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Research Article

Prevention of workplace violence in ED nursing using the implementation of an educational program and a new reporting tool

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Abstract

The Emergency Department (ED) is a place that regularly deals with acute scenarios and people that are generally sensitive in nature. In a fast-paced environment such as this, people can be emotionally charged and react in different ways. Unfortunately, nurses in the ED tend to be most affected. Literature shows that workplace violence incidents that occur tend to involve ED nurses. Furthermore, ED nurses are more inclined to have an attitude that makes them think that any acts of transgression are "part of the job" and incidents usually go underreported. Moreover, reporting tools are usually difficult to use and tend to be a barrier to reporting workplace violence. In this evidence-based project, ED nurses will participate in an educational prevention program that will help equip them with the knowledge and awareness that is needed to decrease the incidence of workplace violence. Furthermore, a new, easy-to-use reporting tool will be implemented for ED staff. An implementation of an easier reporting tool and an education prevention program on the incidence of workplace violence will help reduce the number of future incidents of workplace violence. The purpose of this evidence-based project is to create a "zero tolerance" workplace culture for ED nurses that ultimately decreases the incidence of workplace violence. Based on research, an educational program and new reporting tool will be implemented at an urban community hospital in Westchester. Included is a purpose statement, and operational and conceptual definition, PICO questions, and an evidence-based practice protocol for workplace violence.

More Information

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Keywords: Workplace violence; Reporting tool emergency nursing

Abbreviations: ED: Emergency Department; EBP; Evidence-Based Practice; ACEP: American College of Emergency Physician; OSHA: Occupational Safety and Health Administration; QI: Quality Improvement

Background

The Emergency Department (ED) is, no doubt, an arena of heightened feelings and reactions. When people come to the ED, they can experience an array of emotions; they can be scared, sad, nervous, anxious, or mad. As such, it can be easy for people to take out their emotions on someone else in the ED [1]. According to Stene, Larson, Levy, & Dohlman [2], workplace violence is, "any act or threat of an act of physical violence, harassment, intimidation, or other disruptive behavior by one person toward another in the workplace setting". Workplace violence is an issue that many Americans are cautious of every day. While violence in the ED can happen to anyone, one specific profession that is especially susceptible and vulnerable to workplace violence is Emergency nurses. According to the Occupational Safety and Healthcare Administration [3], healthcare workers are at an increased risk for workplace violence. Nurses work most closely with the patients and their families in the ED. It is important to determine the different kinds of workplace violence nurses are exposed to and how it creates job hazards/ safety issues, affects job satisfaction, & increases turnover rates [4].

Violence towards hospital patients, providers, and staff has increased over the last 15 years in the United States with leading violence rates taking place in the ED [1]. The workplace can come in different forms such as physical, emotional, or verbal abuse. While most cases of workplace violence occur externally from patients/ visitors it can also occur in ED nursing internally, between staff. According to OSHA [5], some workplace violence risk factors include poor workplace environment design, poor lighting in corridors/ rooms/ parking lots, working in areas with higher crime rates, high employee turnover rates, and inadequate security.

While there are many reasons and risk factors that attribute to workplace violence at the level of the patient and the ED environment, one main reason could be due to the organization. A main organizational risk in workplace

violence is inadequate security [1]. While many EDs invest in security departments and incorporate safety support and protocol, there are some EDs that do not. It can be costly to add security personnel to ED entrances and at various points in the ED. Moreover, many hospitals might have security, but that security is not as tight as it should be [1]. According to Weyand, Junck, Kang, & Heiner [1], it was found that hospitals employ a variety of security protocols according to their financial ability and some rely on local police. Furthermore, it was found that there were no standardized requirements or recommendations and there was an overall lack of familiarity with ED/ hospital security plans [1]. According to Jon Huddy (ACEP), having a security "presence" and "visibility" is most important Huddy [6], explains that any ED can have people sitting watching cameras, but what provides a sense of safety is having security staff actually present and walking around the ED. Other forms of safety support that might promote a safer ED include incorporating bulletproof glass, metal detectors, surveillance cameras, panic buttons, lockdown protocol, and de-escalation rooms [6]. Huddy [6] concludes that EDs should evaluate their security and workplace violence protocol/ policies.

