Addressing Workplace Violence Through In-Person Training

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NURS 703B: DNP Project

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Submitted to: Virginia Elder DNP, PMHNP, FNP

This paper is submitted in partial fulfillment of the requirements for the Doctor of Nursing Practice degree.

Abstract

The purpose of this improvement project is to increase staff's safety and confidence with regard to workplace violence. Throughout the healthcare system, workplace violence is a growing issue of concern and psychiatric healthcare settings increase the risk of workplace violence. The implementation site for this project is a 24-bed acute behavioral health unit located within a non-profit hospital. Due to the restrictions from the Covid 19 pandemic, staff at the site in which this improvement project took place did not have any in-person trainings for over two years. The aim of this project was to train 100% of staff on workplace violence prevention through an in-person format. At the end of the training, feedback surveys were emailed to staff to assess staff's response to the trainings. Incidents of workplace violence occurring on the unit during the quarter prior to implementation and during the implementation phase of this project were analyzed using run charts. At the conclusion of the implementation phase, 98% of staff members working on the behavioral health unit completed training. The post training feedback survey responses were positive overall, with many requests for additional in-person trainings. During the implementation phase, incidence of workplace violence increased, this could be a result of more accurate reporting after completing the training. More data spanning a longer period of time is needed to better understand the impact of in-person workplace violence prevention trainings.

Addressing Workplace Violence Through In-Person Training

Problem Description

Across the healthcare system, workplace violence is a growing issue of concern. Workplace violence, specifically type II, includes verbal or physical assault toward an employee by a client, family member, or customer (Brophy et al., 2017). Healthcare workers experience workplace violence at a rate higher than those in any other profession. Healthcare workers are four times more likely to require time off from work due to injury from workplace violence than any other injury (Phillips, 2016). In hospitals participating in the Occupational Health Safety Network, nurses had the highest incidence of workplace violence injuries (Groenewold et al., 2018). During the second quarter of 2022, Press Ganey found that two nurses were assaulted every hour (Press Ganey, 2022). Psychiatric healthcare settings place employees at an even higher risk for workplace violence. Approximately 40% of psychiatric providers reported being physically assaulted at work, and psychiatric nursing aides experience workplace violence at 69 times the national rate of workplace violence (Phillips, 2016). Despite these alarming rates of workplace violence in the healthcare system, incidents of workplace violence are often underreported. It is estimated that approximately 50% of verbal assaults go unreported, and 40% of physical assaults go unreported (Devnani, 2021). The American Psychiatric Nurses Association (2022) workforce report found that less than two thirds of psychiatric nurses reported feeling safe at work, with 54% of respondents identifying the level of training they received as a factor influencing their feelings of safety at work.

Workplace violence has a negative impact on the employee, the patient, and the organization. Not only can workplace violence cause physical injury, it can also have psychological consequences for the employee (D'Ettorre & Pellicani, 2017). This can cause high

rates of staff turnover and employee absenteeism, placing a burden on the organization (D'Ettorre & Pellicani, 2017). The financial burden of workplace violence is difficult to quantify and is often underestimated since some of the costs are intangible—such as decreased morale, increased staff fears, and problems with recruitment and retention (Beech & Leather, 2006).

The setting for this improvement project is a 24-bed acute psychiatric unit located within a 310-bed non-profit hospital. The Covid-19 pandemic placed an extra burden on staff and caused an increase in staff turnover. New social distancing policies limited in-person training opportunities, leaving many newer employees without in-person training or safe occasions to practice necessary skills. The hospital currently has a workplace violence prevention program that includes online training modules, flags on patient charts with a history of violent behavior, an incident reporting system, and optional post incident debriefings. Like many psychiatric facilities, this unit faces challenges addressing workplace violence. The purpose of this improvement project is to improve staff confidence and safety by implementing an in-person workplace violence prevention training and assess its impact on workplace violence outcomes.

