is consistent with research showing males exhibit

aggression in a more physical way compared to females (Williamson et al. 2013). The age of the

patient is also an important consideration. Elderly patients are shown to exhibit more violent

behavior (Gerberich et al., 2004; Hahn et al., 2013; Williamson et al., 2013), perhaps a

consequence of cognitive impairment due to dementia or delirium (Williamson et al., 2013).

James et al. (2006), however, reported that patients 16 to 30 years of age exhibited 45.2% of

reported aggression, although this result was solely from the emergency department setting,

while the prior studies were conducted in the whole hospital environment.

There are other specific patient characteristics which have been shown to be associated

with increased violence, such as being single (Williamson et al., 2013); living in a "deprived"

situation (James, 2006); being of aboriginal descent (Williamson et al., 2013); and being a war

veteran (Williamson et al., 2013). Williamson et al. offers a discussion that decreased quality of

life and lower social supports are associated with single divorced or never married patients,

which may be linked with increased aggression. Williamson et al., as well, discusses that war

veterans experience increased incidence of posttraumatic stress disorder, which could cause an

exacerbation of symptoms during illness and hospitalization, leading to increased aggression. No

reason is offered by the authors for increased aggression demonstrated by those living with poverty or of aboriginal status. Both conditions, however, are generally recognized as contributing to negative challenges for people, which may decrease quality of life and perhaps contribute to increased anger and aggression.

Staff Characteristics

The characteristics of staff must be considered in any discussion regarding workplace violence. Both age and level of experience of staff members, for example, is correlated with varied results. Younger healthcare workers tend to experience more aggression (Crilly et al., 2004; Gerberich et al., 2004; Hahn et al., 2013; Jonker et al., 2008; Rose, 1997). Crilly et al. suggested that more experienced nurses encountered more violence, while another study indicated that more experienced nurses were subjected to less violence (Jonker et al., 2008). Hahn et al. (2013), on the other hand, determined that level of experience was not a factor in the amount of aggression experienced. These varied results may stem from differing perceptions of violence by staff members, or from underreporting of aggressive episodes. Gender of nursing staff also produced discrepant results, with both female (Crilly et al., 2004) and male (Gerberich et al., 2004) staff reporting experience with more aggressive episodes. Again, underreporting of incidents, or small numbers and response levels of male staff may contribute to the differences. In addition, shift work appears to increase chances of experiencing violence (Zampieron et al., 2010), with individuals working evening shifts and part-time employees encountering more aggressive episodes (Crilly et al., 2004).

The perceptions of staff are an important consideration when examining workplace violence. As an example, training in de-escalation or dealing with a patient exhibiting aggression

might be expected to decrease violent incidents. However, increased training has been shown to

increase reports of patient violence (Hahn et al., 2013). Is this increased reporting due to staff

members actually recognizing patient actions as aggressive due to education in violent

behaviours, whereas, without this education, aggression may have been perceived differently?

Certainly, much research shows that nurses underreport aggression (James et al., 2006; Spector

et al, 2014; Stone et al., 2011; Tam et al., 1996; Williamson et al., 2013; Zampieron et al., 2010),

since aggression might be considered as a normal reaction of persons with a mental illness or in

distress (Blando et al., 2013; Jonker et al., 2008). Additionally, staff who rate aggression as a

personal means for defusing stress, or have confidence in management of violence, report less

violent interactions (Hahn et al., 2013). Blando et al. (2013) report that "factors associated with

nurses' perceptions of safety were not strongly associated with actual rates of violence" (p.

496). The concern with staff perceptions on violence is that nurse perceptions, while important,

may not always be associated with actual rates of violence. Thus, a situation that is perceived by

a nurse as safe may in reality not be safe.

Environmental/Situational Factors

Traits of the environment in which patients and staff encounter each other are

contributing factors to workplace violence. Certain hospital units, due to the types of patients

and their experiences, have higher levels of patient aggression. Psychiatry, emergency

departments, nursing homes and long term care facilities, rehabilitation centres, occupational

health, areas using anesthesia, intensive care units, and step-down units (Chen et al., 2008;

Gerberich et al., 2004; Hahn et al., 2013; Hesketh et al., 2003; Spector et al, 2014), as well as

locked units (Jonker et al., 2008; Tam et al., 1996) have higher aggressive incidents. The

presence of visitors (Blando et al., 2013) can increase aggression levels. Emergency departments

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have specific factors such as lengthy wait times, cramped environment, overcrowding, staff

being unfamiliar with patients, and the unpleasantness of the environment (Angland, Dowling, &

Casey, 2014; Blando et al., 2013; Crilly et al., 2004; James et al., 2006; Lau, Magarey, &

McCutcheon, 2004) which can increase aggression levels. In such areas, the presence of safety

equipment and security guards, as well as the response time and training level of security

(Angland et al., 2014; Blando et al., 2013; Crilly et al., 2004) contribute to perceived increased

safety.

Organizational Factors

There are numerous organizational factors which contribute to the rate of workplace

violence. Complex workloads, understaffing, and diminished resources negatively influence the

work environment in such areas as staff morale, education and training of staff, wait times, and

resource availability (Gerberich et al., 2004; Hesketh et al., 2003). Underreporting might occur

due to lack of support and direction by management (Atawneh et al., 2003; Hesketh et al., 2003;

Rose, 1997) or the time commitment of completing paperwork (Hesketh et al., 2003). Decreased

staff safety is a potential result. Guidelines in dealing with aggressive incidents, such as outlining

the reporting of aggression, taking legal action against patients demonstrating aggression,

conducting post-incident debriefing, creating and implementing policies concerning individuals

who repeatedly demonstrate aggression, monitoring aggression levels of individuals within care

facilities, and providing updates to staff, are areas where the organization can influence

workplace aggression (Baby et al., 2014; Gerberich et al., 2004; James et al., 2006). It is

important for front-line nurses to feel that security is important to senior management (Blando

et al., 2013). Ways in which upper management can indicate the importance of safety to direct

care staff is by providing appropriate education, supporting research to study and improve

safety, and involving nurses in decision making around safety (Baby et al., 2014; Blando et al., 2013).

Critique of the Scientific Process in the Studies Reviewed

The studies chosen for the literature review are from either quantitative research, qualitative research, or literature reviews. Sixteen articles are descriptive quantitative studies, two articles are qualitative studies, and two articles are reviews of the existing literature.

Quantitative Research Studies

The majority of the research in the literature review are descriptive studies. Descriptive studies, whether they are cross-sectional, retrospective, or epidemiological, are inherently of weak strength (Public Health Agency of Canada [PHAC], 2014). Therefore, the weak strength of all descriptive studies must be taken into account when reviewing the literature.

Two main areas to be addressed when critiquing descriptive studies are bias and rigor. The presence of bias and rigor are indicators of the validity and reliability of the study. In the following section, both topics, in regards to the research articles, will be examined.

Bias.

Bias is a potential problem in any research as results may be inaccurate if bias is present. The descriptive studies do not show selection bias, as the study subjects are either nurses or health care workers in general. There is, however, the potential for information bias in many of the studies, which could influence findings. Two types of information bias are noted, namely social desirability bias and recall bias.

The major concern regarding quality of all descriptive studies is the real problem of underreporting. Underreporting may happen for numerous reasons, as previously indicated, and is noted by most of the authors included in this literature review. However, despite the great probability that underreporting is likely occurring, the studies do indicate that high percentages of nurses are enduring workplace violence by patients. Knowing that reported numbers are likely lower than what is actually occurring adds even more seriousness to the problem of violence towards nurses.

Another concern with the findings in general is recall bias. The questionnaires in the descriptive studies ask that nurses recount different types of violent episodes that have occurred in the past. Most studies required nurses or health care worker to recall events over the past 12 months (Atawneh et al., 2003; Chen et al., 2008; Gerberich et al., 2004; Hahn et al., 2013; Jonker et al., 2008; Zampieron et al., 2010), while other studies ask for recall of events over a shorter time frame (Crilly et al., 2004; Hesketh et al, 2003). It would not be unusual that some events or details would be forgotten. Many of the researchers do acknowledge recall bias as a potential limitation to the research process.

Rigor.

Rigor concerns the quality of the research process itself. It is influenced by the selection of participants, the measurement instruments, and the statistical analysis. Several authors address these topics as potential strengths or limitations in their articles. The articles are of varying quality in regards to rigor.

Sample size is an important consideration, since large numbers of participants or high participation rates indicate that the power of the study is high enough to produce statistically

significant results. High numbers of participants, or high participation rates, were indicated in a number of studies (Blando et al., 2013; Chen et al., 2008; Gerberich et al., 2004; Hahn et al., 2013; Hesketh et al., 2003; and Zampieron et al., 2010). High sample numbers are also included in the studies by James et al. (2006), Stone et al. (2011), Tam et al. (1996), and Williamson et al. (2013), where incident reports are accessed to gather data. Other studies, however, involved low sample size, which would cause one to question the validity of the results (Atawneh et al., 2003; Crilly et al., 2004; Duxbury & Whittington, 2005; Jonker et al., 2008; Rose, 1997).

The instruments used in the surveys of participants are of varied quality. Instruments which are standardized or which have undergone extensive testing and use by numerous researchers are of higher validity. As well, an instrument is considered valid if it measures what it is supposed to measure (Polit & Beck, 2012). Several of the authors indicate the use of valid instruments in the research process (Atawneh et al., 2003; Chen et al., 2008; Crilly et al., 2004; Duxbury & Whittington, 2005; Hahn et al., 2013; Jonker et al., 2008; Stone et al., 2011; Zampieron et al., 2010). Several of the research studies, however, either utilized untested instruments (Rose, 1997); indicated that reliability and validity were untested (Hesketh, et al., 2003); or provided little to no information on instruments used (Gerberich et al., 2004).

Appropriate statistical analysis is necessary to indicate significance of an association between variables. Statistically significant results are of importance in quantitative research as it indicates a direct effect of one variable upon another. Higher level statistical testing used on generated data will result in showing significant results, and it is also a good indicator that the study has sufficient power. The studies included in this literature review that use higher level statistical testing are the research of Blando et al. (2013), Hahn et al. (2013), Jonker et al. (2008), Stone et al. (2011), Williamson et al. (2013), and Zampieron et al. (2010). Thus, the results of

these studies are indicative of having sufficient power in order to obtain valid results. The

research of Atawneh et al. (2003), Chen et al. (2008), Crilly et al. (2004), Gerberich et al. (2004),

Hesketh et al. (2003), James et al. (2006), and Tam et al. (1996), do not indicate the power of

study, nor do the results indicate being statistically significant. Thus, there would be a lower

assumed validity to the results shown in these works. One paper (Rose, 1997) does not include a

discussion of statistical analysis, thus this paper is of low validity.

Qualitative Studies

The two qualitative studies (Angland et al., 2014; Baby et al., 2014) are of high quality.

The aims of both are clearly stated, with comprehensive literature to support the importance of

the topic. The studies describe the methodology utilized (thematic analysis), as well as detailed

information on participant selection, data gathering, and data analysis. Results are clearly

specified, with one study including a diagrammatic representation (Angland et al., 2014). Ethical

concerns and conflict of interest are addressed.

A deficit of both studies, as indicated in the limitations sections by the authors, is that

generalizability is limited since participant numbers are low. However, while generalizability is

an important criterion for measuring quality of quantitative research, the issue of

generalizability is more controversial when considering its importance to qualitative research

(Polit & Beck, 2010). Instead, richness of data, which offers a thick description of experiences, is

considered to be of more importance when evaluating qualitative research (Polit & Beck, 2010).

Another limitation noted is that neither article provides recommendations for future research

nor implications for nursing practice.

