# TITlE PAGE

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Project Title: A Multi-Site Intervention to Reduce Violence in Hospital Emergency Departments

Grant Number: 1R010H009544

Project Period: 9/1/2008 to 2/28/2013

Final Report Date: 4/15/2013

# ABSTRACT

In 2006, the Bureau of Labor reported that 60% of workplace assaults occurred in healthcare, and most of the assaults were committed by patients. Healthcare support occupations had an injury rate of 20.4 per 10,000 workers due to assaults, and healthcare practitioners had a rate of 6.1per 10,000; this compares to the general sector rate of only 2.1 per 10,000. As significant as these numbers are the actual number of incidents is much higher due to the gross underreporting in healthcare that is related to the perception that assaults are part of the job. Recent evidence indicates that nurses and other direct care providers who work in emergency departments (EDs) are at greater risk of violence than other providers. Although there are numerous epidemiological studies that have emphasized that ED violence is a prevalent and serious problem, there are no published accounts of interventions to reduce this alarming trend. The purpose of this intervention study is to partner with six hospitals to test a multi-dimensional intervention to prevent assaults against ED workers and reduce the related negative consequences. Primary study aims are to test the effectiveness of an intervention to: 1) reduce assaults against ED workers from patients and visitors, 2) decrease acute stress disorder symptoms, absences, and loss of productivity after assaults and physical threats, and 3) increase employees' feelings of safety and self-confidence in managing aggressive patients and visitors. Secondary study aims are to: 1) develop and implement processes and procedures for ensuring the intervention is planned with stakeholder input and involvement, and 2) develop and implement processes that increase the capacity of the EDs to sustain the intervention. The EDs will be randomly assigned as an intervention or control site. The intervention was developed using the Haddon Matrix, violence research, and feedback from ED managers. All ED employees who provide direct care at the six hospitals will be invited to participate in the study. Data on assaults, physical threats, stress, and productivity will be collected for nine months before and nine months after implementation of the program. The Diffusion of Innovations Theory will be used to plan, implement, evaluate and sustain the intervention. Focus groups with ED employees, managers and patients will be conducted to obtain information that will guide the implementation of the intervention. The research methods will include strategies that focus on fostering collaborations among the participating EDs and among the researchers, practitioners, and employees. In addition to having experienced violence researchers, this interdisciplinary team also includes an ED physician and nurses who have working relationships with key players in our partnering EDs. The proposed research is essential to advance progress in the field of violence in the healthcare sector and could serve as a model for EDs as well as high risk settings such as psychiatric, long-term care, and critical care units.

Emergency Departments (EDs) are becoming dangerous work settings for employees due to the increased violence from patients and visitors. There are no published accounts of strategies that will reduce this alarming trend. This study will test an intervention that could improve the work conditions for over 1million ED healthcare workers and improve the care for millions of patients who visit EDs each year.

# SUMMARY OF PROGRESS

## A. Study Aims

The purpose of this study was to partner with six hospitals to test the effectiveness of a multi-component intervention to prevent violence against emergency department (ED) workers and reduce the negative consequences of violence.

Primary Aims were to test the effectiveness of an intervention to:

1. Reduce violence against ED workers from ED patients and visitors.
2. Decrease acute stress disorder symptoms, absences, and loss of productivity after assaults and physical threats.
3. Increase feelings of safety and self-confidence in managing aggressive patients and visitors.

Secondary Aims were related to the development and implementation of the intervention:

4. To ensure interventions are planned with stakeholder input and involvement.
5. To increase the EDs' capacity to sustain the interventions after research completion.

This four-year study consisted of three phases: 1) assessment and planning [Year 1], 2) planning and implementation [Years 2 and 3], and 3) evaluation and institutionalization [Year 4}. Six hospital emergency departments (EDs) participated in the study, three as intervention sites and three as comparison sites. The intervention was implemented during June- August, 2010 after a year of planning and nine months of pre-intervention data collection. Nine months of post-intervention data was collected. Formative evaluation was also conducted during this period to evaluate the implementation of the intervention. Additionally, we collected a final survey from the subjects at the intervention sites and conducted a post-intervention meeting with ED managers to evaluate the program.

