

WORKPLACE VIOLENCE TRAINING FOR NURSES
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FINAL REPORT

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CONTENTS

Title	1
Contents.....	2
Terms and Abbreviations.....	3
Abstract.....	4
Highlights / Significant Findings.....	5
Translation of Findings	7
Outcomes / Relevance / Impact.....	8
Scientific Report	9
Publications	18
Appendices	19
A1: Initial Curriculum Draft.....	20
A2: Expert Panel Review Guide Formative	28
A3: Summary of Expert Review Formative	29
A4: Focus Group Guide Formative	34
A5: Summary of Focus Groups Formative	35
A6: Revised Curriculum	37
A7: Prototype Sample Screens.....	47
A8: Expert Panel Review Guide Summative	49
A9: Focus Group Leader's Guide Summative.....	51
A10: Summary of Focus Groups Summative	57
A11: Inclusion Enrollment Report.....	60

Terms and Abbreviations

(none)

Project Summary / Abstract

Background

Research has shown that nurses are at very high risk of being victims of workplace violence from patients as well as coworkers. For hospitals, consequences of workplace violence against nurses can lead to deterioration in the quality of care to patients, increased errors, worsened patient outcomes, lower patient satisfaction, and have negative effects on recruitment. Results from a 2001 survey of registered nurses by the American Nurses Association revealed that health and safety concerns played a major role in nurses' decisions about leaving the profession – 25% of the nurses surveyed reported a fear of sustaining work-related assault

The American Association of Colleges of Nursing issued a Position Paper in 1999 emphasizing the inclusion of violence-related content as essential content in nursing curricula, yet training remains incidental. The American Nurses Association, the International Council of Nurses and the American Academy of Nursing, as well as health care labor unions, have called for increased research to identify effective interventions.

Proposed Intervention

Vida Health Communications, Inc. plans to develop and evaluate *Workplace Violence Training for Nurses*, a two-part multi-media training package for professional (registered) nurses working in a hospital setting. It will include a self-paced web-based learning program to help nurses understand, assess, prevent, and respond to violence in the workplace. The curriculum will make extensive use of video and multimedia to share expert opinions, victims' experiences and to provide visual case studies to demonstrate effective strategies for assessment, prevention and response, thus allowing for behavior modeling. The program will be divided into five stand-alone modules covering various aspects of nursing workplace violence. Self-administered tests for each module will help to track acquisition of essential knowledge, attitudes, and skills. Continuing education credits will be awarded to program graduates. A separate Workshop Leader's Toolkit will help hospital-based nurse educators conduct workshops (e.g., in-service training) on workplace violence.

This Phase I research study developed and tested with focus groups a curriculum and a prototype of the proposed web-based learning program.

Key Findings

- There is a significant divide between how front-line nurses and workplace violence policy experts perceive the issue. Experts see policy at the core of solutions to workplace violence. Nurses ask how policy can be effective without buy-in from those who the policy affects.
- Nurses fear being blamed for acts of violence even when they themselves are the victims. Nurses distrust management's motivations for policy implementation fearing that a failure to closely adhere to policy will create opportunities for nurse blaming. Nurses also feel that patients' rights often supersede nurses' rights and that this can have a detrimental impact on workplace safety.
- Lateral violence between co-workers, including bullying and verbal abuse, was a paramount concern to all nurses.
- There was agreement that the prototype predicts an excellent training for a wide variety of nurse audiences in settings ranging from nursing schools to in-service continuing education offerings.
- All participants liked the use of the dramatic enactments to illustrate case studies.

Application to the Workplace

The results of this Phase I research suggest that there is a significant need for better communication and understanding between institutional administrators and front-line nursing staff. For workplace violence policies to be effective, nurses must feel that they are participants in authoring the policies that affect them. Education of nurses around workplace violence issues, violence prevention, policy making and advocacy strategies will help to engage and empower nurses to work within their institutions to effect policies that they can buy in to.

Highlights / Significant Findings

The specific aims of Phase I were to:

1. Establish the curriculum for the web-based learning program for nurses
2. Produce a prototype of the home page and one functional training module of the curriculum
3. Evaluate the content and feasibility of the training module using focus groups representative of the target audience
4. Develop and refine Phase II plans for production, evaluation, and distribution

Curriculum Design

1. Workplace Violence Knowledge and Prevention Strategies

Workplace violence and abuse is a hot button topic for many nurses. There is wide disparity in views on what constitutes violence and abuse in the workplace and what may be appropriate responses to such incidents across differing clinical scenarios. Nurses want to learn what they can do, both individually and as a group, to reduce incidence of workplace violence and abuse. Lateral violence between co-workers, including bullying and verbal abuse (often referred to as “the culture of nursing”), was of major concern to all participants. Young nurses coming out of school need to be better prepared for the violence and abuse of the nursing workplace. The program should speak to nurses specifically rather than generically to all workers in healthcare settings. Each module of the training should stand alone and offer continuing education credits.

2. Workplace Violence Policies

Most nurses do not feel adequately informed about the workplace violence policies of their workplaces. Nurses fear being blamed for acts of violence even when they themselves are the victims. Nurses distrust management’s motivations for policy implementation fearing that a failure to closely adhere to policy will create opportunities for nurse blaming. Nurses feel that patients’ rights often supersede nurses’ rights and that this can have a detrimental impact on workplace safety. The ability to access this training outside of work is important due to concerns about privacy and distrust of management.

Prototype Design

1. General responses:

- Both focus groups conveyed clearly positive responses to the training module. *I think it's a great program... Seemed real; grabbed our interest. This is a great learning experience – great discussion points.*
- There was agreement that the prototype predicts an excellent training for a wide variety of nurse audiences in settings ranging from nursing schools to in-service continuing education offerings. *Every hospital has a competency review for JCAHO; this would be fantastic for annual review... Would have a value for hospital administrators to help them understand what nurses go through...Also for use in nursing schools.*
- Focus group participants understood the tool’s potential to be mediated individually at any time, at work or at home, and also in facilitated small and large group learning situations.
- Participants objected to the use of the term “training” in the program title, preferring “education” instead.

2. Responses to the use of acted case study scenarios to support learning objectives:

- Response to the use of dramatic enactments in a case study approach was positive: *It's all there in the opening scene; caught my attention very quickly... I really liked the case scenario – it felt real.*

- All participants like the use of the dramatic enactments to illustrate case studies. Some found the use of flashback as a discovery device to be confusing *It's confusing to do it in this order; it would be helpful to see how the events escalate in order.*
- Participants recognized and appreciated diversity represented in the casting of the actors: *I liked the inclusion, diversity and persona of the nurse.*
- Most participants found the acting convincing although some pointed to spots where they felt there was *a bit of a soap opera feel.* Ironically, most criticism was leveled at the one true nurse in our cast.

3. Responses to interface design:

- Participants liked having the capacity to navigate easily through the screens and know where one is at all times. *"Controls are great; like the 1 of 24."* A few expressed a preference for left hand navigation.
- Subjects tended to find the screen layout busy, in particular the title bar and text at the top of the screen and offered a variety of helpful suggestions for streamlining such as removing the copyright information, providing the opportunity to increase/decrease text size, having the controls disappear when appropriate.
- Participants felt that the imagery and colors of the home page depicted an emergency department and expressed a preference for use of brighter colors and images that suggested interpersonal relationships rather than a workplace environment that they see every day.

Translation

The results of this Phase I research suggest that there is a significant need for better communication and understanding between institutional administrators and front-line nursing staff. For workplace violence policies to be effective, nurses must feel that they are participants in authoring the policies that affect them. Education of nurses around workplace violence issues, violence prevention, policy making and advocacy strategies will help to engage and empower nurses to work within their institutions to effect policies that they can buy in to.

When completed in Phase II, *Workplace Violence Training for Nurses* will offer:

A Self-Directed Web-based Learning Curriculum that addresses theory, practice, and policy implications of the growing problem of violence and abuse experienced by nurses in the workplace. Emphasis is placed on violence prevention, and the immediate and long-term health and safety of front-line nurses. The self-paced curriculum will consist of the following five individual modules:

- i. Module 1: The Roots and Manifestations of Workplace Violence and Abuse
- ii. Module 2: Consequences of Workplace Violence and Abuse
- iii. Module 3: Risk Assessment and Prevention
- iv. Module 4: Crisis Interventions
- v. Module 5: Policy and Legal Issues In Workplace Violence

The training will be developed in Flash® with each module functioning as a stand-alone course within the framework of the curriculum. All modules will make extensive use of video and graphics to share expert opinions, experiences of violence and provide case studies that demonstrate effective strategies for assessment, prevention and response, thus allowing for behavior modeling. Self-administered tests for each module will help to track acquisition of essential knowledge, attitudes, and skills. Continuing education credits will be awarded for the completion of each module. Total seat time for the curriculum is expected to be about four hours.

A Workshop Leader's Toolkit will support nurse trainers who conduct workshops (e.g. in-service training) on workplace violence. It will also make the program accessible to nurses and hospitals (e.g. those in rural areas) without requiring access to high speed internet service necessary for the web-based program. The toolkit will consist of the 5 modules from the web-based learning program, each on its own DVD-ROM plus a workshop facilitator's guide. The DVDs will be playable from any computer. For group learning modalities this might be a laptop connected to a flat screen monitor or projector. At the completion of each module learners would be able to complete an on-line test for continuing education credits. This test would not require a high speed internet connection.

Outcomes / Relevance / Impact

The results of this Phase I study will be used to guide the Phase II research study which includes production and evaluation of the educational intervention. Phase I findings reveal that experienced nurses are highly interested in the topic of workplace violence and particularly lateral violence. They feel it is a topic that is not discussed enough among nurses but affects all nurses. Young nurses just starting their careers should be prepared for the realities of workplace violence and be equipped with basic skills for handling incidents. Nurses believe the patient-centered care model has the potential to undermine their authority and places them at greater risk for violence. As a result, nurses may distrust the motivations of management for implementing new policies which some may view as creating new opportunities for nurse-blaming. Nurses believe that the personality traits that led them to become nurses play a role in their acceptance of violence as “part of the job” of nursing. A comprehensive educational program for nurses about workplace violence will offer nurses an understanding of the factors influencing nursing workplace violence, help them develop the skills necessary to cope with and respond to workplace violence, and offer them long term strategies for engaging in organizational change.

Scientific Report

1.1 Key personnel

Name	Title	Dates of Service	# Hours
Lisa McElaney, MFA	P.I.	September 1, 2007 – April 5, 2008	158
John Craine, MBA, MS	Co-Investigator	September 1, 2007 – April 5, 2008	386
Allison Humenuk, AB	Producer	September 1, 2007 – April 5, 2008	249
Allison C. Morrill, JD, PhD	Evaluator	September 1, 2007 – April 5, 2008	116
Eliza Hutchinson, BA	Research Asst.	September 1, 2007 – April 5, 2008	225

1.2 Specific Aims of Phase I

The specific aims of Phase I were to:

- Establish the curriculum for the web-based learning program for nurses
- Produce a prototype of the home page and one functional training module of the curriculum
- Evaluate the content and feasibility of the training module using focus groups representative of the target audience
- Develop and refine Phase II plans for production, evaluation, and distribution

It is important to note that, as a condition of funding, Vida was asked by the funding institute to cut our original budget by about \$35,000 or approximately 25%. Therefore, some significant adjustments to the research plan and prototype design were required to cope with this reduced level of funding. These were made in consultation with program officials. Overall, we were still able to achieve the stated specific aims.

1.3 Results

1.3.1 *Results: Web-based learning program content*

Based on extensive review of the literature and expert Hoff's considerable research experience in this area, Hoff and Co-Investigator Craine developed the initial proposed curriculum for the web-based learning program. This curriculum was subsequently vetted through two rounds of review by the other project experts (Bain, Nachreiner, Slatin) and three focus groups of registered nurses and nursing educators.

Step 1: Draft initial proposed curriculum

As initially conceived, the web-based learning program would cover:

- sociocultural and individual roots of violence, abusive, and bullying behavior;
- identification, assessment and prevention skills and strategies;
- appropriate responses to injured workers and their perpetrators;
- work environment factors associated with violence;
- the health and social ramifications of violence for both victim/survivors and perpetrators;
- social change strategies aimed at institutional health and safety policies and protocols that promote the well-being of nurses and, by extension, the quality of patient care.

The final program would also offer continuing education credits for registered nurses across multiple disciplines.