The two articles of mixed method design (Duxbury & Whittington, 2005; Stone et al., 2010) provide limited information to critique the qualitative method. Neither article included sufficient information concerning participant selection, with one article not including inclusion or exclusion criteria (Duxbury & Whittington, 2005), and the other article not discussing this topic at all (Stone et al., 2010). Duxbury and Whittington (2005) do not discuss theoretical orientation, while Stone et al. (2010) does. Stone et al. gathered qualitative information through a questionnaire and, therefore, there are no quotes included in the article which would add to the richness of the results. Both research studies, however, do include implications for nursing practice. The qualitative section of these two articles are of medium quality.

Reviews

Two reviews were selected for appraisal. The review by Spector et al. (2014), which is a meta-analysis, includes a thorough definition of the methodology by which appropriate research was chosen, thus increasing its validity. There was no discussion of this methodology in the literature review by Lau et al. (2004). Spector et al. (2014), however, did not include non-English articles in the review, thus applicable research may have been missed. While both research articles provide a review of the literature, they have limitations. Small sample sizes and little standardization of the different studies are acknowledged as limits by Spector et al. (2014). While these limits may also apply to the research by Lau et al. (2004), the authors do not acknowledge them in their paper. Both authors do provide a summary of implications for nursing and gaps in knowledge on which future research could focus. The paper by Spector et al. (2014) is of medium quality. The article by Lau et al. (2004), being a literature review, was not included in the critique in the literature review tables.

Gaps in Knowledge – Where Does Future Research Lie?

Most of the authors of the research studies chosen for the literature review express

gaps in knowledge in the area of aggression towards nurses. These gaps can be summarized in

five areas:

1. Identify risk factors or patterns to violence.

    Research, such as analytical or prospective studies, to identify specific risk factors,

    patterns, or causes of violence, would be useful to further develop an understanding of how

    aggression is initiated and progresses (Crilly et al, 2004; Gerberich et al., 2004; Hahn et al.,

    2013; James et al., 2006; Lau et al., 2004). This type of research could assist in the

    development of proactive and preventative measures.

2. Examine effective solutions to reduce levels of violence against nurses.

    Researchers acknowledge the need for more research into methods to handle violence.

    Certain areas of nursing are seen to be more high risk than others (Chen et al., 2008), and

    that the type of intervention used should be appropriate to the setting (Tan et al., 1996).

    Research into all methods of intervention, including de-escalation, is encouraged to manage

    violence against nurses (Lau et al., 2004; Spector et al., 2014; Stone et al., 2011).

3. Determine the effect of the environment, management, and culture on nurse

    aggression.

    The philosophy of the organization is acknowledged to contribute to views on workplace

    violence. Thus research to support a meaningful framework for management to provide

    guidance in the area of violence towards nurses would be helpful in reducing violence (Baby

et al., 2014; Duxbury & Whittington, 2005). Research into risk assessment, training, reporting, staffing, and resource management would contribute knowledge to the field of workplace violence (Hahn et al., 2013; Hesketh et al., 2003; Jonker et al., 2008; Williamson et al., 2013).

4. Examine violence from the perspective of the nurse.

Awareness of nursing staff's perceptions towards violence by nursing staff are important in order to enact appropriate violence management strategies. Thus, research into what nurses perceive to be the cause of aggression, and the implications of applying appropriate interventions, is important to building an understanding of the nurse's role in workplace violence (Blando et al., 2013; Duxbury et al., 2005; Hahn et al., 2013).

5. Examine violence from the perspective of the patient.

There is an acknowledged lack of information of patients' perspectives regarding violence towards nurses. Research into this area would be useful in exploring why patients become violent, and how to prevent such situations (Hahn et al., 2013; Lau et al., 2004; Zampieron et al., 2010.

Theoretical Framework – General Aggression Model

The General Aggression Model (GAM) is an integrative framework that incorporates several mini-theories on aggression (Anderson & Bushman, 2002). It is used to offer insight into aggressive behavior and to aid in the development of appropriate interventions. GAM focuses on the person in the situation or episode. There are three main foci: inputs, routes, and outcomes.

4. The inputs focus on two factors: person factors such as traits, gender, beliefs, and

   values; and situational factors such as provocation, frustration, pain, and drugs.

5. There are three routes: cognition, affect, and arousal, which are interconnected.

6. The outcome involves appraisal, resulting in either thoughtful or impulsive action.

GAM incorporates aspects of the person's personality, past, and future expectations.

When using GAM as a guideline for workplace violence, the patient's traits, such as age,

psychiatric diagnosis, and presence of substance use are incorporated as a person factor. The

situational factors, such as wait times, and interaction with nursing staff are included as the

second input. The routes of cognition, affect, and arousal detail the reality of how the patient

accepts and analyses the inputs. Finally, as a result of the inputs and routes, the outcome, after

appraisal, will result in either a non-violent situation or a violent outburst.

A nurse could apply GAM to a workplace incident involving aggression. The nurse would

assess the personal traits of the patient, as well as the environment in which a situation is

occurring. By understanding that a patient's reaction is influenced by such characteristics, the

nurse might be able to change a factor in a situation, such as moving a patient to a quiet area, in

order to alter the effect. Thus, the output would be changed from, for example, one of

increasing thoughts of anger to a decrease in agitation. In another example, a nurse might

recognize that the route by which information is received may be altered. In a patient

experiencing auditory hallucinations, for example, cognitive ability is affected such that the

patient's perception of a situation is far different from reality. By understanding that cognitive

changes might result in violence, interventions may be enacted to provide a safe, nurturing

environment to the patient, which could produce an output of decreased risk. Both situations

provide examples using GAM, where potentially aggressive situation are deescalated and

workplace violence is avoided. GAM, therefore, provides a model by which patient aggression

can be studied, and interventions can be conceived.

Conclusion

Workplace violence is a real issue for nurses. This statement is overwhelmingly

supported by the literature. In order to put strategies in place to combat workplace violence,

one must understand where such violence originates. The literature reveals that there are

multiple aspects that influence violence, namely characteristics of the nurse, the patient, the

environment, and the organization, all of which exist within and are influenced by the values of

our society. Violence, therefore, is the result of a complex interaction of multiple factors. When

the various aspects of violence are examined using the General Aggression Model as a guide, a

greater understanding of causes of and solutions to violence is revealed.

The literature has several common conclusions. One is that workplace violence is

underreported (James et al., 2006; Spector et al, 2014; Stone et al., 2011; Tam et al., 1996;

Williamson et al., 2013; Zampieron et al., 2010). There are varying reasons given for this,

including lack of time and management support (Atawneh et al., 2003; Hesketh et al., 2003;

Rose, 1997) and varying perceptions of what actually is violence (Hahn et al., 2013). Despite

underreporting, however, most studies overwhelmingly showed significant aggression towards

nurses (Atawneh et al., 2003; Blando et al., 2013; Chen et al., 2008; Crilly et al., 2004; Hahn et

al., 2013; James et al., 2014; Stone et al., 2011; Tam et al., 1996; Zampieron et al., 2010), which

leads one to understand there is far more violence happening than what is reported. Another

common conclusion is that less severe forms of aggression, for example verbal aggression, are

likely not being reported (Chen et al., 2008; James et al., 2006; Stone et al., 2011; Tam et al.,

1996). This may be due to aggression being seen as a normal part of nursing, thus justifying, or

perhaps excusing, its use by patients (Jonker et al., 2008; Zampieron et al., 2010). As well, the

literature supports the view that nurses' perceptions are important to consider (Blando et al.,

2013). One study determined that what nurses believe will keep them safe, may not actually

contribute to workplace safety (Blando et al., 2013). Thus, it is important to differentiate

between the perception of safety and the reality of safety. It is important to note, however, that

nurses' perceptions cannot be discounted, as acknowledgement of this viewpoint contributes to

overall job quality. Finally, the perceptions of the patient should be taken into account, as it is

likely different from the viewpoint of the nurse.

There are many areas of workplace violence towards nurses that can be further

explored. In this practicum project, I hope to use the results of this literature review to examine

perceptions of aggression in psychiatric nursing and to determine what interventions may

improve workplace safety. Hopefully, this project will provide a link between cause of aggression

and appropriate interventions, which will add to nursing knowledge and help improve nursing

safety in the workplace.

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Appendix B: Literature Summary Tables

Literature Summary Tables

Improving Safety of Nursing Staff:

Challenge and Solutions Regarding Safety for

Nursing Staff in Acute Care Psychiatric Settings

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Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Angland et al. (2014)	Purpose: To explore nurses' perceptions of the factors that cause violence and aggression in an Irish emergency department. Design: Qualitative descriptive study using thematic analysis. Participants: 12 emergency department nurses. Methods: Interviews. Measurements: Note taking and tape-recording of interviews; audit trail. 2 researchers reviewed interview, and an experienced ED nurse independently coded transcripts.	- 2 main themes, 7 sub-themes. - 2 themes: environmental factors and communication factors. - 4 sub- themes under environmental factors: waiting times; overcrowding/lack of space; security issues; triage related issues. - 3 sub-themes under communication factors: interpersonal relationships; attitude of staff; fear and vulnerability.	Conclusions: - Different definitions of aggression and violence; aggression seen as a verbal act; violence defined as physical resulting in injury. - Waiting times was seen as highest causative factor of violence and aggression. - Inadequate staff resources associated with long delays. - Triage is likely area for violence. - Overcrowded corridors associated with aggression. - Presence of security reduced aggression; although security not always present when needed. - Poor communication contributing factor to aggression. Comments: - Good communications and early establishment of empathetic rapport important to avoiding violence in ED. - Nurses may be intolerant to drunk, psychiatric and substance using patients. - Friends and relatives of patients are source of violence. Limitations: small sample size; not generalizable to other settings (note that generalizability may not be considered a limitation in qualitative research)

			Rating: Strong.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Atawneh et al. (2003)	Purpose: To determine the degree and effects of violence among nurses in an ED. Design: Descriptive study. Participants: all nurses in an ED in a general hospital in Kuwait. April, 2002. Methods: 3 questionnaires. Measurements: incidence rates	- 86% nurses experienced violence. - 70 of 70 nurses experienced verbal assault; 13 of 70 nurses (16%) experienced physical assault. - 96% nurses experience negative after-effects. - 78% worried about workplace violence. - 44% thought training would be useful. - 19% received training. - No nurses were advised by hospital authorities to report violent incidents.	Conclusions: -Physicians have higher reports of violence. - Nurses report more negative after-effects than physicians, reason unknown. Comments: -Lower reports of physical assaults in this study possibly due to different measurement instruments; cultural factors. Limitations: small sample size; possible recall bias; instruments not standardized; foreign research thus context relating to society and healthcare delivery may decrease generalizability. Rating: Design: Weak. Quality: Medium. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Baby et al. (2014)	Purpose: To explore and describe psychiatric mental health nurses experiences of patient assaults. Design: Qualitative study; thematic analytical approach Participants: 14 RNs and LPNs working in mental health services in a large regional health board in New Zealand. Methods: Semi-structured interviews. Measurements: Interviews transcribed verbatim and sub-themes identified.	- 3 themes: nature of assaults; impact of assaults; support strategies. - nature of assaults relates to factors such as personality traits, professional expertise, clinical roles, static and dynamic factors. - verbal abuse is most prevalent form of abuse. - there is a perceived violation to personal safety despite nature of assault. - assaults impacts different facets of life; including fear for self, anxiety, distress, long-term personal and professional changes, using it as a learning experience, financial constraints, dealing with lack of remorse from patients. - support strategies are most common from peers, less so from management; debriefing at the appropriate time is important; legal implications are not always supported.	Conclusions: -the three themes identified four components of the workplace violence cycle: precedents; nature of abuse; defining elements; aftermath. - precedents included organizational, nursing, and perpetrator culture. - nature of abuse includes verbal, physical, and sexual. - defining elements refers to the nature of the relationship, power, and behaviour. - aftermath involves devastating effects of the victim, workplace, wider community; loss of confidence; burnout; strained family and social relationships; and financial constraints. Comments: -for workplace policies regarding safety to be effective, the needs of nurses in direct patient care must be identified, thus nurses must be involved in decision making. - education regarding aggression and violence in nursing is required. - there is a lack of research regarding workplace violence. Limitations: low participant number; not generalizable (note that generalizability may not be considered a limitation in qualitative research); limited to mental health nurses.