## B. Studies and Results

### B.l Focus Group Study (Aims 4-5)

Focus groups were conducted as part of the first phase ofthis project and to support efforts to develop the intervention employing an action research approach. The Haddon matrix was used as the framework to identify and plan for intervention strategies to implement pre-event (pre-assault), during event (assault) and post-event (post-assault). Twelve focus groups with ED managers, employees and patients were conducted at the three intervention EDs over a 4-month period (January 09- April 09). There were 3 manager groups, 6 employee groups and 3 patient groups. All managers who supervised direct care providers in the ED were invited to participate in the manager focus group at their respective hospital. Out of 37 eligible managers, 24 persons attended one of the three manager focus groups. Following these meetings, 171 randomly chosen employees at the three intervention EDs were invited by letter to participate in a one-hour focus group. Forty-seven employees attended one of six focus groups. After the employee focus groups, 95 patients were randomly selected and invited to participate in a focus group meeting at the ED where they received care and were recruited. Twenty-five patients participated in the focus groups. During the focus group meetings a member of the research team provided an introduction about the project with information about the partnerships, the CDC's support as the funding agency, and an overview of the focus group. After this 15-minute presentation, the participants were asked to participate in a 45-minute audio-taped focus group.

The purposes of the manager and employee focus groups were to: a) assess the benefits and limitations of the strategies currently being used for violence prevention and management, b) identify potential strategies, c) assess barriers to implementation of strategies, d) identify strategies for implementation of the intervention, and e) capture beliefs regarding violence prevention efforts in general. The purpose of the patient focus meetings differed from that of the manager and employee focus groups in that the primary purpose of these discussions was to gather data that will help ensure that the planned intervention included an exhaustive list of feasible components to reduce patient and visitor anxiety, stress, frustration, and anger when visiting the ED for care. Transcripts were completed for the focus groups and were analyzed by identifying themes from the manager, employee, and patient focus group meetings according to the Haddon matrix.

Findings were organized according to the proposed intervention strategies in the before-, during-, and after-the-assault timeframe for the employees, managers and patients. Quotations were used to provide support and examples for the themes. Discussions during the focus groups with ED managers, employees, and patients supported the literature by identifying that violence in the emergency department is increasing, that it is a major concern for those who work and visit emergency departments, and that intervention are needed to reduce the violence. The data also showed that the planned intervention strategies were relevant, feasible, and comprehensive. In addition, with the exception of a few items, the employees and managers agreed on what was needed to prevent and manage violence against health care workers. This agreement and support should help the implementation of the intervention in the emergency department. The results from the focus groups were used to plan and implement the violence prevention program in the three intervention EDs.

A manuscript based on the focus groups "Using Action Research to Plan a Violence Prevention Program for Emergency Departments Journal of Emergency Nursing" was published in *Journal of Emergency Nursing* (see C. Publications below}

B. 2. Description of Baseline Survey Results

Two hundred thirteen direct care providers from the six participating hospitals agreed to participate in the study and completed the baseline questionnaire during August and early September 2009. The following surveys were completed by the 213 participants:

a. Demographic and Occupational survey
b. Baseline Violence survey
c. Violent Experiences survey
d. Feelings of Safety survey
e. Confidence in Preventing Violence survey
f. Post -Traumatic Stress Disorder (PTSD} Checklist (PCL)- Civilian Version

Examples of findings from the analyses (descriptive and ANOVA computations} included:

- 58% responded "no" to having received violence education during the previous 12 months and 42% responded "yes"
- 98.2% had experienced verbal harassment at least once from a patient during previous 6 months
- 54% had experienced verbal harassment at least once from a visitor during previous 6 months
- 67% percent responded that they had experienced verbal harassment more than 5 times from a patient during previous 6 months
- 33% had experienced more than 5 incidents from visitors during previous 6 months
- 54% had incurred a physical assault from a visitor in the previous 6 months
- 2% had incurred a physical assault from a visitor during previous 6 months
- 67% had been physically threatened at least once from a patient during previous 6 months
- 30% had been physically threatened at least once by a visitor during previous 6 months
- No statistically significant differences in the frequency of violence for *age,* job title, patient population, and hospital location.
- Sexual harassment was the only category of violence affected by gender with women having a greater frequency
- Feelings of safety were inversely related to the frequency of WPV
- Women were significantly more likely to feel unsafe and have less confidence in dealing with WPV
- 95% had called security for assistance at least once during previous 6 months
- 21% had called security 6 or more times during the previous six months