Craine and Hoff drafted an initial proposed curriculum consisting of the following six modules:

Module 1: The Roots and Manifestations of Workplace Violence and Abuse

Module 2: Consequences of Workplace Violence and Abuse

Module 3: Risk Assessment and Prevention

Module 4: Crisis Intervention

Module 5: Policy and Legal Issues In Workplace Violence

Module 6: Violence Prevention in Historic and Human Rights Perspective

Step 2: Expert review of draft curriculum

The draft curriculum was next submitted for review to the panel of experts along with a list of questions to consider. Questions to the expert panel covered:

- Relevance, balance and quantity of information – How important is this information, what have we overemphasized? What needs to be fleshed out? What have we omitted? What should we omit?
- Clarity and accuracy – Have we presented the information in a fashion suitable for the target audiences? Is the information correct? Is the information organized properly?
- What module would make the most effective prototype?

Results of Expert Review

All three expert reviewers expressed their belief in the importance of this research topic and course curriculum; however, they split over what the objectives and goals of the curriculum should be. The two nurses, Nachreiner and Bain, were strongly supportive of the curriculum as it was drafted and offered suggestions about the organization and presentation of the content. They agreed that a nurse-centric approach was appropriate. This is summed up by expert Nachreiner's comment:

"I think the other key here (and in some of the other modules) is to address why so often nurses accept this (violence) as part of the job. Prevention, policies, etc. are hard to implement when there is a lack of buy-in from the groups that violence should not simply be accepted."

The nurses agreed that the curriculum should be modular offering continuing education credits for each module and that the prototype should be developed for either module 2 (manifestations and consequences) or module 3 (assessment).

Slatin, whose expertise is in workplace violence policy, expressed a different view, stating that organizational and policy responses are the only ways to enact real change in workplace violence.

"I find this syllabus to be overly clinical in its orientation, which lends the curriculum to a focus on individual action rather than organizational response. If the goal is to prevent healthcare workplace violence and its consequences, then the emphasis needs to be on organizational action."

Step 3: Focus group review of draft curriculum

Concurrent with the expert review, three focus groups of registered nurses reviewed the curriculum. They were recruited through the Massachusetts Nurses Association (MNA) and Massachusetts Association of Registered Nurses (MARN), each of which emailed our recruitment flier its members. One focus group consisted of front line nurses (n=7), one of nurse educators (n=8), and one a mixture of both (n=7). Participants represented a range of practice disciplines and professional roles including psychiatric, perioperative, anesthesia, labor & delivery, oncology, full-time faculty, associate faculty, clinical nurse specialist, staff nurse. Due to the strong interest in this topic, recruitment was easy. All focus groups were filled within days and several individuals were placed on waiting lists.

Table 1. Characteristics of Focus Group Participants

Form of Participation	Staff Nurse	Nurse Educator	Male	Female	White	African American	Asian	Age Range
Group 1 – front line nurses	7	0	0	7	6	1	0	47-62
Group 2 – nurse educators	0	8	1	7	8	0	0	44-65
Group 3 - mixed	4	3	0	7	6	1	0	50-61

TOTALS	11	11	1	21	20	2	0	Avg = 54
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Each focus group member was emailed a copy of the proposed curriculum and focus group review guide several days in advance of their meeting so they would have time to digest the material. The investigators believed that this would lead to more meaningful and thoughtful discussion during the limited 2.5-hour session compared with having their first exposure to the content occur at the focus group. The focus groups were conducted by Craine and Dr. Hoff who was also available afterwards in case a member might have an emotional reaction to the content or recall a traumatic event. Focus groups were audio recorded to facilitate transcription. Individuals were not identified on either the recording or the transcription.

Results of Focus Group Review

Key findings from the formative focus groups included:

- Workplace violence and abuse is an important topic that affects many nurses.
- There is wide disparity in views on what constitutes violence and abuse in the workplace and what may be appropriate responses to such incidents across differing clinical scenarios.
- Lateral violence between co-workers, including bullying and verbal abuse, was of major concern to all participants.
- Nurses want to learn what they, both individually and as a group, can do to reduce incidence of workplace violence and abuse.
- Nurses fear being blamed for acts of violence even when they themselves are the victims. Nurses distrust management's motivations for policy implementation fearing that a failure to closely adhere to policy will create opportunities for nurse blaming.
- Nurses are not well informed around current policies and guidelines about workplace violence.
- Nurses feel that patients' rights often supersede nurses' rights and that this can have a detrimental impact on workplace safety.
- Nurses feel that conflicts between doctors and nurses are handled very differently (and inequitably) compared to conflicts between nurses.
- The ability to access this training outside of work is important due to concerns about privacy.
- Young nurses coming out of school need to be better prepared for the violence and abuse of the nursing workplace
- Module 6 Unit 1 (The Nursing Profession and Exploitation of Nurses in Historical Perspective) should be the first unit of the curriculum because it speaks to nurses about nursing.
- The program should speak to nurses specifically rather than all workers in healthcare settings.
- Each module of the training should stand alone and offer continuing education credits.
- The prototype should come from Module 3: Risk Assessment and Prevention.

The formative process deviated somewhat from the original research protocol which had called for key informant interviews followed by scripting and mockup of the prototype to be tested by focus groups. This change was made because upon completing the six module curriculum, the investigators felt a need for end user input at an earlier point in the process. Doing so would better ensure that time and energy spent developing a prototype script and storyboards would be appropriately well directed.

Step 4: Revise the curriculum

Following review of the draft curriculum by experts and focus groups, Craine and Hoff analyzed the responses and revised the curriculum to include these substantive revisions:

- Module 6: Violence Prevention in Historic and Human Rights Perspective was eliminated and its units were integrated into other modules. Specifically, Unit I: The Nursing Profession and Exploitation of Nurses in Historical Perspective was moved to the opening of Module 1 per the recommendations of our experts and focus groups. Unit II: Nursing and Public Action for Lasting Change and Unit III: Long-

term Strategies to Prevent and Reduce Workplace Violence and Abuse were incorporated into Module 5: Policy Issues in Workplace Violence.

- Module 3: Assessing Risk as First Step in Preventing Violence and Abuse was restructured into two tracks, one for nurse-patient violence (Type 2), the other for lateral violence (Type 3) to reflect the fact that assessment and response to these types of violence might differ considerably.
- Module 2 Unit 3: Connecting Roots of Violence to Crisis Outcomes was moved to Module 4: Crisis Intervention
- Numerous clarifications and examples were added throughout the curriculum.

Revisions to the curriculum continued to be made throughout the development of the prototype. As a result, the home page for the prototype reflects a total of six modules rather than the five modules named in the final curriculum outline. Given that the budget for graphics had already been exceeded and the inconsistency did not affect the evaluation, investigators elected to implement the design corrections in Phase II.

Step 5: Script the Prototype

The consensus of focus groups and experts was that we should develop the prototype from Module 3: Risk Assessment and Prevention. The instructional design team (Craine, Hoff, McElaney, Kornblith, Humenuk, VPG) discussed a range of clinical scenarios that might prove effective in conveying the key concepts of risk assessment. Consideration was given to whether the team should seek NIH program staff and IRB approval to interview victims of violence in order to draft a scenario based on an actual encounter or to craft a scenario based on Dr. Hoff's work. Time and cost constraints led us to choose the latter option. Considerations for the scenario included:

- It must be authentic for the end users, both visually and emotionally
- It must present an act of aggression that is undeniable yet not too violent to disturb most users or cause injury to the actors
- It must not use highly offensive language
- The antagonist should not be easily stereotyped
- The cast should reflect diversity in the workplace
- It must provide the necessary teaching points to demonstrate the key concepts of assessment
- It must be executable given our budgetary and temporal constraints

Hoff developed a preliminary script for a scenario that presented an example of Type 4 violence (family member on nurse). Craine and Kornblith developed an instructional approach that organized dramatic scenes around key teaching points. Craine and Hoff then scripted the module's didactic narrative to complete the content of the prototype.

In the scenario, the husband of a patient in labor and delivery becomes verbally abusive to the protagonist nurse and eventually pushes her. The featured nurse then discusses the incident with a colleague and reflects back on the day's events looking for clues she missed that might have alerted her to the husband's potential for violence. The nurse then assesses the husband for dangerousness using protocols developed by Hoff.

Step 6: Script review

Next, the script was reviewed for accuracy and authenticity by expert Nachreiner and two nurses, Julie Malen, a front line labor & delivery nurse at St. Elizabeth's Hospital in Boston and Jennie Tardie, a labor & delivery nurse manager at Boston Medical Center. All reviewers felt that the scene of violence and events leading up to it were realistic. Tardie thought that the violence wasn't extreme enough and that most nurses would just shrug it off due to the stress of the moment. Malen, interestingly, felt the scenario pointed to domestic violence in the patient's home life and therefore felt that our nurse protagonist should have taken more specific actions to report her concerns and to help her patient. Domestic violence screening is now standard practice in hospitals seeking accreditation from the Joint Commission and several states mandate the reporting of domestic violence injuries to police. All reviewers suggested that the level of assessment of the husband demonstrated by our protagonist would be unrealistic in their hospital environments given the demands on the nurse and that they would refer the assessment to a social worker. Reviewers acknowledged that this might not be an option in all hospitals.

Since the purpose of the module was to demonstrate assessment strategies, Craine and Hoff revised the script to have the primary assessment performed by a social worker. This approach would retain the assessment demonstration but take the focus off of the nurse. They also drafted a new, additional scene between the protagonist and coworker to suggest other possible intra-organizational strategies.

1.3.2 Results: Prototype

Using the revised scripts, the production team began preparing various elements of the prototype. Craine drafted technical specifications for the prototype and worked with Vida's graphic designer to develop a clean and functional home page and module user interface. Two design concepts were created in Adobe Illustrator® and then reviewed by all members of the research team and a final design selected. The designs were then forwarded to VPG and rendered in Flash®.

The production team (McElaney, Humenuk, Hutchinson) began preproduction activities which included casting for the four dramatic roles, location scouting and scheduling of production personnel and activities. Production took place in a room on the labor and delivery floor of Brigham and Women's Hospital in Boston. A *verité* / documentary approach using a single, hand-held camera was used to lend authenticity and immediacy to the dramatic scenes.

Humenuk and McElaney reviewed the hours of raw video and edited them in Final Cut Pro® down to five short sequences consistent with the script. Craine reviewed the sequences and Humenuk made the appropriate revisions. Humenuk and Craine then went through the raw video to build a library of still images for use in the program. Craine edited and formatted the images in Adobe Photoshop®. Humenuk recorded the voice-over narrations for the program and edited the audio files. All assets were forwarded to VPG for integration into the prototype. With the assets in place, several rounds of quality assurance testing were required to prepare the prototype for evaluation.

The final result is a 34 screen prototype consisting of a home screen, 21 main content screens and 12 activity answer screens drawn from Module 3: Risk Assessment. The prototype features a video case study presented in five acted video sequences, each supporting a section of the didactic narrative. Three interactive user activities ask the learner to select from a menu of actions based on knowledge they accrue as they move through the prototype.

A copy of the prototype can be found on the disc accompanying this application.

1.3.3 Results: Summative Evaluation of Prototypes

The primary objectives for evaluating the prototype were:

1. To test learner response to the use of acted case study scenarios to support the module's learning objectives;
2. To test the user interface design (UX) including layout of screen elements, color palettes, screen controls, and navigation scheme with target users.

It must be noted that the prototype is not intended to be a complete module on workplace violence assessment which would have consumed a great deal more time and resources than were available for this Phase I.

Summative Review by Panel of Expert Consultants

Research Director Morrill developed a reviewer's guide for the expert consultants that included a hyperlink to the on-line prototype. Sample questions included:

1. What is your overall reaction to the Home Page design? ... to the Module 3 pages design?
 - a. Visual appeal; Color palette; Layout; Images
2. How was it navigating the site? (aside from the fact that many pages are inactive)
 - a. to and from the home page; to the active module; within the module
3. How well does the module cover the topic? What would you add or omit?
4. Does the content flow make sense? Why or why not?

Expert Bain said *"Overall I think the program and Module 3 are excellent. Easy to follow, narrative and acting appropriate to the setting. BRAVO, best on- line education I have ever seen."*

Nachreiner also liked the prototype but found that her internet connection was not fast enough to offer a satisfactory user experience.

