EVALUATION OF A COMPREHENSIVE ED VIOLENCE PREVENTION PROGRAM

Authors: Gordon L. Gillespie, PhD, RN, PHCNS-BC, CEN, CPEN, FAEN, Donna M Gates, EdD, RN, FAAN, Tammy Mentzel, BS, Ahlam Al-Natour, PhD, RN, and Terry Kowalenko, MD, Cincinnati, OH, Irbid, Jordan, Ann Arbor, MI
Section Editors: Tomi St. Mars, RN, MSN, CEN, FAEN and Anna Maria Valdez, RN, PhD, CEN, CFRN

Health care clinicians are at high risk for workplace violence (WPV) from patients and visitors,[1–3] with 25.5% reporting at least 1 recent incident of victimization.[4] Researchers found that WPV has negative effects on providers' stress, ability to provide safe and competent care, job satisfaction, and turnover.[2,5,6] In response, several states enacted legislation making assaults against health care workers a felony or requiring employers to implement WPV prevention programs.[7,8] Professional organizations voiced their concerns about the safety of health care workers. The Emergency Nurses Association's 2010 position statement *Violence in the Emergency Care Setting* states, "Health care organizations have a responsibility to provide a safe and secure environment for their employees and the public."[9]

Few WPV prevention programs for health care settings are noted in the literature, and those programs are limited in scope and evaluation.[10–12] In response to this program gap, we partnered with 3 emergency departments to plan, implement, and evaluate a multifaceted, comprehensive WPV prevention program. Emergency departments are often cited as the health care setting with the highest incidence of WPV.[13–15] The overall goal of our program was to develop a comprehensive approach for creating a safer work environment and make recommendations for future programs. It was hoped that the new information gleaned from this work could be used by nursing leaders and employees in a variety of health care settings. The purpose of this article is to describe the process and methods used to implement and evaluate the WPV prevention program.

Methods

SETTING AND PARTICIPANTS

The program was initiated at 3 US hospital emergency departments from different hospital organizations: an urban Level I Trauma Center, an urban hospital, and a suburban hospital. The Level I Trauma Center has a separate psychiatric emergency department adjacent to the adult-only emergency department. The urban and suburban emergency departments serve a general ED population: adult, pediatric, and psychiatric patients. Although the project was aimed at the entire emergency department, clinicians providing direct patient care (ie, nurses, physicians, and unlicensed assistive personnel) were specifically targeted for risk reduction and evaluation. The overall project was approved by the institutional review boards of the university and respective hospitals. Although patients participated during the development of the WPV program, data from patients were not collected for the project evaluation.

ACTION RESEARCH

We used the principles of action research as guidance for program planning, implementation, and evaluation.[16] The goal of action research is for academic researchers to partner with clinicians for opportunities to reflect on clinicians' practice and implement informed actions to reduce WPV exposures. Methods are rooted in the concerns of clinicians in real-world settings. Characteristics include action

Gordon L. Gillespie, *Member, Greater Cincinnati Chapter and Treasurer, Ohio Emergency Nurses Association*, is Assistant Professor and Robert Wood Johnson Foundation Nurse Faculty Scholar, College of Nursing, University of Cincinnati, Cincinnati, OH.

Donna M. Gates is Adjunct Professor, College of Nursing, University of Cincinnati, Cincinnati, OH.

Tammy Mentzel is Project Director, College of Nursing, University of Cincinnati, Cincinnati, OH.

Ahlam Al-Natour is Assistant Professor, College of Nursing, Jordan University of Science and Technology, Irbid, Jordan.

Terry Kowalenko is Professor of Emergency Medicine and Medical Education, Medical School, University of Michigan, Ann Arbor, MI.

research being cyclical, having separate but mutually dependent steps, being participative, generating data, and being a reflective process.