The results from the baseline surveys were used to develop the manuscript "Occupational and Demographic Factors Associated with Violence in the Emergency Department", which was published in *Advanced Journal of Emergency Nursing* (see C. Publications below}.

B.3. Longitudinal Surveys

In September *2009,* the pre-intervention longitudinal survey collection began via Survey Monkey. Pre-intervention monthly data was collected for nine months. Some results of the study include the following:

- 827 total violent events (assaults and physical threats) were reported
- Rate: 4.146 events per person in 9 months
  5.528 events per person in 12 months
- Significant predictors for feelings of safety (free from violence) included frequency of events, gender and occupation.
- Significant predictors for feelings of confidence included gender, occupation, hospital type, and hospital location.
- Significant predictors for assaults included educationallevet and for threats included educational level and hospital patient population. Employees' age, gender, and years of ED experience did not predict frequency of assaults or threats.
- Significant predictors for acute stress symptoms after a violent event included perpetrator gender, occupation (nurses were highest injury, debriefing and presence of weapon).
- The only significant predictor of productivity after a violent event included acute stress symptoms. Age, gender, and type of event were not related to acute stress or ability to work.

Results from the 9 month pre-intervention surveys were prepared for a manuscript entitled, "Prospective Study of Violence Against ED Workers" and was published *in The American Journal of Emergency Medicine* (see C. Publications).

B.4. Assault Logs (18 months)

Also in September 2009 all six EDs began to collect data on assaults and physical threats using Assault Logs. The managers instructed all staff that the hospitals would be tracking all events using the anonymous assault logs. Five hundred fourteen assault logs were collected during the nine months of pre-intervention data collection period and 266 were collected for the post-intervention data collection period. The assault logs have not been analyzed to-date. When comparing the assault log data to the Monthly Surveys and Violent Event Surveys, it is clear that employees did not report many of the assaults and threats using this reporting mechanism.

B.S. Intervention Development, Implementation and Evaluation (Specific Aims 4-5)

The team partnered with the three intervention ED employees, managers and administrators to develop the violence prevention intervention. This included representatives from nursing, medicine, security, social work, registration, and psychiatry. The intervention consisted of three components: 1) education and training, 2) policies and procedures, and 3) environmental changes. Implementation of the intervention took place during June, July and August 2011. The research team met with hospital employees and managers regularly during the planning and implementation of the intervention. The research team drafted initial policies and procedures for each hospital after discussions with all stakeholders. The policies and procedures were reviewed and revised several times based on feedback from employees, managers and administrators. The ED managers and staff were responsible for "rolling out" the policies and procedures with assistance from the research team. The research team developed the on-line and tabletop educational strategies based on research, focus group data (B.1. Focus GroupsL and feedback from stakeholder meetings. Technology staff from the University worked with the hospital technology personnel to facilitate the use of the on-line training. The research team trained staff at the EDs to conduct the in-person tabletop discussions. A research team member was present at all tabletop discussions to monitor fidelity to the intervention and to support the hospital trainer as needed. During year *4,* formative and summative program evaluation was conducted and provided important data to support ongoing revisions and improvement of the intervention. Additionally, the program evaluation provides new information to administrators, nurse educators and staff who want to plan a comprehensive program to improve the safety of their workplaces.

Program evaluation consisted of the following:

Formative evaluations took place for nine months after implementation. On a monthly basis, the project director used a checklist and notes to assess for fidelity of the intervention components at the three intervention EDs.

- Employees rated the on-line and classroom training program after completion of each.
- Intervention subjects were asked to complete a survey to rate the entire program and the individual components.
- Summative evaluation took place with the intervention ED managers and educators to evaluate the violence prevention program and each of its components.

