The Development of a Workplace Violence Education Huddle Program and Facilitator's Manual

by © Allison Bragg

A report submitted to the School of Graduate Studies in partial fulfillment of the requirements

for the degree of

Master of Science in Nursing

Faculty of Nursing

Memorial University of Newfoundland

December 2021

St. John's, Newfoundland and Labrador

Abstract

Background: Workplace violence (WPV) is any physical or verbal threat or action directed towards working people. WPV from patients and visitors in healthcare is a worldwide issue. Acute care nurses require additional education and training to help prevent and manage WPV from patients and visitors. **Purpose:** To develop a learning resource and an accompanying facilitator's manual for nurses in acute care on the prevention and management of WPV from patients and visitors. **Methods:** 1) Comprehensive literature review 2) consultations with acute care medical-surgical nurses and other key stakeholders 3) environmental scan to determine existing resources 4) development of the learning resource. **Results:** The literature supported that WPV from patient and visitors was a problem that negatively impacted patients, nurses, and the healthcare system. The consultations supported a need for education and key topics were identified to cover in the learning resource. Potential interventions to prevent and manage WPV were identified in the environmental scan and literature review. The literature review, environmental scan, and consultations supported the development of the WPV Education Huddle Program and Facilitator's Manual. This resource was created with the intention of a facilitator delivering the education to small groups of nurses (e.g., approximately six) during working hours. The resource consists of eight Education Huddles that cover an overview of WPV and information and strategies to prevent and manage WPV from patients and visitors. Each Education Huddle contains reflective discussion questions, case study questions, and handouts. **Conclusion:** The educational resource will be provided to clinical educators within a tertiary care center in Eastern Health to deliver to their unit.

Keywords: Workplace violence, patients, visitors, assessment, prevention, management, impact, education huddles, adult learning, Relational Inquiry

Acknowledgements

I knew that completing this Master of Science in Nursing program while working full time would be challenging at times, but I did not anticipate how time consuming it could be. This accomplishment would not have been possible without the support of many people over the last three years. I would like to acknowledge those who have helped me along the way.

To my husband, Kevin, thank you for your unwavering love and support. I am grateful for the all the proofreading, cooked meals, and housework. I look forward to spending more time together and contributing to our home!

To my parents, Beverley and Derrick, thank you for your love and support. Thank you for providing a listening ear during difficult days and always encouraging me to keep going. You have always been my biggest supporters.

To my practicum supervisor, Kathleen Stevens, your calming presence was paramount during the development of this practicum project. I have learned so much from you over the last few months. Your guidance, support, and encouragement did not go unnoticed, and for that I thank you very much.

To my friend, Elizabeth Burry, I would not have survived this Master of Science in Nursing program without you. Thank you for always having a listening ear, insightful suggestions, but most of all, thank you for always being my friend.

To my colleagues and key stakeholders of this project: Thank you for providing informal suggestions, participating in interviews, providing formal and informal feedback on this resource, and supporting me through this process.

To the nurses experiencing workplace violence, I hope that this resource provides you with the knowledge to help prevent and manage your exposure to workplace violence from

patients and visitors.

Table of Contents

DEVELOPMENT OF A WORKPLACE VIOLENCE EDUCATION HUDDLE PROGRAM AND FACILITATOR'S MANUAL

Workplace violence (WPV) in healthcare is a worldwide issue (Li et al., 2020). WPV is defined as any verbal or physical violent act or threat directed toward working persons (National Institute for Occupational Safety and Health (NIOSH), 2020). WPV is classified into four types: type one is criminal intent, type two is customer/client, type three is worker on worker, and type four is personal relationships. Type two is the most common type of violence in healthcare. WPV can be further divided into three categories: physical, sexual, and psychological (Registered Nurses Association of Ontario (RNAO), 2019). Physical violence entails any action that involves force against another. This may include hitting, punching, pushing, biting, or any other form of physical aggression. Sexual violence is any physical or verbal behaviours based on gender or sexuality. Psychological violence is threatening, intimidating, or demeaning behaviours exhibited by a person through actions such as shouting, swearing, criticizing, and passive aggression (RNAO, 2019).

A well-conducted national online survey of 7153 regulated Canadian nurses determined that 29.2% experienced physical violence a few times per year, while 7.9% reported physical violence every day (Hall & Visekruna, 2020). As well, 21.2% and 20.6% experienced verbal abuse from patients or family members every day and a few times per week, respectively. When compared to other healthcare professionals, nurses are at the highest risk of WPV due to their direct and continued contact with patients (International Council of Nurses (ICN), 2000). Patients are responsible for the occurrence of 80% of WPV in healthcare (Occupational Safety and Health Administration (OSHA), n.d.).

The impacts of WPV are substantial, affecting nurses, patients, and healthcare organizations. Nurses experience physical, psychological, emotional, and financial implications from WPV (Lanctôt & Guay, 2014). Nurses exposed to WPV have suffered from physical

injuries such as back, neck, or shoulder pain, have been bitten and bruised, and have required time off work to recover from these injuries. As well, nurses exposed to WPV have experienced burnout, emotional exhaustion, depression, anxiety, fear, and feelings of incompetence. The time off work, counselling sessions, and potential legal fees have created a financial burden for nurses (NIOSH, 2020). WPV can compromise patient care and patient safety (Kim et al., 2021; Lanctôt & Guay, 2014). Lastly, turnover rates and absenteeism because of nurse's exposure to WPV results in financial costs to the healthcare system (NIOSH, 2020).

The occurrence of WPV and the associated effects on nurses, patients, and healthcare systems have highlighted the need to assist acute care nurses in preventing and managing WPV from patients and visitors. Education regarding preventing and managing WPV for nurses on acute care inpatient units is lacking. To protect themselves and their patients, nurses require knowledge and skills in these areas. The development of a WPV Education Huddle Program and an accompanying Facilitator's Manual met the recommendations of acute care nurses: a series of short in-person education sessions. The topics in the manual were developed based on the recommendations from the literature, current WPV education resources, practicing nurses, nurse leaders, and security personnel. The aim is for this resource to be implemented by a facilitator (e.g., clinical educator) during work hours to assist acute care nurses in preventing and managing WPV.

Goals and Objectives

The overall goal of the practicum project was to create an evidence-based resource that addressed the needs identified by acute care medical-surgical nurses in relation to the management and prevention of WPV from patients and visitors.

The key practicum objectives were:

1. To describe WPV in health care;
2. To identify the needs of the medical-surgical nurses in relation to preventing and managing WPV from patients and visitors;
3. To identify current resources for identifying, preventing, managing, and reporting WPV from patients and visitors within Eastern Health and other healthcare authorities to determine what exist and where improvements could be made;
4. To develop a resource to assist nurses with the prevention, management, and reporting of WPV from patients and visitors; and
5. To demonstrate the Advanced Practice Nursing (APN) competencies of education, research, leadership, and consultation and collaboration in identifying, preventing, and managing healthcare WPV.

Overview of Methods

In developing the resource for this practicum project, data was collected using a literature review, environmental scan, and consultations with key stakeholders. A literature review was conducted to determine the occurrence, impact, and factors contributing to WPV. The literature review provided promising evidence that specific interventions, that included education, could potentially improve healthcare workers' knowledge and skills, confidence, and attitudes towards WPV. A comprehensive review of the literature can be found in Appendix A.

An environmental scan followed the literature review to determine what resources were currently being used and the guidelines and policies in place for WPV within the regional health authorities (RHAs) in Newfoundland and Labrador (NL). A detailed report of the information found in the environmental scan can be found in Appendix B. Lastly, the conduction of consultations was directed by the findings of the literature review and environmental scan. The

consultations determined the perceptions of the key stakeholders in relation to WPV from patients and visitors and recommendations for addressing this issue. A complete overview of the findings of the consultations can be found in Appendix C.

The data collected using these three methods supported the development of an education resource entitled The WPV Education Huddle Program Facilitator's Manual. This developed resource can be found in Appendix D. An overview of the work completed in the literature review, environmental scan, consultations, and educational resource will be covered in the sections below.

Summary of Literature Review

Two key questions guided the literature review: what is the impact of WPV and what resources or interventions help nurses effectively prevent and manage WPV caused by patients and visitors on an acute care inpatient hospital unit? An integrative literature search using Google Scholar, Cumulative Index to Nursing and Allied Health Literature (CINHAL), PubMed, and Cochrane Libraries yielded a total of 206 analytic and descriptive articles. Key search terms of "violence," "nursing," "prevention," "intervention," and "strategy" were used. MeSH terms of "health occupations," "workplace," "persons," "patients," "clients," and "inpatients" were searched in PubMed. Only English language studies were included. Since effective interventions to decrease WPV are useful regardless of the date, studies were searched from inception to present. The search incorporated all health care settings as interventions utilized in these units may be transferable to an inpatient medical-surgical unit. Studies conducted in developing countries or in settings that did not share similar characteristics to the Canadian healthcare system were not included as the experience of WPV may not be applicable. Reference lists of relevant studies were hand searched for additional studies that were pertinent to the key

questions.

Using the Critical Appraisal Skills Program (CASP; 2018) and the Public Health Agency of Canada Critical Appraisal Tool Kit (PHAC; 2014), qualitative and quantitative studies were analyzed respectively. The review of the literature determined that WPV in healthcare was a worldwide issue (Li et al., 2020) with significant impacts on nurses, patients, and the healthcare system. Systematic reviews, medium quality cross-sectional studies, well-conducted exploratory and phenomenological studies, and documents from large reputable organizations such as NIOSH, RNAO, and International Council of Nurses (ICN), determined the impacts of WPV and contributing factors. This literature supported the need to address the prevention and management of WPV in healthcare.

To determine interventions to assist nurses in preventing and managing WPV, one systematic review (Geoffrion et al., 2020), one RCT (Artnez et al., 2017), and four uncontrolled before and after studies (UCBA) (Adams et al., 2017; Brunero et al., 2021; Lamont & Brunero, 2018; Story et al., 2020) were identified in the literature. To determine the strength of the evidence and the inherent usefulness of the six analytic studies chosen in providing potential interventions to prevent and manage WPV, the studies were critically appraised using the PHAC (2014) Critical Appraisal Tool Kit. The systematic review (Geoffrion et al., 2020) analyzed the effectiveness of education and training in preventing and minimizing WPV in healthcare. It was determined to be high quality and the authors concluded that the studies analyzed had a high risk of bias due to the self-reporting nature of the studies. Arnetz et al.'s (2017) RCT evaluated the effectiveness of an individualized Action Plan and was determined to be a strong design with high quality. UCBA studies are weak designs (PHAC, 2014). Using the PHAC (2014) critical appraisal tool, the quality of all four UCBA studies were rated as medium (Adams et al., 2017;

Brunero et al., 2021; Lamont & Brunero, 2018; Story et al., 2020). One UCBA study focused on the effectiveness of education provided through a tabletop exercise (Brunero et al., 2021), two studies evaluated the effectiveness of compressed education sessions (Adams et al., 2017; Story et al., 2020), and one study monitored the outcome of a full day workshop (Lamont & Brunero, 2018). The literature tables for these studies can be found in Appendix A of this report.

From the literature review, interventions to address WPV that were directed towards nurses were categorized in to six delivery methods: one-day education, online education, compressed education (i.e., one to three hours), extended education sessions (i.e., multiple sessions), open discussions, and multi-component strategies. Outcomes measured in the studies appraised were: frequency of WPV, knowledge and skills, confidence, and attitudes. From the literature, weak, direct evidence, with some inconsistent results, from multiple low, medium, and high-quality studies that used various strength designs (e.g., weak, moderate, and strong designs) suggested that WPV interventions were effective in helping nurses reduce, manage, and prevent WPV. Due to the weak evidence, no conclusions could be made but trends were noted.

The findings were promising that a WPV resource had potential to reduce WPV and increase knowledge and skills, increase confidence, and improve attitudes of healthcare professionals. Online training, open discussions, compressed education, and one-day training sessions seemed to have the most promising impact on the outcomes measured. Educational strategies that provided case studies of actual or slightly modified patient encounters seemed to have the most potential in reducing WPV. From the findings, it was suggested that the resource be unit specific and be provided on a regular basis to have a lasting impact.

To help determine how to implement a WPV education resource, the literature was reviewed for applicable theoretical underpinnings. Knowles' Theory of Andragogy and

Relational Inquiry (RI) were chosen to guide the development and implementation of the WPV Education Huddle Program. The six assumptions of Knowles' Theory (2015), the learners' self-concept; the role of the experience; the readiness to learn; orientation to learning; motivation; and the need to know, were applicable to the delivery of education to prevent and manage WPV. From the literature and consultations, it was evident that WPV was a concern in acute care settings. Nurses had experience with being exposed to or witnessing WPV and they wanted to learn how to prevent and manage WPV and how to protect themselves. They recognized the need for education and the relevance of the topic to their unit.

RI is formed by two overlapping concepts, relational consciousness and inquiry as a form of action (Doane & Varcoe, 2015). Relational consciousness allows nurses to be mindful of the situation in which they are providing care. It is the relational interplay between the intrapersonal (i.e., what is occurring within the person), interpersonal (i.e., what is occurring between all the people involved), and contextual (i.e., what is occurring in the surrounding environment) experiences of the individual. In the case of WPV, there are often multiple contributing factors that lead to violent or aggressive outburst. Learning and understanding these factors and their relationship is essential. The inquiry is defined as a form of action. It is how nurses choose to navigate their care based on the knowledge they have received. In considering the relational interplay during a potential or ongoing aggressive or violent event, nurses make the best decisions based on the intrapersonal, interpersonal, and contextual information (Doane & Varcoe, 2015).

The information obtained from the literature review helped determine the type of resource most suitable to target WPV for acute care nurses. From the literature, an in-person, group intervention seemed to have promise in educating participants on how to prevent and

manage WPV. This knowledge guided the consultations with key stakeholders to determine their chosen method of educational delivery, providing the foundation for The WPV Education Huddles Program. The information in the background of the literature review (i.e., definition, incidence and prevalence, impacts, and contributing factors) provided the content for the first WPV Education Huddle, an overview of WPV. No previous interventions applied an Education Huddle technique. However, Brunero et al. (2021) used a tabletop exercise, exhibiting a similar strategy for content delivery, and influenced the development of the Education Huddles. The in-depth literature review can be found in Appendix A.

Summary of Environmental Scan

The purpose of the environmental scan was to determine: the content and delivery methods used to address the issue of WPV in acute care in Canada; recommendations made by large reputable international organizations related to WPV; and the guidelines and policies surrounding WPV that have been implemented by RHAs (Central Health (CH), Western Health (WH), Eastern Health (EH), and Labrador-Grenfell Health (LGH)) in the Province of NL. The rationale for limiting specific resources to Canada was that these resources would be delivered in healthcare authorities that shared a similar culture and characteristics to that of the NL healthcare authorities. On an international level, efforts and strategies suggested by large reputable organizations such as the ICN, NIOSH, and the World Health Organization (WHO) were reviewed to provide direction for the creation of a WPV prevention and management resource. CH, EH, and LGH's guidelines and policies surrounding WPV were analyzed to search for information and direction regarding preventing and managing WPV. A comprehensive overview of the findings of the environmental scan can be found in Appendix B.

Ethical approval by the Health Research Ethics Review Board was not required for this

environmental scan. The resources provided from websites are readily available to the public. RHAs and WPV resources were referenced appropriately. The completed Health Research Ethics Authority Screening Tool can be found in Appendix B of the environmental scan.

Educational content and delivery methods were explored in the environmental scan. Violence prevention information and training plans from Canadian healthcare authorities, specifically British Columbia (BC), Ontario and Nova Scotia (NS) provided insight into current training programs, education plans, and potential templates. The Canadian Federation of Nurses Union (CFNU) provided a centralized location of various WPV prevention toolkits used across Canada. Provincial health authorities, Registered Nurse's unions, and occupational health and safety websites for BC, Ontario, and NS were accessed to determine WPV prevention resources that were available to nurses and healthcare professionals.

From the above resources, educational content and delivery methods were identified. Content to be covered included defining and understanding WPV, identifying risk factors of WPV, communication and de-escalation skills, legal aspects of WPV (e.g., rights and responsibilities of patients, visitors, and nurses), reporting, and debriefing. To deliver the education, asynchronous online education, case studies, open discussions, simulations, in-services, safety huddles, and assessment tools were identified in the environmental scan as utilized and recommended delivery methods. Unfortunately, enrollment fees for specific WPV education resources promoted by BC and NS limited the information that could be obtained. An email was sent to the Provincial Violence Prevention Curriculum (PVPC) for additional information, but none could be provided without enrollment into the course.

The RHA's WPV policies and procedures provided an outline of the roles and responsibilities of the healthcare professionals who have responsibilities in the prevention and

management of WPV. These policies identified what was expected of nurses, such as setting boundaries that violence will not be tolerated. Additionally, specific policies used in EH provided direction for recognizing, preventing, managing, and communicating the occurrence of aggressive behaviours of patients and visitors. Information from WH could not be obtained, despite emails and calls to the Occupational Health and Safety department.

The recommendations for content and delivery methods used in other Canadian health authorities also provided a foundation for the development of the WPV Education Huddles Program. The information obtained from the environmental scan was used to guide the consultations with key stakeholders to determine if specific content and delivery methods would be appropriate for their needs. The content used and suggested in the resources and the policies used in EH guided the content delivered in The WPV Education Huddle Program and Facilitator's Manual.

Summary of Consultations

The key stakeholders for this project are the nurses experiencing or at risk of WPV, unit leaders (e.g., Clinical Educators, Care Facilitators, management), Protection Services personnel, and individuals with WPV expertise. From this pool of key stakeholders, twelve voluntary individual interviews were conducted with: six medical-surgical acute-care inpatient nurses; one Care Facilitator (i.e., unit charge nurse); two staff members from Protection Services; a local researcher of WPV in acute care, Glenys Moran; and two other key stakeholders with experience in providing education and leadership. From the consultations, it was evident that WPV perpetrated from patients and visitors is an issue on inpatient units. Ethical approval by the Health Research Ethics Review Board was not required for the consultations. The full consultation report and the completed Health Research Ethics Authority Screening Tool can be

found in Appendix C.

The interview questions focused on content and delivery methods and were based on information identified in the literature review and environmental scan. The interviews helped to determine the gaps in knowledge, highlighting information that needed to be included in the resource. As WPV is a sensitive topic, the phone numbers for the mental health crisis line and Employee Family Assistance Program (EFAP) were provided to participants prior to beginning the interview. As the interviews were voluntary, stakeholders were notified that they could skip any questions or end the interview at any time if they felt uncomfortable.

Using content analysis, six themes were identified from the consultations: nurses' perspective of WPV, risk factors for WPV, impact of WPV on nurses and patients, barriers and facilitators for nurses in preventing and managing WPV, educational needs (i.e., content, mode of delivery, and administration), and barriers and facilitators in providing WPV prevention and management education to nurses. From the key stakeholders' responses, it was apparent that they recognized WPV, and nurses had been subjected to verbal and physical abuse from patients and/or visitors. The impact of WPV on patients and nurses was evident with avoidance being a major impact to patient care and negative personal emotional and mental effects on nurses.

Of particular importance in the consultations, was determining the content and the desired mode of delivery of the education. Participants reported the need to have education on what WPV is, how to identify those at risk, de-escalation techniques, and management processes. The need to know how to manage aggressive situations once they occur and when to involve security and police were identified as learning needs. Reporting was noted to be of importance by stakeholders to ensure there was a paper trail surrounding the occurrence of violence to identity that it was an issue. Online and in-person education was suggested with most

participants in favour of in-person education. From the participants' responses, short, informal, in-person education sessions, based on actual patient events seemed to have the most support. Participants supported the implementation of safety huddles, providing the basis of the creation of the WPV Education Huddle Program. Additionally, it was recognized that education should start in nursing school, upon hire, and occur annually. Participants suggested a poster that would illustrate a step-by-step approach for nurses in preventing and managing WPV. Unfortunately, due to the workload in creating the WPV Education Huddle Program and accompanying Facilitator's Manual, this was not able to be developed at this time.

It was important to identify the barriers and facilitators for nurses in preventing and managing WPV and in the implementation of a resource from the perspective of the key stakeholders. Workplace culture and education were noted as barriers to nurses preventing and managing WPV. It was noted that if violence was accepted as part of the culture than nurses will not attempt to prevent or manage it. Moreover, without changing this perception, interventions could potentially have limited usefulness. From the consultations, it was noted that nurses were not equipped with the education to de-escalate or manage violent patients or visitors, impacting their ability to be successful in preventing and reducing WPV. In the delivery of a WPV resource, the support of management and executives and collaboration with security were identified as facilitators in the creation and delivery of a WPV resource. Identifying these barriers and facilitators was important in providing direction for the development and implementation of a successful educational resource.

The consultations provided the opportunity to discuss the information acquired in the literature review and environmental scan with key stakeholders, the individuals dealing with WPV from patients and/or visitors. With the stakeholders' support of safety huddles and their

input on content and delivery methods, the WPV Education Huddle Program and accompanying Facilitator's Manual was created. Additionally, by identifying barriers, such as workplace culture, it is evident that this way of thinking must be targeted at the beginning of the WPV Education Huddles in attempt to alter this mindset and for the success of the resource.

Summary of Resource

From the evidence obtained in the literature review, environmental scan, and consultations, a WPV Education Huddle Program and accompanying Facilitator's Manual was developed. The purpose of this program is to provide education to acute-care nursing staff regarding the prevention and management of WPV from patients and visitors. The intended audience of this program are Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Personal Care Attendants (PCAs). They will be referred to as nurses and participants throughout the discussion of the WPV Education Huddle Program and accompanying Facilitator's Manual. The aim of this manual is to guide the delivery of this education. The manual is not to be distributed to learners. Handouts will be provided to participants, reviewing the content. The full resource can be found in Appendix D.

Eight WPV Education Huddles were created using the format of safety huddles. For this educational initiative, WPV Education Huddles are short education sessions of approximately six people that are carried out on site during work hours. These Huddles are intended to last approximately 15 minutes. The timing for the Huddle will vary based on the availability of the highest number of nurses and routines of the unit. It is recommended to discuss timing with the Unit Manager, Care Facilitator, and nurses to determine an appropriate time. It is intended for these Huddles to be completed twice during a nursing shift to provide opportunity for the greatest number of nurses to attend.

The expected roles of the facilitator in delivering the WPV Education Huddles are provided in the manual. Facilitators will deliver the Huddle in the suggested time frame, utilize strategies to engage the nurses, and encourage participation. In following Knowle's Theory of Andragogy and RI, the facilitator has the role of relating the information to real-life nursing situations. WPV may be a sensitive topic for some nurses. It is important that the facilitator be aware of the sensitivity of the topic and confirm confidentiality of the Huddle. The content and discussions of the Huddle may evoke uncomfortable feelings based on the nurses' experience with WPV. The provision of contact numbers for mental health assistance lines and the acknowledgement that thoughts and feelings of WPV shared within the Huddle will remain within the Huddle are important. Lastly, facilitators should evaluate each Huddle and the WPV Education Huddle Program using formative, summative, and process evaluations to determine areas of success and those requiring improvements.

Recommendations are provided at the beginning of the manual to assist facilitators in delivering the Education Huddles. To have the greatest opportunity for success, it is recommended that facilitators review content, practice timing, and print required handouts prior to the Huddle. As the Huddles are only 15 minutes in length, it is important to be cognizant and effectively use the time provided. Since the Huddles are conducted during working hours, a location that allows nurses to remain available to their patients is essential. Additionally, facilitators must recognize that some Huddles may need to be rescheduled due to the demands of the unit and that nurses may have to leave to tend to patient care.

Each Huddle follows the same format. A brief introduction is provided for the facilitator at the beginning of each section with the provision of a scripted lead-in statement to begin. Each Huddle contains the following:

- An introduction to the Huddle for the facilitator
- Learning objectives
- Preparation required prior to the Huddle (e.g., printing handouts and policies)
- Suggested order for delivery of content
- Introduction and housekeeping items for the participants
- Contact phone numbers for the EFAP and mental health crisis line
- A brief overview of previous Huddles found in the Appendix of the manual
- Information for each topic
- One to three discussion questions
- Case study
- Key message(s)
- Quick reference handout sheet

Each WPV Education Huddle follows the same format. As noted, each Huddle begins with an introduction and ends with a key message. As WPV may be a sensitive topic for participants the contact numbers for the EFAP, a program to assist employees with difficult home and work life situations, and the mental health crisis line are provided at the beginning of each Huddle and included with each handout. The Huddles end with the delivery of a key message that summarizes the important points of the Huddle.

In each Huddle, blue bars indicate the beginning of a new topic. To promote interactive learning and reflection, one to three discussion questions are asked throughout the Huddle. These questions are distinguished by a light grey box outlined in blue. The same case study is referred to at the end of each Huddle to give participants an opportunity to reflect on their own experiences with WPV and then apply new knowledge related to WPV. As well, the case study

allows facilitators to conduct formative evaluations and determine if the Huddles are successful in delivering content to the participants. Each Huddle is accompanied by a handout. Handouts are provided for current and previous Huddles and will posted on the unit bulletin board for those who missed the session.

It is important to recognize that these Huddles have been created for the EH RHA. The terms used in this RHA (e.g., code white for violent and aggressive situations), the presence of onsite security, local support services, and policies may differ between health authorities. The Huddles can be adapted for other RHAs, other clinical settings such as long-term care, and nursing education programs. The topics covered in each WPV Education Huddle are outlined below.

WPV Education Huddle #1: Workplace Violence Overview

In the first WPV Education Huddle an overview of WPV is provided. Learning outcomes for this Huddle are to identify WPV, recognize the negative impacts of WPV, identify factors that contribute to WPV, and apply content to a case study. The key message of Huddle #1 is for participants to recognize that WPV is present in acute-care inpatient nursing units and has a negative impact on nurses' physical, mental, and emotional health, patient care, and on the healthcare system.

WPV Education Huddle #2: Assessments and Policies

In the second WPV Education Huddle the following content is covered: application of RI in assessing potential or actual violent patients; two potential risk assessment tools, the STAMPEDAR framework (Chapman et al., 2009) and the Acute Care Violent Assessment Tool (VAT) (Public Services Health and Safety Association (PSHSA, 2017); and organizational policies related to managing WPV. The learning outcomes for Huddle #2 are to to discuss RI and

its application in caring for potential or actual aggressive patients and visitors, describe assessment tools that identify risk behaviours, to understand and apply organizational policies, and apply content to the case study.

The application of a theoretical lens, RI, is suggested in assessing the patient and determining the plan of care. RI is comprised of relational consciousness (i.e., the relational interplay between the intrapersonal, interpersonal, and contextual experiences of an individual) and inquiry as a form of action. By assessing the patients and visitors using relational consciousness nurses can determine a plan of care to prevent and manage aggression.

Next, in keeping with RI two assessment tools are presented. The STAMPEDAR list nine specific cues that may indicate the risk of violence from patients (Chapman et al., 2009). The Acute Care VAT provides an immediate assessment of the patient's risk of violence by identifying behaviours that are associated with a risk of violence. Risk factors are assigned a corresponding score that determines suggested actions for the healthcare provider to take to address the situation. This assessment tool also considers contributing factors that are patient specific and provides guidance related to de-escalation techniques, based on the patient's assessment (PSHSA, 2017).

Specific to the RHA, policies that address managing violent patients by allowing nurses to flag patients as high risk of violence and determining when chemical or physical restraints should be initiated are reviewed in the Huddle. The key message for Huddle #2 is application of RI, evidence-based tools, and monitoring patients for signs and symptoms of violent outburst could prevent violence from occurring. If violent outburst from patients cannot be prevented, using appropriate policies can help protect yourself and others.

WPV Education Huddle #3: De-escalation and Personal Protection

The third WPV Education Huddle focuses on de-escalation and personal protection strategies. The learning outcomes of Huddle #3 are to define de-escalation, identify personal protection efforts, and apply the techniques and strategies to the case study. In this Huddle de-escalation is defined; suggestions of potential verbal and non-verbal de-escalation techniques and personal protection strategies are delivered; and how to safely terminate a potential violent nurse-patient/visitor relationship is identified. The key messages of Huddle #3 is that actions can be taken to de-escalate situations and nurses can also utilize strategies to protect themselves from potentially aggressive situations.

WPV Education Huddle #4: Nurse and Patient Rights and Visitation

The fourth WPV Education Huddle focuses on the rights of nurses and patients and the visitation policy for the RHA. The learning outcomes for this Huddle are to identify rights of nurses and patients, explain the visitation policy, and apply content to the case study. The rights of nurses to work in a workplace free from violence is discussed in relation to the ethical obligations of nurses to provide safe, competent, and ethical care. As well, the eleven rights of patients in Canada and the visitation policy for the RHA are discussed. The key message of Huddle #4 is that nurses have a right to a safe workplace free of violence. Patient and visitors do not have the right to demonstrate physical, verbal, or sexual violence.

WPV Education Huddle #5: Responding to a Violent Situation: Part One

The fifth WPV Education Huddle is part-one of a two-part series on how to respond to a violent situation. The learning outcomes for this Huddle are to identify the role of security, to understand when and how to contact security, and the information to provide to security personnel when they arrive on the unit; to apply the RHA's Code White policy (aggressive

behaviours); and apply content to the case study. The key messages of Huddle #5 are to view security as a vital part of the team and to collaborate with them to address WPV from patient and visitors. Additionally, a key point emphasized in this Huddle is to call a code white before verbal de-escalation has been shown to be unsuccessful.

WPV Education Huddle #6: Responding to a Violent Situation: Part Two

The sixth WPV Education Huddle is the second part of the responding to a violent situation two-part series. The learning outcomes for this Huddle are: to identify the role of police; when to contact these supports; to identify the information to provide to police; to identify and utilize safety huddles; and apply content to the case study. There are two key messages for Huddle #6. First, recognize when violence has moved beyond the scope of security and when local police must be contacted to protect patients and staff. Second, when aggressive situations are occurring or have the potential to occur, safety huddles are an effective way to communicate potential or actual violent situations to protect unit staff members and patients.

WPV Education Huddle #7: Reporting and Documenting

The seventh WPV Education Huddle focuses on reporting and documenting. The learning outcomes for this Huddle are to recognize the importance of reporting and documenting WPV, identify where and who to report violence to, determine appropriate information to include in documentation, and apply content to a case study. The key message for Huddle #7 is that reporting WPV identities a need for support and increases the likelihood that administration will allocate resources to address the issue.

WPV Education Huddle #8: Debriefing

The eighth and final WPV Education Huddle is focused on debriefings and the EFAP. The learning outcomes for this Huddle are to define and determine the need for debriefings,

recognize the availability of EFAP and the assistance it provides, and apply content to the case study. The key messages for Huddle #8 are that debriefings are essential for individuals who were involved in or witnessed violent events to assist with recovery and sometimes supports such as EFAP, are needed in addition to or separate from debriefings.

Discussion of APN Competencies

The Canadian Nurses Association (CNA) (2019) have created six competencies for Advanced Practice Nursing (APN): direct comprehensive care, health system optimization, education, research, leadership, and consultation and collaboration. These competencies are based on nursing knowledge, theory, and research and enhanced by clinical experience. For this practicum project I have exhibited the following APN competencies: education, research, leadership, consultation and collaboration, and optimizing health system. The ways in which I have exhibited these competencies will be discussed in this section.

Education Competency

The identification of nurses' learning needs and the development of resources to meet those needs are a component of the education competency of APNs (CNA, 2019). Through an integrative literature review and consultations, I identified the learning needs of the medical-surgical nurses regarding preventing and managing WPV. Through the creation of the WPV Education Huddle Program and accompanying Facilitator's Manual, I have targeted these needs. The dissemination of new knowledge is another educational competency of APN (CNA, 2019). I have prepared a journal article to submit to *Nurse Educator*, outlining the development and implementation of WPV Education Huddles as a teaching strategy to prevent and manage WPV. A copy of the journal article can be found in Appendix E.

Research Competency

The CNA (2019) state that Advances practice nurses should be able to identify, appraise, and apply research, practice guidelines, and current best practice. For this practicum project I completed a literature review to determine the occurrence of WPV, the impact on nurses, patients, and healthcare organizations, contributing factors to WPV, and interventions to help prevent and manage WPV from patients and visitors. I critically appraised the research used in the literature review using the PHAC (2014) Critical Appraisal Tool Kit and the CASP (2018) tool for quantitative and qualitative data, to find best-practice evidence for interventions to prevent and manage WPV. Education guidelines and provincial and international programs focused on WPV were also explored to determine their usefulness for the target population.

The CNA (2019) recognizes the conduction of research to be a competency of APN. I conducted research through consultations with key stakeholders to determine the needs of the nurses, their preferred delivery methods for WPV education, and any potential barriers and facilitators in preventing and reducing WPV.

Leadership

Leadership competencies are important in APN. Identifying problems and initiating change to address issues at an individual level and identifying needs of nurses reflects leadership (CNA, 2019). As a staff RN on a busy medical surgical unit, I recognized the impact of WPV and the lack of educational supports. Through consultations, it was apparent that WPV was indeed an issue for nurses on inpatient units. I aimed to combat these issues through the development of the WPV Education Huddle Program and accompanying Facilitator's Manual.

Consultation and Collaboration

The CNA (2019) recognizes the importance of consulting and collaborating with

members of the healthcare team to develop risk management strategies. In conducting the research to determine how to best meet the needs of the medical-surgical nurses regarding WPV, consultations were completed with key stakeholders. Individuals who were impacted by the violence and individuals who work to help prevent WPV were consulted to assist in the development of a WPV education resource. These collaborations were essential to create a resource that was appropriate and applicable for nurses' needs. In the development of the educational resource, collaboration continued with staff nurses, a clinical educator, unit manager, and Protection Services to provide feedback on the program and the Facilitator's Manual. Collaboration with these stakeholder and unit managers will continue with the implementation of this resource.

Optimizing Health System Competencies

Contributing to the effective functioning of health systems is a competency of APN (CNA, 2019). In completing the consultations, it was determined that education regarding how to prevent and manage WPV in acute care inpatient units was lacking, identifying a gap in the health system. Implementation of a resource to address this gap will contribute to the effective functioning of the unit and in turn the health system. Additionally, recommendations for revisions of current policies were identified by the key stakeholders. The aim of this project is not to implement policy change, however, information regarding nurse's perception of the policies and their use, specifically the inconsistent use of the Aggressive Violent Behaviour policy, have been shared with the unit manager.

Next Steps

The distribution of the WPV Education Huddle Program Facilitator's Manual will begin with clinical educators in one tertiary care center in EH. A paper and electronic copy will be

provided to the appropriate clinical educators. The implementation of the WPV Education Huddles will be unit specific. For evaluation purposes, the clinical educators will be encouraged to implement the Huddles within three months of receiving the resource. From the literature review it was determined that education provided on a regular basis has a lasting impact.

The intended plan is to create an evaluation tool for the facilitator for formative and summative evaluations. Formative evaluation will measure participant learning and will be useful to determine if participants are gaining any knowledge from the Huddles. Results of the formative evaluation will help the facilitator determine the level of understanding of the group and if changes will need to be made to improve the learning experience throughout the delivery process. Participant's ability to apply content to the case study in each Huddle will allow the facilitator to perform formative evaluation. Summative evaluation will measure the learning after completion of the program and could be used to revise the program to better meet the learning needs of the target audience. A pre and post-test will be developed and distributed to participants to determine their knowledge regarding WPV before and after the completion of the program.

Additionally, a process evaluation tool will be created and used to evaluate the delivery of the WPV Education Huddle Program. This will determine if the content was delivered as intended or if there were any issues in relation to implementation, such as timing, location, or length of the Huddles. Based on the findings from the formative, summative, and process evaluations, the WPV Education Huddle Program and accompanying Facilitator's Manual can be revised to better serve the target audience, acute care inpatient nurses.

To determine outcome evaluation the Unit Manager and the Protection Services Department can monitor the number and details of reported violent encounters on the unit for 12-months after the implementation of the WPV Education Huddles. It will be important to consider

that the number of violent events may increase with education and the encouragement of reporting.

As mentioned in the consultation summary, key stakeholders suggested a poster be developed and posted on the unit. The poster was not developed as part of this program. To address the need to have visible information on the unit related to WPV, the Education Huddle handouts will be posted on the unit bulletin board. As part of next steps, a poster will be developed taking the evaluation results into consideration.

Conclusion

The development of an evidence-based resource to assist acute care nurses in the prevention and management of WPV from patients and visitors was the aim of this practicum project. The completion of a literature review, environmental scan, and consultations demonstrated the impacts of WPV, confirmed the need for a resource, and provided direction regarding the development of the WPV Education Huddle Program and Facilitator's Manual. The occurrence and impact of WPV and promising interventions to improve healthcare workers' knowledge and skills, confidence, and attitudes towards WPV were identified in the literature review. From the literature review Knowles Theory of Andragogy and RI were identified to provide the theoretical and philosophical underpinnings for the development and implementation of the resource. From the environmental scan, information from other Canadian healthcare authorities and reputable international organizations demonstrated what education resources existed and what content was deemed to be essential. The roles and responsibilities of healthcare professionals and departments in the preventing and managing WPV were identified in the policies from RHAs, with EH policies playing an integral role in the resource content. The consultations determined the needs, expectations, and wants of the key stakeholders, the

medical-surgical nurses, to ensure the creation of a resource that would be beneficial to the target population.

The information gathered in the literature review, environmental scan, and consultations guided the creation of the WPV Education Huddle Program and Facilitator's Manual. Through the creation of this resource, I exhibited many APN competencies. While the research and development of this educational resource is essential, the outcomes from its implementation and evaluations will be equally as important. I plan to meet the APN education competency related to dissemination through the submission of an article related to the development of the project to the professional peer-reviewed nursing journal, *Nurse Educator*.

References

Adams, J., Knowles, A., Irons, G., Roddy, A., & Ashworth, J. (2017). Assessing the effectiveness of clinical education to reduce the frequency and recurrence of workplace violence. *Australian Journal of Advanced Nursing, 55*(3), 8-15. http://doi.org/10.3316/INFORMIT.946627915561528

Arnetz, J., Hamblin, L., Russell, J., Upfal, M., Luborsky, M., Janisse, J., & Essenmacher, L. (2017). Preventing patient-worker violence in hospitals: Outcome of a randomized controlled intervention. *American College of Occupational and Environmental Medicine, 59*(1), 18-27. http://doi.org/10.1097/JOM.0000000000000909

Brunero, S., Dunn, S., & Lamont, S. (2021). Development and effectiveness of tabletop exercises in preparing health practitioners in violence prevention management: A sequential explanatory mixed methods study. *Nurse Education Today, 103*, 104976. http://doi.org/10.1016/j.nedt.2021.104976

Canadian Nurses Association. (2019). *Advanced practice nursing. A pan-Canadian framework.* https://cna-aiic.ca/-/media/cna/page-content/pdf-en/advanced-practice-nursing-framework-en.pdf?la=en&hash=76A98ADEE62E655E158026DEB45326C8C9528B1B

Critical Appraisal Skills Programme. (2018). *CASP qualitative studies checklist.* https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Chapman, R., Perry, L., Styles, I., & Combs, S. (2009). Predicting patient aggression against nurses in all hospital areas. *British journal of nursing (Mark Allen Publishing), 18*(8), 476–483. https://doi.org/10.12968/bjon.2009.18.8.41810

Geoffrion, S., Hills, D. J., Ross, H. M., Pich, J., Hill, A. T., Dalsbø, T. K., Riahi, S., Martínez Jarreta, B., & Guay, S. (2020). Education and training for preventing and minimizing

workplace aggression directed toward healthcare workers. *The Cochrane database of systematic reviews*, *9*(9), CD011860. https://doi.org/10.1002/14651858.CD011860.pub2

Hall, L. M. & Visekruna, S. (2020). Outlook on nursing: A snapshot from Canadian nurses on work conditions pre COVID-19. *Canadian Federation of Nurses' Union.* Retrieved June 2021, from https://nursesunions.ca/wpcontent/uploads/2020/12/CFNU_outlook_ENfinal_web.pdf

Doane, G., & Varcoe, C. (2015). *How to nurse: Relational inquiry with individuals and families in changing health and health care contexts*. Wolters Kluwer/Lippincott Williams & Wilkins.

International Council of Nurses. (2000). *Abuse and violence against nursing personnel.* http://www.icn.ch/psviolence00.htm.

Kim, S., Mayer, C., & Jones, C. B. Relationships between nurses' experience of workplace violence, emotional exhaustion, and patient safety. *Journal of Research in Nursing, 26*(1-2), 35-46. http://doi.org/10.1177/1744987120960200

Knowles, M. S., Holton, E. F., III, & Swanson, R. A. (2015). *The adult learner: The definitive classic in adult education and human resource development* (8th ed.). Elsevier.

Lamont, S. & Brunero, S. (2018). The effect of a workplace violence training program for generalist nurses in the acute hospital setting: A quasi-experimental study. *Nurse Education Today,68*,45-52. http://doi.org/10.1016/j.nedt.2018.05.008

Lanctôt, N. & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression and Violent Behaviour,19,* 492-501. http://dx.doi.org/10.1016/j.avb.2014.07.010

Li, Y. L., Li, R. Q., Qiu, D., & Xiao, S. Y. (2020). Prevalence of workplace physical violence

against health care professionals by patients and visitors: A systematic review and meta-analysis. *International journal of environmental research and public health*, *17*(1), 299. https://doi.org/10.3390/ijerph17010299

National Institute for Occupational Safety and Health. (2020, September 22). *Occupational violence.* Center for Disease control and prevention. https://www.cdc.gov/niosh/topics/violence/default.html

Nursing Solutions Incorporated. (2021). *NSI National health care retention & RN staffing report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

Occupational Health and Safety Administration (OHSA). (n.d). *Workplace violence in healthcare.* https://www.osha.gov/sites/default/files/OSHA3826.pdf

Public Health Agency of Canada. (2014). *Critical appraisal toolkit.* https://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Public Services Health and Safety Association. (2017). Individual client risk assessment toolkit for healthcare settings. https://workplace-violence.ca/wp content/uploads/2021/04/VPRASEEN0417-ICRA-Toolkit-Resource-Manual-V1.3-2017.12.12.pdf

Registered Nurses' Association of Ontario (RNAO). (2019). *Preventing violence, harassment and bullying against health workers (2nd ed.).* www.RNAO.ca/bpg

Story, A., Scott, S., Harris, R., & Vogelsmeier, A. (2020). An evaluation of nurses' perception and confidence after implementing a workplace aggression and violence prevention training program. *Journal of Nursing Administration*, *50*(4), 209-215. http://doi.org/10.1097/NNA.0000000000000870\

Appendices

Appendix A: Literature Review Report

The Development of a Workplace Violence Education Huddle Program and Facilitator's Manual: A Review of the Literature

Allison Bragg, 201122595

Memorial University of Newfoundland and Labrador

Workplace violence (WPV) in healthcare is a worldwide issue (Li et al., 2020). One in five healthcare professionals experience physical violence annually (Li et al., 2020). Registered Nurses (RNs) are at risk of being exposed to WPV everyday by patients and support persons. The physical and psychological impacts of WPV on nurses are substantial, with implications that result in both negative patient and organizational outcomes. Staff on surgical units may have continued exposure to violent outburst daily due to the patients' length of stay (Jackobsson et al., 2020).

The key questions guiding this review are what is the impact of WPV and what resources or interventions help RNs effectively prevent and manage WPV caused by patients and visitors on an inpatient acute care hospital unit? An integrative literature review will be conducted to determine the incidence, prevalence, and impact of WPV on RNs, patients, families, and organizations. Risk factors for WPV perpetrated by patients and visitors will also be determined. Due to the small number of studies and the low quality of the studies no conclusion can be drawn regarding which mode of delivery is more effective for delivering WPV interventions, but some clear trends were noted for the outcomes of knowledge, skills, confidence, and attitude. From the literature there is weak, direct evidence that the use of interventions such as open discussions, condensed in person education, and one day education that use active learning strategies such as case studies, simulations, and role playing, improve nurses' confidence and knowledge in preventing and managing violent or aggressive patients and support persons. These findings have implications for the development of a resource for nurses to manage and prevent WPV.

Search Methods

The aim of this literature review is to determine the incidence and prevalence of WPV, the associated impact and risk factors, and to determine the effectiveness of strategies in

preventing and mitigating WPV for RNs. A literature search was completed using Google Scholar, CINHAL, PubMed, and Cochrane Libraries using key search terms of "violence," "nursing," "prevention," "intervention," and "strategy." MeSH terms of "health occupations," "workplace," "persons," "patients," "clients," and "inpatients" were searched in PubMed. Only English language studies were included. Since effective interventions to decrease WPV are useful regardless of date, studies were searched from inception to present. The search incorporated all health care settings as interventions utilized in these units may be transferable to an inpatient medical-surgical unit. Studies in developing countries or in settings that do not share similar characteristics to the Canadian healthcare system were not included as the experience of WPV may not be applicable. Reference lists of relevant studies were hand searched for additional studies that were pertinent to the key questions.

The literature search yielded a total of 206 articles of analytic and descriptive nature from inception to present. Critical appraisal of quantitative and qualitative articles was completed using the Public Health Agency of Canada (PHAC) (2014) Critical Appraisal Tool Kit and the Critical Appraisal Skills Programme (CASP) (2017), respectively. From the literature, interventions to assist RNs with the issue of WPV were identified. Literature summary tables summarizing these studies can be found in Appendix A.

Background

Before exploring interventions that RNs in acute care can use to prevent and manage WPV it is important to define and classify WPV and understand the issue in relation to: incidence and prevalence, impact on nurses, patients, and the healthcare system, and factors contributing to WPV. These topics will be summarized in this section followed by an analysis of interventions and strategies.

Definition and Classification of Workplace Violence

WPV is defined as any verbal or physical violent act or threat directed toward working persons (National Institute for Occupational Safety and Health (NIOSH), 2020). WPV is classified into four types: type one is criminal intent, type two is customer/client, type three is worker on worker, and type four is personal relationships (Registered Nurses Association of Ontario (RNAO), 2019). Type two is the most common source of violence in healthcare (RNAO, 2019) and will be the focus of this literature review.

WPV can be further divided into three categories: physical, sexual, and psychological (RNAO, 2019). Physical violence entails any action that involves force against another. This may include hitting, punching, pushing, biting, or any other form of physical aggression. Sexual violence is any physical or verbal behaviours based on gender or sexuality. Psychological violence is threatening, intimidating, or demeaning behaviours exhibited by a person through actions such as shouting, swearing, criticizing, and passive aggression (RNAO, 2019). There was no literature identified in this review that addressed sexual WPV. Therefore, this review will focus on physical and psychological violence only.

Incidence and Prevalence

When compared to other healthcare professionals, nurses are at the highest risk of WPV due to their direct and continued contact with patients (International Council of Nurses, 2000). Patients are responsible for the occurrence of 80% of WPV in healthcare (Occupational Safety and Health Administration (OSHA), n.d.). A recently well conducted meta-analysis that included a total of 65 quantitative studies reported one-year prevalence estimates for 61,800 health care professionals from 30 countries (Li et al., 2020). The pooled one-year prevalence of workplace physical violence against health care professionals perpetrated by patients or visitors was 19.33%

(95% confidence interval (CI): 16.49–22.53%). Statistics Canada (2005) conducted a national survey on WPV experienced by Canadian nurses. Physical violence was experienced by 28.8% of nurses in their last year of work and 43.6% reported feeling emotionally abused in the last year. In more recent years, a national online survey of 7153 regulated Canadian nurses determined that 21.2% and 20.6% experienced verbal abuse from patients or family members every day and a few times per week, respectively (Hall & Visekruna, 2020). From the same sample, 29.2% experienced physical violence a few times per year, while 7.9% reported physical violence every day.

The incidence and prevalence of WPV may be higher. A medium quality cross-sectional study conducted on 1781 nurses in a large academic medical center in the United States of America (USA), determined that the incidence of WPV was almost 59 times higher than the reports (142.53 actual events vs 2.42 reports per 1000 patient days) (Kim et al., 2021). Additionally, a well conducted qualitative study using a phenomenological approach was carried out in an Australian emergency department (ED) to determine RN's attitudes towards WPV (Horgarth et al., 2016). From the study it was determined that measuring the prevalence of WPV is a difficult task as it is often accepted as "just part of the job" and therefore underreported (Horgarth et al., 2016. p. 78). Underreporting makes it difficult to determine the extent of the issue of WPV.

Impact of Workplace Violence

WPV negatively impacts RNs, patients, and the healthcare system. Nurses may be directly impacted by WPV or be exposed as a bystander. The impact on nurses results in concerning consequences for patient care and costs for the healthcare system. These impacts will be explored in the following section.

Impact on Nurses

Nurses' physical and mental health can be negatively impacted from aggressive patients and patient support persons (Lancot & Guay, 2014; Havaei et al., 2020; Chapmen et al., 2009). Authors of a well conducted systematic review analyzed 68 analytic and descriptive quantitative studies, including cohort, controlled before after (CBA), and cross-sectional studies, to determine the impact of WPV on healthcare workers (Lancot & Guay, 2014). Back, arm, and head injuries, abrasions, bites, and bruises were recognized to be common physical injuries sustained by nurses (Lancot & Guay, 2014). Five studies in the systematic review recognized ongoing pain as an issue and the need to seek medical attention was identified as an outcome of physical violence in nine of the studies (Lancot & Guay, 2014). These findings were supported by an additional cross-sectional study of medium quality conducted with a sample of 537 medical-surgical nurses in Canada after the completion of the systematic review (Havaei et al., 2020). From the findings it was determined that nurses suffer muscle skeletal injuries from physical violence ($r = 0.33$, $p < .01$) (Havaei et al., 2020).

The psychological impact of WPV can be extensive. An association between exposure to WPV and an impact on psychological health was determined in 47 of the 68 studies examined in the systematic review (Lancot & Guay, 2014). Development of posttraumatic stress disorders was identified in four of the studies. Depression was an outcome that was common in nine studies and anxiety was a consequence of WPV determined in eleven studies. Burnout was experienced by healthcare providers in six of the studies, with emotional exhaustion being recognized to be higher in individuals who experienced WPV in comparison to those who did not (Lancout & Guay, 2014). The occurrence and effect of emotional exhaustion due to exposure to WPV was further supported by a medium quality cross-sectional study of 1781 nurses

conducted in the USA (Kim et al., 2021). From the study there was a weak correlation between the occurrence of emotional exhaustion and exposure to physical violence from patients (r = 0.16, p = <0.001), verbal aggression from patients (r = 0.18, p <0.001), and verbal aggression from visitors (r = 0.18, p <0.001)

The systematic review divided psychological and emotional consequences into separate outcomes (Lancot & Guay, 2014). At least one emotional consequence of WPV was an outcome of twenty-five studies from the systematic review. Feelings of frustration, hatred, and resentment were common (Lancot & Guay, 2014). These findings were supported in Chapmen's et al.'s (2009) descriptive exploratory qualitative study of nurses working in long term and acute care in a single Australian hospital. From this study, nurses who had experienced WPV reported feelings of fear, anger, apprehension, and incompetence regarding their ability to provide patient care. These nurses felt that these feeling often followed them home and impacted their everyday lives.