The goal of the project was to develop partnerships among academic researchers and ED clinicians and leaders to implement a WPV prevention program tailored to the unique ED settings while increasing the likelihood of program implementation and sustainability. The partnership was initiated by the academic researchers. Initial entree was facilitated by the networking of the researchers having prior relationships with the ED leaders from prior projects and the leaders' membership in the Greater Cincinnati Emergency Nurses Association. The professional networking that occurred before the project initiation allowed for an open discussion between the academic researchers and ED leaders to tackle the problem of mutual interest and importance.

PROGRAM OBJECTIVE

Program planning included both formative and summative evaluation not only to identify whether the program was successful but also to provide information regarding factors that facilitated or hindered the project's success. This information is critical for program revisions and future planning. The program objective was to implement a sustainable comprehensive emergency department–based WPV prevention program in collaboration with stakeholders.

PROGRAM ASSESSMENT

Assessment and planning for the project took place over a 21-month period and included several strategies to assess the emergency departments' risk factors. A 9-month WPV incidence was trended to determine the extent of WPV as a local problem. The average clinician experienced 0.461 violent events per month, which extrapolated to 5.5 physical threats and assaults per person per year; there was no significant difference in rates among the partner sites.[17] A review of the research literature was conducted to identify known risks for and causes of ED WPV.[2,3,10] Focus groups were held with ED leaders (physicians, nurse managers, nurse educators), employees, and patients to identify WPV prevention, management, and post-incident strategies already in place, as well as additional interventions that may be helpful.[18] Walkthroughs were done to identify environmental risks. Meetings were held with emergency department–based safety committees to identify further risks and strategies for reducing risks. WPV-relevant policies were reviewed. Multiple meetings were then held with medicine, nursing, security/police, registration, management, social work, and psychology

to plan the intervention. By use of the assessment data, an intervention was proposed by the academic researchers and discussed with ED leaders and staff.

PROGRAM INTERVENTION

Data supported the need for a multicomponent intervention: WPV policies and procedures, WPV education, and environmental changes. Best practice policies and procedures were written and then tailored to each emergency department in collaboration with the ED leaders. Revisions of the plan and documents continued until approved by ED leaders, staff, and senior hospital administrators. Written policies and procedures for each partner site included each of the following sections: strategies for risk assessment, maintaining a safe environment, communication of risk, response to violent events, recordkeeping, surveillance, and post-incident care. The education component included uniform online training that provided didactic content for WPV prevention, management, and post-incident recovery, as well as an interprofessional class for participants to apply new policies, procedures, and online training.[19] Environmental changes were site specific, based on assessments and availability of site funds. All 3 sites adopted a process to alert nonclinical staff (eg, environmental services) that a violent person was in the room. In addition, the suburban emergency department installed panic buttons, locked doors, and closed-circuit cameras, subcomponents already in place at the other partner sites.

PROGRAM IMPLEMENTATION

The program was specifically aimed at all ED clinicians including physicians, nurses, and unlicensed assistive personnel and was implemented over a simultaneous 3-month period. The new policies and procedures were diffused using the intranet, flyers, posters, staff meetings, name badge cards, and an interprofessional class session.

PROGRAM EVALUATION

The program was evaluated through a formative evaluation of the program implementation and a summative evaluation of the program and components. The formative evaluation took place over a 9-month period after implementation. Monthly, the project director used a checklist to assess the fidelity of the intervention during her ED rounds. She documented notes related to her monthly assessments. The data for the 9 months were summarized in narrative format (Table 1).