Results included:

- The degree of success varied among the sites and intervention components. The smaller, suburban ED has the best results for institutionalizing and sustaining the intervention components over the nine month period.
- Three hundred twenty-two employees evaluated the on-line education and 353 completed the classroom evaluation. For the on-line education, 63% percent (n=195) of the non-physician participants agreed or strongly agreed that the training quality was high and 74% (n=230) agreed or strongly agreed that the training was beneficial. Only eight percent (n=26) disagreed that the on-line training was beneficial.
- The classroom evaluations were higher. Including all participants except physicians, 94% (n=326) agreed or strongly agreed that the training met objectives and 91% (n=315) agreed or strongly agreed that the training was beneficial. Only three percent disagreed (n=12) that the training was beneficial.
- Of the 80 employees asked to complete the program evaluation survey, 66% (n=53) participated. Results varied based on occupation and ED site. For the total group, the mean rating (1- 10 scale) for the benefit of the program was 5.04 (n=53). Nurses evaluated the benefit ofthe program the highest (n= 35; mean=5.34) whereas physicians evaluated the program's benefit the lowest (n=9; mean=3.44). The smaller suburban hospital employees evaluated the program's benefit higher (n= 12; mean=6.58) than the urban ED (n=12; mean=5.75) and the urban Levell trauma ED (n=29; mean=4.10). Surveillance and monitoring was identified as the most important violence prevention component (mean=8.59). Policies and procedures were rated as the least important (mean=6.86).
- Overall the managers and nurse educators described the program as very positive and believed the program would be beneficial at reducing violence. The two components identified as the most important were the classroom education, and the environmental assessments and improvements. The two components identified as the least effective were the levels of awareness and having early assessment screening done with all patients.

A manuscript entitled "Evaluation of a Comprehensive Violence Prevention Program" was developed and has been accepted for publication. See C. Publications.

B. 6 Description of Violent Events over the 18 Months of Survey Data Collection

MONTHLY SURVEYS (Table 1)

During the 18 months of data collection, there were a total of 1333 reported events on the Monthly Surveys of which 346 (26%) were physical assaults and 987 (74%) were physical threats. The mean monthly incident rate for assaults was 0.11and 0.31for physical threats. The mean rate for 18 months was 1.66 for assaults and 4.72 for physical threats. The number of assaults experienced by the 209 participants during the 18 month period ranged from 0 to 17 with 55% (n=116) of the subjects having experienced at least one assault. The number of physical threats experienced by the 209 participants during the same period ranged from 0 to 59, with 83% (n=175) ofthe participants having experienced a physical threat at least once. Eighty-six percent (n=179) of the participants had been either threatened or assaulted at least once during the 18 months.

ANOVA computations found no significant differences in assault or physical threat rates based on gender, hospital location or occupation. For gender, the p-values were 0.31, 0.78 and 0.24 (events, assaults, threats) and for hospital location p-values were 0.24, 0.74 and 0. For job title p-values were 0.02, 0.07 and 0.04, but none remained significant after adjustment for multiple comparisons.

VIOLENT EVENT SURVEYS (Table 2)

Two hundred and forty (96%) assaults were committed by patients, whereas 499 (86.3%) physical threats were committed by patients. Ten (4%) of the assaults and 79 (13.7%) ofthe physical threats were committed by visitors. Chi-square computations found that the age of the perpetrator was significant ($p<0.0001$) with the 70-90 age perpetrator

groups accounting for a higher number of assaults and fewer numbers of threats than expected. The gender of the perpetrator was also significant (p<O.OOOl), with females accounting for more assaults than expected and males accounting for more threats than expected. Perpetrator chief complaint was significant (p<.OOOl) with pain diagnosis having a lower frequency of assaults than expected and mental status diagnosis having a higher frequency of assaults than expected. The time of the incident was not significant; 70% of assaults and 63% of threats occurred between noon and 12 midnight.