"Most of the problems I ran into were because of the delay in loading the video or narrative, and perhaps this can be taken care of with specifying exactly what kind of system settings are necessary, and connections etc. It was frustrating to be waiting for things to load, so I would read ahead, then the video would be ready, and I was ready to move on."

Expert Slatin again focused his comments on the policy portion of the final curriculum suggesting that the research team could benefit from adding an expert in healthcare workplace violence policy. He recommended Jonathan Rosen of the New York State Public Employees Federation who has been added to our Phase II team.

Summative Review by Users

Summative focus groups resembled the formative focus groups in most regards.

Sample. Participants were drawn from the same individuals who took part in the formative focus groups and interviews. Although they are likely to have been influenced by their prior participation, on balance – given that we did not plan to draw statistical inferences from the data of small focus groups – we concluded that their input would be more valuable because they had already devoted considerable thought to the topic. Retention was excellent in that all of the providers who took part in a formative focus group attended one of the two summative focus groups. At this point it was no longer deemed necessary to hear separately from the nurse-educators, so the groups mixed these roles.

Procedures. Vida's Director of Research, Morrill, served as focus group leader and created the Focus Group Leader's Guide. Investigators considered whether to let focus group members review the prototype in advance to give them more time to reflect on it. They decided against this option for several reasons. First, there was no way to ensure that all focus group members would have the time, access or inclination to view the program prior to the focus group. Second, because the prototype was not completely functional, the investigators were concerned users would focus on the non-functional elements rather than those elements they wanted to evaluate. It was decided that Dr. Morrill would provide a guided review using a computer attached to a projector.

Each focus group began by viewing the entire prototype. Members were asked to reflect upon the content of the prototype given their own experiences. Dr. Morrill then used the Leader's Guide to lead the discussion. Vida production staff were not present so that members would be at liberty to share their perceptions of the prototype. Proceedings were audio-taped and transcribed to written form. Participants received a stipend of \$100.

Measures. Sample questions included:

1. How appropriate is the approach for you?
2. Is the content at an appropriate level?
3. How well does the program grab your interest?
4. What do you think of the layout? ... the navigation controls?
5. How do you react to the narrator? ...the characters?
6. How realistic or believable is this scenario?
7. Is there anything in the prototype that bothered you or annoyed you?

Results.

Presented here are the key findings from the focus groups related to the objectives of the summative evaluation. It must be reiterated that the prototype is not a complete module on workplace violence assessment. In their zeal to discuss this program, focus group participants were eager to move beyond the scope of the evaluator's questions to discuss what they felt was lacking in the prototype. Most of their suggestions address items that were already included in the five module curriculum and will find their way into the final program.

Overall reaction to the prototype:

- Both focus groups conveyed clearly positive responses to the training module. *I think it's a great program... Seemed real; grabbed our interest. This is a great learning experience – great discussion points.*
- There was agreement that the prototype predicts an excellent training for a wide variety of nurse audiences in settings ranging from nursing schools to in-service continuing education offerings. *Every hospital has a competency review for JCAHO; this would be fantastic for annual review... Would have a value for hospital administrators to help them understand what nurses go through...Also for use in nursing schools.*
- Focus group participants understood the tool's potential to be mediated individually at any time, at work or at home, and also in facilitated small and large group learning situations.
- Participants objected to the use of the term "training" in the program title, preferring "education" instead.

Objective 1: Test Use of Acted Case Study Scenarios to Support Learning Objectives

- Response to the use of dramatic enactments in a case study approach was positive: *It's all there in the opening scene; caught my attention very quickly... I really liked the case scenario – it felt real.*
- All participants like the use of the dramatic enactments to illustrate case studies. Some found the use of flashback as a discovery device to be confusing *It's confusing to do it in this order; it would be helpful to see how the events escalate in order.*
- Participants recognized and appreciated diversity represented in the casting of the actors: *I liked the inclusion, diversity and persona of the nurse.*
- Most participants found the acting convincing although some pointed to spots where they felt there was *a bit of a soap opera feel.* Ironically, most criticism was leveled at the one true nurse in our cast.

Objective 2: Test User Interface Design

- Participants liked having the capacity to navigate easily through the screens and know where one is at all times. *"Controls are great; like the 1 of 24."* A few expressed a preference for left hand navigation.
- Subjects tended to find the screen layout busy, in particular the title bar and text at the top of the screen and offered a variety of helpful suggestions for streamlining such as removing the copyright information, providing the opportunity to increase/decrease text size, having the controls disappear when appropriate.
- Participants felt that the imagery and colors of the home page depicted an emergency department and expressed a preference for use brighter colors and images that suggested interpersonal actions.

One of the more interesting focus group results was how the groups began to critique the behaviors of the nurse protagonist in the video sequences even as they affirmed the veracity of her character. *We would never do that in family centered care...she's right in his face, it looks like a cockfight is about to breakout...I know lots of nurses like that.* This confirmed for the investigators the strengths of using video to model behaviors in order to foster lively group discussions.

1.3.4 Results: Plan for Phase II

Production, Evaluation, Marketability, Distribution

Based on the results of the prototype review, the following improvements to the prototype will be implemented in Phase II:

- Provide an instructional design that presents theory followed by case study to reinforce learning
- Introduce more interactive learning elements
- Further reduce file sizes to promote faster loading of the videos and images
- Use less narration and more text to facilitate faster learning styles of educated adult learners

- Develop a more open screen design for better legibility of text
- Utilize images and color palettes that relate to interpersonal communications

In addition to recruiting workplace violence policy expert Jonathan Rosen, the investigators have added Martha Griffin, PhD, Director of Nursing Education and Research at Boston Medical Center and an expert in lateral violence in nursing, and Jane Lipscomb, PhD a professor at University of Maryland School of Nursing and recognized researcher and expert in nursing workplace violence. The investigators have also assembled a permanent five-member advisory panel of Boston-area nurse-managers and educators to serve as a sounding board for all program design decisions.

In Phase II the curriculum will be completed and the web-based learning and Workshop Leaders Toolkit produced. The plan to evaluate the educational program is set forth in Section 5 of the Phase II application which also includes a detailed Commercialization Plan.

1.3.5 Importance of findings

Phase I findings reveal that experienced nurses are highly interested in the topic of workplace violence and particularly lateral violence. They feel it is a topic that is not discussed enough among nurses but affects all nurses. Young nurses just starting their careers should be prepared for the realities of workplace violence and be equipped with basic skills for handling incidents. Nurses believe the patient-centered care model has the potential to undermine their authority and places them at greater risk for violence. As a result, nurses may distrust the motivations of management for implementing new policies which some may view as creating new opportunities for nurse-blaming. Nurses believe that the personality traits that led them to become nurses play a role in their acceptance of violence as “part of the job” of nursing. A comprehensive educational program for nurses about workplace violence will offer nurses an understanding of the factors influencing nursing workplace violence, help them develop the skills necessary to cope with and respond to workplace violence, and offer them long term strategies for organizational change.

1.3.6 Changes in specific aims since initiated

There were no changes to the specific aims laid out in the Phase I submission.

1.3.7 Inclusion Enrollment Report – See Appendix 11

1.4 Technology developed

This research adapted existing web and Flash® video technologies to deliver an innovative media-rich training in a format generally accessible to the target audiences of hospital-based registered nurses.

1.5 Current status of the product

The product is currently under development. A curriculum for registered nurses has been developed and a prototype web-based learning module demonstrating a baseline instructional design concept has been produced and tested.

1.6 Status of FDA approval

N/A

1.7 Company benefit

This and other SBIR research projects have benefited Vida Health Communications through: 1) developing our expertise in important issues of public health; 2) allowing us to turn our skills toward helping underserved populations we have yet to reach with media training; 3) enabling us to partner with other leading researchers and experts in this field of study; 4) development of our staff in terms of their knowledge and understanding of important health issues; 5) enabling us to develop effective public health interventions that might easily be overlooked by a purely commercial enterprise; 6) enabling us to address health topics and areas of need that might not offer a rapid return on investment; 7) allowing us to help support and ensure the dissemination of important public health research being conducted by other researchers; 8) adding to the credibility of our research and public health interventions; 9) stabilizing company cash flow and job retention.

1.8 Name of resulting product, process, or service

Workplace Violence Training for Nurses

1.9 Current number of employees

The total full time equivalent number of employees is six.

Publications

(none)

APPENDICES

A1: Initial Curriculum Draft.....	20
A2: Expert Panel Review Guide Formative.....	28
A3: Summary of Expert Review Formative	29
A4: Focus Group Guide Formative	34
A5: Summary of Focus Groups Formative.....	35
A6: Revised Curriculum.....	37
A7: Prototype Screen Grabs.....	47
A8: Expert Panel Review Guide Summative.....	49
A9: Focus Group Leader's Guide Summative.....	51
A10: Summary of Focus Groups Summative.....	57
A11: Inclusion Enrollment Report	60

Appendix 1
Workplace Violence Training for Nurses
Initial Curriculum Draft

Course Description

This web-based course addresses theory, practice, and policy implications of the growing problem of violence and abuse experienced by nurses in the workplace. Emphasis is placed on violence prevention, and the immediate and long-term health and safety of front-line nurses.

Major concepts include:

- sociocultural and individual roots of violence, abusive, and bullying behavior;
- prevention strategies;
- appropriate responses to injured workers and their perpetrators;
- work environment factors associated with violence;
- the health and social ramifications of violence for both victim/survivors and perpetrators;
- social change strategies aimed at institutional health and safety policies and protocols that promote the well-being of nurses and, by extension, the quality of patient care.

The course is structured into the following six major areas of study:

Module 1: The Roots and Manifestations of Workplace Violence and Abuse

Module 2: Consequences of Workplace Violence and Abuse

Module 3: Risk Assessment and Prevention

Module 4: Crisis Intervention

Module 5: Policy and Legal Issues In Workplace Violence

Module 6: Violence Prevention in Historic and Human Rights Perspective

Each module is further divided into two or more Units. Longer Units, such as those anticipated in Modules 3 and 4, will be further subdivided into Sessions, so that each can be completed in a 20 minute block. At the end of each Unit, students will be asked to complete a short evaluation.

Upon satisfactory completion of the entire course, students will be eligible to apply for continuing education credits. It is expected that this complete course will qualify for 6-8 contact hours.

For the purposes of this Phase I prototype, only one Unit or Session (to be determined) will be produced in its entirety.

Instructional Design Framework and Conventions (for discussion and development)

- Unit opens with a compelling video sequence, such as a personal tale of violence or an expert testimonial, appropriate to the topic.

- Text and image presentation (with voiceover narration) of primary topic content supported by video expert testimonials and examples.

- Exercises for students to apply theory to simulated practice situations drawn from key informants, front-line nurses, and research.

- Evaluation

Module 1: The Roots and Manifestations of Workplace Violence and Abuse (weight=10%)

Key Questions: Why, among many health workers, are nurses at such high risk of violence and abuse? How does knowing the ORIGINS of a problem influence action outcomes?

Learning Objectives:

1. Identify the interrelated roots of violence, or factors explaining the occurrence of workplace violence.
2. Describe how knowledge of these factors forms the groundwork for targeted action to prevent violence and abuse.
3. Identify the major types of violence, crossover factors among types, and intersection with bullying behavior, verbal and emotional abuse.
4. Examine the Crisis Paradigm (Hoff 2001) as basis for prevention and intervention.

Unit I: Intersecting Factors Influencing Workplace Violence and Abuse:

- Individual
 - o Stress, history of childhood abuse or neglect, history of domestic violence
- Sociocultural
 - o Gender stereotyping and socialization into aggressive or submissive role behavior; domestic violence spillover to workplace
- Political Economy
 - o e.g. - Institutional "bottom line" profit margins and management decision to shortchange investment in worker health and safety through inappropriate staffing ratios and inadequate physical security measures.
- Recognizing intersecting factors in specific workplace scenarios with violence potential:
 - o e.g., bullying and assaultive behavior, verbal and emotional abuse

Unit II: Types and Manifestations of Violence as Foundation for Prevention Strategies

- Type I - Criminal Intent:
 - o e.g friend of injured gang member enters Emerg. Dept. with gun and threats to staff.
- Type II - Customer/Client:
 - o e.g. patient in substance abuse treatment insults, then strikes nurse after discussion of treatment protocol.
- Type III - Worker-on-Worker:
 - o e.g. supervisor blames injured staff nurse for her "incompetence" in not detecting patient's violence potential; fails in appropriate post-incident support, implies there's something wrong with her, and advises nurse to "seek counseling" vs. assisting with reporting the abuse.
- Type IV - Personal Relationship,
 - o e.g. abusive husband follows wife to hospital Labor and Delivery, threatening spouse and nursing staff
- The public face of violence, abuse and bullying
 - o e.g., hitting, biting, spitting, cursing, threats to harm, calling names, putting a person down, public correction for mistakes
- Management's legacy of "blaming the victim"
- Abuse and violence viewed by workers and management as "part of the job"

Unit III: Connecting Roots of Violence to Crisis Outcomes

- Crisis Paradigm (Hoff 2001, p. 18) See attached
- Abuse and the Downward spiral: societal and other victim-blaming (Hoff 2001, 45) See attached.