The consequences of ED violence are many. These consequences have implications at the level of the patient, the profession of nursing, and the organization as a whole. When violence occurs in the ED, patient safety and satisfaction is at risk. Violence is a form of distraction for all staff members. Patient safety and medical error can be increased. Studies show that, in hospitals in which nurse dissatisfaction/ burnout is lower, patient satisfaction was higher [5].

With respect to the specialty of ED nursing, workplace violence can make the ED a toxic environment. Workplace morale and motivation can decrease if nurses are distracted by violence. Sometimes violence can result in residual drama, negative vibes and feelings, and even post-traumatic stress disorder [5]. This could result in loss of production at work. Overall, ED nurses are affected by decreased job satisfaction and increased turnover [5].

ED workplace violence and its effects on nurses ultimately affects the hospital as a whole. When instances of violence occur, the hospital can experience financial repercussions for those who require medical care and compensation for lost work [5]. The hospital also loses time and money if and when nurses leave their job if they do not feel safe. According to OSHA [5], the cost of replacing a nurse is approximately $27,000- $103, 000. Increased nurse turnover rates encourage the cycle of ED violence [5]. This is because an increased turnover rate is a risk factor for workplace violence in healthcare because conditions that lead to higher stress levels in workers can increase the risk of both internal and external violence [5].

Significance of the problem

Workplace violence is prevalent in EDs in the United States. According to the Emergency Nurses Association [7], almost 50% of Emergency physicians report being physically assaulted while 70% of Emergency nurses reported being physically assaulted. Furthermore, both physicians and nurses state that experiencing violence in the workplace is detrimental and hinders high-quality patient care [7]. There are various causes and risk factors that attribute to violence in the ED. Determining how workplace violence affects ED nurses is significant for the nursing profession because anything that affects a nurse's ability to complete his or her job appropriately requires assessment and resolution. Patient care and safety are reliant upon the healthcare providers to be alert, focused, and able to carry out their job properly [7]. In one study, it was found that nurses under-reported workplace violence and there was a lack of proper regulation for workplace violence prevention [8].

Purpose statement

The purpose of this Evidence-Based Project is to create a "zero tolerance" workplace culture for ED nurses that ultimately decreases the incidence of workplace violence. Based on research, an educational program and new reporting tool will be implemented at an urban community hospital in Westchester.

Conceptual definition

According to Segen's Medical Dictionary, workplace violence is defined as "any act of violence that occurs in a work environment, which may be committed by one worker against another, by outsiders, or by former employees" [9].

Operational definition

ED nurse knowledge of workplace violence will be assessed using a survey tool (Appendix A). This survey tool will be used to measure their knowledge, attitude, and experiences with workplace violence. Furthermore, reporting of future instances of workplace violence will be measured using an incident reporting tool (Appendix C) This tool will allow ED nurses to be able to report all forms of violence including mental, physical, verbal, or emotional abuse or transgressions according to their personal experiences. Furthermore, workplace violence incidents will be measured in the future using benchmarking and monitoring. Data will be collected using the reporting tool to determine the number of reports after its implementation. These numbers will be compared to the reports of incidents using the hospital's original method of reporting. Overall, this project will utilize surveys, Likert rating scales, and questionnaires to measure the success of implementing an educational program and the new reporting tool in decreasing workplace violence (Appendix A and Appendix C).

Theoretical framework

The theoretical framework for this paper is based on

Mary Johnson and Kathleen Delaney's Theory of Violence Prevention in their grounded theory study [10]. The belief of "keeping the unit safe" is the ideology behind this paper's position that ED security and safety support plays a large role in violence prevention and nurse job satisfaction by extent. According to this theory, a safe environment is necessary for patients and staff. Without a safe environment, patients cannot focus and work on their reasons for hospitalization. Furthermore, nurses are not able to focus and provide the necessary patient care. This framework serves as a way for nurses and organizational leaders to evaluate the security of units and provides evidence of the complexity of keeping them safe [10].