WPV can also have a financial impact on nurses. No research literature pertaining to the personal financial impact of WPV was identified. However, a large reputable organization, the NIOSH (2020) identified that a loss of work, out of pocket cost of care, or potential legal expenses could place financial strain on the individual (NIOSH, 2020). The physical and psychological impacts of WPV can result in a loss of work which may equate to a loss of income. Moreover, pending the extent of the violent encounter, nurses may suffer out of pocket cost for therapy for physical injuries or psychological trauma. If nurses choose to take legal action against a patient or visitor for aggressive encounters, they would be responsible for any associated cost (NIOSH, 2020).

Impact on Patients

Patient care can be compromised due to WPV (Lancot & Guay, 2014; Kim et al., 2021).

From a well-conducted systematic review of 68 studies, it was determined that the quality of time nurses spend with patients, the care they provide, and the interest they had in their patients was impacted by WPV (Lancot & Guay, 2014). In the medium quality cross-sectional study of 1781 nurses working in a large academic medical center in the USA, it was recognized that nurses felt that patient safety was directly impacted as a result of their exposure to physical violence from patients (p <0.01) (Kim et al., 2021). Patient safety was determined to be indirectly impacted by emotional exhaustion of the nurse as a result of physical violence from patients and verbal violence from patients and visitors (p<0.001). The feelings created from previous experiences with violent or aggressive encounters may remove the pleasure nurses feel when interacting with patients. This can create a level of fear surrounding patient interactions and in turn reduce the amount of time nurses spent with their patients (Chapman et al., 2009). Through avoiding patient contact, patient care is negatively impacted. Disruption in patient care was a theme developed in Chapman et al.'s (2009) descriptive exploratory qualitative study with a delay in care being recognized by a participant.

Research studies have addressed the impacts of WPV on patient care from a nursing, medical, or organizational perspective however, a gap in the literature exists in determining the impact from the perspective of a patient or support person. A single cross-sectional study of the perspective of patients in a psychiatric ward in the United Kingdom (UK) was identified. Participants reported that the use of chemical and physical restraints after a violent outburst left them feeling like prisoners (Duxburry & Whittington, 2004). With a lack of research, little is known about the impact on those demonstrating the violent behaviours or the patients and families exposed to this violence in acute care areas.

Impact on the Healthcare System

There are financial costs for the healthcare system related to WPV. In Ontario, it is estimated that WPV in hospitals cost $23.8 million annually (Government of Ontario, 2015). Jacobson Consulting Incorporated (2017) provided an analysis of absenteeism and overtime for the Canadian Federation of Nurses based on Statistics Canada data: In 2016, it was estimated that the cost of absenteeism for nurses across Canada for illness and disability was $989 million dollars. This equates to the salary and workload for 15,900 nurses. When nurses are not able to work, more staff must be hired or recruited to fill these openings. The Advisory Board Company (2000) reports that turnover cost of one RN is $42, 000 to $64 000 USD depending on the specialty area. This amount incorporates the recruitment process, orientation time, decreased productivity for new employees, loss of organizational knowledge, and potential errors. There are no recent studies conducted on the turnover cost. As this statistic is over twenty years old, it can be assumed that this value is greater due to inflation.

NIOSH (2020) reports that 80% of nurses do not feel safe in their workplace. A national online survey of 7153 regulated Canadian nurses determined that 21.7% of nurses had intention to leave the nursing profession (Hall & Visekruna, 2020). While this value is not solely reflective of the impact of WPV it demonstrates a turnover that could be impacted by the presence of WPV. A high quality cross-sectional study conducted in Taiwan determined that turnover intention of RNs was significantly impacted by both self-experience ($\beta = 0.179$, $p<0.001$) and witnessing workplace violence ($\beta = 0.089$, $p<0.001$) (Chang et al., 2018). Moreover, the results of a well conducted descriptive exploratory qualitative study determined absenteeism to be a common theme reported by nurses after exposure to WPV (Chapmen et al., 2009). Evidently, absenteeism, disability, and poor retention are costly for the healthcare system.

Contributing Factors for Workplace Violence

There are various factors that contribute to the risk of WPV; factors related to the nurse, patient, organization, and environment each can play a role in the risk of violent encounters. These factors will be explored in the next section.

Factors Related to the Nurse

Being in direct contact with patients instantly increases nurses' risk of exposure to WPV (International Council of Nurses, 2000). Authors of four well conducted cross-sectional studies completed in Thailand, China, and Australia reported that age and years of experience of the nurse directly correlated to the incidence of physical and verbal assault (Chaiwuth et al., 2020; Wei et al., 2016; Zhang et al., 2017; Pich et al., 2017). From these studies it is apparent that younger staff and those with less experience are at a higher risk of WPV. Findings of the Australian study of ED nurses determined that the risk of violence decreased for nurses after 40 years of age (Odds Ratio (OR) = 0.41, 95% CI 0.24 - 0.69, $p = 0.001$) and for those with greater nursing experience (OR = 0.96, 95% CI 0.93, 0.99, $p = 0.006$) (Pich et al., 2017). These results were mirrored in the study of risk factors of violence of acute care RNs in two Thailand hospitals (Chaiwuth et al., 2020). Being less than 35 years of age was a risk factor for physical violence (OR 3.1, 95%CI 1.2-7.3, p=0.012) and less than ten years of experience was a risk factor for verbal violence (OR 2.4, 95%CI 1.3-4.5, p=0.005). These findings suggest that RNs with less experience may have different needs related to preventing and managing WPV.

Patient Factors

Patient factors may also contribute to the potential of workplace violence against nurses. Authors of a high quality controlled before-after (CBA) study determined that the risk of violence from patients can be predicted by previous history of aggression in the ED (OR = 47.2,

95% CI, 34.2-54.9, p<0.001) or inpatient unit (OR= 11.4, 95% CI, 12.2-29, p<0.001) and a history of psychosis (OR= 170.4, 95% CI, 38.5-59.3, p <0.01), schizophrenia (OR = 7.8, 95% CI, 19.9-38.8, p <0.001), bipolar OR= 7.8, 95% CI 17.9-36.4, p <0.001), and depression (OR = 2, 95% CI, 11.3-27.8, p = 0.05)(Claudius et al., 2018). A well conducted cross-sectional study conducted in an Australian ED determined substance misuse (X^2 = 15.18, p<0.001) and delirium (X^2= 6.65, p=0.01) to also be contributing factors to aggressive patient behaviours (Pich et al., 2017). Additionally, an aging population, specifically those with dementia, present as a risk for WPV against healthcare workers (House of Commons, 2019).

While a patient's past behaviours and history can assist in predicting violence, communication can also play a role. Results from a well conducted cross-sectional study conducted on psychiatric units in the UK determined that patients felt that the nursing staff had poor communication skills and ineffective listening, contributing to aggressive outburst from patients (Duxbury & Whittington, 2004). Similar findings were reported in Angland et al.'s (2014) well conducted qualitative study that used a phenomenological approach. Twelve RNs from an ED in Ireland were interviewed to determine the impact of communication factors and the risk of violence. From the interviews conducted, a lack of communication between healthcare professionals and the patient, and poor inter-professional communication were recognized to contribute to patient and patient advocate aggression (Angland et al., 2014).

There are factors that contribute to violence that are common across all hospital settings and those that are more specific to a surgical patient population (Jakobsson et al., 2020; Fields et al., 2018; Williamson et al., 2020). A medium quality CBA study examined the aggressive outcomes associated with postoperative patients (Fields et al., 2018). These authors reported that, 2.5 of 1000 patients experienced emergent agitation after surgery which progressed to delirium

in 16% of cases. A CBA study of two medical wards in Australia determined confusion from delirium or dementia to be the third highest risk factor for WPV, being a history of violence and substance abuse, with aggression occurring in 47% of this patient population (Adams et al., 2017). Additionally, there was a strong association between agitation post operatively and the placement of tubes such as a urinary catheter, nasogastric tube (NG), tracheostomy, or chest tube (Fields et al., 2018). A medium quality prospective cohort study was conducted in the Intensive Care Unit (ICU) to examine the occurrence of aggression in patients suffering from traumatic brain injuries (TBI) (N=30) (Williamson et al., 2020). Due to the nature of the injury, patients with TBIs were often impulsive and agitated: 56.7% of the patients experienced agitation, 20.7% expressed anger, and 31% exhibited violent behaviours during their ICU admission (Williamson et al., 2020). From the phenomenological study of ED nurses in Australia, it has been recognized that nurses often excuse violence and aggression exhibited in these patient populations as nurses deem these actions to be beyond the patient's control (Horgarth et al., 2016).

Organizational and Environmental Factors

Organizationally, there are factors that influence the potential for nurses to be exposed to WPV. A well conducted cross sectional study of acute care RNs in Thailand was completed to determine risk factors of WPV in tertiary hospitals (Chaiwuth et al., 2020). From the results, staffing ratios were recognized to play a role in the occurrence of WPV, with a higher patient to nurse ratio resulting in more physical violence (OR 6.4, 95%CI 2.1-19.3, p=0.001) (Chaiwuth et al., 2020). The results of a well conducted phenomenological study of twelve RNs in an Ireland ED indicated that physical environment also played a role in the aggression exhibited by patients and their families (Angland et al., 2014). The ED nurses interviewed believed that overcrowding and long wait times were linked to violent outbursts. Moreover, these nurses believed that violent

encounters could be minimized if security were easily accessible or readily available (Angland et al., 2014). In addition, a lack of staff training and preparedness, workplace cultures, and management that are not invested in protecting staff from WPV present as risk factors for WPV (NIOSH, 2020)

There are environmental factors that contribute to the potential of WPV (NIOSH, 2020). These risks can be divided into four categories: opportunity to gain access, events that increase stress, opportunities to be used as weapons, and limiting staff's ability to respond to violent events (NIOSH, 2020). Unmonitored entryways or stairwells, poor lighting, and unsecured rooms all provide an opportunity for individuals to gain access to a unit. There are events that may increase an individual's stress unrelated to their admission such as poor signage and environmental conditions. This increase in stress increases a person's risk of violence. Additionally, in the hospital setting, there is equipment and hospital décor or furniture that may be used a weapon against healthcare professionals. Lastly, a lack of security systems, alarms, or devices in the environment limits the healthcare professional's ability to respond to violent situations and notify others (NIOSH, 2020).

Conclusion

WPV in healthcare and against nurses is a serious issue that has a negative impact on nurses, patients, and the healthcare system. Personal factors of the nurse, patient factors, and organizational and environmental factors all play a role in the occurrence of WPV. To address this problem interventions for nurses are needed to help reduce, manage, and prevent WPV.

Interventions to Manage and Prevent Workplace Violence

One of the primary objectives of this literature review was to identify interventions that would help nurses prevent and manage WPV perpetrated from patients and visitors in acute care

areas. A well-conducted Cochrane systematic review that analyzed the effectiveness of education and training in preventing and minimizing WPV in healthcare (Geoffrion et al., 2020) was identified in the literature search. Since the review, an uncontrolled before after (UCBA) study (Brunero et al., 2021) that focused on the effectiveness of education developed through a tabletop exercise was published. An additional four analytic studies were analyzed: one randomized controlled trail (RCT) (Artnez et al., 2017) and three UCBA studies that were not included in the systematic review (Adams et al., 2017; Lamont & Brunero, 2018; Story et al., 2020). These studies evaluated the effectiveness of an individualized Action Plan (Arntez et al., 2017), compressed education sessions (Adams et al., 2017; Story et al., 2020), and a full day workshop (Lamont & Brunero, 2018).

The next sections will provide a critical appraisal of these studies and present information on the specific interventions, the measurement tools used, and the results. This appraisal will be followed by a summary of the findings.

Overview of Studies and Critical Appraisal

To determine the strength of the evidence and the inherent usefulness of the studies in providing potential interventions to prevent and manage WPV, the studies were critically appraised using the PHAC (2014) Critical Appraisal Toolkit. One systematic review, one RCT, and four UCBA studies were identified. An overview and critical appraisal of each study will be provided in this section.

The well conducted systematic review analyzed nine analytic studies: three RCTs, four clustered RCTs (CRCTs), and three CBA studies (Geoffrion et al., 2020). The review included a total of 1688 participants comprised of nurses, nurses aid, and general healthcare workers from long term care, psychiatric wards, hospitals, or health centers. Studies were conducted in the

USA, Switzerland, the UK, Taiwan, and Sweden. The systematic review was determined to be high quality with the use of multiple reviewers using rigorous inclusion and exclusion criteria, a broad search of the literature for non-English and grey literature, and appropriate statistical analysis for areas that were suitable for a meta-analysis. The authors of the systematic review determined that due to the high risk of bias as a result of self-reporting there were no high-quality studies that tested WPV interventions for nurses and based on their review the evidence was not sufficient to show that interventions were effective.

Using the PHAC (2014) critical appraisal tool, Arnetz et al.'s (2017) RCT was determined to be a strong design with high quality. Sophisticated analysis, sufficient power, concurrent analysis of groups, and random allocation contributed to the high quality of this study. Limitations to the study, such as the creation of WPV prevention plans in the control groups over the duration of the study, were not large enough to impact drawing a conclusion regarding the effectiveness of the intervention.

UCBA studies are weak designs (PHAC, 2014). Using the PHAC (2014) critical appraisal tool, the quality of the studies was rated as medium (Adams et al., 2017; Lamont & Brunero, 2018; Brunero et al., 2021; Story et al., 2020). Only Adams et al. (2017) controlled for confounding with the analysis using linear regression. Confounding was not controlled for using analysis in the remaining three studies and poor retention of participants was also an issue (Brunero et al., 2021; Lamont & Brunero, 2018; Story et al., 2020). Low response rate and no matching of participants before and after the educational intervention were limitations of Adams et al.'s (2017) study.

Six different interventions were identified from the literature: one day in person education (Geoffrion et al., 2020; Lamont & Brunero, 2018), asynchronous online education

(Geoffrion et al., 2020), compressed in person education (i.e., one to two hours in length) (Geoffrion et al., 2020; Adams et al., 2017; Story et al., 2020), extended education (Geoffrion et al, 2020), open discussion (Geoffrion et al., 2020; Brunero et al. 2021), and multicomponent strategies (Arntez et al., 2017). Each of these strategies will be discussed in greater detail in the upcoming sections.

The effectiveness of these interventions were measured based on the frequency of WPV (Geoffrion et al., 2020; Arntez et al., 2017; Adams et al., 2017), self-rated knowledge (Geoffrion et al., 2020; Adams et al., 2017; Brunero et al., 2021; Lamont & Brunero, 2018; Story et al., 2020), skills (Adams et al., 2017; Geoffrion et al., 2020), confidence (Brunero et al., 2021; Adams et al., 2017; Lamont & Brunero), attitudes (Geoffrion et al., 2020), and impact on healthcare professionals (Geoffrion et al., 2020). From the additional analytic studies that were not included in the systematic review, Confidence in Coping with Patient Aggression Instrument was the only measurement tool used in more than one study (Lamont & Brunero, 2018; Story et al., 2020). The interventions examined in each study can be categorized into one-day education sessions, online training, compressed training (1-4 hours), open discussions, or multicomponent interventions. Each intervention and the associated outcomes will be discussed in the following section.

One-Day Education Session

The impact of a one-day training session was examined in two studies, one UCBA study completed in Australia (Lamont & Brunero, 2018) and a CBA study conducted in the UK and included in the systematic review (Geoffrion et al., 2020). Similarities were noted in the content covered and strategies used to deliver the content. Education in the UCBA study was delivered to 78 nurses in two medical wards by mental health nurse experts (Lamont & Brunero, 2018).

Enquiry based learning, simulation, and psychomotor training were used to educate staff on WPV recognition, communication, and management techniques. The CBA study examined in the review focused on risk assessment, diffusion strategies, and follow up using role play and relaxation techniques (Geoffrion et al., 2020). Data collection followed a shorter period of time in Lamont and Brunero's (2018) study, occurring immediately before the workshop and two weeks later. Changes in nurse's clinical behavioral intention and confidence in managing verbal and physical aggression was measured using the Continuing Professional Development Reaction Questionnaire and Confidence in Coping with Patient Aggression instrument, respectively. Data collection tools were not specified for the CBA study, but it was noted that collection occurred one-month pre and post education (Geoffrion et al., 2020). These two studies measured different outcomes: frequency of WPV, knowledge and skills, and confidence. The results are presented below.

Frequency of Workplace Violence

The impact on the frequency of WPV was examined in the CBA study included in the systematic review (Geoffrion et al., 2020). There were no statistically significant findings in WPV frequency after the delivery of a one-day education session, but aggressive incidences were noted to decrease by 31%. While not statistically significant, this finding may hold clinical significance.

Knowledge and Skills

Knowledge and skills were assessed in the UCBA study (Lamont & Brunero, 2018). Participant's knowledge and skills in relation to behavioral intention (i.e., "the individual's motivation to adopt a specific behavior or not" (Légaré et al., 2014, p. 2) of formulating violence risk assessment and management plans, using de-escalation techniques during escalating

aggression, and using breakaway techniques were analyzed on the basis of five constructs: intention, social influence (i.e. approval or disapproval of adaption of behaviour by significant persons), beliefs and capabilities, morals and norms, and beliefs about consequence (Lamont & Brunerio, 2018). Changes in behavioral intention scores were significant in all areas except the social influences of breakaway techniques. A large effect size was noted when assessing the impact of beliefs and capabilities in formulating violence risk assessment and management plans (M 5.96 vs 6.24, $p = 0.017$), using de-escalation techniques during escalating aggression (M 6.17 vs. 6.52, $p = 0.004$), and using breakaway techniques (M 5.73 vs. 6.23, $p = 0.001$).

Confidence

Nurses' confidence in coping with WPV was an outcome measured in the UCBA study (Lamont & Brunero, 2018). A statistically significant finding in self-reported confidence in coping with WPV was recognized two weeks after implementation of a one-day workshop (means 52.8 vs. 72.4, $p < 0.001$).

Summary

The implementation of a one-day education session had a positive impact on WPV frequency and a statistically significant impact on development of knowledge, skills, and confidence. While the reduction in WPV incidences was not statistically significant, a decrease in the number of incidences was noted after the implementation of the education day (Geoffrion et al., 2020). Knowledge, skills, and confidence were all significantly improved after the educational workshop delivered by Lamont and Brunero (2018). The results of these studies are promising. However, as there are few studies that have evaluated the effectiveness of using one-day education that covered various topics related to WPV a conclusion cannot be drawn related to whether or not this approach is effective

Asynchronous Online Education

Four studies tested the effectiveness of online education. Two RCTs, one CRCT, and one CBA study all conducted in the USA and included in the systematic review measured the effectiveness of online education for reducing WPV and increasing knowledge, confidence, and attitudes of healthcare workers (Geoffrion et al., 2020). The same researcher conducted three of the studies analyzed in the systematic review: both RCTS and the CRCT. Training was based on the initial research, which used videos and images to provide education on the Assessment Investigation Do something (AID) approach and the provision of situational skills. The educational strategies used in the five online modules to provide education in the CBA study were not discussed. Topics covered were risk assessment, de-escalation, skills development, and debriefing. Data were collected at baseline and at two intervals for both RCTs and the CRCT through investigator constructed questionnaires with established reliability and validity. Data were collected one and sixteen days after the intervention in one RCT. Follow up data were collected four and eight weeks after completion of the online training in the other RCT and at eight and sixteen weeks after education in the CRCT. Data collection occurred two weeks before and after the completion of the online module in the CBA study using the Workplace Violence Questionnaire and Demographics tool. Asynchronous online education ranged from a single 3-hour session, two separate sessions, and a self-paced module that typically took a day to complete (Geoffrion et al., 2020). These four studies measured different outcomes: frequency of WPV, knowledge, and attitudes. The results are presented below.

Frequency of Workplace Violence

The frequency of WPV was measured in the CRCT and CBA study (Geoffrion et al., 2020). A decrease in the incidence of reported assaults was noted in the CRCT after the

completion of the online module. The CBA study in the review reported a significant decrease in the average number of aggressive encounters 30 days after the education training (Standardized Mean Difference (SMD) -1.24, 95% CI -2.16 - -0.33).

Knowledge

One of the RCTs included in the systematic review reported that the increase in participants' knowledge regarding WPV was statistically significant after online education (SMD 0.86, 95% CI 0.34 to 1.38) (Geoffrion et al., 2020). A large, maintained effect in the increase in knowledge after the provision of video education in the CBA study was also noted, but results were not provided.

Attitudes

Attitudes were noted to be positively impacted in three of the four studies analyzed in the systematic review (Geoffrion et al., 2020). Attitudes improved significantly in one RCT (SMD 1.23, 95% CI 0.69 -1.78). From the meta-analysis of another RCT and CRCT a statistically significant impact on attitudes after online education was reported (SMD 0.33, 95% CI 0.05-.061).

Summary

Overall, the online education sessions were noted to have promising impacts on WPV frequency and knowledge in assessment risk and de-escalation. As few studies examine these outcomes, additional research is needed to draw a conclusion. Nonetheless, there is moderate evidence that online education impacts attitudes towards managing WPV were positively impacted.

Compressed In-Person Education

Four studies tested the effectiveness of compressed in-person education. The effects of

providing education in short classroom sessions were analyzed in a CRCT and an RCT in the systematic review (Geoffrion et al., 2020) and two UCBA studies conducted in Australia and the USA (Adams et al., 2017; Story et al., 2020). The CRCT conducted in the USA provided two, two-hour education sessions delivering education on risk factors, management, and communication (Geoffrion et al., 2020). The method through which the education was provided was not identified. The other three studies utilized similar strategies to deliver the content (Geoffrion et al., 2020; Story et al., 2020, Adams et al., 2017). Case studies were used in all three studies. Discussions and role playing, or simulations, were used to deliver education in the RCT included in the systematic review (Geoffrion et al., 2020) and Story et al.'s (2020) education session. While sharing similar education delivery methods, these studies varied in the length of time. The RCT conducted in Taiwan offered a three-hour classroom session to 392 participants (control group = 192, intervention group = 200) (Geoffrion et al., 2020). Adams et al. (2017) conducted a one-hour education session for 59 frontline workers. While Story et al. (2020) provided a two-hour education session for 43 nurses. Baseline information collection differed between studies. Baseline data was collected immediately prior to the intervention in the RCT reviewed in the systematic review (Geoffrion et al., 2020) and by Story et al. (2020). Adams et al. (2017) collected data six months prior to education while data collection occurred two weeks prior to the intervention in the CRCT (Geoffrion et al., 2020). The CRCT had a short term follow up of two weeks while the remainder of the studies had a lengthier follow up period at three months (Story et al., 2020; Geoffrion et al., 2020) and six months (Adams et al., 2017).

There were some similarities and differences in the studies in relation to outcomes measured. Confidence in coping with patient aggression was measured in both Story et al.'s (2021) study and the RCT examined in the systematic review (Geoffrion et al., 2020). The

Perception of Patient Aggression Scale (POAS-S) and the Management of Aggression and Violence Attitude Scale were also used in the RCT to determine awareness of aggression and attitude towards aggression, respectively. The use of violence reports from the healthcare organization was used in both Adams et al.'s (2017) study and the CRCT in the systematic review (Geoffrion et al., 2020). Confidence and self-assessment capability were also measured in Adams et al.'s (2017) study using a Likert scale developed for the study. Frequency of WPV, knowledge and skills, confidence and comfort were the outcomes measured in these four studies. The results are presented below.

Frequency of Workplace Violence

The impact of compressed educational sessions on the occurrence of WPV was measured in Adams et al.'s (2017) study and the CRCT study included in the systematic review (Geoffrion et al., 2020). No statistically significant findings were obtained in either study. Nonetheless, the medical wards included in the Australian study had a 45% reduction in workplace violence six months after intervention (Adams et al., 2017).

Knowledge and Skills

Knowledge of nurses' roles in prevention or management techniques was measured in Adams et al.'s (2017) study. An increase in knowledge was statistically significant (r^2= 0.391, 95% CI 0.256 0.542, p=0.001) 6 months after a 1-hour education session (Adams et al., 2017). Moreover, a statistically significant improvement in the use of using de-escalation techniques (p=0.001) was also determined.

Confidence and Comfort

Confidence was measured in two studies (Story et al., 2020; Adams et al., 2017) and one study (Story et al., 2020) measured comfort as an outcome. Confidence was measured in two

areas: coping with WPV (Story et al., 2020) and managing aggressive or violent events (Story et al., 2020; Adams et al., 2017). In Story et al.'s (2020) study, 37.6% of participants reported an increase in confidence in coping with aggression in the workplace three months after the educational session (M 55.1 vs 75.8, p=0.000). Additionally, there was also a 23.6% increase in comfort in dealing with violent events (M 6.73 vs 8.32, p=0.0066) (Story et al., 2020). However, no statistically significant results were obtained in the increase in confidence in managing aggressive or violent situations for either study (Adams et al., 2017; Story et al., 2020). Nonetheless, while not statistically significant, confidence in this area did increase by 24.4% after the educational session in Story et al.'s (2020) study.

Attitudes

The RCT assessed in the systematic review analyzed awareness of WPV, attitudes, and self-efficacy but only the results for attitudes were presented and discussed (Geoffrion et al., 2020). A statistically significant moderate effect of attitudes in the education group was determined (SMD 0.78, 95% CI 0.58-0.99).

Summary

Overall, with the use of compressed in-person education there were no statistically significant reductions in the occurrence of WPV, though incidences did decrease. Knowledge and skills were significantly improved with emphasis placed on the effectiveness of de-escalation skills (Adams et al., 2017). An increase in confidence was seen in coping with WPV but no statistical significance in confidence was achieved in managing aggressive or violent events. Confidence in coping with WPV was statistically significant (Story et al., 2020). The results of these studies are promising for an increase in knowledge and skills and confidence. However, as

few studies have examined the effectiveness of in person condensed education, a conclusion cannot be drawn to determine if this approach is effective.

Extended Education Session

Only one study examined the effectiveness of an extended education session. A CRCT conducted in Switzerland and included in the systematic review (Geoffrion et al., 2020) assessed the effectiveness of education dispersed over multiple sessions. The CRCT provided 20, 50-minute sessions delivered over five days (Geoffrion et al., 2020). Causes and types of aggression, conflict management, communication, violence prevention, breakaway techniques, and post-aggression procedures were covered in the sessions. Role playing was noted to be education delivery method used. Outcomes of perception, attitudes, and skills were measured using the POAS-S, Tolerance Scale, and Impact of Patient Aggression on Careers Scale (IMPACS), respectively.

Attitudes

Participants in the CRCT study did not experience a statistically significant change in their attitudes towards WPV (Geoffrion et al., 2020).

Adverse Outcomes for Staff

Differing from the outcomes measured in the other interventional strategies, the impact of patient aggression on healthcare workers was examined in the CRCT of the systematic review (Geofrroin et al., 2020). The development of adverse moral reactions (i.e., reactions that occurred after an aggressive event, before and after the implementation of the education and training intervention) were analyzed. The CRCT determined a small negative effect on the personal impact of staff but results were not statistically significant.

Summary

The outcomes of an extended education session were not statistically significant for the outcomes of attitudes and personal impacts on staff. Overall, the use of extended education did not have a positive impact. Due to the use of a single study the evidence was weak and a conclusion cannot be drawn on the effectiveness of extended education.

Open Discussions

Two studies focused on open discussions**.** A single CRCT conducted in Sweden included in the systematic review (Geoffrion et al., 2020) and an UCBA study carried out in Australia (Brunero et al. 2021) used open discussion to provide education to healthcare professionals regarding WPV. The CRCT used staff meetings to discuss the violent encounters that occurred on the unit as soon as possible (Geoffrion et al., 2020). After the violent event open discussions on identified risk factors, management techniques, and differing perspectives and ideas occurred. Brunero et al. (2021) used a single tabletop exercise with 49 local managers, educators, and senior managers to provide education regarding WPV prevention and management. A standardized scenario based on an actual patient event was presented and discussions were facilitated with presentation slides and questions. Data were collected immediately prior to both interventions, two weeks after the tabletop exercise (Brunero et al., 2021) and 12 months after continuous staff meetings in the CRCT (Geoffrion et al., 2020). A 10-point Likert scale was created to determine confidence for the participants in Brunero et al.'s (2021) study. Violence incidence forms were used in the CRCT to collect data on the occurrence of violent events (Geoffrion et al., 2020). Data collection tools to determine change in knowledge, confidence, and attitudes in the systematic review were not provided. These two studies measured different outcomes: frequency of WPV, knowledge, and confidence. The results are presented below.

Frequency of Workplace Violence

The CRCT examined in Geoffrion et al.'s (2020) review analyzed the occurrence of WPV incidences through incident reports. There was no statistically significant impact on the reporting of WPV after the continued provision of open discussions.

Knowledge

The CRCT included in Geoffrion et al.'s (2020) systematic review did not find any statistically significant findings in the personal knowledge obtained by the participants after the ongoing staff meetings. Nonetheless, the intervention group determined that the ongoing discussions gave them a better awareness of risk situations (36% vs. 29%), how to avoid or mitigate potentially violent situations (34% vs. 26%), and how nurses could manage aggressive patients or persons in the workplace (33% vs. 25%) in comparison to the control group. Brunero et al. (2021), on the other hand, reported a statistically significant increase in the understanding nurses had after the tabletop exercise regarding their own role (M 6 vs. 9, p <0.001), their co-worker's role (M 6 vs 9, p <0.001), and the response team's role (M 6 vs. 9, p <0.001) in a code black (aggressive patient) situation.

Confidence

Confidence was not assessed in the CRCT examined in the systematic review (Geoffrion et al., 2020). However, an overall increase in confidence for managing violence was significant after Brunero et al.'s (2021) tabletop exercise (M 6 vs. 9, p <0.001).

Summary

The implications of an open discussion style education session were positive. Knowledge was noted to increase in both studies but was only determined to be statistically significant in one (Brunero et al., 2021). An overall increase in confidence in managing violent events was determined in Brunero el al.'s (2021) study. Nonetheless, the frequency of WPV reports was not

significantly impacted (Geoffrion et al., 2020). While the results of these studies are promising, a conclusion cannot be made on the effectiveness of the interventions due to the low number of studies.

Multi-Component Strategies

Arnetz et al. (2017) conducted an RCT focused on administration, behaviour, and environmental components in reducing WPV. A checklist from Occupational Health and Safety Administration (2004) was provided to the unit managers and autonomy was granted to create an action plan that was specific to the issues faced by the unit. Data regarding the occurrence of WPV were collected from the central reporting system two years prior to the initiation of the action plan and three years after implementation. Online surveys were provided to managers to determine the extent to which the action plan was implemented and to determine if the control groups implemented any WPV prevention strategies. No other outcomes were measured.

Frequency of Workplace Violence

WPV was significantly reduced six months after the introduction of the action plan (IRR 0.48, 95% CI, 0.29-0.80, $p<0.01$) (Arntez et al., 2017). No significant findings were determined at 12, 18, 24-month follow-ups. Additionally, workplace injuries were also significantly reduced 24 months after the introduction of the action plan (IRR 0.37, 95% CI, 0.17-0.83, $p<0.05$). No significant findings were found in the remainder of the follow-up intervals. While these results are promising, with only a single study, no conclusion can be drawn on the effectiveness of this strategy.

Summary of the State of the Evidence

Applying the PHAC (2014) definitions of terms to rate evidence and the criteria for rating evidence the overall conclusion that is drawn is that there is weak, direct evidence, with some

inconsistent results, from multiple studies that were low, medium, and high-quality and that used various strength designs (e.g., weak, moderate, and strong designs) that WPV interventions are effective in helping nurses reduce, manage, and prevent WPV. The variation in participants, type of interventions, measurement instruments, timeframes of measurement, the comparisons being made, and the self-reporting nature of the studies may have been important factors impacting the findings. Some clear trends were noted that suggest that these interventions are promising for decreasing WPV, increasing knowledge and skills, increasing confidence, and improving attitudes. Only one study reported the effect on adverse outcomes so no trend could be identified.

A sub-analysis of the strategies used to deliver the WPV intervention was also completed to determine if a particular mode of delivery was more effective than another. The strategies were categorized into: one-day education, online education, compressed in person education, extended education, open discussion, and multi-component strategies. Due to the small number of studies in each category and the low quality of the studies no conclusion can be drawn regarding which mode of delivery is more effective for delivering WPV interventions, but some clear trends were noted. These trends will be discussed.

The effectives of educational strategies on outcomes of knowledge, skills, confidence, and attitudes are promising. From the studies, one day education sessions, open discussion education sessions, and compressed learning that focuses on actual patient encounters seem to have the most promising results in relation to increasing knowledge and confidence. Education delivered through active learning means such as case studies, role playing, simulation, videos, and open discussion have shown an increase in knowledge and confidence in coping with or managing WPV. However, due to the limited number of weak studies testing the effectiveness of these specific strategies, the evidence is weak. Of the educational interventions assessed, online

education showed the most promise in relation to the outcome of attitude.

Only one study considered the impact of a multi-component strategy that was unit specific. The strategy targeted behavioral, environmental, and administrative changes (Arnetz et al., 2017). Behavioral changes were targeted using educational strategies such as debriefing and online learning. Consumer service and active shooter education, team building exercises, and de-escalation training were examples of areas targeted using education. Environmental changes such as an increase in security presence, locked units, and panic alarms were implemented on different units. Staffing changes and monthly hospital safety, occupational health, and security meetings were examples of administrative changes that were implemented on specific units. The results of this study showed an impact on the frequency of WPV and workplace injuries (Arnetz et al., 2017). It important to note that a unit specific plan tailored to meet the needs of the stakeholders may be important in reducing violence and workplace injury (Arnetz et al., 2017).

Overall, it can be determined that WPV frequency, the knowledge, skills, confidence, and attitudes of healthcare professions can be targeted using specific interventions. An analysis of the literature determines that while there are some promising results, more research is needed to draw a conclusion to determine which intervention is most effective. Stronger evidence is needed through the conduction of strong, high quality analytic studies such as RCTs, CRCTs, non-randomized controlled trail (NRCT), and mixed methods studies such as sequential exploratory studies, and a replication of studies with differing samples using the same interventions, outcomes, and measurement tools.

Implications of Findings

The findings support that a WPV resource has potential to reduce the frequency of WPV and increase knowledge, confidence, skills, and improve attitude. In relation to specific strategies

no conclusion can be drawn because of limited studies, weak designs, variation in outcomes measured, and inconsistent results. However, there are strategies that show promise, and these should be explored in the consultations.

The evidence suggests that not all strategies are effective in reducing WPV or improving the knowledge, confidence, or skills of healthcare professionals. Educational strategies that provide case studies of actual or slightly modified patient encounters seem to have potential in reducing WPV. From the systematic review, it was noted that the impact of online training had consistently positive impacts on the occurrence of WPV, knowledge, and attitudes of healthcare providers. Moreover, Arnetz et al.'s (2017) study offered an interesting perspective with the creation of an action plan tailored to each unit. Creating an educational resource based on the needs of the RNs is more likely to yield a desirable outcome. Using components of open discussions and condensed education, synchronous online education could be a potentially successful intervention in assisting RNs to prevent and manage aggressive patients and visitors.

From the findings of the systematic review (Geoffrion et al., 2020) and (Arnetz et al., 2017) it is apparent that educational interventions may not have long term effects. This suggests that the educational strategy may have to be provided on a regular basis to impact the occurrence of WPV and the negative consequences on the nurse, patient care, and healthcare system. A primary educational intervention and follow-up sessions could be considered.

While education alone will not eliminate WPV for nurses working in acute care, it potentially can improve knowledge of WPV, support the development of skills to manage WPV, improve confidence and attitudes, and decrease the frequency of WPV. Nurses cannot control the actions of patients or patient support persons, but they can be provided with a toolkit to help them learn to predict, adapt, and manage aggressive encounters.

Theoretical Framework

The nurses that this resource will aim to serve are adults. While differing in levels of experience, they have completed a Bachelor of Nursing degree and are currently working in the acute care setting. To create a resource that will best meet the needs of this population, Knowles' Theory of Andragogy (1984), which focuses on adult learners, will provide the theoretical framework for the development and delivery of this intervention. There are six assumptions of the Theory of Andragogy regarding adult learners that apply to the development of a learning resource for surgical nurse: 1) the learners' self-concept, 2) the role of the experience, 3) the readiness to learn, 4) orientation to learning, 5) motivation, and 6) the need to know (Knowles et al. 2015). Each of these assumptions will be described below.

The learners' self-concept assumption is based on the notion that adult learners should be independent and responsible for their own learning (Knowles et al., 2005). Through being more self-directed in learning, adults are able to form a better awareness of their self-concept (Knowles et al., 2015). Adults are responsible for their own decisions. The recognition that adults are in control of their own learning is important in seeking educational opportunities.

Adults have accumulated life experience. It is an assumption of andragogy that experience will impact learning (Knowles et al., 2015). The nurses that this educational resource will target will likely have personal experience with workplace violence, have witnessed violence, or have heard co-workers discussing workplace violence during their career. Nurses will be able to call on and share these experiences in learning how to work to prevent, manage, and cope with workplace violence.

Readiness to learn is an assumption of andragogy (Knowles et al., 2015). For adults to have the desire to learn something new, it must be relevant to their current situation. They must

see the use of the information in their everyday lives (Knowles et al., 2005). Since type two violence is viewed as an issue for nurses, an educational resource that provides instruction on how to prevent and manage violence would be determined useful.

Education is more likely to be effective if it can be applied to real-life situations (Knowles et al., 2015). Adults like to be able to use the information they have learned immediately. When caring for patients and families and considering that some conditions result in patients being susceptible to becoming violent it is a competency needed by all RNs

Motivation and the need to know are large factors in learning. As an RN, the internal motivators such as increased quality of life, job satisfaction, or an increase in self-esteem (Knowles et al., 2015) would facilitate the learning regarding workplace violence prevention and management. Additionally, adults need to know why they need to learn something (Knowles et al., 2005). They need to how it affects their life and why learning it is important to them.

Conclusion

From the literature review it is evident that nurses are often subjected to violence and aggression from patients and patient support persons. WPV impacts RNs who are exposed to or witness aggression, patient care, patient safety, and the healthcare organization as a whole. With the knowledge of the impact of WPV, it is essential to develop a resource to assist with the prevention and management of physically and verbally aggressive encounters with patients and support persons. Through recognizing contributing factors such as a patient's previous history with violence or mental health related issues, and the effects of poor communication and overcrowding, these areas can be targeted in the delivery of an educational strategy.

The education and training programs appraised in this literature review ranged from self-paced online modules to multi-day workshops. There is weak evidence to suggest that education

and training interventions reduce WPV and improve knowledge, skills, and attitudes regarding WPV. From the studies conducted, the tabletop exercise or a condensed education session that is provided on a regular basis seem to have the most promising results to provide RNs with education to prevent and manage WPV. Information obtained from this literature review can be utilized to assist acute care medical-surgical nurses in preventing and managing WPV from patients and support persons on their unit.

References

Adams, J., Knowles, A., Irons, G., Roddy, A., & Ashworth, J. (2017). Assessing the effectiveness of clinical education to reduce the frequency and recurrence of workplace violence. *Australian Journal of Advanced Nursing, 55*(3), 8-15. http://doi.org/10.3316/INFORMIT.946627915561528

Arnetz, J., Hamblin, L., Russell, J., Upfal, M., Luborsky, M., Janisse, J., & Essenmacher, L. (2017). Preventing patient-worker violence in hospitals: Outcome of a randomized controlled intervention. *American College of Occupational and Environmental Medicine, 59*(1), 18-27. http://doi.org/10.1097/JOM.0000000000000909

Angland, S., Dowling, M., & Casey, D. (2014). Nurses' perception of the factors which cause violence and aggression in the emergency department. A qualitative study. *International Emergency Nursing, 22*(3), 134-139. http://doi.org/10.1016/j.ienj.2013.09.005

Brunero, S., Dunn, S., & Lamont, S. (2021). Development and effectiveness of tabletop exercises in preparing health practitioners in violence prevention management: A sequential explanatory mixed methods study. *Nurse Education Today, 103*, 104976. http://doi.org/10.1016/j.nedt.2021.104976

Chaiwuth, S., Chanprasit, C., Kaewthummanukul, T., Chareosanti, J., Srisuphan, W., & Stone, T. E. (2020). Prevalence and risk factors of workplace violence among registered nurses in tertiary hospitals. *Pacific Rim International Journal of Nursing Research*, *24*(4), 538-552. Retrieved from https://he02.tci-thaijo.org/index.php/PRIJNR/article/view/227889

Chang, Y.P, Lee, D. C., & Wang, H. H. (2018). Violence- prevention climate in the turnover intention of nurses experiencing workplace violence and work frustration. *Journal of*

Nursing Management, 26, 961-971. http://doi.org/10.1111/jonm.12621

Chapman, R., Perry, L., Styles, I., & Combs, S. (2009). Consequences of workplace violence directed at nurses. *British Journal of Nursing, 18*(20), 1256-1261. http://doi.org/10.12968/bjon.2008.17.20.45121

Claudius, I. A., Desai, S., Davis, E., & Henderson, S. (2017). Case-controlled analysis of patient-based risk factors for assault in the healthcare workplace. *Western Journal of Emergency Medicine,18*(6), 1153-1158. http://doi.org/10.5811/westjem.2017.7.34845

Critical Appraisal Skills Programme. (2017). *CASP qualitative studies checklist.* https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Fields, A., Huang, J., Schroeder, D., Spring, J. & Weingarten, T. (2018). Agitation in adults in the post-anesthesia care unit after general anesthesia. *British Journal of Anesthesia, 121*(5), 1052-1058. http://doi.org/10.1016/j.bja.2018.07.017

Geoffrion, S., Hills, D. J., Ross, H. M., Pich, J., Hill, A. T., Dalsbø, T. K., Riahi, S., Martínez-Jarreta, B., & Guay, S. (2020). Education and training for preventing and minimizing workplace aggression directed toward healthcare workers. *The Cochrane database of systematic reviews*, *9*(9), CD011860. https://doi.org/10.1002/14651858.CD011860.pub2

Government of Ontario. (2015, August, 12). *Ontario taking action to better protect health care workers.* https://news.ontario.ca/en/release/33878/ontario-taking-action-to-better-protect-health-care-workers

Hall, L. M. & Visekruna, S. (2020). *Outlook on nursing: A snapshot from Canadian nurses on work conditions pre COVID-19.* Canadian Federation of Nurses' Union.

Havaei, F., Astivia, O. L. O., & MacPhee, M. (2020). The impact of workplace violence on medical-surgical nurses' health outcome: A moderated medication model of work

environment condition and burnout using secondary data. *International Journal of Nursing Studies, 109,* 103666. http://doi.org/10.1016/j.ijnurstu.2020.103666

Hogarth, K., Beattie, J., & Morphet, J. (2016). Nurses' attitudes towards the reporting of violence in the emergency department. *Australasian Emergency Nursing Journal, 19,* 75-81. http://doi.org/10.1016/j.aenj.2015.03.006

House of Commons Canada. (2019). *Violence facing healthcare workers in Canada. Report of the standing committee on health. https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10589455/hesarp29/hesarp29-e.pdf*

International Council of Nurses. (2000). *Abuse and violence against nursing personnel.* http://www.icn.ch/psviolence00.htm.

Jacobson Consulting Inc. (2017). T*rends in Own Illness- or Disability-Related Absenteeism and Overtime Among Publicly Employed Registered Nurses. Quick Facts 2017.* https://nursesunions.ca/wp-content/uploads/2017/05/Quick_Facts_Absenteeism-and-Overtime-2017-Final.pdf

Jakobsson, J., Axelsson, M. & Ormon, K. (2020). The face of workplace violence: Experience of healthcare professionals in surgical hospital wards. *Nursing Research and Practice.* https://doi.org/10.1155/2020/1854387

Kim, S., Mayer, C., & Jones, C. B. Relationships between nurses' experience of workplace violence, emotional exhaustion, and patient safety. *Journal of Research in Nursing, 26*(1-2), 35-46. http://doi.org/10.1177/1744987120960200

Knowles, M. (1984). *The modern practice of adult education: From pedagogy to androgogy.* Associated Press, Follett Publishing Co.

Knowles, M. S., Holton, E. F., & Swanson, R. A. (2005). *The Adult Learner: The Definitive*

Classic in Adult Education and Human Resource Development. Taylor & Francis Ltd.

Knowles, M. S., Holton, E. F., III, & Swanson, R. A. (2015). *The adult learner: The definitive classic in adult education and human resource development* (8th ed.). Elsevier.

Lamont, S. & Brunero, S. (2018). The effect of a workplace violence training program for generalist nurses in the acute hospital setting: A quasi-experimental study. *Nurse Education Today*,*68*,45-52. http://doi.org/10.1016/j.nedt.2018.05.008

Légaré, F., Borduas, F., Freitas, A., Jacques, A., Godin, G., Luconi, F., Grimshaw, J. (2014). Development of a simple 12-item theory-based instrument to assess the impact of continuing professional development on clinical behavioral intentions. *PLoS One 9*(3), 1–10. http://doi.org/10.1371/journal.pone.0091013

Li, Y. L., Li, R. Q., Qiu, D., & Xiao, S. Y. (2020). Prevalence of workplace physical violence against health care professionals by patients and visitors: A systematic review and meta-analysis. *International journal of environmental research and public health*, *17*(1), 299. https://doi.org/10.3390/ijerph17010299

National Institute for Occupational Safety and Health. (2020, September 22). *Occupational violence.* Center for Disease control and prevention. https://www.cdc.gov/niosh/topics/violence/default.html

Occupational Health and Safety Administration (OHSA). (n.d). *Workplace violence in healthcare.* https://www.osha.gov/sites/default/files/OSHA3826.pdf

Occupational Health and Safety Administration (OHSA). (2004). *Guidelines for preventing workplace violence for healthcare and social services workers.* *https://www.hsdl.org/?view&did=730267*

Papa, A. & Venella, J. (2013). Workplace violence in healthcare: strategies for advocacy. *Online*

Journal of Issues Nursing, *18*(1), 5. http://doi.org/10.3912/OJIN.Vol18No01Man05

Pich, J. V., Kable, A., & Hazelton, M. (2017). Antecedents and precipitants of patient-related violence in the emergency department: Results from the Australian VENT Study (Violence in Emergency Nursing and Triage). *Australasian emergency nursing journal, 20*(3), 107–113. https://doi.org/10.1016/j.aenj.2017.05.005

Public Health Agency of Canada. (2014). *Critical appraisal toolkit.* https://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Registered Nurses' Association of Ontario (RNAO). (2019). *Preventing violence, harassment and bullying against health workers (2nd ed.).* www.RNAO.ca/bpg

Spector, P.E., Zhou, Z.E., Che, X.X. (2013). Nurse exposure to physical and nonphysical violence, bullying and sexual harassment: a quantitative review. *International Journal of Nursing Studies, 51*(1) 72- 84. http://doi.org/10.1016/j.ijnurstu.2013.01.010

Speroni, K. G., Fitch, T., Dawson, E., Dugan, L., Atherton, M. (2014). Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *Emergency Nursing*, *40*(3), 218-228. http://doi/org/10.1016/j.jen.2013.05.014

Statistics Canada. (2005). *Findings from the 2006 national survey of the work and health of nurses.* https://secure.cihi.ca/free_products/NHSRep06_ENG.pdf

Story, A., Scott, S., Harris, R., & Vogelsmeier, A. (2020). An evaluation of nurses' perception and confidence after implementing a workplace aggression and violence prevention training program. *Journal of Nursing Administration*, *50*(4), 209-215. http://doi.org/10.1097/NNA.0000000000000870

The Advisory Board Company. (2000). *Reversing the flight of talent: Nursing retention in an era of gathering shortage*. Advisory Board Company.

Wei, C. Y., Chiou, S.T., Chien, L. Y., & Huang, N. (2016). Workplace violence against nurses-Prevalence and association with hospital organization characteristics and health promotion efforts: Cross-sectional study. *International Journal of Nursing Studies 56*,63-70. http://doi.org/10.1016/j.ijnurstu.2015.12.012

Williamson, D. R., Cherifa, S., I., Frenetter, A. J., Mitjans, M. S., Charbonney, E., Cataford, G., Williams, V., Palacios, J. L., Burry, L., Mehta, S., Arbour, C., & Bernard, C. (2020). Agitation, confusion, and aggression in critically ill traumatic brain injury- a pilot cohort study. *Pilot Fesilbility Study, 6*(1), 193. http://doi.org/10.1186/s40814-020-00736-5

Zhang, L., Wang, A., Xie, X., Zhou, Y., Li., Yang, L., & Zhang, J. (2017). Workplace violence against nurses: A cross-sectional study. *International Journal of Nursing Studies, 72*, 8-14. http://doi.org/10.1016/j.ijnurstu.2017.04.002

Appendix A: Literature Summary Tables

Key Question: What types of resources or interventions are being used to help prevent and manage workplace violence by patients and visitors in healthcare?

Legend: V: Valid, R: Reliable, IRR: Incidence rate ratios, CI: Confidence Interval, M: Mean, FTE: Full time equivalents, WPV: Workplace violence, Code Black: Violent situation, USA: United States of America, GEE Analysis: Generalizing Estimating Equations

Table 1

Systematic Review of Education and Training to Reduce Workplace Violence Aggression Towards Healthcare Workers

Study	Methods	Results	Comments
Geoffrion et al. (2020) Systematic Review <u>Aim:</u> to assess the effectiveness of education and training interventions developed to prevent and minimize workplace violence directed toward healthcare workers by patients and patient advocates	9 studies (3 RCTs, 4 Clustered RCTs and 2 Controlled Before After studies (N = 1688) • USA, Switzerland, the United Kingdom, Taiwan, and Sweden. Setting: long-term care (n = 3); psychiatric ward (n = 2); hospitals or health centers (n =4) Sample: Nurses and nurses aids (n = 7), general healthcare workers (n=2) Interventions: Online programs (n=4), face-to-face programs (n=5), long duration (up to 52 weeks) (n=5), short duration (n=4), short term follow up (less than 3 months) (n=8), long term follow up (greater than 1 year) (n=1) Cochrane Central Register of Controlled Trials, MEDLINE (PubMed), ISDOC, Embase,	**Episodes of Aggression** • 1/5 studies showed significant results • Online education: Signfiifcant reduction in WPV frequency (Standard Mean Difference -1.24, 95% CI -2.16 to -0.33) • Uncertainty of evidence in short term follow ups (3 months) • No change in aggression in long term follow up (1 year) **Personal Knowledge** • 1/2 studies showed significant results • Online education: (SMD 0.86, 95% CI 0.34 to 1.38) • Low certainty evidence that knowledge increased in the short term follow up • No increase knowledge in long term follow up **Attitudes** • 4/5 showed significant results • Meta-analysis statistically significant: SMD 0.59, 95% CI 0.24 to 0.94	High Quality • Strengths: Searched non-English, grey literature • 4 Reviewers • Appropriate meta-analysis used where applicable Limitations of evidence: high risk of bias in 7 studies due to self reporting and the heterogeneity of outcome measures and educational approaches. <u>Conclusion:</u> The overall incidence of WPV is not

	CINAHL, PsycINFO, US National Institute for Occupational Safety and Health bibliographic database of literature on occupational safety and health (NIOSHTIC), NIOSHTIC-2, HSELINE, GRADE approach to determine study quality PRIMSA flow diagram to record selection	• Low-certainty evidence improved attitudes in the short term **Skills (empathy)** • No statistically significant results for 2 of studies that assessed empathy • Low certainty evidence showed no improvement in the short term **Adverse Patient Outcomes** • Low certainty evidence shows no change in the single study assesses this outcome	reduced with education. Education could provide RNs with knowledge, skills, and attitudes to manage aggression.