Module 2: The Consequences of Workplace Violence and Abuse (weight=15%)

Key Questions: What happens to the abused nurse—personally and professionally? How is this connected to quality of patient care?

Learning Objectives:

1. Describe the typical responses to abusive or assaultive behavior
2. Identify epidemiological and socioeconomic outcomes of workplace violence.
3. Distinguish between “professional duty,” violence and abuse as “part of the job”, and healthy/unhealthy crisis responses.
4. Demonstrate application of forensic psychiatry principles in response to perpetrators and survivors of workplace violence.

Unit I: Typical Personal Responses to Violence and Abuse (see Crisis Paradigm)

- Biophysical stress response
 - o hyperventilation, sweating, hives, nausea, diarrhea, involuntary shaking
- Emotional
 - o fear, anger, anxiety, guilt, shame, flight-fright impulse
- Cognitive
 - o interference in usual problem-solving ability, inability to concentrate
- Behavioral
 - o avoiding usual social interaction; leaving work early to avoid further danger, hazardous driving as result of upset and high anxiety
- Recognizing in self and others the distinction between “normal” and “unhealthy” or dangerous responses to injury
 - o Striking back; self-blame; misguided acceptance of abuse as “part of the job”; taking overdose of pills. [Maybe adapt Table 3.3., in Hoff, 2001, p. 86 to crisis episode in workplace.... Effective and Ineffective Crisis Coping]
- Identifying “zero tolerance” and assertive behavior vs. retaliatory and punitive responses to violence

Unit II: Epidemiological and Socioeconomic Consequences of Workplace Violence

- morbidity and mortality rates resulting from victim-blaming and “downward spiral”
- effects on quality of care (injured, unhealthy nurses cannot perform to standards of care)
- economic and “bottom line” impact of neglecting workers’ health and safety

Unit III: Accountability, Excusing, and Victim/Survivor Healing Process

- Basics of “forensic psychiatry” in workplace violence context
- Legal and mental health grounds for excusing violence and abuse
- Emotional healing process for victim vis-a-vis cognitive status of abusive patient
- Agency policies regarding accountability for violent behavior
- Eliciting support and learning to “break the silence”
- Making “personal injury” a “public issue” for response by reporting
- Assessing adequacy and nurses’ knowledge of reporting protocols
- Engagement of front-line nurses at policy and institutional management level re- intersection between healthcare and criminal justice measures on behalf of those with potential of danger to others.

Module 3: Assessing Risk as First Step in Preventing Violence and Abuse (weight=30%)

Key Question: How can nurses reduce the incidence of workplace violence and abuse through informed use of clinical and other research evidence regarding risk of assault and homicide? (See Crisis Paradigm, Box 2)

Learning Objectives:

1. Identify factors to recognize in practice as danger signals for violence and abuse.
2. Apply screening and risk assessment strategies using structured protocols and interview skills in typical workplace scenarios with clients, co-workers, and supervisors.

Unit I: Risk Assessment Criteria

- No scientific basis for absolute “prediction” of violence
- Much evidence-based data for assessing immediate danger
 - o Statistical/demographic factors: Limited relevance in individual situations
 - o Personality factors: motivation, aggression, inhibition, habit
 - o Situational factors: e.g., possession of weapon, behavior of would-be victim
 - o Interaction between these variables.
- Interface between healthcare and penal institutions regarding treatment of patients with criminal as well as mental illness histories).

Unit II: Prevention Tactics in Potentially Dangerous Situations

- Recognize verbal and non-verbal cues to threatening and violent behavior; e.g., “If I can’t see my family (or be seen by the doctor) NOW, you’ll be sorry.” Throwing things; trying to grab a nurse.
- Verbal response tactics, e.g.: “I know you’re upset... I’m doing the best I can to take care of you, and I really won’t tolerate your speaking to me like that.” Don’t argue with patient.
- Behavioral: e.g., Stay close to the door; press security button; call for help.
- Rely on team work and social support, ALWAYS report what happened.
- Power and dis-empowerment issues.

- Overall, patients are “one-down” vis-a-vis health providers’ power, and often feel intimidated in healthcare settings, especially by staff using their authority for power and control.
- Violence by definition is an abuse of power
- Authoritarian attitudes by healthcare providers may incite abuse or assault as a patient’s response to feeling helpless and dis-empowered, or to their perceived treatment in an abusive or disrespectful manner

Unit III: Apply Risk Assessment Criteria to Typical Clinical Scenarios

- using established communication and behavioral strategies in the nurse-patient relationship
- Risk-to-life Screening Tool for use in hospital triage (Hoff & Rosenbaum, 1994—connects victimization, homicide and suicide risk factors—to be attached)
- Assessment Scale to Assess Immediate Dangerousness to Others (see Hoff 2001, page 293)
- Apply risk assessment criteria using the Assessment Scale in Type 2 and Type 4 violence scenarios in the workplace.

Module 4: Crisis Intervention in the Workplace (weight=20%)

Key Question: What are the basics of crisis intervention that every nurse should know – i.e., the Crisis Paradigm, Box 3?

Learning Objectives:

1. Identify and apply in selected examples the emergency measures and crisis care that should be available to victim/survivors of violence and abuse in the workplace.
2. Describe and apply to examples the longer-term service and compensation needed by some injured nurses.

Unit I: Emergency and Crisis Intervention in Situations of Immediate Danger

- non-injurious physical prevention and intervention strategies
- if physical restraint is necessary, follow established agency protocol, including respectful communication with patient about why physical restraint is being used.
- apply protocols for debriefing of assault survivors, including other patients

Unit II: Crisis Counseling and Follow-up Service for Victim/Survivors

- Coordination of institutional employee counseling service with outside providers
- Loss, change, and grief work (in event injury requires job change)
- Coping with possible mis-placed guilt for a perpetrator held legally accountable
- Classic crisis counseling: Addressing Emotional, Cognitive, and Behavioral facets of Positive crisis resolution (See Crisis Paradigm, Box 4a)
- Engage with agency re- just Workers Compensation in event of disability from injury

Module 5: Policy Issues in Workplace Violence (weight=10%)

Key Questions: How do agency policy and NIOSH standards influence the incidence of violence, administration response when it occurs? How are front-line nurses engaged in drafting and enforcing NIOSH standards and agency policies?

Learning Objectives:

1. Examine health and safety policies and protocols in a selected (or simulated) health agency for adherence to NIOSH standards of workplace safety.
2. Identify strategies nurses can employ with administrators responsible for policy to ensure adherence to national and local safety standards.

Unit I: NIOSH and JCAHO Standards for Worker Safety

- Criteria and clinical protocols (as per JCAHO accreditation) for routine screening of patients for history and current risk of violence.
- Staff training on NIOSH standards and individual agencies' policies for employee health and safety.

Unit II: Training on Standards, Enforcement, and Diversity Issues

- Clear policies, training, and mechanisms for enforcement of policies in event of life-threatening violence.
- Clear and consistent policies for reporting violence and abuse, including assurance of job security and non-retaliation against employees who do report.
- Strategies and training assuring the protection of nurses and others more vulnerable to violence and abuse on various diversity grounds, e.g., immigration status, gender, race.
- Mechanisms publicly known and available to all nurses to assure front-line nurses inclusion in agency policies regarding violence and employee health and safety.

Module 6: Violence Prevention in Historic and Human Rights Perspective (weight=15%)

Key Questions:

Why has the healing profession of nursing been subject to exploitation, abuse, violence—and even burning at the stake with witches in the Middle Ages (Ehrenreich & English, 1973, *Witches, Nurses, and Midwives*)—over centuries through the current era? As the largest well-educated professional group among healthcare providers, why are nurses (and the assistants they supervise) the majority of assaulted and emotionally abused workers?

Learning Objectives:

1. Examine gender issues and the “culture of nursing” as contextual features of nurse abuse and a factor in “nurse shortage”.
2. Critique a trainer-training toolkit that nurse trainers and educators can use to address Modules of this Syllabus in Continuing Education and related contexts.

Unit I: The Nursing Profession and Exploitation of Nurses in Historical Perspective

- nursing historically defined as “extension of mother role” and “women’s work”
- gender roles and expectation of subservient attitude and role; e.g., some sociologists have defined nursing as a “semi-profession”
- “culture of nursing” and oppressed group behavior, e.g., silence as consent.

Unit II: Nursing and Public Action for Lasting Change

- Individual and group reflection on status of nursing
- Public display of reasons for nurse “shortage” vis-a-vis work environment conditions
- Self-care strategies, e.g., impact on health by adaptation and acceptance of status quo
- Basic human rights and workers’ rights, e.g., for nutrition and bathroom breaks, and just compensation for workplace injury.

Unit III: Long-term Strategies to Prevent and Reduce Workplace Violence and Abuse

- Social change strategies
- readiness for change;
- rational discourse regarding facts of violence and workplace risks;
- moral persuasion tactics, i.e., protect workers because it’s the right thing to do;
- power tactics, e.g. organizing, work stoppage, etc.
- Distinct but inter-connected action change
- by individual nurses,
- healthcare agency administrators,
- by nursing professional organizations,
- by nurse educators in universities and colleges preparing nurses.
- Education’s role: Nursing students’ right to formal education regarding violence and violence prevention BEFORE entering the practice arena, e.g., AACN (American Association of Colleges of Nursing) Position Paper (1999) re- violence issues as essential curriculum content.

Appendix 2
Workplace Violence Training for Nurses
Expert Review Guide - Formative

Instructions

1. Please first read through the attached MS Word file called 'Proposed Course Outline.doc'
2. Read through the course outline again, this time thinking about the questions below and how they relate to the audience of practicing RNs who would be taking this course. You may type your comments directly into this document and email it back to us.
3. Complete the stipend reimbursement form, sign and fax it back to us at 617.864.4334

Questions

1. Thinking about the course outline as a whole, what is your general impression regarding:
 - relevance of the subject matter
 - stated objectives for the training
 - comprehensiveness of the course as proposed
2. Thinking about Modules one through six, what suggestions do you have regarding each of the modules with respect to:
 - Weight given to each module relative to the complete course
 - Topics covered
 - What have we missed?
 - What have we overemphasized, underemphasized?
 - Organization of content
 - Does the course content flow logically?
 - Are there opportunities to expand, condense or combine units, topics, modules?
3. In our Phase I research, we will be producing a prototype of one 20 minute unit or session. Among these 6 Modules, which do you suggest we select as the Prototype for this project? Why? Provide rationale based on experience.
4. Can you offer any additional ideas or suggestions for successful completion of this project?

Appendix 3

Workplace Violence Training for Nurses Summary of Expert Review Formative

EB = Evie Bain

NN = Nancy Nachreiner

CS = Craig Slatin

1. Thinking about the course outline as a whole, what is your general impression regarding:

relevance of the subject matter –

EB: I think the course is excellent as it expands on previous educational offerings related to WV and Abuse Recognition and Prevention strategies

NN: I think this is an incredibly important topic, for a high risk population, and with exposures that result in very serious consequences. I think the ideas are very interesting.

CS: Relevance: Workplace violence is a serious problem in healthcare, particularly for nurses and nursing assistants. Therefore, education and training about workplace violence is an important measure in overall efforts to prevent workplace violence in healthcare settings.

stated objectives for the training

EB: 1 – 3 are straightforward and easily understood

comprehensiveness of the course as proposed

EB: excellent, thorough and easily understood, concepts straightforward

CS: This course is surprisingly weak in discussions of workplace violence prevention programs, an essential element for preventing risk and harm. No government standard for workplace violence prevention exists. California OSHA, federal OSHA, and NIOSH all have guidelines.