The summative evaluation began with a sample of 80 employees completing an online program evaluation. Employees rated the program benefit using a scale from

TABLE 1
Summary of program fidelity during 9-month post-implementation period

Program subcomponent	Program director's comments from monthly fidelity assessments
1. Rounding in lobby	Two hospitals performed rounding consistently; 1 emergency department did not and identified that it was staffing dependent.
2. Screening all patients for early signs of potential escalation	A screening checklist was developed and initially planned to be used for all ED patients as a means to communicate potential risk to other employees. The checklist evolved to being used as needed to communicate early signs of potential escalation of violence. The majority of clinicians found it useful as a reminder to be alert to the early signs of escalation.
3. Concealed weapon assessment question during triage	One emergency department was consistent; clinicians routinely asked about the presence of weapons as part of the triage assessment. Several weapons had been turned over to security for proper storage at all 3 emergency departments. At 1 emergency department, where there was inconsistency, some clinicians commented that they were uncomfortable asking about concealed weapons. At the other emergency department, which was also inconsistent, some clinicians commented that they did not feel safe asking the question when they were alone with a patient in triage.
4. Flagging patients with a history of violence or exhibiting signs of potential violence	Two sites initiated a system that worked consistently. Two of the hospitals found flagging to be very important. One emergency department flagged inconsistently.
5. Levels of awareness alerting employees of violent risk level in emergency department	No emergency departments did this in any meaningful way. The reason given was the size of the emergency department, with one indicating that it was too large to communicate the levels and one saying that it was too small and that levels are communicated by word of mouth. The larger emergency department thought a tracker board to display the levels would be helpful.
6. Violent event response table	A table was developed with clear instructions as to what employees are to do in certain violent situations. The ED clinicians thought the table was helpful and used it in theory. Several ED clinicians did not have the response card on their identification badge as planned.
7. Care after violent event	Clinicians were consistently knowledgeable as to the procedures to take if they were a victim of WPV. This was particularly true if an injury occurred.
8. Reporting violence and debriefing	Clinicians were consistently knowledgeable as to the procedures for reporting a violent event. Clinicians reported that any debriefing that occurred was done informally with their manager.
9. Post-incident reviews	One emergency department consistently posted reviews of violent incidents. One emergency department was inconsistent with their reviews, whereas the last emergency department was not doing them.
10. Quarterly surveillance reports	One of the emergency departments was doing the reports and sharing them with the clinicians. Two of the emergency departments were not consistently doing these.

0 (no benefit) to 10 (extremely beneficial) and rated the ease of following the program using a scale from 0 (extremely difficult) to 10 (extremely easy). Employees identified their beliefs regarding the level of commitment to the program by themselves, colleagues, and administration on a scale from 0 (no commitment) to 10 (total commitment). Lastly, participants rated the importance of the WPV prevention subcomponents from 0 (not important) to 10 (extremely

important). Means were computed to report the results. Participants were given an opportunity to add comments. In addition, all employees who completed the educational component evaluated the education for content, format, instructor effectiveness, and time required to complete the training.

Finally, a program evaluation meeting was held with nurse managers and educators from the 3 emergency

TABLE 2
Summary of program evaluation meeting with ED managers and educators (n = 6)

Overall, how beneficial do you believe the violence prevention program was in reducing violence?

1. All managers and nurse educators verbalized their beliefs that the program was beneficial in reducing violence in their departments.
2. The classroom training was rated particularly high with all managers and stated overall compliance was good.
3. Physician participation was very low in 2 emergency departments. One manager identified that the environmental changes were the most important and beneficial component.

Discuss your ability to adapt and follow the new WPV prevention policies.

1. One manager stated that it was initially a challenge, with another stating that the program's adoption was slow.
2. There were several comments about the need for increased administrative and physician support for the changes.
3. One manager commented that the new policies and procedures led to increased dialogue about WPV.

To what degree did your emergency department comply with the new WPV prevention policies and procedures?

1. The managers uniformly stated that overall compliance was good, with compliance really depending on the particular intervention subcomponent.

To what degree did your emergency department comply with each of the specific intervention components and subcomponents?