Table 2

Analytic Studies of Interventions to Prevent, Manage, and Reduce Workplace Violence Against Healthcare Workers

Study/Design	Methods	Results	Comments
Adams et al. (2017) Uncontrolled Before-After Aim: Monitor the outcomes of a clinically based education program to determine if clinical education helps participants to determine those high risk for WPV and decreases the frequency of WPV	Total N = 59 Convenience sample of front-line staff (RNs 41 pre, 45 post, Enrolled Nurse, Assistants in Nursing, Personal Care Assistants) Setting: Australia, 2 medical wards Educational Strategy: • 1 hour education session using hypothetical case studies and inpatient scenarios during shift • Key areas of focus: assessment, planning, implementation, post-incidence Outcomes & Measures: (R&V) • 6 months retrospective and prospective 1) Violent/Aggressive incidents measured using hospital records (Code black, staff accident and incident forms, hazard forms, clinical incidence forms, patients notes) 2) Confidence and self-assessed capability to prevent/manage workplace violence measured using self-administered questionnaire using 1-5 Likert Scale 3) Knowledge assessed with open ended questions Analysis: Linear regression	**Knowledge** (CI 0.256-0.542, *p*=0.001) An increase in self-perceived knowledge (6/10 to 8/10) **Confidence:** An increase in self-perceived confidence in managing aggressive patients was not significant (10/15-11/15) (CI -0.073- 0.119, *p*=0.627) **Capability:** An increase in self-perceived capability in managing aggressive patients was not significant (6.5/10-7/10) (CI -0.104 -0.195, *p*=0.545) **Frequency of Workplace Violence** Decreased by 45% but not statistically significant (31 reports pre-intervention, 17 post intervention) **Skills Developed with Clinical Education:** Verbal de-escalation use increased post education (*p*=0.001, 1df) (Change in score not provided) **Perpetrators and Incidence**	Strength: **Weak** Quality: **Medium** • Single location • Low response rate Response rate pre (43%) and post intervention (42.5%) similar • Participants not matched • Controlled for confounders using linear regression • Knowledge increased significantly, more education may be needed to affect confidence and capability • Definition of Likert score values not provided

Study/Design	Methods	Results	Comments
		• High risk: history of violence, substance abuse and confusion (delirium/dementia) • 47/48 reports of violence met these characteristics	
Arnetz et al. (2017) Randomized controlled trial Purpose: To determine how violence in the workplace will be impacted with the introduction of violence prevention interventions (unit specific action plans) through monitoring population-based incidence rates and patient to worker violence	N= 42 units (2,862 participants) identified as 'high risk' based on hazard risk matrix selection: Acute care nursing, ICU, ED, psychiatry, surgery and security **Country/Setting**: 7 hospitals in USA **Intervention Group**: 21 units (n= 1,612 employees: 810 FTEs) One 45-minute walk through. Stakeholders or researchers met with unit supervisors who were given a 3-year WPV report for their unit (WPV and injury cost rates) • Supervisor and staff were asked to identify potential risks and provided an adapted checklist to create an Action Plan specific to unit with 3 components: Administration, Behavioral, and Environmental **Control Group:** 20 units (n= 1,251 employees: 659 FTEs) Outcomes and Measures • Incidence rates of WPV and worker injury (3 years pre and 2 years post-intervention in 6-month intervals): Central	Analysis Chi-square, IRR, CI, GEE analysis (modelling) **Incidence of violence** 6 months: IRR0.48, 95% CI, 0.29-0.80, $p<0.01$ • Not significant for other intervals **Rate of Violence per 100 FTE comparison within intervention group** • 24 months: 13.77 (IRR 1.71 (95% CI 1.20, 2.43, $p<.01$)) • Not significant at other intervals **Rate of violence per 100 FTE-Invention group compared to control group** • 6 months: 6.71 vs 14.36 (IRR 0.48(95% CI 0.29,0.80, $p<.01$)) • Not significant at other intervals • **Workplace injuries related to violence:**	Strength: **Strong** Quality: **High** • Sufficient power • Groups assessed concurrently at 6-month intervals • GEE analysis used to control for cofounders • Targeted high risk areas • Randomization to groups • Involvement of stakeholders **Sample Action Plans:** Environment: Increase frequency of security rounds, locked units Administration: Staffing mix in scheduling; monthly WPV meeting with hospital safety, occupational health and security

Study/Design	Methods	Results	Comments
incidence and outcome injury	reporting system linked to the hospitals human resources system. • Action plan: Online survey for supervisors to determine implementation of planned strategies in intervention groups and control groups implemented any prevention plans	• More total number of workplace injuries reported in intervention group (not significant) • No statistically significant findings at 6,12, or 18 months • Statistically lower risk of workplace injuries at 24 months on intervention units: IRR 0.37, 95% CI, 0.17-0.83, $p<0.05$	Behavior: consumer service and active shooter education, team building exercises, de-escalation training, debriefing, use of online training for education delivery
Brunero et al. (2021) Uncontrolled Before and After (mixed methods study using a sequential explanatory design that comprised an UCBA and followed by a qualitative study to evaluate the effectiveness of the intervention) Aim: To determine the	N= 49 (local managers, educators, and senior managers) Setting: 450 bed tertiary care center in Sydney, Australia High risk violent settings: med/surg wards, respiratory/infectious disease, spinal care, renal care, corrections health, rehab Educational Strategy: A single Tabletop exercise (length of time not provided) • Standardized scenario (created from amalgamation of actual events) • Round table style discussion • Presentation slides and facilitated open discussion Outcomes and Measures: • Baseline and 2 weeks post exercise • Participants' confidence and understanding of code black experiences measured using 10-point Likert scale (1= no confidence, 10=	**Understanding personal role during code black** Pre-test: M=6, Post-test: M=9 U= 235.5, $p<0.001$ **Understanding co-worker's roles during code black** Pre-test: M=6, Post-test: M=9 U=197.5, $p<0.001$ **Understanding roles of code black response team** Pre-test: M=6, post-test= 9 $U=171$, p<0.001 **Understanding strategies for managing violence within the zero-tolerance policy** Pre-test: M=6, Post-test: M=9 U= 19, $p<0.001$ **Overall confidence in managing violence**	Strength: **Weak** Quality: **Medium** • Staff RNs not included in sample • Baseline sample characteristics not provided • No control groups • No matching of participants pre and post study • Poor retention:73% • Did not control for confounding with statistical analysis Role Clarity: Participants note that ongoing simulation training helps with role ambiguity

Study/Design	Methods	Results	Comments
effectiveness of tabletop exercises in preparing health care workers in violence prevention and management in a tertiary care center	complete confidence) created for the study (R&V) Analysis Mann-Whitney *U* test	Pre-test: M=6, Post-test: M=9 *U*= 82.5, *p*<0.001	Adult Learning: Safe, calm learning space helped participants identify learning gaps, roles, interventions, and strengths Organization Support: Transparent process, policies, frequent core training, emotional support to overcome potential barriers
Lamont, S. & Brunero, S. (2018) Uncontrolled Before and After Purpose: To examine effects of a workplace violence training program within an acute hospital setting of areas identified as high risk	N= 78 nurses (Clinical nursing, senior nursing, assistant nursing roles) Setting: 440 bed metropolitan tertiary care hospital in Sydney, Australia • Acute care, long term care, and community Educational Strategy: One day workshop • Led by 2 Mental Health Liaison Nurse Consultants (experts) • Education delivered through enquiry-based learning, simulation, and psychomotor training Outcomes and Measures: (pre workshop and two weeks post workshop) • Demographic Data: Questionnaire Data collection instruments V & R • Change in health practitioners' clinical behaviour intentions: Continuing	**Formulating a risk assessment and management plan:** 1) Intention: -2.172 (*p*=0.033) 2) Social influence: -3.713 (*p*<0.001) 3) Beliefs & capabilities: -7.903 (*p*<0.001) 4) Moral norms: -3.42 (*p*=0.001) 5) Beliefs about consequences for each objective: -2.429 (*p*=0.017) **Using de-escalation techniques** 1) Intention: -2.525 (*p*=0.013) 2) Social influence: -3.887 (*p*<0.001) 3) Beliefs & capabilities: -6.288 (*p*<0.001) 4) Moral norms: -2.923 (*p*=0.005) 5) Beliefs about consequences for each objective: -2.954 (*p*=0.004)	Strength: **Weak** Quality: **Medium** • 75% retention • Adequate sample size with power of 80% (required to be 71) • Questionnaires were matched pre and post education • Did not control cofounders with statistical analysis • Definition of Likert Score values not provided

Study/Design	Methods	Results	Comments
	Professional Development Reaction Questionnaire (12-point Likert scale) • 5 constructs evaluated in each objective: 1) Intention, 2) Social influence, 3) Beliefs & capabilities, 4) Moral norms, 5) Beliefs about consequences for each objective • Confidence in managing verbal and physical aggression: Confidence in Coping with Patient aggression instrument (10 point Likert scale) <u>Analysis</u> - Means, Standard deviation, Paired t-test	**Breakaway techniques:** 1) Intention: -5.340 (p<0.001) 2) Social influence: -0.836 (p=0.406) 3) Beliefs & capabilities: -6.450 (p<0.001) 4) Moral norms: -3.305 (p=0.001) 5) Beliefs about consequences for each objective: -10.796 (p<0.001) **Confidence in coping** -10.769 (p<0.001)	
Story et al. (2020) Uncontrolled Before and After Aim: To determine how a workplace violence prevention training program impacts nurses' perception and confidence of violent and	N= 43 nurses (930 eligible nurses) <u>Setting:</u> 361 bed Academic HealthCare Center acute care hospital in midwestern USA <u>Educational Strategy:</u> 2-hour classroom training using PowerPoint presentation, case scenario, video, role playing, Q&A, handouts Training education included: • WPV defined, 4 types of WPV • Aggression/violence recognition • Behaviour management techniques • Response plan/reporting <u>Outcomes and Measures:</u> Staff's perceived confidence: Confidence in coping with patient aggression instrument (V & R) 10 items • 11-point scale: 1= very uncomfortable, 11= very comfortable	**Confidence in Coping (all 10 items)** • Baseline M= 55.1 • 3 months post training M=75.8 37.6% increase in confidence in coping with aggression (p=.0000) • Retention of knowledge maintained at 3 month follow up (M=79 (immediately after intervention), Decrease of 2.2 at 3 months but not statistically significant (M=75.8, p=0.700) **Perception with Violent Events** • Pre training M= 6.73 • Post training M= 8.32 23.6% increase in comfort in dealing with aggressive patients (p=.0066) **Confidence with Aggression and Violent Events**	<u>Strength:</u> **Weak** <u>Quality:</u> **Medium** • Poor response rate • Poor retention of participants for follow up (22 participants of initial 43 returned 3-month survey) • Did not control or confounders with statistical analysis

Study/Design	Methods	Results	Comments
aggressive encounters	• Survey conducted at baseline, immediate post training, and 3 months post training Analysis: Means, Friedman test, Bonferroni correction	• Pretraining M= 6.37 • Post training M= 7.91 24.4% (p=.0726) felt self-assured in the presence of aggressive patient: not significant but exceed the 5% increase expectation of the study (percentage of confidence value not provided for pre-training)	

Appendix B: Environmental Scan Report

The Development of a Workplace Violence Education Huddle Program and Facilitator's Manual: A Review of the Literature

Allison Bragg, 201122595

Memorial University of Newfoundland and Labrador

Workplace Violence (WPV) is defined as any verbal or physical violent act or threat directed toward working persons (National Institute for Occupational Safety and Health (NIOSH), 2020). Type two violence, or customer/client violence, is the most common source of violence in healthcare (Registered Nurses Association of Ontario (RNAO), 2019). When compared to other healthcare professionals, nurses are at the highest risk of WPV due to their direct and continued contact with patients (International Council of Nurses (ICN), 2000). WPV has been an issue for nurses on 4NB. The patient population served on the unit such as patients with traumatic brain injuries, confusion from anesthetic or infection, and substance misuse and abuse increase the risk of violence. Nonetheless, the risk of exposure to verbal and physical violence exists in the absence of these risk factors in patients and visitors who are alert and orientated.

The aim of this practicum project is to develop a resource to help prevent and mitigate nurses' risk for WPV perpetrated by patients and visitors. From the literature review, various education and training methods have been employed in an attempt to reduce WPV and increase nurses' knowledge and confidence. In order to create a resource that best meets the needs of the nurses of 4NB, an environmental scan is required to determine what strategies and resources already exist.

The purpose of this environmental scan was to determine the current content and delivery methods used to address the issue of WPV in acute care and to determine the guidelines surrounding WPV that have been implemented by regional health authorities (RHAs) in the province. Current resources used and promoted nationally and internationally could be modified to fit the needs of the nurses of 4NB. Using content analysis, the strategies, interventions, and resource content retrieved in the environmental scan will be outlined to assist with the

development of a WPV resource for the nurses of 4NB.

Objectives of the Environmental Scan

The objectives of the environmental scan were as follows:

1. To find specific examples of current workplace violence resources for nurses and healthcare workers,
2. To review current EH and other NL RHA policies and procedures for managing, preventing, and reporting workplace violence (e.g. Central Health, Western Health, and Labrador-Grenfell).

Data Collection Methods

The environmental scan was conducted on three targeted sources: specific WPV toolkits and resources used in other Canadian provinces, international WPV education and recommendations, and the policies and procedures developed in each RHA in Newfoundland and Labrador (NL) in relation to WPV. The environmental scan of specific resources was limited to Canada. The rationale for this limitation was that these resources would be delivered in healthcare authorities that shared a similar culture and characteristics to that of the NL healthcare authorities. On an international level, efforts and strategies suggested by large reputable organizations such as the ICN, NIOSH, and the World Health Organization (WHO) were reviewed to provide direction for the creation of a WPV prevention and management resource. Lastly, WPV policies in Eastern Health (EH), Central Health (CH), and Labrador-Grenfell Health (LGH) were reviewed and compared to identify the current guidelines regarding preventing and managing WPV and any limitations of the policies currently used in EH.

Canadian Workplace Violence Education and Training

Violence prevention information and training plans from Canadian healthcare authorities,

specifically British Columbia (BC), Ontario, and Nova Scotia (NS) provided insight into current training programs, education plans, and potential templates. The Canadian Federation of Nurses Union (CFNU) provided a centralized location of various WPV prevention toolkits used across Canada. Provincial health authorities, Registered Nurses's (RNs) unions, and occupational health and safety websites for BC, Ontario, and NS were accessed to determine WPV prevention resources that were available to nurses and healthcare professionals.

International Workplace Violence Education

Large reputable health related organizations were searched on the internet. International resources that were publicly available were accessed. Of specific interest was a training manual developed by the ICN, International Labour Organization, WHO, and Public Services International (2005). This training manual provided an in-depth guide for the development of a resource or program to target WPV in the healthcare sector. Additionally, the NIOSH (2020) provided a free access asynchronous online learning module for WPV.

Newfoundland and Labrador Regional Health Authorities

Policies and procedures from EH were acquired using the intranet. The Human Resources (HR) department for the other three RHAs in the province were contacted to avail of any WPV policies in their healthcare authority. WPV prevention and management policies for CH, LGH, and EH were obtained. Despite continued efforts, the policies for WH were unable to be obtained at this time.

Data Analysis and Management

Information obtained from these resources were saved electronically on a personal, password protected computer. Each provincial and international resource was placed in an electronic file and separated based on location. The policies and procedures for each RHA were

separated and colour coded. Content analysis was used to analyze the data retrieved. The data were analyzed to determine the content and delivery methods used and recommended nationally and internationally as well as the current guidelines, roles, recommendations, and practices used in the RHAs.

Relevant and useful data was compiled into four separate tables. Three tables focused on the education content and delivery used in BC, NS, Ontario, and by the international organizations: the first table provided a detailed outline of the interventions and strategies used or recommended (Appendix A), the second table addressed the education content (Appendix B), and the third simplified the delivery methods used (Appendix C). A separate table was created for the policies used in the RHAs in relation to WPV (Appendix D). This table was categorized based on roles and responsibilities, interventions, and policies.

Ethical Considerations

The Health Research Ethics Authority Screening Tool was completed (Appendix E). Based on the results, ethical approval was not required for this project. The resources provided from websites are readily available to the public. RHA and WPV resources were referenced appropriately.

Results

The results obtained from the environmental scan are divided into two sections: educational content and delivery methods used nationally and internationally, and an overview of policies used in the RHAs in relation to WPV. NS, BC, Ontario, and international organizations have created educational curriculums, implemented sessions, or developed evidence-based guidelines to facilitate education of WPV. An overview of these resources, the educational

content, and the methods of delivery are presented in this section.

Overview of Educational Curricula and Resources

The Nova Scotia Health Authority (NSHA) adopted the Nonviolent Crisis Intervention (NVCI) from the Crisis Prevention Institute (CPI) for healthcare professions in level 2 or 3. Staff from the NSHA received training from the CPI to become a trainer for NVCI. Factors that determine the healthcare professionals' level of risk or the delivery method in which this training was provided was not discussed. Nonetheless, the NSHA recommend bi-annual recertification (NSHA, 2018).

The BC healthcare authority aimed to address WPV management and prevention through the creation of their own resource, the Provincial Violence Prevention Curriculum (PVPC) (Health Employers Association of British Columbia, n.d.). The BC PVPC was created in 2010 and revised in 2015 to include trauma informed care, dementia care, and pediatric care. Education is offered through a combination of e-modules, classroom sessions, and re-fresher training. The PVPC education program theory is comprised of three parts: formal education; learning and applying in the workplace; and support, reporting, and follow up (Provost et al**.,** 2020). A total of fifteen recommendations for violence prevention education in healthcare is provided. These recommendations focus on the development of a baseline knowledge, active learning, the need for refresher education, and support post violent incidence. Some of these recommendations will be addressed in the upcoming section regarding the delivery of education.

The RNAO (2019) created an evidence-based practice guideline for dealing with WPV. The guideline addressed several areas involved in reducing and managing WPV, one of which was education. Educational suggestions and assessment tools provided in this guideline will be discussed later in this report.

The ICN et al. (2005) created a framework for a training manual that addressed WPV in the healthcare sector. The goal of training was to facilitate action through being adaptable to the setting. The manual suggested a three-day training program using a mixture of educational strategies that will be discussed in upcoming sections.

Educational Content

The education content required in a WPV resource was identified by the topics covered in the education provided in NS and BC, as well as the suggestions made by RNAO (2019) and the ICN et al. (2005). A condensed overview of the education suggested in the three Canadian provinces and internationally can be found in Appendix B. First and foremost, the need to have an awareness and understanding of violence was recommended by the RNAO (2019) and the ICN et al. (2005) and addressed in the PVPC (Health Employers Association of British Columbia, n.d). Due to the workplace culture of violence being accepted as a "part of nursing" (Horgarth et al., 2016. p. 78), this is critical starting point. Identifying factors that contribute to violence was an educational component that was incorporated in the education officered in NS (CPI, 2021) and BC (Health Employers Association of British Columbia, n.d) and a recommendation put forth by the RNAO (2019). Communication skills in regard to de-escalating situations and responding to aggressive situations were identified as a critical component of education in all of the resources that were assessed (CPI, 2021; Health Employers Association of British Columbia, n.d; ICN et al., 2005; RNAO, 2019). The legal aspects of WPV (RNAO, 2019) and the rights and responsibilities of nurses, patients, and visitors (ICN et al., 2005) were areas that were suggested to be covered in these guidelines and covered by the education delivered in NS (NSHA, 2018). Reporting, an important part of dealing with WPV was covered in the PVPC (Health Employers Association of British Columbia, n.d) and the online education promoted in

NS (Aware-NS, 2020a). Lastly, the importance of post-incidence debriefing was addressed in the education provided by two of the Canadian healthcare authorities (CPI, 2021; Health Employers Association of British Columbia, n.d).

Educational Strategies

From the environmental scan it was determined that education has been delivered using asynchronous online education and in person. Suggestions for education delivery were provided by the RNAO (2019), the ICN et al. (2005), and the education recommendations put forth by BC (Provost et al**.,** 2020). Asynchronous online education, in person education, and assessment tools will be discussed in this section. An overview of the method of delivery can be found in Appendix C.

Online Education

Online education is a frequently used medium to reach a larger number of people in various locations. Asynchronous online education is currently being used by the BC Health Authority, the NIOSH, and the NSHA to deliver education regarding WPV prevention. From evidence-based research conducted by the RNAO (2019) online education is suggested for adult learning as it assist with the development of fundamental skills and techniques.

In BC, the PVPC entails an online learning module for all members of the healthcare team (Health Employers Association of British Columbia, n.d.). Nurses in areas that are deemed to be low risk of violence are to complete a 7-part 3-hour e-module. Those who work in an area of medium to high risk are to complete an eight-part 3.5-hour e-module covering the same information with an added module on creating behavioural care plans. No information on what the healthcare authority defines to be low, medium, or high risk was provided. However, the education is mandatory and monitored in certain regional authorities in the province such as

Vancouver Costal Health (n.d).

Internationally, the NIOSH (2020) provides an online WPV prevention module from the Center of Disease and Control that addresses type two and type three (i.e. worker to worker), violence. The online education defines WPV, discusses risk factors, prevention strategies for nurses and the organization, and response after violent encounters. Education is provided using slide shows and personal stories of nurses who have experienced WPV from patients. A quiz is provided after each module with an additional section that promotes active learning through thought provoking exercises.

Similar to BC, all staff of the NSHA receive level one education through two e-learning modules (NSHA, 2018). These modules provide an overview of the Internal Responsibility System and the employee and employer roles, responsibilities and rights. Online education is also provided in the NSHA for incident reporting (Aware-NS, 2020a), highlighting the importance of incident reports after violent encounters.

In-Person Education

While online education is gaining traction in a multitude of places, in person education remains relevant. Methods incorporated in in-person education that have been used nationally and internationally are open discussions, case studies, in-service sessions, and simulation training.

Open Discussions. The ICN et al. (2005) determined that group discussions were useful in the delivery of WPV education. The BC's PVPC suggest interactive discussions to provide formal education (Provost, 2020). Safety huddles have been suggested in learning and applying in the workplace to discuss safety as a part of culture. To provide a medium for open discussions, safety huddles have also been utilized in the NSHA in effort to manage and reduce WPV

(Aware-NS, 2020b). When concerns regarding WPV arise, the safety huddles are initiated. These huddles are kept to approximately 15 minutes and are used to ensure communication and awareness between front line workers and nurse managers or unit leaders. These huddles keep staff members informed and allow discussion about safety concerns. The utilization of these huddles contributes to problem solving skills and aid in the follow-up of issues. In supporting and following up after violent encounters, the PVPC suggest team discussions and debriefs (Provost et al**.,** 2020).

Case studies. Case studies have been deemed to be effective in the delivery of education to adults regarding WPV (ICN et al., 2005). In the training manual, case studies of type two and type three violence were provided. For example, one study examined a nurse who worked in long term care and felt that violence was a part of her job due to the age and situations of her patients. In providing formal education in BC's PVPC, actual lived stories of nurses' experiences with WPV and examples specific to the clinical area are recommended (Provost et al**.,** 2020). Additionally, from evidence-based research, the RNAO (2019) suggest open discussions of personal stories to support and promote the reporting of violent incidences.

In-Service Session. The RNAO (2019) recommended in-service sessions to raise knowledge and awareness of therapeutic tools such as de-escalation techniques. The handouts and power-point presentations suggested by the international groups (ICN et al., 2005) could be incorporated into these sessions.

Simulation Training. The RNAO (2019) recommend simulation training in the delivery of WPV education. Using evidence-based research, the RNAO (2019) determined that simulation training is beneficial as it offers a safe space for learning. It was suggested that role playing of real clinical situations be used to provide learning in a controlled area. Moreover,

simulation training encourages interprofessional teamwork (RNAO, 2019). Practicing and team training are also suggestions offered by the BC health authority in learning and applying in the workplace based on the implementation of the PVPC (Provost et al**.,** 2020). While these recommendations are evidence-based, there are no further suggestions or outlines provided in the delivery of this recommendation.

Assessment Tools

The use of assessment tools is a resource of importance in both the NS and Ontario programs and identified as a method of violence prevention by the NIOSH (2020). The NSHA created the Violence in the Workplace Hazard Identification Form (Capital Health, 2009). This form is a chart that identifies the risk of violence based on the score obtained from various questions. The Public Services Health and Safety Association (PSHSA) (2017) in Ontario created an Acute Care Violence Assessment Tool (VAT). This tool helps staff to score a patient's risk of violence and any triggers that may exacerbate the situation. The VAT is presented as a check list and a poster for quick reference. Suggestions for most appropriate placing of the poster is not provided. Similarly, the NIOSH (2020) recommends a triage tool and an indicator for violent behaviour tool to assess for the potential of violence. The triage tool is comprised of five yes or no questions to determine a patient's potential for aggression. The acronym STAMP is used as an indicator for violent behaviour. The patient or visitor will be assessed based on staring or eye contact, tone and volume of voice, presence of anxiety, mumbling speech, and pacing. A modification to this acronym, STAMPEDAR, was suggested by the RNAO (2019). The acronym STAMPEDAR recognizes additional risks posed by the emotions, disease processes, and assertiveness of the individual and the resources of the staff and facility. In comparing the assessment tools used, the VAT, triage tool, and the STAMP or

STAMPEDAR acronym is more user friendly than the Workplace Hazard Identification Form. Additionally, the VAT takes the nurse's workload into account.

In Ontario, the RNAO (2019) provides additional assessment forms and tools for dealing with WPV. In particular for acute care settings is the Aggressive Behaviour Assessment Tool (BRAT), a tool supported by the RNAO (2019). This tool is a ten item yes or no assessment tool evaluating areas such as anxiety, staring, history of violence or mania, and confusion or cognitive impairment. Additionally, the preparing for a meeting with a potentially violent client is an useful guide provided by the RNAO (2009). Information on communication, body language, and terminating relationships with an aggressive client is provided in this guideline.

Policies and Procedures

The WPV policies used in EH (2013), Central Health (CH) (2011), Western Health (WH), and Labrador Grenfell Health (LGH) (2018) can help determine areas that have been recognized to be important in WPV prevention and areas in which need improvement. As mentioned, violence prevention policies were received from three of the four RHAs in the province, EH, CH, and LGH. WPV policies that outline the roles and responsibilities of professionals involved in preventing, managing, and following up on WPV reports are available in three of the RHAs. There are policies relating to WPV that are available in EH but not used in LGH or CH. The following section will provide details on these policies.

Workplace Violence Prevention Policies

Each policy for the three RHAs clearly state that WPV will not be tolerated and followed a similar pattern in addressing and preventing potential violent encounters. The policies each outlined the roles and responsibilities of specific employees and departments and addressd the need for education and training.

Roles and Responsibilities. Following a similar format, the roles and responsibilities of management and supervisors, employees, and occupational health and safety (OHS) are outlined in the policies from each RHA. The roles and responsibilities of the employees and departments of the three RHAs are similar. EH (2013) includes the roles and responsibilities of protection services, a department not addressed in CH or LGH.

***Management and Supervisors*.** Each RHA includes the same expectations for their leaders. Identifying risk and informing staff of risk of violence from patients and visitors is a responsibility of all managers. The inclusion of a violence prevention checklist in semi-annual inspections is a role of the managers of LGH that is not expected in CH or EH as per their policies. The provision of direction to the employee family assistance program (EFAP) is noted in all three of the policies to provide support for employees after a violent encounter if required. However, in EH (2013) this responsibility is placed on the department of Human Resources (HR) and not the manager.

Employees. It is the employee's responsibility to tell patients and visitors that aggressive behaviour is not accepted (EH, 2013; LGH, 2018). The requirement of nurses to set these boundaries is important. The duty of employees to identify potential risks and report potential indicators and actual incidences of violence is outlined in each RHA's policy (EH, 2013; LGH, 2018; CH, 2011). However, suggestions for how to set boundaries and actions to identify risks was not provided in these specific policies. Nonetheless, identifying risks were outlined in an additional policy in EH addressing preventing and managing WPV in the emergency department (ED) (EH, 2018).

***Occupational Health and Safety*.** The input of OHS in developing, establishing, implementing, and providing recommendations regarding WPV is identified in all three RHAs

policies. OHS in EH (2013) and LGH (2018) also have the role of reviewing WPV incidence statistics to determine trends.

Protection Services. EH (2013) is the only RHA that addressed the roles of protection services in preventing and managing WPV. The establishment of code white teams, the conduction of risk and targeted violence assessments, and consultations with program managers and employees regarding recommendations based on assessments are identified roles of protection services.

Education and Training. The provision of education and training is addressed by each RHA. EH (2013) aims to review the violence prevention policy in general orientation, orientate staff to code whites based on the respective site, and provide additional education and training as deemed necessary by management. LGH's (2018) policy does not comment on general orientation but mentions employees and managers attending WPV training identified by the healthcare authority. Responsibility of WPV education and training is placed on both managers and employees in all RHAs. Managers must provide their employees with training and education based on the risk of WPV and employees must take responsibility for their own learning and complete the education. However, neither policy from the RHAs indicate that education is mandatory or if completion will be monitored. Moreover, the method by which education will be provided, how to find the education session, the need for annual training, or the importance of refresher courses is not identified in either policy.

Aggressive Violent Behaviour. The Aggressive Violent Behaviour (AVB) policy was provided by Eastern Health (2017) and a similar policy was not identified in the other RHAs. An AVB alert can be issued based on any behaviour that staff deem to put them at risk of injury. This policy allows communication amongst healthcare providers to ensure safety of all

employees. The process for assigning an AVB designation, how to communicate the designation with other healthcare employees who have contact with the patient, and process for reviewing the designation is outlined in the policy. The decision to place an AVB alert on a patient occurs in consultation with the clinical team. Once the decision is made to issue the alert, the employee must document the violent episode in the chart, complete a Clinical Safety Reporting System (CSRS) report and the Employee Incident Report and Investigation form, notify the department manager or manager on call, and connect with site security. The patient will then be moved to a private room. An AVB designation is communicated using an electronic flagging system and visual cues. An AVB alert is entered into Meditech and a purple sticker is placed on the patients' chart or white board that is not visible to the public, and a sign specific to the policy, which prompts individuals to check with nursing staff prior to entering the room, is placed on the patient's door. An AVB alert remains on the patient's file for future admissions until they decide to have it reviewed through contacting client relations. However, depending on the circumstance surrounding the aggressive behaviour, the AVB alert may or may not be removed.

Preventing Workplace Violence in the Emergency Department. EH (2018) also provides a policy on prevention and management of WPV in the ED. Once again, a policy similar in nature was not identified in the LGH or CH. The risk factors for violence, de-escalation techniques, and calling code whites are outlined in the policy. Information extends into the involvement of police if the situation moves beyond the control of security or involves participants that are not receiving patient care and cannot be managed. Code whites are outlined in further detail in a separate policy. Since violence can occur on any unit within EH, it is interesting that this policy is directed towards the ED only as information such as the identified risk factors and de-escalation techniques is applicable for other units.

Summary of Findings

Asynchronous online education provides passive education has been used to deliver information to healthcare providers, delivering a baseline of knowledge that can be built upon. However, from the recommendations and guidelines set forth by the RNAO (2019), the ICN et al. (2005), and the PVPC (Provost et al.**,** 2020) it is evident that there is great value in active learning techniques such as case studies, open discussions, and simulations. In consultations, the preference of synchronous online education or in person education to deliver this information will be investigated.

The policies and procedures provided by the RHAs in relation to WPV provide an outline of the roles and responsibilities of the healthcare professionals who have a role in the prevention and management of WPV. These policies outline what is expected of nurses and what they are required to know. One short coming of the policies was the lack of direction in fulfilling specific roles. Nonetheless, specific policies used in EH provide direction for recognizing, preventing, managing, and communicating the occurrence of aggressive behaviours of patients and visitors.

Conclusion

The environmental scan provides valuable information on the content and delivery methods of education that currently exist and how the issue of WPV is addressed by EH, CH, and LGH. In delivering education, online modules have been implemented and delivered on a provincial and international level. From the international training manual (ICN et al., 2005), PVPC (Provost et al., 2020), and RNAO (2019) it is recognized that education should be potentially extended beyond virtual learning to have a greater impact. Other strategies such as open discussion, the use of case studies, in-services supplemented with handouts and power point presentations, and simulations have been recommended nationally and internationally.

From the WPV resources and the RHAs policies identified important topic to address in a resource are: defining WPV, recognizing roles and responsibilities, reporting and debriefing, follow-up, and information and actions to prevent and manage violence. It is through assessing these educational tools and resource content that potential resources for the nurses of 4NB can be developed.

References

Aware-NS. (2020a). *Incident reporting.* https://sg7.82b.myftpupload.com/courses/incident-reporting/

Aware-NS. (2020b). *Safety huddles tip sheet.* https://secureservercdn.net/45.40.148.234/sg7.82b.myftpupload.com/wp-content/uploads/2020/12/3-LL-Safety-Huddles-Tip-Sheet.pdf

Capital Health. (2009). *A guide to workplace violence prevention program.* https://www.cdha.nshealth.ca/safety-injury-prevention/workplace-violence-prevention

Central Health. (2011, July 5). *Violence prevention.* Central Health

Crisis Prevention Institute. (2021). *Nonviolent crisis intervention.* https://www.crisisprevention.com/en-CA/Our-Programs/Nonviolent-Crisis-Intervention

Eastern Health. (2013, August 5). *Violence prevention, response and support.* Eastern Health.

Eastern Health. (2017, December 13). *Aggressive-violent behaviour (AVB) alert (acute care only).* Eastern Health.

Eastern Health. (2018, May 4). *Prevention and management of violence/aggression in the emergency room.* Eastern Health.

Employers Health Association of British Columbia. *Violence prevention.* https://www.heabc.bc.ca/Page4270.aspx#.YMOszy0ZM6g

Hogarth, K., Beattie, J., & Morphet, J. (2016). Nurses' attitudes towards the reporting of violence in the emergency department. *Australasian Emergency Nursing Journal, 19,* 75-81. http://doi.org/10.1016/j.aenj.2015.03.006

International Council of Nurses. (2009). *Prevention and management of workplace violence.* https://www.icn.ch/sites/default/files/inlinefiles/PS_C_Prevention_mgmt_workplace_violence.pdf

International Council of Nurses. (2000). *Abuse and violence against nursing personnel.* http://www.icn.ch/psviolence00.htm.

International Labour Organization, International Council of Nurses, World Health Organization (WHO), & Public Services International. (2005). *Framework guidelines for addressing workplace violence in the health sector: The training manual.* https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_1088542.pdf

Labrador-Grenfell Health. (2018, January). *Workplace violence prevention.* Labrador-Grenfell Health.

Nachreiner, N. M., Gerberich, S. G., Ryan, A. D., McGovern, P. M. (2007). Minnesota nurses' s study: Perceptions of violence and the work environment. *Industrial Health, 45*(5), 672-678. https://doi.org/10.2486/indhealth.45.672

Nova Scotia Health Authority. (2018). *Improving workplace safety in Nova Scotia's community emergency department: Annual progress report January 2018.* https://www.nshealth.ca//sites/nshealth.ca/files/workplace-safety-progress-report-nsha-final.pdf

Provost, S., MacPhee, M., Daniels, M., & McLeod, C. (2020). *Realist evaluation of violence prevention in BC healthcare.* http://pwhr.sites.olt.ubc.ca/files/2021/01/REVPE-WorkSafeBC-Final-Report-Dec-2020.pdf. Partnership for work, health, and safety.

Public Services Health and Safety Association. (2017). Individual client risk assessment toolkit for healthcare settings. https://workplace-violence.ca/wp-content/uploads/2021/04/VPRASEEN0417-ICRA-Toolkit-Resource-Manual-V1.3-2017.12.12.pdf

Registered Nurses Association of Ontario. (2009). *Preventing and managing violence in the workplace.* https://rnao.ca/sites/rnaoca/files/Preventing_and_Managing_Violence_

in_the_Workplace.pdf

Registered Nurses Association of Ontario. (2019). *Preventing violence, hassasssment and bullying against healthcare workers.* www.RNAO.ca/bpg

The National Institute for Occupational Safety and Health (NIOSH). (2020, September 20). Workplace violence prevention for nurses. Occupational Violence. https://www.cdc.gov/niosh/topics/violence/training_nurses.html

Vancouver Coastal Health. (n.d). *Violence prevention.* https://vchorientation.ca/non-point-of-care/violenceprevention/#resource

Appendix A

Table 1

Current Workplace Violence Resources for Nurses utilized or suggested by Health Authorities in Ontario, British Columbia, Nova Scotia, by and International Organizations

Strategy	Ontario	BC	NS	International
Online Education	• Online education is a suggested delivery approach for adult-learning • Suggest to use modules, videos and discussion boards, or a series of courses with written assignments • Advantage: content can include various learning methods and it can be tailored to fit the learners needs • Fundamental skills and techniques and can be developed by using online interactive assessments and detailed explanations to enhance content	Provincial violence prevention curriculum (PVPC) • Low risk: 7 parts 3hr e-module Topics covered: 1) Introduction to violence prevention, 2) recognizing risk and behaviours, 3) point of care risk assessments, 4) de-escalation communications, 5) de-escalation strategies, 6) determining when to get help, and 7) reporting and communicating post-incidence • Medium to high risk: 8 part 3.5 hr e-module	• All nursing staff complete 2 e-modules • Overview: internal responsibility system, roles, and responsibilities • Online education for incident reporting	NOISH online education module from CDC • Free access • Covers type two (i.e., client/customer violence) and type three (i.e., worker to worker) violence • American based • Videos from nurses sharing their experiences of WPV • Slideshow provides passive education • Divided into units covering: o Definitions, types, and prevalence o WPV consequences

	understanding and learning • Online learning is cost-effective and reduces travel time RNAO (2019)	Topics Covered: Same as low risk with one added module on creating behavioural care plans • Graphics, video and quiz at the end of each module for both low and medium to high risk education		○ Risk factors for type 2 violence ○ Risk factors for type 3 violence (not applicable for this project) ○ Prevention strategies for organizations ○ Prevention strategies for nurses ○ Intervention strategies ○ Post event response ○ 5 case study units • Case studies with videos and discussion questions
Educational Curriculums and Resources	The RNAO (2019) created practice guidelines • Recommendations for dealing with workplace violence • Uses evidence-based research • Recommends education	• Online, classroom, and refresher training • 15 recommendations for violence prevention education in healthcare divided into three categories: 1) formal education: baseline knowledge	Nonviolent Crisis Intervention (NVCI) • Adopted from the Crisis Prevention Institute (CPI) • Used for healthcare professions in level 2 or 3. • Staff from the NSHA received training from the	The ICN, WHO, Public Services International, and International Labour Office (ILO) (2005) created a framework for a training manual addressing workplace violence in the healthcare sector

	• Defines violence or unacceptable behaviours
	• Risk factors:
	  ○ Behavioral or psychological
	  ○ Biological
	  ○ Environmental or situational
	  ○ Socioeconomic
	• Assessment using promoted assessment tools, potential solutions such as de-escalation techniques, and managing aggression
	• Related ethical and legal issues
		2) learning and applying in the workplace
		3) support and follow up: continuing education and support/follow up post violent incident.
			CPI to become a trainer for NVCI
			• Overview: communication skills, responding to defensive behaviours, environmental factors, and post incidence debriefing
			• Content delivery is not identified
				• Goal of training: facilitate action through being adaptable to the setting.
				• Topics to be covered in a training program:
				1) awareness and understanding of violence,
				2) rights and responsibilities,
				3) choosing the best approach, recognizing, and
				4) assessing violence, intervention, monitoring, and evaluation.

Assessment Tools	Acute Care Violence Assessment Tool (VAT) (RNAO, 2009) • Score a patient's risk of violence and any triggers that may exacerbate the situation • Check list • Poster for quick reference (no		Violence in the Workplace Hazard Identification Form • Chart that identifies the risk of violence based on the score obtained from various questions • Lengthy to complete	NOISH (2020) recommend: Triage tool • 5 Yes/No questions to determine the needs of the patients and their potential for violence Indicator for Violent Behaviour

	placement suggestion) • User friendly Aggressive Behaviour Risk Assessment Tool (ABRAT) (RNAO, 2019) • 10 yes/no questions • Specific to medical/surgical areas • Anxiety, history, confusion/cognitive impairment, shouting, staring, agitation Preparing for meeting with a potentially violent client tool (RNAO, 2009) • Guideline • Communication • Body language • Terminating relationships with an aggressive client Acronym STAMPEDAR: Risk of violence and corresponding cues (RNAO, 2019) • **S**taring and eye contact			• Acronym STAMP: Five distinctive elements of observable behavior that indicate the potential for violence in patients and visitors • **S**taring and eye contact • **T**one and volume of voice • **A**nxiety • **M**umbling • **P**acing Danger Assessment Tool • Typical indicators to determine a person's immediate danger to others • Indicators assessed: o Assaultive or homicidal ideations o History of assault/homicide o Substance misuse o Support system o Plan and obtainable means • Rated on scale of 1-5: ranges from no

	• **T**one and volume of voice • **A**nxiety • **M**umbling • **P**acing • **E**motions • **D**isease process • **A**ssertiveness • **R**esources			predictable risk of assault or homicide (1) to very high risk of homicide (5)
In- Service	In-service sessions to raise knowledge and awareness of therapeutic tools such as de-escalation techniques (RNAO, 2009)			Handouts and PowerPoint presentations recommended that could be used for in-service education
Case Study		Formal Education: • BC's PVPC • Actual lived stories and examples specific to the clinical area are recommended (Provost et al**.,** 2020).		Suggested in the training manual to provide education.
Open Discussions		Formal Education: • BC's PVPC • Interactive discussions • Safety huddles Supporting and following up:	Safety huddles • Initiated when concerns regarding workplace violence arise • Approximately 15 minutes	

		• BC's PVPC • Team discussions and debriefs	• Ensure communication and awareness between front line workers and nurse managers and unit leaders. • Keep staff members informed and allow discussion about safety concerns. • Contributes to problem solving skills • Aid in the follow-up of issues	
Simulation	• Realistic, safe space for learning to occur • Strategies include role playing real clinical situations in a controlled area • Encourages interprofessional teamwork • Attitudes can be addressed, and safety can be improved (RNAO 2019)	Learning and applying in the workplace: • Practicing and team training		
Continuing Education	• Based on evidence based research, the RNAO suggest consistent	• PVPC education mandatory in some BC healthy authorities	• Bi-annual NVCI recertification recommended	

	reinforcement and support for re-education to integrate learned techniques and strategies into clinical practice • Yearly mandatory re-education is required within some organizations • Leadership and organizational support are instrumental to successful organizational culture changes and continued education			

Appendix B

Table 2

Education Content utilized or suggested by Health Authorities in Ontario, British Columbia, Nova Scotia, and International Organizations

Education Content	Ontario	BC	NS	International
Define/Develop Understanding of WPV	X	X	X	X
Risk Factors of WPV	X	X	X	X
Communication and De-escalation Skills	X	X	X	X
Legal Aspects: Rights and Responsibilities of Patients, Visitors, and Nurses	X	X	X	X
Reporting	X	X	X	X
Debriefing	X	X	X	X

Key: X: Content not included X: Content included

Appendix C

Table 3

Education Content Delivery Methods utilized or suggested by Health Authorities in Ontario, British Columbia, Nova Scotia, and International Organizations

Content Delivery Methods	Ontario	BC	NS	International
Asynchronous Online Education	X	X	X	X
Case Study	**X**	X	**X**	X
Open Discussions	X	X	X	**X**
Simulation	X	X	**X**	**X**
In-Service	X	**X**	**X**	X
Assessment Tools	X	**X**	X	X

Key: X: Delivery method not used or suggested X: Delivery method used or suggested

Appendix D

Table 4

Policies and Procedures on Workplace Violence from Three RHAs in Newfoundland and Labrador

Component	Eastern Health	Central Health	Labrador Grenfell Health
Roles and Responsibilities of Manager/Supervisor	• Identifying risk and informing staff of risk	• Identifying risk and informing staff of risk • Direction of staff to the employee family assistance program (EFAP)	• Inclusion of a violence prevention checklist in semi-annual inspections • Identifying risk and informing staff of risk • Direction to the employee family assistance program (EFAP)
Roles and Responsibilities of Employees, Volunteers, and Affiliates	• Tell patients and visitors that aggressive behaviour is not accepted • Identify potential risks and report potential indicators and actual incidences of violence	• Identify potential risks and report potential indicators and actual incidences of violence	• Tell patients and visitors that aggressive behaviour is not accepted • Identify potential risks and report potential indicators and actual incidences of violence
Roles and Responsibilities of Occupational Health and Safety (OHS)	• Developing, establishing, implementing, and providing recommendations regarding workplace violence • Reviewing WPV incidence statistics to determine trends	Developing, establishing, implementing, and providing recommendations regarding workplace violence	• Developing, establishing, implementing, and providing recommendations regarding workplace violence • Reviewing WPV incidence statistics to determine trends

Roles and Responsibilities of Protection Services	• Establishment of code white teams • Conduction of risk and targeted violence assessments • Consultations with program managers and employees regarding recommendations based on assessments	Not addressed	Not addressed
Roles and Responsibilities of HR	• Direction of staff to the EFAP	Not addressed	Not addressed
Reporting	• Employee incident report on violent encounters	• Employee incident report on violent encounters	• Employee incidence report and investigations form on violent encounters
Education	• Completed during general orientation • Site specific orientation for code whites • Further education can be provided if deemed necessary • Methods to deliver education not identified	• Managers should ensure training and education is provided • Employees have a responsibility to complete education and training • Methods to deliver education not identified	• Employees to attend violence prevention education offered from the health authority • Managers should ensure training needs are met • Methods to deliver education not identified
Follow up	• EFAP if needed	• Support for employees • Debriefing • EFAP	• Support provided by manager • EFAP
Aggressive Violent Behaviour	• Policy • Alert placed on any patient who staff deem to put them at risk of injury • Document event in patient's chart	No Policy	No Policy

	• CSRS and Employee incident report must be completed • Manager (department or on-call) and security must be notified • Electronically flagged in Meditech, purple sticker on patients' chart, "consult with nursing staff prior to entering" sign on patient's door • Can be removed by patient or substitute decision maker by contacting client relations		
Prevention and management of violence/aggression in the ED	• List of risk factors to monitor patient and families/visitors for to identify potentially violent situations • De-escalation techniques provided • When to implement code whites identified: When the situation is beyond the staff's ability to control • When to contact police: threat, weapons present, when aggressor is not a patient or is threatening patients, when situation is beyond controlling with code white.	No Policy	No Policy

Appendix C: Consultation Report

The Development of a Workplace Violence Education Huddle Program and Facilitator's Manual: A Review of the Literature

Allison Bragg, 201122595

Memorial University of Newfoundland and Labrador

From the literature, it is recognized that WPV is an issue for nurses. As a Registered Nurse (RN) for the last 6 years, I have been exposed to and witnessed both physical and verbal aggression from patients and family members on the unit. Anesthetic, infection, and head injuries sometimes lead to confusion which can result in patients being combative and verbally abusive. Nurses have been punched, pushed, have had things thrown at them, been sworn on, and belittled by these patients. These behaviours from this population typically subside after a couple of days. While some of these outbursts can be connected to confusion, these encounters have also occurred with individuals who are alert and orientated to person, place, and time. Verbal aggression and threats have been uttered by patients and family when they feel that their care is delayed or inadequate. Nurses are physically and emotionally impacted by these encounters. After a recent verbally aggressive family member my colleagues and I reported feeling scared, worthless, and unsure of our rights as nurses. Nurses reported not knowing how to effectively handle the aggressive situation, being unsure of the right time to contact security, and the feeling that their care for their other patients was inadequate due to the time spent dealing with the hostile situation.

The aim of this practicum project is to provide the acute care inpatient nurses with a resource to help mitigate and manage their exposure to and experience of WPV. Consultations allowed the information obtained in the literature review and environmental scans to be discussed with key stakeholders, to determine its usefulness in relation to the content of a resource and the mode of delivery for any education required. To best address the need surrounding a WPV prevention and management resource, the consultation process also examined the potential barriers and facilitators that exist for such a resource. Through gaining an understanding of the nurses' perception of WPV and their opinions of specific strategies and

content, a resource can be developed to target the specific needs of the nurses. Additionally, consultations with local experts in the area and Protection Services offered insight into the exposure of WPV for acute care RNs and contributed to a greater understanding regarding WPV and the effectiveness of possible interventions.

Objective(s) for the Consultations

The goal of these consultations were to understand the content, mode of delivery, and potential barriers and facilitators related to prevention and management of WPV and implementation of a resource. From the consultations it is hoped that a resource that effectively addresses the needs of the RNs is developed. The objectives of the consultations were:

1. To identify the specific needs of the acute care inpatient nurses in relation to managing and preventing WPV,
2. To identify potential barriers and facilitators to prevention and management of WPV for nurses,
3. To determine what content nurses need from a resource to manage and prevent WPV,
4. To determine how to effectively deliver a resource for managing and preventing WPV (i.e., mode of delivery, potential barriers and facilitators related to implementation of a resource).

Data Collection

There were five sources of information that were consulted: the front-line nursing staff from a medical-surgical inpatient unit, a local researcher with expertise in WPV in acute care, and other key stakeholders with education and leadership experience. Emails and messages were sent to the key stakeholders to invite them to voluntarily participate in the interviews. Participants were notified that the interview would not be recorded but notes would be taken and

shared with my practicum supervisor, Dr. Kathleen Stevens. Interviewees were notified that information would be stored on a locked, personal computer and deleted when the project was completed and that no identifying information would be shared in the report. Additionally, as the interview content could be difficult for staff nurses who were exposed to WPV, contact information for the Mental Health Crisis Line and the Family Employee Assistance Program were provided.

Acute Care Medical-Surgical Nurses

GroupMe, a communication app used for all nursing staff on the unit, was used to seek voluntary participation of the staff. This app is used to disseminate information. Three separate conversations existed within the app: one to book RNs for shifts, one for educational information, and one for general information. A message was sent into the general information conversation to ask for voluntary participation. A script for participation can be found in Appendix A.

Seven members of the medical-surgical nursing staff in varying positions were interviewed. As hoped, one nurse with less than five years seniority and one with greater than five years of seniority from each side of the schedule completed the interview. These interviews provided well a rounded insight into the experiences, needs, and opinions of the nurses of the unit. An interview guide was used to facilitate the interview (See Appendix B). A combination of closed and opened ended questions were asked through in-person and telephone interviews, based on the interviewee's preference. Semi-structured interviews were used to gain insight into the experiences, barriers, facilitators, needs, and potential resources for the RNs.

Other Key Stakeholders

Since nurses are the targeted population for this resource, their input was essential.

However, there are other stakeholders whose insights and opinions help to create and deliver the resource. To ensure confidentiality these stakeholders will be referred to as "key consultants" for this report.