The purpose of this evidence-based project is to create a "zero tolerance" workplace culture for ED nurses that ultimately decreases the incidence of workplace violence. Based on research, an educational program to increase awareness on workplace violence and a new workplace violence reporting tool for ED nurses will be implemented at an urban community hospital in Westchester.

To find sufficient, reliable data for this literature review, multiple searches were conducted. As articles were searched, the first criteria that was used in the selection process was to use articles that were peer-reviewed and full-text. Databases that were used were Nursing and Allied Health, PubMed, and ProQuest. Keywords that were used for searches included the following: "emergency", "nursing", "workplace", "violence", "reporting", "prevention", "education", "reporting", "underreporting", and "tool". Since this is a project that specifically deals with workplace violence in emergency nursing, only articles that discussed this topic for EDs and nurses were included. Workplace violence that did not include Emergency nursing were excluded. Articles were only included if they were written in English and if they were written within the last five years (2015-2020). This inclusion/ exclusion criterion was used to prevent any possible misunderstandings or outdated data. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines helped to keep the research on track and helped to screen articles and the selection process. The selection of articles was done so by screening publication dates within the last five years, article titles, and inclusion criteria.

Literature review

The quasi-experimental study describes the unfortunate background of workplace violence among healthcare workers. According to the researchers, healthcare workers can be on the receiving end of violence that can take different forms and abuse towards healthcare workers was four times more likely than other occupational groups [11]. According to Ming, et al. [11], a well-designed workplace violence training program for healthcare workers includes simulations and educational programs. This study shows that there is a lack of attention to risk assessment and that learning activities are helpful in mimicking real-life situations and are immersive with the goal of demonstrating real-life scenarios. These educational programs help with decision-making and critical thinking in situations in which healthcare workers are faced with dilemmas such as workplace violence [11]. Also, simulation education is often used in nursing and is considered effective for teaching strategic skills [11]. In this study, 66 participants were enrolled from a 3000-bed medical center. Convenience sampling was used. Participants were nurses which included ED, medical, and surgical nurses [11]. These nurses were placed in a three-hour-long simulation education course and completed a pretest prior to and after the course. The interventions of this study consisted of training programs and simulation teaching. The teaching part consisted of an introduction to workplace violence, simulation-based communication, real case and group discussions, videotaped simulations of real case scenarios, coping strategies, and discussions after watching the videos [11]. The questionnaires assessed basic information, perception of aggression scale, and confidence in coping with patient aggression. 44 of the 66 participants reported that they had experienced some type of workplace violence. 40 of the 66 participants said they had never had violence training courses.

An article describes the possible benefit of a comprehensive program that aims to prevent violence in EDs against nurses. This was a quantitative study part of a participatory action research project. In an 18-month period, contributors to part in a participatory action research design with different activities such as diagnosis, action planning, and evaluation. The implementation of a workplace violence program consisted of an educational part and a managerial continued education part. The purpose of this program was to familiarize nurses with the topic of workplace violence and its extent. It also trained nurses on anger management, stress management, and conflict resolution. Afterward, during the evaluation phase, the number of patients/ family violence against nurses and the nurse's fear of violence were measured. This study showed that nurses were exposed to verbal violence at least once within the last year. 22.2% of the participants had experienced physical violence within the last year [12]. Many of the participants did not even report incidents because they thought the reporting process was ineffective and supervisors did not act when they did report it. This study showed that the number of verbal violence (~86%) significantly decreased after implementing a workplace violence prevention program (p = 0.007, CI = 95%) [12]. In addition, concerns and the fear of violence also decreased after implementation as measured by a collective evaluation four months after the implementation. Most nurses came to believe that incidents of workplace violence were preventable and manageable. Nurses also came to

believe that workplace violence is indeed not common workplace practice, as opposed to their previous beliefs that workplace violence 'comes with the job' [12].