Available Knowledge

A review of the literature was completed to assess available knowledge with regard to addressing workplace violence in psychiatric settings. A literature search was conducted using Pubmed, Psychinfo, and Medline. Risk factors associated with workplace violence typically fall into three categories: patient risk factors, environmental risk factors, and staff risk factors. Patient risk factors include a history of violent behavior, a psychotic disorder, substance use issues, or other impairments in cognition and impulse control (Arbury et al., 2017; Lipscomb & El Ghaziri, 2013). Lack of security, blind spots or areas that are difficult to monitor, long patient wait times, and unsecured furnishings that could be used as weapons are environmental

characteristics contributing to workplace violence. Risk factors related to staff include a lack of de-escalation and evasion techniques, negative attitudes, and working in understaffed conditions (Arbury et al., 2017; Lipscomb & El Ghaziri, 2013).

The Occupational Safety and Health Administration (OSHA; 2015) released guidelines for workplace violence prevention programs that includes five parts: Management commitment and worker participation, worksite analysis and hazard identification, hazard prevention and control, safety and health training, and recordkeeping and program evaluation. Key components of the workplace prevention program are education and training. Training helps raise safety and health knowledge across the workforce, provides tools to identify safety and security hazards, and helps staff address potential problems before they arise (Arbury et al., 2017; OSHA, 2016). All employees should receive training upon hire, and at least annually thereafter; high risk environments could benefit from more frequent trainings (OSHA, 2016). Effective training programs include an opportunity to practice skills through role playing, simulations, or drills (Arbury et al., 2017; OSHA, 2016).

Rationale

The Institute for Healthcare Improvement's (IHI) Model for Improvement (MFI) was used as the framework for this project as it is used in a variety of settings, including healthcare systems (Langley et al., 2009). A Plan, Do, Study, Act (PDSA) cycle was developed to implement and test change on a small level prior to implementing systemic change throughout the hospital (IHI, 2021). Based on the root-cause analysis, in-person trainings for violence prevention have been limited, preventing staff from practicing skills. OSHA guidelines suggest a minimum of annual in-person training that includes a simulation learning opportunity to practice de-escalation and evasion techniques (OSHA, 2016).

Specific Aims

The behavioral health unit implemented a quality improvement initiative based on the IHI's MFI with the aim to train 100% of staff on violence prevention, including simulations to demonstrate skills, by December 14, 2022. The long-term goal of this project is to implement in-person violence prevention simulation trainings hospital wide.

Context

This improvement project took place in a 24-bed acute psychiatric unit located within a 310-bed non-profit hospital located in a rural area. There are no other acute psychiatric units within a 150-mile radius of the project site. At the start of implementation, the unit's staff included two psychiatrists, two physician assistants, three therapists, four unit secretaries, 47 staff registered nurses, and 41 mental health aides. Due to the COVID-19 pandemic, staff have not completed in-person education, trainings, or skills practice sessions in the previous two years. Subsequently, newly hired staff have not received in-person workplace violence prevention trainings.

An online violence prevention training module was assigned to all staff prior to the implementation of this improvement project. The training included education on de-escalation, restraints, and evasion techniques, with videos demonstrating skills. At the conclusion of the online module there was a feedback survey regarding the online module. The feedback survey results revealed many requests for opportunities to practice the skills in the module. With restrictions for in-person trainings being lifted, unit management was in full support of the improvement project.

Interventions

Current staff employed as a therapist, unit secretary, registered nurse, or mental health aide, were required to attend a two-hour in-person workplace violence prevention training. Trainings were offered twice per week for nine weeks starting in October of 2022 and ending in December of 2022. Trainings were held at various times of day to accommodate both day shift and night shift staff. Training sessions were facilitated by the unit's staff development specialist and the workplace violence prevention coordinator. Trainings included opportunity to practice de-escalation, evasion, and restraint techniques. During the second half of the training, staff demonstrated competency by working together in multiple simulation scenarios. To assess staff response and attitudes regarding the trainings, staff received feedback surveys by email at the end of the training (see appendix A).

Training facilitators kept track of staff that attended the trainings and sent out reminder emails to those still needing to complete training. The workplace violence prevention coordinator provided data on reported physical assaults on the unit for the duration of the improvement project. Data of physical assaults occurring on the unit was obtained from the Midas RER reporting system, HR-65 employee injury reports, and security assault logs.

Measures

The outcome measure for this project is the incidence rate of workplace violence in the quarters prior, during, and after the implementation of in-person staff training. The process measure for this project is the percent of staff who attended in-person workplace violence prevention training. The balancing measure for this project is staff's attitude towards the workplace violence prevention training.