In delivering an educational resource, it was important to seek insight from those who have experience in creating and delivering educational content. Information on how to best deliver the educational content to the nurses to meet their needs was achieved through consultations with this key consultant. To seek expertise in this area, an email was sent to invite individuals to participate in an interview (See Appendix C for script). Data collection took place using a semi-structured telephone interview. The interview used to guide this consultation can be found in Appendix D.

While obtaining information from frontline workers provides the richest information, evidence is also needed from those who oversee the nurses. To gain an overview of the occurrences of WPV, consultation with leadership was needed. Through this consultation factors that increase the risk of violence, a unique perspective of what WPV resources are lacking, and what will pose as facilitators or barriers in implementing a resource were determined. A leadership perspective was helpful to determine potential resources, suggestions for areas to be addressed, and strategies to do so. An email was used to seek voluntary participation from leadership. The email used can be found in Appendix E. Information was collected using an informal telephone semi- structured interview (See Appendix F for the interview guide).

Protection Services play a vital role in violence prevention and management. Consultations with Protection Services personnel provided a different perspective on the areas that should be addressed in a violence prevention and management resource for nurses and provided an understanding of the roles of security and their perception of WPV in acute care.

These consultations provided understanding to determine if the potential resources aligned with the efforts of security personnel and their insight into the needs of nurses regarding WPV. Barriers and facilitators that may be experienced by nurses in preventing and managing violence, as well as the barriers and facilitators in creating a WPV resource for nurses, were acknowledged from a different perspective. Suggestions on how to best target the identified needs of the nurses were provided in these consultations. Protection Services personnel were contacted via email to seek voluntary participation (see Appendix G). Two semi-structured interview guides of open and closed ended questions were used for the telephone interviews (See Appendix H and I).

Local Researcher and Nurse Educator, Glenys Moran

Glenys Moran a local researcher and Nurse Educator at the Centre for Nursing Studies was interviewed. Ms. Moran has conducted local studies into the experience of RNs with WPV in acute care, with an increased focus on the risk of violence in patients suffering from substance misuse and abuse. After conducting research locally, she had valuable insight into the issues experienced and the insights of acute care RNs here in Newfoundland and Labrador. From her research, she was able to identify likely potential barriers and facilitators for WPV and areas that need to be addressed (e.g., content required in a resource).

Ms. Moran was contacted via e-mail inviting her to participate in an interview (See Appendix J). A virtual interview using Webex was conducted. An interview guide of both closed and opened-ended questions was used to facilitate the interview (See Appendix K).

Data Analysis and Management

With permission from the interviewees, written notes were taken during the interview. A verbal summary of the notes was provided to the interviewee at the end of interview to ensure an accurate understanding was obtained. Written notes from the interviews were transcribed to a

Word document and saved in a password protected final on a personal computer. Interview notes were shared with my practicum supervisor, Dr. Kathleen Stevens, to ensure rigor. Thematic analysis was used to analyze the results. The data were clustered based on common themes or ideas that were identified in the consultations. These themes will be addressed in the results section.

Ethical Considerations

Informed consent was obtained from the individuals involved in the consultations. Participants were notified that the information gained from the interview will be used to create a resource to assist the nurses in preventing and managing WPV and that participation was voluntary. Participant's agreement to complete the interviews was considered consent to use the information obtained. Each participant was designated a numeric code to ensure anonymity. A file that contains the key for the codes was saved in another location so that participants can be identified to be contacted again if needed. All information was saved in password protected file on a locked, personal computer. Participants will remain anonymous in the dissemination of the results. The exception would be Glenys Moran. Permission was obtained to share the results of her research in the final practicum report. Based on the Health Research Ethics Authority (HREA) Screening Tool ethical approval was not required for this project (Appendix L).

Results

The results obtained from the consultations were divided into themes. Six themes were identified from the interviewees' responses. These themes were: nurses' perspective of WPV, risk factors for WPV, impact of WPV on nurses and patients, barriers and facilitators for nurses in preventing and managing WPV, educational needs (i.e., content, mode of delivery, and administration), and barriers and facilitators in providing WPV prevention and management

education to nurses. These themes will be discussed in this section.

Nurses Perspective of Workplace Violence

When asked about WPV, most nurses identified verbal aggression first. They reported yelling, shouting, swearing, belittling, intimidating, raised voices, and threats as types of verbal aggression. This response was followed by "anything physical." All participants had to be prompted to provide examples of physical violence (i.e., kicking, hitting, pushing, biting, punching, swinging, or throwing items). The impacts, which will be discussed in the upcoming section, were also very focused on the mental or emotional impact of violence rather than physical injuries.

Nurses were asked do you feel that you know your rights as a nurse regarding protecting your own safety and your license when dealing with aggressive patients and families? Responses raged from "What rights? We have no rights" to "Yeah, I think so." Many of the nurses felt that the rights in healthcare were focused on the patient and not the nurse. One nurse shared an encounter with a patient where they "wrestled". They said if they had not intervened the patient likely would have punched their co-worker, but they wondered what the repercussions for them would have been if the patient had reported this incident.

Based on the Eastern Health policy (2013), a role of nurses is to set boundaries in an attempt to prevent WPV. Most of the nurses interviewed for this project did not feel that this should be a role for nurses, nor did they feel comfortable in setting these boundaries. Only one nurse reported feeling comfortable setting boundaries but reported that they did not do it. This participant felt that nurses first goal is to care for sick patients. They felt that nurses "trust before they mistrust" and often do not set boundaries until it is too late. Setting boundaries was reported to be a "good idea in theory," but nurses set themselves up to be exposed to verbal violence if

individuals do not like the boundaries that were set.

Risk Factors

Participants were asked what they considered to be risk factors that precipitated WPV from patients, families, and visitors. One participant stated that "everyone has the potential to become aggressive- Some things increase a person's risk to become aggressive." From the participant's responses the risk factors identified were categorized into patient related factors (e.g., patient diagnosis), communication, and system related factors.

Patient Related Factors

The patient's diagnosis, necessary treatment, and past medical and social history were noted to play a role in the occurrence of WPV from patients. Altered cognitive states such as dementia, developmental delays, substance misuse or withdrawal, or the result of a traumatic brain injury (TBI) were reported by nurses and key consultants to play a role in the occurrences of violence for patients. Confusion because of medication, anesthetic, and infection were also recognized by participants to increase a patient's risk of violence. One key consultant felt that the current global situation of the COVID-19 pandemic had impacted people's ability to cope, playing a role in the occurrence of WPV.

Communication

Nurses and key consultants commented on the frustration experienced by patients and support persons because of poor communication between them and healthcare providers, and hospital staff. A key consultant felt that this lack of clarity begins when patients come into the facility and often gets taken out on the nurses on the inpatient unit. Personalities clashes and reactive personalities were also noted to increase the risk of violence.

System Related Factors

Nurses and key consultants believed that a delay in care and unrealistic expectations could lead to violence. One participant noted that families are sometimes not educated on the way in which healthcare facilities work and become upset if their experience does not meet their expectations. A delay in procedures or operations or an inability to see a physician immediately was noted by nurses as factors that caused patients and families to become upset. A key consultant also commented on the stimulation created by the business of inpatient units contributing to the risk of violence.

Impact of Workplace Violence

WPV impacts the nurse exposed to the violence, the care of the patient precipitating the violence, and the patients that witness the violence.

Impact on Nurses

From the interviews, the impact of WPV on nurses was identified firsthand and from the perspective of other key stakeholders. "Nurses have an expectation and a right to a safe environment to do their job. When that is lost, it impacts the nurse." This quote from a nurse is supported by the responses of all those interviewed. Most of the responses from nurses focused on an emotional impact of WPV: Fear, stress, and anxiety coming to work were emotions that were expressed. One nurse reported that nurses were anxious coming to work, wondering if they would have the "difficult" patient or family for that shift. Absenteeism and sick leave were reported to be a result of both physical and emotional impacts of WPV. PTSD was also a common outcome shared by nurses. From interviews conducted with nurses and the local researcher, Glenys Moran, nurses reported that they felt an internal ethical conflict when dealing with WPV as they wanted to avoid the patient to protect themselves but also wanted to provide the best possible care to the patient.

Impact on Aggressive Patients

From the interviews with nurses, a common theme regarding the impact on patients was avoidance of the patient by staff. Nurses reported avoiding the aggressive patient and family to prevent any sort of aggressive outburst. On the other hand, it was reported that nurses sometimes would "go above and beyond" regardless of their workload to try to please the patient or family and prevent aggressive encounters from occurring. When patients were physically aggressive to the point that physical and chemical restraints had to be used, nurses felt that the patient's recovery was impacted. From Glenys Moran's study, a lack of continuity of care was recognized to have a potential impact on the care received by the aggressive patients. To preserve staff, nurses often rotated taking care of aggressive patients. This was self-preserving for staff but could impact the care of the patient. Lastly, the feeling that patients were "rewarded" for bad behaviour was reported by nurses. After violent outbursts, patients were often placed in a private room. While this was done to protect the other patients in the room, to some it felt like patients were being rewarded for bad behaviour.

Impact on Other Patients Exposed to Violence

Other patients on the unit were also considered to be negatively impacted by aggressive patients and families. Interviewees reported that dealing with aggressive events delayed the care of other patients. From her local research, Glenys Moran noted that nurses worked in pairs when providing care for aggressive patients, but the staffing levels did not change. This meant a potential delay in care for other patients as two RNs were tied up with a potentially aggressive situation. Other patients being fearful and stressed were common feelings that were identified by the nurses. They noted that this impacted their healing and recovery. A nurse reported that dealing with WPV led to distraction and impacted focus. As a result, the care the nurse was able

to provide their patients was negatively impacted.

Barriers to Nurses Preventing and Managing Workplace Violence

Participants were asked what they saw as barriers to nurses preventing and managing WPV. The barriers identified were: workplace culture, staffing workload, nursing experience, lack of education, and limited reporting. These will be discussed in this section.

The obstacles created by workplace culture was reported by all participant groups. Normalizing WPV, the belief that WPV was part of the job, or making excuses for patients' actions were common themes noted by the participants. Participants felt that if nurses believed that violence was a part of nursing, they would not attempt to prevent or manage the violence. Moreover, it was noted that WPV against nurses was not talked about enough by the public. Participants felt that the public did not realize that violence was an issue for nurses.

Nursing workload and experience were common themes noted to impact nurse's ability to prevent or manage WPV. Nurses felt that a high nurse-to-patient ratio or workload potentially impacted the ability of the nurse to recognize signs of violence and to effectively de-escalate the situation. Additionally, the lack of experience of staff was noted to be a hurdle for nurses in dealing with WPV.

A lack of education regarding WPV was noted to hinder nurses' ability to recognize signs of violence and to manage violent outburst. From the interviews with all participant groups, it was determined that nurses were not equipped with non-violence crisis intervention training or formally educated on non-verbal cues. Without this knowledge, it made it difficult for nurses to effectively prevent and manage aggressive patients and support persons. Furthermore, a lack of reporting of the occurrence of WPV due to a lack of education on the importance of reporting and the extensive reporting process were noted to be barriers by nurses and key consultants.

From the interviews a single differing perspective on WPV came through. One key consultant felt that there were no barriers. From this individuals' perspective, knowing how to prevent and manage WPV was just as important as learning any other nursing skill and should be viewed to the same standard.

Facilitators to Nurses Preventing and Managing Workplace Violence

Based on the interview responses, education, support, communication, and staffing have been recognized by participants to play a role in assisting nurses to prevent and manage WPV. These facilitators will be discussed in this section.

Multiple interviewees from all participant groups reported education to assist nurses in preventing and managing WPV. One key consultant reported that "knowledge is power." Having the education to recognize potential violent outburst and how to effectively manage these situations was recognized to be essential. Respondents also reported education to assist them in coping with dealing with violent encounters as a facilitator of managing WVP.

Support was also identified by nurses and key consultants as helping nurses effectively prevent and manage WPV. From the responses, this support should come from management and security. It was suggested that collaboration with security would help nurses in preventing and managing violent exposures. Key consultants felt that security should be involved in potentially aggressive situations as soon as possible in an attempt to prevent escalating situations.

Communication was also identified as a large component in facilitating violence prevention. Nurses and key consultants felt that communication between staff members and units and adequate reporting of previous incidences allowed nurses to be aware of the potential of violence. An open line of communication between nurses and security was also reported to be essential by key consultants and nurses.

Lastly, staffing in relation to experience and workload were recognized to facilitate nurses in preventing and managing WPV by nurses and key consultants. An improved nurse-to-patient ratio would allow nurses more time to assess situations and manage those that occur. Additionally, experience in recognizing or managing violent encounters was identified in considering a staffing mix. The age of the nurse was a facilitator recognized by one nurse. They noted that some older patients were more trusting of older nurses when they were in a state of delirium.

Education for Nurses

Education was identified as an important component in assisting nurses to prevent and manage WPV. From the interviews, the nurses reported never receiving formal education on WPV. Through the interviews from key consultants, it was determined that there was no formal education for acute care inpatient units. A key consultant reported that areas such as the Emergency Department and Long Term Care had additional education for staff. For inpatient units, managers had to get approval for staff members to attend these education sessions. Nurses and key consultants noted attending a WPV symposium or an education session in the past and commented that it was effective. Education content, delivery methods, and delivery times were addressed in the interviews. An overview of the various educational content and delivery modes recommended by the participants can be found in Appendix M and N, respectively. The responses from the nurses, key consultants, and Ms. Moran regarding these questions will be addressed in the next section.

Education Content

In the interviews, participants were asked what they thought should be covered in an educational component to prevent and manage WPV. It was recognized that education should

focus on what WPV is, how to identify those at risk, de-escalation techniques, management processes, and the importance of reporting.

Nurses and key consultants believed that education should begin with baseline line information regarding WPV. WPV should be defined, and different types of WPV identified. From the responses, participants shared that they felt WPV had been normalized and education is needed to change this perception. It was reported that nurses often provided excuses for their patients regarding WPV. Nurses must be educated that violence should never be excused, regardless of the situation the patients and their support persons are in.

In attempting to prevent WPV from occurring, the importance of recognizing visual cues, risk assessments, and learning de-escalation and communication techniques were reported to be important by all participant groups. One key consultant who has previous training in Nonviolent Crisis Prevention felt that the "body will show people want it wants to do." Through recognizing these non-verbal cues, interventions can be used to prevent violence from occurring. Additionally, risk assessments and potential triggers were reported as areas that should be covered. Specific education on the risk of violence for the patient population (i.e., those suffering from delirium, reactions from anesthesia, drug and alcohol withdrawal, and TBIs) was suggested by nurses. A key consultant noted that at present, nurses have no formal training of de-escalation techniques. How one person attempted to manage or prevent a situation may not be the same as another. It was noted that some nurses can escalate situations instead of de-escalating them. Having the education on a uniform approach to de-escalate situations would be beneficial.

Many nurses reported being unsure of their rights as nurses when managing violent patients or support persons. Stemming from this lack of understanding, was the suggestion to cover this concept in an educational component. One nurse questioned the right to refuse care

and rights of the patient and the visitor, creating an area that needs to be addressed in education. A key consultant noted that visiting the hospital was a privilege and not a right. It was suggested for nurses to be made aware of security processes and the roles of security officers in the event of violent situations. Moreover, the need to understand the criminal component to WPV was addressed by a key consultant. Nurses voiced the need to know when police should be involved and what the role of police would be.

The importance of reporting was an educational component that was identified by all participant groups as a topic that should be covered in an educational session. A key consultant identified that if WPV on a unit was not reported, it appeared that the unit did not have an issue and therefore no resources would be implemented to combat the issue. Another key consultant saw reporting as a way to communicate the prevalence of violence and help keep co-workers safe. In addition to reporting, nurses stated the need to understand where to document or communicate the occurrence of violence from visitors or family members.

Education Delivery

To have the most impact, the way in which the educational content is delivered is essential. From the interviews, participants, with the exception of one key consultant, thought that shorter education sessions would be more beneficial than a full-day session. Participants felt that a full day may be long and "dragged out" and individuals would lose interest. Participants suggested education sessions that lasted one to two hours.

Participants were asked if education would be better delivered in person or as a synchronous online education session. While online education was noted to have some benefits, most nurses and key consultants thought that in person education would be better. While still recommending in person learning, a few participants commented that people may share more if

they were online and not in person. More specifically, a nurse suggested that the education session be contained to specific units. This participant reported that they would be feel comfortable sharing with their "work family" but would not share if the session was open to other healthcare professionals from other units.

Multiple nurses and key consultants supported the delivery of informal education based on actual patient events. The use of open discussions and safety huddles were suggested or supported by multiple respondents. Nurses suggested that safety huddles be used frequently and as soon as possible after any kind of violent event, big or small. From a key consultant's previous experience, case studies did not achieve the same impact as personal stories.

The use of passive education was noted to have value by a few participants. Active learning with a mixture of passive education was suggested by a few key consultants and nurses. One key consultant suggested that lecture type style would be beneficial for some educational content.

Nurses and key consultants suggested collaboration with security personnel in preventing and managing WPV. One nurse suggested a presentation from security personnel. This presentation could provide the education needed regarding the role of security and when they should be contacted to assist with escalating situations.

The development of a poster was suggested by a few nurses and key consultants. One nurse felt that posters for quick reference, such as those for pressure wounds and patient transfers, were utilized by nurses regularly and would be beneficial. A poster that offered a step-by-step approach on preventing and managing WPV that addressed nurses' roles, actions, who to call, and where to report was suggested.

Education Administration

Many of the participants felt that WPV was not recognized by the general public. Nurses, key consultants, and Ms. Moran felt that WPV education should begin in nursing school. One nurse felt that nursing students were shielded from WPV. Students were not assigned to verbally or physically aggressive patients and aggression was not an issue that is covered in depth in nursing school. While keeping students from aggression is not necessarily a bad thing to do, it makes it difficult for them to handle these situations when they become RNs as they have not had previous experience. All participants felt that education should occur at orientation with annual refreshers. Some nurses suggested including WPV in annual education days.

Barriers to Implementing Workplace Violence Resource

All participants groups were asked what they saw as barriers to implementing a WPV resource. The barriers identified were: workplace culture, reporting, time, and money. These will be discussed in this section.

Workplace culture was identified as a large barrier to the implementation of a WPV resource. If nurses accept violence because it is "part of the job," a resource will not be well received or utilized. A key consultant noted that until nurses have the mindset that violence will not be tolerated a resource will not be useful.

Reporting was noted to be a hinderance to the development of a WPV resource. As noted by a key consultant, if nurses do not report violence, it will appear that violence is not an issue on that unit. Therefore, the need for a resource is not identified and support from the organization may not come through.

Lastly, time and money are barriers that were identified in multiple interviews from all participant groups. Time in the respect of the person creating the resource and the time for those to attend or utilize the resource implemented. One key consultant noted that funding for the

implementation of a resource is always an issue regardless of the resource.

Facilitators to Implementing Workplace Violence Resources

Participants were asked what they saw as facilitators to implementing a WPV resource. Based on the interview responses, support, collaboration, awareness, and initiatives were recognized to facilitate the implementation of WPV resource. These facilitators will be discussed in this section.

Support was a major factor that was identified by the interviewees. All participant groups recognized that support is needed from the care facilitators, physicians, the manager, and Eastern Health executives. One key consultant reported that if nurses are not supported by the "higher ups" than any actions and resources are all for nothing. Another stated that organizational commitment is needed to provide nurses with the education and resources to prevent and manage WPV.

Collaboration and working teams (i.e., a group of healthcare workers with the same aim of determining and delivering ways to reduce and prevent WPV) were suggested as ways to facilitate the implementation of a WPV resource. Participants believed that collaboration between security would be helpful in initiating such a resource. In addition to collaboration, nurses thought that the individuals involved in implementing a WPV resource should have experience or knowledge in the area to be effective. Moreover, a nurse suggested asking for the opinions of those that need the WPV resource prior to implementation.

Awareness of WPV was recognized as a factor that would contribute to the implementation of a resource. Nurses and key consultants believed that nurses and the public need to be aware that WPV exist and that is will not be tolerated. A workplace culture that does not tolerate violence is needed to assist in the effective delivery of a WPV resource.

From the interviews, it was identified that nurses may need an initiative to attend education sessions regarding WPV. Providing them with education hours for attending or a lunch and learn were identified by nurses as ways to attract their attention. One nurse noted that WPV is prevalent enough in acute care that nurses would be inclined to seek education to improve their work lives.

Summary of the Findings

From the interviews conducted is it apparent that WPV precipitated from patients and support persons is an issue for the nurses in acute care inpatient units. Verbal violence seems to be more prevalent with consequences that impact the nurses and their patients such as anxiety and avoidance of patients. The development of an educational session was well received by the participants. Participants reported the need to have education on verbal cues, risk factors, and de-escalation techniques to prevent violence. The need to know how to manage aggressive situations once they occur and when to involve security and police were recognized to be important. Reporting was noted as an area that was not used to its full potential due to time constraints but recognized to be important as well. From the participants' responses, an informal, in person education session based on actual patient events seemed to have the most support. It was recognized that education should start in nursing school, upon hire, and annually. Additionally, a poster that illustrates a step-by-step approach for nurses in preventing and managing WPV was suggested. To have a successful educational resource, support must come from clinical leaders, managers, and the healthcare organization executives.

Implications of Findings

The purpose of these consultations was to aid with the development of a resource to assist acute care nurses in preventing and managing WPV. From these consultations it was evident that

a resource is needed and at present, does not exist. Education for WPV is lacking for nurses in acute care and was reported as a strategy to assist in preventing and managing WPV. Using the insights and suggestions from the key stakeholders, a resource can be created to meet the needs of acute care nurses. From the perspective of the respondents, there are areas that required education such as non-verbal cues, risk factors, and de-escalation techniques. Since most of the respondents felt that active learning based on actual events was better than passive learning, these education topics will need to be addressed and supplemented with actual events to implement what has been learned. While online education was noted to have its benefit, it was recommended to complete WPV education in person. This will be taken into consideration when creating a WPV resource. Additionally, a visual aid to supplement information on WPV prevention and management will be created. Since collaboration with security was suggested, security should be contacted during the development of the resource to ensure it follows along with their protocols.

Conclusion

Twelve individual interviews were conducted for this project. From these consultations valuable information was collected. Nurses' perspective and experiences of WPV were identified, demonstrating the ongoing occurrence of WPV experienced by these nurses. Risk factors such as substance abuse and poor communication were discussed. The impacts of WPV on nurses and patients were identified, supporting the need of a resource to assist in preventing and managing WPV. From the consultations the barriers and facilitators to nurses preventing and managing WPV, such as support, communication, and education, were discussed. Education was noted to be a large component of improving the nurses' ability to prevent and manage WPV. Education on verbal cues, risk factors, de-escalation techniques, management strategies, and

when to involve security and police were recognized to be important. This education was suggested to start in nursing school and continue into the workforce. While education will not eliminate violence, it can help to prevent and mitigate exposure.

References

Eastern Health. (2013, August 5). *Violence prevention, response and support.* Eastern Health.

Appendix A: Script to ask for Acute Care Medical-Surgical Nurses Participation

Hello,

As most of you are aware, I am currently working on my Master of Nursing degree and completing my final practicum project. For my final project, I am aiming to create a resource to help nurses in the prevention and management of workplace violence, specifically tailored to acute care medical-surgical units. To create a resource that will meet the needs of acute care nurses, I am looking for voluntary participation of seven nurses in varying positions. Ideally, I would like to interview a nurse with less than five years of experience and one with greater than five years of experience from each side of the schedule.

As mentioned, participation in this consultation will occur using an interview. Questions will focus on your experience with workplace violence, the barriers to preventing and managing workplace violence and what you feel is needed in a resource to be useful. Resources and interventions will be discussed to determine their potential effectiveness. The interview will last 20-30 minutes and can occur in person at work, over the telephone, or virtually, depending on your preference. This interview will not be recorded, and I will be taking notes during the discussion. Information obtained from the interview will remain confidential, locked on a personal computer, and deleted after the completion of the project. There will be no identifying information from the interview included in the final report, and interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens.

If you have any questions or would like to participate in the research, direct message me or text or call at 709-699-8936. Participation is voluntary.

Thank you for your time,
Allison

Appendix B: Interview Guide for Acute Care Medical-Surgical Nurses

Thank you for agreeing to assist me in developing a workplace violence resource for our unit. Before we begin, I just want to remind you that participation is voluntary. You do not have to answer all questions and you may terminate the interview at any time. The interview will not be recorded but I will be taking notes. The notes will be transcribed into a Word document and saved on my personal, locked computer. Information obtained from the interview will be used for a final report, but there will be no identifying information provided. Interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens. Once the project is complete, the information will be deleted.

As the questions we cover may result in difficult emotional responses, I want to again remind you that you do not have to answer questions that make you uncomfortable in anyway. Simply ask to pass the question and we will move on. Please ask to stop the interview at any point if you feel it is necessary. If this interview evokes any difficult emotions regarding your previous experience of workplace violence, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact Tina Simpson, the Regional Coordinator for the Family Employee Assistance Program at 777-3153.

Do you have any questions?

Let's get started!

1. How long have you been a RN?
2. What do you consider to be workplace violence? (Physical aggression-pushing, hitting, biting, verbal aggression- yelling, belittling, passive aggression)
3. Have you been exposed to workplace violence in the last year? How often?
4. What is your experience with workplace violence from patients and family? (physical

aggression- throwing items, pushing, kicking, hitting, psychological- yelling, belittling, swearing)

5. What education have you received in the past regarding WPV? (where, when, how long, topics) Was this education helpful?
6. What do you think are risk factors that precipitate WPV from patients? Families/visitors? (communication, overcrowding, confusion, infection, substance misuse/abuse, traumatic brain injury, delay in procedures/surgeries)
7. In your opinion, what is the impact of WPV from patients or visitors on the nursing staff? (Fear, resentment, ethical/legal issues, anxiety, physical injuries, sick leave, loss of job satisfaction)
8. From your experience, how does WPV impact the care of the patient or family precipitating the violence? (Avoid, spend less time, rewarded for behaviour)
9. How does WPV impact other patients who are exposed to the aggressive encounters? (Delay in care, fear)
10. If a patient and family have been identified as being at risk for violence how is this communicated to the nurse assigned to the patient and other members of the team? (Safety huddle, GroupMe, AVB Protocol, Kardex, verbal handover)
11. What are some barriers you can identify that impact a nurse's ability to prevent or manage WPV? (Age, experience, education, workplace culture as it is accepted as part of the job, workload, reporting process, high turnover on unit, staff,)
12. What are some facilitators that may improve a nurse's ability to prevent or manage WPV? (Age, experience, education, workplace culture, policy, security support, team support, communication re. patient at risk for violence – on the unit and when receiving

transfers)

13. Do you find EH policies and procedures helpful in preventing and managing workplace violence? If yes, why? If no, why not? Are they easily accessible? (Code white, AVB protocol)
14. A requirement of the EH policy for employees is to set boundaries in relation to aggressive behavior and identify risks and report potential indicators and actual incidences. What are your thoughts on this requirement? (do you feel comfortable doing this, confident doing this)
15. Do you feel that you know your rights as a nurse in regard to protecting your own safety and your license when dealing with aggressive patients and families?
16. Have you been referred to the EAP by HR after a violent incident?
17. What strategies or interventions do you think will help reduce or prevent nurses' exposure to violence and violent encounters? (Education sessions, open discussions on actual patient events (debriefing), online education, risk assessment/screening tools (with poster for quick reference), communication tools)
18. What strategies or interventions do you think will help nurses manage exposure to violence violent encounters? (Education sessions, debriefing, safety huddles, online education)
19. What type of educational training do you think would work best to increase nurse's confidence and knowledge in preventing and managing workplace violence? (open discussions on actual patient events, debriefing, online education (synchronous vs asynchronous), active vs passive education (case studies, role playing, simulation, videos)
20. What information or topics do you think should be included in an educational resource to

help improve nurse's knowledge and confidence in reducing and managing WPV? (Communication, body language, terminating relationships with aggressive clients, risk assessments, de-escalation techniques, reporting, management, documentation, nurses' rights)

21. What would you like to see in a toolkit to manage and prevent WPV? (education for nurses, brochures for families related to procedures/surgeries that can cause patients to be aggressive, assessment tools, screening, unit meetings, walkthroughs, policies)
22. Would you prefer an education session during work hours or on your day off? Which would yield the greatest number of staff? Which would have the best impact? How long do you think the session should be? (1 hour, afternoon, full day)
23. What are some potential barriers you can think of in the creation and delivery of an educational resource? (money, time, workplace culture, lack of interest, collaboration with security)
24. What would help facilitate the creation and delivery of an educational resource? (organizational support (manager, healthcare facility), CPP hours, workplace culture)
25. When do you think nurses should receive WPV education? (orientation, updated yearly)
26. Is this anything else you would like to share?
27. Would you be willing to be contacted during the development of this resource if needed?

Thank-you for your time and sharing your experience and opinion

Appendix C: Email to ask Participation from those with Experience in Creating and Delivering Educational Content

Hello, my name is Allison Bragg. I am a Master of Nursing student and I am currently working on completing my final practicum project. For my final project, I am developing a resource to help acute care nurses on inpatient units in the prevention and management of workplace violence from patients and visitors. To create a resource that will meet the needs of nurses working in acute care inpatient units, I would like to gain your perspective on the issue of workplace violence and the content required for such a resource.

Participation in this consultation will occur using an interview and is voluntary. Questions will focus on three areas. First, your perspective of workplace violence and the needs of the nurses. Second, the barriers and facilitators to creating and delivering a resource to assist nurses in preventing and managing workplace violence. Third, what mode of delivery you feel would most effectively meet the needs of the nurses. Potential resources or interventions will be discussed in relation to content and mode of delivery to determine their potential effectiveness. The interview will last 25-30 minutes and can occur in person at work, over the telephone, or virtually, depending on your preference. This interview will not be recorded, but I will be taking notes during the discussion. Information obtained from the interview will remain confidential, locked on a personal computer, and deleted after the completion of the project. There will be no identifying information from the interview included in the final report, and interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens.

If you have any questions or would like to participate in the research, reply to this email or call or text at 709-699-8936. Participation is voluntary.

Thank you for your time.
Sincerely,
Allison Bragg

Appendix D: Interview Guide

Thank you for agreeing to assist me in developing a workplace violence resource for our unit. Before we begin, I just want to remind you that participation is voluntary. You do not have to answer all questions and you may terminate the interview at any time. The interview will not be recorded but I will be taking notes. The notes will be transcribed into a Word document and saved on my personal, locked computer. Information obtained from the interview will be used for a final report, but there will be no identifying information provided. Interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens. Once the project is complete, the information will be deleted. Do you have any questions before we begin?

1. Do you feel that nurses have experienced any challenges related to WPV from patients and visitors?
2. What factors do you think contribute to WPV from patients and visitors in general? (experience, novice, new to unit, overcrowding, poor communication, patient population, high turnover, causal staff)
3. What factors do you think contribute to WPV from patients and visitors on medical-surgical inpatient units? (experience, novice, new to unit, ward, delays in surgery, patient population, high turnover, causal staff)
4. What education have you received in the past regarding WPV? (where, when, how long, topics) Was this education helpful?
5. What educational opportunities exist that you are aware of to help nurses prevent and manage WPV?
6. What do you think are the learning needs of acute care nurses in general in relation to WPV? (communication techniques, de-escalation, screening, risk assessments, reporting,

self-care, understanding the policy and procedures)

We need to know to de-escalate, how to manage, who to call (visual pathway)

7. What strategies or interventions do you think will help reduce nurses' exposure to violence or help nurses manage violent encounters? (education, training, debriefing)
8. What do you think are barriers for nurses in preventing WPV? (Age, experience, workplace culture, RN workload, time, unclear policies)
9. What do you think facilitates preventing WPV? (Age, experience, workplace culture)
10. What do you think are the barriers to managing WPV? (Age, experience, workplace culture, time, unclear policies)
11. What do you think facilitates managing WPV? (Age, experience, workplace culture, safety huddles, education, screening tools)
12. What would you like to see in a toolkit to manage and prevent WPV? (education for nurses, brochures for families related to procedures/ surgeries that can cause patients to be aggressive, assessment tools, screening, unit meetings, walkthroughs, policies)
13. What do you think would be beneficial in an educational component? (communication techniques, de-escalation, screening, risk assessments, reporting, self-care, presentation from security services)
14. From your experience in providing educational sessions, what do you think is the preferred method for delivery of education? (In person education, compressed (1-2 hours, afternoon), 1-day, online (synchronous vs asynchronous), posters)
15. Do you think resource content that was based on actual patient events would be more beneficial than hypothetical scenarios?
16. For this type of educational training, would open discussions be more beneficial than a

lecture type setting?

17. When do you think nurses should receive WPV education? (orientation, updated yearly)
18. What are potential barriers for implementing a WPV resource? (Time, money, support, workplace culture, staff turnover)
19. What are facilitators for implementing a WPV resource? (organizational support, workplace culture, walkthroughs, collaboration with security)
20. Is there anything else you would like to share about WPV? (Comments, suggestions, feedback)
21. Would you be willing to be contacted during the development of this resource if needed?

Thanks for your time and sharing your experience with this issue.

Appendix E: Email to ask for Leadership Participation

Hello, my name is Allison Bragg. I am a Master of Nursing student and I am currently working on completing my final practicum project. For my final project, I am developing a resource to help acute care nurses on inpatient units in the prevention and management of workplace violence from patients and visitors. In order to create a resource that will meet the needs of nurses working in acute care inpatient units, I would like to gain your perspective on the issue of workplace violence in acute care.

Participation in this consultation will occur using an interview and is voluntary. Questions will focus on three areas. First, the occurrence of workplace violence from patients and visitors on our unit. Second, the barriers and facilitators to preventing and managing workplace violence from patients and visitors. Third, what you feel is needed in a resource for nurses on our unit in preventing and managing workplace violence from patients and visitors. Potential resources or interventions will be discussed in relation to content and mode of delivery to determine their potential effectiveness. The interview will last 25-30 minutes and can occur in person at work, over the telephone, or virtually, depending on your preference. This interview will not be recorded, but I will be taking notes during the discussion. Information obtained from the interview would remain confidential, locked on a personal computer, and deleted after the completion of the project. There will be no identifying information from the interview included in the final report, and interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens.

If you have any questions or would like to participate in the research, reply to this email or call or text at 709-699-8936. Participation is voluntary.

Thank you for your time,
Allison

Appendix F: Interview Guide for Leadership

Thank you for agreeing to assist me in developing a workplace violence resource for our unit. Before we begin, I just want to remind you that participation is voluntary. You do not have to answer all questions and you may terminate the interview at any time. The interview will not be recorded but I will be taking notes. The notes will be transcribed into a Word document and saved on my personal, locked computer. Information obtained from the interview will be used for a final report, but there will be no identifying information provided. Interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens. Once the project is complete, the information will be deleted. Do you have any questions before we begin?

1. Do you feel that your staff have experienced any challenges related to WPV from patients and visitors?
2. Are you able to provide any statistics related to WPV incidents on your unit? (number of code whites in the last year, workplace violence reports)
3. What is the impact of workplace violence on your staff and unit as a whole? (Missed work, anxiety, fear, PTSD, injuries)
4. What is the impact of workplace violence on patients and families? (Delay in care, avoidance, resentment)
5. What factors do you think contribute to WPV from patients and visitors in general? (experience, novice, new to unit, overcrowding, poor communication, patient population, high turnover, causal staff)
6. What factors do you think contribute to WPV from patients and visitors on your unit specifically? (experience, novice, new to unit, ward, delays in surgery, patient population, high turnover, causal staff)

7. What education have you received in the past regarding WPV? (where, when, how long, topics) Was this education helpful?
8. What educational opportunities exist that you are aware of to help nurses prevent and manage WPV?
9. What do you think are the learning needs of your staff in relation to WPV? (communication techniques, de-escalation, screening, risk assessments, reporting, self-care, understanding the policy and procedures)
10. What strategies or interventions do you think will help reduce nurses' exposure to violence or help nurses manage violent encounters? (education, training, debriefing)
11. What happens after violent encounters? (how do nurses deal with it -reporting, debriefing)
12. What do you think are the barriers to preventing WPV? (Age, experience, workplace culture, RN workload, time, unclear policies)
13. What do you think facilitates preventing WPV? (Age, experience, workplace culture)
14. What do you think are the barriers to managing WPV? (Age, experience, workplace culture, time, unclear policies)
15. What do you think facilitates managing WPV? (Age, experience, workplace culture, safety huddles, education, screening tools)
16. What would you like to see in a toolkit to manage and prevent WPV? (education for nurses, brochures for families related to procedures/ surgeries that can cause patients to be aggressive, assessment tools, screening, unit meetings, walkthroughs, policies)
17. What would you like covered in an educational component? (communication techniques, de-escalation, screening, risk assessments, reporting, self-care, presentation from

security services)

18. What do you think is the preferred method for delivery of education? (In person education, compressed (1-2 hours, afternoon), 1-day, online (synchronous vs asynchronous)
19. Do you think resource content that was based on actual patient events would be more beneficial than hypothetical scenarios?
20. When do you think nurses should receive WPV education? (orientation, updated yearly)
21. What are potential barriers for implementing a WPV resource? (Time, money, support, workplace culture, staff turnover)
22. What are facilitators for implementing a WPV resource? (organizational support, workplace culture, walkthroughs, collaboration with security)
23. Is there anything else you would like to share about WPV? (Comments, suggestions, feedback)
24. Would you be willing to be contacted during the development of this resource if needed?

Appendix G: Email to ask for Protection Services Participation

Hello, my name is Allison Bragg. I am a Master of Nursing student and I am currently working on completing my final practicum project. For my final project, I am developing a resource to help acute care nurses on inpatient units in the prevention and management of workplace violence from patients and visitors. As protection services are essential in assisting nursing staff in the management and prevention of patient and visitor aggression, I am seeking your voluntary participation in this endeavor.

Participation in this consultation will occur using an interview. Questions will focus on your experience with workplace violence from patients and visitors in acute care, the role of protection services in these situations, the barriers and facilitators of preventing and managing workplace violence from patients and visitors in acute care, and the areas that, in your opinion, need to be addressed in a resource for nurses. The interview will last 15-20 minutes and can occur over the telephone or virtually, depending on your preference. This interview will not be recorded, and I will be taking notes during the discussion. Information obtained from the interview would remain confidential, locked on a personal computer, and deleted after the completion of the project. There will be no identifying information from the interview included in the final report, and interview responses will only be utilized by myself and shared with my practicum supervisor, Dr. Kathleen Stevens.

If you have any questions or would like to participate in the interview and contribute to the development of this resource, please contact me by replying to this email. Participation is voluntary.

Thank you for your time,
Sincerely,
Allison Bragg

Appendix H: Protection Services Interview Guideline (A)

Thank you for agreeing to assist me in developing a resource focused on the prevention and management of workplace violence from patients and visitors for the acute care nurses on inpatient units. Before we begin, I just want to remind you that participation is voluntary. You do not have to answer all questions and you may terminate the interview at any time. The interview will not be recorded but I will be taking notes. The notes will be transcribed into a Word document and saved on my personal, locked, computer. Information obtained from the interview will be used for a final report, but there will be no identifying information provided. Interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens. Once the project is complete, the information will be deleted. Do you have any questions before we begin?

1. What is the role of protection services in the event of a physically or verbally aggressive patient and/or visitor on an acute care unit?
2. Are protection services notified when there is a patient admitted with a history of violence or aggression? If so, how does this communication occur?
3. Are you able to share statistical data of the number of workplace violence incidences in the Health Sciences Centre in the last year?
4. Do you feel that nurses use protection services to their full capacity? (Do they call for assistance to de-escalate situations and/or for assistance with restraining patients). If yes, how do they use them? If no, why don't they use them?
5. What are factors contributing to aggressive patients and visitors in acute care areas? (overcrowding, wait time, substance misuse/abuse, communication, restrictions)
6. What are barriers you see related to nurses preventing and managing WPV? (experience,

age, workload, time, unclear re. the policy and procedures)

7. What are facilitators? (experience, policies, education, working groups, clear communication between security and nurses, understanding each other's' roles)
8. What would facilitate the implementation of a resource to help nurses prevent and manage workplace violence? (collaboration between nurses and security, education brochures for patients and families outlining acceptable and unacceptable behaviour in the hospital setting, assessment tools, screening, unit meetings, walkthroughs)
9. What are some barriers in the implementation of a resource? (Time, money, staff, turnover of staff)
10. From a protection services perspective, what content do you think should be included in an educational resource on WPV prevention and management for nurses? (De-escalation, communication with the patient and family, communication with security personnel, risk assessment, management techniques, reporting)
11. Anything else you would like to add?
12. Would you be willing to be contacted during the development of this resource if needed?

Thank you for your time.

Appendix I: Protection Services Interview Guideline (B)

Thank you for agreeing to assist me in developing a workplace violence resource for the medical-surgical acute care nurses. Before we begin, I just want to remind you that participation is voluntary. You do not have to answer all questions and you may terminate the interview at any time. The interview will not be recorded but I will be taking notes. The notes will be transcribed into a Word document and saved on my personal, locked computer. Information obtained from the interview will be used for a final report, but there will be no identifying information provided. Interview responses will only be utilized by me and shared with my practicum supervisor, Dr. Kathleen Stevens. Once the project is complete, the information will be deleted. Do you have any questions before we begin?

1. What is the role of protection services in the event of a physically or verbally aggressive patient and/or visitor in acute care areas (inpatient areas)?
2. What happens when you are called to come to an inpatient unit because of a WPV issue with a patient and/or visitor?
3. How is this communicated to you? (code white, called to come assist)
4. What is communicated to you? (room number) Is this sufficient?
5. Is there anything else that you think should be communicated to you in the initial contact? (dx, number of people involved, behavior)
6. As security officers, what is your role when you are contacted by nursing staff to assist with aggressive or violence patients or visitors?
7. Do you feel that nurses attempt to manage the situations themselves before they contact you? How do you think they attempt to manage it?
8. Is there any information regarding your role as a security officer that you believe nurses

are unaware of? If yes, what is the impact of this?

9. What are barriers related to nurses preventing and managing WPV? (Experience, age, workplace demands, lack of clarity re. policy and procedures, not communicating details of the situation)
10. What are facilitators? (Education, working groups, support from organization, understanding and applying the policy, clear communication)
11. What would facilitate the implementation of a resource to help nurses prevent and manage workplace violence? (collaboration between nurses and security, walkthroughs, education brochures for families outline acceptable and unacceptable behaviour in the hospital setting, assessment tools, screening, unit meetings)
12. What are some barriers in the implementation of a resource? (Time, money, staff)
13. From your experience in assisting nurses with aggressive situations, are there areas that you believe should be targeted in an educational resource to assist nurses in increasing knowledge and confidence in how to prevent and manage aggressive situations? (de-escalation techniques, communication, physical restraints, risk screening tools)
14. Is there anything else you would like to add?
15. Would you be willing to be contacted during the development of this resource if needed?

Appendix J: Script to ask for Local Researcher Participation

Hello, my name is Allison Bragg. I am Master of Nursing Student and I am currently working on completing my final practicum project. As you know, for my final project, I am working to create a resource to help nurses in the prevention and management of workplace violence from patients and visitors. Due to your previous research into workplace violence in acute care, I am seeking your voluntary participation in this endeavor and your permission to use information from this interview as part of my final report.

Participation in this consultation will occur using an interview. Questions will focus on the information you have gathered on workplace violence in acute care and your personal opinion on the development of potential resources based on your knowledge and experience. The interview will last 20-25 minutes. Before we begin, I want to remind you that this interview is voluntary. You may stop at any time and you do not have to answer all questions. This interview will not be recorded. I will take notes during the interview, which will be transcribed into a word document and saved on my personal computer until the end of this project. When the project is completed, the data will be deleted. As the information you share is related to the evidence from your own personal research, would it be okay if I used the information as part of my report?

Do you have any questions?

Thank you for your time. Let's get started!

Appendix K: Interview Guide for Local Researcher: Glenys Moran

1. It is my understanding that you completed research of workplace violence (WPV) on nurses in acute care. Can you tell me about your research? (Setting, Sample, Design, outcomes, implications for nursing)
2. What evidence in your research suggests that workplace violence (WPV) from patients and visitors is an issue in acute care? (absenteeism, WPV reports, injuries)
3. From your research, what were the nurses' perception of WPV? (Part of the job, not the patient's fault, zero tolerance)
4. What were the contributing factors to aggression from patients or visitors that you identified in your research? (lack of nurses knowledge and confidence, communication, overcrowding, experience/age of nurse, confusion, infection, substance misuse/abuse, nurse: patient ratio, belief that it's part of the job)
5. What was the impact of WPV on other patients and families? (delay in care, inadequate care, upsetting, stressful, impacted their care)
6. What was the impact of aggressive patients and visitors on staff? (Physical injuries- bites, scratches, bruises, MSK injuries, psychological/emotional, fear, resentment, PTSD, anxiety, impact on home life, missed work)
7. Were there any barriers in nurse's ability to prevent and manage aggressive situations that you identified during your research? (age, experience, workload, policy, workplace culture)
8. From your research, what are the needs of nurses in acute care in regard to preventing and managing workplace violence?
9. Did the nurses in your study make comment on the EH policies? Did they find them to be helpful? (Code white policies, AVB protocol) If yes – how? If no – why?

10. Are there any violence prevention action plans or resources that have been implemented in the areas you have researched? If so, what were they? What did they entail?
11. What resources do you think would be needed in a toolkit? (screening tools, pamphlets for families that overview aggression that can happen from delirium and anesthetic, communication processes for staff and security)
12. What educational topics do you think would be needed in a toolkit? (De-escalation, communication, code whites, risk management, risk assessment, AVB protocol, roles and responsibilities, legal/ethical issues)
13. From your research, what would you think is the best approach for delivery of education for preventing and managing WPV? (in person learning, compressed education, full day workshops, online learning (asynchronous vs synchronous))
14. From the literature, educational strategies based on actual patient situations have been shown to have a positive impact on the knowledge and education of nurses regarding WPV. What are your thoughts on these educational strategies?
15. Active learning techniques were also shown to have positive impacts in regards to nurses confidence and knowledge in managing WPV? What are your thoughts on these educational strategies in comparison to passive learning? (Case studies, role playing, simulation, videos)
16. Risk assessment tools and checklist have been used in provinces such as Ontario and Nova Scotia to predict aggression and direct nursing care. What is your opinion on these tools from your research? Would they be beneficial?
17. In British Columbia, some healthcare authorities have made a WPV learning module mandatory for all staff. Do you think that this is something that should be considered here in NL? Why or why not?

18. When do you think nurses should receive WPV education? (orientation, annually)

19. What are potential barriers for implementing a WPV resources – what are facilitators?

20. Is there anything else you would like to share?

21. Would you be willing to be contacted during the development of this resource if needed?

Appendix L: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Allison Bragg

Title of Practicum Project: Workplace Violence Resource for Medical-Surgical Acute Care Nurses

Date Checklist Completed: June 14, 2021

This project is exempt from Health Research Ethics Board approval because it matches item number _____3_____ from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix M

Table One

Education Content Suggested by Key Informants

Education Content	Acute Care Medical- Surgical Nurses	Key Consultants	Local Researcher, Glenys Moran
What workplace violence is/Workplace culture	X	X	X
Body language and nonverbal cues	X	X	X
De-escalation and communication techniques	X	X	X
Risk factors/Triggers of aggression	X	X	X
Rights and roles of nurses	X	X	X
Roles of security officers/ When to involve security	X	X	X
Reporting and documenting violence	X	X	X
How to cope with workplace violence/ Aftercare of nurse	X	X	X
Physical protection techniques (i.e., self defence)	X	X	X

Legend: X: Not suggested; X: Suggested

Appendix N

Table Two

Education Delivery Methods Suggested by Key Informants

Education Delivery	Acute Care Medical- Surgical Nurses	Key Consultants	Local Researcher, Glenys Moran
Debriefing/Open Discussion	X	X	X
In person	X	X	X
Synchronous Online	X	X	X
Poster	X	X	X
Short Session (1-2 hours)	X	X	X
Full day education	X	X	X
Case study based on actual events	X	X	X
Safety huddle	X	X	X
Education administration starting in nursing school	X	X	X
Education administration in orientation	X	X	X
Annual education	X	X	X

Legend: X: Not suggested; X: Suggested

Appendix D

Workplace Violence Education Huddle Program

Facilitator's Manual

Table of Contents

Introduction

Welcome to the Workplace Violence (WPV) Education Huddle Program Facilitator's Manual. This manual has been developed for facilitators (e.g., clinical educators) to provide education to acute care nursing staff regarding the prevention and management of WPV from patients and visitors. This document is intended for the facilitator to use when delivering the WPV Education Huddles. The manual is not to be distributed to learners. Handouts to summarize previous and current Huddles will be provided to participants during each Education Huddle.

The Facilitator Role

As a facilitator you have the responsibility to deliver the content using a process and in an environment that supports adult learning. The roles and responsibilities of the facilitator are as follows:

- Deliver content concisely,
- Maintain focus,
- Confirm confidentiality,
- Relate relevance of topics to real-life nursing,
- Remain cognisant of time,
- Address the sensitivity of the topic of WPV and provide contact information for mental health resources,
- Offer encouragement to contribute to discussions or ask questions, and
- Reflect on each Huddle to determine successes and improvements.

About the Program

The purpose of the WPV Education Huddle Program is to address the nurses' learning needs related to WPV from patients and visitors that were identified from consultation with key stakeholders. The intended audience of the Education Huddles are acute care nurses (e.g., Registered Nurses, Licensed Practical Nurses, and Personal Care Attendants) on inpatients units. The Education Huddles can be adapted or modified for other areas such as long-term care and nursing education programs.

Education Huddles are short informative groups of approximately six people that are carried out on site during work hours. Each Huddle is intended to be approximately 15 minutes in length. The timing for the Huddle will vary based on the availability of the highest number of nurses and routines of the unit. The Huddles should be completed in order and at a rate of at least one per week to maintain continuity for participants.

The topics of each Huddle can be found below.

1. **WPV Education Huddle #1: Workplace Violence Overview.** The first Huddle introduces WPV, provides a definition of WPV, addresses the incidence and

prevalence of WPV, identifies the impact of WPV, and factors contributing to WPV.

2. **WPV Education Huddle #2: Assessment and Policies.** The second Huddle focuses on assessment using theory and two evidence based tools and two Eastern Health policies, the Aggressive Violent Behaviour (ABV) Policy and Least Restraint Policy.
3. **WPV Education Huddle #3: De-escalation and Personal Protection Strategies.** The third Huddle covers de-escalation techniques and personal protection strategies.
4. **WPV Education Huddle #4: Rights and Visitor Policy.** The fourth Huddle covers the rights of the nurse and patient as well as visitor guidelines.
5. **WPV Education Huddle #5: Responding to Violent Situations: Part One.** The fifth Huddle addresses the role of security, when and how to involve these supports, and the Code White policy.
6. **WPV Education Huddle #6: Responding to Violent Situations: Part Two.** The sixth Huddle is a follow up to Huddle #5 and focuses on the role of local police, when and how to involve these additional supports, the information to share with them, and safety huddles.
7. **WPV Education Huddle #7: Reporting and Documenting.** The seventh Huddle covers reporting and documenting.
8. **WPV Education Huddle #8: Debriefing.** The eighth and final Huddle focuses on the health and wellbeing of employees. This Huddle addresses debriefing after experiencing or witnessing violent or aggressive events. The Employee Family Assistance (EFAP) is reviewed.