2. Thinking about Modules one through six, what suggestions do you have regarding each of the modules with respect to:

Weight given to each module relative to the complete course

EB: Not sure how this was derived, length?, complexity? Since all modules are essential to understanding the problem, why not give equal weight...maybe it is an academic issue that I am not aware of

Topics covered - What have we missed?

EB: Although we are focusing on violence against nurses and other caregivers, I think there should be some emphasis on the patient a victim of vicarious traumatization.

NN: Module 1 - I think the other key here (and in some of the other modules) is to address why so often nurses accept this as "part of the job." Prevention, policies, etc. are hard to implement when there is a lack of buy-in from the groups that violence should not simply be accepted.

CS: Module 2: 1st objective needs to make clear what is under consideration for "typical responses" – does this mean personal or organizational or both? It needs to be both and the emphasis should be on the organizational since the goal should always be appropriate followup, treatment, and then prevention, and that requires organizational responses. The units show that only the personal was intended. That may be appropriate for this module, but that means another module is needed to focus on organizational responses.

Module 2: 2nd – I think "epidemiological" is not the correct word/concept. I think what is meant here is the concept "adverse health outcomes" "Identify adverse health and socioeconomic outcomes of workplace violence."

Module 3: I would prefer to see this chapter address not only how nurses themselves using research and public health evidence to reduce the incidence of workplace violence, but how risk assessment is to be applied by the organization to determine appropriate workplace violence prevention measures – not just reduction. I think that this training will be a lot more interesting and useful if instead of having a clinical orientation it presents an organizational change orientation. There is plenty of room in the latter orientation for discussions about individual clinical practices to avoid exposure to violence. But, what nurses, as workers, need to understand is how they can be change agents in the healthcare work environment.

Module 4: I would add another objective – Understand how crisis intervention protocols and procedures are essential elements of a workplace violence prevention program, and how to incorporate them into such programs. Every module should relate to the need to establish a comprehensive workplace violence prevention program.

Module 5: Insufficient coverage of violence prevention program development and implementation. Unit 2 begins to address these (federal & state guidelines), but in what appears to be a vague and almost clinical way. I suggest that this module be organized around the components of recommended violence prevention programs, and that it include discussions of how nurses can push to accomplish development and implementation of programs that are facility specific and based on these guidelines. This module should have a discussion about the important role of labor unions, giving examples of how unions in New York and Massachusetts have worked to pass legislation that mandates healthcare workplace violence prevention measures (law in NY and proposed legislation in MA). Key elements of Workplace Violence Prevention

Programs include: 1) Management Commitment and Employee Involvement; 2) Risk Assessment / Worksite Analysis; 3) Hazardous Prevention and Control; and 4) Recordkeeping and Evaluation. An example of an exemplar program could be included in the curriculum.

Additional objectives for this module should include: Examine examples of legislative strategies to establish violence free healthcare workplaces – looking at the NY law to protect state workers and the legislation proposed by the Massachusetts Nurses Association.

Also, Understand and be able to apply the various government and JCAHO guidelines for comprehensive healthcare workplace violence prevention programs.

Also, Examine the role of nurse and healthcare worker unions in promoting state, national, and facility level policies and protocols for preventing healthcare workplace violence through comprehensive violence prevention programs.

Module 6: Although there is documentation of historical abuse of nurses, the level of injury seen in healthcare today is unprecedented at least in the history of healthcare since the late 19th century. This module needs to address the healthcare system restructuring of the past 25 – 30 years in order to help students understand the primary political and economic determinants of existing healthcare workplace violence.

What have we overemphasized, underemphasized?

EB: From what I have read, you are right on...

CS: I find this syllabus to be overly clinical in its orientation, which lends the curriculum to a focus on individual action rather than organizational response. If the goal is to prevent healthcare workplace violence and its consequences, then the emphasis needs to be on organizational action.

Module 2, Unit III talks about the agency, but I would like to see a discussion of how the agency (healthcare provider organization) needs to be held accountable for preventing workplace violence.

Every module should relate to the need to establish a comprehensive workplace violence prevention program.

Organization of content - Does the course content flow logically?

NN: think about the most logical order for the modules, once more supporting information is in place. For example, first establishing why this is such an important topic (in general, then specifically for nurses), then consequences of violence, prevention, and the use of policies. The final step could be an example. This looks like a great start!

Are there opportunities to expand, condense or combine units, topics, modules.

EB: Would have to read complete text to determine this...only to add some patient outcomes as above. That will get the additional attention from nurses, nurse educators and h/c administrators as well as patient advocates.

CS: Module 6, Unit III may be more appropriate to be in Module 5. Otherwise, the organization seems ok.

NN: Regarding the order of the modules: I think it makes sense to start with the roots/manifestation of violence (perhaps Modules 1 and 6 could be combined, as they both look at the broader picture of violence), then you could describe why this is such an important problem for nurses (Module 2). After establishing why this is so important for nurses in Module 2, you could frame it as what can be done (Modules 4 and 5) regarding prevention & policies. Module 4 could then be more of a "practice" module, on how to apply these skills.

So the general format would be: Background of violence; why this is important for nurses, ideas on prevention/control of violence; and finally an example.

3. In our Phase I research, we will be producing a prototype of one 20 minute unit or session. Among these 6 Modules, which do you suggest we select as the Prototype for this project? Why? Provide rationale based on experience.

EB: Either **Module 2** – to get nurses, etc. thinking about a problem they deny exist or **Module 3** to instill a bit of risk assessment and prevention skills.

NN: (Your Question 3) I'd suggest on either focusing on **Module 2** (Consequences of Workplace Violence and Abuse) or **Module 3** (Risk Assessment and Prevention). First, I think these are really the two modules that will be of the most interest to practicing nurses, and second, I think this is where most of the research on work-related violence and nursing has been conducted. Module 2 can provide a good example that highlights WHY this is such an important issue, which I think would be a strength in submitting the next proposal. For example, in our work with the Minnesota Nurses' Study (Gerberich, S.G., Church, T.R., McGovern, P.M., Hansen, H., Nachreiner, N., Geisser, M., Ryan, A.D., Mongin, S.J., and Watt, G.D. (2004). An epidemiological study of the magnitude and consequences of work-related violence: The Minnesota Nurses' Study. Occupational and Environmental Medicine, 61, 495-503.), we described the variety of consequences for both physical and non-physical violence, including injury outcomes, symptoms, lost work time, persistent problems, etc. We also described how the consequences for non-physical violence appeared more severe than physical violence. Highlighting some of the known research on this topic would be very helpful. The second option (Module 3) on risk assessment and prevention may be particularly interesting to practicing nurses who are concerned about this problem in their work environment already, or anticipate problems could occur in the future. This might be the most helpful to give examples on what can be done to protect nurses, but I think there is less well-established research from comprehensive studies that can really document causation and effective interventions.

Can you offer any additional ideas or suggestions for successful completion of this project?

EB: Not sure if the plan is 6 modules with CE credits or 6 modules with college credit. If it is individual modules for CE, **individual credit per module might be a more appealing process rather than 8 hours on line.** I think the course is so well done, vital and interesting that it would not be a problem getting learners to come back for successive modules, especially if they had to work from 1 toward 6 rather than pick and choose a

module. I think an 8 hour commitment up front is huge in the light of the 2007 life and work environment. If the course is simply college credit, then the audience will return by requirement. Could it be both?

CS: Intended Audience. It is not clear who the audience is. Will this be a course for existing nurses or for students seeking a nursing degree? This course syllabus is more appropriate for the former group. I wonder the context in which a nurse would take this course if it is for working nurses, as professional training. If this is for students who have not necessarily entered the field of nursing but who hope to, then some changes may be needed so that a student unfamiliar with the clinical setting can understand the scenarios, questions, and general content being presented.

Unless nurses become well versed in the measures needed to establish violence prevention programs, the training will fall short of its goal of helping to prevent these problems.

Appendix 4
Workplace Violence Training for Nurses
Focus Group Review Guide Formative

1. General Impression: Please comment on your view of the course outline as a whole for its relevance

Probe: Overview, Objectives, Content, Comprehensiveness, Allocation of time per module

2. Module Critique: What suggestions do you have regarding specific modules?

Module 1

Module 2 [etc through all 6]

3. Prototype: Among these 6 Modules, which do you suggest we select as the Prototype for this Phase 1 project?

Probe: Why? Provide rationale based on experience

4. Additional ideas or suggestions for successful completion of this project?

5. Could you recommend a colleague who might contribute to this project by being interviewed individually as a Key Informant? If so, please inquire of this person and obtain permission for us to contact her/him by [date]

6. Violence and Abuse Training Scenario: If you have a story or experience of violence or verbal/emotional abuse in the Workplace (positive or negative) that might contribute to Learning Objectives in any of the 6 Modules, would you be willing to share this scenario with us for consideration? If so, please send us a brief description of same with names, demographics and other details altered for protection of confidentiality.

7. Wrap-up: Any additional comments or suggestions?

8. Evaluation: What is your assessment of the value of this proposed web-based training on the issue of Violence and Abuse in the Workplace?

Appendix 5

Workplace Violence Training for Nurses Summary of Focus Groups Formative

The three formative focus groups took place at Vida Health Communications on October 30, November 1, and November 5, 2007. One group consisted of front line nurses (7), one of nurse educators (8), and one of a mixture of both (7).

Overall Impression of the Outline

The overall reaction to the proposed curriculum for a Web-learning was positive among the three focus groups. Participants found the amount of information presented to be appropriate and the organization clear.

Many participants reacted negatively to the term “training,” suggesting instead using “education” or “learning.”

Participants requested more emphasis on public and institutional policy issues surrounding violence in the workplace. Additionally, they felt that the program should focus particularly on nurses rather than address the range of specialties represented in the workforce at health care settings.

Almost all participants emphasized that the topic of lateral (provider-on-provider) violence must be covered in greater depth. Many felt that bullying and verbal nurse-on-nurse violence is more harmful than physical violence because it is far more frequent and insidious. They reported that hospital administrations do not address lateral violence, and that hospital workers, in general, stay quiet about the topic despite its pervasiveness. Multiple respondents stated that this is the most important issue to address in a Web-learning program. *“I think that the staff that I deal with wants to talk about that extensively, wants to spend time reading about it, wants to hear everybody else’s stories.”*

Participants’ Thoughts on How Web-Learning Would be Used

The majority of participants reported that they would do the training at home, feeling compelled to take care of patients while at work. Additionally, they reported the need for privacy, as taking the course at work may cause concerns among coworkers or administration that they would rather not address. They reported that the only continuing education they complete at work are those mandated by their workplace.

Respondents indicated that the Web-learning may be used in a variety of settings, ranging from a teaching device in undergraduate or graduate programs, to train nurses already working, and as a pre-conference educational tool. Some reported that they envision the program used as part of courses supplemented by class discussion. Others imagined that nurses will use the program individually, completing the training module by module on personal computers. They expressed general doubt that hospital administrations would mandate this type of education.

Participants’ Critique of Curriculum

Module 1: The Roots and Manifestations of Workplace Violence and Abuse

Participants expressed the desire for: 1) a clear conceptual framework by which to understand and learn about workplace violence in health care settings; and 2) concrete evidence, practice guidelines, best practices etc. in the first module. They asked for more information on historical and cultural factors that affect levels and types of violence experienced in nursing. Participants also discussed the culture of hospitals and nursing and the ways in which nurses are expected to absorb abuse as part of their job. Generally, they felt that violence is a pressing, important and undiscussed issue that is not addressed enough in their workplaces: ... *“You know, if you question there’s sort of a bureaucracy that has enormous pressure on it every minute and then you’re expected to absorb a lot of internal violence.”*

Participants also discussed their sense that the culture of nursing is so patient-centered that harm to nurses is seldom addressed. *"The client is always right, the customer is always right. That's the mentality that we have."*

Module 2: Consequences of Workplace Violence and Abuse

Participants felt that information in Module 2 is what they believe administrators, especially, need to learn. They also felt that the module should be more nurse-specific, explaining why it is that nurses, in particular, experience the levels of violence that they do. *"Is there something in particular about the nursing setting? Is it that we have to deal with life and death situations and we are more brittle? Is it that the patients are more brittle?"*

Module 3: Risk Assessment and Prevention

Respondents agreed that Module 3 provided critical practical information. However, they felt that the key questions were too focused on patient-nurse violence while the content inferred other types of violence (i.e. nurse-on-nurse). Concerns were expressed that by teaching assessment techniques, the training may imply that nurses should be able to avoid all violence and thus be blamed in case of an incident. Additionally, multiple participants said that this information will be difficult to learn without interactive activities or role plays. They agreed that video would be the best alternative to actual role plays, especially if vignettes incorporated modeling of behavior (what to say and how to say it) for nurses.