Analysis

This project was implemented over a five-month period, starting in October of 2022 and ending in February of 2023. Data was analyzed monthly during the implementation phase of this project. Run charts were used to compare the number of staff that completed in-person training and incidents of workplace violence. A thematic analysis was used to assess qualitative data regarding staff's attitudes toward the online and in-person trainings through a self-reported anonymous survey.

Ethical Considerations

Staff were informed about this project before implementation, and staff were reminded about this project during the in-person trainings. The post training feedback surveys were voluntary, and staff were aware their responses would be used for this project. By completing the voluntary survey, staff agreed to participate in this project. No identifying characteristics of the patients or staff members were used to analyze the incidence of workplace violence data. This project was submitted to the OHSU Investigational Review Board (Study #00025399) and was determined not to be research with no further review needed.

Results

Eighty-six staff members completed the in-person training during the implementation phase of this project (see Appendix B). Three staff members were on leave during the time of this project and were not required to complete the training. Five staff members that were employed at the beginning of this project were no longer employed by the conclusion of implementation. One staff member did not complete the training.

The number of staff trained did not appear to decrease the incidence rate of workplace violence on the unit (see Appendix C). In the months prior to implementation, the number of

workplace violence incidents were zero in July, two in August and one in September. During the months of implementation, the number of workplace violence incidents were one in October, four in November, and three in December.

Of the 86 staff members that completed the in-person training, only 33 staff members completed the optional post training survey. Ninety-four percent of survey respondents reported the in-person training to be helpful in increasing their safety at work. Eighty-five percent reported feeling confident in their ability to safely use evasion techniques after practicing these skills in the training. Several respondents requested additional trainings and practice sessions in verbal de-escalation and physical restraint techniques. One respondent recommended, "Practicing placement of mechanical restraints during this class so people can get comfortable and have muscle memory as mechanical restraint types change drastically between institutions." Another respondent suggested, "Regular optional in-person training would be good for those of us that feel rusty since we might not get the opportunity to use those skills regularly."

Discussion

After taking into consideration staff members who were on leave and staff turnover during implementation, the total number of staff members working on the unit dropped to 87 by the end of the implementation phase of this project. Eighty-six staff members completed the in-person training, yielding a 98% completion rate.

It is unclear why only 33 staff members completed the post training survey. Possible factors contributing to the low completion rate include anonymity of the survey prevented ability to track survey completion, no incentive was offered for survey completion, and surveys were emailed to staff members several days after completing the training. The workplace violence coordinator sent follow up reminder emails in attempt to increase responses, but these efforts

were only minimally successful. Future study may benefit from implementing changes to garnish more survey responses, such as making the survey mandatory, tracking of completion through the education training system, or having staff complete the survey in-person at the time of training.

The survey responses indicated that staff considered the training to be helpful in keeping them safe at work. Overall, the feedback in the additional comments section of the survey showed the training was well received by staff. Many of the comments expressed appreciation for the in-person format and the opportunity to practice de-escalation and evasion skills. A common theme in the additional comments section was the request for additional trainings.

The in-person training did not appear to decrease the number of physical injuries experienced by staff as a result of workplace violence. In fact, there appeared to be an increase in incidents of workplace violence during the implementation phase of this project. It is uncertain what caused the increase in workplace violence as there are many variables that could contribute to these outcomes. Some variables to consider in future PDSA cycles would be patient census, patient acuity, and staffing conditions. Additionally, increased training tends to lead to an increase in reporting workplace violence incidents (The Joint Commission, 2021). With many staff members completing the in-person training during this time period, it's possible that staff were reporting incidents more accurately, resulting in the observed increase.

The data on workplace violence is reported to OSHA as number of injuries, but clinically it is worth looking at the data in terms of workplace violence events. Analyzing the data as events shows how an individual patient event can impact multiple staff members. Interestingly, the number of workplace violence events is consistent with the number of workplace violence events in the months prior to implementation. However, during the months of implementation,

there appears to be a discrepancy between injuries and events. In November of 2022, there are four reported injuries resulting from three different workplace violence events. In December of 2022, there are three reported injuries resulting from two different workplace violence events. This discrepancy during implementation could further suggest an increase in more accurate reporting post training. The duration of this improvement project provided a limited time frame to observe the outcomes of the trainings on incidence of workplace violence. Continued data observation is needed to better understand the impact of the training on workplace violence in this setting.