Using the Facilitator's Manual

This resource manual will provide you with the information needed to deliver and evaluate WPV Education Huddles. Text presented in *italics* represents the information to be delivered to participants. The following information is provided for each WPV Education Huddle:

- Objectives,
- Preparation instructions,
- Suggested order for content delivery and time to be spent on each section,
- Introduction,
- Contact information for EFAP and mental health crisis line,
- A brief overview of previous Huddles,
- Relevant information for each topic with lead-in statements provided for each section,
- One to three discussion questions (The discussion questions can be found in a light grey box),
- A case study that will be introduced in the first Huddle and referred to throughout the remainder of the program (Appendix A),
- Key message(s), and
- A quick reference handout sheet.

Suggestions and Recommendations

- Review and practice the suggested outline and content prior to implementation. As the

Education Huddles are occurring during work hours, it is important for you to be prepared to deliver the content in the 15-minute timeframe.

- Review the preparation section and have handouts ready prior to the WPV Education Huddle.
- Meet with the unit Manager and Care Facilitators prior to initiating the program to determine what would work best for the unit (e.g., night shift, weekends, day shift, etc.).
- Visit the nurses during their report to determine if there is a time during the shift where they feel they may have 15 free minutes.
- Conduct the WPV Education Huddle twice per shift to allow all the nursing staff working that shift the opportunity to attend.
- Before beginning an Education Huddle, verbalize an understanding of nurses needing to leave to attend to patient care but ask them to do so as quietly as possible to avoid disruption.
- Recognize the importance of being flexible (e.g., if the unit is too busy the sessions may need to be rescheduled).
- Identify a quiet place to facilitate the Education Huddle that allows the nurses to remain available to their patients. For example, a report room could be an appropriate setting for the Education Huddles.
- Plan for formative, summative, and process evaluation. The understanding achieved from the Huddle can be evaluated using the case study questions. Additionally, an evaluation after the completion of all eight Huddles can be provided to staff to assess their learning and seek feedback for improvements related to the content and delivery method of the program.

Copyright

Two assessment tools, the STAMPEDAR Framework (Chapman et al., 2009) and the Acute Care Violence Assessment Tool (Public Services Health and Safety Association (PSHSA), 2017), are used in this educational program to help participants in identifying the risk of violence. The copyright for each is as follows:

1) STAMPEDAR Framework

- This STAMPEDAR Framework can be used for educational/training purposes such as this WPV Education Huddle Program up to a maximum of 999 participants over five years. An additional copyright will need to be obtained to use this assessment tool provided by the Facilitator's Manual after December 2026.

2) The Acute Care Violence Assessment Tool

- All material copyright 2021 Public Services Health & Safety Association. You may use and reproduce these materials as required for training and education purposes only.

WPV Huddle #1: Workplace Violence Overview

The purpose of WPV Education Huddle #1 is to provide an overview of WPV.

Objectives

By the end of WPV Education Huddle #1 participants will be able to:

1. Define and identify WPV,
2. Discuss incidence, prevalence, impact, and factors contributing to WPV,
3. Recognize that WPV is unacceptable, and
4. Apply content to a case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print copies of the following for participants:
  - Case study (Appendix A)
  - Handout for Huddle #1 (Appendix B)

Suggested Order for Content Delivery

1. Introduce staff to the WPV Education Huddle Program
2. Distribute handouts
3. Ask discussion question
4. Define and classify WPV
5. Identify the prevalence of WPV in healthcare in Canada
6. Ask discussion question
7. Present impact of WPV
8. Present contributing factors to WPV
9. Review case study and ask corresponding questions
10. Deliver key message

Introduction

- To begin, you should first introduce the WPV Education Huddles, providing an overview of what to expect. The following points should be reviewed with participants.
- Suggested time for delivery: **1 minute**

Lead-in Statement: *Welcome to the WPV Education Huddle Program. First, I would like to present an overview of the program and some housekeeping items.*

- *The aim of the WPV Education Huddle Program is to increase the nurses' awareness of WPV and to assist nurses in preventing and managing WPV.*
- *Eight Education Huddles lasting approximately 15 minutes each will be conducted over the next couple of months.*
- *The timing of each Huddle will vary based on the availability of most of the nurses.*

- *Two Education Huddles will be conducted during one shift to accommodate as many participants as possible.*
- *Handouts will be provided at the end of each Huddle and placed on the bulletin board.*
- *Handouts from previous Huddles will be provided at the beginning of each session and accompanied by a brief overview for those who were not present during the previous session.*
- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *WPV may be a sensitive topic based on your experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.*
- *If the content and discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or the Regional Director of the Employee Family Assistance Program (EFAP) at 777-3153.*
- *The first WPV Education Huddle will focus on what WPV is, incidence and prevalence, the impact of WPV, and contributing factors.*
- *Any questions before we begin?*

What is Workplace Violence?

- Begin with a discussion of the participant's perceptions of WPV. Next, define WPV, identify the classification, and provide examples.
- Suggested time for delivery: **4 minutes (2 minutes for discussion, 2 minutes for content)**

Discussion Question:
What is your perception of WPV? What does WPV mean to you?

- ***Workplace Violence*** *is defined as any verbal or physical violent act or threat directed toward working persons. There are four types:*
    1. *Type one is criminal intent,*
    2. *Type two is customer/client,*
    3. *Type three is worker on worker, and*
    4. *Type four is personal relationships.*
- *Type two is the most common source of violence in healthcare and will be the focus of these Education Huddles.*
- *WPV can be further divided into three categories:* ***physical****,* ***sexual****, and* ***psychological.***

1. ***Physical violence*** *entails any action that involves force against another. This may include hitting, punching, pushing, biting, or any other form of physical aggression.*

    Examples based on actual clinical experiences of Registered Nurses (RNs):
    1) "One night shift I was rounding on my patients in the middle of the night. I walked into my patient's bed space to find him standing up next to his bed. As I spoke to him to ask if he was okay, he turned around and without speaking placed his hands around my neck and pushed me against the wall. I was unable to call for help and my co-workers were not aware that I was going into a patient room.

Thankfully, after a few seconds he released me, and I was able to run away and call for help."
2) "A patient had a bad reaction to the anaesthetic from surgery. She wanted to leave the unit but could not leave since she was a fresh post-op patient. Despite multiple attempts to rationalize with her, the patient tried to leave the room. I tried to stop her from leaving by blocking her exit. She punched me in the face."

2. ***Sexual violence*** *is any physical or verbal behaviours based on gender or sexuality.*
   Examples based on actual clinical experiences of RNs:
   1) "I was sitting 1:1 with an impulsive patient as a new grad. The patient started calling me "baby" and "sexy." I told a senior staff member about the inappropriate comments, and she replied "oh, that's just John."
   2) "A patient we had on the unit was known to "accidentally" touch nurses inappropriately during care. Nurses were on edge caring for this patient."

3. ***Psychological violence*** *is threatening, intimidating, or demeaning behaviours exhibited by a person through actions such as shouting, swearing, criticizing, and passive aggression.*
   Examples based on actual clinical experiences of RNs:
   *1) "A patient was unhappy with the response time to his call bell. As a result, he walked into the hallway and loudly said "where's that b****" referring to me."*
   2) "One time a patient's family were unhappy with the wait time for surgery. When I told them that the patient had been bumped for the evening and would have to fast again in the morning he stated: "Someone is going to hear from me about the way this place is run. You people are useless.""

Incidence and Prevalence of WPV

- To support the argument that WPV is a problem you will provide statistics on the incidence and prevalence of WPV.
- Suggested time for delivery: **1 minute**

Lead-in Statement: *WPV is a real issue within healthcare.*

- *In 2005, a Canadian survey determined that physical violence was experienced by 28.8% of nurses in their last year of work and 43.6% reported feeling emotionally abused in the last year* (Statistics Canada, 2005).
- *A national online survey of 7153 regulated Canadian nurses completed in 2020, determined that 21.2% experienced verbal abuse from patients or family members every day and 20.6% experienced verbal abuse a few times per week. From the same sample of nurses, 29.2% experienced physical violence a few times per year, while 7.9% reported physical violence every day* (Hall & Visekruna, 2020).

Impact of WPV

- To demonstrate the effects of WPV, the impact of WPV on nurses, patients and the healthcare system will be addressed.

- You will begin this section with a discussion question followed by a description of the impacts of WPV identified from the literature.
- Suggested time for delivery: **4 minutes (1 minute for discussion, 3 minutes for content delivery)**

Lead-in Statement: *WPV negatively impacts nurses, patients, and the healthcare system. Let's explore this further.*

Discussion Questions: ***From your own experience, what do you think is the impact of WPV on:***
- ***nurses,***
- ***patients, and***
- ***the healthcare system?***

Prompts:
- *Physical, mental, emotional, or financial burden on nurses*
- *Delay in patient care, avoidance of patients*
- *Absenteeism, staff turnover*

- ***Nurses'*** *physical, mental, and emotional health can be negatively impacted by WPV, and nurses may also be subjected to financial burden due to implications of WPV. Examples of impacts on nurses are:*
    - *Back, arm, and head injuries, abrasions, bites, and bruises were recognized to be common physical injuries.*
    - *Nurses who were subjected to WPV from patients reported depression, anxiety, post-traumatic stress disorder, burn out, emotional exhaustion, frustration, resentment, fear, and apprehension.*
    - *A loss of work, out of pocket cost for physical or mental health treatments because of WPV exposure, or potential legal expenses could place financial strain on nurses.*
- ***Patient*** *care can also be impacted by WPV. Examples of impacts on patient care are:*
    - *Patient safety can be impacted because of the emotional exhaustion felt by the nurses. Emotional exhaustion of nurses has been linked to an increase in work-related infections, medication errors, and patient falls.*
    - *Fear of patient interactions can lead to avoidance of the patient.*
    - *The disruption of WPV from patients and/or visitors can lead to a delay in care.*
- *The implications of WPV on nurses impacts the* ***healthcare system.*** *Examples of impacts on the healthcare system are:*
    - *Absenteeism, disability, and poor retention result in a financial cost to the healthcare system.*
    - *It is estimated that the turnover cost of one Registered Nurse (RN) is an average of $40,038 USD (Nursing Solutions Incorporated, 2021). This is approximately $50, 100 CAD.*
    - *A national online survey of 7153 regulated Canadian nurses determined that 21.7% of nurses had intention to leave the nursing profession (Hall & Visekruna,*

2020). While this value is not solely reflective of the impact of WPV it demonstrates a turnover that could be impacted by the presence of WPV.

Factors Contributing to WPV

- The factors contributing to WPV will be reviewed in this section.
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *There are various factors that contribute to the risk of WPV; factors related to the nurse, patient, organization, and environment each can play a role in the risk of violent encounters.*

- ***Nurse-related Risk factors:***
    - *Nurses' direct and continued contact with patients immediately increases their risk of WPV.*
    - *Research has shown that age and experience have been noted to play a role in the occurrence of WPV with a younger age of nurses and lack of nursing experience identified as risk factors.*
- ***Patient-related Risk Factors:***
    - *History: Previous history of violence in the emergency department or inpatient units; history of mental illness such as psychosis, schizophrenia, bipolar, and depression; a history of substance misuse; and dementia increase the risk of violence.*
    - *Poor communication: A lack of communication between healthcare providers and patients was reported to increase the risk of violence from patients and visitors.*
    - *Postoperative: The placement of tubes or drains, and the occurrence of post-operative agitation or delirium can increase the risk of violence.*
    - *Traumatic brain injuries: The impulsivity and agitation associated with traumatic brain injuries pose the risk of violence.*
    - *Hospital Experience: Patients' experience with other departments and staff prior to being admitted to a unit may increase their risk of violence (Example: Patient may be verbally aggressive in radiology waiting room).*
- ***Organizational Risk Factors:***
    - *Higher patient to nurse ratio may result in more physical violence.*
    - *Overcrowding and long wait times are linked to violent outbursts.*
    - *A lack of staff training and preparedness increase the risk of violence.*
    - *Workplace cultures and management that are not invested in protecting staff from WPV present as risk factors for WPV.*
- ***Environmental Risk Factors** can be divided into four categories:*
    1. *Opportunity to gain access: Unmonitored stairwells, poor lighting, unsecured rooms increase risk of violence.*
    2. *Events that increase stress: Things such as environmental conditions and poor signage may increase the risk of violence.*
    3. *Opportunities to use objects as weapons (e.g., décor, hospital furniture, equipment) may increase the risk of violence.*
    4. *Limiting staff ability to respond to violent events: A lack of security systems, alarms, or devices to respond to violent situations or notify others may increase*

healthcare workers exposure to violence.

Case Study

- To help apply the content of WPV Education Huddle #1, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **3 minutes**

Lead-in Statement: *We will apply the content we covered in this Huddle to a case study.*
Question:

1. *Are there any contributing factors you can identify in the case study that may have led to the violent outburst?*

Key Message

- The facilitator will end the WPV Education Huddle with the delivery of a key message.

Lead-in Statement: *We will conclude today's Huddle with a key message:*

Workplace violence is present in acute care inpatient nursing units and has a negative impact on nurses' physical, mental, and emotional health, patient care, and on the healthcare system.

References

Angland, S., Dowling, M., & Casey, D. (2014). Nurses' perception of the factors which cause violence and aggression in the emergency department. A qualitative study. *International Emergency Nursing*, *22*(3), 134-139. http://doi.org/10.1016/j.ienj.2013.09.005

Chaiwuth, S., Chanprasit, C., Kaewthummanukul, T., Chareosanti, J., Srisuphan, W., & Stone, T. E. (2020). Prevalence and risk factors of workplace violence among registered nurses in tertiary hospitals. *Pacific Rim International Journal of Nursing Research*, *24*(4), 538-552. Retrieved from https://he02.tci-thaijo.org/index.php/PRIJNR/article/view/227889

Chapman, R., Perry, L., Styles, I., & Combs, S. (2009a). Consequences of workplace violence directed at nurses. *British Journal of Nursing*, *18*(20), 1256-1261. http://doi.org/10.12968/bjon.2008.17.20.45121

Fields, A., Huang, J., Schroeder, D., Spring, J. & Weingarten, T. (2018). Agitation in adults in the post-anaesthesia care unit after general anaesthesia. *British Journal of Anaesthesia, 121*(5), 1052-1058. http://doi.org/10.1016/j.bja.2018.07.017

Hall, L. M. & Visekruna, S. (2020). *Outlook on nursing: A snapshot from Canadian nurses on work conditions pre COVID-19.* Canadian Federation of Nurses' Union. https://nursesunions.ca/wp-content/uploads/2020/12/CFNU_outlook_ENfinal_web.pdf

Jacobson Consulting Inc. (2017). *Trends in own illness- or disability-related absenteeism and overtime among publicly employed registered nurses. Quick facts 2017.* https://nursesunions.ca/wp-content/uploads/2017/05/Quick_Facts_Absenteeism-and-Overtime-2017-Final.pdf

Lanctôt, N. & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression and Violent Behaviour, 19*, 492-501. http://dx.doi.org/10.1016/j.avb.2014.07.010

National Institute for Occupational Safety and Health. (2020, September 22). *Occupational violence.* Center for Disease Control and Prevention. https://www.cdc.gov/niosh/topics/violence/default.html

Nursing Solutions Incorporated. (2021). *NSI National health care retention & RN staffing report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

Registered Nurses' Association of Ontario (RNAO). (2019). *Preventing violence, harassment and bullying against health workers (2nd ed.).* http://www.rnao.ca/bpg

Statistics Canada. (2005). *Findings from the 2005 national survey of the work and health of nurses.* https://secure.cihi.ca/free_products/NHSRep06_ENG.pdf

Williamson, D. R., Cherifa, S., I., Frenetter, A. J., Mitjans, M. S., Charbonney, E., Cataford, G., Williams, V., Palacios, J. L., Burry, L., Mehta, S., Arbour, C., & Bernard, C. (2020). Agitation, confusion, and aggression in critically ill traumatic brain injury- a pilot cohort study. *Pilot Feasibility Study, 6*(1), 193. http://doi.org/10.1186/s40814-020-00736-5

WPV Education Huddle #2: Assessment and Policies

The purpose of WPV Education Huddle #2 is to apply Relational Inquiry (RI) in assessing potential or actual violent patients, to become familiar with assessment tools for identifying risk of aggression in patients, and review Eastern Health's Aggressive Violent Behavior (AVB) Alert Policy and Least Restraint Policy.

Note: The policies addressed in this WPV Education Huddle are Eastern Health policies. These sections can be modified or excluded to reflect the policies and regulations of the health authority in which you are delivering the Huddle.

Objectives

By the end of WPV Education Huddle #2 participants will be able to:

1. Apply RI in providing care for potentially aggressive patients,
2. Describe the STAMPEDAR Framework and Acute Care Violence Assessment Tool (VAT),
3. Identify potential signs of aggression,
4. Discuss the use of the AVB policy and Restraint policy,
5. Apply the AVB alert policy as necessary,
6. Identify when chemical or physical restraints must be initiated, and
7. Apply the content to a case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print copies of the following for participants:
    - Case study (Appendix A)
    - Handout for Huddles #1- #2 (Appendix B)
    - STAMPEDAR framework (Appendix C)
    - Acute Care VAT assessment tool (Appendix D)
    - Eastern Health's *Aggressive Violent Behaviour Alert Policy* (Appendix E)
    - Eastern Health's *Least Restraint- Mechanical and Environmental Policy* (Appendix F)

Suggested Order for Content Delivery

1. Introduction
2. Distribute handouts
3. Provide a brief review of the previous Education Huddle
4. Discuss RI and its application in caring for potential or actual aggressive patients
5. Ask discussion question
6. Present the STAMPEDAR framework (Appendix C)
7. Present the Acute Care VAT assessment tool (Appendix D)

8. Provide participants with a copy of the AVB policy and restraint policy for reference (Appendix E)
9. Discuss the AVB policy and the application and removal of the AVB alert
10. Discuss chemical and physical restraints and their initiation
11. Review the case study and ask corresponding questions
12. Deliver key message

Introduction

- To begin the WPV Education Huddle you should first provide an overview of today's Huddle and review the housekeeping items. The following points should be reviewed with participants.
- Suggested time for delivery: **1 minute**

Lead-in Statement: *Today's WPV Education Huddle is focused on the application of RI, violence assessment tools, and the application of Eastern Health's AVB policy* and *Least Restraint policy. Before we begin, I will review some housekeeping items.*

- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *As mentioned in the previous Huddle, WPV may be a sensitive topic based on your experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.*
- *If the content and discussion evoke any difficult emotions regarding your previous experiences related to WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.*
- *Any questions before we begin?*

Review

- You will provide a brief review of the previous Huddle to support participants' understanding of the content (See Appendix I for overview).
- Suggested time for delivery: **1 minute**

Lead-in Statement: *Before we begin discussing assessment tools and policies, we will first have a brief review of the previous WPV Education Huddle for any participants who may have missed it* (Refer to Appendix I).

Relational Inquiry

- Providing care for aggressive patients will be viewed using a theoretical lens, RI.
- In this section you will apply RI to caring for a potential or actual aggressive patient
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *A nursing theory, RI, can be applied to aggressive patient situations to help you assess the situation and provide nursing care.*

- *RI is formed by two overlapping concepts:* ***Relational Consciousness*** *and* ***Inquiry as a form of action*** *(Doane & Varcoe, 2015).*
    - ***Relational Consciousness*** *allows nurses to be mindful of the situation in which they are providing care.*
        - *It is the relational interplay between the intrapersonal (i.e., what is occurring within the person), interpersonal (i.e., what is occurring between all the people involved), and contextual (i.e., what is occurring in the surrounding environment) experiences of the individual.*
        - *In the case of WPV, there are often multiple contributing factors that lead to violent or aggressive outburst. Learning and understanding these factors and their relationship is essential.*
    - *The* ***Inquiry*** *is defined as a form of action.*
        - *It is how nurses choose to navigate their care based on the knowledge they have received through relational consciousness.*
        - *In considering the relational interplay during a potential or ongoing aggressive or violent event, nurses make the best decisions based on the intrapersonal, interpersonal, and contextual information.*

Signs of Aggression

- In this section the participant's perception of potential signs of aggression will be assessed.
- You will deliver the STAMPEDAR framework and the Acute Care VAT. Refer to Appendix C and D to assist with content delivery.
- The section will begin with a discussion question.
- Suggested time for delivery: **5 minutes (1 minutes for discussion, 2 minutes for STAMPEDAR framework, and 2 minutes for Acute Care VAT)**

Lead-in Statement: *With RI in mind, we will now look at the signs of aggression and how to monitor for potential violent outbursts from patients and visitors.*

Discussion Question: ***What are some signs that patients or visitors may have the potential to become aggressive?***

1. STAMPEDAR Framework

Lead-in Statement: *First, we will review the STAMPEDAR Framework. Please refer to the STAMPEDAR handout* (Appendix B).

- ***STAMPEDAR*** *is an acronym that can help nurses determine the risk of violence. The acronym list nine different components and corresponding cues that nurses should be mindful of when providing care* (Review components and cues from handout in Appendix B).

2. Acute Care Violence Assessment Tool

Lead-in Statement: *Next will be look at Ontario's Public Services Health and Safety Association's (2017) Acute Care VAT. Please refer to the Acute Care VAT handout* (Appendix C).

- *The Acute Care VAT provides an immediate assessment of the patient's risk of violence by identifying behaviours that are associated with a risk of violence.*
- *The aim of this tool is to identify interventions that improve worker safety and maintain quality patient care.*
- *Risk factors are assigned a corresponding score that determines suggested actions to take. This assessment tool also considers contributing factors that are patient specific and provides guidance related to de-escalation techniques, based on the patient's assessment* (Review identifying behaviours, interventions, and contributing factors from handout in Appendix C).

Aggressive Violent Behaviour Policy

- The AVB policy is used to alert members of the healthcare team of the risk of violence from a patient. In this section you will review the Eastern Health policy.
- Suggested time for delivery: **2 minutes**
- **NOTE:** The AVB policy is specific to Eastern Health. If you are delivering this Education Huddle in a facility outside of Eastern Health, you may skip this section, use it as a discussion piece to determine if the AVB policy could be a useful tool for your own health authority, or modify this section to review policies relevant to WPV that are used in your facility.

Lead-in Statement: *When violent or aggressive behaviours have been demonstrated, action should be taken to notify other members of the healthcare team. In Eastern Health, the implementation of the AVB alert is initiated. Copies of the AVB policy* (Appendix D) *have been passed around if you would like to refer to them after the Huddle.*

- ***AVB** is any behaviour or threat that gives workers a reason to believe that they are at risk of injury.*
- *These behaviours includes physical violence, intimidating or threatening gestures, throwing or shaking objects, stalking, direct verbal threats of harm or death, using objects to injure others, intentional destruction of property, and the presence of a gun or other weapon.*
- *By using an assessment tool, such as the VAT, the risk of violence can be determined.*
- ***Main points to remember in initiating an AVB alert for a patient:***
    - *Place patient in private room, if possible;*
    - *Complete order entry for AVB in Meditech. The AVB will be attached to the patient for future admissions unless it is reviewed by Client Relations and removed;*
    - *Implement visual cues: Place a purple sticker on chart or white board out of view of the public and place the sign included in the policy on the patient's door that states "consult with nursing staff prior to entering patient room;"*
    - *Documentation: Complete Clinical Safety Reporting System (CSRS) report, employee incident report, and investigation form. Documentation in the patient's chart providing an accurate and timely assessment of the event is required. Reporting and documentation will be covered in WPV Education Huddle # 7;*
    - *Notify manager and site security;*

- *If the risk of injury from the patient is **LOW,** notify patient or next of kin that an AVB alert has been implemented and provide an AVB alert brochure. If safety is threatened, do not notify patient until it is safe to do so; and*
- *Nursing staff do not have control over the removal of the AVB alert in the patient's electronic record. The patient or next of kin can have the AVB alert assessed for removal through Client Relations.*

Restraints

- In this portion of the Education Huddle, you will cover actions that can be taken by the nurse in managing WPV from patients if de-escalation techniques such as those to be discussed in WPV Education Huddle #3 do not work.
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *Sometimes verbal de-escalation techniques do not work. When the safety of patients and staff are threatened and there is a risk of damage to property restraints may have to be used. There are two common types of restraints that are used in acute care: **chemical** and **physical**.*

1. ***Chemical Restraints***
   - *Chemical restraints are any type of medication that is used to prevent or inhibit a particular type of behaviour or movement.*
   - *There are oral and intramuscular (IM) options for the delivery of chemical restraints.*
   - *The method of delivery will be patient and situation dependent. If the patient is distrusting and refusing medications, an IM injection will have to be administered. If the patient is agreeable to taking medications, oral options will allow the patient to feel as though they still have some control over their decisions.*
2. ***Physical Restraints***
   - *Physical restraints are used to limit a patient's movement. Eastern Health uses the **least restraint approach**. This means that all other options to de-escalate a situation or protect a patient have been deemed ineffective.*

- *Restraints should only be initiated if patient or staff safety is threatened, and all other de-escalation methods have been ineffective.*

Case Study

- To help apply the content of WPV Education Huddle #2, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **2 minutes**

Lead- in Statement: *We will apply the content we covered in this Huddle to the case study introduced in the first Huddle.*

Questions:

1. *How would you use RI to assess the patient and determine the plan of care?*
2. *Using the STAMPEDAR framework, were there any signs of potentially aggressive behaviour?*
3. *Looking at the Acute Care VAT, what score would you give this patient?*
4. *Did the actions of the patient warrant the placement of an AVB alert?*

Key Message

- You will end the WPV Education Huddle with the delivery of a key message.

Lead Statement: *We will conclude today's Huddle with a key message.*

The application of RI, evidence-based tools, and monitoring patients for signs and symptoms of violent outburst could prevent violence from occurring. If violent outburst from patients cannot be prevented, using appropriate policies can help protect yourself and others.

References

Chapman, R., Perry, L., Styles, I., & Coombs, S. (2009b). Predicting patient aggression against nurses in all hospital areas. *British Journal of Nursing*,*18*(8), 476-83. http://doi.org/10.12968/bjon.2009.18.8.41810

Eastern Health. (2017, December 13). *Aggressive-violent behaviour (AVB) alert (acute care only).* Eastern Health.

Eastern Health. (2019, June 11). *Least restraint- mechanical and environmental.* Eastern Health.

Public Services Health and Safety Association. (2017). Individual client risk assessment toolkit for healthcare settings. https://workplace-violence.ca/wp-content/uploads/2021/04/VPRASEEN0417-ICRA-Toolkit-Resource-Manual-V1.3-2017.12.12.pdf

WPV Education Huddle #3: De-escalation and Personal Protection

The purpose of WPV Education Huddle #3 is to provide an overview of de-escalation techniques and personal protection strategies nurses can utilize when providing care for potentially aggressive patients.

Objectives

By the end of the WPV Education Huddle # 3 participants will be able to:

1. Define de-escalation,
2. Implement potential de-escalation techniques when dealing with aggressive patients or visitors,
3. Identify personal protection strategies to use in potentially violent situations, and
4. Apply the content to a case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print copies of the following for participants:
  - Case study (Appendix A)
  - Handouts for Huddles #1- #3 (located in Appendix B)

Suggested Order for Content Delivery

1. Introduction
2. Distribute handouts
3. Provide a brief review of the previous Education Huddles
4. Define de-escalation
5. Discuss verbal and nonverbal techniques to de-escalate situations.
6. Ask discussion question
7. Address how to provide care to violent or aggressive patients safely
8. Discussing terminating aggressive interactions
9. Review case study and ask corresponding questions
10. Deliver key message

Introduction

- To begin the WPV Education Huddle first provide an overview of today's Huddle and review the housekeeping items. The following points should be reviewed with participants.
- Suggested time for delivery: **1 minute**

Lead-in Statement: *Today's Education Huddle is focused on de-escalation techniques and personal protection strategies. Before we begin, I will review some housekeeping items.*

- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *As mentioned in the previous Huddles, WPV may be a sensitive topic based on your*

experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.

- *If the content and discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.*
- *Any questions before we begin?*

Review

- In this section you will provide a brief review of the previous Huddles to support participants' understanding of the content (See Appendix I for overview).
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *Before we begin discussing de-escalation techniques and personal protection strategies, we will first have a brief review of the previous two WPV Education Huddles for any participants who may have missed them* (Refer to Appendix I).

De-escalation

- In this section you will define de-escalation and provide verbal and nonverbal de-escalation strategies.
- Suggested time for delivery: **2 minutes**

Lead in Statement: *When patients or visitors become violent or aggressive, de-escalation techniques can be initiated to help prevent escalation.*

- ***De-escalation** is a strategy used to prevent and/or reduce the escalation of aggressive and violent incidents, and to decrease the need for mechanical and chemical restraints.*
- *Verbal and non-verbal communication can be used to de-escalate a situation.*
- *When attempting to de-escalate a situation there are two important concepts to keep in mind:*
    1. *The importance of staying safe in a potentially unsafe situation, and*
    2. *The need for continued compassionate and patient-centered care.*

Verbal and Nonverbal Strategies to Defuse Angry Patients or Visitors

- Be polite and considerate. Introduce yourself and call the patient by name.
- Make your first contact neutral. Ask the patient how you can help. Speak slowly, quietly and confidently. Do not interrupt.
- Do not make assumptions. Ask patients why they are behaving a certain way. Acknowledge the patient's feelings and concerns.
- Confirm your understanding of the issue or problem by repeating what the patient or visitor has said.
- Avoid using medical terms.
- Be honest. Making promises you cannot keep will cause distrust.
- Keep the patient's attention focused on the current issue.

- Always attempt to explain delays.
- Avoid giving commands.
- Assess the need for medication and offer medication as appropriate.
- Explain that violence is unacceptable and the outcomes that will occur if violence continues.

Source: Registered Nurses Association of Ontario (RNAO) (2019a) and RNAO (2019b)

- *It is important to assess situations to determine if de-escalation is possible. The ability to determine when situations have moved past verbal de-escalation is important.*

Providing Care for Potentially Violent Patients

- You will provide participants with potential actions to protect themselves and others in the event of a violent or aggressive patient and/or visitor.
- Suggested time for delivery: **4 minutes (2 minutes for discussion and 2 minutes for content)**

Lead-in Statement: *Despite your best efforts, some patients or visitors may become verbally or physically aggressive. As a nurse, you must become familiar with ways to help protect yourself when patients have been recognized to have the potential to become violent.*

Discussion Question: ***When providing care to patients who have the potential to become violent, what are some actions you can take as a nurse to protect yourself?***

Self-Protection Strategies

- Do not invade personal space and position yourself on the same level.
- Place yourself so that you have a clear exit.
- Use calm body language (e.g., hands open, attentive facial expression, relaxed posture).
- Avoid pointing, gesturing, and making sudden movements.
- Avoid touching the person, staring eye contact, wearing jewelry that can be pulled, and wearing tight clothing as it can restrict movement.
- Remove items around the neck or be sure they have a breakaway feature.
- Utilize security: If a patient has a known history of aggression, have security present on the unit during interactions. **Security Telephone number: 777-7280.**
- Work in teams. If patient is wearing down one staff member, have another take over.
- Assess for Aggressive Violent Behaviour Alert. Ensure alert is applied if necessary to protect others.

Terminating Aggressive Interaction

- *When safety is threatened, terminate the interaction.*
- *Calmly interrupt conversation and inform the patient or visitor that the conversation is over.*
- *Leave the patient room and inform staff, manager, and site security.*

Source: National Institute for Occupational Safety and Health (2020), RNAO (2019b), and RNAO (2009)

Case Study

- To help apply the content of WPV Education Huddle #3, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **3 minutes**

Lead-in Statement: *We will apply the content we covered in this Huddle to the case study introduced in the first Huddle.*

Questions:

1. *Are there any de-escalation techniques that the nurse could use in this situation?*
2. *What are some actions the nurse could take to protect themself?*
3. *Did the nurse put themself at a risk of violence while caring for this patient? If so, how?*

Key Message

- You will end the WPV Education Huddle with the delivery of a key message.

Lead Statement: *We will conclude today's Huddle with a key message.*

Actions can be taken to de-escalate situations. However, nurses can also utilize strategies to protect themselves from potentially aggressive situations.

References

National Institute for Occupational Safety and Health. (2020, September 22). *Occupational violence.* Center for Disease Control and Prevention. https://www.cdc.gov/niosh/topics/violence/training_nurses.html

Registered Nurses' Association of Ontario. (2019). *Preventing violence, harassment and bullying against health workers (2nd ed.).* www.RNAO.ca/bpg

Registered Nurses' Association of Ontario. (2019). *Promoting safety: Alternative approaches to the use of restraints.* https://rnao.ca/sites/rnao-ca/files/Promoting_Safety_-Alternative_Approaches_to_the_Use_of_Restraints_0.pdf

Registered Nurses' Association of Ontario. (2009). *Preventing and managing violence in the workplace.* https://rnao.ca/sites/rnaoca/files/Preventing_and_Managing_Violence_in_the_Workplace.pdf

WPV Education Huddle #4: Rights and General Visitation

The purpose of WPV Education Huddle #4 is to provide an overview of the rights of nurses and patients and review the visitation policy.

Note: The policies addressed in this WPV Education Huddle are Eastern Health policies. These sections can be modified or excluded to reflect the policies and regulations of the health authority in which you are delivering the Huddle.

Objectives

By the end of WPV Education Huddle #4 participants will be able to:

1. Identify the rights of nurses and patients,
2. Apply the visitation policy in managing visitors who exhibit unacceptable behaviour, and
3. Apply content to a case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print copies of the following for participants:
  - Case study (Appendix A)
  - Handouts for Huddles #1- #4 (Appendix B)
  - Eastern Health's (2021) *Family Presence and General Visitation Policy* (Appendix G)

Suggested Order for Content Delivery

1. Introduction
2. Distribute handouts
3. Provide a brief review of the previous Education Huddles
4. Identify the rights of nurses and their ethical obligations
5. Ask discussion question
6. Address components of the visitation policy and the occurrence of unacceptable behaviour demonstrated by visitors
7. Identify rights of patients
8. Review case study and ask corresponding questions
9. Deliver key message

Introduction

- To begin the WPV Education Huddle you should first provide an overview of today's Huddle and review housekeeping items. The following points should be reviewed with participants.
- Suggested time for delivery: **1 minute.**

Lead-in Statement: *Today's Education Huddle is focused on the rights of nurses and patients and Eastern Health's visitors' policy. Before we begin, I will review some housekeeping items.*

- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *As mentioned in the previous Huddles, WPV may be a sensitive topic based on your experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.*
- *If the content and discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.*
- *Any questions before we begin?*

Review

- You will provide a brief review of the previous Huddles to support participants' understanding of the content (See Appendix I for overview).
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *Before we begin discussing the rights of nurses and patients and the visitor's policy, we will first have a brief review of the previous three WPV Education Huddles for any participants who may have missed them* (Refer to Appendix I).

Nurses' Rights

- Identifying the rights of nurses in preventing and managing WPV is essential.
- This section will begin with rights of nurses and ethics related to the duty to provide care.
- You will ask a discussion question to allow nurses to share their thoughts and opinions.
- Suggested time for delivery: **3 minutes (1 minute for content and 2 minutes for discussion)**

Lead-in Statement: *In preventing and managing WPV from patients and visitors, it is important to identify the rights of nurses.*

- *The Canadian Nurses Association (CNA) and Canadian Federation of Nurses Union (CFNU) (n.d.) believe that:*
  All nurses have the right to work in a respectful environment that is free from any form of violence and bullying and to work where these are not tolerated as part of a nurse's job.
- *According to the Occupational Health and Safety Act of Newfoundland and Labrador (1978) workers can refuse to do work that they have reason to believe to be unsafe or dangerous to their personal health and safety or the health and safety of others.*
- *It is important to note that refusing to do work should not be the first step. If care is deemed unsafe, then actions must first be taken to try to rectify the issue.*

Discussion Question*: As a nurse you have an ethical duty to provide safe, compassionate, competent, and ethical care. How can you provide this standard of care when your own safety is threatened?*

Eastern Health's Visitation Policy

- The presence of visitors and support persons is recommended for the health and well-being of patients. However, visitation must occur in accordance with the policy guidelines.
- You will provide an overview of the important components of Eastern Health's visitation policy.
- Suggested time for delivery: **2 minutes**
- **NOTE:** The visitor's policy is specific to Eastern Health. If you are delivering this Education Huddle in a facility outside of Eastern Health, please refer to the health authority's visitation policy to modify this section.

Lead-in Statement: *Visitors are an important part of patients' recovery process.*

- *Eastern Health supports the presence of family and support persons.*
- *In Eastern Health patients are permitted to identify support persons who can be present for 24 hours a day.*
- *The remainder of visitors must follow the visiting guidelines enacted by the unit (typically 11am-9pm).*
- *Unacceptable behaviours exhibited by visitors will not be tolerated.*
- *Eastern Health (2013) recognizes behavior as being abusive/aggressive/threatening when:*
    - *the physical and psychological safety of persons and their property has been threatened; and*
    - *extreme intentional or un-intentional behavior is exhibited.*
- *If unacceptable behaviour such as being abusive, aggressive, or threatening is demonstrated by the support person/caregiver or general visitor, the health care professional assigned to the patient will:*
    - *inform the person(s) of the unacceptable behaviour;*
    - *make efforts to resolve the issues that does not compromise the care or safety of others; and*
    - *contact or consult with security if unable to resolve the unacceptable behaviour. This could potentially result in the removal of the support person/caregiver, substitute decision maker, or visitor from the property.*
- *If visitors are demonstrating physical or verbal aggression or not following visiting guidelines, security should be notified. In the event of unresolved or ongoing disturbances, the Protection Services department can issue a "Trespass Notice" to visitors. This will restrict them from visiting the site. This is typically used when police become involved.*

Patient Rights

- In the event of a violent or aggressive patient, it is important to remember that patients have rights.
- In this section, you will identify the 11 rights outlined for patients within Canada.
- Suggestion time for delivery: **2 minutes**

Lead-in Statement: *Canadian residents have a right to medically necessary healthcare. We will discuss 11 rights of patients that must be met in all Canadian provinces. Patients must have the right to:*

1. *Receive appropriate and timely care,*
2. *Be treated with dignity and respect,*
3. *Receive health services without discrimination,*
4. *Have their personal and health information protected from disclosure,*
5. *Have access to their health information unless, in the opinion of a relevant health professional, the disclosure could result in immediate and grave harm to the patient's health or safety,*
6. *Refuse consent to any proposed treatment,*
7. *Receive information relating to any proposed treatment and options,*
8. *The recognition of their Representative or Substitute Decision-maker,*
9. *The recognition of their Advance Directive,*
10. *A second opinion, and*
11. *Pain and symptom management.*

Source: Canadian Health Advocates Incorporated (2021)

- *These rights do not include the right to be physically or verbally abusive to healthcare providers. When patients are a safety risk to themselves or others and verbal and non-verbal de-escalation methods are ineffective, restraints can be initiated. Refer to Huddle #2 for information regarding restraints and Huddle #3 for de-escalation techniques.*

Case Study

- To help apply the content of WPV Education Huddle #4, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **3 minutes**

Lead-in Statement: *We will apply the content we covered in this Huddle to the case study introduced in the first Huddle.*

Questions:

1. *Do you feel that any of the patient's rights were impacted in the care he received?*
2. *Are the nurses' rights to a safe workplace free of violence being violated in this scenario? Why or why not?*
3. *Would the use of physical or chemical restraints be appropriate in this scenario? Why or why not?*

Key Message

- You will end the WPV Education Huddle with the delivery of a key message.

Lead-in Statement: *We will conclude today's Huddle with a key message.*

Nurses have a right to a safe workplace free of violence. Patient and visitors do not have the right to demonstrate physical, verbal, or sexual violence.

References

Canadian Health Advocates Incorporated. (2012). *Canadian patient rights.* https://canadianhealthadvocatesinc.ca/patient-rights/

Canadian Nurses Association and Canadian Federation of Nurses Union. (n.d.). *Joint position statement workplace violence and bullying.* http://cna-aiic.ca/~/media/cna/page-content/pdf-en/workplace-violence-and-bullying_joint-position-statement.pdf

Eastern Health. (2013, August 5). *Violence prevention, response, and support.* Eastern Health.

Eastern Health. (2018, May 4). *Prevention and management of violence/aggression in the emergency room.* Eastern Health.

Eastern Health. (2019, June 11). *Least restraint- mechanical and environmental.* Eastern Health.

Eastern Health. (2021, April 19). *Family presence and general visitation.* Eastern Health.

Occupational Health and Safety Act, c23 s43. (1978). https://www.assembly.nl.ca/legislation/sr/statutes/o03.htm

WPV Education Huddle #5: Responding to Violent Situations Part 1

The purpose of WPV Education Huddle #5 is to educate participants on the role of onsite security and review Eastern Health's (EH) Code White Policy.

Note: The policies addressed in this WPV Education Huddle are EH policies. These sections can be modified or excluded to reflect the policies and regulations of the health authority in which you are delivering the Huddle.

Objectives

By the end of WPV Education Huddle #5 participants will be able to:

1. Identify the role of onsite security officers concerning aggressive patients and visitors,
2. Identify when and how to contact security,
3. Apply EH's Code White Policy,
4. Discuss the roles of security and nurses in Code White situations,
5. Identify information to report to security in the event of their involvement, and
6. Apply content to a case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print copies of the following for participants:
  - Case study (Appendix A)
  - Handouts from Huddles #1 - #5 (Appendix B)
  - EH's (2018) *Prevention and Management of Violence/Aggression in the Emergency Room Policy* (Appendix H)

Suggested Order for Content Delivery

1. Introduction
2. Distribute handouts
3. Provide a brief review of the previous Education Huddles
4. Provide background information on the security personnel
5. Identify role of security personnel
6. Ask discussion question
7. Discuss when and how to contact security
8. Outline of information to share with security
9. Review the EH Code White Policy
10. Review Code White Action Plan
11. Review the case study and ask corresponding questions
12. Deliver key message

Introduction

- To begin the WPV Education Huddle you should first provide an overview of today's Huddle and review the housekeeping items. The following points should be reviewed with participants.
- Suggested time for delivery: **1 minute.**

Lead-in Statement: *Today's Education Huddle is focused on the role of security, when and how to contact them, the information to share with them, and Eastern Health's Code White Policy. Before we begin, I will review some housekeeping items.*

- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *As mentioned in the previous Huddles, WPV may be a sensitive topic based on your experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.*
- *If the content and discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the Family Employee Assistance Program at 777-3153.*
- *Any questions before we begin?*

Review

- You will provide a brief review of the previous Education Huddles to support participants' understanding of the content (See Appendix I for overview).
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *Before we begin discussing onsite security and Code Whites, we will first have a brief review of the previous four WPV Education Huddles for any participants who may have missed them* (Refer to Appendix I).

Onsite Security Personnel Health Sciences Centre

- In this section, you will provide an overview of the onsite security services located at the Health Sciences Centre.
- The roles of security personnel and when to contact security will be covered.
- This section will include a discussion question to determine participants' perceptions of security.
- Suggested time for delivery: **3 minutes (2 minutes for discussion and 1 minute for content delivery).**
- **Note:** This section is specific to onsite security at the Health Sciences Centre in EH. This section may be excluded or modified to reflect the security at your healthcare authority.

Lead-in Statement: *We will now discuss onsite security. We will address some important background information, their role in healthcare, when to contact them, and how to contact*

them.

Important Information about Onsite Security Officers:

- *The security officers for the Health Sciences Centre are contract agents. For example, Palladian security holds this contract at present.*
- *Security officers have:*
    - *Non-crisis intervention training.*
    - *Verbal de-escalation skills.*
    - *Force training which provides them with the knowledge to remove visitors or assist with physically restraining patients using the proper techniques.*

Role of Security Officers

- *Complete sporadic walk throughs of the unit (no set/specified time);*
- *Contact nursing units to confirm access for visitors after hours and at high-alert times (e.g., pandemic);*
- *Support staff when dealing with unacceptable behaviours by patients and visitors;*
- *Participate in code white situations as members of the Code White Team;*
- *Provide a security presence on the unit when nurses provide care to aggressive patients. Nurses can call onsite security to make this request, or an arrangement may be made between the Unit Manager and the Protection Services Department Manager based on the situation; and*
- *Escort visitors from the premises when unacceptable behaviours are displayed.*

Discussion Question: ***When dealing with aggressive patients or visitors when would you usually contact security?***

When and How to Contact Security

- *Security Officers are trained in verbal and nonverbal de-escalation techniques. Security Officers recommend that staff contact them before situations with patients and/or visitors starts to escalate (e.g. when still using verbal negotiation with the patient and/or visitor).*
- *Preventative measures are better than reactive measures. A code white is reactive.*
- *At the Health Sciences Centre security can be contacted by dialing 7280.*

Information to Share with Security Officers

- *When security officers ask for information, nurses are sometimes concerned about breaching patient confidentiality. Security officers do not need to know admitting diagnosis or any other medical information unless it pertains to the potential cause of the patient's aggression.*
- *Safety trumps privacy in the event of violent or aggressive encounters.*
- *Information to share with security personnel include:*
    - *The behaviours exhibited by the patient or visitor;*
    - *Any risk to the safety of the patient, staff, or security officer;*
    - *Any de-escalation attempted;*
    - *History of violence and any interventions that worked better than others;*

- *Patient history or diagnosis if it pertains to unacceptable or violent behaviour; and*
- *The nursing plan of care (e.g., the patient needs to be assisted back to bed and restrained and/or the nurse needs to give medication).*

Code White

- You will provide an overview of the EH Code White policy in this section.
- Suggested time for delivery: **5 minutes**
- **Note:** The Code White Policy and Action Plan is specific to EH. This section may be excluded, used as a discussion piece, or modified to reflect the policies or regulations within in health authority in which you are delivering the WPV Education Huddle Program.

Lead-in Statement: *In the event of an aggressive situation, a code white can be called. Components of the code white; the Code White Team members; and the roles of the Code White Team, nurses, and staff will be discussed in this section.*

- ***Code white** is defined as an aggressive situation.*
- *The goal of a code white is to prevent injury to the aggressive patient, other patients, and staff members and to prevent damage to property.*
- *A code white helps to ensure best and safe care until the patient's unacceptable behaviours change.*
- *Code whites are called when a violent situation is imminent or in progress.*
- *Staff members on the Code White Team have training and education in crisis intervention and de-escalation techniques.*
- *At the Health Sciences Centre a code white is called by dialing 2000.*
- *The caller notifies the operator to call a code white. It is essential to specify the code type so that the operator is clear what process to initiate. For example, if the caller says code, the operator may assume a code blue and the wrong team members will arrive. The caller reports the unit number and location of the aggressive event (e.g., room number, elevator, waiting room, etc.). For example: Code white, 3 West, room 137B.*
- *When a code white is called, verbal de-escalation techniques have likely proven to be ineffective. However, sometimes the presence of security is enough for the unacceptable behaviour to cease.*
- *A code white may involve the administration of chemical restraints and/or the application of physical restraints.*
- *Documentation and debriefing are important components of a code white. These will be discussed in WPV Education Huddle #7 and #8, respectively.*
- *EH (2018) has created a Code White Action Plan that outlines the responsibilities of the staff involved, specific nursing duties, and the duties of the Code White Team members.*
    1. ***Staff Responsibilities***
        - *move individuals at risk of danger to a safe space (if possible);*
        - *reduce stimulation (e.g., turn off radios, televisions, remove visitors);*
        - *reduce activity;*
        - *speak calmly and quietly;*
        - *provide details of the incident to the Code White Team Leader. Often the*

Team Leader wears a white shirt; the other members wear yellow or blue. The Team Leader will collect information regarding the event;
- *help the Code White Team as needed; and*
- *notify the manager or supervisor.*

2. Nursing Specific Responsibilities
- *Contact the physician to obtain orders for:*
  - *medication (oral and/or intramuscular),*
  - *restraints, if necessary,*
  - *seclusion, if necessary or possible (seclusion is not common in acute care areas);*
- *prepare and give medication if needed;*
- *continue to provide care to the remaining patients in the area. Oftentimes nurses determine which staff will attend to the code white situation while the remaining staff attend to other patients;*
- *participate in a debriefing following the incident; and*
- *complete required documentation and incident reports.*

3. Code White Team Members Responsibilities
- *report to the scene of the incident as quickly as possible;*
- *follow the direction of the Team Leader and inform them if unable to assume a "hands- on" position (i.e. physically remove or restrain aggressive individual);*
- *participate in a debriefing after the incident;*
- *report any injuries sustained to the team leaders; and*
- *assist with documentation as needed.*

Case Study

- To help apply the content of WPV Education Huddle #5, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *We will apply the content we covered in this Huddle to the case study introduced in the first Huddle.*

Questions:
1. *During the patient's violent outburst, when do you think would have been the appropriate time to contact security? What information would you share?*
2. *Would the patient's behaviours have deemed it necessary to call a code white? Why or why not?*
3. *What would be the process of calling a code white?*
4. *What would be the nurse specific responsibilities during a code white?*

Key Message

- You will end the Education Huddle with a key message that summarizes the important components of the Huddle.

Lead-in Statement: *We will conclude today's Huddle with a key message.*

Security should be viewed as a vital part of the team and used to their full potential. Code whites are called when aggressive situations need to be managed and verbal de-escalation efforts are not proving effective.

References

Eastern Health. (2018, May 4). *Prevention and management of violence/aggression in the emergency room.* Eastern Health.

Eastern Health. (2021, April 19). *Family presence and general visitation.* Eastern Health.

WPV Education Huddle #6: Responding to Violent Situations Part 2

The purpose of WPV Education Huddle #6 is to educate participants on the role of local police and discuss safety huddles.

Note: The policies addressed in this WPV Education Huddle are Eastern Health policies. These sections can be modified or excluded to reflect the policies and regulations of the health authority in which you are delivering the Huddle.

Objectives

By the end of WPV Education Huddle #6 participants will be able to:

1. Identify the role of local police concerning aggressive patients and visitors,
2. Identify when and how to contact local police,
3. Identify information to report to local police in the event of their involvement,
4. Identify and utilize safety huddles, and
5. Apply content to a case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print copies of the following for participants:
  - Case study (Appendix A)
  - Handouts from Huddles #1 - #6 (Appendix B)
  - Eastern Health's (2018) *Prevention and Management of Violence/Aggression in the Emergency Room Policy* (Appendix H)

Suggested Order for Content Delivery

1. Introduction
2. Distribute handouts
3. Ask discussion question
4. Identify when to contact police
5. Outline information to share with police
6. Introduce and discuss safety huddles
7. Ask discussion question
8. Review the case study and ask corresponding questions
9. Deliver key message

Introduction

- To begin the WPV Education Huddle you should first provide an overview of today's Huddle and review the housekeeping items. The following points should be reviewed with participants.