1. Environmental changes were perceived as effective by all managers and nurse educators.
2. Online training was generally characterized as being too long with technology issues that were challenging for some clinicians.
3. Classroom training was well liked. Only 1 emergency department had physician participation and support.
4. Lobby rounding to assess risks varied depending on the department, component, and individual employee and staffing. For example, although lobby rounding was viewed as important, managers stated that compliance depended on patient capacity and staffing.
5. Screening patients for early signs of potential escalation was being used and found to be helpful but not as intended, with too many patients being flagged.
6. Asking about a concealed weapon during triage varied among the ED clinicians, as did their comfort level in asking. Weapons were turned over by patients in all 3 emergency departments.
7. Flagging patients with a history of violence or exhibiting signs of potential violence was consistently used by all emergency departments.
8. Levels of awareness to alert employees of violence risk level in the emergency department was the most difficult intervention for clinicians to understand and generally was not being used.
9. The violent event response procedure and table were determined to be helpful to aide clinicians in identifying specific actions. The table added as a name badge card was not found to be helpful or used by the clinicians.
10. Care after a violent event was done consistently if managers became aware of an event. Some reported discussing events at meetings.
11. Reporting a violent event remained a problem, with clinicians providing reasons for why they did not report violent events.
12. Post-incident review using a root cause analysis process for more severe violent events was consistently performed by managers.

How would you rate the partnership between academia and hospital emergency departments?

1. It was evaluated as positive uniformly by all managers, though sometimes challenging when priorities at the emergency departments and hospitals conflicted with the project.

departments to discuss the program implementation after the post-implementation period was complete. The discussion questions are outlined in Table 2. The discussion was transcribed and summarized.

Results

FORMATIVE EVALUATION OF PROGRAM IMPLEMENTATION

The academic researchers and ED leaders were able to diffuse the program at the emergency departments over the 3-month implementation period. The degree of success varied among the sites and for the individual program subcomponents. The smaller, suburban emergency department had the best results for institutionalizing and sustaining the intervention subcomponents over the 9-month post-implementation period. The larger, urban Level I Trauma Center had the least success for institutionalization and sustainment. Table 1 shows a summary of the fidelity assessments during the 9-month post-implementation period.

SUMMATIVE EVALUATION OF PROGRAM AND COMPONENTS

Of the 80 employees asked to complete the program evaluation, 66% (n = 53) did so. Employees (n = 53) rated the overall program as moderately beneficial (mean, 5.0). Nurses (n = 35) evaluated the benefit of the program the highest (mean, 5.3), whereas physicians (n = 9) evaluated the program's benefit the lowest (mean, 3.4). The suburban ED employees (n = 12) evaluated the program's benefit higher (mean, 6.6) than the urban ED employees (n = 12) (mean, 5.8) and the Level I Trauma Center employees (n = 29) (mean, 4.1).

Employees (n = 53) rated the ease of program implementation as moderately easy (mean, 5.9). Nurses (n = 35) rated the ease of program implementation the highest (mean, 6.0), with physicians (n = 9) next (mean, 5.7) and then unlicensed assistive personnel (n = 5) (mean, 4.6). Employees at the suburban emergency department (n = 12) rated the ease of program implementation the highest, with a mean of 6.2, followed by the Level I Trauma Center (n = 29) (mean, 5.9) and the urban hospital (n = 12) (mean, 5.7).

Employees rated the level of commitment for program adoption and fidelity as higher for themselves (mean, 8.2) than for other employees (mean, 7.0) and ED leadership (mean, 6.8). Unlicensed assistive personnel rated their personal commitment higher (mean, 8.4) than that of physicians

(mean, 8.3) and nurses (mean, 8.1). Employees at the suburban ED rated leaders' commitment higher (mean, 7.3) than that of employees at the urban emergency department (mean, 7.0) and Level I Trauma Center (mean, 6.3).

The importance of program components/subcomponents ranged from a high of 8.6 (very important) for surveillance and monitoring to a low of 6.9 (important) for policies and procedures. In addition to surveillance, components/subcomponents deemed as most important were environmental changes, education, and post-incident care.

