

Implementing a Workplace Violence Prevention Program to Promote a Culture of Safety

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Background and Significance

Healthcare Professionals	Nurses	Triggers
 More than 50% have experienced workplace violence (WPV) injuries Type II assaults (patient to staff) 	 95% have experienced verbal or physical abuse Healing within pediatric ambulatory care 	 Long waits Poor staffing Caregiver stress Busy workflow Treatment expectations
(Phillips, 2016) (United States DOL, 2018)	(Keller et al., 2018) (Albalwei et al., 2021)	(Paul, 2018)

•Underreporting, tolerance, lack of confidence, training Systems •Decreased wellbeing, clinical outcomes, care experience • Unsafe work environments, low performance/retention (Duan et al., 2019; Hester et al., 2016; OSHA, 2016; Phillips, 2016; Schwartz & Bjorklund, 2018; US DOL, 2018; US DOL, 2021; Van Den Bos et al., 2017) •\$2.7 billion in 2016 \rightarrow violence prevention and response •Nurses and nursing assistants at increased risk for Economy injuries resulting in missed workdays Rising workers compensation claims, healthcare waste (OSHA, 2015; Van Den Bos et al., 2017) No universal training program or zero-tolerance signage •WPV knowledge and confidence Focus Staff perception of a culture of safety (Almendrala, 2017; Blouin, 2017; Brous, 2018; Hester et al., 2016; Hoyle et al., 2018; IHI, 2021; NIOSH, 2020; Sharma et al., 2019; Workplace Violence Prevention for Health Care and Social Service

QI Intervention

WPV Prevention Campaign

 Staff training: WPV identification, risk factors, patient-staff communication, relationship building, safety culture awareness

(IHI, 2021; NIOSH, 2020)

	AGGRESSIV BEHAVIOR WILL NOT B TOLERATED
There is zero tolerance for	

all forms of aggression; incidents may result in removal from this facility or prosecution in pressing charges for aggressive behavior they encounter while caring fo

ce Workers Act, 2020)	
Head With the speak sp.	Pre-intervention scores (<i>M</i> = 65%, <i>SD</i> = 10, <i>n</i> = 4)
Heart (fel that I can safely speak up.	Post-intervention scores (<i>M</i> = 87%, <i>SD</i> = 11.55, <i>n</i> = 3)
Voice	Difference not

vice	Difference not
	significant, U = 1, z =
	1.58, p = .057 (1 tail)
ils to thesk up	with a large offect si

r = .65



(MEAN)

Sample: RNs,	APNs, LPNs, medical service assistants, d operational and front desk staff (n=50)	Discussion	•	edback: useful, need for nal procedures, and environmental	
Pre-, post-, two-week post-intervention surveys in three NJ pediatric ambulatory care practices		Strengths	 Feasibility, technology, organizational leadership support Valid and reliable CCPAI 		
Demographics, level of Type II WPV knowledge, level of confidence in coping with patient aggression NIOSH knowledge assessment, Confidence in Coping with Patient Aggression Instrument (Buterakos et al., 2020; Mishra et al., 2019; NIOSH, 2020; Thackrey, 1987) Descriptive & inferential statistics (two-sample <i>t</i> test and Mann-Whitney U test)		Limitations	•Small samp •Simultaneo •COVID-19 p	ample size, fixed time frame aneous implementation of new EHR -19 pandemic f retention data, not matching pairs	
Outco Response Results	 Four staff completed pre- and post- survivinone completed two-week post- survey Seven staff attended WPV prevention tr At least 50% have experienced verbal as Highest post-implementation score incr Categories of risk factors (25% → 100%) 	veys; aining ssaults ease: 5)	ture iendations	 Practice Large diverse sample, multimodal recruitment, training, and survey implementation Matching pre/post pairs Measuring knowledge and confidence retention 	
ntervention s (<i>M</i> = 65%, <i>SD</i> =	 Signage posted in three pediatric and signadult practices One campaign email sent to pediatric signal sent to pediatric sentence setting the sentence setting se	tor		 Establishing WPV procedures & preparedness committees Focused interdisciplinary training on environmental safety Campaign expansion to support just culture focus, empower staff, and reduce WPV risk alwei et al., 2021; Lamont & Brunero, 2018; Ming et al., 2019; Mohr et 	
= 4) intervention s (<i>M</i> = 87%, <i>SD</i> =	65 59.5 64.5	= 11.96, <i>n</i> = 4) Post-intervention scores (<i>M</i> = 64.5, <i>SD</i>	al., <i>i</i>	2018; Wyatt, 2016)	

= 19.67, *n* = 4)

Difference not

CCPAI SCORE (MEAN)

significant, t(4) = -0.52, p = .32 (1 tail)



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