REPORTING, DEBRIEFING, AND INJURIES

Participants did not report 60% of the assaults and 62% of the physical threats. For 88% of assaults and 89% of physical threats, subjects did not receive any formal or informal debriefing. Of those who did receive debriefing, 98% received informal debriefing. Twenty percent of assaults (n=SO) reported on the violent events resulted in injury. Although not significant the injury rate decreased from 12% to 8% for the intervention and comparison groups. There was no significant difference between the intervention and the comparison groups.

B.7 Hypothesis Testing (Aims 1-3)- Effectiveness ofthe Intervention

The hypothesis that the intervention emergency departments would have a significant change in violent events compared to the comparison emergency departments was not supported. Both the comparison and intervention groups had a significant decrease in number of assaults and threats (Table 3). All six emergency departments had a decrease in number of assaults from pre- to post-intervention. All but one of the comparison emergency departments also had a decrease in physical threats from pre- to post-intervention. No comparison emergency department had a significant decrease in assaults or threats. However, the suburban intervention emergency department did demonstrate a significant (p<O.OS) decrease in number of assaults and the Trauma 1emergency department had a significant decrease in physical threats. The suburban intervention emergency department had almost a 50% decrease in assaults. The hypotheses that the intervention would decrease acute stress disorder symptoms, absences, and loss of productivity after assaults and physical threats were not supported. Likewise the hypotheses that the intervention would increase employees' feelings of safety and self-confidence in managing aggressive patients and visitors were not supported.

Several historical events likely contributed to why the study hypotheses were not supported. During the study a comparison hospital undergoing Centers for Medicare and Medicaid Services review was pressured by potential closure to conduct violence prevention training due to a serious violence-related incident. All staff in that ED underwent training. Also during the study several national organizations brought attention to the problem of violence in EDs, including the Emergency Nurses Association with a national study and the Joint Commission's sentinel alert. The ENA study received national publicity and was frequently addressed in the ENA's publications and conferences. Managers at all the EDs were made aware of the Joint Commission's new attention to violence. In addition, a Hawthorne effect likely occurred at the comparison sites. The employees and managers at these three hospitals frequently alluded to the fact that they were becoming increasingly aware of and concerned about the increasing violence in EDs. The data collection itself (surveys and anonymous lock box in departments) served as reminders of violence. A manuscript is being developed to disseminate the final results.

Table 1. Violent Event Rates by Subject's Gender, Occupation and Type of Hospital ED

| | N | Assaults Mean | Assaults SD | Assaults Range | Physical Threats Mean | Physical Threats SD | Physical Threats Range | Total Events Mean | Total Events SD | Total Events Range |
|---|---|---|---|---|---|---|---|---|---|---|
| Gender (subject) | | | | | | | | | | |
| Male | 60 | 1.58 | 2.43 | 0-12 | 3.90 | 5.05 | 0-28 | 5.48 | 7.19 | 0-40 |
| Female | 149 | 1.68 | 2.30 | 0-17 | 5.05 | 6.90 | 0-59 | 6.74 | 8.32 | 0-63 |
| Both | 209 | 1.66 | 2.34 | D-17 | 4.72 | 6.44 | 0-59 | 6.38 | 8.02 | 0- 63 |
| Occupation (subject) | | | | | | | | | | |
| Physician | 42 | 0.90 | 1.14 | 0-4 | 2.29 | 2.66 | 0-12 | 3.19 | 3.34 | 0-16 |
| Registered Nurse | 117 | 1.90 | 2.60 | 0-17 | 5.89 | 7.54 | 0-59 | 7.79 | 9.18 | 0-63 |
| Licensed Practical Nurse | 2 | 0.50 | 0.71 | 0- 1 | 1.50 | 0.71 | 1- 2 | 2.00 | 0.00 | 2- 2 |
| Physician Assistant | 5 | 0.20 | 0.45 | 0- 1 | 0.60 | 0.55 | 0- 1 | 0.80 | 0.84 | 0- 2 |
| Paramedic | 13 | 1.62 | 1.85 | 0- 5 | 3.77 | 3.44 | 0- 9 | 5.38 | 4.98 | 0-14 |
| PCA | 22 | 2.50 | 2.91 | 0-12 | 5.32 | 6.59 | 0-28 | 7.82 | 9.14 | 0-40 |
| Nurse practitioner | 8 | 1.00 | 1.41 | 0-4 | 3.75 | 4.23 | 0-12 | 4.75 | 4.83 | 0- 14 |
| Hospital type | | | | | | | | | | |
| Levell trauma | 130 | 1.74 | 2.23 | 0-12 | 5.40 | 7.04 | 0-59 | 7.11 | 8.51 | 0-63 |
| Urban | 41 | 1.41 | 1.88 | 0- 7 | 3.88 | 5.93 | 0-31 | 5.29 | 7.41 | 0-37 |
| Suburban | 38 | 1.63 | 3.08 | 0-17 | 3.42 | 4.21 | 0-21 | 5.05 | 6.66 | 0-38 |