- Suggested time for delivery: **1 minute.**

Lead-in Statement: *Today's Education Huddle is focused on the role of local police, when and how to contact them, the information to share with them and the utilization of safety huddles. Before we begin, I will review some housekeeping items.*

- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *As mentioned in the previous Huddles, WPV may be a sensitive topic based on your experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.*
- *If the content and discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.*
- *Any questions before we begin?*

Review

- You will provide a brief review of the previous Education Huddles to support participants' understanding of the content (See Appendix I for overview).
- Suggested time for delivery: **3 minutes**

Lead-in Statement: *Before we begin discussing police and safety huddles, we will first have a brief review of the previous five WPV Education Huddles for any participants who may have missed them* (Refer to Appendix I).

Contacting Local Police Authority

- In this section you will address the need to contact local police in the event of violent or aggressive patients and/or visitors.
- Start the section by asking a discussion question to determine participant's perceptions regarding contacting police.
- Content will be delivered after the discussion.
- Suggested time for delivery: **4 minutes (2 minute for discussion and 2 minutes for content delivery)**

Lead-in Statement: *Sometimes unacceptable behaviours are beyond the control of nurses or security.*

Discussion Question: ***When do you think local police should be contacted in the event of violent or aggressive patients and/or visitors?***

- ***Local police should be contacted when:***
    1. *There is a real or perceived threat that lives are in danger,*
    2. *Code white situations move beyond the control of the Code White Team members,*
    3. *A sharp-edged weapon or firearm is present,*
    4. *The violent or aggressive individual is not present on hospital grounds (i.e., aggressor has followed you beyond the confines of your place of work),*

5. *The violent or aggressive individual is not a patient and threatens the safety of staff, patients, and/or visitors, and*
6. *Individuals want to report a violent incident or press charges against the aggressor (e.g., a sexual or physical assault or destruction of property has taken place).*

Lead-in Statement: *When police are contacted, they will require specific information. Use common terms as the police officers may not know the meaning of the codes used in the healthcare facility.*

- ***Provide the following information when contacting local police:***
  - *Nature of the incident;*
  - *Location of the incident;*
  - *The behaviour exhibited by the aggressor;*
  - *Any weapons that are involved and how they are being used;*
  - *Any injuries sustained by parties involved or aggressor;*
  - *The number of people involved and if they can exit the situation safely;*
  - *A description of the aggressor (e.g., name, race, sex, age, height, hair colour/style);*
  - *If the aggressor has left the premise, the time they left and the direction they were traveling in; and*
  - *Names of any witnesses or contact persons.*

- *If you are unable to stay on the phone due to the presence of the aggressor, leave the phone off the hook so 911 operators can hear.*
- *Police will assume control of the situation when they arrive.*

Safety Huddles

- In this section you will discuss safety huddles, how they are carried out, the relevant information to be shared, and the benefits of this strategy.
- Suggested time for delivery: **(3 minutes: 2 minutes for content, 1 minute for discussion)**

Lead-in Statement: *One way to communicate risk of violence to co-workers and staff members is by using safety huddles.*

- ***What are safety huddles?***
  - *Safety huddles are brief meetings that last 15 minutes or less.*
  - *They are used to keep staff informed of potential or current issues at work.*
  - *They can be used to educate, review work, and develop action plans to manage current or potential issues.*

- ***When should safety huddles be conducted?***
  - *Safety huddles can occur at regularly scheduled times or can be called for at any time.*
  - *There can be post-event huddles or daily huddles:*

A) ***Post-event huddles***
- *Occurs after an event, incident, or near miss and a staff member experiences WPV.*
- *Used to:*
  - *rectify any worker, patient, or system needs, and*
  - *discuss incidents that have occurred at other hospitals to help prevent it from occurring at your hospital.*

B) ***Daily huddles***
- *Used to:*
  - *provide staff with information regarding a patient or visitor that is at risk of violence to help prevent a violent encounter,*
  - *formulate an action plan,*
  - *review the threats to safety in the last 24 hours,*
  - *review current potential safety threats*
  - *determine if there are any high-risk patients or family on the unit, and*
  - *determine if there any other departments that should be notified of issues on your unit.*

- ***Important points to consider regarding safety huddles:***
  - *Safety huddles must be conducted by a leader and be short and focused.*
  - *Objectives for the huddles are important to ensure the huddle stays on track.*
  - *Everyone in the huddle has a voice.*
  - *Anyone that is affected by potential or actual violence should be included (e.g., ward clerk, domestic worker, medical service assistant, etc.).*
  - *A process for follow-up should be used.*

Discussion Question*: Do you think your unit would benefit from safety huddles? Why or why not?*

Case Study

- To help apply the content of WPV Education Huddle #6, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **2 minutes**

Lead- in Statement: *We will apply the content we covered in this Huddle to the case study introduced in the first Huddle.*

Questions:

1. *Would local police authorities have to be contacted during this event? At what point should they be contacted?*
2. *Should a safety huddle have been initiated? What would be the benefit? What kind of information do you think would be shared?*

Key Message

- You will end the Education Huddle with a key message that summarizes the important components of the Huddle.

Lead-in Statement: *We will conclude today's Huddle with a key message.*

When violence moves beyond the scope of on-site security, local police enforcements must be contacted to protect patients and staff. Safety huddles are an effective way to communicate potential or actual violent situations to unit staff.

References

Eastern Health. (2018, May 4). *Prevention and management of violence/aggression in the emergency room.* Eastern Health.

Eastern Health. (2021, April 19). *Family presence and general visitation.* Eastern Health.

WPV Huddle #7: Reporting and Documenting

The purpose of WPV Education Huddle #7 is to highlight the importance of reporting and documenting WPV.

Note: The content of this WPV Education Huddle is based upon the reporting requirements of the four Regional Health Authorities of Newfoundland and Labrador. Reporting WPV may need to be modified to reflect the policies and regulations of the provincial health authority in which you are delivering the Huddle.

Objectives

By the end of WPV Education Huddle #7, participants will be able to:

1. Identify appropriate channels to report WPV,
2. Recognize the importance of reporting and documenting WPV,
3. Identify the appropriate and essential information to include in documentation, and
4. Apply content to a case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print copies of the following for participants:
  - Case Study (Appendix A)
  - Handouts for Huddles #1- #7 (Appendix B)

Suggested Order for Content Delivery

1. Introduction
2. Distribute handouts
3. Provide a brief review of the previous Education Huddles
4. Ask discussion question
5. Discuss the importance of reporting
6. Identify appropriate channels for reporting
7. Examine appropriate documentation according to the Canadian Registered Nurses of Newfoundland and Labrador (CRNNL)
8. Review case study and ask corresponding questions
9. Deliver key message

Introduction

- To begin the WPV Education Huddle you should first provide an overview of today's Huddle and review the housekeeping items. The following points should be reviewed with participants.
- Suggested time for delivery: **1 minute.**

Lead-in Statement: *Today's Education Huddle is focused on reporting and documenting WPV. Reporting and documenting are two important components in the prevention and management of WPV. Before we begin, I will review some housekeeping items.*

- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *As mentioned in the previous Huddles, WPV may be a sensitive topic based on your experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.*
- *If the content and discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.*
- *Any questions before we begin?*

Review

- You will provide a brief review of previous Huddles to support participant's understanding of the content (See Appendix I for overview).
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *Before we begin discussing reporting and documenting, we will first have a brief review of the previous six WPV Education Huddles for any participants who may have missed them* (Refer to Appendix I).

What is the Importance of Reporting Workplace Violence?

- In this section you will address the importance of reporting WPV.
- A discussion question will be posed to determine participant's perceptions of reporting WPV.
- Suggested time for delivery: **3 minutes**

Lead-in Statement: *As identified in the first Huddle, WPV is a real issue in healthcare. However, it is suspected that the occurrence of violence is much higher due to a lack of reporting.*

Discussion Question: ***What do you think would be the main reason for individuals to not report WPV? What do you think would be the benefits of reporting?***

- ***When an incident is reported it helps ensure that:***
    1. *Client care is kept at the forefront,*
    2. *Risks are managed,*
    3. *Feedback is provided regarding the situation,*
    4. *Lessons are learned and shared, and*
    5. *Employees are supported in the event of an injury or adverse event.*
- *If WPV is not reported, it appears as though it is not an issue.*

Reporting WPV

- In this section you will provide participants with information regarding the process of reporting WPV.
- Suggested time for delivery: **4 minutes**

Lead in Statement: *It is important to report WPV. We will now discuss the process of reporting WPV, and the required documentation required in Eastern Health (EH).*

1. ***Manager/Supervisor***
    - *The manager or supervisor of the unit must be notified, either by phone or email, of a violent situation involving patients and visitors.*

2. ***Provincial Incident Employee Reporting System (PIERS)***
    - *The PIERS electronic incident reporting system is used in NL Regional Health Authorities (RHAs).*
    - *The purpose of this system is to determine the cause of the WPV situation.*
    - *The system links situations to determine associations, trends, and patterns.*
    - *It is used for incidents with patients and visitors.*
    - *The details relevant to PIERS:*
        a) *Who: Who was affected by the incident?*
        b) *What: What happened?*
        c) *When: When did the incident occur?*
        d) *Injury: Were any injuries sustained by the employee?*
        e) *Patient Handling: Patient handing assessment*

3. ***Clinical Safety Reporting System (CSRS)***
    - *An electronic reporting system used in all NL RHAs.*
    - *Completed by the person who identified or witnessed the occurrence.*
    - *This reporting system includes an assessment of the outcome of the occurrence.*
    - There are various levels of occurrences as identified by EH (2021):
        a) *Non-client related: The incident was not directly related to patient care.*
        b) *Level 0: Close class: the incident did not occur or reach the patient, but further management may be required.*
        c) *Level 1: An incident occurred but the patient was not harmed.*
        d) *Level 2: An incident occurred that required the need for increased patient assessment, but no treatment was required.*
        e) *Level 3: An incident occurred that harmed the patient and required treatment.*
        f) *Level 4: An incident occurred that caused temporary harm and negatively impacted the patient's health or quality of life.*
        g) *Level 5: An incident occurred that resulted in permanent change for the patient regarding their ability to function as normal.*
        h) *Level 6: An incident occurred that resulted in the death of a patient.*
4. ***Patient's record***

- *In the event of an aggressive encounter, a progress note must be completed in the patient's record, reporting the details of the event.*

Documenting Violent Incidents

- When a violent encounter occurs, the incident must be documented in the patient record.
- You will overview the important information to address in a patient note.
- **Note:** The information for this section was obtained from the CRNNL. If you are delivering this Education Huddle outside of NL, please refer to your nurse regulator to modify this section.
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *Documentation is a vital part of nursing. We will now discuss the important information to consider when documenting a violent or aggressive encounter with a patient. The CRNNL (2010) has provided a document regarding the documentation standards for nurses in NL.*

- ***Things to Consider when Documenting:***
  - *Be clear and concise: use objective data and facts.*
  - *Avoid generalizations: words like "appears," "seems," or "apparently" are not recommended in documentation. For example, do not say "patient appears agitated." Instead say "patient pacing hallway, muttering, with a furrowed brow."*
  - *Avoid bias: Do not make value judgments. Only document what can be supported by facts.*
  - *Identify subjective comments: Use quotations when reporting the thoughts, feelings, or statements made by the patient.*
  - *Re-read documentation before it is submitted. Electronic documentation cannot be erased.*
  - *The patient's chart should only include information that is relevant to the care of the patient.*
  - *Documentation should be first-hand information. If two or more nurses are involved in a single patient's care, the primary nurse should document the situation. The documentation should be reviewed by the other nurses involved, making an additional note for any other information that was not included.*

Case Study

- To help apply the content of WPV Education Huddle #7, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **3 minutes**

Lead- in Statement: *We will apply the content we covered in this Huddle to the case study introduced in the first Huddle.*

Questions:

1. *Do you feel that the incident with the patient should be reported? Why or why not?*
2. *Who should the nurse report the incident to?*
3. *Would the nurse complete the PIERS form and CSRS? Why or why not?*
4. *What information should be included in the note for the patient's record?*

Key Message

- You will end the WPV Education Huddle with the delivery of a key message.

Lead Statement: *We will conclude today's Huddle with a key message.*

Reporting WPV identifies a need for support. By reporting violence, resources and support will be allocated to address the issue.

References

Association of Registered Nurses of Newfoundland and Labrador. (2010). *Documentation standards for registered nurses.* *https://www.crnnl.ca/sites/default/files/documents/ID_Documentation_Standards.pdf*

Eastern Health. (2013, August 5). *Violence prevention, response, and support.* Eastern Health.

Eastern Health. (2018, May 4). *Prevention and management of violence/aggression in the emergency room.* Eastern Health.

Eastern Health. (2021, June 17). *Occurrence reporting and management.* Eastern Health.

Kim, S., Mayer, C., & Jones, C. B. Relationships between nurses' experience of workplace violence, emotional exhaustion, and patient safety. *Journal of Research in Nursing, 26*(1-2), 35-46. http://doi.org/10.1177/1744987120960200

Workplace Health, Safety and Employee Family Assistance Program. (2018, May 24). *Patient incident employee reporting system.* Eastern Health, Central Health, Labrador Grenfell Health, & Western Health.

WPV Education Huddle #8: Debriefing

The purpose of WPV Education Huddle #8 is to provide information related to debriefing and the Employee Family Assistance Program (EFAP).

Note: The EFAP is provided to Eastern Health (EH) employees. This section may be modified to reflect the support programs offered in the provincial health authority in which you are delivering the Huddle.

Objectives

By the end of WPV Education Huddle #8, participants will be able to:

1. Determine the need for debriefing sessions,
2. Recognize the availability of EFAP, and
3. Apply content to the case study.

Preparation

- ✓ Review content and practice timing
- ✓ Print handouts for WPV Education Huddles #1- #8 (Appendix B)

Suggested Order for Content Delivery

1. Introduction
2. Distribute handouts
3. Provide a brief review of the previous Education Huddles
4. Explain debriefings
5. Identify when debriefings should be conducted
6. Ask discussion question
7. Explain EFAP
8. Review case study and ask corresponding questions
9. Deliver key message
10. Conclude the WPV Education Huddles Program

Introduction

- To begin the WPV Education Huddle you should first provide an overview of today's Huddle and review the housekeeping items. The following points should be reviewed with participants.
- Suggested time for delivery: **1 minute.**

Lead-in Statement: *Today's Education Huddle is focused on debriefings and EFAP. Before we begin, I will review some housekeeping items.*

- *If you must leave to attend to patient care, please do so quietly to avoid disruption.*
- *As mentioned in the previous Huddles, WPV may be a sensitive topic based on your*

experiences. Participants are encouraged and supported in removing themselves from the Huddle if they become uncomfortable. No explanation is required.

- *If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.*
- *Any questions before we begin?*

Review

- You will provide a brief review of previous Huddles to support participants' understanding of the content (See Appendix I for overview).
- Suggested time for delivery: **3 minutes**

Lead-in Statement: *Before we begin discussing debriefing and EFAP, we will first have a brief review of the previous seven WPV Education Huddles for any participants who may have missed them* (Refer to Appendix I).

Debriefing

- In this section you will address the importance of debriefing and when debriefing should be conducted.
- Participants will be asked if they have taken part in a debriefing session before.
- Suggested time for delivery: **3 minutes (2 minutes for content, 1 for discussion)**

Lead-in Statement: *After any violent encounter, no matter how big or small, a debriefing may be warranted.*

Debriefing *is defined by EH (2013) as "a structured crisis intervention tool designed to assist a homogeneous group of people after an exposure to the same significant traumatic event" (p.6).*

- *A debriefing can occur within 48-72 hours after a critical incident and up to two weeks after the event.*
- *All individuals who witnessed or were involved in the incident can participate in the debriefing.*
- *The purpose of a debriefing is to alleviate the impact of the traumatic event, aid in the recovery of those exposed, and determine who needs further assistance.*
- *There are operational debriefings and critical incidence stress debriefings:*
  - *Operational debriefings should occur immediately after a traumatic event. They are the normal debriefing processes available to healthcare professionals.*
  - *Critical incidences debriefings are more specialized than operational debriefings but should not replace operational debriefings. Critical incidences are personal or community traumatic events that overwhelm normal coping skills.*
- *Employees must notify managers of an incident as soon as possible so that a debriefing can be arranged. If managers are not notified, they may be unaware that an event happened and therefore not arrange a debriefing.*

Discussion Question*: If anyone has been involved in a debriefing session, would you like to share your thoughts on the session and any benefits or drawbacks?*

Employee Family Assistance Program

- It is important for staff to be aware of resources that are available to them. Therefore, you will present and explain the EFAP to participants.
- Suggested time for delivery: **2 minutes**
- **Note:** EFAP is specific to the RHAs in NL. This section can be modified to reflect the support program offered by your health authority if this WPV Education Huddles Program is being delivered outside of NL.

Lead in Statement: *In the event of issues at home or at work, RHAs provide staff with the EFAP.*

- *The EFAP is a short-term employee benefit program.*
- *The goal of EFAP is to enhance the health and wellness of employees and improve productivity.*
- *It is offered to employees, employees' spouse or common-law partner, or dependents of the employee who live in the same home and are less than 21 years of age.*
- *EFAP helps with personal problems associated with home and/or work life.*
- *The EFAP coordinator completes assessments, referrals, and follow-up counselling services for employees and family members experiencing issues at work or at home.*
- *Employees are offered a maximum of six one-hour sessions per 12-month period. Unused sessions cannot be carried into the next year.*
- *Re-entry into program occurs with reassessment from the EFAP regional coordinator.*

It is important to consider that employees should participate in their own healthy practices to assist in managing critical incidents. Exercise, good eating habits, and support groups are personal ways to assist in managing critical incidents.

Case Study

- To help apply the content of WPV Education Huddle #8, a case study based on a clinical event will be discussed. Details of the clinical event have been altered to maintain confidentiality.
- Read the case study (Appendix A) to the group and ask the following questions.
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *We will apply the content we covered in this Huddle to the case study introduced in the first Huddle.*

Question:

1. *Do you feel that staff should have a debriefing after caring for this patient? Why or why not?*

Key Message

- You will end the Education Huddle with a key message that summarizes the important components of the Huddle.

Lead-in Statement: *We will conclude today's Huddle with a key message.*

Debriefing is essential for individuals who were involved in or witnessed violent events to assist with recovery. The EFAP is an additional support program that is available for staff and their families.

References

Aware-NS. (2020b). *Safety huddles tip sheet.* https://secureservercdn.net/45.40.148.234/sg7.82b.myftpupload.com/wp-content/uploads/2020/12/3-LL-Safety-Huddles-Tip-Sheet.pdf

Eastern Health. (2013, April 22). *Critical incidences stress management.* Eastern Health.

Eastern Health. (n.d.). *Family employee assistance program.* easternhealth.ca/employees-and-physicians/ohs-efap/efap/

Safe Care BC. (2019). *Safety huddles.* https://www.safecarebc.ca/wp-content/uploads/2019/11/Safety-Huddle-Book-November-13-FINAL.pdf

Wagner, C., Theel., A, & Handel, S. (2015). *Safety huddles. A guide to safety huddles.* http://www.wsha.org/wp-content/uploads/Worker-Safety_SafetyHuddleToolkit_3_27_15.pdf

WPV Education Huddle Conclusion

- You can conclude the WPV Education Huddle Program with a summary.
- Suggested time for delivery: **2 minutes**

Lead-in Statement: *This concludes the WPV Education Huddles Program.*

- *The aim of these Education Huddles was to provide acute-care inpatient nurses with the knowledge and skills to prevent and manage WPV.*
- *WPV from patients and visitors should not be tolerated. These Huddles helped to address the reality of WPV in healthcare and its potential impacts.*
- *During this program nurses were provided with information to support the application of RI, risk assessments, and evidence-based strategies in clinical practice such as de-escalation techniques and protection strategies.*
- *Nurses were given guidance on the application of restraints, calling code whites, initiating the AVB protocol, and contacting security or local police.*
- *The importance of communicating violent incidents using safety huddles, CSRS,*

PIERS, and patient notes were addressed. Reporting and documenting are important components in WPV.

- *Debriefings are important to help alleviate the stress of a traumatic incident. EFAP may need to be availed of in some instances.*
- *It is hoped that these WPV Education Huddles provided strategies to help nurses manage and prevent WPV from patients and visitors.*
- *Any questions, comments, or concerns.*

Appendix A: Case Study: Aggressive Patient

Mr. August was admitted to the unit for removal of a foreign body to his leg. The patient came to the floor post-operatively and was sleepy on arrival. In completing the admission data, the nurse noted that the patients had a history of alcohol misuse and schizophrenia. The nurse relayed this information onto staff. Overnight the patient slept and was pleasant and cooperative on nursing assessments.

The next day Mr. August became much more alert and active on the unit. He reported discomfort to his leg frequently the next day. The nurses medicated him with pain medications as ordered. While administering the patient morphine via a subcutaneous injection, he started to mutter something under his breath. The nurse asked him what he has said. Mr. August stared at the nurse silently before stating "I said, you are lying about the dose of pain medication." The nurse was taken back by this comment.

Throughout the shift the patient became much more disruptive on the unit. He was pacing the halls with a clenched jaw and furrowed brow. In his room he was loudly speaking ill of the nurses, medical staff, and the care he was receiving, using vulgar language. A patient on the ward called the nurse in and asked if she could be moved to a new room whispering that she was "afraid of the patient."

The nurses became uncomfortable providing care for the patient. They were concerned by the continued accusations regarding his care and were unsettled by the tone and aggression he demonstrated when he spoke. Since the patients in the ward feared Mr. August, he was moved into a private room. During one shift, the patient rang the call bell. When the nurse entered the room, the patient was noticeably upset that the nurse had "taken too long" to answer. The nurse apologized, explaining that she had three other patients and had been tied up. When the nurse left the room to get the patient his patient medications as requested, there was a loud crash against the door. The nurse opened the room door to discover that the patient had thrown his lunch tray against the door as she left the room.

Later in the shift, the patient required his dose of intravenous (IV) antibiotics. The nurse entered the room and noted that the IV pump was on the far side of the room, on the inside of the bed. After the patient's earlier outburst, she was uneasy about going into the room but felt that the patient needed the antibiotics to get better. Placing the patient's health above her own safety, the nurse entered the room and administered the medication.

Appendix B
Workplace Violence Education Huddle Handouts

Workplace Violence

Workplace Violence Overview

Education Huddle #1

- **Nurses are at high risk of Workplace Violence (WPV) and it is a common occurrence in healthcare settings.**
- **WPV** is defined as any verbal or physical violent act or threat directed toward working persons. There are four types:
  1. Criminal intent,
  2. Customer/client (most common in healthcare),
  3. Worker on worker, and
  4. Personal relationships.
- WPV can be further divided into three categories:
  1. **Physical violence**: any action that involves force against another (e.g. hitting and punching)
  2. **Sexual violence**: any physical or verbal behaviours based on gender or sexuality.
  3. **Psychological violence**: threatening, intimidating, or demeaning behaviours exhibited by a person (e.g. shouting and criticizing).
- **Impacts of WPV:**
  - **Nurses:** physical (e.g. back, arm, and head injuries); psychological/emotional (e.g. depression and post-traumatic stress disorder); financial: loss of work, out of pocket expenses for physical/psychological therapy or legal expenses
  - **Patients:** patient safety can be impacted due to emotional exhaustion of nurses, avoidance of patients, and disruption to patient care
  - **Healthcare System:** WPV results in absenteeism, turnover, and disability which is costly to the healthcare system.
- **Factors Contributing to WPV**
  1. **Nurse Related Factors:** Direct and continued patient contact, younger age, and lack of experience
  2. **Patient Related Factors:** history of violence, substance abuse/misuse, mental illness; poor communication; postoperative; and traumatic brain injury
  3. **Organizational:** Lack of education of staff, overcrowding, and higher patient to nurse ratio
  4. **Environmental:** opportunity to gain access, events that cause stress, item to be used as weapons, and limiting staff's ability to respond to violent events

***Key Message*: Workplace violence is present in acute care inpatient units and has a negative impact on nurses' physical, mental, and emotional health, patient care, and on the healthcare system.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Workplace Violence

Assessment and Policies

Education Huddle #2

• Assessment

Relational Inquiry is a nursing theory that can help nurses prevent and manage WPV and involves:

- **Relational Consciousness:** the relation interplay between the intrapersonal (i.e., what is occurring within the person), interpersonal (i.e., what is occurring between all the people involved), and contextual (i.e., what is occurring in the surrounding environment) experiences of the individual.
- **Inquiry as a form of action** is how nurses choose to navigate their care based on the knowledge they gained from assessing the relational interplay.

1) STAMPEDAR Framework

- **STAMPEDAR** is an acronym that can help nurses determine the risk of violence. The acronym lists nine different components and their associated cues that nurses should be mindful of when providing care: **S**taring, **T**one, **A**nxiety, **M**umbling, **P**acing, **E**motions, **D**isease process, **A**ssertive/non-assertive behaviours, **R**esources

2) Acute Care Violence Assessment Tool (VAT)

- The aim of this tool is to identify interventions that improve worker safety and maintain quality patient care.
- The Acute Care VAT provides a quick assessment of the patient's risk of violence. Risk factors are assigned a score that determines suggested actions.

• Policies

1) Aggressive Violent Behaviour (AVB) (*Eastern Health Policy Number: HR-OH(O)-020)*

- AVB is any behaviour or threat that gives a worker reason to believe they are in danger
- Nursing Responsibilities
  - Notify manager and on-site security
  - Move patient to private room and place policy sign on room door
  - Enter AVB alert in Meditech, place purple sticker on chart or whiteboard out of public view
  - Notify patient of placement of AVB alert and provide brochure if risk of injury is low
  - Complete documentation in patient chart, PIERS, and CSRS
- **Removal of an AVB alert is NOT a nursing duty and must be reassessed by client relations**

2) Least Restraint *(Eastern Health Policy Number: PRC-080).*

- **This policy is** used when all other de-escalation methods have been exhausted and there is a risk of injury to patients and/or staff
  - **Chemical restraints:** Medication that is used to prevent or inhibit a particular type of behaviour
  - **Physical restraints:** Equipment to limit or restrict patient's movement.

***Key Message*: The application of RI, evidence-based tools, and monitoring patients for signs and symptoms of violent outburst could prevent violence from occurring. If violent outburst from patients cannot be prevented, using appropriate policies can help protect yourself and others.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Workplace Violence

De-escalation and Personal Protection

Education Huddle #3

De-escalation Techniques

- Be polite and considerate. Introduce yourself and call the patient by name
- Make your first contact neutral. Ask the patient how you can help. Speak slowly, quietly and confidently. Do not interrupt.
- Do not make assumptions. Ask patients why they are behaving a certain way. Acknowledge the patient's feelings and concerns.
- Confirm your understanding of the issue or problem by repeating what the patient or visitor has said.
- Avoid using medical terms.
- Be honest. Making promises you cannot keep will cause distrust.
- Keep the patient's attention focused on the current issue.
- Always attempt to explain delays.
- Avoid giving commands.
- Assess the need for medication and offer medication as appropriate.
- Explain that violence is unacceptable and the outcomes that will occur if violence continues.

Personal Protection Strategies

- Do not invade personal space and position yourself on the same level.
- Place yourself so that you have a clear exit.
- Use calm body language (e.g., hands open, attentive facial expression, relaxed posture).
- Avoid pointing, gesturing, and making sudden movements.
- Avoid touching the person, staring eye contact, wearing jewelry that can be pulled, and wearing tight clothing as it can restrict movement.
- Remove items around the neck or be sure they have a breakaway feature
- Utilize security: If a patient has a known history of aggression, have security present on the unit during interactions. **Security telephone number: 7280**
- Work in teams. If patient is wearing down one staff member, have another take over.
- Assess for Aggressive Violent Behaviour Alert. Ensure alert is applied if necessary to protect others.

Terminating an Aggressive Interaction

- Calmly and politely tell the person the conversation is over.
- Leave the room and call security or a code white, as required.
- Notify co-workers of event and complete an incident report

***Key Message*: Actions can be taken to de-escalate situations. Nurses can also utilize strategies to protect themselves from potentially aggressive situations.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Rights of Nurses, Patients and Visitation Policy

Workplace Violence

Education Huddle #4

- **Nurse's Rights:** All nurses have the right to work in a respectful environment that is free from any form of violence and bullying and to work where WPV is not tolerated as part of a nurse's job.

- **Patient's Rights:** Patients have the right to:
    1. Receive appropriate and timely care,
    2. Be treated with dignity and respect,
    3. Receive health services without discrimination,
    4. Have their personal and health information protected from disclosure,
    5. Have access to their health information unless, in the opinion of a relevant health professional, the disclosure could result in immediate and grave harm to the patient's health or safety,
    6. Refuse consent to any proposed treatment,
    7. Receive information related to any proposed treatment and options,
    8. The recognition of their representative or substitute decision-maker,
    9. The recognition of their advance directive,
    10. A second opinion, and
    11. Pain and symptom management

- **Eastern Health's Visitation Policy** (Policy Number QRM-040)
    - Visiting a hospital facility is a privilege
    - Eastern Health supports the presence of visitors and support persons
    - Designated support persons can visit 24/7
    - General visitors must follow visiting hours (1100-2100)
    - Visitors who demonstrate unacceptable behaviour will be asked to leave

Key Message: **Nurses have a right to a safe workplace free of violence. Patient and visitors do not have the right to demonstrate physical, verbal, or sexual violence.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Workplace Violence

Responding to Violent Situations: Part 1

Education Huddle #5

Security

- **The role of security is to:**
  - support staff when dealing with unacceptable behaviours by patients and visitors;
  - escort visitors from the premises when unacceptable behaviours are displayed;
  - respond to a code white situation as members of the Code White Team.

- **When to contact security:** As early as possible. Early intervention is proactive and preferred.

- **Information to share with security officers regarding a violent situation:**
  - Behaviours exhibited by the patient and/or visitor,
  - Any de-escalation attempted,
  - Patient history and diagnosis, if it pertains to current aggression, and
  - Nursing plan of care (e.g., plan to use physical or chemical restraints)

- **Code white** is defined as an aggressive situation.
  - The goal of a code white is to prevent injury to the aggressive patient, other patients, and staff members and to prevent damage to property.
  - **Calling a code white at the Health Sciences Centre:**
    1. Dial 2000,
    2. Identify that you want to call a code white**,**
    3. State location (i.e., floor and room number).

Key Message: **Security should be viewed as a vital part of the team and used to their full potential. Code Whites are called when aggressive situations need to be managed and verbal de-escalation efforts are not proving effective.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Responding to Violent Situations: Part 2

Workplace Violence

Education Huddle #6

Role of Police

- **When to contact police regarding a violent situation:**
  - A real or perceived threat that lives are in danger,
  - A situation has moved beyond the control of the Code White Team,
  - Presence of sharp-edged weapon or firearm,
  - The violent individual is not present on hospital grounds,
  - The violent individual is not a patient and threatens the safety of staff or patients, and
  - To press charges against an aggressor
- **Information to provide to police:**
  - Nature and location of the incident,
  - Behaviours exhibited by the aggressor,
  - Any weapons involved,
  - Any injuries sustained by any parties involved or the aggressor,
  - The number of people involved and if they can exit safely,
  - A description of the aggressor (e.g., name, race, sex, age, height, hair colour/style)
  - If the aggressor has left the premise, report time and direction of departure , and
  - Names of any witnesses or contact persons

Safety Huddles

- Brief meetings that last 15 minutes or less that can occur daily or after a WPV occurrence.
- The purposes of safety huddles are to inform staff of potential or current issues, educate staff, review work, and develop action plans

***Key Message*: When violence moves beyond the scope of on-site security, local police enforcements must be contacted to protect patients and staff. Safety huddles are an effective way to communicate potential or actual violent situations to unit staff.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Workplace Violence

Reporting and Documenting WPV

Education Huddle # 7

- **Why is reporting workplace violence (WPV) important?**
  1. Ensures client care remains a priority (i.e. ensuring patients are safe during violent outburst)
  2. Risks are managed
  3. Feedback is provided regarding the situation
  4. Lessons are learned and shared
  5. Support is provided for a worker if an injury is sustained
  6. Support is provided to workers who experienced an adverse event

- **Where to Report WPV**
  1. Eastern Health Occurrence Form submitted to the Manager/Supervisor
  2. Provincial Incident Employee Reporting System (PIERS)
  3. Clinical Safety Reporting System (CSRS)
  4. Patient record

- **Important Considerations for Documenting WPV**
  - Be clear and concise: Use objective data and facts.
  - Avoid generalizations: Words like "appears," "seems," or "apparently" are not recommended in documentation. Example: Do not state "patient appears agitated." Instead, state "patient pacing hallway, muttering, with a furrowed brow."
  - Avoid bias: Do not make value judgments. Only document what can be supported by facts
  - Identify subjective comments using quotations
  - The patient's chart should only include information that is relevant to the care of the patient
  - *For more information on reporting and documentation visit your Regional Health Authorities policies and the College of Registered Nursing of Newfoundland and Labrador*

***Key Message*: Reporting WPV identities a need for support. By reporting violence, resources and support will be allocated to address the issue.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Workplace Violence

Debriefing and Employee Assistance

Education Huddle # 8

- **Debriefing** is a structured voluntary crisis intervention strategy designed to assist a group of people after exposure to the same significant traumatic event.
  - Debriefings should occur 48-72 hours or up to 2 weeks after an event
  - The benefits of debriefing are:
    - Alleviate the impact of the traumatic event,
    - assist with recovery, and
    - determines who needs additional assistance.
  - It is the employee's responsibility to inform employer/manager of a traumatic event
  - There are operational debriefings and critical incidence stress debriefings:
    - Operational debriefings should occur immediately after a traumatic event. They are the normal debriefing processes available to healthcare professionals.
    - Critical incidences debriefings are more specialized than operational debriefings but should not replace operational debriefings. Critical incidences are personal or community traumatic events that overwhelm normal coping skills.

- **Employee Family Assistance Program (EFAP)**
  - These supports are available for workers in addition to or separate from debriefings
  - Short-term employee benefit program
  - Goal is to enhance health and well-being of employees and increase productivity
  - Available to employees, their spouse/common-law, and dependents less than 21 years of age who live in the same household
  - EFAP helps with personal problems associated with home and/or work life.
  - Entitled to a maximum of six, one-hour sessions per 12-month period. Unused sessions cannot be carried over
  - Re-entry into program occurs with reassessment from EFAP regional coordinator

Key Message: **Debriefings are essential for individuals who were involved in or witnessed violent events to assist with recovery.**

If the content or discussions evoke any difficult emotions regarding your previous experience of WPV, please avail of the Mental Health Crisis Line at 1-888-737-4668 or contact the Regional Coordinator for the EFAP at 777-3153.

Appendix C: STAMPEDAR Framework

Component	Cues
Staring	• Staring • Not breaking eye contact/no eye contact
Tone	• Tone and volume of voice • Calling out in a loud voice • Aggressive tone • Demanding • Name calling • Swearing
Anxiety	• Anxiety • Agitated • Requiring reassurance
Mumbling	• Muttering
Pacing	• Refusing to stay in room • Refusing to stay in bed
Emotions	• Unhappy • Frightened • Frustrated • Dissatisfied with care
Disease Process	• Confusion • Intoxication (alcohol or drugs)
Assertive/non-assertive	• Disrespectful • Confrontational • Not assertive • Over assertive
Resources	• Long wait times • Inexperienced staff • Staff knowledge and skill level • Inappropriate communication style

Used with permission (Chapman et al., 2009b)

Appendix D: Public Services Health and Safety Association Acute Care Violence Assessment Tool (VAT)

Acute Care Violence Assessment Tool (VAT)

This form is to be completed by clinical healthcare worker or manager/supervisor.

Click on the box above to insert your logo

Patient's Name: _____

Identification #: _____

☐ **Initial Assessment** ☐ **Reassessment**

Section A: Risk Indicators

Read the list of behaviours below and identify behaviours that will require specific care interventions. A score of 1 is applied for past occurrence of any of the History of Violence behaviours; and additional scores of 1 are applied for each observed behavior. Add the scores — the maximum is 12.

HISTORY OF VIOLENCE: Score 1 for past occurrence of any of the following:	SCORE
▪ Exercising physical force, in any setting, towards any person including a caregiver that caused or could have caused injury ▪ Attempting to exercise physical force, in any setting, towards any person including a caregiver that could cause injury ▪ Statement or behaviours that could reasonably be interpreted as threatening to exercise physical force, in any setting, against any person including a caregiver that could cause injury	
OBSERVED BEHAVIORS: Score 1 for each of the observed behaviour categories below.	**SCORE**
Confused (Disoriented – e.g., unware of time, place, or person)	
Irritable (Easily annoyed or angered; Unable to tolerate the presence of others; Unwilling to follow instructions)	
Boisterous (Overtly loud or noisy – e.g., slamming doors, shouting etc.)	
Verbal Threats (Raises voice in an intimidating or threatening way; Shouts angrily, insulting others or swearing; Makes aggressive sounds)	
Physical Threats (Raises arms / legs in an aggressive or agitated way; Makes a fist; Takes an aggressive stance; Moves / lunges forcefully towards others)	
Attacking Objects (Throws objects; Bangs or breaks windows; Kicks object; Smashes furniture)	
Agitated/Impulsive (Unable to remain composed; Quick to overreact to real and imagined disappointments; Troubled, nervous, restless or upset; Spontaneous, hasty, or emotional)	
Paranoid / suspicious (Unreasonably or obsessively anxious; Overly suspicious or mistrustful – e.g., belief of being spied on or someone conspiring to hurt them)	
Substance intoxication / withdrawal (Intoxicated or in withdrawal from alcohol or drugs)	
Socially inappropriate / disruptive behaviour (Makes disruptive noises; Screams; Engages in self-abusive acts, sexual behaviour or inappropriate behaviour – e.g., hoarding, smearing feces / food, etc.)	
Body Language (Torso shield – arms / objects acting as a barrier; Puffed up chest – territorial dominance; Deep breathing / panting; Arm dominance – arms spread, behind head, on hips; Eyes – pupil dilation / constriction, rapid blinking, gazing; Lips – compression, sneering, blushing / blanching)	
TOTAL SCORE	
Patient's Risk Rating: ☐ Low (0) ☐ Moderate (1-3) ☐ High (4-5) ☐ Very High (6+)	

Completed By (Name/ Designation)_____ **Date:** _____

Section B: Overall Risk Rating

Apply the total behaviour score to the Risk Rating Scale to determine whether the patient's risk level is low, moderate, high or very high. Each level provides cues for further action to consider. If moderate or high / very high risk is determined, complete Section C to identify factors that may trigger or escalate violent, aggressive, or responsive behaviour and ensure the care plan includes measures to avoid or reduce risk behaviours identified.

Overall Score	Actions to take
Low **Score of 0**	▪ Continue to monitor and remain alert for any potential increase in risk ▪ Communicate any change in behaviours, that may put others at risk to the unit manager / supervisor ▪ Ensure communication devices / processes are in place (e.g., phone, personal safety alarm, check-in protocol and / or global positioning tracking system)
Moderate **Score of 1-3**	▪ Apply flag alert ▪ Promptly notify manager / supervisor so they can inform relevant staff and coordinate appropriate patient placement, unit staffing, and workflow ▪ Alert security and request assistance as needed. Ensure to inform security of risk management plan ▪ Scan environment for potential risks and remove if possible ▪ Ensure section c is completed and initiate the violence prevention care planning process – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers ▪ Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care) ▪ Be prepared to apply behaviour management and self-protection teachings according to organizational policy/ procedures that are appropriate for the situation - training programs provided may include GPA, Montessori, SMG, P.I.E.C.E.S, U-First, Stay Safe MORB training, self-defense ▪ Ensure communication devices / processes are in place (e.g., phone, personal safety alarm, check-in protocol and / or global positioning tracking system) ▪ Communicate any change in behaviours, that may put others at risk to the unit manager / supervisor ▪ Inform client of vat results, when safe to do so other ▪ Other:_____
High **Score of 4-5** **OR** **Very High** **Score of 6+**	▪ Apply flag alert ▪ Promptly notify manager / supervisor so they can ensure relevant staff are on high alert and prepared to respond ▪ Alert security and request security assistance as needed. Ensure to inform security of risk management plan ▪ Scan environment for potential risks and remove if possible ▪ Ensure section c is completed and initiate the violence prevention care planning process – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers ▪ Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care ▪ Be prepared to apply behaviour management and self-protection teaching appropriate for the situation in accordance to organizational policy / procedures – training programs provided may include GPA, Montessori, SMG, P.I.E.C.E.S, U-First, Stay Safe, MORB training, self-defense ▪ Initiate applicable referrals ▪ Ensure communication devices / processes are in place (e.g. Phone, personal safety alarm, check-in protocol and / or global positioning tracking system) ▪ Communicate any change in behaviours, that may put others at risk, to the unit manager / supervisor so they can coordinate appropriate patient placement, unit staffing, and workflow ▪ Call 911 / initiate code while response as necessary ▪ Inform client of vat results, when safe to do so ▪ Other: _____

Section C: Contributing Factors

Physical, psychological, environmental, and activity triggers can lead to or escalate violent, aggressive or responsive behaviours. Documenting known triggers and behaviours and asking your patient or substitute decision maker (SDM) to help identify them can help you manage them more effectively and safely. Use the information collected and the intervention resources listed on p.2 and p.11 to develop an individualized violence prevention care plan and a safety plan to protect workers at risk.

QUESTION FOR CLIENT:	CONSIDERATIONS – Select any that Apply			
	PHYSICAL	**PSYCHOLOGIAL**	**ENVIRONMENTAL**	**ACTIVITY**
To help us provide the best care possible, please describe if there is anything during your stay that could cause you to become agitated, upset or angry e.g., I am agitated when…	☐ hunger ☐ pain ☐ infection ☐ new medication ☐ other_____	☐ fear ☐ uncertainty ☐ feeling neglected ☐ loss of control ☐ being told to calm down ☐ being lectured ☐ other_____	☐ noise ☐ lighting ☐ temperature ☐ scents ☐ privacy ☐ time of day ☐ days of the week ☐ visitors ☐ small spaces/ overcrowding ☐ other_____	☐ bathing ☐ medication ☐ past experiences ☐ toileting ☐ changes in routine ☐ resistance to care ☐ other_____
What works to prevent or reduce the behaviour(s) e.g., When I am agitated, it helps if I…	☐ Go for a walk ☐ Listen to music ☐ Watch TV ☐ Draw ☐ Read (Bible/Book) ☐ Have space and time alone ☐ Talk 1:1 with _____(who?) ☐ Participate in activities ☐ Consult a family member or friend	**POTENTIAL DE-ESCALATION TECHNIQUES** Identify potential de-escalation strategies using above information such as respect personal space, actively listen, offer choices, give eye contact, use humor		

Used with Permission (PSHSA, 2017)

Appendix E: Aggressive Violent Behaviour Alert

AGGRESSIVE-VIOLENT BEHAVIOUR (AVB) ALERT (ACUTE CARE ONLY)	Occupational Health & Safety HR-OH(o)-020

Issuing Authority	**Collette Smith, Vice President** Signed by Collette Smith Dated May 25, 2017
Office of Administrative Responsibility	Occupational Health & Safety Division; Quality, Patient Safety and Risk Management
Author	Tara Hunt, Occupational Health & Safety Coordinator
Level	Two (II)
Original Approval Date	May 25, 2017
Effective Date	December 13, 2017
Scheduled Review Date	May 2020
Actual Review Date	
Revised Date(s)	

Overview

Eastern Health acknowledges that violence in the workplace is an occupational health and safety hazard that can cause harm. Eastern Health is committed to providing a safe workplace and will take all reasonable steps to prevent violence.

POLICY

Aggressive/Violent behavior (AVB) as noted in the definition section, is defined as any behavior, including threats, that gives staff reasonable cause to believe he/she is at risk of injury.

Any patient who is assessed to be at risk of AVB will be subject to an alert being placed on their health record to warn health care workers. The alert is placed on the health record using both an electronic flagging system and visual indicators. This is to ensure that all staff that come in contact with the patient are aware of the risk of potential violence and aggression, and that the appropriate care is provided to the patient. AVB Alert designation will not impact the standard of care for a patient.

Confidentiality will be maintained wherever possible. Information which relates to the alert will be shared with staff(s) in the circle of care as required through a verbal report, chart documentation, and visual cues (i.e. purple indicator on the white board where applicable and if located away from public viewing) a sign on the patient door that will advise staff and visitors to see nursing staff before entry but will not identify patient as having AVB.

Staff(s) are expected to maintain a high level of confidentiality when they are aware of this type of sensitive personal health information.

Staff(s) involved in an AVB incident must document the incident(s) of aggression or violence: 1) in the patient chart, 2) in the Clinical Safety Reporting System (CSRS), 3) on the Employee Incident Report Investigation form, and 4) complete the Aggressive/Violent Behavior (AVB) Alert Checklist.

The patient or substitute decision maker will be notified by the assigned nurse in consort with the clinical team providing care to the patient that an AVB Alert designation has been placed on the patient's health record when it have been determined that their level of risk for injury in notifying the patient of the Alert is low. This will be verbal and a brochure provided for written notification (See Appendix A).

A patient or substitute decision maker may request a review of the AVB Alert designation on their chart at any time by contacting the department manager or Client Relations at 777-6500 or 1-877-444-1399. The AVB alert designation may remain in place or be removed from the patient chart depending on the outcome of the review.

Scope

This policy applies to all agents who come in contact with acute care patients.

Purpose

This policy provides a formal process for staff to alert other healthcare providers within the circle of care of a patient that has displayed aggressive violent behavior toward staff, and appropriate care is provided to the patient. This policy will help to ensure the safety of both staff and patients.

Procedure

Assessment of Aggressive/Violent Behaviour (AVB) and Immediate Interventions

If AVB (see definition section) is identified in a patient:

- After assessing the situation, activate Code White as per Emergency Code site protocol or notification of site Security or Police (for persons accompanying the patient) if necessary at any time.

- If Code White activation is not required:
  - Avoid being placed in a position of physical risk. Remain calm and in a non-confrontational, non-threatening manner try to deescalate the situation and notify the physician if required (Refer to linkages section: *Prevention and Management of Violence/Aggression in*

Emergency Room Policy; Violence Prevention, Response and Support policy; Code White-Physical Restraint-Seclusion-Mental Health and Addictions)

- Notify the patient that his/her behavior is unacceptable.

- The assigned nurse in consort with the clinical team providing care to the patient will consider whether Eastern Health's AVB Alert should be implemented based on the definition of AVB.

If an AVB Alert is placed on a patient (immediate interventions):

- Assign the patient to a private room. If this is not possible, the nurse assigned to the patient will determine the level of observation required. Refer to the Client Observation Policies regarding the types of observations and how to execute these processes.

- Ensure that other staff involved in the current episode of care, are aware of the risk/incident of aggression or violence through
  - a verbal report,
  - chart documentation, and
  - visual cues (i.e. purple indicator on the white board where applicable and if located away from public viewing) and a sign on the patient door stating "Consult with nursing prior to entering patient room" (See Appendix B).

- At any transition of care (admission, transfer or discharge), provide information about the risk of AVB to other healthcare providers through a verbal report as well as written transfer of information tools such as SHARE forms and referral forms (see Linkages section).

- Ensure comprehensive, accurate and timely documentation of the aggressive/ violent incident in the patient chart and the Aggressive/Violent Behavior (AVB) Alert Checklist (Ch-1646).

- Complete a CSRS report and the Employee Incident Report and Investigation form. Notify the department manager (designate or manager on call), and site security (or Protection Services if there is no site security) if required.

Implementation of an Eastern Health Aggressive/Violent Behaviour Alert

Following an AVB incident, the nurse assigned to the patient is required to:

- Inform the patient or substitute decision maker that an AVB Alert has been placed on his/her chart and provide the AVB Alert brochure (see Appendix A) when the clinical team have determined their level of risk for injury in notifying the patient of the Alert is low.

- Complete an Order Entry for the implementation of the AVB Alert detailing why the AVB Alert was placed on the patient.

- Implement visual cues:
  - Place a purple sticker on the registration sheet of the inpatient chart (or in ER on the patient's label or addressograph)
  - Place a purple sticker on the white board next to the patient name (where applicable and if located away from public viewing),
  - Place the sign on the patients door stating "Consult with nursing prior to entering patient room" (see Appendix B).

- Ensure comprehensive, accurate and timely documentation of the aggressive/ violent incident on the patient chart in the progress note. For admitted patients, document interventions in the patient's care plan.

- Inform the manager/designate of the incident.

- Complete the Aggressive/Violent Behaviour Alert checklist and place on the front of the patient's chart.

Admitting Clerks:

- Enter the AVB Alert via Meditech on the day the Order Entry was received from the nurse assigned to the patient requesting the AVB Alert.

On Admission (Inpatient)

Check the patient's electronic health record for an AVB Alert designation.

If a patient has an AVB Alert designation:

Admitting Clerk:

- Provide verbal notification to staff in circle of care (where applicable).
- Place a purple sticker on the registration sheet of the patient's chart

Nurse assigned to the patient with the AVB designation:

Must review and assess the details of the AVB Alert in the Meditech Patient Care Inquiry (PCI) Module, to determine if staff are at risk of injury during the current episode of care.

If staff are at risk of injury, follow the below immediate interventions.

If staff are NOT at risk of injury, do NOT implement the AVB Alert requirements.

- Place a purple sticker next to the patients name on the white board (in the nursing station, where applicable and if located away from public viewing)
- Place a sign on the patient door stating "Consult with nursing prior to entering patient room" (see Appendix B).

- Assign the patient to a private room. If this is not possible, the nurse assigned to the patient will determine the level of observation required. Refer to the Client Observation Policies regarding the types of observations and how to execute these processes.

Registration (Outpatient and Emergency Department)

Check the patient's electronic health record for an AVB Alert designation.

If an AVB Alert designation is active:

Registration Clerk:

- Provide verbal notification to staff in circle of care.
- Place a purple sticker on the registration sheet of the patient's chart

Nurse assigned to the patient with the AVB designation:

Must review and assess the details of the AVB Alert in the Meditech Patient Care Inquiry (PCI) Module, to determine if staff are at risk of injury during the current episode of care.

If staff are at risk of injury, follow the below immediate interventions.

If staff are NOT at risk of injury, do NOT implement the AVB Alert requirements.

- Place a purple sticker next to the patients name on the white board (where applicable and if located away from public viewing)
- Refer to PCI (Patient Care Inquiry) and assess the level of risk to determine if security should be notified to mitigate the risk of an incident.

Review of Aggressive/Violent Behaviour Alert Designation

- A review of the AVB Alert designation on a patient's chart will be at the request of the patient or substitute decision maker. The patient or substitute decision maker may request a review at any time by contacting Client Relations at 777-6500 or 1-877-444-1399.

- When a review has been requested by the patient/ substitute decision maker the clinical team involved in the implementation of the AVB Alert, the department manager, and the patient/substitute decision maker will meet to discuss the Alert designation. Where appropriate the departmental manager may involve additional stakeholders in the review process such as representatives from: Occupational Health & Safety; Quality, Patient Safety and Risk Management; Pastoral Care & Ethics; Legal Services etc).

- The AVB alert designation may remain in place or removed from the patient chart depending on the outcome of the review.

- At a minimum the Aggressive Violent Alert (AVB) policy will be audited annually by the AVB Committee (see Linkages section) to ensure compliance to the definition of AVB.