The employees (n = 315) who completed the educational component provided both positive and constructive feedback. Employees reported that, overall, the online training was valuable but too long and fraught with technical problems. The classroom training was preferred over the online training. Employees believed that the classroom training could help them translate the content to their clinical practice. The training did lead to significant increases in WPV knowledge.[19]

Overall, the managers and nurse educators described the program as very positive and believed that the program would be beneficial at reducing WPV (Table 2). The 2 components/subcomponents identified as most important were the classroom education and the environmental assessments and improvements. The 2 components/subcomponents identified as the least effective were the levels of awareness and conducting a WPV assessment screening at triage for all patients.

Discussion

Nurse managers and educators reported that the action research partnership between academic researchers and clinicians was very positive. They shared that because they have many competing priorities, the partnership and assistance were extremely valuable. In particular, they valued the expertise needed to evaluate the program and recommend revisions. In retrospect, the group discussed that they may have attempted too many interventions over a 3-month implementation period. However, these were the subcomponents remaining from an even longer wish list of interventions narrowed because of resource availability and potential for success.[18] Competing priorities also contributed to implementation challenges (eg, visits from The Joint Commission and Centers for Medicare & Medicaid Services). The action research process allowed ED leaders and employees to reflect systematically on their practice and make informed actions for improvements. The project remained rooted in ED clinician concerns and

maintained the characteristics of action research that it be cyclical, require mutually dependent steps, be participative, generate data, and be a reflective process. The experience provides support for partnerships between academic researchers and clinicians as a process to tackle social problems such as WPV.

Overall evaluation of the WPV prevention program was mixed. It was not surprising that the physicians rated the benefit of the program the lowest. Only a few physicians participated in the planning meetings, and only a few physicians (n = 12) participated in the program's educational component. Whereas nurse managers required nurses and unlicensed assistive personnel to complete the educational component, physician leaders in 2 emergency departments did not. Although WPV against emergency physicians is a recognized problem,[3] having physicians value and complete WPV training will continue to be challenging because of physicians' competing time, reimbursement demands, and not being employees of the emergency department. The lack of physician participation was interesting given the discussion by Peek-Asa et al[11] indicating that physicians were commonly excluded from training and needed to be included. Strategies to increase participation need to use data reflecting a critical need for change, leverage physician and hospital leadership relationships to support change, solicit physician champions to engage physician peers, and communicate the importance of physician contributions.

Employees rated surveillance and monitoring as the most important strategy for reducing WPV against employees. Yet, the monthly fidelity assessments and the program evaluation meeting with the ED managers and educators indicated that this intervention subcomponent was one of the least successfully implemented in all 3 emergency departments. The only reason given by managers and educators for this was that employees do not report incidents, a consistent problem reported in the literature.[2,11] Surveillance remains important in WPV programs[11]; however, surveillance cannot be effectively leveraged to offer meaningful recommendations for change without valid data to determine problem severity, evaluate hazard control methods, and identify educational needs. Gates et al[2,18] found that health care employees do not report WPV for several reasons, including undervaluing the importance of reporting, not having time to complete reports, and believing that nothing changes in response to reporting. Involving employees in the surveillance and monitoring of WPV could help adoption. The ED safety committee is an optimal group to diffuse the program, ensure adherence to regular WPV surveillance and monitoring, and champion the need to report incidents. Unfortunately, recordkeeping

was rated as the second lowest subcomponent in terms of importance in reducing WPV. This finding may be related to employees not recognizing any benefit of recordkeeping as a form of WPV prevention.