Module 4: Crisis Intervention

Participants expressed concern with the hospital systems' disregard of violent incidents. Many agreed that while hospitals may have procedures for reporting violence, intervention, and follow-up, the fact is that in practice these are not generally made known to nurses.

Module 5: Policy and Legal Issues in Workplace Violence

Participants requested more information on hospital policies and wanted advice on how to learn and navigate their own hospital systems of reporting and handling violence. They also asked for links to professional organizations such as NACHRI, AORN, ANA, AWHONN.

Module 6: Violence Prevention in Historic and Human Rights Perspective

The response to Module 6 in all three focus groups was very strong and positive. The majority of respondents felt that Module 6 should be placed first in the training, as it struck them most as nurses. They felt that this module addressed the situation of nurses most specifically.

What to Create for the Prototype

The responses were split on which modules we should create for a prototype. About half of participants felt we should create Module 3, as it provided the most concrete and important information. Others felt we should produce Module 6 because of its strength in speaking most directly to nurses.

Appendix 6
Workplace Violence Training for Nurses
Revised Curriculum

Course Description

This web-based self-directed course addresses theory, practice, and policy implications of the growing problem of violence and abuse experienced by nurses in the workplace. Emphasis is placed on violence prevention, and the immediate and long-term health and safety of front-line nurses.

Major concepts include:

- sociocultural and individual roots of violence, abusive, and bullying behavior;
- identification, assessment and prevention skills and strategies
- appropriate responses to injured workers and their perpetrators;
- work environment factors associated with violence;
- the health and social ramifications of violence for both victim/survivors and perpetrators;
- social change strategies aimed at institutional health and safety policies and protocols that promote the well-being of nurses and, by extension, the quality of patient care.

The course is structured into the following five major areas of study with projected time allotments for each module:

Module 1: The Roots and Manifestations of Workplace Violence and Abuse (27-36 minutes)

Module 2: Consequences of Workplace Violence and Abuse (27-36 minutes)

Module 3: Risk Assessment and Prevention (54-72 minutes)

Module 4: Crisis Intervention (36-48 minutes)

Module 5: Policy and Legal Issues In Workplace Violence (36-48 minutes)

Each module is further divided into two or more Units of study, each of which can be completed in a single computer session. At the end of each Unit, learners will be asked to complete a short evaluation. Upon satisfactory completion of the entire course, learners will be eligible to apply for continuing education credits. It is expected that this complete course will qualify for 3 to 4 contact hours.

For the purposes of the Phase I prototype, the focus was on Module 3 as recommended by all of our formative focus groups. The prototype uses a single scenario of Type IV violence to illustrate key concepts of assessment and prevention from a clinical perspective. The framework used here for clinical assessment and crisis intervention is Dr. Hoff's Crisis Paradigm, a copy of which can be found attached for reference.

Due to budget constraints of Phase I, the prototype is not a finished Module. There may also be inconsistencies between it and this course syllabus. Therefore, the prototype should be viewed as representative of our intended approach to instruction.

Module 1: Background: The Roots and Manifestations of Nursing Workplace Violence and Abuse (27-36 minutes)

Key Questions:

- Why, among many health workers, are nurses at such high risk of violence and abuse?
- How does knowing the ORIGINS of a problem influence action outcomes?
- What factors influence workplace violence and abuse and how do they interact?
- How is workplace violence manifested?

Learning Objectives:

5. Consider the historical attitudes, roles and views of the nursing profession as contextual features of nurse abuse.
6. Identify the interrelated roots of violence, or factors explaining the occurrence of workplace violence.
7. Describe how knowledge of these factors forms the groundwork for targeted action to prevent violence and abuse.
8. Identify the major types of violence, crossover factors among types, and intersection with bullying behavior, verbal and emotional abuse.
9. Examine the Crisis Paradigm (Hoff 2001) as basis for prevention and intervention (copy attached)

Unit I: The Nursing Profession and Exploitation of Nurses in Historical Perspective

- nursing historically defined as “extension of mother role” and “women’s work”
- gender roles and expectation of subservient attitude and role; e.g., some sociologists have defined nursing as a “semi-profession”
- “culture of nursing” and oppressed group behavior, e.g., silence as consent.
- “Lateral Violence” – abuse between colleagues

Unit II: Intersecting Factors Influencing Nursing Workplace Violence and Abuse:

- Individual Factors
 - o Stress, history of childhood abuse or neglect, history of domestic violence
- Sociocultural Factors
 - o Gender stereotyping and socialization into aggressive or submissive role behavior; domestic violence spillover to workplace; open environment of hospitals and other healthcare settings; abuse and violence viewed by workers and management as “part of the job” ;
- Political & Economic Factors
 - o e.g. - institutional “bottom line” and regulatory considerations; management policies and decisions that may shortchange investment in worker health and safety; staffing ratios; inadequate physical security measures; level of support and compensation for injured workers; Management’s legacy of “blaming the victim”

- Recognizing intersecting factors in specific workplace scenarios with violence potential:
 - o e.g. bullying and assaultive behavior, verbal and emotional abuse; lateral violence

Unit II: Types and Manifestations of Violence as Foundation for Prevention Strategies

- The public face of violence, abuse and bullying
 - o e.g., hitting, biting, spitting, cursing, threats to harm, calling names, inappropriate touching, putting a person down, public correction for mistakes
- Type I - Criminal Intent:
 - o e.g. ER staff members robbed at gunpoint
- Type II - Customer/Client:
 - o e.g. patient in substance abuse treatment insults, then strikes nurse after discussion of treatment protocol.
- Type III - Worker-on-Worker:
 - o e.g. supervisor blames injured staff nurse for her "incompetence" in not detecting patient's violence potential; fails in appropriate post-incident support, implies there's something wrong with her, and advises nurse to "seek counseling" vs. assisting with reporting the abuse; bullying by peers
- Type IV - Personal Relationship,
 - o e.g. abusive husband follows wife to hospital Labor and Delivery, threatening spouse and nursing staff

Unit III: Connecting Roots of Violence to Crisis Outcomes

- Crisis Paradigm (Hoff 2001, p. 18) See Attachment A
- Abuse and the Downward spiral: societal and other victim-blaming (Hoff 2001, 45) Attachment B

Module 2: The Consequences of Nursing Workplace Violence and Abuse (27-36 minutes)

Key Questions:

- What happens to the abused nurse—personally and professionally?
- How is this connected to quality of patient care?

Learning Objectives:

5. Describe the typical responses to the trauma of violence and abuse
6. Identify epidemiological and socioeconomic outcomes of nursing workplace violence.
7. Distinguish between “professional duty,” violence and abuse as “part of the job”, and healthy/unhealthy crisis responses.
8. Demonstrate application of forensic psychiatry principles in response to perpetrators and survivors of workplace violence.

Unit I: Typical Responses to the Trauma of Violence and Abuse (see Crisis Paradigm)

- Biophysical stress response
 - o hyperventilation, sweating, hives, nausea, diarrhea, involuntary shaking
- Emotional
 - o fear, anger, anxiety, guilt, shame, flight-fright impulse; post-traumatic sequelae
- Cognitive
 - o interference in usual problem-solving ability, inability to concentrate
- Behavioral
 - o avoiding usual social interaction; leaving work early to avoid further danger, hazardous driving as result of upset and high anxiety
- Recognizing in self and others the distinction between “normal” and “unhealthy” or dangerous responses to injury
 - o Striking back; self-blame; misguided acceptance of abuse as “part of the job”; taking overdose of pills.
- Identifying “zero tolerance” and assertive behavior vs. retaliatory and punitive responses to violence

Unit II: Epidemiological and Socioeconomic Consequences of Workplace Violence

- morbidity and mortality rates resulting from victim-blaming and “downward spiral”; differential responses to physical and emotional abuse: consequences of emotional abuse often more serious, e.g. “my physical wounds are healed, but i’ll never forget the horrible things he said to me.”
- effects on quality of care (injured, unhealthy nurses cannot perform to standards of care)
- economic and “bottom line” impact of neglecting workers’ health and safety, e.g. experienced nurses leaving after abuse and non-supportive response from administration results in additional cost to train new workers.

Unit III: Accountability, Excusing, and Victim/Survivor Healing Process

- Basics of “forensic psychiatry” (the interface between criminal justice and mental health factors) in workplace violence context
- Legal and mental health grounds for excusing violence and abuse
- Emotional healing process for victim vis-a-vis cognitive status of abusive patient
- Agency policies regarding accountability for violent behavior
- Eliciting support and learning to “break the silence”
- Making “personal injury” a “public health and policy issue”, e.g. clear and consistent reporting protocols.
- Assessing adequacy and nurses’ knowledge of reporting protocols
- Engagement of front-line nurses at policy and institutional management level re- intersection between healthcare and criminal justice measures on behalf of those with potential of danger to others.

Module 3: Risk Assessment and Prevention Skills (54-72 minutes)

Key Question:

- How can nurses reduce the incidence of workplace violence and abuse through informed use of clinical and other research evidence regarding risk of assault and homicide?

Learning Objectives:

3. Identify verbal and non-verbal factors to recognize in practice as danger signals for violence and abuse.
4. Identify protocols and procedures for reporting and handling of incidents for protection of nursing staff.
5. Apply screening and risk assessment strategies using structured protocols and interview skills in typical workplace scenarios with clients, co-workers, and supervisors.

Unit I: Clinical Risk Assessment and Prevention Strategies for Types 2 & 4 Violence

- No scientific basis for absolute "prediction" of violence
- Much evidence-based data for assessing immediate danger
 - o Statistical/demographic factors: Limited relevance in individual situations
 - o Personality factors: motivation, aggression, inhibition, habit
 - o Situational factors: e.g., possession of weapon, behavior of would-be victim
 - o Interaction between these variables.
- Power and dis-empowerment issues.
 - o Overall, patients are "one-down" vis-a-vis health providers' power, and often feel intimidated in healthcare settings, especially by staff using their authority for power and control.
 - o Violence by definition is an abuse of power
 - o Authoritarian attitudes by healthcare providers may incite abuse or assault as a patient's response to feeling helpless and dis-empowered, or to their perceived treatment in an abusive or disrespectful manner
- Recognize verbal and non-verbal cues to threatening and violent behavior;
 - o e.g., "If I can't see my family (or be seen by the doctor) NOW, you'll be sorry." Throwing things; trying to grab a nurse.
- Communication Skills and Verbal response tactics
 - o e.g.: "I know you're upset... I'm doing the best I can to take care of you, and I really won't tolerate your speaking to me like that." Don't argue with patient.
- Physical / Behavioral response
 - o : e.g., Stay close to the door; press security button; call for help.
- Multidisciplinary Team response tactics
 - o Rely on team work and social support, ALWAYS report what happened.
- Apply Risk Assessment Criteria to Typical Clinical Scenarios
 - o using established communication and behavioral strategies in the nurse-patient relationship
 - o Risk-to-life Screening Tool for use in hospital triage (see Prototype)
 - o Assessment Scale to Assess Immediate Dangerousness to Others (see Prototype)
 - o Apply risk assessment criteria using the Assessment Scale in Type 2 and Type 4 violence scenarios in the workplace.

Unit II: Lateral (Type 3) Violence Response and Prevention Strategies

- Abuse between peers
- Definition and sequelae

- Contextual features: history and culture of nursing (expands on Module 1: Unit 1 content)
- Supervisor on worker violence/ abuse
- Predominantly verbal and emotional abuse, not physical assault
- Resulting psychological trauma often longer-lasting than healing from physical wounds, relative to nature of relationship and expectations of peer supports
- Working within the institutional framework
- Conflict resolution

Module 4: Crisis Intervention in the Workplace (36-48 minutes)

Key Question:

- What are the basics of crisis intervention that every nurse should know?

Learning Objectives:

3. Identify and apply in selected examples the emergency measures and crisis care that should be available to victim/survivors of violence and abuse in the workplace.
4. Describe and apply to examples the longer-term service and compensation needed by some injured nurses.