RESPONSIBILITIES

All Staff:

- Observe and identify behaviors of patients that meet the definition of AVB (see Policy Section).
- Report any concerns to the nurse assigned to the patient.
- Document incidents of AVB in CSRS and Employee Incident Report and Investigation Form

Registered Nurses and Physicians:

- Identification, prevention and management of AVBs in patients.
- Complete the Aggressive/Violent Behavior (AVB) Alert Checklist
- Initiate AVB Alert designation through Order Entry detailing why the Alert was placed on the patient.
- Inform the patient or substitute decision maker that an AVB Alert has been placed on his/her chart and provide the AVB Alert brochure (see Appendix A) when the clinical team have determined their level of risk for injury in notifying the patient of the Alert is low.
- Nurse assigned to the patient with the AVB designation must review and assess the details of the AVB Alert in the Meditech Patient Care Inquiry (PCI) Module, to determine if staff are at risk of injury and whether immediate interventions are required during the current episode of care.

- Ensure purple indicators are added to:
  - the registration sheet of the inpatient chart (or in ER on the patient's label or addressograph)
  - the white board next to the patient name (where applicable and if located away from public viewing)

- Place the sign on the patients door stating "Consult with nursing prior to entering patient room" (see Appendix B).
- Determine the level of observation required when an AVB Alert is placed on a patients chart. Refer to the Client Observation Policies regarding the types of observations and how to execute these processes.
- Ensure comprehensive, accurate and timely documentation of the aggressive/ violent incident on the patient chart.

Managers:

- Ensure implementation, staff education and compliance with the Aggressive Violent Behaviour (AVB) Alert policy and procedures.
- Ensure staff to report and document AVB of patients.
- Ensure the review of patients designated by an AVB Alert is completed per policy.
- Ensure staff report incidents of AVB in CSRS and Employee Incident Report Investigation form.

- Investigate the reported incidents of AVB Alert to
  - determine the contributing factors and the root cause of the incident
  - implement the appropriate controls to mitigate the risk and
  - prevent reoccurrence and potential injury to staff and patients.

Registration/Clerical staff (Emergency and Inpatient Areas Only)

- Enter the AVB Alert via Meditech on the day the Order Entry was received from the nurse assigned to the patient with the AVB designation.

- If an AVB Alert is identified upon registration:
  - Verbally notify clinical staff
  - Place purple cues on the patient chart

Supporting Documents *(References, Industry Best Practice, Legislation, etc.)*

- Occupational Health and Safety Act and Regulations, NL
- Flagging Patients' record for History of Violence or Aggression Policy(2013) (The Ottawa Hospital, No.: 01075)
- Workplace Violence Prevention- Flagging Process for Patients Exhibiting Acting our Behaviour Policy(2013) (Toronto East General Hospital)
- Alert System: Designation, Identification and Review of Clients at Risk for Aggressive Behaviour Policy (2010). (Fraser Health)
- Violent Behavior Against Staff by Patients, Visitors or Staff Members. (2012). (Capital Health)
- Eastern Health's Mission and Values

Linkages

- Aggressive/Violent Behavior (AVB) Alert Checklist (Ch-1646)
- Client Safety Reporting System (CSRS) occurrence report
- Client Surveillance (Acute/long term care) Exemption: Mental Health And Addictions Program) 204(NUR)-2-020
- Code White-Physical Restraint-Seclusion-Mental Health and Addictions 275P-EPS-010
- Emergency Codes HAZ-EC-150
- Employee Incident Report Form Ch-0198
- Hazard Recognition, Evaluation and Control HR-OH(O)-140
- Levels of Client Observation: Mental Health and Addictions: In Patient Units and Psychiatric Assessment Unit 275H-CPC-150P
- Occurrence Reporting and Management QRM-080
- Prevention and Management of Violence/Aggression in Emergency Room 310-ER-SAF-30
- SHARE Form Transfer of Information For temporary transfer from unit ch-0231
- SHARE Transfer of Information ch-1211
- Transfer of Information- Client Patient Resident Transfer- Temporary or Permanent Transfer (non – Physician) PRC-175

- Violence Prevention, Response and Support HR-OH- 150

Key Words

Aggression, aggressive, alert, assessment, AVB, behaviour, flag, hazard, injury, intervention, Patient Care Inquiry, PCI, order entry, prevention, risk, safety, threat, violence, violent

Definitions & Acronyms

Agent(s)	A person other than an employee authorized by Eastern Health to act on its behalf. This includes physicians, volunteers, students, pastoral care workers as well as staff of contractors.
Aggressive/Violent Behaviour	Aggressive/Violent behavior (AVB) is defined as any behavior, including threats, that gives a worker reasonable cause to believe he/she is at risk of injury and includes: • Physical violence (hitting, shoving, pushing, punching, biting, spitting, groping, pinching, scratching or kicking) • Intimidating or threatening gestures (such as shaking fists at a person, pounding a desk or other object, punching a wall, screaming). • Throwing or striking objects • Stalking • Direct verbal threats of harm or death • Using an object to injure a person • Intentional destruction of property • Presence of a gun or other weapon
Aggressive/Violence Behaviour Alert	A process to alert health care workers of patients who pose a potential risk of aggressive/violent behavior toward staff
Patient Care Inquiry (PCI)	A module offered in Meditech that provides health care professionals easy access to complete clinical and administrative patient information.
Staff	Include all employees, physicians, volunteers, & students.
SHARE Form	A transfer of information tool used at the transition of care.

Appendix A
Aggressive/Violent Behaviour Alert:
Information for patients and/or Substitute Decision Makers

HELP US FOCUS ON PROVIDING SAFE AND EFFECTIVE CARE

Eastern Health is committed to creating and maintaining a safe and healthy workplace where all individuals are respected. Accordingly, Eastern Health does not accept or tolerate violent or abusive behavior of any kind and will take reasonable steps to prevent violence.

Eastern Health

CONTACT INFORMATION

Client Relations
777-6500
1-877-444-1399 (Toll-Free)

Did you know?

Studies show that more than 50% of health care workers in Canada are victims of violent or abusive behavior. each year.

Eastern Health

AGGRESSIVE/ VIOLENT BEHAVIOUR ALERT

INFORMATION FOR PATIENTS AND/OR SUBSTITUTE DECISION MAKER

Eastern Health

PATIENT NAME

_____

DATE

_____

An Aggressive/Violent Behaviour (AVB) Alert has been placed on your health record. This Alert is intended to notify other health care providers within your circle of care of the risk for aggressive or violent behavior by

□ You, the patient

If you have any questions or concerns regarding the AVB Alert designation on your health record. You or your substitute decision maker may request the removal of the Alert at any time by contacting:

Eastern Health Client Relations
(709) 777- 6500
1-877-444-1399 (toll-free)

Please read this brochure for additional information.

WHAT IS AN AVB ALERT?

An AVB (Aggressive/Violent Behaviour) Alert is a process designed to notify staff of a patient that has shown aggressive or violent behavior while on Eastern Health property.

Aggressive or violent behavior includes:

- Physical intentional violence (hitting, shoving, pushing, punching, biting, spitting, groping, pinching, scratching or kicking)
- Intimidating or threatening gestures (such as shaking fists at a person, pounding a desk or other object, punching a wall, screaming).
- Throwing or striking objects
- Stalking
- Direct verbal threats of physical harm or death
- Using an object to injure a person
- Intentional destruction of property
- Presence of a weapon

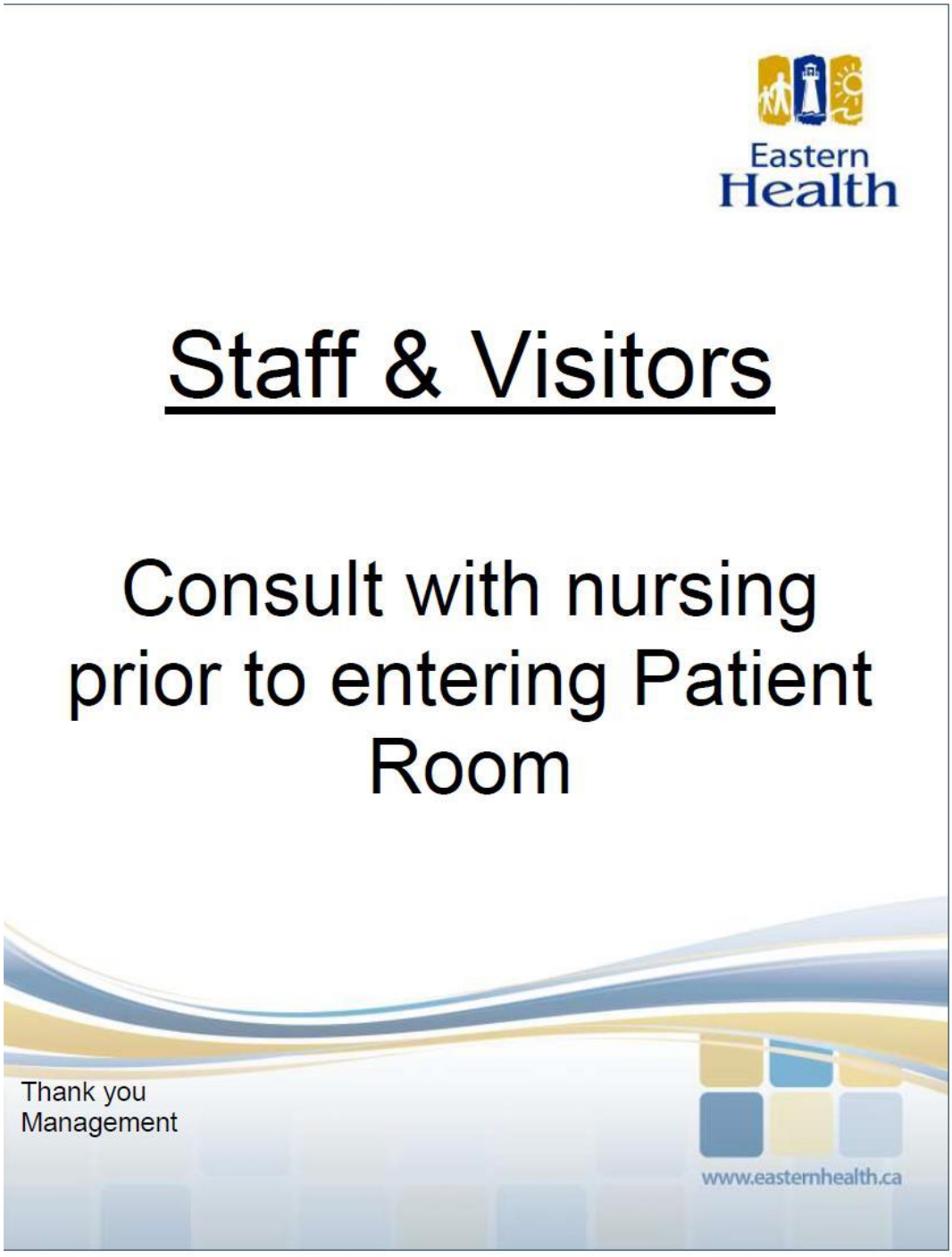
WHY IS AN AVB ALERT PLACED ON MY HEALTH RECORD?

It was determined, by Eastern Health staff within your circle of care, that you have demonstrated aggressive or violent behavior during a recent stay or visit to one of our facilities. This Alert ensures that staff within your circle of care are aware of the Alert. This will help staff ensure a safe environment for other patients, and themselves while providing the appropriate care to you, our patient!

HOW WILL AN AVB ALERT AFFECT ME AND MY CARE?

Having an AVB Alert on your health record will not impact the quality of care you will receive while a patient with Eastern Health. You will continue to receive the highest standard of care that we can provide.

Appendix B
AVB Alert Sign



Appendix F: Least Restraint Policy

LEAST RESTRAINT –
MECHANICAL AND ENVIRONMENTAL

Patient-Resident-Client Care
PRC-080

Issuing Authority (sign & date)	**Judy O'Keefe, Vice President Clinical Service** Signed: Judy O'Keefe Dated: June 11, 2019
Office of Administrative Responsibility	Office of the Vice President Long Term Care Eastern Health
Author	Least Restraint Policy Review Working Group
Level	II (Two)
Original Approval Date	September 17, 2012
Effective Date	
Scheduled Review Date	January 2022
Actual Review Date	
Revised Date(s)	June 2019

OVERVIEW

This is a global policy that applies to all Eastern Health mechanical and environmental restraint use **except**:

- Bedrails
- Temporary immobilization of a part of the body as required for a medical treatment such as splints or casts.
- Temporary immobilization used during transportation such as safety belts on stretchers.
- Secured entrance (doors) to a unit or facility
- Therapeutic Quiet Room - Community Mental Health Youth Treatment Centre
- Postural support/positioning devices **used solely for** customized seating and recommended by Occupational Therapists. Postural support/positioning devices are used when assisting clients to maintain a desired seating position that they are otherwise unable to achieve which in turn affects their participation in daily activities (e.g. ability to self-feed, propel chair).

Restraint (mechanical or environmental) is defined as the use of any method, mechanical device, material, or equipment that restricts a person's freedom of movement including immobilization or reduction of the ability of an individual to access or move his/her body or body parts.

Types of mechanical and environmental restraints:

- Mechanical (e.g. waist, thigh, pelvic, limb, 4 - 5 point restraints, restrictive clothing, chair with locked table top).
- Environmental (e.g. safe room, seclusion room).

POLICY

Policy Statements

1. Eastern Health (EH) supports a philosophy of least restraint and promotes strategies to minimize restraint use consistent with client's right to freedom, dignity, respect, and choice.
2. Restraint(s) may be indicated when a client is at risk of harm to self or others and all strategies to maintain safety and minimize restraint use have been exhausted.
3. Restraint use requires assessment, monitoring and observation, reassessment, and documentation.
4. The least restrictive restraint device is used.
5. Restraints must be discontinued at the earliest and safest opportunity.
6. Restraint use is a temporary measure and strategies to reduce or discontinue restraint use must continue to be assessed (see Attachment A: Part 2).
7. Restraints cannot be used as discipline or as a substitute for treatment.
8. Only commercially manufactured restraints are used. Introduction of new restraint products must be referred to the EH Product Quality and Safety Committee for review and approval.
9. Long Term care does NOT use the following types of restraints:
    - Restraints with locks that can only be released by a separate device such as a key or magnet (e.g. Segufix, Posey, Pinel)
    - Jacket or Vest restraints
    - Pelvic Holders (e.g. Posey Foam/ Posey Breezeline Pelvic Holders)

   Programs referring residents using these types of restraints must plan to safely remove the restraint prior to admission to Long Term Care.

Policy Details

1. Assessment

An assessment of the client by the health care professional is required to identify behaviors of risk and explore underlying factors contributing to the client's behavior for which restraint may be indicated (e.g. medication, physiological, psychological, or environmental factors).

A **Decision Tree** (Attachment A: Part 1) **for Restraint Use in Eastern Health** (Potential or Imminent/Actual) guides the health care professional in determining the course of action/interventions to take depending on the client's behavior and level of risk.

Restraint use is a last resort when strategies to minimize restraint use (Attachment A: Part 2) have been ineffective and a client remains at risk of harm to self or others.

2. Order for Restraint

2.1 A physician or nurse practitioner (NP) order is required for restraints.

- Prior to application where there is a potential risk for harm to self or others.
- Within 12 hours of application where there is an imminent/actual risk for harm to self or others. **Exceptions**:
  - **Mental Health and Addictions Program:**
    - **4 - 5 point restraints**- physicians must be present to assess clients for certification and initiation of 4 - 5 point restraint and may only order 4 - 5 point restraint following consultation with attending psychiatrists or psychiatrists-on-call.
    - **Seclusion** - physicians must be notified within thirty (30) minutes of the initiation of seclusion and complete a face-to-face assessment and a written order within one (1) hour of initiation of seclusion.
  - **Safe Room** – A physician must perform a face-to-face assessment of the patient within thirty (30) minutes of being placed in the safe room and complete a written order to continue/discontinue the intervention of the safe room and determine a further plan of care.

3. Consent for Restraint

3.1 EH does not use a restraint consent form. Verbal consent of the client or their substitute decision maker (SDM) must be obtained and documented in the health record when restraints are indicated. Clients and their SDM will be informed about least restraint and strategies used to minimize restraint use.

3.2 Consent for restraint is not required for clients certified under the Mental Health Care and Treatment Act.

3.3 The healthcare professional most responsible for initiating the restraint discusses and obtains consent with the client and/or substitute decision maker (SDM) and documents in the health record the following:

- Reason for restraint
- Type of restraint for use
- Potential risks if restraint is not used
- Potential risk of restraint use
- The intended outcome of using restraint

3.4 Consent must be obtained and documented **prior to** restraint application in situations of **potential risk** of harm to the client and/or others. When a restraint is refused, the healthcare professional must inform the client/substitute decision maker of the risks involved in refusal and document in the health record. See Policy LEG-050 Consents-Legal

3.5 Restraint may be implemented **with or without consent** to protect against **imminent/actual risk** of harm to the client and/or others. Documentation of all interventions and rationale for restraint is required. If the situation changes from imminent/actual risk to potential risk then consent is required for continued restraint use.

4. Application of Mechanical Restraint

4.1 Determine the restraint device based on client assessment.

4.2 The health care professional and/or health care provider can apply a mechanical

restraint.

4.3 Mechanical restraints will be applied and maintained according to manufacturer's guidelines and follow Health Canada and Risk and Safety Management Alert System (RASMAS) regarding the use of restraints.

4.4 It is the responsibility of clinical areas to ensure scissors and other quick release devices (e.g. magnet keys) are readily available for access by staff if there is an immediate need to release a mechanical restraint. Scissors must be safely stored when not in use.

4.5 Ensure that the waist belt cannot slide up over the client's chest. For those clients deemed at risk, use side straps or other accessories (as per manufacturer's guidelines) to limit patient movement from side to side and to limit "helicoptering" (i.e. turning in bed head to toe).

4.6 For all types of mechanical restraints ensure side rails are in the up position when restraints are being used and any gaps between split bed rails blocked with a manufactured solid gap barrier that effectively prevents the client from sliding through the gap in bed rails (Health Canada, 2007).

4.7 Ensure that mechanical restraint systems used on beds are attached to the bed frame and not the side rails. Ensure the part of the bed frame they are attached to moves with the client as the bed height and articulation are adjusted. Otherwise, tightening or loosening of the restraint may occur as the bed's position is adjusted (Health Canada, 2007).

4.8 All magnetic buttons must be replaced before expiry date according to manufacturer's guidelines

4.9 Distance must be maintained between a cardiac device and restraint magnetic keys to avoid interference with pacemaker functioning. Refer to restraint product manufacturer guidelines for the recommended distance for specific devices.

4.10 Restraint must be cleaned and disinfected between each client use and when visibly soiled using EH approved cleaners and disinfectants (refer to manufacturer's instructions).

5. Monitoring and Observation of Clients in Restraint

5.1 Monitoring and observation includes ongoing assessment, monitoring and observation and documentation for the following:

- signs of distress or injury associated with the application of the restraint
- circulation and range of motion in the restrained extremities
- readiness for reduction or discontinuation of restraint.

5.2 **Clients must be monitored and observed for the development of potential harmful effects or complications when restraints are used. Harmful effects may include:**

- psychological distress (e.g. fear, anxiety, agitation, increased confusion, depression, loss of dignity, altered sleep)
- decrease in functional status (e.g. deconditioning, decreased mobility, increased dependence)
- bowel/bladder incontinence and constipation
- hydration and nutritional status alterations (e.g. decreased appetite, dehydration)
- increased risks for falls
- musculoskeletal alterations (e.g. contractures, nerve damage decreased muscle

mass or tone)
- physical pain
- cardiovascular system alterations (e.g. changes in blood pressure, edema)
- impaired skin integrity (e.g. bruising, abrasions, pressure ulcers)
- impaired respiratory function (e.g. pulmonary embolism)
- death (asphyxia, aspiration, strangulation)

5.3 **Constant observation is required for:**
- 4 or 5 point restraints
- Safe room
- Seclusion

5.4 **Close observation is required for** all other types of mechanical restraints. A higher level of observation may be required depending on the type of restraint being used and the client's condition/behaviors.

6. Temporary Release and Re-Securing of Mechanical Restraints

6.1 Mechanical restraints must be released and re-secured a minimum of every two (2) hours to allow for range of motion (ROM), toileting, and other care. Clients in 4 or 5 point restraints - temporarily release and re-secure one limb every fifteen (15) minutes on a rotational basis.

6.2 The health care professional can determine additional periods for temporary release based on assessment of the client and level of risk.

6.3 Document temporary release of mechanical restraints on the health record. If the client is **NOT** temporarily released from restraint, rationale must be documented on the health record (including assessment of the client's condition).

6.4 Assess the need for extra staff assistance (e.g. 2 staff) when providing care to clients in restraints (e.g. toileting, fluids/meals, medication administration, and assessment).

7. Reassessment of the Need for Restraint and Renewal of Orders for Restraints

7.1 Reassessment of the need for restraint is the responsibility of the health care professional. **In the Mental Health and Addictions Program -** a physician or psychiatrist is required to reassess the need for restraint during a face-to-face assessment.

Reassessment includes assessment of the client's behavior and the continued need for restraint use.

7.2 4-5 point restraints:
- Reassessment and documentation of the need for restraint a minimum of every 2 hours.
- Renewal of orders a minimum of every12 hours (exception: renewal of orders every 2 hours in Mental Health and Addictions Program).

7.3 Safe room and seclusion:
- Reassessment and documentation of the need for restraint a minimum of every 4 hours
- Renewal of orders every 4 hours

7.4 All **other** types of mechanical or environmental restraints:
- Reassessment and documentation of the need for restraint a minimum of every 24

hours
- Renewal of orders every 7 days

7.5 Strategies to minimize restraint use must be considered and documented on an ongoing basis

8. Discontinuation and Reduction of Restraints

8.1 **Mechanical-** The health care professional can make the decision, with rationale documented, to reduce a restraint to a lesser restraint or remove the restraint. The physician or NP **MUST** be notified of the change in the client's behavior, rationale for reduction or removal of restraint decision and discussion for level of observation required.

8.2 Under the Mental Health and Addictions Program the health care professional can discontinue seclusion or 4-5 point restraint. The physician or psychiatrist is notified to assess the level of observation and provide an order for discontinuation.

9. Documentation

The following documentation in the client's health record is required when a restraint is used:

- Physicians or NP order
- Strategies to minimize restraint use
- Assessment and reassessment of the need for restraint
- Discussion of restraint use with client and/or SDM/parent/guardian
- Discussion of consent for restraint use with client or SDM
- Date and time of initiation of restraint
- Type of restraint
- Monitoring and observation (Record of Surveillance ch-0018)
- Reduction or discontinuation of restraint including rationale

10. Education

It is the responsibility of each program to provide education on types of restraints and the alternatives used within their program.

11. Audit

Each program is responsible for ensuring the completion of audits for compliance with policy.

Scope

This policy applies to all EH health employees, physicians, and agents who are involved in the use of restraint for clients.

Purpose

To promote a culture and practice of least restraint.
To facilitate safe and appropriate use of least restraint for clients and staff.

Procedure

	Potential Risk of Harm to Self or Others	Imminent/Actual Risk of Harm to Self or Others
1. Assess for Risk of Harm	The health care professional will perform an assessment of the client including underlying factors contributing to behavior, level of risk, and any strategies to minimize restraint use before deciding to restrain.	The health care professional will: • Immediately assess the situation and need for restraint • Attempt to de-escalate the behavior if appropriate • Call for extra support as applicable (E.g. Code White, Security, Police).
2. Obtain Order for Restraints	The health care professional will obtain an order **prior** to the application of least restraint.	The health care professional will obtain an order within 12 hours of application restraints except: • **Mental Health and Addictions Program:** ○ 4 or 5 point (obtain order to initiate) ○ Seclusion (obtain order within 1 hour) • **Safe Room** (obtain order within 30 minutes)
3. Discuss Restraint Use/ Obtain Consent	The health care professional will obtain and document consent of the client or their SDM **prior** to least restraint application.	The health care professional will apply least restrictive restraint **with or without** consent to protect against the risk of emergent harm to the client and/or others.
4. Apply Restraint		
5. Observe, Reassess and Renew Order for Restraint		

	Observation Requirements	Reassessment of need for restraint	Renewal of order for restraint	Other considerations
Mechanical restraint (excluding 4 or 5 point)	Close Observation (minimum of every 15-30 minutes)	Minimum of every 24 hours	Every 7 days	A higher level of observation may be required depending on the type of restraint being used and the client's condition/behaviors.
4 or 5 point restraint	Constant Observation	Minimum of every 2 hours	Minimum of every 12 hours (Exception: every 2 hours for Mental Health and Addictions)	A minimum of two staff are present for: ○ Toileting ○ Fluids and meals ○ Medication administration Assessment of the client
Seclusion (seclusion room and/or safe room)	Constant Observation	Minimum of every 4 hours	Minimum of every 4 hours	

6. Document in the health record
For more details refer to POLICY section.

Supporting Documents *(References, Industry Best Practice, Legislation, etc.)*

- A Guide to the *Long-Term Care Homes Act, 2007* and Regulation 79/10 (2007). Retrieved from http://health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf
- Canadian Nurses Protective Society. (2004). Patient restraints. *InfoLaw, 13* (2). Ottawa, ON: Author.
- Coffey-Hickey, T. A. (2006). Constant Care Resource Manual for the Health Care Corporation of St. John's.
- College of Nurses of Ontario. (2017). Practice Standard: Restraints. Retrieved from http://www.cno.org/globalassets/docs/prac/41043_restraints.pdf
- Health Canada. (2007). *Important Safety Information on the use of Waist and Torso Patient restraints- Notice to Hospitals*. Retrieved from http://hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/_2007/restraints_dispositifs_nth-aah-eng.php
- Health Canada. (2008). Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards. Retrieved from http://www.hc-sc.gc.ca/dhp-mps/md-im/applic-demande/guide-ld/md_gd_beds_im_ld_lits-eng.php
- Health Quality Ontario Long-Term Care Restraints. (2015). Best Practices. Retrieved from http://qualitycompass.hqontario.ca/portal/long-term-care/Restraints?extra=pdf
- Healthcare Insurance Reciprocal of Canada (HIROC). 2009. The use of restraints: Recommendations from a recent inquest. *The HIROC Connection, 20.* Author.
- Healthcare Insurance Reciprocal of Canada (HIROC). 2014. Medical Risk Reference Sheet: Mismanagement of Restraints. Retrieved from https://www.hiroc.com/getmedia/89a2e95d-91aa-4063-9ce1-0403b6e2c09c/Mismanagement-of-Restraints_5.pdf.aspx?ext=.pdf
- Mental Health Care and Treatment Act. (2007). Retrieved from http://www.health.gov.nl.ca/health/mentalhealth/mentalhealthact.html
- Patient Restraints Minimization Act (2001). Ministry of Health and Long Term Care. retrieved from https://www.ontario.ca/laws/statute/01p16
- Personal Health Information Act. (2011). Retrieved from http://assembly.nl.ca/Legislation/sr/statutes/p07-01.htm
- RNAO (2012). Clinical Best Practice Guidelines. *Promoting Safety: Alternative approaches to the use of restraints.* Retrieved from http://rnao.ca/sites/rnao-ca/files/Promoting_Safety_-_Alternative_Approaches_to_the_Use_of_Restraints_0.pdf
- Statement of Rights and Responsibilities for Clients, Patients, and Residents of Eastern Health. Retrieved from http://intranet.easternhealth.ca/EH/DynPage.aspx?PageID=299
- Substitute Decision Makers Act (1995). *An Act Respecting Advance Health Care Directives and the Appointment of Substitute Health Care Decision Makers*. Retrieved from *http://www.assembly.nl.ca/Legislation/sr/Annualstatutes/1995/A04-1.c95.htm*

Linkages

Policies:

1. **275P-EPS-015** Use of Seclusion Mental Health Addictions
2. **310-ER-SAF-20** Utilization of the Safe Room – Emergency Planning, Safety/Security

3. **275H-EPS-020** Emergency Use of 5-Point Restraint- Emergency Plan, Safety and Security
4. **310-ER-SAF-30** Prevention and Management of Violence/Aggression in the Emergency Room
5. **275CS- YTC- 9210** Therapeutic Quiet – Youth Treatment Centre
6. **275H-JWPS-290** Seclusion Room – Janeway Psychiatry Services
7. **275H-JWPS-360** Blanket Restraint
8. **3542(GROUND)-OPS-080** Use of Physical Restraints – Safety and Security
9. **3541(AIR)-SFT-110** Use of Physical Restraints-Operations
10. **204(NUR)-2-020** Client Surveillance (Acute/Long Term Care) Exemption; Mental Health and Addictions Program
11. **275H-CPC-150** Levels of Client Observation
12. **LEG-050** Consents- Legal
13. **204(NUR)-2-030** Fall Prevention and Intervention: Adult Acute Care and Long Term Care
14. **592-SFT-020** Falls Prevention: Home and Community Care
15. **PRC-028** Delirium Protocol Adult Acute Care – Exemption Mental Health and Addictions Program
16. **214CC-MED-140** Guidelines for the Identification and Management of Delirium in Critical Care
17. **PRC-130** Positive Client Identification
18. **307-QRS-140** Bed Entrapment Prevention- Long Term Care
19. **HAZ-EC-150** Emergency Codes

Forms:

1. EH Record of Surveillance Form ch-0018

Key Words

Restraint, restraints, least restraint, seclusion, safe room

Definitions & Acronyms

Agent	A person other than an employee authorized by Eastern Health to act on its behalf. Agent in this policy refers to contracted security personnel working within Eastern Health facilities or affiliated with Eastern Health.
Client	Refers to patients, residents, and clients in all sectors (long term care, acute care and community).
Certification	A client is involuntary admitted to and detained in a psychiatric unit as identified under the Mental Health Care and Treatment Act (2007).

Emergent Risk	Emergent risk is defined as immediate threat of harm to client or others.
Health Care Professional	A person licensed or registered under an Act of the province to provide health care (e.g. registered nurses, licensed practical nurses, social workers).
Health Care Provider	Refers to unregulated health care providers (e.g. personal care attendants).
Least Restraint	Least restraint is defined as an approach whereby restraints are used only as a temporary means and when all other possible alternative interventions are considered ineffective.
Restraint	The use of any method, mechanical device, material, or equipment that restricts a person's freedom of movement including immobilization or reduction of the ability of an individual to access or move his/her body or body parts.
Restraint- Environmental	The control of a person's mobility by restricting the available geographical area (Canadian Nurses Protective Society, 2004). Refers to any barrier or device that limits the locomotion of an individual, and thereby confines an individual to a specific geographical area or location (e.g. safe room, therapeutic quiet room, seclusion room).
Restraint- Mechanical	The use of any devices with the intent to limit personal freedoms including immobilization or reduction of the ability of an individual to move his/her body or body parts (e.g. waist belts, 4 - 5 point restraint, mittens, chairs with table tops).
Seclusion (Seclusion Room and Safe Room)	The involuntary confinement of a client in a designated visually observable locked room (**Seclusion Room, Safe Room**), with the client being under constant supervision. **Seclusion rooms** are designated spaces in mental health and addictions program units (psychiatric units) ONLY. If certified clients cannot be immediately conveyed to psychiatric units, designated **Safe Rooms** may be used to detain certifiable clients. Three hospitals within EH with designated **Safe Rooms** include: Burin Peninsula Health Care Centre, Carbonear General Hospital, and Dr. G. B. Cross Memorial Hospital.
Substitute Decision Maker	A person appointed by the maker of an advance health care directive to make health care decisions on his or her behalf, or a person deemed appropriate to make health care decisions on behalf of the resident as per section 10

	of the Substitute Decision Makers Act (1995). *Advanced Health Care Directives Act*

Policy History This policy replaces the following policies:

Policy #	Policy Name	Date Revised

Appendix G: Family Presence and General Visitation Policy

FAMILY PRESENCE AND GENERAL VISITATION	Quality, Patient Safety and Risk Management QRM-040

Issuing Authority	**Ken Baird, Vice President** Signed by Ken Baird Dated April 19, 2021
Office of Administrative Responsibility	Quality, Patient Safety and Risk Management. Client- and Family- Centred Care
Author	Darlene Didham, Client- and -Family-Centred Care Consultant
Level	One (I)
Original Approval Date	August 31, 2017
Effective Date	Upon Signature
Scheduled Review Date	August 2020; April 2024
Actual Review Date	April 19, 2021
Revised Date(s)	April 19, 2021

Overview

Eastern Health is committed to maintaining a safe, secure, comfortable, inclusive, and equitable healthcare environment, demonstrating respect for the diverse needs of clients, families, and staff, and supportive of People Centred Care (PCC). PCC encompasses the term Client- and Family- Centred Care.

Research demonstrates that the presence and participation of one's family as essential partners in care enhances the client and family experience of care, improves safety, and facilitates continuity of care.

It is important for clients to experience the support of family and friends to the degree they wish. Family Presence establishes the ability of a support person, identified by the client or Substitute Decision Maker (SDM), to be present twenty-four hours a day. General visitation hours are available for family and visitors not specified as the support person or caregiver.

The word *client* is also used to represent *patient* and *resident*. (See definitions)

POLICY

1. When accessing health care services, including outpatient, clinic, inpatient stay, emergency room visit or long-term care placement, clients are informed

of the practice of Family Presence and advised that they can identify a support person.

2. Where available and appropriate, clients are provided with an information brochure on Family Presence in a language of their choice.

3. To meet the needs of the client, timely provisions are made as appropriate for:
    a. engagement of a family/caregiver or friend, identified by the client or SDM, to support with language,
    b. engagement of a community agency appropriate to the culture, preferences and needs of the client/family,
    c. access to Eastern Health Interpretation Services. See Diversity and Inclusion intranet resources for contact information for over the phone interpreting services and Bilingual Services Office, http://pulse.easternhealth.ca/UserPage.aspx?pageid=3169
    d. engagement of Eastern Health's Aboriginal Patient Navigators (APN), http://www.easternhealth.ca/OurServices.aspx?d=1&id=2426&p=74

4. More than one support person can be identified by the client or a Substitute Decision Maker (SDM). Only one support person at a time can be present 24 hours a day, unless otherwise agreed upon by the client/ SDM, support person and the health care team.

5. All other persons, considered visitor(s), are required to follow the general visitation guidelines.

6. Considerations and provisions are made to support an inclusive approach to the definition of family (e.g., cultural considerations).

7. Considerations of and provisions are made for the use of virtual formats for visitation and family presence, to support access and engagement in care planning.

8. At no time is the support provided to the client by the support person considered to be in place of the health care duties and responsibilities of the healthcare provider.

9. Health care decisions are made by the client, or the SDM if the client is deemed unable to make their own decisions. The support person, if different from the SDM, only provides health care support to the degree the client/SDM wishes.

10. Family presence may be considered in some restricted service areas, where possible, upon consideration of the needs of the client, safety, and potential risk factors, e.g., Operating Room (OR) for caesarean (C-Sections), Medical Imaging (MI) procedures or for some invasive procedures, such as Endoscopy (to the point of patient sedation).

11. Alternate guests/support (e.g., personal pets, animal assisted therapy) will be supported where possible and must be pre-arranged with the health care team (see relevant organizational policies for pet visitation, such as Infection Prevention and Control for Pet Therapy and Pet Visitation IPC-156 and Infection Prevention and Control for Service Animals IPC-157).

12. Staff must adhere to the Privacy and Confidentiality Policy ADM – 030.

13. Support Person

    a. The client/SDM chooses their support person and the degree to which that individual participates in their care.
    b. The client/SDM has the right to change the support person identified.
    c. Any changes to the identified support person are to be communicated to the health care professional assigned to the client and documented accordingly in the client's health record.
    d. If the client ceases to be competent to make and communicate health care decisions and name a support person, the Substitute Decision Maker (SDM) is contacted by the health care professional assigned to the client to determine if they want to name a support person. Should there be no SDM the healthcare professional will reference protocol in Section 10 of the Advanced Health Care Directives Act.
    e. The support person can be present twenty-four (24) hours a day, as per the client/SDM preference.
    f. A support person's child(ren) are considered visitors and subject to general visitation.

14. General Visitation

    a. Visitors are welcome within the visiting hours of 1100-2100, unless otherwise designated. It is recognized that some specialty units may have unit specific hours. These units are to have Visiting Policy Guidelines created specifically for their unit and these guidelines are to be posted on their unit, and the information made available to clients, family, and the public.
    b. Only two visitors per client are permitted at one time, unless otherwise identified by the care provider, the client and family as part of the health care plan (e.g., A culturally sensitive lens for health care visitation may identify more than two visitors at one time, as determined in consultation with the healthcare team)
    c. Children under the age of 12 years are welcome to visit during general visitation hours and require supervision by an adult who is not the client.

15. All Support Persons and Visitors

    a. Must be informed, by the health care professional assigned to care of the client, on infection prevention and control practices (e.g., additional precautions and isolation rooms).
    b. Must follow infection prevention and control practices (e.g., proper hand hygiene) and are asked to not visit if they are ill.
    c. Washrooms designed for persons receiving care are for their use only. Public washrooms are available within all sites.
    d. Are expected to follow the Scent Safety Policy, HR-OH(o) – 270.
    e. Are expected to follow the Smoke- Free Environment Policy ADM.

16. Infectious Disease Outbreak/Pandemic:

    a. In the event an infectious disease outbreak requires visiting and or family presence restrictions for public health and safety, the health care team and Infection Prevention and Control (IPAC) will work with clients/SDM, support persons/caregivers to ensure they are able to support the client and family, according to outbreak management guidelines, as determined by IPAC and the Medical Officer of Health (MOH) and provincial guidelines. See relevant IPAC policies and Emergency Operations Committee(s) for additional guidance. (e.g., IPC-185 Outbreak Management for Acute and Long-Term Care, and 114-IPC-020 Infection Control Practitioners - ICP- Guideline – Outbreak Management).

17. Unacceptable Behaviour:

    If unacceptable behaviour (e.g., verbal and/or physical abuse) by the support person/caregiver, or general visitor occurs the health care professional assigned to client care will:

    a. Inform the person(s) of the unacceptable behaviour.
    b. Make efforts, without compromise to the safety of others, to resolve concerns with consideration of appropriate alternate options.
    c. Contact or consult with Protective Services if unable to resolve the unacceptable behaviour which may result in the removal of the support person/caregiver, SDM, or visitor.

Scope

This policy applies to all employees, students, and physicians, affiliated with Eastern Health.

This policy should be read in conjunction with other specialized service area visitation policies, such as, 275H-FOR-020 Visitor Policy: Forensic Division, 275CS-YTC-9280 Visitation-Approved Visitor List, 270CH-NICU-25 Visiting Guidelines for the Neonatal Intensive Care Unit-NICU Only

Purpose

The purpose of this policy is to:

- Support an environment that demonstrates Client- and Family-Centred Care; balancing client needs with the health care team's responsibility to provide safe and quality care.

- Provide process for communicating information regarding expectations for family presence and general visiting to clients/SDM, support person, caregiver, family, and visitors.

Procedure

1. At the beginning of a health care service, including outpatient, clinic, pre-admission, inpatient stay, emergency room visit or long-term care placement, the healthcare professional will:

   1.1 Ask clients/SDM to:
   a. Identify the support person and how they will be involved in care.

   b. Clarify client preferences regarding who may be present during rounds, exams, and procedures.

   1.2 Advise the client/SDM that an individual that is legally prohibited from having contact with them cannot be identified as the support person/caregiver. Should the client/SDM identify any person(s) known to be legally prohibited from contact, they cannot be identified by the client/SDM as the support person. This will be enforced by Protective Services.

   1.3 Document the identified support person in the client health record and communicate this with the healthcare team.

1.4 Document all client/SDM requests to prohibit or restrict visitors in the client health record. The healthcare professional will communicate this information to the appropriate manager, unit employees, admitting department, and switchboard.

1.5 Provide a copy and use an information brochure: *Family Presence: Your Role in Your Loved One's Care* to support discussion with the client/SDM and support person of the following:

a. Proper hand hygiene.
b. Role of the support person and expectations for engagement in the level of care the client/SDM and support person agree to.
c. Expectations for personal belongings. See relevant policy/policies related to personal belongings, lost/misplaced items. Belongings must not obstruct the health care provider's ability to provide care.

1.6 Discuss family presence and visitation limitations with the client/SDM and support person, in consultation with the health care team.

In situations where there are shared rooms, the family presence discussion will include:

a. consideration of the physical space and limitations,
b. consideration of culture, personal preferences, and needs,
c. a balance between providing support for family presence and allowing enough rest, recovery and privacy for the client and other clients in the room,
d. consideration of the privacy and rights of all clients in the shared room, and expectation that the support person may be asked to step outside of the room for brief periods of time for care and privacy of the other clients in the room,
e. expectation that the client/SDM and support person respect the privacy rights of other clients in the shared rooms, and not disclose or repeat private information they may overhear.

2. Infectious Disease Outbreak/Pandemic

2.1 Efforts to ensure support person and/or caregiver presence during an infectious disease outbreak/pandemic includes:

a. The distinction of support person and/or caregiver as separate from general visitors and general visiting restrictions.
b. Family presence for the following exceptions if restrictions require limiting support person/caregiver presence:
   i. Palliative Care and End of Life (as deemed by the health care professionals),
   ii. Pediatric in-patient, Emergency,
   iii. Labour and delivery patients,
   iv. Inequities in the care of some populations where the absence of family support persons/caregivers, as essential partners in

care, may result in additional risk and unintended harm, such as severe physical, functional, cognitive, or mental health decline. This includes, but is not limited to:

- feeding support,
- mobility
- personal care,
- communication and decision making,
- behaviour,
- mental health crisis.

3. A Review of Family Presence and visiting restriction(s) by the emergency operations committee (EOC) or designate, including the healthcare team, the client/SDM, and the support person/caregiver to determine at what point in-person support can resume; and what measures to reduce risk are required. Measures to reduce risk may include providing additional education and personal protective equipment to the support person/caregiver.

4. Virtual Visitation:

4.1 Virtual visitation may be requested or is offered for clients in situations where factors impact or prohibit the ability to have visitors physically present.

4.2 In the event an infectious disease outbreak/pandemic occurs, and general visitation is restricted:

- The client/SDM can seek/ or is asked by a health care professional if they wish to have virtual visitation.
- Support is offered to a client to:
  i. assist in use of their own electronic device (if needed) or
  ii. the client may use the unit/program electronic device for virtual access (if available).

5. Virtual Care Planning Discussions:

5.1 A member of the health care team will use organization approved secure virtual platforms for care planning that requires the use of virtual family presence for support person(s), and if possible, other identified family, to be part of care planning discussions.

6. Family Presence during a Code (Resuscitation):

6.1 The determination of a support person's presence during a code (resuscitation) will be made as early as possible in the individual health care planning, in consultation with the client/SDM and the health care team and documented in the health care record. (See relevant policy, Family Presence During Resuscitation 310-ER-SAF-4).

6.2. If a code is called in a shared room, support persons present with other clients will be asked to step outside the room.

7. Family Presence during Invasive Procedures:

The determination of a support person's presence during invasive procedures (e.g., endoscopy), or procedures with a risk of exposure to radiation or magnetic fields (e.g., medical imaging), will include consideration of client needs, safety, physical space, and confidentiality. In the case of an invasive procedure, supporting family presence may be considered to the point of client sedation. In the case of medical imaging, supporting family presence will require a review of the risk of radiation exposure to the support person and completion of safety MRI screening for non-patients. (See relevant policy, Magnetic Resonance (MR) Environment 415(MR)- SAF- 010 and Safety Screening for Individuals form).

7.1 Examples of client circumstances for consideration of family presence during invasive procedures such as endoscopy, or for medical imaging procedures will include the following:

- Age
- Have a cognitive impairment.
- Identify with Anxiety.
- Translation is required.
- Consideration of cultural needs.
- Physical limitations/assistance is required.

7.2 Mitigation or reduction of risk of radiation exposure for support persons in medical imaging will include such things as: wearing a protective gown and/or presence behind a shield/protective barrier. Reduction of risk due to strong magnetic fields will include comprehensive screening of any support person that accompanies a patient into the MRI scanner room as well as a removal of jewelry and all clothing (except undergarments). A hospital gown will be provided.

8. When the main entrance is locked after general visitation hours, the healthcare professional will inform the client/SDM and support person of the appropriate site-specific alternate entrance.

9. Roles and Responsibilities:

9.1 Health Care Professional/Physicians/Students

- Provide and use the Family Presence: *Your Role in Your Loved One's Care* pamphlet to clients and families to support discussion and identification of support person(s).
- Consider the client and family needs for general visitation and family presence from a lens of inclusion. For example, consider cultural needs and values.

- Inform the client and support person of the client's rights and responsibilities.http://www.easternhealth.ca/OurServices.aspx?d=2&id=734&p=202
- Advise of the visiting guidelines for general visitation.
- Identify and document in the plan of care the client/SDM's request for a support person/caregiver.
- Communicate and work collaboratively with the client and support person.

9.2 Telecommunications Operators

- Announce the start and end of general visiting hours each day.

9.3 Protection Services/ Contracted Security Personnel (site dependent)

- Call the unit/service area to confirm the support persons/caregiver's presence to ensure access is confirmed.
- Provide direction for identified support persons/caregivers to access clients outside of the standard visitation hours.
- Support employees in addressing unacceptable behaviours by a support person/caregiver or visitors during general visitation.
- Escort support persons/caregivers and/or visitors who display unacceptable behaviour from facility property when requested by appropriate Healthcare Professional/Manager/Director/Designate.

9.4 Directors and Managers/ or Designates

- Ensure that all employees are educated on the policy.
- Ensure that family presence and general visitation information is posted on each unit and information is available in a pamphlet.

Guideline

1. The definition of Family:
    - is made by the client or SDM,
    - in recognizing that the client/SDM identifies who family is, there is consideration of an inclusive context of family presence (e.g., cultural considerations). If challenges present with managing an inclusive lens of family, given the balance of rest, recovery, and privacy needs of other clients in a multi- bed ward, for instance, consider supportive discussions with the client/SDM and/or the family to identify a plan for family presence. Additionally, consultation with internal and/or external resources may be needed to support clarity of needs and reasonable family presence (e.g., the Aboriginal Patient Navigators, or a community agency).

2. Expectations:

Support Person:

- Talks about, agrees to, and provides support to the client to the degree the client/SDM wishes, and the support person/caregiver is comfortable.
- Is a partner in care with the health care team.
- Introduces themselves to staff and identifies their role as support person/caregiver and how they would like to participate in care, as agreed to by the client/SDM.
- Prepares for the transition to home (personal, personal care home or Long-Term Care home) or community care. Asks questions and ensures that the client's questions have been answered. Knows what will be needed afterwards (medications, treatment, equipment, follow-up appointments) and what changes in the client's condition should be reported to health care providers.
- Is respectful of the privacy and needs of other clients and their families.
- In a shared room, steps outside when requested by the health care professional to support the privacy needs of other clients/patients/residents and their families.
- Minimizes noise disruption to maximize opportunities for rest and recovery.
- If the need arises to change or add a shared role for the identified support person/caregiver (ex. support person becomes ill and can no longer carry the role or requires assistance to carry the role) the client/SDM, support person/caregiver discusses this need with the health care professional to consider an alternate designation of support person/caregiver.

Supporting Documents *(References, Industry Best Practice, Legislation, etc.)*

- Planetree Patient Directed Visiting. https://resources.planetree.org/wp-content/uploads/2017/04/23.-Patient-Directed-Visitation-Primer.pdf

- Family Presence Policies Take Hold Across Canada. Better Together Campaign: http://www.cfhi-fcass.ca/WhatWeDo/better-together

- Better Together, Family Presence Resources: https://www.cfhi-fcass.ca/innovations-tools-resources/item-detail/2020/05/20/better-together-change-package and https://www.cfhi-fcass.ca/what-we-do/spread-and-scale-proven-innovations/better-together

- Policy Guidance for the Reintegration of Caregivers as Essential Care Partners https://www.cfhi-fcass.ca/docs/default-source/itr/tools-and-resources/policy_guidance_en.pdf?sfvrsn=292a980e_4
- Changing Hospital "Visiting" Policies and Practices: Supporting Family Presence and Participation, Executive Summary. Institute for Patient and Family Centered Care (IPFCC). http://www.ipfcc.org/resources/visiting.pdf
- Better Together: Partnering with Families. Changing the Concept from Families as "Visitors" to Families as Partners. Better Together Toolkit: http://www.ipfcc.org/bestpractices/better-together-partnering.html
- Better Together: Re-Integration of Family Caregivers as Essential Partners in Care in a Time of COVID-19. https://www.cfhi-fcass.ca/docs/default-source/itr/tools-and-resources/bt-re-integration-of-family-caregivers-as-essential-partners-covid-19-e.pdf?sfvrsn=5b3d8f3d_2
- Statement of Rights and Responsibilities for Clients, Patients, and Residents of Eastern Health. http://www.easternhealth.ca/OurServices.aspx?d=2&id=734&p=202
- Institute for Patient and Family Centered Care (2017). Changing Hospital "Visiting" Policies and Practices: Supporting Family presence and Participation. https://www.ipfcc.org/resources/visiting.pdf
- *"Family Presence: Your Role In Your Loved One's Care"*, Brochure, Eastern Health, 2019. http://www.easternhealth.ca/DownFile.Aspx?fileid=5030
- Newfoundland and Labrador Human Rights Commission, Legal Guidelines https://thinkhumanrights.ca/guidelines-and-faqs/
- An Act Respecting Human Rights, Chapter H-13.1 https://assembly.nl.ca/Legislation/sr/statutes/h13-1.htm
- Equity and Inclusion Lens Handbook, Version 2018, City of Ottawa and City for All Women Initiative (CAWI) https://documents.ottawa.ca/sites/documents/files/ei_lens_hb_en.pdf
- Equity at McGill, https://www.mcgill.ca/equity/resources/definitions
- *Patient-Centered Culturally Sensitive Health Care: Model Testing and Refinement.* Tucker et al. Health Psychol. 2011 May; 30(3): 342–350. doi:10.1037/a0022967. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3092156/pdf/nihms-276878.pdf

Linkages

- Policy 270CH-NICU-25. Visiting Guidelines for the Neonatal Intensive Care Unit, (NICU only).
- Policy 275H-JWPS-060. Visiting Guidelines.
- Policy 275H-FOR-020. Forensic Visitor Policy.
- Policy 310-ER-SAF-40. Family Presence During Resuscitation
- Policy HR-OH-100. Harassment Free Workplace
- Policy HR-OH-050. Civility and Respect
- Policy QRM-100. Responding to Complaints.
- Policy QRM–080. Occurrence Reporting and Management.
- Policy HR-OH-060. Critical Incident Stress Management (CISM).
- Policy HR-OH (o)-070. Employee Incident Investigation.
- Policy HR-OH (o)-080. Employee Incident Reporting
- Policy IPC-200. Routine Practices
- Policy ISP-130. Disclosure of Information to Police.
- Policy IPC-185. Outbreak Management for Acute and Long-Term Care.
- Policy 114-IPC-020 Infection Control Practitioners (ICP) Guideline– Outbreak Management
- Policy IPC-150. Hand Hygiene
- Policy ADM-135. Smoke-Free Environment
- Policy HR-OH(o) – 270. Scent Safety
- Policy ADM – 030. Privacy and Confidentiality
- Policy HR-OH-150. Violence Prevention, Response and Support
- Policy HR-OH(O)-020. Aggressive-Violent Behaviour (AVB) Alert (Acute Care Only)
- Policy 310-ER-SAF-30. Prevention and Management of Violence/Aggression in the Emergency Room
- Policy HR-OH(O)-310. Working Along or in Isolation-Community Based Programs
- Policy 275CS-YTC-640. Family Engagement
- Policy 410-CSE-010. Quality Policy Customer Service
- Policy 280-PCH-210. Responding to Complaints- Personal Care Home Programs
- Policy 275CS-YTC-690. Orientation of Youth and Families-Guardians
- Policy 257CS-YTC-9280. Visitation - Approved Visitor List
- Policy 270-MNG-GEN-001. Visiting Hours and Guidelines- Woman's Health Inpatient Unit (Health Sciences Centre).
- Policy IPC-156. Infection Prevention and Control for Pet Therapy Dogs and Pet Visitation
- Policy 415(MR)-SAF- 010. MRI Safety
- Form CH-1373 Magnetic Resonance (MR) Environment Safety Screening for Individuals. Initial Visit (Part 1).