Table 2. Description of Events by Patient's Chief Complaint, Time of Day; and Perpetrator's Age and Gender

| | Assaults | | Threats | |
|---|---|---|---|---|
| | N | % | N | % |
| Chief complaint (patient) | | | | |
| Substance abuse | 46 | 18 | 136 | 23 |
| Psychiatric conditions | 85 | 34 | 164 | 28 |
| General medical | 22 | 9 | 48 | 8 |
| Trauma | 15 | 6 | 30 | 5 |
| Pain | 20 | 8 | 106 | 18 |
| Mental Status | 39 | 15 | 23 | 4 |
| Unknown | 25 | 10 | 73 | 13 |
| Time of assault | | | | |
| 12-6 AM | 39 | 16 | 111 | 19 |
| 6 AM- noon | 36 | 14 | 104 | 18 |
| Noon-6 PM | 96 | 38 | 197 | 34 |
| 6 PM-12 Midnight | 80 | 32 | 166 | 29 |
| Gender (perpetrator) | | | | |
| Male | 126 | 50 | 386 | 67 |
| Female | 126 | 50 | 194 | 33 |
| Age (perpetrator) | | | | |
| 0-10 | 5 | 2 | 0 | 0 |
| 11-20 | 16 | 6 | 44 | 8 |
| 21-30 | 66 | 26 | 160 | 28 |
| 31-40 | 43 | 17 | 143 | 25 |
| 41-50 | 47 | 19 | 133 | 23 |
| 51-60 | 24 | 10 | 77 | 13 |
| 61-70 | 15 | 6 | 5 | 1 |
| 71-80 | 22 | 9 | 8 | 1 |
| 81-90 | 12 | 5 | 3 | 1 |

Table 3. Pre- and Post-intervention Monthly Rates by Intervention and Hospital Groups

| | Assaults | | | | Physical Threats | | | |
|---|---|---|---|---|---|---|---|---|
| | Pre- | Post | Change | p | Pre | Post | Change | p |
| Comparison | 0.10 | 0.06 | 0.04 | <0.01 | 0.27 | 0.19 | 0.08 | <0.01 |
| Trauma 1 | 0.10 | 0.06 | 0.04 | ns | 0.28 | 0.18 | 0.10 | ns |
| Urban | 0.13 | 0.07 | 0.06 | ns | 0.34 | 0.26 | 0.08 | ns |
| Suburban | 0.08 | 0.02 | 0.06 | ns | 0.14 | 0.15 | 0.01 | ns |
| Intervention | 0.17 | 0.13 | 0.04 | <.05 | 0.49 | 0.37 | 0.12 | <0.01 |
| Trauma 1 | 0.18 | 0.15 | 0.03 | ns | 0.60 | 0.47 | 0.13 | <0.02 |
| Urban | 0.12 | 0.07 | 0.05 | ns | 0.29 | 0.18 | 0.11 | ns |
| Suburban | 0.20 | 0.11 | 0.09 | < 0.05 | 0.34 | 0.27 | 0.07 | ns |
| ALL EDs | 0.13 | 0.08 | 0.05 | <0.01 | 0.37 | 0.25 | 0.08 | <0.01 |

C. Publications

Published

Gates, D. M., Gillespie, G. L., Smith, C., Rode, J., Kowalenko, T., & Smith, B. (2011). Using action research to plan a violence prevention program for emergency departments. Journal of Emergency Nursing, 37(1), 32-39. doi: 10.1016/j.jen.2009.09.013. PubMed PMID: 21237365.