			Rating: Strong.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Blando et al. (2013)	Purpose: To assess how nurses' perception of safety and violence was affected by their work environment; to determine if this perception correlates with actual risk. Design: Cross-sectional study, mixed methods study design. Participants: 457 nurses (34 emergency department; 143 psychiatric), working in hospitals in California and New Jersey. Methods: In-person interviews; questionnaires. Measurements:	- ED nurses: significantly more likely to feel unsafe (14%) than psychiatric nurses (4%). - Significantly more psych nurses (27%) report frequent verbal abuse than ED nurses (18%). - ED nurses: 6% who reported frequent verbal abuse and 5% who had been assaulted felt unsafe. - Psych nurses: 1% who reported frequent verbal abuse and 1% who were assaulted felt unsafe. - ED nurses: significantly less positive about safety than psychiatric nurses. - Psych nurses received more violence training. - 7 variables were significantly associated with nurses' perception of safety in the workplace: adequate security equipment; adequate training of security guards; adequate response time for security; amount of verbal abuse; updates on patterns of violence; receiving information on individual violent events and methods of prevention; and feeling that security was important to senior management.	Conclusions: -Workplace features that improve perception of safety may not lower assault rates. - ED nurses: less secure than psych nurses despite both having significant assault risks. - Disconnect between staff perceptions and actual safety. Comments: - ED nurses may feel less secure due to unfamiliarity with patients; patients seeking drugs; presence of family members; less training in de-escalation - Psych nurses may feel more secure due to familiarity with patients; linking behavior with a mental illness; and having training in de-escalation. - Despite disconnect between perception and actual safety, management must address perceptions due to impact on quality of care and employee retention. - Nurses who perceive themselves as safe may be at greater risk of violence as perception may obscure the actual risk.

	Fisher's exact tests; logistical and linear regression; cross tab observations; univariate logistic regression; multiple linear regression.	- Certain workplace variables (security response time, incidents of verbal abuse, adequacy of security equipment, regular updating on violence, importance of security to management) were not predictive of assault rates.	Strengths: cross sectional study; high participation. Limitations: potential recall bias; different time frames for nurse interviews and assault data. Rating: Design: Weak. Quality: Strong. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Chen et al. (2008)	Purpose: To determine prevalence and possible risk factors of workplace violence at a large psychiatric institution. Design: Quantitative; cross-sectional study. Participants: 222 of 231 employees (nurses, nurse aides, clerks). Large psychiatric hospital (for patients with schizophrenia) in rural area of eastern Taiwan. Methods: Standard questionnaire. Measurements: Multiple logistical models.	- 25% participants reported workplace violence during past year. - 60% encountered some type of violence during employment. - 55% had moderate level of anxiety about workplace violence. - Of violent incidents, 7.7% involved weapon; 46.2% resulted in physical injury; 30.8% needed medical treatment. - about 70% incidents occurred during daytime. - patients most common aggressors. - fewer than 20% victims had PTSD symptoms. - more than half respondents considered events were preventable.	Conclusions: -Prevalence rate of violence higher at this hospital than other hospitals. - Psychiatric units one of most frequent sites of workplace violence. - Higher the level of anxiety about workplace violence, the more vulnerable workers were to physical violence. Comments: -Due to presence of weapons in physical violence, mandatory check of dangerous tools at admission and after leave. - Because verbal violence is so frequent, it may not be perceived as a major concern for injury or source of worry. - Training for high risk groups may decrease aggression. Strengths: high participation rate.

			Limitations: not generalizable (one hospital specific to care of patients with schizophrenia); potential recall bias; perhaps lack of willingness to share information. Rating: Design: Weak. Quality: Strong. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Crilly et al. (2004)	Purpose: To study violence towards ED nurses by patients. Design: Descriptive, longitudinal cohort design study. Participants: 71 of a total 108 ED nurses participated. Included 2 public EDs in South East Queensland, Australia. Methods: 4 instruments (questionnaires). Measurements: Pearson's correlation; chi square; t test.	- 50% nurses reported violence in the past 5 months. - majority of nurses reporting violence were mid 30s, female, relatively experienced, and working part-time. - 86 patients were responsible for 110 violent incidents. - 53% verbal violence, 26% physical violence. - evening shift was most violent; day shift was least violent. - being sworn at was most common form of violence. - being pushed was most common form of physical violence. - many incidents involved multiple forms of violence. - most verbal violence in	Conclusions: - Alcohol, drugs, and behavior associated with mental illness are precipitating patient factors associated with violence. - Wait times cited as a precipitating factor; 39% violent patients waited over the amount of time determined appropriate by their triage category. - Unpleasant ED environment may be contributing factor. Comments: - Violence is a concern nationally and internationally. - Front-line ED nurses are often the targets of violence. - Wait times as determined by triage method may be acceptable by the medical profession but may not be acceptable or understood by the public. - High rate of violent patients

		triage. - average wait time of violent patients: 66.2 min. - 24% violent patients did not wait to see doctor. - over half of all violent episodes involved patients who had prolonged waiting time, in excess of government recommended guidelines. - qualities of violent patients: demanding behavior and requesting attention (44%); mental illness; and irrational behavior (19%).	with mental illness may be explained by health policy related to de-institutionalization of individuals with mental illness. - Victims of violence may suffer ramifications beyond the violent episode, due to repeated violence, insufficient support, and fear of reprimand. - Presence of security may not always be beneficial, as nursing interventions are often the first line of management. Limitations: possible underreporting; only two EDs studied, in one region; only patient violence studied. Rating: Design: Weak. Quality: Strong. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Duxbury and Whittington, (2005)	Purpose: To study staff and patient perspectives on the causes of patient aggression and way it is managed. Design: Descriptive study (convenience sample). Participants: 80 nurses and 82 patients from 3 mental health wards. Methods: Questionnaire survey and semi-	- internal factor: nurses saw mental illness as strong precursor to aggression; while patients disagreed. - external factor: environmental factors recognized by both nurses and patients as problematic. - situational factor: poor communication and ineffective listening skills seen by patients as precursors to aggression (staff disagreed). - nurses supported use of	Conclusions: -Nurses view internal (patient) characteristics as main causative factor; patients view external and situation factors. - Both nurses and patients recognize environment as cause of aggression. - de-escalation is viewed as unsuccessful by patients, successful by nurses. Limitations: only 3

	structured interviews. Measurements: descriptive statistics, independent t tests; audio taping and transcription of interviews.	medication, seclusion, patients did not.	wards studied, thus generalizability not recommended; small convenience sample, which may threaten external validity; validity of patient sample questionable; instruments are new, may require more testing to increase validity, reliability. Rating: Design: Weak. Quality: Strong. Evidence: Direct. Qualitative: Medium.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Gerberich et al. (2015)	Purpose: To identify magnitude and potential risk factors for violence. Design: Epidemiological study. 2 phases: Phase 1 – survey; Phase 2 – case-control study. Participants: 6300 nurses (RNs and LPNs) randomly sampled. 78% response rate. Methods: survey questionnaires. Measurements: multiple logistic regression analysis.	-96% female; average age 46. - assault rate: 13.2 per 100 persons (physical violence); 38.8 per 100 persons (verbal violence). - 75% of those reporting physical assault also reported verbal assault. - for non-physical violence: 7% reported sexual harassment; 17% reported threats; 34% reported verbal abuse (past 12 months). - >90% physical violence from patients. - violence associated with: impairment due to illness (>80%); prescribed medication (18%); 66 years and older; 8% not-impaired. - aggressors primarily male. - most commonly reported consequences of abuse by victims: frustration, anger, fear/anxiety/stress, irritability. - 8% of nurses physically assaulted and nearly 13% nurses reporting non-physical assaults reported persistent problems. - 27% perceived violence a problem in workplace. - 52% perceived violence preventable.	Conclusions: -Males and younger workers had increased likelihood to experience violence. - Greatest risk for violence in nursing home, long term care, rehab facility, emergency department, psychiatric department, ICU, and occupational health. - Violence affects employee, employer, co-workers, and personal contacts. Comments: - There are multiple effects, e.g. reduced productivity, increased turnover, absenteeism, and decreased staff morale. - Non-physical violence have more severe consequences than physical violence. - Patient care for those at high risk for violence (elderly, impaired) must be investigated to enact safety criteria (e.g. flagged charts). - Much non-physical violence from persons other than patients (e.g. coworkers, supervisors, etc.). Limitations: potential recall, information, and response bias. Rating: Design: Weak. Quality: Strong. Evidence:

			Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Hahn et al. (2013)	Purpose: To explore risk factors associated with patient and visitor violence (PVV) directed against health professional. Design: Retrospective cross-sectional study. Participants: 4845 health care professionals (multidisciplinary) in one Swiss university hospital. May and July, 2007. Methods: 3 instruments (questionnaires). Measurements: Multiple logistic regression.	- 85% professionals experienced PVV. - older workers experienced less PVV. - workers who received training in aggression management experienced almost double PVV. - certain wards experienced less PVV than others. - health professionals in areas with patients over 65 years of age had 1.47 times risk of PVV. - professionals working with visitors had 1.42 times odds of PVV. - dominant variable for verbal violence: professionals' education level, age, training in aggression management, confidence in managing aggression, perception of preventive measures, and patients' age. - dominant variable for physical violence: gender, training in aggression management, patients' age, visitor group, and ward type. - dominant variable for threats: training in aggression management, perception that aggression is	Conclusions: - PVV is significant problem for health professionals in general hospitals. - Verbal violence is most prevalent form of violence. - Characteristics of health professionals influence experiencing violence (e.g. younger workers, confidence in management of physical violence, rating of preventive measures as unimportant, rating aggression as emotionally letting off steam all reduce experience of violence). - Having training in aggression management increases risk of experiencing PVV. - Characteristics of patients increase risk of PVV: over 65 years, working with visitors (family members). - general hospital settings, emergency rooms, anesthesia, intermediate care, step-down units are workplaces with high risk for PVV. Comments: -PVV is a serious workplace problem, not just restricted to high-risk areas (ED and psychiatric units). - Training in management of aggression may increase employees' perception of violence. Limitations: variety in definitions of PVV; potential over- or under-reporting; complexity of true

		emotionally "letting off steam", patients' age, and visitor group.	situation may not be able to be measured by regression analysis. Rating: Design: Weak. Quality: Strong. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Heskeith et al. (2003)	Purpose: 1. To examine the occurrence, sources and reporting of workplace violence among nurses in different clinical hospital settings. 2. To examine and address related issues. 3. To make suggestions for violence prevention. Design: Descriptive study. Participants: 2648 of 5479 nurses (48.3% response) in BC and AB working in acute care hospitals. September 1998 – February 1999. Methods: Survey (form of questionnaire). Measurements: ANOVA; Tukey's HSD; Pearson's r correlation.	- nurses in ER and psych have highest incidence of violence. - med-surg nurses have highest incidence of physical assaults. - 1 in 5 nurses experienced violence. - psych nurses more likely to report violence. - nurses experienced no violence had highest job satisfaction; nurses experienced multiple forms of violence had lowest job satisfaction.	Conclusions: - Violence is not limited to traditionally high risk areas. - Violence had impact on nurses' job satisfaction. Comments: - Under-resourced staff are more likely to experience violence due to frustration from low quality of care (from low staffing and few resources). - Ethical dilemma (therapeutic relationship); burdensome paperwork; lack of institutional support; dissuasion from co-workers may lead to underestimating seriousness of abuse and underreporting. Limitations: no limitations provided by authors; however, underreporting of aggressive incidents can be presumed; data gathered is over 15 years old. Rating: Design: Weak.