An integrative review of an article that depicts institutional strategies to prevent violence in nursing. The initial sample size was 252 and after a thorough review, 14 articles were selected and assessed according to how EDs/healthcare centers/ hospitals/ urgent care dealt with educational actions, programs, policies, and prevention [13]. Most of the articles were quantitative research studies. Interventions in the studies were carried out in EDs/healthcare centers/ hospitals/ urgent care. In the United States, there were three different prevention programs that were followed. They were the Bullying Elimination Nursing In Caring Environment (BE NICE) program, the Workplace Violence Prevention Program (VAT), and the Nurse-Nurse Horizontal Violence Prevention Program. This integrative review found that there are effective measures to help prevent nursing workplace violence. When such programs are implemented in an organization, it creates a noteworthy reduction in violence incidents [13].

A study examined the reporting of workplace violence in the ED. It also explored staff's attitudes toward violence and the act of reporting incidents. This was a month-long prospective look at ED violence and aggression reporting. This data was then compared with previously reported data. This study was completed at a teaching hospital that experiences about 90,000 cases per annum. In a month-long campaign, emergency staff was encouraged to report violent incidents. A paper incident form was used to record events. These forms were then handed off to the shift manager. Overall, there were 7,896 cases during the audit month. There were 107 forms that were turned in. The most common day for reporting was on Saturday (n = 31). The most common location of incidents was in the resuscitation area (37%). The various forms of workplace violence that was experienced were verbal abuse/ threat (n = 98) and physical assault/ threat (n = 38) [14].

A study suggests a three-step approach to minimize workplace violence in emergency care relating to violence presenting for behavioral health patients in the setting of emergency care. The study goes into depth, describing the magnitude of the problem of workplace violence as well as risk factors. Some risk factors for workplace violence include staff shortage, increased patient morbidities, and the absence of a workplace violence prevention program [15]. Furthermore, there are many emotional consequences of workplace violence such as depression, anxiety, insomnia, and other stress-related disorders. It was discovered that, in a survey with a sample size of 300, 63% of respondents said that their workplace had a zero-tolerance policy for the hospital, but it was not enforced nor was it supported. Many respondents felt that the policy was ineffective. 72% of respondents said that workplace violence is anticipated. The article then goes on to explain that there is an importance in not just workplace violence prevention programs, but also the commitment from the management of the organization [15]. In incidences of psychiatric ED workplace violence, education of verbal de-escalation is a high priority. This is used conjointly with pharmacologic intervention for acute agitation. Safety measures for extreme cases include implementing duress alarm buttons throughout the department and providing a map of those buttons to nurses/ healthcare workers [15].

A retrospective, observational study was performed to look at and determine the various aggressions that are experienced in a large-sized hospital and analyzed aggression data over a three-year period. This study included 10,970 health workers in a large university hospital. There were various domains for which data was collected including demographics of the worker that was assaulted, aggression (type of activity being done at the time of aggression such as patient care, office activity, hall activity), type of aggression, aggressor, and consequences of aggression. Risk analysis was calculated using epiR and meta-package [16] and the meta-analysis utilized a fixed and random effect. The epiR tool allowed for an analysis of the epidemiological data and utilized functions for adjusting factors such as frequency which was used to compute confidence intervals around incidence risk and rate estimates [16]. The findings from this analysis included that 3.3% of the workers or 364 workers stated that they experienced at least one aggressive act. The study also found that the majority of assaulted workers were found to be females (77.5%), the most prevalent type of aggression was found to be verbal (76.9%), and, that nurses reported the highest incidents of violence (64.3%). Moreover, the highest acts of aggression occurred during patient care/ patient support (72%), most incidents of aggression were reported to be verbal (76.9%) and the patient was the most common aggressor (46.7%) [16].