Conclusion

Although this improvement project did not meet the specific aim of training 100% of staff on workplace violence prevention, the efforts of this project yielded a 98% training completion rate. The response rate for the post training feedback was low with only 33 staff members completing the survey. The responses from the feedback survey revealed positive staff attitudes towards the trainings and many requests for additional training opportunities. More data spanning a longer duration of time is needed to determine if in-person workplace violence prevention trainings are an effective intervention in decreasing the incidence in workplace violence.

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Appendix A

Staff Feedback Survey Post In-Person Training

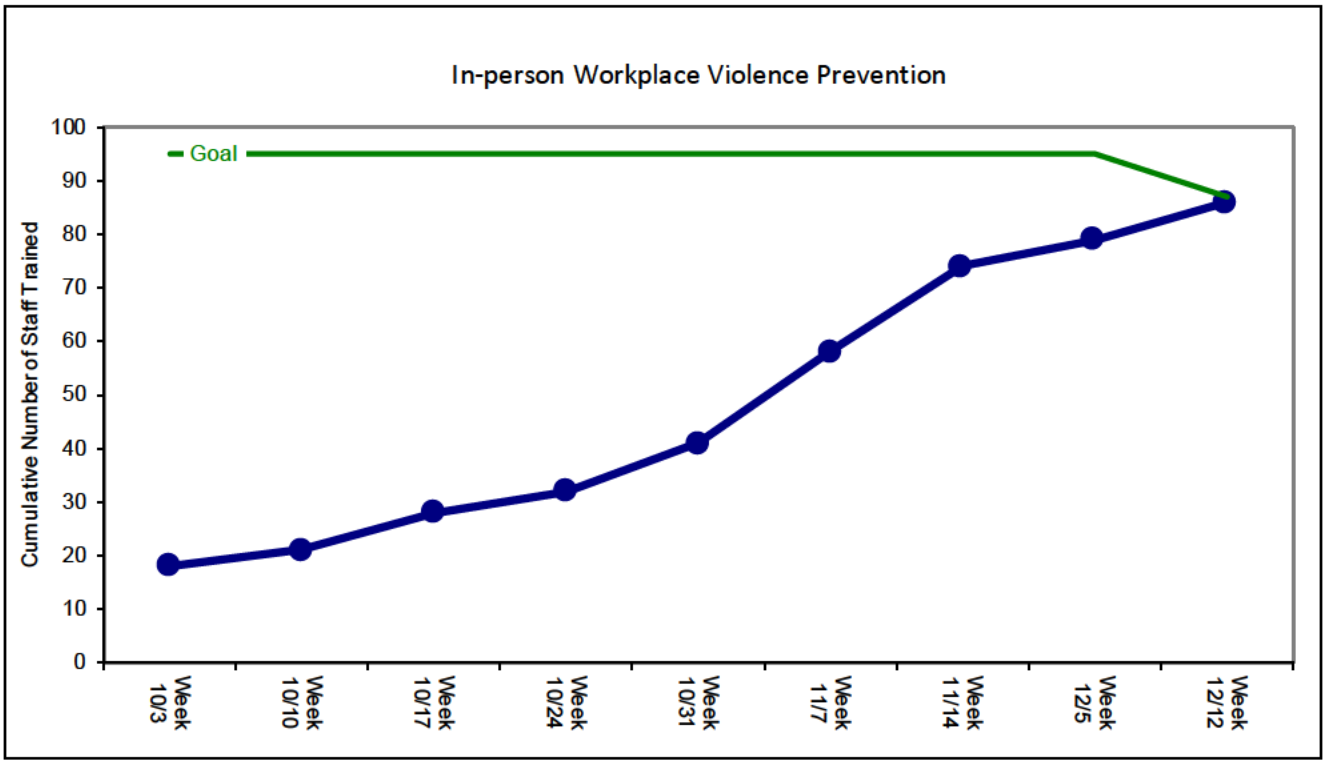
1. After completing this training, I feel confident in my ability to engage evasion techniques.
    a. Disagree
    b. Slightly Disagree
    c. Neutral
    d. Slightly Agree
    e. Agree