			Quality: Medium. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
James et al. (2006)	Purpose: To examine characteristics of aggressive incidents and violence towards emergency department staff. Design: Retrospective review. Participants: 218 incident reports filed by staff in the emergency department of Queen's Medical Centre, Nottingham, UK. November 1, 2002 – October 31, 2003. Methods: Incident reports were reviewed. Particular variables were chosen for examination; these variables were	- 187 individuals involved in 218 incidents. - 14 individuals accounted for 20.6% of the 218 incidents. - 88.2% were patients; 11.8% were visitors. - 64.7% male. - 45.2% of assailants were 16-30 years of age, majority older. - Assailants tended to live in wards ranked "more deprived" (p<0.0001). - 52.3% of aggressors were thought to be under the influence of alcohol. - 5.0% of aggressors were thought to be under the influence of illegal substances. - 11.9% of occasions involved reference to wait times. - 13.8% of assailants voiced suicidal ideations or had been	Conclusions: - Assailants frequently young males. - Repeat offenders caused large number of incidents. - Assailants tended to live in "more deprived" areas. - Alcohol is associated with violent incidents. Comments: -Department should monitor aggression to detect repeat offenders. - Provisions to handle repeat offenders would be useful. - Legal action may be a choice to try and prevent future incidents. - A prospective study comprising post-incident reviews may offer insight into the causes of violence and aggression. - Guidelines should address what happened during the incident and identify trigger factors and the role of each person involved. Limitations: low reporting of aggression, particularly for those that are less severe; reporting of

	selected by examining 10 incidents which occurred prior to the study period. Measurements: Multiple logistic regression analysis.	referred to psychiatry. - There were 89.9% incidents of verbal aggression; 51.8% of threatening language or behavior; 32.1% of actual or attempted physical violence.	inpatient violence may be more likely than of non-inpatients; retrospective review, which is limited to only what is recoded on a standard form (for example, information on present of alcohol and wait times was not specifically mentioned). Rating: Design: Weak. Quality: Medium. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Jonker et al. (2008)	Purpose: To determine nurses' perceptions of the prevalence of aggression, nurses' attitudes towards patient aggression, the use of coercive interventions. Design: Quantitative cross-sectional research design. Participants: 85 (of 113) nurses working in a mental health institution in the east part of the Netherlands. February – March, 2007. Methods: 2 questionnaires Measurements: Descriptive analyses; independent t-tests; linear regression analyses.	- majority of nurse report "never/rarely" being confronted with aggression. - more nurses on a closed wards reported more aggression than those on a semi-closed ward. - 60% of confrontations were non-threatening verbal aggression; 30% were passive aggressive. - 80% nurses reported "never/rarely" experiencing sexual intimidation. - male nurses had higher intent and used less coercive interventions. - non-bachelor-educated nurses and nurses with more than 12 years experience showed higher self-efficacy for management of patient aggression. - nurses perceived considerable support from colleagues when confronted with patient aggression.	Conclusions: - Nurses perceived sometimes being confronted with aggression. - Nurses are confronted with patient aggression once every other day. - Aggression is seen as an offensive and destructive behavior. - Nurses feel competent in managing aggression. - Nurses experience much social support from colleagues. Comments: - Patient aggression may be considered a regular part of mental health nursing, since there are high incidences of aggression; however nurses do not perceive this as a major problem. - Nurses perceive patient aggression as destructive and offensive, differing from earlier studies showing aggression was protective and communicative; the reason for this might be that modern society is more hardened. - More experienced nurses intend to use less coercive interventions. - More experienced nurses better recognized signs of aggression - Less experienced nurses are more vulnerable to patient aggression. Limitations: results not generalizable to other institutions; potential recall bias; potential socially desirable response; small sample size; use of mean

			substitution for missing data. Rating: Design: Weak. Quality: Strong. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Rose (1997)	Purpose: 1. What proportion of staff experienced violence; 2. Frequency of attacks; 3. If violence reported/sick leave taken; 4. If age and experience changed attitudes to violence, and reporting; 5. Level of staff training. Design: Descriptive study. Participants: 27 of 36 nurses in accident and emergency department, St. James's Hospital, Dublin, Ireland. Methods: questionnaire. Measurements: Not detailed.	-60% nurses and attendants physically assaulted at least once. - 40% assaulted within past year. - 91% worried about being physically assaulted. - 63% nurses did not document latest incident of verbal abuse; 21% nurses did not document latest incident of physical abuse. - higher percentage of nurses with longer years of working documented abuse. - immediate colleagues supportive; response from management ranged from very supportive to unhelpful. - 36% nurses; 27% all staff required sick leave - more than 1/5 staff had training in dealing with abusive patients.	Conclusions: -Nurses perceive management and legal system as inadequate. - 1/3 abuse not reported. - Staff feel they are not given sufficient training or support to deal with aggression. - Younger, more inexperienced staff members more likely to be victim of violence. Comments: -Training, security, and personal alarms implemented in unit. Limitations: underreporting; small sample size. Rating: Design: Weak. Quality: Medium. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Spector et al. (2014)	Purpose: To estimate exposure rates by type of violence, setting, source, and world region. Design: Quantitative review of the nursing literature. Participants: 136 articles; included 151,347 nurses worldwide. Methods: Meta-analysis. Measurements: Percentages obtained from sample data.	- 36.4% report physical assault. - 67.7% report non-physical assault. - 50.5% report general violence (not specified). - physical violence more prevalent in psychiatric, geriatric, emergency departments.	Conclusions: -Violence may be underreported. Comments: -Violence prevention programs need to be comprehensive to deal with all workplace violence. - Violence exposure for nurses in universal. - There are regional and country differences to rates and sources of violence. Limitations: several of studies had small sample size; studies not all comparable across type, setting, source, and region; little standardization. Rating: Quality: Medium.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Stone et al. (2011)	Purpose: To investigate swearing and verbal aggression in Australian inpatient settings. 1. To investigate if patient characteristics related to verbal aggression; 2. Explore relationship between aggression and patient motivation; 3. Investigate interventions; 4. Investigate aggression and impact on nurses. Design: 2 parts: 1. Descriptive study, mixed methods approach; retrospective; 2. qualitative study. Participants: 1. 9,623 reports, for 384 employees. 2. Survey of 107 nurses. Australian inpatient hospital. Method: 2 instruments (1. standardized checklist and questionnaire with rating scales; 2. open ended short answer questions). Measurements: 1. General linear model;	-average number of more serious incidents of verbal aggression significantly higher than less serious incidents. - average number of less serious incidents of physical aggression significantly higher than more serious incidents. - significantly higher verbal aggressive incidents with diagnosis of psychosis. - perceived cause of verbal aggression was organic brain damage. - 1.9 interventions per incident. - most frequent interventions: talking to patient (70%); increasing level of observation (40%); oral medication (25%); seclusion and segregation (20%). -high frequency of exposure to swearing; 29% nurses sworn at 1-5 times per week; 7% sworn at continuously. - 50% report distress to exposure to swearing. - swearer: patient (76%); 18 years or older (66%); male (56%).	Conclusions: -Verbal aggression most frequent type of aggression. - More male patients reported; more severe for female patients. - Patients with psychosis, anxiety have more aggressive incidents than patients with MDD. - Patients with psychosis show more verbal than physical aggression. Comments: -May be under estimation of low levels; leading to not recognizing early cues, thus leading to escalation. -Factors intrinsic to patient are recognized more as motivators for aggression than extrinsic factors; this belief may provide justification to use of medical treatment for aggression (or to absolve nurses with poor communication skills). - There are limited interventions to deal with aggression. Limitations: possible underreporting, particularly less severe aggression, or staff having high threshold for verbal aggression. Rating: Design: Weak.

| | Poisson distribution. 2. Grouping under main themes; using priori coding. | | Quality: Strong. Evidence: Direct. Qualitative: Medium. |

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Tam et al. (1996)	Purpose: To gather information about violence in a hospital, and to discuss implications of findings for hospital policy. Design: Prospective study. Participants: Staff members of a 74-bed psychiatric facility in Montreal, Quebec. January 1, 1992 – December 31, 1992. Methods: Reports completed by staff members to report violent incidents were reviewed. Measurements: Chi-square tests.	- 46 patients were responsible for 133 incidents. - 15 patients accounted for 75% of incidents. - 123 incidents involved physical assault. - mean age of violent patients: 42.5 +/- 19.6 years. - highest rate of violence: patients with organic brain syndrome, schizophrenia (.01 and .006 incidents per patient day, respectively). - 86% incidents on inpatient ward, 60% on locked ward. - punching or hitting were most prevalent violence (40%). - grabbing (15%) and scratching (5%) accounted for more injuries. - RNs were most frequent target (48%). - 44% episodes were not preceded by agitation.	Conclusions: -Episodes of violence are underreported. - Serious episodes were determined to not be underreported in this study. - Minority of patients associated with majority of attacks (e.g. one patient with mental retardation). - Patients with schizophrenia were associated with higher rates of violence. - Relatively few episodes associated with containment. Comments: -Training in aggression should focus on most common methods of assault in the facility. - Constant awareness that aggression could occur is necessary. - It is a myth that all violence can be spotted and dealt with early. Limitations: aggressive incidents reported likely did not include less severe types of aggression (e.g non-verbal aggression); one institute studied, which limits generalizability; older

			data.
			Rating: Design: Weak. Quality: Medium. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Williamson et al. (2013)	Purpose: To determine patient factors associated with aggression in order to inform screening and prevention protocols. Design: Retrospective audit. Participants: Clinical staff of general wards at St. Vincent's Hospital, Melbourne. January 1, 2009 – June 30, 2009. Methods: Audit of code grey event reports and medical records of patients who had code grey event. Note that a code grey event involves the activation of an alert to assemble emergency response staff to assist staff during unarmed patient aggression. Measurements: Chi-square, bivariate, logistic regression.	- 71.1% male, 28.3% female with code grey event (non-code grey event: 55.7% male, 44.3% female). - association between code grey and gender is significant (p=.04). - highly significant difference in age (60.7 years non-code grey; 68.6 code grey). - significantly higher (3.8%) Indigenous Australian background (p=.027). - significantly higher code grey persons were never married (p=.02). - significantly higher (4X) code grey persons were registered with Department of Veterans' Affairs (p=.01). -patients admitted to hospital via ED twice as likely to have code grey event than those not admitted via ED. - delirium: 21.8% of code grey patients, 2 of non-code grey patients. - dementia: 12.8% of code grey patients, 1.3% of non-code grey patients. - no associations with persons with non-English backgrounds, acquired brain injury, depression, or schizophrenia.	Conclusions: - Older age, delirium, and dementia are associated with code grey incidents. - Males, persons never married, those receiving Veteran's Affairs, those admitted through ED all were associated with greater code grey incidents. Comments: -Promotion and education about assessment tools for older people would help in recognizing dementia/delirium. - Males more likely to behave more aggressively than females. - Marital status may be linked to levels of support, quality of life, and aggression. - Veterans may experience PTSD , thus increasing risk of aggression. Limitations: The study reports only incidents resulting in code grey, therefore any other acts of aggression (when code grey was not involved) are not included; two different sources of data, with inconsistent terminology; missing and incomplete data; diagnoses information gathered from discharge summaries, therefore may not explain code grey

			situation.
			Rating: Design: Weak. Quality: Medium. Evidence: Direct.