A quality improvement (QI) activity study directed towards a level 1 trauma center. A survey was sent to 154 members of a nursing care team which resulted in a 74% response rate. It was found that the reporting process was inconsistent and incidence in the ED was underreported. This study used the Emergency Department Assessment Tool provided by the Emergency Nursing Association and an educational program was implemented. Follow-up and support was provided from nursing leadership. Post-education surveys were provided to determine comprehension. This study found that the nurses' perception of workplace violence being something that "comes with the work territory" was reduced by 50% post-implementation. Findings from this study demonstrated that, as knowledge increased, reporting increased, and ED nurses perceived the workplace environment to be safer [2]. 108 RNs participated in an initial survey and then follow-up surveys was completed

by 112 nurses. In the response to the question, "Is workplace violence part of the job in the ED?", 75.8% of respondents said "no", a 31.6% increase from the initial survey pre-intervention. The response to the questions of whether the respondent knew that acts of workplace violence could be prosecuted was that 65% said "yes" in the initial survey and this increased to 78% in the follow-up survey [2].

A self-report study probe into the idea that workplace violence is underreported. A cohort of 446 hospital employees responded to questionnaires. 364 of the respondents were female. 157 of them were > 50 years old. Most of the respondents worked in acute care or in the ED. The aim of this study was to compare self-reporting to administrative documentation. It also examined reporting patterns of reporters and under reporters. It was found that a greater number of questionnaire respondents self-reported (62%) compared with those who documented the incident (12%). Also, in this study, ED employees had the greatest number of underreported incidents (30.9%) [17].

A narrative review study analyzed literature for current approaches to reducing workplace violence in the ED. It also focused on the evaluation of emergency response program effectiveness. It utilized PubMed and CINAHL and analyzed 10 intervention studies. In this study, it was found that workplace violence-affected 90% of emergency nurses. Most emergency nurses regard workplace violence as "inevitable" or "part of the job" [18]. Various current approaches were found to be utilized for workplace violence in the ED. They include guiding principles for mitigating workplace violence, scenario-based training, rapid training, hybrid educational intervention, and rapid response teams [18].

A study supports that workplace violence in the ED is underreported. This phenomenological approach study used two focus groups in an ED to identify the attitudes, enablers, and barriers of ED nurses reporting workplace violence. The setting for this study was a large metropolitan ED at a hospital that is a 640-bed tertiary referral center. This study used purposive sampling to include ED nurses who had previously known experiences of workplace violence. It was found that nurses accepted violence as part of their job and, because of this, they were less likely to report incidents [19]. According to this study, workplace violence incidents were not considered "violent" when there was no actual physical injury. The formal reporting system that was in place was a barrier for reporting due to the fact that it was difficult to use and not user-friendly and it was time-consuming [19].

All in all, the literature shows that there is a significant occurrence of workplace violence. ED nurses experience most of the violent acts as they work in an acute setting [2,8,11-14,16-19]. Workplace violence presents itself in various ways. It can be physical violence and also it is a verbal, emotional, or psychological threat as well. Literature also shows that ED nurses think that workplace violence comes with the job and that it is normal to experience these things [14,18,19]. At the very least, ED nurses think that any type of workplace violence that does not end in an actual physical injury is not a violent incident.

ED nurses underreport workplace violences incidents [2,14,16,17]. The main reasons that seem to be similar throughout for underreporting are due to concerns of confidentiality and the lack of user-friendly reporting tools. ED nurses are unable to complete an incident report due to the high work volume/ stress and difficult formal interface. There is a need for a reporting tool that is easy to use and quick to fill out [16].

Authentic leadership is important in integrating an educational workplace violence prevention program that will actually work [8]. A zero-tolerance policy must be enforced and backed up by the organization [8]. It is important that ED nurses must be educated on workplace violence and their attitude towards the situation should be acknowledged. Educational programs are created to educate ED staff and HR management in order to generate a zero-tolerance environment [2,8].

Implementing the educational protocol and new reporting tool

The purpose of this Evidence-Based Project is to create a "zero tolerance" workplace culture for ED nurses that ultimately decreases the incidence of workplace violence. Based on research, an educational program and new reporting tool will be implemented at an urban community hospital in Westchester.