2. After completing this training, I feel confident in my ability to immediately be able to get help during a crisis situation.
    a. Disagree
    b. Slightly Disagree
    c. Neutral
    d. Slightly Agree
    e. Agree

3. How helpful was this training in preparing you to protect yourself?
    a. Not Helpful
    b. Slightly Helpful
    c. Neutral
    d. Helpful
    e. Very Helpful

4. Additional comments on how your employer can improve your safety skills competency at work.

Appendix B


In-person Workplace Violence Prevention
Goal
Cumulative Number of Staff Trained
100
90
80
70
60
50
40
30
20
10
0
Week 10/3
Week 10/10
Week 10/17
Week 10/24
Week 10/31
Week 11/7
Week 11/14
Week 12/5
Week 12/12

Appendix C


Incidence of Workplace Violence
Number of Incidents of Workplace Violence
5
4
3
2
1
0
Goal
July
August
September
October
November
December
January

Appendix D

Letter of Support from Clinical Agency

Date: *07/06/2022*
Dear Elizabeth Galvan,

This letter confirms that I, Jennifer Nidalmia, allow Elizabeth Galvan (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately July 5, 2022 to April 30, 2023.
This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s)**: Asante Rogue Regional Medical Center Behavioral Health Unit
- **Project Plan: Use the following guidance to describe your project in a <u>brief</u> paragraph.**
    - Identified Clinical Problem: There is currently no required hands-on training in de-escalation and evasion techniques. Increasing acuity combined with high staff turnover is resulting in an increase in assaultive behavior toward staff.
    - Rationale: The Institute for Healthcare Improvement's (IHI) Model for Improvement (MFI) will be used as the framework as it is used in a variety of settings, including healthcare systems (Langley et al., 2009). A Plan, Do, Study, Act (PDSA) cycle was developed to implement and test change on a small level prior to implementing systemic change (IHI, 2021). Based on the root-cause analysis, in person trainings for violence prevention have been limited, preventing staff from practicing skills. OSHA guidelines suggest a minimum of annual in person training that includes a simulation learning opportunity (OSHA, 2016).
    - Specific Aims: The behavioral health unit will implement a quality improvement initiative based on the IHI's Model for Improvement with the aim to train 100% of staff on violence prevention. Staff will participate in simulations to demonstrate skills learned by November 1, 2022. The long-term goal of this project is to implement violence prevention simulation trainings hospital wide.
    - Methods/Interventions/Measures: Current staff will be required to attend a two hour in person training and complete a competency demonstration check off at the end of training. Trainings will include opportunity to practice de-escalation, evasion, and restraint techniques. The outcome measure for this project is the incidence rate of workplace violence during and after the implementation of staff training. The process measure for this project is the percent of staff that attended in person workplace violence prevention training. The balancing measure for this project is staff's attitude towards the workplace violence prevention training and the perceived burden of the training.
    - Data Management: This project will be implemented over a five-month period, starting in October of 2022 and ending in February of 2023. Data will be analyzed at two, four, and five month intervals post implementation. Run charts will be used to compare percent of staff that completed training versus incidents of workplace violence. A thematic analysis will be used to assess qualitative data regarding staff's attitudes toward the training through a self-reported survey.
    - Site(s) Support: The site of this project will provide support by facilitating communication with staff, providing resources for mock code grey/trainings, and by making data regarding code grey events available.
    - Other:

During the project implementation and evaluation, Elizabeth Galvan will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact Elizabeth Galvan and Virginia Elder (student's DNP Project Chairperson).

Regards,

Appendix E

IRB MEMO

Research Integrity Office
3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

NOT HUMAN RESEARCH

January 24, 2023

Dear Investigator:

On 1/24/2023, the IRB reviewed the following submission:

Title of Study:	Addressing Workplace Violence Through In-Person Training: A Quality Improvement Study
Investigator:	Virginia Elder
IRB ID:	STUDY00025399
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The OHSU IRB Office