Study	Purpose, Design, Participants, Method, Measurements	Results	Conclusions, Comments, Strengths, Limitations, Rating (PHAC, 2014)
Zampieron et al. (2010)	Purpose: Quantify aggression towards nurses; describe characteristics of aggressors and victims; and examine the association. Design: Cross-sectional study. Participants: 595 of 700 nurses in two health care institutions in Italy. Methods: Questionnaire (35 multiple choice). Developed based on questionnaires from prior research studies. Measurements: Preliminary descriptive variable analysis; chi-square test; Fisher's exact test.	- 49.4% reported at least one episode of aggression in the past year. - 81.6% reported verbal aggression. - 4.8% reported physical aggression. - 13.6% reported both types aggression. - 57% aggressors were patients. - 66% aggressors were male, 88% Italian, 59% <50 years. - 52.6% reported aggressive event. - 52% victims were female. - age, level of education, professional roles not associated with risk of aggression. - most aggression in psychiatric, emergency, geriatric units. - increased aggression with	Conclusions: - Violence and aggression towards nurses are widespread in Italy and often disregarded. - Nurses reporting negative feelings about their work, stress, dissatisfaction, and fatigue perceive more violence and aggression. - Only approximately 50% nurses report violence. Comments: - Assess patient satisfaction at the managerial level to improve care; particularly in geriatric, psychiatric and emergency units - Improved communications, establishment of supportive relationships with families, improved service delivery, reduced wait times might decrease aggression. - Focus on job motivation, participatory leadership, and promotion of best working conditions, attention to workload and staffing concerns would address staff dissatisfaction. - Appropriate security, documenting patients prone to aggression, alarm system, training re aggression, mandatory reporting of aggression. - Nurses and institutions should reduce tendency to justify violent behavior. Strengths: high participation rate (85%).

| | | shift workers. - association noted between aggression and nurses reported being tired; stressed; or not satisfied with jobs (all p<0.001). | Limitations: retrospective study; decreased validity due to cross-sectional study; measures perceptions of aggression, not actual aggression

Rating: Design: Weak. Quality: Medium. Evidence: Direct. |

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Appendix C: Consultation Report

Consultation Report

Improving Safety of Nursing Staff:

Challenges and Solutions Regarding Safety for

Nursing Staff in Acute Care Psychiatric Settings

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Workplace violence is an unfortunate reality in nursing (Bonner & McLaughlin, 2007; Crilly, Chaboyer, & Creedy, 2004). Despite declarations of zero tolerance (Canadian Nurses Association [CNA], 2005), violence continues to occur. Thirty-four percent of nurses report episodes of physical violence while 47% of nurses report emotional abuse. Nurses in the psychiatric setting report higher levels of violence, with 47% of psychiatric nurses reporting episodes of physical assault, and 70% of psychiatric nurses reporting emotional abuse (Shields & Wilkins, 2009). With the continuance of violence despite the expressed goal of zero tolerance, the examination of issues related to violence in the workplace as well as strategies to increase safety of nursing staff, specifically in the psychiatric setting, are important to undertake.

Workplace violence incorporates multiple types of behaviours. The Canadian Centre for Occupational Health and Safety (2012) describe five examples of workplace behavior:

11. Physical attacks, such as hitting and pushing;

12. Verbal abuse, including swearing and insulting language;

13. Threatening behaviours, for example, shaking fists, destroying property, and throwing objects;

14. Threats, both verbal or written, with an intent to cause harm; and

15. Harassment, including behaviours such as words, gestures, or bullying, which demean, embarrass, humiliate, or cause alarm.

It is important to recognize that violence in the workplace can originate from patients, families, visitors, coworkers, and other workplace colleagues (Howerton-Child &

Mentes, 2010). This practicum will focus on violence perpetuated by consumers of psychiatric services, namely patients, families, and visitors.

There are numerous reports in the media describing workplace abuse against nurses, describing episodes such as nurses being exposed to threats, being spat at, called vulgar names, and experiencing cuts and bruises as well as severe trauma resulting in the need for surgery (Canadian Broadcasting Corporation [CBC] News, 2013; CBC News, 2015; Greater Toronto Area [GTA] News, 2015; Yahoo News, 2014). In my own experience, I have had a patient grab my arm, had several patients run towards me, had items thrown at me, and have on multiple occasions, been called obscene names. Workplace aggression results in many negative effects for nurses, including work dissatisfaction, stress, fatigue, loss of confidence, increased apathy towards patients, strained personal relationships, and financial hardships (Baby, Glue, & Carlyle, 2014; Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013; Zampieron, Galeazzo, Turra, & Buja, 2010). While strategies have been put in place to create a safer environment, abuse continues. I question: Are there other strategies available to increase nurse safety in psychiatric settings?

In order to enact strategies to increase nurse safety, it is important to consider all aspects related to violence in health care setting (patient characteristics, the environment in which patients and nurses interact, nurses' own personal traits and perceptions, and organizational policies) that combine to influence aggression against nurses (Hahn, Muller, Hantikainen, Kok, Dassen, & Halfens, 2013; Jonker, Goossens, Steenhuis, & Oud, 2008; Ramacciati, 2014; Zampieron et al., 2010). Whatever the cause, addressing

workplace violence is important for nurses, as well as for patients and health care in general. Thus, it is imperative to examine workplace violence using a multi-dimensional approach (Ramacciati, 2014) in order to gain an understanding of this important health care issue.

Consultation Process

One important step to achieving an understanding of patient perpetuated violence and, subsequently, to offering solutions for controlling such violence is to undertake consultations with key stakeholders in order to gain an understanding of the individual professional opinions and concerns related to the issue. As revealed through a literature review, workplace violence is multi-dimensional (Ramacciati, 2014), incorporating multiple aspects (patient characteristics; the environment in which patients and nurses interact; nurses' own personal traits and perceptions; and organizational policies) (Hahn et al., 2013; Jonker et al., 2008; Ramacciati, 2014; Zampieron et al., 2010). Therefore, it is imperative to consult with those persons who are involved in the workplace at each level (direct care, managerial, policy development, and workplace quality and safety) in order to gather and to evaluate the multiple viewpoints which influence how workplace violence is experienced and perceived. By consulting with key stakeholders from each level of the organization, an understanding of the perceptions and expectations surrounding workplace violence within the workplace itself can be evaluated and understood from multiple viewpoints. Consultation, combined with evidence based practice as reflected in the literature, as well as an understanding of interventions enacted at similar hospital, will all contribute to the furthered understanding of workplace

violence. Only with such a comprehensive approach can workplace violence be addressed effectively.

The consultation process consisted of several steps. First, a list of objectives was established to guide the process. Next, key stakeholders were identified as participants, based on specific workplace roles involving either direct or indirect involvement in areas of psychiatric health care where workplace violence could occur. A questionnaire was then formulated to collect relevant information. Data were collected, keeping in mind important aspects such as consent, privacy, data management, and data analysis. Finally, results of the consultation process were analyzed and summarized in tabular form. The results of the consultation process will be utilized in the process to produce a paper, presentation, and policy statement in order to address the problem of workplace violence.

Objectives

The objectives for the consultation were established to inform the goal of the practicum, which is two-fold; to identify levels of aggression in acute care psychiatric settings, and to identify solutions to increase safety of nursing staff in psychiatric acute care settings. As a result, several objectives were determined. Appropriate persons with knowledge and expertise in psychiatric nursing, policy development, or management had to be identified and then approached as key informants for consultation. Specific questions would be compiled to collect relevant data. Data would then be analyzed to produce conclusions to contribute knowledge to the field of workplace violence. The objectives for the consultation were listed as follows:

1. Identify key stakeholders with expertise in the patient population (patients in psychiatric settings); mental healthcare, and organizational policies.

2. Collect information from stakeholders to contribute to understanding of violence in psychiatric settings

3. Determine perceived issues of importance to those working in settings who are at risk for or who are exposed to workplace violence.

4. Determine perceived issues of importance to those who manage, influence policies, or collect data on violence for psychiatric settings where violence occurs.

5. Compile information from multiple sources regarding workplace violence, in order to provide a comparison and summary of results.

6. Present results to key stakeholders as a policy paper.

Participants

The identification of key informants was important so that information would be collected from persons with a vested interest and knowledge of the area of workplace aggression, psychiatric nursing, or the Mental Health and Addictions Program within the Eastern Regional Health Authority. Representatives from management and administration within the Mental Health and Addictions Program, Eastern Health, were identified due to knowledge of the psychiatric program, its policies, statistical information regarding violent episodes, resource allocation, and budgetary limitations. Professional Practice Consultants were included as they could provide information specific to nursing policies in the Mental Health and Addictions program. Quality and Risk Management Consultants were contacted since they could provide information

concerning reporting mechanisms and statistics for aggression against nurses. Practicing psychiatric nurses, either in a supervisory role, or who provide direct patient care, in a psychiatric unit within the Mental Health and Addictions Program in the Health Authority, were chosen since their views of perception and levels of violence provide opinions of the nurses who are recipients of aggression. As a result, a total of nine individuals were identified for inclusion as key stakeholders. Participation was voluntary. Consent to participate was implied when the questionnaire was returned to the writer.

Questionnaire

After a discussion with Nicole Snow, practicum supervisor, a survey containing six questions was created to collect relevant information. Questions were devised to collect information on the definition of workplace violence, reporting mechanisms, issues surrounding underreporting, and potential interventions that may improve nurse safety. An email containing this survey, in addition to a letter which requested assistance as a consultant, provided background information of the practicum project, and included relevant references, was formalized. The Director of Mental Health and Addictions was contacted and provided with a copy of this email for endorsement. All key stakeholders were contacted by telephone or in person prior to distribution to inform them of the survey, and to receive approval to have it sent to them. Once the survey was approved by the Director, the survey was then distributed to all key informants either by email attachment or in person in hard copy format. Key stakeholders who had not provided a response within a three week time period were contacted by telephone as a reminder.

The questionnaire is included as Appendix A. The letter to the key informants is

included in Appendix B. The checklist for the Health Research Ethics Authority

Screening Tool was completed and ethical approval was not required. The checklist is

included as Appendix C.

Data Collection, Management, and Analysis

Completed surveys were collected either via email or in person through a hard

copy version. Once received, all collected data were kept in a secure location in the

researcher's home. Computerized information was stored on a private computer, which is

password protected. Hard copies of results were stored in a locked filing cabinet in a

secure location, accessible only by the researcher. Names of participants and data were

kept separate, so as to deter identification. In order to maintain confidentiality,

identification of opinions expressed by specific individual participants will not be

revealed.

Seven of nine key stakeholders completed the survey. Individual results were

analyzed and compared. A table containing comparisons of results is included in

Appendix D.

<div align="center">

Results

</div>

Definition of Workplace Violence

All seven stakeholders agreed with the definition of workplace violence as

incorporating multiple types of actions, including physical and verbal abuse, threatening

language and behaviours, and harassment (Canadian Centre of Occupational Health and

Safety, 2012). This finding is important in establishing that workplace violence

perpetuated by patients has a broad definition that is accepted by key stakeholders within the Health Authority. Therefore, any policies or decisions regarding the collection of statistics related to violence, as well as the initiation and enforcement of strategies to combat workplace violence, should incorporate each type of violence included within this definition.

Level of Aggression

Most of the respondents reported that the number of aggressive episodes had increased over time. These opinions were mainly based upon observation and experience as opposed to actual statistics, particularly the views expressed by the registered nurses involved in direct patient care. One experienced psychiatric nurse stated "Working … for years changed from isolated incidents of aggression to daily occurrences and even multiple incidents in a shift". Another psychiatric nurse, stated that "the incidence of violence has increased. Mainly in the form of verbal aggression and threatening behavior". This reported increase in aggression should be of great concern to psychiatric nurses and to providers of healthcare in general.