Educational protocol

The most important part of this EBP is to ensure that ED staff is educated regarding workplace violence. Increasing awareness will help to change everyone's perspective towards this issue and hopefully encourage zero-tolerance for workplace violence at the level of the ED staff as well as organizational leaders. The educational protocol will be implemented at an urban community hospital in Westchester (Appendix B). It will consist of a 5-week program. The first three weeks will consist of lecture seminars and the last 2 weeks will consist of simulation labs. The timeline for the educational protocol implementation will be as follows:

Week 1: will concentrate on spreading awareness of the risks, prevalence, and effects of workplace violence. Current incidents will be shared with ED staff and hospital management and executives. This week will be used to create a sense of urgency. Educational awareness will be installed in various points of the ED (bulletin boards, break rooms, emails, flyers, etc).

Week 2: will concentrate on explaining what exactly workplace violence is. It will cover various definitions and educate staff on the different forms it can take.

Week 3: will target ED nurses' beliefs and perspectives towards workplace violence. This week, ED nurses will have to try to unlearn what they think they know about workplace violence and relearn what literature says it is. Workplace violence is not just part of the job.

Week 4: will start the simulation part of the educational protocol. During this week, the new reporting tool (Appendix C) will be implemented, and ED staff will have a chance to learn how to use the tool and practice using it. Training is important during this week so that they become familiar with how to use the tool.

Week 5: will also consist of simulation and learning activities on how to spot workplace violence and what to do if it happens. This will include watching sample videos and group activities so that ED nurses can practice real-life scenarios. De-escalation techniques and reiteration of formal reporting will be reviewed.

New reporting tool

Literature shows that current reporting tools are a barrier and ED nurses find that using formal reporting is cumbersome and time-consuming. Oftentimes, reporting tools take approximately 15-20 minutes to complete. In the ED, these minutes are precious and cannot be wasted. The lack of an easy, efficient reporting tool is the cause for underreported incidents of ED workplace violence [2,14,16,17].

Therefore, a tool will be created for this project which will include a simple, easy-to-use interface geared to ED nurses (Appendix C). This reporting tool was created using evidence-based literature. According to literature, ED nurses underreport workplace violence incidents due to concerns of confidentiality and due to lack of user-friendly reporting tools [2,14,16,17]. ED nurses are unable to complete an incident report due to the high work volume/ stress and difficult formal interface [16]. This reporting tool was created to be a new, quick, easy-to-use form of reporting in the ED. They will be able to document pertinent information quickly. The new reporting tool will collect information on participants that were involved and the date and time of the incident. Furthermore, witnesses of the events can also report what they saw occur to get different perspectives and witnesses documented. ED staff will be trained on how to properly use it. The tool will be downloaded by IT to all ED software and will be easy to find using a simple desktop icon for computers. An app will also be created so that ED staff can access this reporting tool from phones. The ability to report on the go will hopefully eradicate underreporting of workplace violence in the ED.

Methodology

According to Melnyk-Masurek and Fienout-Overholt, Kotter and Cohen's Model of Change says that the key to implementing change is to appeal to people's emotions [20]. There are eight steps that make up this implementation plan. According to this model, people are less likely to create a change in their behavior if they are only presented with facts. On the other hand, they are more likely to change if their emotions are influenced. These eight steps will be used to implement the necessary changes and processes [20].

The first four steps act to "de-freeze the existing culture".

Step 1: Increase a sense of urgency

Creating a sense of urgency is important to show staff and management that there is an important issue that requires their attention. Recent and current violence cases that Emergency nurses have experienced over the past year will be spread around during meetings to show everyone that there is a need for urgency. At this moment in time, surveys will be sent out to ED nurses to determine their perception of workplace violence.

Step 2: Build the guiding team

An Emergency nursing task force committee will be created to guide implementation. This must include not only Emergency nurse leaders, but also administration, management, and other Emergency staff. It is important that this task force understand the vision and the steps that will be required for improvement. An IT team will also be hired to start with the creation of an easy-to-use reporting tool (Appendix C).