Unit I: Emergency and Crisis Intervention in Situations of Immediate Danger

- the Haddon Matrix of potential strategies to prevent violence against workers:
 - o measures in pre-event, event, and post-event phases
 - o factors to consider in each phase: host (victim), agent (assailant & weapons), physical environment (structures & facilities), social environment (norms, policies & procedures) [see runyan, 2001, p. 170]
- non-injurious physical prevention and intervention strategies
- if physical restraint is necessary, follow established agency protocol, including respectful communication with patient about why physical restraint is being used.
- apply protocols for debriefing of assault survivors, including other patients

Unit II: Crisis Counseling and Follow-up Service for Victim/Survivors

- Coordination of institutional employee counseling service with outside providers
- Loss, change, and grief work (in event injury requires job change)
- Coping with possible mis-placed guilt for a perpetrator held legally accountable
- Classic crisis counseling: Addressing Emotional, Cognitive, and Behavioral facets of Positive crisis resolution (See Crisis Paradigm, Box 4a)
- Engage with agency re- just Workers Compensation in event of disability from injury

Module 5: Policy Issues in Workplace Violence (36-48 minutes)

Key Questions:

- How do agency policy and NIOSH guidelines influence the incidence of violence, administration response when it occurs?
- How are front-line nurses engaged in drafting and enforcing NIOSH standards and agency policies?
- What can nurses do to promote lasting change?

Learning Objectives:

3. Examine health and safety policies and protocols in a selected (or simulated) health agency for adherence to NIOSH standards of workplace safety.
4. Identify strategies nurses can employ with administrators responsible for policy to ensure adherence to national and local safety standards.
5. Identify long-term strategies to prevent workplace violence and abuse

Unit I: NIOSH and JCAHO Standards for Worker Safety

- Criteria and clinical protocols (per JCAHO accreditation requirements) for routine screening of patients for history and current risk of violence; (connect to module 3—triage & risk assessment tools)
- Staff training on NIOSH guidelines and individual agencies' policies for employee health and safety.

Unit II: Training on Standards, Enforcement, and Diversity Issues

- Multi-dimensional and system-wide prevention strategies: individual, worker groups, administration, regulatory bodies [see rosen, 2001]
- Clear policies, training, and mechanisms for enforcement of policies in event of life-threatening violence.
- Clear and consistent policies for reporting violence and abuse, including assurance of job security and non-retaliation against employees who do report.
- Strategies and training assuring the protection of nurses and others more vulnerable to violence and abuse on various diversity grounds, e.g., immigration status, gender, race.
- Mechanisms publicly known and available to all nurses to assure front-line nurses inclusion in agency policies regarding violence and employee health and safety.

Unit III: Nursing and Public Action for Lasting Change

- Individual and group reflection on status of nursing
- Public display of reasons for nurse "shortage" vis-a-vis work environment conditions
- Self-care strategies, e.g., impact on health by adaptation and acceptance of status quo
- Basic human rights and workers' rights, e.g., for nutrition and bathroom breaks, and just compensation for workplace injury.

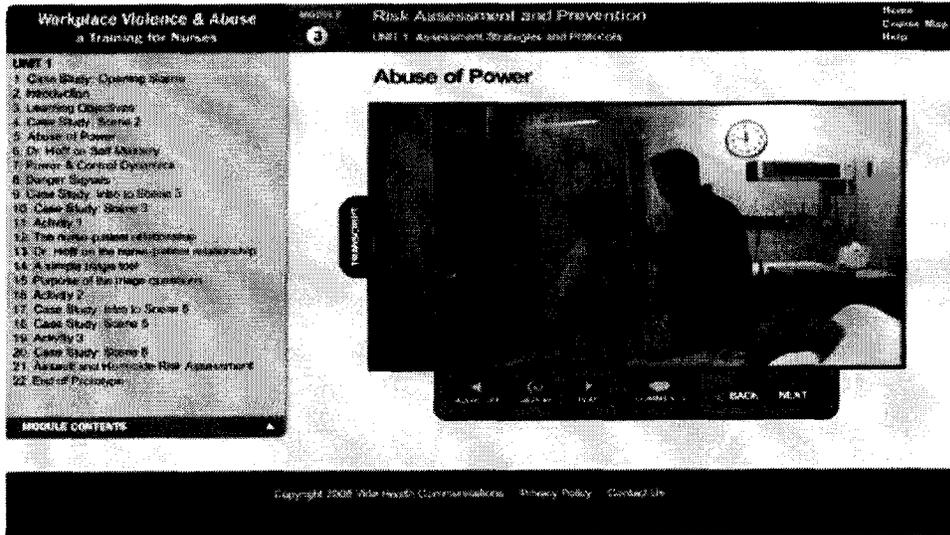
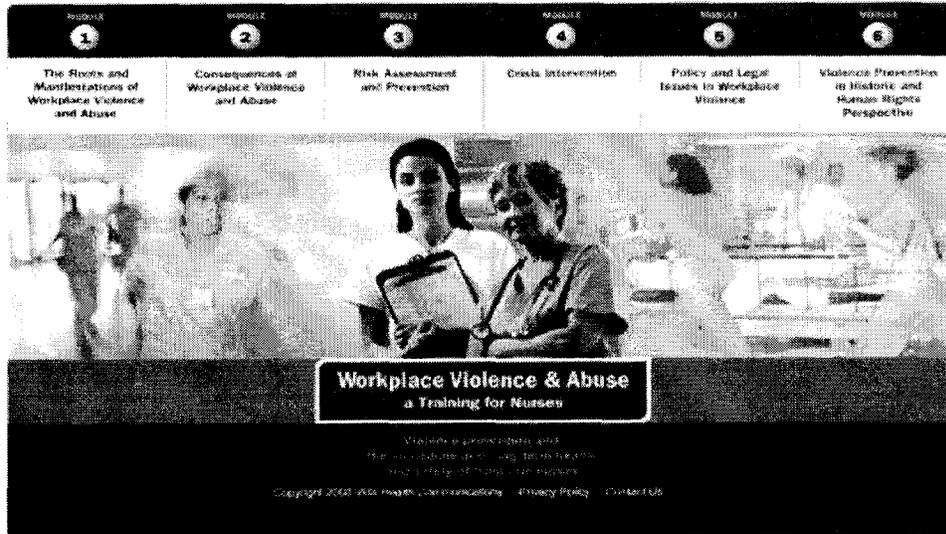
Unit IV: Long-term Strategies to Prevent and Reduce Workplace Violence and Abuse

- Strategies for nationwide movement from “guidelines” to enforceable standards.
- Social change strategies:
 - o acceptance that there is a problem; readiness for change;
 - o rational discourse regarding facts of violence and workplace risks;
 - o moral persuasion tactics, i.e., protect workers because it's the right thing to do;
 - o power tactics, e.g. organizing, work stoppage, etc.
- Distinct but inter-connected action TO ACHIEVE change:
 - o by individual nurses,
 - o healthcare agency administrators,
 - o by nursing professional organizations,
 - o by nurse educators in universities and colleges preparing nurses.
- Education's role
 - o : Nursing students' right to formal education regarding violence and violence prevention BEFORE entering the practice arena, e.g., AACN (American Association of Colleges of Nursing) Position Paper (1999) re- violence issues as essential curriculum content

Appendix 7

Work Place Violence for Nurses

Sample Screen Shots



Appendix 7

Work Place Violence for Nurses

Workplace Violence & Abuse
a Training for Nurses

MODULE CONTENTS

Week 1
3

Risk Assessment and Prevention
UNIT 1: Assessment Strategies and Protocols

Home
Course Map
Help

Case Study - Opening Scene

VIDEO

Rita
Where's Robert? He's been gone so long.

Nurse Jones
We tried to call the house and reach him on his cell but there was no answer. He'll be here soon, don't worry, I'm here with you, OK? I'll be here the whole time.

Robert
What's going on here?

Nurse Jones

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Workplace Violence & Abuse
a Training for Nurses

MODULE CONTENTS

Week 1
3

Risk Assessment and Prevention
UNIT 1: Assessment Strategies and Protocols

Home
Course Map
Help

Activity 1

TRANSCRIPT

What did Nurse Jones learn during her intake interview and subsequent conversation with Rita Avery that might offer clues to Robert's potential for violence or abuse?

Click on each of the answers to learn more.

1. Robert is excited about the baby.
2. Robert is worried about Rita's missing sister.
3. Rita believes that Robert loves her.
4. Robert sometimes yells at Rita and her children.

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Appendix 8
Workplace Violence Training for Nurses
Expert Panel Review Guide Summative

Instructions

We recommend that you proceed as follows:

1. First, visit the web site, which is at: <http://demo.vpg.com/vidahealth/prototype/> (use control-click to follow link, or paste it in your browser).
2. Review all of the active web pages, taking notes about anything you want to remember. **Only the following pages are active:**
 - o Home
 - o Module 3 (*all* pages in module 3)
3. Read through the questions about the website
4. Revisit website pages as you answer the questions.

Caveats

1. Please keep in mind that this is neither a complete module nor a complete training. This prototype represents only one small segment of the intended program to test feasibility.
2. The prototype is a work-in-progress. Portions of it may appear unfinished or be entirely non-functional.

It is not necessary to answer every question or comment on every item. If you do not have any comment, just proceed to the next one. Given your subject-matter expertise, we are especially eager for your input on Part C.

1.10 A. Web Site Look and Feel

1. What is your overall reaction to the **Home** Page design? ... to the **Module 3** pages design?
 - o Visual appeal
 - o Color palette
 - o Layout
 - o Images
2. What appears to be the intended audience and purpose of the web site?
 - o How appropriate is the web site look and feel for the audience/purpose?
3. Any comment on appearance or layout of specific pages

1.11 B. Web Site Usability

4. How was it navigating the site? (aside from the fact that many pages are inactive)
 - o to and from the home page
 - o to the active module
 - o within the module
5. How did the slide/video controls work?
 - o Locating the controls
 - o Interpreting the controls
 - o Performance

6. How helpful was the narration?
7. How useful and useable was the text box?
 - o Did you read along with the narration? Did you scroll down?
8. Any comment on usability of specific pages

1.12 C. Content of Module 3

9. How closely does the module content align with the module title?
10. How well does the module cover the topic? What would you add or omit?
11. Does the content flow make sense? Why or why not?
12. How well did the program sustain your interest?
 - o Which aspects were the most interesting?
 - o Which aspects were the least interesting and how would you fix them?
13. Consider the Case Study:
 - o The Case Study as a whole:
 - What did you like/dislike about this case study?
 - What worked or didn't work about this case study?
 - o The portrayal of violence:
 - Does it seem genuine?
 - How appropriate is it for use as a teaching moment?
14. Did any prototype content strike you as inaccurate?
15. Did anything in the prototype confuse, bother or annoy you?
16. Any comment on content of specific pages

1.13 D. General Questions about the Program Curriculum

17. How likely would you/providers be to use this program?
 - o As a resource
 - o For CEU credits
18. Would the program be more useful for individual learning or for group learning?
19. What can you suggest to improve the program?

Appendix 9
Workplace Violence Training for Nurses
Focus Group Leader's Guide Summative—3/4/08

Preliminary Housekeeping

- Consent forms. *New participant signs & turns in one copy; Vida staff sign and give a copy for participant to keep. Return participants only get one to review.*
- Demographic questionnaire – all participants
- Name tags – first name, big letters. Thanks, it helps us.
- Refreshments – get up, help yourselves
- Rest room locations
- Brief break in the middle
- Discuss is private, only for the people here, not others
- Introductions and our roles - not production staff
- Tape recording
 - we'll tell when turn it on
 - don't tap on table.
- Take turns speaking
 - like to hear from everyone
 - easier to transcribe

Orientation

We will be reviewing:

a **prototype** of **one active segment** of the proposed web-based training

You may remember that in the first focus group you reviewed the proposed curriculum.

Target Audience:

- Registered Nurses who work in hospital settings

Goal:

- The goal of the program **overall** will be to increase nurses' understanding of how to assess, respond to and prevent violent incidents at work.
- The goals of **this prototype segment** are:
 1. to get your interest and attention
 2. present strategies for dealing with a violent incident in a hospital setting
 3. demonstrate some structured protocols for assessing a perpetrators risk for further violence

Objectives of the Focus Group:

Your reactions and suggestions for:

1. Content of this prototype segment
2. Approach represented in the prototype
3. Usability of the web interface

Procedures:

1. First, we'll go through the entire prototype segment from start to finish (about 20 minutes)
2. Take notes about anything you want to remember. All of the slides are numbered in the lower right corner. *DISTRIBUTE PAPER & PENS FOR NOTE-TAKING.*
3. Please especially take note of anything in the program
 - seems confusing to you, or
 - bothers you for any reason at all.
4. We'll ask you to answer some general questions about the program as a whole.
5. Then we'll re-visit specific parts of the prototype, stopping along the way to ask some more specific questions.