Two participants referenced reports of Code White events as an indicator for aggression. Code Whites are a formal system of alarm and response that is initiated when aggression or the potential of aggression occurs. A group of assigned nursing professionals respond to provide support in the prevention or minimization of violence in order to protect patients, staff, and others. Code White Level 1 is called when a minimal number of assigned persons are required, Code White Level 2 is called when a maximum number of assigned persons are needed, and Code White Level 3 is called when police

involvement is required. One participant noted that the number of Code White Level 2

incidents in the Health authority have increased in the past several years. However, it was

acknowledged by another participant that the increase in Code Whites may not be

representative of actual aggression, but potential aggression, thus may not be indicative

of incidents of actual workplace violence. As well, it was acknowledged by one

participant the occurrence of Code White events does fluctuate, as it may be influenced

by an individual patient within the hospital who may be the source of multiple episodes

of Code Whites (either potential or actual aggression). This leads to the question whether

statistics of Code White events are useful in determining levels of workplace violence.

One would have to individually review each report to determine if workplace violence is

involved, using the current system of Code White reporting. Additionally, one would

question if the potential of violence (presumably the potential of physical violence) is

actual workplace violence; it could be assumed that there is something about the

behaviour of the patient that is concerning enough to staff to initiate a Code White event.

However, is this "something" actual workplace violence?

Another participant indicated that the number of presentations to the psychiatric

assessment unit (PAU) have increased in the past several years, which may be an

indicator of increased aggression. Persons arrive to PAU either as walk-ins from the

general public, accompanied by police, or as patients consulted from medical hospitals.

There were no statistics included regarding an actual increase in the percentage of

workplace violence in PAU. However, it may be assumed that with increased total

numbers of persons presenting to PAU, there would be a correlated increase in aggressive

episodes.

Reporting of Aggression

All seven respondents indicated that episodes of aggression are reported by the

Clinical Safety Reporting System (CSRS), the official reporting system within the Health

authority to document unexpected events. Every report made through CSRS is

automatically sent to the unit manager; thus the manager would be notified by this

method as well. It would have been interesting to explore if key stakeholders believed or

knew that incidents of non-physical aggression (such as verbal abuse, and threatening and

harassing behaviours) were reported using CSRS. If this is not the case, then CSRS is not

a comprehensive system to track all episodes of aggression.

Most of the direct care providers indicated that documentation in patients' charts

is a method to record aggression. Based on personal experience, I feel that more of the

different types of aggression (namely verbal abuse, threatening behaviour, verbal threats,

and harassment) would be officially reported using this method than by any other

method. Thus, the likeliest method to trace most episodes of workplace violence would

be through a review of patients' charts.

Two stakeholders indicated that employee incident reports is another method to

report aggression. However, it must be noted that this method is used if the employee

loses time from work. It might be implied that aggression requiring this type of reporting

would be of the more "extreme" types of aggression, namely physical assaults involving

temporary physical harm or incapacitation. However, it would be interesting to explore if

employee incident reports are being used appropriately and thoroughly in all cases requiring such reporting. There is likely under- utilization of this resource within the organization; it would be important to determine if this method collects all information it is supposed to collect, particularly involving episodes of all types of patient aggression which could have an accumulated mental and emotional effect on employees. As well, three participants suggested notifying police was a method to report aggression. Again, it might be assumed this method would be used for more "extreme" types of aggression such as physical assaults or threats, thus this method of report would collect minimal information on all types of aggression.

Three participants stated that the manager would be notified; however it must be noted that the manager is automatically notified once a CSRS report is initiated. One participant said that management would be notified only if physical assault was involved, while another reported that the on call physician would be made aware. I believe that if the manager and the on-call physician were notified, it would be of an informal nature, during the giving of report, or informal discussion of events on the unit. A review of the policies within the Health authority concerning reporting of aggression would be important to determine if appropriate measures are being taken when workplace aggression occurs.

Underreporting

Despite the identification of multiple methods to report aggression, five participants stated they suspected underreporting of aggression, while two participants indicated they were unsure or did not know. One respondent indicated that there is a

tendency in all workplaces to underreport incidents, so perhaps this is not unusual.

There were multiple reasons identified for underreporting. The belief that aggression is part of the mental state of the patient, thus is not deliberate or is excusable, was identified by the majority of the participants as a reason for underreporting. One participant stated that "all behaviour tends to be contributed to the mental state of clients, even alcohol intoxication". It was stated by a participant that certified patients tend to be spared consequences of behaviour due to their "mental status" at the time. Another participant indicated that a patient's "insight / judgement" contributed to whether an incident would be considered to be workplace violence.

Most participants indicated a reason for underreporting was the feeling that reporting will not result in change or meaningful action to decrease violence. One participant indicated that when no feedback is given to staff after a report is filed, the report itself may be seen as meaningless. In addition, one participant stated that the lack of consequences to the aggressor could be a reason not to report, thus acknowledging a sense of futility when nothing results of making a report. As one participant put it: "a big portion of underreporting is the lack of support … and the feeling that nothing will be changed".

Four participants stated that underreporting could be due to the belief that aggression is part of the job. One participant identified the belief that aggression is an "accepted aspect of psychiatric nursing". Another described how "there seems to be an expectation to accept some level of aggression", and that, with aggression being "almost a daily occurrence", "it tends to become the new normal". Four participants also stated

that there would be no need to report certain types of aggression (such as verbal insults, threatening behaviour) but will report other types of aggression (such as physical). Two participants stated that lack of time or not knowing how to report may be reasons for underreporting of aggression.

A participant indicated that the removal of "contact pay" as a benefit for psychiatric nurses added to the culture that "aggression is part of the job". Contact pay was a financial benefit given to nurses in the Mental Health and Addictions Program in the past as a bonus in consideration of the potential for aggression. Contact pay was discontinued several years ago; thus newly hired nurses do not receive this benefit. The very existence of contact pay implies that the risk for violence was higher in this workplace, which is acknowledged in the literature (Hesketh et al., 2003; Shields & Wilkins, 2009; Zampieron et al., 2010). Therefore, contact pay was a means for administration to acknowledge this increased risk, and to provide employees with a benefit for this risk. With discontinuance of contact pay, is there an implication either that the administration no longer recognizes the increased risk for psychiatric nurses, or that nurses should not benefit because of this risk? Another participant also stated that Code Whites that are called to aid staff in escorting patients to other units due to the potential for violence do not require CSRS reporting because they are an "everyday occurrence". It was questioned that staff or management desensitization could account for lack of reporting, again suggesting that the potential for aggression is just a "normal" part of the job.

Interventions to Improve Safety

All seven participants indicated that the presence of security guards and improved training on de-escalation techniques for staff would be useful interventions to improve safety. One participant mentioned that security staff should be required to have specialized training in de-escalation techniques. Six participants stated that a better environment and improvements to the unit would help increase safety levels, while others thought that improved wait times (in PAU) and more activities for patients could help. One participant offered that support from peer groups could assist patients while waiting to be seen. Respondents also indicated that increased focus on staff safety by health care institutions would contribute to increased safety. One respondent said that the existence of a workplace safety team, made up of staff and management, would be an organizational means to include staff in improving safety in the workplace.

Almost half of the stakeholders indicated that an increase in staffing levels would improve safety. One participant disagreed with this point indicating that an increase in security, as opposed to professional clinical staff, would be a better means to increase safety. Another respondent indicated that appropriate staffing levels were important. Experience level and gender of staff were both mentioned as characteristics that would be useful in considering when staffing psychiatric units. One respondent indicated that some patients respond better to either male or female staff members, thus gender of staff should be acknowledged as a component in controlling aggression.

There were multiple other considerations cited. An increased role of an experienced charge nurse to manage the running of the unit, the presence of police with patients with the potential for aggression, and an increased attention to nicotine

replacements are areas that could contribute to safety. Other participants mentioned the importance of reinforcing consequences of acts of aggression, and showing low tolerance to aggression, however methods by which these statements could be effectively achieved were not offered.

Two psychiatric nurses report that much of the aggression has been attributed to an increase in the use and availability of street drugs. Thus, many patients present to PAU under the influence of drugs, seeking more drugs, or going through withdrawal from substances. The unit must clearly state that no narcotics or methadone will be prescribed. Additionally, an increase in Addictions Services for such patients would offer them the actual assistance that is applicable to their situation, rather than leaving them with little option but to seek out help or drugs at local emergency departments.

<div align="center">**Implications for the Practicum Project**</div>

The overall goal of this practicum is two-fold: to identify levels of aggression in acute care psychiatric settings, and to identify solutions to increase safety of nursing staff in psychiatric acute care settings. Towards this end, information collected from multiple data sources should be utilized in order to gather a thorough understanding of the issues. The consultation process permitted the gathering of opinions of key stakeholders involved in psychiatric health care provision with the Health authority. These opinions would, ideally, inform decisions that affect health care, in this case, namely the safety of psychiatric nursing staff. Consultations are, however, just one part of the process to study workplace aggression in psychiatric settings. The information gathered from the literature search is important as it establishes effective interventions that are based on evidence

based practice. Additionally, a review of current policies within the Health authority is important to determine current expectations on action regarding episodes of workplace violence. As well, an examination of methods to explore and decrease workplace violence towards nursing staff in other similar institutions, such as Centre for Addictions and Mental Health in Toronto, Ontario, would be a useful contribution towards the goals of this practicum. Therefore, the results of the consultations will be examined in the context of additional information, in order to provide recommendations regarding the improvement of safety for nursing staff in the psychiatric setting.

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Appendix A

N6660 - Practicum

Improving safety of nursing staff: Challenges and solutions regarding safety for nursing staff in acute care psychiatric settings.

Questionnaire: Consultation with Key Informants

1. Indicate what you consider to be workplace violence? (Please check all that apply)

____ Physical attacks

____ Verbal abuse

____ Threatening behavior (physical, for example, throwing items, shaking fists, destroying property)

____ Verbal threats

____ Harassment (bullying, demeaning remarks, sexual inferences)

____ Other:

2. How are episodes of aggression reported?

3. To your knowledge, have the number of aggressive episodes increased (in the past five years)? If you can provide statistics or details, please do so here.

4. Do you suspect, or are you aware, that aggressive episodes are not reported?

____ Yes

____ No

____ Unsure or Do Not Know

Comments:

5. If you suspect underreporting, what do you think is the reason? (Please check all that kapply)

____ Lack of time

____ Unsure how to report

____ Believe aggression is part of the job

____ Believe aggression is part of the mental state of the patient, thus is not deliberate or is excusable

____ Feeling that reporting will not result in change or meaningful action to decrease violence

____ No need to report certain types of aggression (such as verbal insults, threatening behavior) but will report other types of aggression (such as physical)

____ Other:

6. What do you believe are useful interventions to improve safety in psychiatric units and psychiatric emergency departments? (Please check all that apply)

_____ Presence of security guards

_____ Increase in staffing levels

_____ Improved training on de-escalation techniques

_____ Better environment / improvements to unit

_____ Improved wait times (in emergency department (PAU))

_____ Increased focus on staff safety by health care institution

_____ More activities for patients (in inpatient units)

_____ Other (Please indicate:

Any further comments:

Upon completion, please return to me by one of the following methods:

- Email to u39mms@mun.ca
- Print and place in sealed envelope, return to Michelle Stevenson at MUN School of Nursing via internal mail
- Print and call for me for pick up

Thank you for your contribution.

Appendix B

To whom it may concern:

My name is Michelle Stevenson. I am a student in the Masters program at MUN School of Nursing. I am also employed as a psychiatric nurse in the Mental Health and Addictions program at Eastern Health.

I am enrolled in my final practicum courses both this semester and next. My topic for this practicum is improving safety of nursing staff in acute care psychiatric settings. I am contacting you to ask that you consider providing assistance to me as I complete my proposed project. Due to your professional role, I feel that your opinion and knowledge will be useful to contribute to this area of research. Therefore, I have attached a summary of my research topic, in addition to a short questionnaire that I ask you to consider completing in order to provide the information I am seeking.