Step 3: Get the vision right

Getting the vision right is necessary to ensure that proper strategies are chosen [20]. In this case, the vision includes highlighting an educational prevention program to prevent future cases of workplace violence. The educational protocol will include educating staff that workplace violence can take many forms. It is important that they all know and realize that physical harm is not the only form of violence that nurses endure. Furthermore, education will portray the various types of cases that this particular organization has seen over the past year. This will invoke emotion as the cases hit close to home. Another part of getting the vision right for this project will be making sure that staff and management know that there is evidence showing that Emergency nurses are underreporting workplace violence incidents. They should be educated on the reasons this is occurring currently and ways to change that.

Step 4: Communicate for "buy-in"

Communication is key to invoking emotion in all parties [20]. It is vital that the task force and management are all transparent with staff. As policies are reviewed and changes are made, sufficient education is necessary to properly guide all parties. It is essential that task force leaders and ED staff leaders clearly communicate all EBP activities. The task

force and leaders will work together to provide suggestions to create the best form of reporting that will be easy for everyone. It is crucial that ED nurses feel heard.

Steps five-seven functions to help make the change happen.

Step 5: Remove barriers

This step is necessary to decrease the likelihood of this project failing. Obstacles must be removed to create a clear path without resistance [20]. It is imperative to bring possible obstacles to light and hash them out. For example, ED nurses might feel like hospital executives and management might not feel like this is an important issue to them. The lack of knowledge of different types of workplace violence that ED nurses face is another obstacle that must be removed. Finally, the issue of underreporting must be explained.

Possible barriers to creating a new and efficient reporting tool include funding and training. Communication with hospital executives will help to relieve these obstacles. This ties back in with step 1 of portraying the urgency for them to pay attention and provide their input.

Step 6: Create short-term wins

As education sessions begin, it is vital that short-term wins are created to acknowledge that staff is learning new things. Even something as minor as staff realizing that their perception of workplace violence was wrong or desensitized is a win.

Step 7: Don't let up

As time goes by, and emotions regarding this issue begin to ebb, staff must continue to stay interested and feel a sense of urgency regarding this matter. It is important that the designated task force does not let up. Creating change requires everyone involved to feel the need to change.

Step 8: Make the change stick

As the newly educated staff and culture of understanding workplace violence are un-frozen, the changes must stick. At this point, the organization and staff cannot regress. Culture transformation requires no backtracking [20]. This requires continuous communication. Making the changes stick means that proof that the changes are helping should be relayed to everyone for the encouragement.

After implementation and un-freezing the new culture, surveys will be sent out again to ED nurses to determine whether their perception of workplace violence has changed. This data will be compared with the data collected from pre-education and pre-reporting tools.

The way that this EBP will measure if these new implementations are successful is by using survey questions and the new reporting tool before and after implementation (Appendix A and Appendix B). In the beginning, surveys will collect demographic data as well as determine ED nurses' perception of workplace violence. After implementation (6 months later), this EBP will determine how their perception has changed. In addition, the number of reported incidents for this organization will be compared post-implementation via the new reporting tool.

Summary

The implications for nursing and practice include implementing a zero-tolerance workplace violence culture for all. ED nurses should not feel like dealing with violence is just "part of their job". Furthermore, they should know that workplace violence can take different forms and all of them should be properly documented and reported. Perhaps organizational leaders and lawmakers are not giving this issue enough attention because they are not being properly reported [17]. Each form of workplace violence is going to be properly defined so that all staff should know what red flags to look out for. Proper training and forms of communications to de-escalate different scenarios are important to know to prevent further incidents. An easy-to-use, quick, formal reporting tool is vital for nurses and research shows there is a lack of them.

If organizations create a culture of safety for their nurses, then the nurse can properly do their job. The ultimate end goal is for nurses to feel satisfied and safe in their role. The domino effect comes back to the patient and ensures their safety and satisfaction as well. The safety and satisfaction of the nurses also circles back around to the organization and it ensures lower turnover rates, retention, and possibly lower burnout rates.

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