Remember:

This prototype is only one segment of the entire program.

Questions and Probes

I'll ask these questions again after the 2nd time through, but right now, just for a few minutes, I'm interested in your initial impressions.

1. What is your overall reaction to the prototype?
2. How appropriate is the approach for you?
 - o Is the content at an appropriate level?
3. How well does the program grab your interest?
4. Is there anything in the prototype that bothered you or annoyed you? *If yes, please explain.*

HOME PAGE

5. What do you think of the layout?
 - a. How easy is it to know what is covered in the training?
 - b. How easy is it to navigate to the topics you want?
 - c. How do you react to the colors?
 - d. How do you respond to the nurse pictured on this page?
 - e. If you were taking this course, would you want to see anything else on this page?
6. Any other comments on the home page?

SLIDE 1 – PAUSE IMMEDIATELY!

7. What do you think of the layout (text on left, images and video on right)?
 - o The text window is open. Do you prefer it that way, or would you prefer the option to close it?
8. What do you think of the navigation controls?
 - a. Do the controls make sense?
 - o Any controls missing or inadequate?
 - o Any controls that seem unnecessary?
 - b. How easily can you figure out where you are?
 - c. How easily can you find the drop down menu?
 - o Does it function as you would expect?
 - d. Does the header help, or distract from the training?
9. Are there any other features you would like to see incorporated in the design?

SLIDE 1 (SCENARIO)

10. How realistic or believable is this scenario?
11. Is it clear what the act of violence is?
 - o Is this portrayal sufficiently violent to use as a teaching point?
12. Is there enough detail? ... too much?
 - o Parts you would add? ... omit?

SLIDE 2-3 (INTRO & LEARNING OBJECTIVES)

13. How do you react to the narrator?

SLIDES 4-8 (COLLEAGE. ABUSE OF POWER, LEE ANN POWER & CONTROL, DANGER SIGNALS)

14. Any other comments or suggestions on the last few slides?

15. How do you react to the expert?

SLIDES 9-10 (COLLEAGUE, INTAKE & INTERVIEW)

16. Any comments or suggestions on the last few slides?

- Anything confusing?

17. How do you react to each of the actors in these scenes?

- Nurse
- Patient
- Husband
- Nurse colleague?

SHOW SLIDE 11 (ACTIVITY 1)

18. What did you think of these answer choices?

- ... the analysis of each choice?

19. Does this functionality make sense? (click on answer to go to explanatory slide, click on 'return to activity' to return to prior list of answers)

20. Any other comments or suggestions on this part?

SLIDES 12-13 (NURSE-PATIENT RELATIONSHIP)

21. Any comments or suggestions on the last few slides?

SLIDES 14-15 (TRIAGE TOOL)

22. Any comments or suggestions on the last few slides?

SLIDE 16 (ACTIVITY 2 – SUSPICIOUS, WHAT DO?)

23. Any comments or suggestions on the last few slides?

SLIDES 17 (ADMINISTER TRIAGE)

24. Any comments or suggestions on this activity? ... the answer choices? ...the analyses?

SLIDE 19 (ACTIVITY 3 – WHAT ELSE?)

25. Any comments or suggestions on this activity? ... the answer choices? ...the analyses?

SLIDES 20-22 (ASSAULT & HOMICIDE RISK ASSESSMENT, LETHALITY ASSESSMENT RISK SCALE)

26. Any comments or suggestions on the last few slides?

SLIDE 23 (INTERVIEW WITH SOCIAL WORKER)

SLIDE 24 (SCORING RISK ASSESSMENT SCALE)

27. Any comments or suggestions on the last few slides?

THINKING ABOUT THE ENTIRE PROGRAM AGAIN

28. Now that we've dissected the program...
29. What is your overall feeling about it?
30. Are there enough activities? Are they engaging enough?
31. Which parts are most engaging? ... least engaging?
32. How is the "flow" from one part to the next?
 - How clear and easy was the navigation? How well could you find your way around?
 - Is it too linear?
33. Is this something that you might use or recommend to your staff or colleagues?
34. After exploring this prototype segment, would you want to take part in a discussion about workplace violence?
35. After viewing this program, how confident would you feel in deciding to conduct a homicide risk assessment?
36. How might you want to use a program like this?
 - In what context? – self-directed learning? – in-service training?
37. What can you suggest to improve the program?

Appendix 10

Workplace Violence Training for Nurses Summary of Focus Groups Summative

The two summative focus groups took place at Vida Health Communications on March 4 and March 6, 2008. Both groups consisted of a mixture of front line nurses and nurse educators, one group with an attendance of 8 and the other 9 participants.

Overall Reaction to the Prototype:

Both focus groups conveyed clearly positive responses to the training module.

I think it's a great program... Seemed real; grabbed our interest. This is a great learning experience – great discussion points.

There was agreement that the prototype predicts an excellent training for a wide variety of nurse audiences in settings ranging from nursing schools to in-service continuing education offerings.

Every hospital has a competency review for JCAHO; this would be fantastic for annual review... Would have a value for hospital administrators to help them understand what nurse go through... Also for use in nursing schools.

There was almost universal acceptance of the content of the narration and its delivery. “

Narration was outstanding, perfect.”

Focus group participants understood the tool's potential to be mediated individually at any time, at work or at home, and also in facilitated small and large group learning situations.

Response to the approach of using dramatic enactments in a case study approach was positive.

It's all there in the opening scene; caught my attention very quickly... I really liked the case scenario – it felt real.

Participants recognized and appreciated diversity represented in the casting of the scenarios' actors:

I liked the inclusion, diversity and persona of the nurse.

Participants objected to the use of the term “training” in the program title, preferring “education” instead.

Acceptance of the prototype's on-camera expert was low. Participants felt Dr. Hoff's delivery was slow and, in one case, that the content of her commentary was inappropriate to the learning tasks of the module:

Self mastery, as a concept, is too cerebral. Reference to mental illness in expert comments seems out of place; distracting. The theory should be presented in other sections.

The process of debriefing an experience with violence in the workplace is something more than one respondent felt should be addressed.

"There's nothing about the nurses feelings about having to go in and continue working with the family after she has been shoved."

Response to Program Content

Participants expressed a wish that the module include more content on specific, practical steps and recommendations nurses should take when faced with various types violence in the workplace: Patient on nurse, patients' family members on nurse and nurse (or other professional) on nurse.

"On a 20 be unit and you have someone out of control; what do you do to protect everyone?"

"When workplace violence occurs, what does a nurse do? Incident reporting? Self-defense? What do the nurses do; that's what we want to hear."

The fact that the patient in the scene is the possible victim of domestic violence presented an element that confused many participants.

"Domestic violence (element of the scenario) is distracting from the message." The fact that he (the husband in the scene) is an abuser is not relevant to his abuse of the nurse."

Some said they would prefer a more straightforward encounter between nurse and patient rather than between the nurse and a family member.

"Stay focused that this is about nurses tending to themselves; this says if we get shoved we should worry first about the patient and their family (sending the baby to a safe home). The fact that she (the nurse) got shoved was obscured."

A number of participants expected to see more attention paid to lateral violence in the module and suggested that for future module development, this type of violence, difficult as it may be to address and confront, is of critical interest and importance to nurses.

"I've had more incidents of lateral violence than any other kind."

Some participants suggested that rather than depicting an example of physical assault, the program should focus more on varieties of verbal assault.

*"We deal with a lot of verbal aggression and assault behaviors that don't reach the level of homicide."
"It's a mistake to focus on a physical event because verbal aggression is demoralizing and much more frequently."*

Many felt that the process of debriefing, following a violent incident, is important to depict.

"I also think part of this training is validating the experience (of violence in the workplace; taking it out of the dark so that people can talk about it.... I don't think it's well named in our society or profession. People need strategies about how to talk to someone like that because it's not easy."

"We have to make time for that and we never have time."

Several participants felt that the content on the Lethality Assessment Scale was confusing and/or inappropriate to the learning objectives of the module. Many wanted more information about the Scales' evidence base and why it was selected over others.

“When individual tools are mentioned, I want it to be clearly tied to where they come from; supporting references.”

Participants felt that additional content (either for this or other future modules) should draw on the case scenario and address: how staff who has experienced violence would communicate with colleagues on the unit a patient is moved to; recognizing possible warning signs that a person may be a danger; use of stance and body language as protective force; ways to de-escalate tension.

Response to the Prototype’s Functional Attributes

Participants liked having the capacity to navigate easily through 24 screens and know where one is at all times.

“Controls are great; like the 1 of 24.”

A few expressed a preference for left hand navigation.

They tended to find the screen too busy and offered a variety of helpful suggestions for streamlining such as removing the copyright information, providing the opportunity to increase/decrease text size, having the controls disappear when appropriate.

Several pre-visualized features the investigators have in mind for the final product: links to appropriate sources such as NIOS, CDC, etc.; a button for resources and citations on all appropriate screens; and the capacity to print materials throughout

Response to the Prototype’s “Look and Feel”

Participants want the final version to: use brighter colors; avoid the use of “scrub” blue and green; use larger type; avoid still images that depict emergency situations and favor those that picture interpersonal interactions; make use of the whole screen (or as much as possible) when the video scenes play.)

Most participants objected to our on-screen Expert, Dr. Lee Ann Hoff, who happens also to be our lead consultant the author of the books on which our program is based.

Response to the Learning Activities:

Several participants felt that answers in the activities need to be reworded so that learners will go through all of the answers as there is important content even in the “wrong” answer.

“Answers need to clear as to which is best, not best.” Not all participants clicked on all answers.

“Instructions are clear but some of us are so programmed to pick one answer that we don’t listen; I just picked the longest one.”

Participants would prefer that *“audio must not replay every time you go back to the activity screen.”*

Responses to Dramatic Devices and Acting

All participants like the use of the dramatic enactments to illustrate case studies. Some found the story we selected to have a few confusing elements. In particular, the use of flashback was troublesome to several

"It's confusing to do it in this order; it would be helpful to see how the events escalate in order."

Most participants found the acting convincing although some pointed to spots where they felt there was *"a bit of a soap opera feel."* In general, the performances were acceptable to performances although some found a character's accent distracting and some considered the acting inauthentic in the vignettes where Nurse Jones and her colleague discuss the case.

One person felt that there should be more authenticity in depicting a birth setting with beeping fetal monitors and more emergent activity.

"Does not feel like a birthing unit; post partum didn't appear to be a room."

Participants' Feelings about Scenarios' Consistency or Dissonance with Nursing Practice:

The script for a scene which was not videotaped but appeared only in text form was considered unrealistic.

Script for Scene 5 not at all believable....you would never interview that person alone.

Additionally, there were discrepant feelings about whether or not the scenario should only and always depict Nurse Jones doing the right thing as opposed to behaving in ways that open up the possibility to question her behavior.

To some, calling the character "Nurse Jones" as opposed to using her first name or the appellation, "Ms." Was distracting. Others like the professionalism it conveyed.

Responses from participants highlighted the wide array of differences in the ways individual nurses and institutions currently respond to incidents like the one depicted in the scenario.

"The moment you lay hands on you call security. Body slam requires that you call security. That would be the end of it. If you didn't call security it is probably against hospital regs."

"I have colleagues that would act just like this."

Nurse aggravated the situation from the beginning; standing directly in front of him (the husband)"

"Nurse Jones was passive aggressive; family-centered care would sit him down."

"Nurse Jones was too aggressive; didn't engage him (the husband) in the care."

Appendix 11
Workplace Violence Training for Nurses
Inclusion Enrollment Report

Nurses (Focus Groups)			
Ethnic Category	Sex/Gender		
	Females	Males	Total
Hispanic or Latino	0	0	0
Not Hispanic or Latino	21	1	12
Ethnic Category: Total of All Subjects *	21	1	12
Racial Categories			
American Indian/Alaska Native	0	0	0
Asian	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
Black or African American	2	0	2
White	19	1	20
Racial Categories: Total of All Subjects *	21	1	22

* The "Ethnic Category: Total of All Subjects" must be equal to the "Racial Categories: Total of All Subjects."