Please note that individual views of participants will not be identified, and completed questionnaires will be secured. Information that could possibly identify you will be kept separate from the data. If you have any questions or would prefer to complete the questionnaire in person or via telephone conversation, please contact me. My supervisor for this course is Nicole Snow, PhD, RN, CPMHN(C), Assistant Professor, MUN School of Nursing. She is available to discuss my request with you if necessary. She can be contacted at 777-7007 or via email at nicole.snow@mun.ca.

Thank you for considering my request.

Sincerely,

Michelle Stevenson BN RN

MUN School of Nursing

728-9354

Email: u39mms@mun.ca; or m.stevenson@nf.sympatico.ca

Proposed Masters Practicum Project (MUN School of Nursing, Course number: N6660)

Improving safety of nursing staff: Challenges and solutions regarding safety for nursing staff in acute care psychiatric settings.

Violence is an unfortunate reality in nursing (Bonner & McLaughlin, 2007; Crilly, Chaboyer, & Creedy, 2004). Despite declarations of zero tolerance of aggression in the workplace (Canadian Nurses Association [CNA], 2005), violence continues to occur. Thirty-four percent of nurses report episodes of physical violence while 47% of nurses report emotional abuse. These statistics vary dependent on the setting. Forty-seven percent of nurses in the psychiatric setting report being physically assaulted, while 70% of nurses in the psychiatric setting report emotional abuse by a patient (Shields & Wilkins, 2009). Violence, particularly verbal abuse, is so prevalent that it is often considered part of the job (Baby, Glue, & Carlyle, 2014; Jonker, Goossens, Steenhuis, & Oud, 2008). With the continuance of violence despite the expressed goal of zero tolerance, strategies to increase safety of nursing staff are important to examine.

Workplace violence incorporates multiple types of behaviours. The Canadian Centre for Occupational Health and Safety (2012) describe five examples of workplace behavior:

16. Physical attacks, such as hitting and pushing.
17. Verbal abuse, including swearing and insulting language.
18. Threatening behaviours, for example shaking fists, destroying property, and throwing objects.
19. Threats, both verbal or written, with an intent to cause harm
20. Harassment, including behaviours such as words, gestures, or bullying, which demean, embarrass, humiliate, or cause alarm.

It is important to recognize that violence in the workplace can originate from patients, families, visitors, coworkers, and other workplace colleagues (Howerton-Child & Mentes, 2010). This practicum will focus on violence perpetuated by consumers of psychiatric services, namely patients, families, and visitors.

In order to enact strategies to increase nurse safety, it is important to consider all aspects related to violence in health care settings: patient characteristics; the environment in which patients and nurses interact; nurses' own personal traits and perceptions; and organizational policies combine to influence aggression against nurses (Hahn et al., 2013; Jonker et al., 2008; Ramacciati, 2014; Zampieron, Galeazzo, Turra, & Buja, 2010). Thus, the examination of violence requires a multi-dimensional approach (Ramacciati, 2014). Workplace aggression results in many negative effects for nurses, including work dissatisfaction, stress, fatigue, loss of confidence, increased apathy towards patients, strained personal relationships, and financial hardships (Baby et al., 2014; Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013; Zampieron et al., 2010). Whatever the cause, addressing workplace violence is important for nurses, as well as patients and health care in general.

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Appendix C
Health Research Ethics Authority Screening Tool

	Question	Yes	No
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review	☐	**X**
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?	☐	**X**
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. **IF NO** to both questions, continue to complete the checklist.	☐	**X**
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?	**X**	☐
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?	☐	**X**
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?	☐	**X**
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?	**X**	☐
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?	☐	**X**
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)		**2**	**5**
8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?	**X**	☐
9.	Is the project intended to define a best practice within your organization or practice?	☐	**X**
10.	Would the project still be done at your site, even if there were no opportunity	**X**	☐

	to publish the results or if the results might not be applicable anywhere else?		
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program,	**X**	☐
	Organization, or region, rather than using more general terminology such as rural vs. urban populations?		
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?		**X**
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)		**3**	**2**
	SUMMARY **See Interpretation Below**		

Interpretation:

- If the sum of Line A is greater than Line B, the most probable purpose is **research**. The project should be submitted to an REB.

- If the sum of Line B is greater than Line A, the most probable purpose is **quality/evaluation**. Proceed with locally relevant process for ethics review (may not necessarily involve an REB).

- If the sums are equal, seek a second opinion to further explore whether the project should be classified as Research or as Quality and Evaluation.

These guidelines are used at Memorial University of Newfoundland and were adapted from ALBERTA RESEARCH ETHICS COMMUNITY CONSENSUS INITIATIVE (ARECCI). Further information can be found at: http://www.hrea.ca/Ethics-Review-Required.aspx.

Appendix D

Table: Summary of Responses from Key Stakeholders

Question		Total
1.What is workplace violence?	All options	7
2. How are episodes reported?	Charting	3
	CSRS	7
	Reporting to management	3
	Police notification	2
	Reporting to Physician	1
	Incident report	2
3. Have aggressive episodes increased?	Yes	6
	No	
	Unknown	1
4. Is there underreporting?	Yes	5
	No	
	Unknown	2
5. What is the reason for underreporting?	Lack of time	2
	Unsure how	2
	Part of job	4
	Excusable behaviour	5
	No change	5
	Report some types of aggression, not other types	4
6.What are useful interventions to improve safety?	Security	7
	Increase staff	4
	Improved training	7
	Improved environment	6
	Improved wait times	5
	Improved focus on staff safety by administration	4
	More activities	5

Appendix D: Policy Paper

Policy Paper

Improving Safety of Nursing Staff:

Challenges and Solutions Regarding Safety for Nursing Staff in Acute Care Psychiatric

Settings

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Executive Summary

Workplace violence is defined as an act of abuse, threatening behaviour, intimidation, or assault on a person in his or her place of employment (The Canadian Centre for Occupational Health and Safety, 2012). Unfortunately, such violence is a reality for nurses. Workplace violence, particularly verbal abuse, is so prevalent that it is often considered part of the job. There are many documented negative professional and personal results of workplace violence on nurses, health care organizations, and health care in general. Therefore, it is important to understand the factors that influence why patients become violent in order to initiate and support interventions to decrease violence.

In order to gather relevant information, a review of research literature in combination with consultations involving key stakeholders with applicable professional expertise in such areas as psychiatric nursing, management, administration, professional practice, and quality control were conducted. The results overwhelmingly reinforced the fact that workplace violence against nurses does indeed occur in the acute care psychiatric setting. The literature review determined that workplace violence is the result of a complex interaction of four factors: patient characteristics, staff characteristics, environmental considerations, and organizational factors. Upon further data analysis, and taking into account these four factors, two relevant themes were uncovered and further explored. These two themes are reporting and interventions.

Reporting of incidents of workplace violence is important to accurately track and quantify aggressive episodes. Only with documented evidence can the seriousness of

workplace violence be demonstrated, thus providing firm support for necessary action. However, there is an acknowledged under-reporting of workplace violence. One reason for under-reporting is the varying perceptions of nurses. There are multiple reasons for differing perceptions, however it must be acknowledged that nurses who experience workplace violence with frequency may normalize this behaviour. Education on what actually constitutes violence would help affect nurses' perceptions of workplace violence. Another reason for under-reporting is a sense of futility. When there are no observed consequences to violent behaviour in the workplace despite reporting, a sense of disengagement and futility may occur. The inclusion of nurses in the decision making process to formulate policies and investigations regarding workplace aggression is a means to involve nurses in the resultant actions of reporting.

Interventions were identified through the literature review and consultations where action could be initiated to reduce the risk of violence. These interventions are summarized in six areas. Staffing levels was identified as a factor that is related to levels of workplace aggression; half of the consultants and the literature review identified the importance of adequate nursing staff, since complex workloads and understaffing negatively influenced workplace aggression. Regular and updated training in de-escalation techniques was noted to improve workplace safety. Having a physical environment that is esthetically pleasing in addition to being spacious enough to ensure privacy and confidentiality would assist in creating a safer work environment. The existence of appropriate resources for patients with addictions would allow for such patients to receive more appropriate care. Organizational support around sufficient

staffing, education, legal implications, inclusion of front-line staff in decision-making,

and providing updates to staff are areas where administration can show leadership to

decrease workplace violence. Finally, the area of punishment of and consequences to

patients who are aggressive should be discussed as a means to discourage workplace

violence.

Workplace violence is an important issue for nurses and all of health care. It must

be addressed with a commitment to education and training, collaboration, advocacy,

consultation, and research. It is with such a commitment that persons in health care can

examine the problem of workplace violence with the goal of improving safety for nurses

in the psychiatric setting.

Improving Safety of Nursing Staff:

Challenges and Solutions Regarding Safety for Nursing Staff in Acute Care Psychiatric

Settings

Workplace violence incorporates multiple types of behaviours, including physical attacks, threatening behaviours, verbal abuse and threats, and harassment (The Canadian Centre for Occupational Health and Safety, 2012). Workplace violence perpetuated by patients affects nurses (Bonner & McLaughlin, 2007; Crilly, Chaboyer, & Creedy, 2004). In the psychiatric setting, 47% of nurses report being physically assaulted, while 70% report emotional abuse (Shields & Wilkins, 2009). The experience of violence results in many negative effects, such as feelings of anxiety, work dissatisfaction, apathy towards patients, work absenteeism, and related financial costs for the health care institution (Baby, Glue, & Carlyle, 2014; Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013; Edward, Ousey, Warelow, & Lui, 2014; Greenlund, 2011; Zampieron, Galeazzo, Turra, & Buja, 2010). In order to address workplace violence by patients, it is important to understand the factors that influence violence. This understanding will reveal issues that can ultimately lead to the development and incorporation of effective interventions that are both appropriate for patients and result in increased safety for nursing staff.

Several steps were taken to achieve these goals. A review of the research literature concerning the topic of workplace violence in the nursing profession was conducted to gather evidence based information. In addition, in order to enrich these results and to reveal a local perspective, health care professionals of varied expertise within Eastern Health were consulted. As well, contact was initiated with an external

mental health agency (Centre for Addiction and Mental Health (CAMH), Toronto, ON)

to gather additional material. All data were analyzed and the results are presented in the

following document. The ultimate goal of this document is to provide information,

particularly in the areas of reporting and interventions, that can be applied to improve the

safety for nurses in the psychiatric emergency acute care setting.

Factors that Affect Workplace Violence

Workplace violence is a multi-dimensional issue (Ramacciati, 2014),

encompassing four distinct categories: patient characteristics, staff characteristics,

environmental factors, and organizational factors. Each category does not exist in

isolation; it is often an interaction of some or all factors that result in violence.

1. Patient Characteristics

There are patient characteristics, uncovered through research, which are associated

with increased risk for workplace violence. This includes certain types of patients who

appear regularly in psychiatric units. Patients with a psychiatric illness (Crilly et al.,

2004; Duxbury & Whittington, 2005; Gerberich et al., 2004; James, Madeley, & Dove,

2006; Stone, McMillan, Hazelton, & Clayton, 2011; Tam, Engelsmann, & Fugere, 1996;

Zampieron et al., 2010), under the influence of alcohol or illegal substances (Crilly et al.,

2004; James et al., 2006), or who exhibit demanding, attention seeking behaviours (Crilly

et al., 2004) are more likely to become violent in a hospital setting.