Gates, D. M., Gillespie, G. L., Kowalenko, T., Succop, P., Farra, S., & Sanker, M. (2011). Occupational and demographic factors associated with violence in the emergency department. Advanced Emergency Nursing Journal, 33(4), 303-313. doi: 10.1097/TME.Ob013e3182330530. PubMed PMID: 22075681.

Gillespie, G. L., Gates, D. M., & Mentzel, T. (2012). An educational program to prevent, manage, and recover from workplace violence. Advanced Emergency Nursing Journal, 34(4), 325-332. doi: 10.1097/TME.Ob013e318267b8a9. PubMed PMID: 23111308.

Kowalenko, T., Gates, D. M., Gillespie, G. L., Succop, P & Mentzel, T. (2013}. Prospective Study of Violence Against ED Workers. American Journal of Emergency Medicine 31, 197-205. doi: 10.1016/j.ajem.2012.07.010. PubMed PMID: 23000325.

Accepted for Publication:

Gillespie, G. L., Gates, D. M., Mentzel, T., Al-Natour, A., & Kowalenko, T. (2012). Evaluation of a comprehensive violence prevention program. Journal of Emergency Nursing.

Under Review

Gillespie, G. L., Bresler, S., Gates, D. M., & Succop, P. (2012). Symptoms of posttraumatic stress in emergency department workers following workplace aggression. Manuscript submitted to Workplace Health & Safety.

D. Enrollment Data

See Inclusion Enrollment Report Form attached

E. Inclusion of Children

Not included

Not applicable

Program Director/Principal Investigator (Last. First, Middle): Gates, Donna M.

# Inclusion Enrollment Report

This report format should NOT be used for data collection from study participants.

Study Title: A Multi-Site Intervention to Reduce Violence in Hospital Emergency Departments

Total Enrollment: ---------- Protocol Number: ----------

Grant Number: 1R01OH009544

PART A. TOTAL ENROLLMENT REPORT: Number of Subjects Enrolled to Date (Cumulative) by C+hni,.i+" and Race

| Ethnic Category | Females | Males | Sex/Gender Unknown or Not .,..,v,...:: | Total |
|---|---|---|---|---|
| Hispanic or Latino | 1 | 2 | 0 | 3 ** |
| Not Hispanic or Latino | 139 | 60 | 0 | 199 |
| Unknown (individuals not reporting ethnicity) | 69 | 38 | 0 | 107 |
| Ethnic Category: Total of All Subjects* | 209 | 100 | | 309 * |
| Racial ries | | | | |
| American Indian/Alaska Native | 1 | 0 | 0 | 1 |
| Asian | 4 | 5 | 0 | 9 |
| Native Hawaiian or Other Pacific Islander | 0 | 1 | 0 | 1 |
| Black or African American | 20 | 12 | 0 | 32 |
| White | 181 | 78 | 0 | 259 |
| More Than One Race | 2 | 4 | 0 | 6 |
| Unknown or Not Reported | 1 | 0 | 0 | 1 |
| Racial Categories: Total of All Subjects* | 209 | 100 | | 309 * |

PART B. HISPANIC ENROLLMENT REPORT: Number of Hispanics or Latinos Enrolled to Date (Cumulative)

| Racial Catc:yu••c::o | Females | Males | Sex/Gender Unknown or Not Reported | Total |
|---|---|---|---|---|
| American Indian or Alaska Native | 0 | 0 | 0 | |
| Asian | 0 | 0 | 0 | |
| Native Hawaiian or Other Pacific Islander | 0 | 0 | 0 | |
| Black or African American | 0 | 0 | 0 | |
| White | 0 | 1 | 0 | 1 |
| More Than One Race | 1 | 1 | 0 | 2 |
| Unknown or Not Reported | 0 | 0 | 0 | |
| Racial Categories: Total of Hispanics or Latinos** | 1 | 2 | | 3 ** |

* These totals must agree.

** These totals must agree.