Administration has a key role in both addressing the importance of reporting incidents and ensuring that changes based on reporting are visible to employees. Employees rated the policies and procedures component as the lowest in terms of importance in preventing WPV. Narrative comments from physicians at the Level I Trauma Center, where no physicians attended the educational component, indicated that they did not know anything about WPV-related policies and procedures. Although the policies and procedures were discussed and applied during the classroom-based education component, the physicians' lack of knowledge reflects a critical gap in the program's diffusion. It is also possible that employees who rated policies and procedures low were reacting to a potential lack of enforcement and compliance with hospital policies in general. Reasons found to be associated with low compliance include perceived higher-level priorities, fragmented organizational structures, and inadequate communication.

One of the program's major success stories was the environmental changes at the suburban emergency department. During the assessment phase, the project team identified that the emergency department was very accessible to the public and at an increased risk for WPV. This emergency department's high adherence to the WPV program may be a result of the clinicians' seeing the hospital's financial commitment to instilling environmental changes. Interestingly, during the planning meetings, many employees and managers at the suburban and urban emergency departments expressed that adding metal detectors would be the best intervention for reducing WPV. In contrast, employees and managers at the Level I Trauma Center with the metal detector expressed that metal detectors were not necessarily deterrents for WPV.[18] This may be related to the metal detector only being used during nightshift hours. Whereas the environment plays a crucial role in preventing WPV, it is important that employees and managers do not underestimate the importance of a comprehensive approach that includes efforts to reduce risks related to patients, visitors, employees, and the environment.

The classroom education was evaluated more favorably than the online education, even though ED leaders and employees stated during the planning phase that online training was preferred. The online content was necessary because it provided didactic information about WPV, phases of escalation, and strategies to reduce WPV as preparation for the classroom education.[19] The

interprofessional classroom experience was interactive and included problem-based learning exercises using an interprofessional team application process.[19] The online program was revised based on the feedback from the participants to reduce the time commitment; in particular, repetition was reduced with a focus on critical content. ED employees have many time demands, and the required number of training hours continues to increase. Although it is critical that content be essential and presented in the most effective format, it is important that ED leaders not resort to online training based simply on flexibility, cost, and ease of use. Hybrid education as used in this project offers an alternative to choosing between online and classroom strategies. The emergency departments will continue to provide the education to newly hired personnel and are committed to using the program for their annual training competencies.

Support for the program by ED leadership varied, with the majority of support coming from ED nurse managers. Yet, employees perceived ED leadership as the group least committed to the prevention efforts. Security and police involvement was positive, with several officers and managers involved in the planning and implementation phases. A collegial relationship with security officers is essential for an effective WPV prevention program.[20] At 1 emergency department, the social workers and patient escort managers were very supportive and involved as they identified that their employees were also at risk. As described earlier, the physician group was the least engaged in the planning, implementation, and evaluation phases.

Implications

Hospital employees, especially those in the emergency department, will continue to be at risk for WPV from patients and visitors. To support quality improvements and reduce risks, the use of a comprehensive program developed collaboratively between academic researchers and clinicians should emphasize communication and monitoring (surveillance) linked to education and feedback. Single-table discussions need to occur among ED leaders, physicians, clinicians, and safety committee members so that a commitment for WPV prevention, management, and recovery can occur. An interprofessional safety committee can be responsible for ensuring the uniform adoption and implementation of the program.

Whereas certain settings have unique environmental and training needs, a facility-wide approach addressing primary, secondary, and tertiary prevention strategies is highly recommended. Diffusion efforts should include

strategies that engage all stakeholders, including the hard-to-reach physician group. One strategy to accomplish this may be adopting a WPV program at a regional level so that all entities in the regional hospital association are active participants. WPV occurs against all health care workers, and prevention of incidents will continue to be dependent on the involvement of all disciplines. It is critical that all employees know what to do in specific situations and how to communicate risk among themselves so that all employees remain safe. It takes just one untrained and unprepared employee to place other employees and an organization at risk.

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Submissions to this column are encouraged and may be sent to
Tomi St. Mars, RN, MSN, CEN, FAEN
tst33@aol.com
or
Anna Maria Valdez, RN, PhD, CEN, CFRN
annav409@gmail.com