2. Staff Characteristics

There are discrepant results in the literature concerning the association between staff characteristics and workplace violence. For example, the literature reveals different conclusions regarding whether years of nursing experience (Crilly et al., 2004; Hahn, Muller, Hantikainen, Kok, Dassen, & Halfens, 2013; Jonker, Goossens, Steenhuis, & Oud, 2008) or gender of nursing staff (Crilly et al., 2004; Gerberich et al., 2004) influences the level of violence experienced in the workplace. It was noted that staff with training in de-escalation had higher reports of patient violence than staff with less training (Hahn et al., 2013). This may be due to increased awareness of what constitutes violent behavior, thus more incidents are reported. Reasons for underreporting, as revealed by consultants, includes the view that violent behavior is excusable because it is part of the mental state of the patient, or that, when aggression is "almost a daily occurrence", "it tends to become the new normal". Thus, perceptions and knowledge of workplace violence appear to be staff factors in the area of workplace violence.

3. Environmental Factors

Certain hospital units, including psychiatry, emergency departments, nursing homes, long term care facilities, geriatric units, and locked units (Chen, Hwu, Kung, Chiu, & Wang, 2008; Gerberich et al., 2004; Hahn et al., 2013; Hesketh, Duncan, Estabrooks, Reimer, Giovannetti, Hyndman, & Acorn, 2003; Jonker et al., 2008; Spector, Zhou, & Che, 2014; Tam et al., 1996), have higher numbers of aggressive incidents, due to the types of patients present. The presence of visitors (Blando et al., 2013); small spaces, overcrowding, and an unpleasant physical decor (Angland, Dowling, & Casey, 2014; Lau, Magarey, & McCutcheon, 2004); and lengthy wait times in emergency

departments (Angland et al., 2014; Crilly et al., 2004; James et al., 2006) are associated with increased aggression. The presence of safety equipment such as cameras and panic buttons, and security guards specially trained in de-escalation techniques (Angland et al., 2014; Blando et al., 2013; Crilly et al., 2004), contribute to a perceived increase in safety, as indicated by both the literature and by consultations.

4. Organizational Factors

It is important for nurses to know that security is important to senior management (Blando et al. 2013). Several factors influenced by administration were acknowledged by the literature and by consultants as contributing to the safety of nurses. Complex workloads, understaffing, and diminished resources negatively influence the work environment. The result is decreased education and training of staff, less time with patients, increased wait times, and decreased resource availability (Gerberich et al., 2004; Hesketh et al., 2003), that result in potential increases in workplace violence. Both the consultants and the literature stated that involvement of nurses in organizational decision-making processes concerning workplace violence is a means of increasing workplace safety, and of showing that nurse safety is important to the organization (Baby et al., 2014; Blando et al., 2013). Thus, collaboration with all levels within the workplace is important in reviewing policies and procedures around workplace violence.

Relevant Issues

After the literature review, the problem of under-reporting became apparent. The literature indicated that perceptions of nurses was one factor that affected reporting

levels. When this topic was further explored in the consultations, additional factors affecting reporting were determined. Accurate reporting is an important aspect of workplace violence, since under-reporting results in inaccurate statistics that do not truly reflect reality. This could lead to the minimization of workplace violence for nurses. As well, the literature revealed potential interventions that could improve nurse safety. This topic was further explored in the consultations. Analysis of results from the literature review and the consultations allowed an exploration of appropriate interventions, guided by the complex interaction of multiple factors to address violence, are examined. Therefore, what follows is an examination of these two facets, namely reporting and interventions, which are a result of information gleamed from the literature review and the consultations.

1. Reporting

The underreporting of workplace violence is acknowledged by consultants and the literature as commonplace (James et al., 2006; Spector et al, 2014; Stone et al., 2011; Tam et al., 1996; Williamson et al., 2013; Zampieron et al., 2010). This is a serious concern because, without accurate data revealing the true weight of the issue, the overall problem of workplace aggression will be minimized. This, in turn, affects how organizations confront workplace violence. When analyzing the results of the literature search and the consultations, two main themes for underreporting were revealed: perception and futility.

Perception

Individual perceptions are difficult to qualify as they are composed of a combination of our own experiences and values in all aspects of our lives. Nurses with many years of experience working in psychiatry may have normalized violence in the workplace; if it is occurring with frequency, then it could be viewed as regular behavior for the unit (Chen et al., 2008; Jonker et al., 2008). Education on what actually constitutes aggression would help affect nurses' perceptions of workplace aggression. What should be emphasized is that violence is an action. It is not a judgement of the person completing the act of violence. Whatever the source, the act itself is a risk to safety and should be reported. Aggressive actions have the potential to cause harm for the nurse and might also agitate or frighten other patients. It can also further escalate into physical violence. Only by reporting all incidences of aggression can the organization receive a true picture of workplace violence faced by nurses.

Futility

When a nurse reports aggression and nothing is seen to be done, the act of reporting seems pointless. According to the consultations and the literature (Baby et al., 2014; Gerberich et al., 2004; James et al., 2006), nursing staff express a sense of futility and disengagement when there are no observed consequences to violent behaviour in the workplace. As one consultant stated "a big portion of underreporting is the lack of support felt from administration and the feeling that nothing will be changed". There are policies in place for reporting and follow-up after an incident. Post-incident debriefing and updates on investigations into aggressive incidents are important as they are one means to show nurses that workplace safety is important to the administration (Baby et

al., 2014; Gerberich et al., 2004; James et al., 2006). Actual involvement by direct care nursing staff in the decision making process to formulate such policies is another suggestion to ensure effective safety initiatives (Baby et al., 2014).

2. Interventions

There are numerous factors which affect workplace violence. The literature and consultants identified the following areas where changes can be made to reduce the risk of violence: staffing, training in de-escalation, environmental changes, resources, organizational support, and punishment / consequences to perpetrators of violence.

Staffing

Staffing levels affect safety. However, there were differing viewpoints expressed in the consultations as to which type of staff would positively influence workplace safety. When the issue of nursing staff levels was considered, only half of the key stakeholders indicated that an increase in nursing staff would lead to a decrease in violence. This is supported by the literature, which acknowledged that complex workloads and understaffing results in increased aggression (Gerberich et al., 2004; Hesketh et al., 2003). On the other hand, other key stakeholders did not see an increase in nursing staff as being a means to decrease violence. Instead, they identified relying more so on security to achieve this goal. In fact, all consultants, as well as the literature, support the presence of trained security guards as an effective means to positively influence a safe working environment. Staffing mix such as female: male staffing ratios and experience levels were also noted during consultations as having the potential to influence workplace

violence. A review of the appropriate types and numbers of staff would assist in determining how an improvement in staffing would decrease workplace violence.

Training in de-escalation

Improved training on de-escalation techniques for staff was mentioned by all consultants as a way to improve safety. The literature also supports the importance of such training, as it results in increased awareness and reporting of aggression (Hahn et al., 2013). CAMH offers training in de-escalation techniques to staff, to be updated on an annual basis, with more regular training for areas with increased aggression (CAMH representative (F.A.D.), personal communication, March 10, 2016).

Environmental considerations

The physical environment where patients are located influences aggression. Limited, cramped spaces in nursing units decreases options to re-locate patients if escalation in violence is noted. Privacy and confidentiality are also compromised, which could negatively impact a patient's mood and behaviour. An improvement to the overall aesthetics of the space might also be an area of focus to decrease levels of aggression (Angland et al., 2014; Crilly et al., 2004).

Resources related to addictions

Symptoms of addiction are a cause for aggression, as noted by several stakeholders. Patients under the influence of alcohol or drugs, seeking drugs such as narcotics, or undergoing withdrawal are at increased risk of aggression (Crilly et al., 2004; James et al., 2006). The presence of more appropriate services for substance users

would be ideal in order to provide them with more appropriate care. In addition, the amount of aggression related to patients not being permitted to smoke within Eastern Health should be acknowledged and better managed. While having clear guidelines, consistent reinforcement, and readily available nicotine replacement are useful, it is not enough. Despite such interventions, based on evidence obtained, I believe that nurses will continue to encounter workplace violence due to the no smoking policy.

Organizational support

An increased focus on staff safety by health care institutions was mentioned by consultants and by the literature as important to improved workplace safety (Blando et al., 2013). There are many areas where administration can have an effect, including providing clear and supported guidelines regarding workplace violence and supplying a mechanism for nursing staff to manage individuals who repeatedly demonstrate aggression. Support around sufficient staffing, education, legal implications, inclusion of front-line staff in decision-making, and providing updates to staff (Baby et al., 2014; Gerberich et al., 2004; James et al., 2006) are areas where administration can show leadership to decrease workplace violence.

Punishment and consequences

Do repercussions for one's behaviour lead to a decrease in workplace violence? Several consultants expressed the importance of having consequences in response to acts of aggression, which would support a low tolerance to aggression. However, the types of consequences, how they would be implemented, and if they would actually be effective in

increasing nursing safety, is not known. Involvement of legal action for more serious

physical and threatening forms of workplace violence is one route to enact consequences

to dangerous behaviours. However, not all acts of workplace violence are illegal, such as

verbal abuse. The literature review revealed that flagging a patient's chart when multiple

episodes of aggression occur, and having extra staff present when known past

perpetrators are present (Gerberich et al., 2004; Zampieron et al., 2010) are potential

interventions to such behaviour. Further research, nevertheless, should be completed to

determine if the use of consequences or punishment of patients who exhibit violent

behaviour towards nursing staff will result in increased safety. Despite any past acts of

violent behavior, and despite any specific interventions enacted, it must be noted that

maintaining a respectful and confidential environment remains important in the

workplace, even when interacting with patients with a history of violent behavior. Thus,

the balancing of respect, confidentiality, safety, and holding a patient accountable for

violent behaviour is a challenge when confronting the problem of workplace violence.

Areas of Action

The following section lists areas where action is recommended to examine

workplace violence. It encompasses the information gathered from the literature and the

consultations. The ultimate goal of this process is to gain an understanding of workplace

violence towards nurses, with the ultimate goal of improving nursing safety.

1. **Education and Training**

De-escalation training results in increased reporting of workplace violence (Hahn et al., 2013). In addition, de-escalation training was noted by all key stakeholders, as well as the literature (Blando et al., 2013), as an intervention that could improve safety. A commitment by administration to provide regular, repeated, up-dated, and appropriate de-escalation training to nursing staff could result in a decrease of workplace violence. In addition, increased education surrounding addictions issues would assist nurses in dealing with and helping the increased numbers of patients involved with substance abuse.

2. Collaboration

Nursing staff want to be involved in decisions affecting their safety (Baby et al., 2014; Blando et al., 2013). A feeling of futility occurs in nurses when workplace violence continuously occurs, despite engaging in the reporting process. Important issues affecting nurses could be introduced in a collaborative environment with management and administration so that specific concerns, such as staffing and environmental considerations, can be discussed in context with policies and financial issues. This would ensure that all viewpoints are considered during decision-making process.

3. Advocacy

Aggressive behavior that results from patients who abuse substances are one cause of workplace violence (Crilly et al., 2004; James et al., 2006). Several consultants confirmed that patients who are under the influence of drugs, seeking more drugs, or going through withdrawal from substances are at greater risk of aggression. Advocating for appropriate addictions services that are timely and available for those seeking help, as well as

supportive community support for active and recovering users, would be useful to supply the needed support for these patients.

4. Consultation

Sharing information between leading psychiatric institutions within the national and international context on issues regarding workplace violence is a means to improve safety for nurses. Initiating contact with similar institutes to gather and analyze data, explore best practice guidelines, and determine if interventions are adaptable to this institute is a method that could potentially result in improvements.

5. Research

This report is the result of an extensive review of the literature and consultations with key stakeholders. However, there is an acknowledged lack of research on workplace violence (Baby et al., 2014). Therefore, continued research of issues associated with workplace violence (such as prevention, monitoring, and interventions) are encouraged to ensure that relevant, appropriate, and up-to-date measures are being taken to decrease workplace violence. Particularly relevant is the need for more research into addictions and its contribution to workplace violence.

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