Key Words

Family presence, support person, visitor(s), visiting, visitation, family, general visitation, general visiting hours, visiting hours, hours, patient, client preference, cultural sensitivity, culture, virtual, virtual visit, virtual family presence, virtual care planning, essential partners in care, essential, outbreak, substitute decision maker, SDM, caregiver

Definitions & Acronyms

Caregiver	Someone identified by the client and/or their substitute decision-maker to provide direct care to the client (e.g., supporting feeding, mobility, personal hygiene, cognitive stimulation, communication, meaningful connection, relational continuity, and assistance in decision-making). Examples include someone who provides meaningful connection, a privately hired caregiver, paid companions, and translators. A caregiver and a support person may be the same person.
Client	The term 'client' is used to mean the person receiving care, who may also be called a patient, consumer, individual, or resident. (Accreditation Canada)
Client- and Family-Centred Care	A philosophy of care that guides all aspects of planning, delivering, and evaluating services. It includes working collaboratively with clients and their family; providing care that is respectful, compassionate, culturally safe, and competent; and being responsive to needs, values, and culture. (also referred to as patient/resident and family centred care).
Diversity	The unique dimensions, qualities, and characteristics we all possess (Canadian Centre for Diversity and Inclusion, CCDI) Describes the presence of difference within any collection of people, for example, race, indigenous identity, class, gender identity or expression, sexual orientation, age, ability, ethnicity, and religion. (McGill .ca https://www.mcgill.ca/equity/resources/definitions Diversity in Healthcare is the ability of healthcare providers to offer services that meet the unique needs of their clients.
Equitable	Recognizing and addressing barriers to provide opportunity for all individuals and communities to thrive. Often requires differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. (McGill University). https://www.mcgill.ca/equity/resources/definitions

Inclusion	Welcoming and valuing all members of society. Recognizing, reducing, and removing barriers to participation and belonging. https://www.mcgill.ca/equity/resources/definitions An active, intentional, and continuous process to address inequalities in power and privilege and build a respectful and diverse community that ensures welcoming spaces, and opportunities to flourish for all. https://equity.ubc.ca/resources/equity-inclusion-glossary-of-terms/
Inclusive Healthcare	Inclusive healthcare is seeing and serving our clients as individuals, based on their own personal needs. https://www.micromd.com/blogmd/providing-inclusive-healthcare/
Lens of inclusion	Perspective of seeing/recognizing the person first.
Family	Person(s), related (biologically, legally, emotionally), including immediate family, partners, friends, advocates, guardians, substitute decision makers. Client defines the makeup of the family and has the right to decide who is included.
Family Presence	Support persons and caregivers are integral in the care provided for a client and are considered essential partners in care. Therefore, family presence of support persons or caregivers is welcomed 24 hours, 7 days a week.
Health Care Team	Clients/ Substitute Decision Maker and designated support person(s) or caregiver working together with health care providers of different disciplines for the provision of health care services.
Inclusion	It is about creating a culture that strives for equity, and embraces, respects, accepts and values difference. (CCDI)
People Centred Care (PCC)	Defined by the World Health Organization as, "an approach to care that consciously adopts individuals', carers', healthcare professionals, families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people […] People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than person and patient/client-centred care, encompassing not only clinical encounters but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services".

Substitute Decision Maker (SDM)	A person appointed by the maker of an advance health care directive to make a health care decision on his/her behalf or who is designated to do so under Section 10 of the *Advance Health Care Directives Act*.
Support Person	This person is chosen by the client/ substitute decision maker (SDM) and is involved in supporting care. A support person may or may not be biologically, legally, or emotionally related to the client. A support person and caregiver may be the same person. The support person identified by the client or SDM may change, as determined by the client/SDM in consultation with the health care team. The support person can be present during and outside of general visitation hours. The support person is welcomed twenty-four hours of the day, seven days of the week (24-7). The support person role includes supporting a level of care agreed on by the client/patient/resident or Substitute Decision Maker and the health care team.
Unacceptable Behaviour	Behaviour demonstrated by the support person, family or visitor that interferes with safe client care, rest for recovery or the privacy of other clients. Examples include but are not limited to refusal to step outside of the client room when requested for a client/patient round that is related to another client/patient in a shared room, loud noises that interrupt sleep/recovery of the clients.
Virtual Care Planning	The use of approved, secure virtual platforms to include support person and/or caregiver in care planning and decision making when the support person or caregiver cannot be physically present.
Virtual Visitation	General visitation for family not able to be physically present using virtual platforms. Virtual visitation may occur between clients and family using their own devices. All efforts are to be made to ensure privacy for other clients in shared rooms. Virtual visitation may be supported using Eastern Health electronic devices when needed and at times where staff are able to provide and support use of an electronic device.
Visitor	A person who visits the client during general visiting hours and who is not a designated support person or caregiver. Someone not involved in the clients' health care, whose time with the client is discretionary and usually temporary and visiting for purposes that are more social in nature.

Policy History This policy replaces the following policies:

Legacy Board	Policy #	Policy Name	Date Revised
EH	ADM-170	VISITING HOURS AND GUIDELINES – ACUTE CARE	

Key: EH – Eastern Health

Appendix H: Prevention and Management of Violence/Aggression in the Emergency Room

Eastern Health

PREVENTION AND MANAGEMENT OF VIOLENCE/ AGGRESSION IN THE EMERGENCY ROOM	Emergency Plan/Safety/Security 310-ER-SAF-30
Issuing Authority (sign & date)	**Elizabeth Kennedy, Regional Director Emergency Program** Signed by Elizabeth Kenney Dated May 4, 2018
Office of Administrative Responsibility	Emergency Program
Author	Julie Bartlett, RN, BN, ENC(C) Clinical Educator Emergency Program Sandra Gear, RN, MN Regional Program Coordinator Emergency Program
Level	Three (III)
Original Approval Date	October 29, 2014
Effective Date	October 29, 2014; June 13, 2018
Scheduled Review Date	September 2016; May 2021
Actual Review Date	April 23, 2018; May 4, 2018
Revised Date(s)	May 4, 2018

Overview

The workplace should be free of violent threats or actions and staff should feel safe while at work. Workplace violence has been defined as an act of aggression directed towards persons at work and includes physical assault, emotional or verbal abuse, or threatening, harassing or coercive behavior that causes physical or emotional harm. Studies have shown that between 35% and 80% of hospital staff have been physically assaulted at least once during their careers. The Emergency Department is particularly vulnerable to violence because of the 24 hour accessibility to the public and the overall stressful environment (Emergency Nurses Association Workplace Violence Toolkit).

Eastern Health

POLICY

EMPLOYEE RESPONSIBILITIES

Prevention of Violence/Aggression

Emergency Room staff will participate in education and training on interventions to

- Prevent and recognize aggressive/violent behavior
- De-escalate and/or resolve conflict

Management of Violence/Aggression

Emergency Room staff will participate in education and training on the management of violence and aggression including the use of Therapeutic Crisis Intervention (TCI).

Emergency Room staff will participate in Critical Incident Debriefing.

Staff must report all incidents of violence or aggression involving a patient or family member in CSRS (Client Safety Reporting System). If the incident involves an employee injury or near-miss, the employee must complete an Accident/Incident Reporting Form.

Staff must implement an Aggressive-Violent Behaviour Alert on patients who meet the criteria *(See HR-OH(o)-20: Aggressive/Violent Behaviour (AVB) Alert (Acute Care Only).*

PATIENT/FAMILY INTERVENTIONS

Prevention of Violence/Aggression

Information will be available for patients and families related to zero tolerance of violence/aggression (including description of violence/aggressive behaviours). Patients and families will be informed through posters in the ER as well as through the general patient information brochures and Emergency Serivces information available on the Eastern Health website.

Emergency Room staff will minimize patient/family anxiety and frustration by regular communication/updates re wait times and other Emergency Room processes.

Eastern Health

Management of Violence/Aggression

Early recognition of potential or escalating aggression/violence and de-escalation is important. All staff must screen for risk factors for aggression/violence and be alert for signs of potential aggression (see **Appendix A**). If it is identified that a patient/family member is at significant risk for becoming aggressive or violent, the rest of the team must be informed, including on-site security (where this is available).

Significant risk is indicated by:

Presence of one of the following:

- History of physical aggression (if known and still relevant)
- Physically aggressive or threatening
- Verbally hostile or threatening

OR

Presence of three or more of the following:

- Shouting/demanding
- Drug/alcohol intoxication/potential for withdrawal
- Auditory or visual hallucinations
- Threatening to leave/impulsivity
- Cognitive impairment
- Paranoia/suspicious/distrustful
- Withdrawn
- Agitation

Each site must develop a protocol for communication of escalating aggression/violence. This may include the use of panic buttons, intercoms, Vocera etc.

If it is safe, staff must attempt to de-escalate potential aggression and violence (see Procedure – De-escalation of Aggression/Violence). Staff should consider management interventions such as rapid tranquilization and physical interventions for patients exhibiting disturbed/violent behavior (see **Appendix B**) Emergency Room staff must isolate aggressive/violent patients or families and initiate Code White procedures (if developed) (see Procedure – Code White) as required.

Each site should have a site/unit specific Code White Action Plan (see **Appendix C** for sample plan).

A **Code White** response is intended to:

- Regain control of an emergency situation in which a patient's escalating behaviours are beyond the unit staff's ability to control

- Provide the aggressive patient with the best and safest care until he/she regains control of his/her behavior
- Prevent injury to the aggressive patient, other patients, staff, and others
- Prevent property damage.

Code White Principles:

- All staff receive core training and education in crisis intervention and de-escalation techniques.
- Physical intervention is non-violent in dealing with physical aggression.
- Code White team physical intervention is used as a last resort.
- Safety priority occurs in the following order at all times: self and other staff safety, patient/family/visitor safety, and then environment.
- Code White team members must receive training and ongoing regular refresher training.
- Code White team intervention must be organized and undertaken swiftly.
- Debriefing and documentation are an important part of Code White protocols.

Code White Team:

- Membership is determined by the site.
- The responding team should have a minimum of three trained members.

Team members are required to have specific competencies (see **Appendix D).**

PHYSICAL/ENVIRONMENTAL INTERVENTIONS

Prevention of Violence/Aggression

To ensure patient safety and privacy, access to the Emergency Room is restricted. Dependent on the site, this may be through:

- Locked doors to the building (late evening/overnight)
- Locked Emergency Room doors
- Closed doors with signage indicating this is a restricted area
- Surveillance by staff (registration/clerical, security).

Staff must use caution when opening doors to admit patients/families to the site/department. If there are signs that the person seeking entrance is agitated or making threats/threatening gestures, the person should not be admitted to the department/building until there is adequate back-up (security, police, etc).

Management of Violence/Aggression

Each Emergency Room should have:

- A quiet room or area for patients/families
- A safe room or other area for aggressive or violent patients who require medical management.

Other equipment would include:

- Panic buttons or other means to communicate to team members
- Four or five point restraints

Scope

This policy applies to all staff who work in the emergency department setting.

Purpose

This policy provides guidance to managers and staff on the prevention and management of violence/aggression in the Emergency Department.

Procedure

De-escalation of Aggression/Violence

If a patient or family member is angry or upset and is exhibiting signs of potential aggression/violence:

1. Respect the person's personal space (use the 2 X arm length rule). Provide privacy if possible.

2. Introduce yourself and call the person by name. Engage the person in conversation, acknowledging his or her concerns. Remain focused on the issue. Listen to what the person is saying. Recognize the person's needs and feelings.

3. Provide information in a calm, reassuring manner. Be concise using short phrases and sentences and simple vocabulary. Do not argue or threaten. Ensure verbal and non-verbal communication is non-threatening. Communicate respect and empathy, using clear, simple language.

4. Monitor behavior frequently and document.

If this is not effective and the potential for aggression or violence continues to escalate:

1. Call for help or ensure help is available. This could include calling a Code White (see below).

2. Continue to talk to the person, calling them by name. Maintain a calm demeanor. Be soft-spoken and do not become angry.

3. Clarify what is acceptable behavior and consequences of unacceptable behavior without sounding threatening. Offer the person a choice where possible and allow time for him/her to decide.

4. Move the person to a quiet area or have other staff remove patients/family members from the area. If unable to move the person, assess the area for potential weapons and remove these if possible.

5. Maintain adequate, safe distance. Ensure you have a means of escape from the area.

6. Prepare for physical interventions and/or other clinical interventions if necessary. Debrief the person after the episode is over explaining why the interventions were necessary.

Code White

A Code White is in effect when a violent situation is imminent or in progress. The situation is beyond the attending staff's ability to control and assistance is required to regain control of the situation and to ensure the safest care for the individual and patients in the area.

1. Implement site notification procedures for Code White.

2. Implement Code White actions (**see Appendix C**).

3. Physically restrain the person if required and safe to do so. Staff require training to safely physically restrain a person. Mechanical restraints should be applied if required but only in exceptional circumstances.

4. Call the police if:

    - there is a real or perceived threat that lives are in danger
    - staff or the Code White team determines that the situation is beyond their abilities
    - whenever an "edged" weapon or firearm is involved
    - whenever the aggressive behavior occurs off the hospital grounds
    - when the aggressor is not a patient and threatens staff and patient safety and other means of intervention are not available

Provide the police with the required information (see **Appendix E**). When police arrive on the scene, they assume control of the situation.

Following the aggressive/violent incident:

1. Participate in an informal debriefing if possible. Managers or designates must provide prompt support to employees as per HR-OH-060: *Critical Incident Stress Management.* A formal debriefing may be required and should be arranged by the manager.

2. Complete an occurrence report in CSRS and an Employee Incident/Accident Report as appropriate.

3. Implement an Aggressive-Violent Behaviour (AVB) alert on the patient if appropriate.

Guideline

Guidelines for the Use of Physical and Mechanical Restraints (refer to PRC-080: *Least Restraint* policy.

- Staff using physical or mechanical restraints must have training in the safe and appropriate use of these restraints.
- Patients requiring a 4 or 5-point restraint must be assessed for certification per the Mental Health Care and Treatment Act (MHCTA).
- The 4 or 5-point restraint can be applied without the patient's consent as a psychiatric emergency intervention.
- The ER Physician must assess the client as soon as possible and reassess patients in a 4 or 5-point restraint every two hours to determine if the restraint can be removed.
- Patients in 4 or 5-point restraints must be monitored on constant surveillance.
- Patients in 4 or 5-point restraints must be checked hourly for signs of restraint snugness, circulation and skin integrity.
- Two nursing staff must release/re-secure one limb every fifteen minutes, on a rotational basis.
- Four or five-point restraints must be discontinued at the earliest possible opportunity.

Supporting Documents *(References, Industry Best Practice, Legislation, etc.)*

- HR-OH-150 Violence Prevention, Response, and Support

Linkages

- 310-ER-SAF-20: *Utilization of Safe Room*

- 310—ER-BEH-10: *Alcohol and Drugs: Assessment and Interventions for Patients under the Influence of*
- HR-OH-150: *Violence Prevention, Response and Support*
- PRC-080: *Least Restraint*
- HR-OH-060: *Critical Incident Stress Management (CISM)*
- HR-OH(o)-20: Aggressive/Violent Behaviour (AVB) Alert (Acute Care Only).

Key Words

Violence, aggression, Code White

Definitions & Acronyms

Aggression	Behaviours that have no intent to cause harm but result from an underlying physiological/ psychological condition. This would include verbal abuse such as name calling, swearing, yelling, threatening or intimidating.
Violence	Attempted or actual physical force with intent to cause injury to another individual and/or property.

Appendix A: Risk Factors for Violence/Aggression and Signs of Escalating Aggression or Violence

Risk Factors for Violence/Aggression:

Organizational Factors

- Long wait times
- Uncomfortable and stressful environment
- Staff control
- Poor information for patients/families

Patient/Family Factors

- Substance intoxication or withdrawal
- Confusion or disorientation
- Pain or other discomfort
- History of aggression
- History of mental illness
- Sensory losses
- Fear/Anxiety

Signs of escalating Aggression or Violence

- Increased restlessness, body tension, pacing about and excitability
- Raised voice, shouting erratic movements
- Tense, angry facial expression
- Refusal to communicate, no verbal response, withdrawal
- Lack of eye contact
- Unclear thought processes, poor concentration
- Verbal threats or gestures

Appendix B: Rapid Tranquilization

Medications used for rapid tranquilization:

Medication(s) and Dosage	Route	Notes
Haloperidol 5mg Lorazepam 2 mg	IM	May be given together in one syringe
Risperidone 2 mg Lorazepam 2 mg	PO Liquid	Equally effective as Haldol and Lorazepam IM
Zydis 5 mg Risperidone M tabs	PO dissolving in water	Quick dissolving, can't be cheeked

Appendix C: Code White Action Plan Template

Code White Initiation

Any staff member can initiate a Code White if a situation is identified where help is needed.

Procedure: (site specific)

Staff Responsibilities

If a Code White has been initiated in your area, take the following steps:

- If possible, remove all individuals in immediate danger to a safe area.
- Reduce stimulation in the area by turning off radios, TVs, other noise producing equipment.
- Reduce activity.
- Speak calmly and in a quiet manner.
- Provide details of the incident to the Code White Team Leader.
- Assist the Code White team as directed.
- Notify the manager.
-

Nursing Staff Responsibilities (in addition to staff responsibilities above)

- Ensure a physician is contacted to obtain orders for:
    1. Medication (oral and intramuscular)
    2. Restraints if necessary
    3. Seclusion if necessary (and possible)
- Prepare and give medication.
- Attend to the remaining patients in the area.
- Ensure involved staff participate in a debriefing following the incident.
- Ensure documentation is complete.
-

Code White Team Member Responsibilities

- Report to the scene of the incident as quickly as possible.
- Follow the Team Leader's direction and inform him/her if unable to assume a "hands-on" position.
- Participate in a debriefing after the incident and offer recommendations.
- Report any injuries to the Team Leaders.
- Assist with documentation.

Environmental Considerations

- Additional environmental actions (doors to shut/lock, equipment to move etc.)

- Room/area for seclusion

Ensure your personal safety by removing all personal items which could cause injury (pens, stethoscopes, name badges, watches, eye glasses etc.)

Appendix D: Code White Team Member Competencies

Ability to function as an effective team member:

- Rapid and accurate assessment skills of team's capacity to respond to the situation
- Appropriate and effective decision-making skills
- Competence to perform Code White techniques
- Accountability and Responsibility
- Ability to respond and effectively participate in Code White calls
- Ability to function professionally in a stressful situation
- Verbal de-escalation skills
- Recognition of personal limitations

Appendix E: Calling for Police Intervention

Police will require information when a request for their assistance is made. Staff making the call should not tell the police that a Code White is in progress as this does not provide adequate information for the police to respond effectively. Staff should be prepared to provide the following information:

- Nature of the incident (person out of control etc)
- Where the incident is occurring
- The exact behavior of the aggressor
- The involvement of weapons including what the person is doing with the weapon
- Any injuries sustained
- The number of people in the room with the person and if they can safely leave
- A description of the aggressor (name, race, sex, age, height, weight, color/style of hair)
- The time and direction of travel (if the aggressor has left the premises)
- The name of the witness or contact person.

If staff making the call are unable to stay on the line and answer questions, he/she should leave the phone off the hook.

When police arrive on the scene, they assume control of the situation.

Appendix I: Overview of WPV Education Huddles

1. WPV Education Huddle #1 provided an overview of WPV
    - We defined WPV; the types; classifications; the impacts of WPV violence on nurses, patients, and organizations; and contributing factors of nurse, patient, environment, and organization.
    - Please refer to the handout for further information on this Education Huddle.

2. WPV Education Huddle #2 focused on Assessment and Policies
    - Relational Inquiry was discussed as a theory to assess patients and visitors in potential and actual aggressive situations.
    - The assessment tool STAMPEDAR provides a list of cues to monitor for when assessing the potential of violence.
    - The Acute Care Violence Assessment Tool (VAT) is a tool that is used to score the patients risk of violence, provides actions based on the score provided, and addresses potential contributing factors to consider.
    - The AVB policy is initiated for patients who demonstrate behaviours or threats that give workers a reason to believe that are at risk of injury.
    - EH policies provided information on the initiation of physical and chemical restraints.
    - Please refer to the handout for further information on this Education Huddle.

3. WPV Education Huddle #3 focused on de-escalation and personal protection efforts.
    - De-escalation was defined and verbal and non-verbal strategies were provided.
    - Actions taken to promote personal safety were provided.
    - For a list of de-escalation techniques and personal protection efforts please refer to the handout.

4. WPV Education Huddle #4 focused on the rights of nurses and patients and the visitation policy.
    - Nurses' rights, as well as their ethical obligations were discussed.
    - The eleven standard patient rights for all Canadian provinces were identified.
    - Visitation and unacceptable behaviours were reviewed.
    - Please refer to the handout for further education on this Huddle.

5. WPV Education Huddle #5 focused on responding to violent situations.
    - The role of security and when and how to contact them was addressed in this Huddle.
    - The information to share with security was identified.
    - Code Whites were discussed in detail, outlining specific roles of staff, nurses, and code white teams.
    - Please refer to the handout for additional information on this Huddle.

6. WPV Education Huddle #6 also focused on responding to violent situations.
- The role of police, when, and how to contact them was addressed in this Huddle.
- The information to share with security was identified.
- The implementation and importance of safety huddles to communicate violence or potential violence was addressed.
- Please refer to the handout for additional information on this Huddle.

7. WPV Education Huddle #7 focused on reporting and documenting.
- The importance of reporting violence was addressed.
- Where and who to report violence to was provided.
- Important points and information to include in documentation was covered.
- Please refer to the handout for additional information on this Huddle.

8. WPV Education Huddle #8 focused on debriefing and EFAP.
- The importance of debriefing, operational debriefing and critical incidences debriefing were discussed.
- The EFAP was identified and explained.
- Please refer to the handout for additional information on this Huddle.

Appendix E: Journal Article

The Development of a Workplace Violence Education Huddle Program and Facilitator's Manual: Journal Article

Allison Bragg, 201122595

Memorial University of Newfoundland and Labrador

DEVELOPMENT OF A WORKPLACE VIOLENCE EDUCATION HUDDLE PROGRAM AND FACILITATOR'S MANUAL

Workplace Violence Education Huddle Program

Allison Bragg, BNRN; Kathleen Stevens, RN PhD

Authors' Affiliations: Registered Nurse, Eastern Health, St. John's, NL, Canada; Master of Nursing Student, Memorial University, St. John's, NL, Canada (Ms. Bragg); Assistant Professor Memorial University, St. John's, NL, Canada (Dr. Stevens)

Corresponding Author: Ms. Bragg, Memorial University, 300 Prince Phillip Drive, St. John's, NL, Canada, A1B 3V6 (anb441@mun.ca).

The author declares no conflict of interest.

DEVELOPMENT OF A WORKPLACE VIOLENCE EDUCATION HUDDLE PROGRAM AND FACILITATOR'S MANUAL

Abstract

Background: Nurses are at a high risk of workplace violence (WPV) from patients and visitors due to their continued and direct contact with this population. WPV against nurses can have physical, psychological, and financial implications. The negative impact on nurses can result in concerning consequences for patient care and costs for the healthcare system.

Problem: Evidence-based programs are needed to provide acute-care nurses with education concerning prevention and management of WPV from patients and visitors.

Approach: The authors describe a WPV Education Huddle Program. This program consists of eight 15-minute Huddles that can be facilitated by a nurse educator in the clinical area.

Outcomes: The aim of the program is to provide nurses with the knowledge and skills to prevent and manage WPV from patients and visitors.

Conclusion: WPV Education Huddles may be an effective and engaging strategy to educate nurses on WPV prevention and management from patients and visitors.

Key terms: Workplace violence, assessment, prevention, management, relational inquiry

Workplace violence (WPV) in healthcare is a worldwide issue (Li et al., 2020). WPV is defined as any verbal or physical violent act or threat directed toward working persons (National Institute for Occupational Safety and Health (NIOSH), 2020). When compared to other healthcare professionals, nurses are at the highest risk of being exposed to WPV everyday by patients and support persons due to their direct and continued contact with patients (International Council of Nurses, 2000). Patients are responsible for the occurrence of 80% of WPV in healthcare (Occupational Safety and Health Administration (OSHA), n.d.).

WPV has negative consequences for nurses, patients, and the healthcare system. Nurses experience physical, psychological, and financial strain, patient safety and care are compromised, and healthcare systems are financially impacted. The effects of WPV have supported the need to provide education to assist with the prevention and management of WPV from patients and visitors. An integrative literature review, environmental scan, and consultations with key stakeholders supported the development of a WPV Education Huddle Program. The goal of this program is to provide nurses with information, skills, tools, and strategies to assist with the prevention and management of WPV from patients and visitors.

Background

WPV is classified into four types: type one is criminal intent, type two is customer/client, type three is worker on worker, and type four is personal relationships. Type two is the most common type of violence in healthcare. WPV can be further divided into three categories: physical, psychological, and sexual (Registered Nurses Association of Ontario (RNAO), 2019). Physical violence entails any action that involves force against another. This may include hitting, punching, pushing, biting, or any other form of physical aggression. A national well-conducted online survey of 7153 regulated Canadian nurses determined that 29.2% of participants

experienced physical violence a few times per year, while 7.9% reported physical violence every day (Hall & Visekruna, 2020). Psychological violence is threatening, intimidating, or demeaning behaviours exhibited by a person through actions such as shouting, swearing, criticizing, and passive aggression (RNAO, 2019). Hall and Visekruna (2020) also reported that 21.2% and 20.6% of nurses surveyed experienced verbal abuse from patients or family members every day and a few times per week, respectively. Sexual violence is any physical or verbal behaviours based on gender or sexuality (RNAO, 2019). A well-conducted systematic review of 20 studies was completed to determine the prevalence of sexual harassment against female nurses (Kahsay et al., 2020). In total, 46.59% of participants experienced sexual harassment from patients and 27.74% experienced harassment from patient's family.

The impacts of WPV are substantial, affecting nurses, patients, and the healthcare system. Nurses experience physical, psychological, emotional, and financial implications as a result of WPV (Lanctôt & Guay, 2014). Nurses exposed to WPV have suffered from physical injuries such as back, neck, or shoulder pain, have been bitten and bruised, and require time off work to recover from these injuries (Lanctôt & Guay, 2014). Mentally and emotionally, nurses exposed to WPV experience emotional exhaustion (Kim et al., 2021), depression, anxiety, fear, and feelings of incompetence (Lanctôt & Guay, 2014). The time off work, counselling sessions, and potential legal fees create a financial cost for nurses (NIOSH, 2020). WPV can compromise patient care and patient safety due to: nurses avoiding patients, the disruption on the unit (Chapman et al., 2009), and nurses being emotionally exhausted (Kim et al., 2021; Lanctôt & Guay, 2014). Avoidance decreases the amount of time nurses spend caring for their patients and the disruption impacts the care nurses can provide to other patients (Chapman et al., 2009).

Authors of a medium quality cross-sectional study reported a link between emotional exhaustion due to WPV and a corresponding decrease in patient safety (Kim et al., 2021).

WPV results in cost to the healthcare system due to turnover rates and absenteeism (NIOSH, 2020). NIOSH (2020) reported that 80% of nurses do not feel safe in their workplace. Authors of a recent Canadian study, also referenced above, reported that 21.7% of nurses had intention to leave the nursing profession (Hall & Visekruna, 2020). While this result is not solely reflective of the impact of WPV, this issue may be a factor in Registered Nurses' (RN) decisions to leave the profession. It is estimated that the turnover cost of one RN is $40,038 USD (Nursing Solutions Incorporated, 2021).

To meet the identified need of a WPV prevention and management educational resource, the WPV Education Huddle Program was developed in partial fulfillment of a Master of Science in Nursing Program. The need for this resource and the content was determined from an integrative literature review, an environmental scan of reputable Canadian and International organizations, and consultations with key stakeholders (e.g., acute care nurses, clinical nurse educators, nursing supervisors, security personnel, and management). Key stakeholders suggested short, in person education sessions. Huddles were recommended and offered in Nova Scotia (NS) (Aware-NS, 2020) and in British Columbia (BC) health authorities (Provost et al.**,** 2020). In NS, these huddles are provided as safety huddles, initiated to address immediate concerns of WPV that were intended to last 15 minutes or less (Aware-NS, 2020). In BC, huddles are recommended in the Provincial Violence Prevention Curriculum and are used to deliver new content, provide refresher education, promote group discussion about the occurrence of violence and the use of skills, and decrease the normalization of WPV directed towards nurses (The University of BC, 2020). The concept of Education Huddles is based upon the NS and BC

programs. This article describes the creation and recommended delivery of eight WPV Education Huddles designed for clinical educators to deliver to acute care nurses.

Theoretical Underpinnings

Knowles' Theory of Andragogy and Relational Inquiry (RI) formed the theoretical and philosophical underpinnings for the WPV Education Huddle Program. Knowles' Theory of Andragogy focuses on adult learners (Knowles, 1984). As nurses are adults with differing levels of experience and expertise, this theory is valuable for the development and implementation of the WPV Education Huddle Program. RI is an approach to nursing practice that is created by two critical components: relational consciousness and inquiry as a form of action (Doane & Varcoe, 2015). RI is useful in applying the information learned from the WPV Education Huddles into practice.

Theory of Andragogy

There are six assumptions of the Theory of Andragogy regarding adult learners that apply to the development of the WPV Education Huddle Program: 1) the learners' self-concept, as learners are independent and responsible for their own learning; 2) the role of the experience, as learning will be impacted by previous experience; 3) the readiness to learn, an assumption that is based on the relevance of a topic to the learner; 4) orientation to learning, or the ability to apply learning directly into practice; 5) motivation, such as increased quality of life, job satisfaction, or an increase in self-esteem; and 6) the need to know why learning a particular lesson is important (Knowles et al., 2015). Through the consultations it was determined that this topic was relevant to the staff nurses and this format (short in-person sessions with just the unit nurses) was preferred over other formats (e.g., virtual meetings, education with other units). The nurses'

previous experience with WPV and their desire to have the knowledge and skills to prevent and manage future WPV incidences was evident in the consultations.

Relational Inquiry

The goal of RI is wellbeing of the patient, nurse, and the system (Doane & Varcoe, 2015). RI is formed by two overlapping concepts, relational consciousness and inquiry as a form of action (Doane & Varcoe, 2015). Relational consciousness allows nurses to be mindful of the situation in which they are providing care and the relational interplay between the intrapersonal (i.e., what is occurring within the person), interpersonal (i.e., what is occurring between all the people involved), and contextual (i.e., what is occurring in surrounding environment) experiences of the individual. Having relational consciousness provides nurses with the information needed to be effective with their actions. In the case of WPV, there are often multiple contributing factors that lead to violent or aggressive outburst. Through the completion of the WPV Education Huddle Program, nurses will recognize the importance of applying relational consciousness to their practice in the prevention and management of WPV. In doing so, they will gain a greater understanding of the intrapersonal, interpersonal, and contextual factors, their interplay, and in turn be better equipped to navigate potential and actual WPV situations and provide effective nursing care.

Workplace Violence Education Huddle Program

To support delivery of the WPV Education Huddle Program, a facilitator's manual was developed. This manual provides facilitators with: an explanation of the program; information regarding the facilitator role; and content, directions and suggestions for delivering the program. This manual is intended for the facilitator to use when preparing for and delivering the WPV Education Huddles. It is not to be distributed to learners. Learners will be provided with

handouts that provide an overview of each Education Huddle.

The facilitator's role is essential to the effective delivery of the WPV Education Huddles. The facilitator will prepare and direct the Huddle. It is important that the facilitator keep the Huddle to the 15-minute timeframe, be aware of the sensitivity of the topic, confirm confidentiality, encourage participation, and evaluate each Huddle to assess for positive actions or improvements. Suggestions and recommendations to deliver the program are outlined in the Facilitator's Manual. As this program will be delivered during a nursing shift it is important that the facilitator choose a location that allows participants to remain available to their patients, being aware that some Huddles may need to be rescheduled, and being aware that nurses may have to leave during Huddles to attend to patient care. The timing for the Huddle will vary based on the availability of the highest number of staff members and the routines of the unit. It is recommended that the facilitators discuss timing with the unit manager, nursing supervisors, and staff nurses to determine an appropriate time. It is intended for the Huddles to be completed twice during a nursing shift to provide an opportunity for all nurses to attend.

The WPV Education Huddle Program is comprised of eight separate WPV Education Huddles. The purpose of the program is to provide acute care nurses with education concerning the prevention and management of WPV from patients and visitors (an overview of the program content can be found in Table 1). Education Huddles are short (e.g., 15 minute) education sessions of approximately six people that are carried out on site during work hours. Each WPV Education Huddle follows the same format. The Huddles start with learning objectives, the preparation needed (e.g., reviewing content, and printing handouts and policies), the suggested order for delivery of content, housekeeping items, and a scripted introduction. As WPV may be a sensitive topic for participants, the contact numbers for mental health support services are

provided at the beginning of each Huddle. Participants are encouraged and supported in removing themselves if uncomfortable feelings are evoked by the content or discussions. Each Huddle is accompanied by a handout and starts with a brief review of the topics covered in the previous Huddle(s). To promote interactive learning and reflection, discussion questions are asked throughout the Huddle and a case study is referred to at the end of each Huddle to provide participants with an opportunity to apply the content. This strategy also provides the facilitator with an opportunity to conduct formative evaluations. The same case study is referred to throughout the WPV program allowing content to be applied to the same situation (the case study and sample questions can be found in Table 2). Each Huddle ends with the delivery of a key message that summarizes the main point(s).

Each WPV Education Huddle covers a specific topic that was identified as a learning need by the key stakeholders. It is important to note that the WPV Education Huddle Program was created for a specific Regional Health Authority (RHA). The terms used in organizations, presence of onsite security, local support services, and policies may differ. Therefore, this terminology and content may need to be revised for this program to be used in another organization.

WPV Education Huddle #1: Workplace Violence Overview

In the first WPV Education Huddle an overview of WPV is provided. Learning outcomes for this Huddle are to identify WPV, recognize the negative impacts of WPV, identify factors that contribute to WPV, and apply content to a case study. The key message of Huddle #1 is for participants to recognize that WPV is present in acute care inpatient nursing units and has a negative impact on nurses' physical, mental, and emotional health, patient care, and on the healthcare system.

WPV Education Huddle #2: Assessments Tools and Policies

In the second WPV Education Huddle the following content is covered: application of RI in assessing potential or actual violent patients; two potential risk assessment tools, the STAMPEDAR framework (Chapman et al., 2009) and the Acute Care Violent Assessment Tool (VAT) (Public Services Health and Safety Association (PSHSA, 2017); and organizational policies related to managing WPV. The learning outcomes for Huddle #2 are to to discuss RI and its application in caring for potential or actual aggressive patients and visitors, describe assessment tools that identify risk behaviours, to understand and apply organizational policies, and apply content to the case study.

The application of a theoretical lens, RI, is suggested in assessing the patient and determining the plan of care. RI is comprised of relational consciousness (i.e., the relational interplay between the intrapersonal, interpersonal, and contextual experiences of an individual) and inquiry as a form of action. By assessing the patient based on their personal and interpersonal experiences and their environment, nurses can therefore determine their plan of care in preventing and managing aggression.

Next, in keeping with RI two assessment tools are presented. The STAMPEDAR list nine specific cues that may indicate the risk of violence from patients (Chapman et al., 2009). The Acute Care VAT provides an immediate assessment of the patient's risk of violence by identifying behaviours that are associated with a risk of violence. Risk factors are assigned a corresponding score that determines suggested actions for the healthcare provider to take to address the situation. This assessment tool also considers contributing factors that are patient specific and provides guidance related to de-escalation techniques, based on the patient's assessment (PSHSA, 2017).

Specific to the RHA, policies that address managing violent patients by allowing nurses to flag patients as high risk of violence and determining when chemical or physical restraints should be initiated are reviewed in the Huddle. The key message for Huddle #2 is application of RI, evidence-based tools, and monitoring patients for signs and symptoms of violent outburst could prevent violence from occurring. If violent outburst from patients cannot be prevented, using appropriate policies can help protect yourself and others.

WPV Education Huddle #3: De-escalation and Personal Protection

The third WPV Education Huddle focuses on de-escalation and personal protection strategies. The learning outcomes of Huddle #3 are to define de-escalation, identify personal protection efforts, and apply the techniques and strategies to the case study. In this Huddle de-escalation is defined; suggestions of potential verbal and non-verbal de-escalation techniques and personal protection strategies are delivered; and how to safely terminate a potential violent nurse-patient/visitor relationship is identified. The key message of Huddle #3 is to be aware of ways to de-escalate a situation while being mindful of personal protection strategies to stay safe.

WPV Education Huddle #4: Nurse and Patient Rights and Visitation

The fourth WPV Education Huddle focuses on the rights of nurses and patients and the visitation policy for the RHA. The learning outcomes for this Huddle are to identify rights of nurses and patients, explain the visitation policy, and apply content to the case study. The right of nurses to work in a workplace free from violence is discussed in relation to the ethical obligations of nurses to provide safe, competent, and ethical care. As well, the eleven rights of patients in Canada and the visitation Policy for the RHA are discussed. The key message of Huddle #4 is that nurses have a right to a safe workplace free of violence. Patient and visitors do not have the right to demonstrate physical, verbal, or sexual violence.

WPV Education Huddle #5: Responding to a Violent Situation: Part One

The fifth WPV Education Huddle is part one of a two-part series on how to respond to a violent situation. The learning outcomes for this Huddle are to identify the role of security, to understand when and how to contact security, and the information to provide to security personnel when they arrive on the unit; to apply the RHA's Code White policy (aggressive behaviour); and apply content to the case study. The key messages of Huddle #5 are to view security as a vital part of the team and to collaborate with them to address WPV from patient and visitors. Additionally, a key point emphasized in this Huddle is to call a code white before verbal de-escalation has been shown to be unsuccessful.

WPV Education Huddle #6: Responding to a Violent Situation: Part Two

The sixth WPV Education Huddle is the second part of the responding to a violent situation two-part series. The learning outcomes for this Huddle are to identify the role of police, when to contact these supports, and the information to provide to police; to identify and utilize safety huddles; and apply content to the case study. There are two key messages for Huddle #6. First, to recognize when violence has moved beyond the scope of security and when local police must be contacted to protect patients and staff. Second, when aggressive situations are occurring or have the potential to occur, safety huddles are an effective way to communicate the risk of violence to protect staff members and patients.

WPV Education Huddle #7: Reporting and Documenting

The seventh WPV Education Huddle focuses on reporting and documenting. The learning outcomes for this Huddle are to recognize the importance of reporting and documenting WPV, identify where and who to report violence to, determine appropriate information to include in documentation, and apply content to a case study. The key message for Huddle #7 is that

reporting WPV identities a need for support and increases the likelihood that administration will allocate resources to address the issue.

WPV Education Huddle #8: Debriefing

The eighth and final WPV Education Huddle is focused on debriefings and the Employee Family Assistance Program (EFAP). The learning outcomes for this Huddle are to define and determine the need for debriefings, recognize the availability of EFAP and the assistance it provides, and apply content to the case study. The key messages for Huddle #8 are that debriefings are essential for individuals who were involved in or witnessed violent events to assist with recovery and sometimes supports such as EFAP, are needed in addition to or separate from debriefings.

Evaluation

The WPV Education Huddle Program has not been implemented at this time. However, the WPV Education Huddle Program Facilitator Manual was provided to a clinical educator, staff nurses, and nursing manager for feedback. WPV Education Huddle #5 (Responding to Violent Situations: Part One) and #6 (Responding to Violent Situations: Part Two) were provided to the Protection Services Manager for feedback, as this is their area of expertise. These consultants provided feedback on the resource and their suggestions to improve the content and delivery were evaluated and implemented to improve the WPV Education Huddle Program.

Once implemented, the program will be evaluated using formative, summative, and process evaluations. Formative evaluation will measure participant learning and will be useful to determine if participants are gaining any knowledge from the Huddles. Results of the formative evaluation will help the facilitator determine the level of understanding of the group and if changes will need to be made to improve the learning experience throughout the delivery

process. Participants ability to apply content to the case study in each Huddle will allow the facilitator to perform a formative evaluation. Summative evaluation will measure the learning after completion of the program and could be used to revise the program to better meet the learning needs of the target audience. A pre and post-test will be developed and distributed to participants to determine their knowledge regarding WPV before and after the completion of the program.

Additionally, a process evaluation tool will be created and used to evaluate the delivery of the WPV Education Huddle Program. This will determine if the content was delivered as intended or if there were any issues in relation to implementation, such as timing, location, or length of the Huddles. Based on the findings from the formative, summative, and process evaluations, the WPV Education Huddle Program and accompanying Facilitator's Manual can be revised to better serve the target audience, acute care inpatient nurses.

To determine outcome evaluation the Unit Manager and the Protection Services Department can monitor the number and details of reported violent encounters on the unit for 12 months after the implementation of the WPV Education Huddles. It will be important to consider that the number of violent events may increase with education and the encouragement of reporting.

Application to Nursing Practice and Nursing Education

The WPV Education Huddle Program can be adapted and utilized in other practice areas and in undergraduate nursing education. This program was designed for acute care inpatient nurses in a specific RHA in Newfoundland and Labrador, Canada. With modifications and adaptations, this WPV Education Huddle Program can be delivered in other healthcare settings such as long-term care and in other healthcare organizations. The Facilitator's Manual has

content that would not be applicable to all settings. For example, to be used in a different setting, modifications would need to be made regarding specific policies and resources (e.g., onsite security). During the consultation process key stakeholders recommended that WPV education and training begin in undergraduate nursing education. This WPV Education Huddle Program Facilitator's Manual can be modified to meet the needs of students, providing them with essential knowledge regarding WPV before entering clinical areas.

Conclusion

WPV negatively impacts nurses, patients, and the healthcare system. Therefore, it is important for nurses to have the knowledge to prevent and manage WPV from patients and visitors. The WPV Education Huddle Program is an evidence-based educational resource underpinned by the Adult Learning Theory and RI. This program was developed to provide nurses in acute care with the information to effectively recognize, prevent, and manage WPV from patients and visitors. After implementation of this WPV Education Huddle Program, evaluation results will be important to direct any potential modifications and adaptions to better meet the needs of the nurses at risk of and exposed to WPV. While this WPV Education Huddle Program is created for acute care inpatient nurses within a specific RHA, it is hoped that the information can be modified to meet the needs of nurses and nursing students in other settings and healthcare organizations.

References

Aware-NS. (2020). *Safety huddles tip sheet.* https://secureservercdn.net/45.40.148.234/sg7.82b.myftpupload.com/wp-content/uploads/2020/12/3-LL-Safety-Huddles-Tip-Sheet.pdf

Chapman, R., Perry, L., Styles, I., & Combs, S. (2009). Consequences of workplace violence directed at nurses. *British Journal of Nursing, 18*(20), 1256-1261. http://doi.org/10.12968/bjon.2008.17.20.45121

Doane, G., & Varcoe, C. (2015). *How to nurse: Relational inquiry with individuals and families in changing health and health care contexts*. Wolters Kluwer/Lippincott Williams & Wilkins.

Hall, L. M. & Visekruna, S. (2020). Outlook on nursing: A snapshot from Canadian nurses on work conditions pre COVID-19. *Canadian Federation of Nurses' Union.* Retrieved June 2021, from https://nursesunions.ca/wpcontent/uploads/2020/12/CFNU_outlook_ENfinal_web.pdf

International Council of Nurses. (2000). *Abuse and violence against nursing personnel.* http://www.icn.ch/psviolence00.htm.

Kahsay, W. G., Negarandeh, R., Nayeri, N. D., & Hasanpour, M. (2020). Sexual harassment against female nurses: a systematic review. *Biomed Central Nursing, 19*(58). https://doi.org/10.1186/s12912-020-00450-w

Kim, S., Mayer, C., & Jones, C. B. (2021). Relationships between nurses' experience of workplace violence, emotional exhaustion, and patient safety. *Journal of Research in Nursing, 26*(1- 2), 35-46. http://doi.org/10.1177/1744987120960200

Knowles, M. (1984). *The modern practice of adult education: From pedagogy to androgogy.* Associated Press, Follett Publishing Co.

Knowles, M. S., Holton, E. F., III, & Swanson, R. A. (2015). *The adult learner: The definitive classic in adult education and human resource development* (8th ed.). Elsevier.

Lanctôt, N. & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression and Violent Behaviour,19,* 492-501. http://dx.doi.org/10.1016/j.avb.2014.07.010

Li, Y. L., Li, R. Q., Qiu, D., & Xiao, S. Y. (2020). Prevalence of workplace physical violence against health care professionals by patients and visitors: A systematic review and meta-analysis. *International journal of environmental research and public health*, *17*(1), 299. https://doi.org/10.3390/ijerph17010299

National Institute for Occupational Safety and Health. (2020, September 22). *Occupational violence.* Center for Disease Control and Prevention. https://www.cdc.gov/niosh/topics/violence/default.html

Nursing Solutions Incorporated. (2021). *2021 NSI national health care retention and RN staffing report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

Occupational Health and Safety Administration (OHSA). (n.d). *Workplace violence in healthcare.* https://www.osha.gov/sites/default/files/OSHA3826.pdf

Provost, S., MacPhee, M., Daniels, M., & McLeod, C. (2020). *Realist evaluation of violence prevention in BC healthcare.* http://pwhr.sites.olt.ubc.ca/files/2021/01/REVPE-WorkSafeBC-Final-Report-Dec-2020.pdf. Partnership for work, health, and safety.

Public Services Health and Safety Association. (2017). Individual client risk assessment toolkit for healthcare settings. https://workplace-violence.ca/wp content/uploads/2021/04/VPRASEEN0417-ICRA-Toolkit-Resource-Manual-V1.3-2017.12.12.pdf

Registered Nurses' Association of Ontario (RNAO). (2019). *Preventing violence, harassment and bullying against health workers (2nd ed.).* www.RNAO.ca/bpg

The University of British Columbia. (2020, December). *Does it make a difference? Evaluating violence prevention education in BC healthcare.* https://pwhr.sites.olt.ubc.ca/files/2020/12/REVPE-research-brief.pdf

Appendix A

Table 1: Case Study and Sample Question for Each Huddle

Case Study	Sample Questions
Mr. August was admitted to the unit for removal of a foreign body to his leg. The patient came to the floor post-operatively and was sleepy on arrival. In completing the admission data, the nurse noted that the patients had a history of alcohol misuse and schizophrenia. The nurse relayed this information onto staff. Overnight the patient slept and was pleasant and cooperative on nursing assessments. The next day Mr. August became much more alert and active on the unit. He reported discomfort to his leg frequently the next day. The nurses medicated him with pain medications as ordered. While administering the patient morphine via a subcutaneous injection, he started to mutter something under his breath. The nurse asked him what he has said. Mr. August stared at the nurse silently before stating "I said, you are lying about the dose of pain medication." The nurse was taken back by this comment. Throughout the shift the patient became much more disruptive on the unit. He was pacing the halls with a clenched jaw and furrowed brow. In his room he was loudly speaking ill of the nurses, medical staff, and the care he was receiving, using vulgar language. A patient on the ward called the nurse in and asked if she could be moved to a new room whispering that she was "afraid of the patient." The nurses became uncomfortable providing care for the patient. They were concerned by the continued accusations regarding his care and were unsettled by the tone and aggression he demonstrated when he spoke. Since the patients in the ward feared Mr. August, he was moved into a private room. During one shift, the patient rang the call bell. When the nurse entered the room, the patient was noticeably upset that the nurse had "taken too long" to answer. The nurse apologized, explaining that she had three other patients and had been tied up. When the nurse left the room to get the patient his patient medications as requested, there was a loud crash against the door. The nurse opened the room door to discover that the patient had thrown his lunch tray against the door as she left the room. Later in the shift, the patient required his dose of intravenous (IV) antibiotics. The nurse entered the room and noted that the IV pump was on the far side of the room, on the inside of the bed. After the patient's earlier outburst, she was uneasy about going into the room but felt that the patient needed the antibiotics to get better. Placing the patient's health above her	**Huddle One** 1. Are there any contributing factors you can identify in the case study that may have led to the violent outburst? **Huddle Two** 2. Looking at the Acute Care VAT, what score would you give this patient? **Huddle Three** 3. Are there any de-escalation techniques that the nurse could use in this situation? **Huddle Four** 4. Are the nurses' rights to a safe workplace free of violence being violated in this scenario? Why or why not? **Huddle Five** 5. During the patient's violent outburst, when do you think would have been the appropriate time to contact security? **Huddle Six** 6. Should a safety huddle have been initiated? What kind of information do you think would be shared? **Huddle Seven** 7. What information should be included in the note for the patient's record? **Huddle Eight** 8. Do you feel that staff should have a debriefing

own safety, the nurse entered the room and administered the medication.	after caring for this patient? Why or why not?

Appendix B

Table 2: WPV Education Huddles Overview

WPV Education Huddle	**Topic**
WPV Education Huddle #1	Workplace Violence Overview • Definition • Prevalence • Impacts • Contributing factors
WPV Education Huddle #2	Assessment Tools and Policies • STAMPEDAR • Acute Care Violence Assessment Tool • Aggressive Violent Behaviour Policy • Chemical and Physical Restraints
WPV Education Huddle #3	De-escalation and Personal Protection Strategies • De-escalation techniques (verbal and non-verbal) • Personal protection strategies • How to terminate potentially violent working relationship
WPV Education Huddle #4	Nurse and Patient Rights and Visitor's Policy • Nurses' rights • Patients' rights • Visitors' policy and guidelines
WPV Education Huddle #5	Responding to Violent Situation: Part One • Roles of security • How to contact security • Information to provide security • Code Whites (Team members' roles, how to call Code White)
WPV Education Huddle #6	Responding to Violent Situation: Part Two • Roles of police • How to contact police • Information to provide police • Safety huddles
WPV Education Huddle #7	Reporting and Documenting • Who/where to report violence • Information to include in documentation
WPV Education Huddle #8	Debriefing • Importance of debriefing • Employee Family Assistance Program