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Minimizing Workplace Violence by Initiating an Evidence-Based Community Meeting

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B.S. Nursing – University of Missouri-St. Louis, 2016

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in partial fulfillment of the requirements for the degree

Doctor of Nursing Practice with an emphasis in Psychiatric – Mental Health Nurse

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Abstract

Problem: Workplace violence (WPV) in healthcare has become an epidemic demanding change. WPV is three to four times higher in the healthcare industry compared to other workplaces. For this project, WPV will be defined as any act of physical violence from a patient to a staff member. Community meetings are one evidence-based approach to decreasing WPV in psychiatric inpatient hospitals. **Methods:** This descriptive observational project compared data before and after implementing a targeted WPV community meeting, including unit rules, staff and patient expectations, a definition of WPV, and medication options available to reduce anxiety and irritability. This project assessed the impact of the community meetings. The aim was to reduce incidents of WPV by 20% during a 90-day pilot period. The primary outcome measure of interest was the incidence of WPV. The question being addressed: For adult patients aged 18-years and older admitted to an inpatient psychiatric unit, what is the effect of implementing a targeted WPV community meeting on WPV over a 90-day period compared to a general community meeting as conducted prior to its implementation? **Results:** Prior to implementing the targeted WPV community meeting, there were ($N=10$) physical assaults by patients toward staff from June through August 2020. Following implementation from June-August 2021, there were ($N=5$) physical assaults. **Implications for Practice:** Community meetings support the decrease of WPV by encouraging a shift within the culture by setting a climate for respect between patients and staff and creating a safer environment.

Minimizing Workplace Violence by Initiating an Evidence-Based Community Meeting

Workplace violence (WPV) in healthcare has become an epidemic demanding change. WPV is three to four times higher in the healthcare industry compared to other workplaces (Arnetz et al., 2017; Halm, 2017). While WPV occurs throughout the healthcare setting, psychiatric units tend to have nearly one in five patients engage in WPV (d'Ettoree & Pellicani, 2017; Khazaie, Ahmadi, & Maroufi, 2017). Patients admitted to an inpatient psychiatric unit involuntarily tend to have more violent behavior on the unit (Niu et al., 2019). Khazaie et al. (2017) defined WPV as an intentional physical or emotional force on individuals to harm or threaten while at their workplace. Halm (2017) defined WPV as a threat or act of violence, harassment, or threatening behavior. The Occupational Safety and Health Administration (OSHA) outlined WPV as any physical or nonphysical violence directed at an employee (Saragoza & White, 2016). It is evident that WPV can have many definitions, but for this project, WPV will be defined as any act of physical violence by a patient towards a staff member. Community meetings are one evidence-based approach to improving WPV in the inpatient psychiatric setting (Halm, 2017; Lanza, 2017).

Conducting community meetings in the workplace could reduce the incidence of WPV in healthcare among nurses (Halm, 2017). Assault rates are correlated with time spent with patients, which could explain the vulnerability of nurses (see Phillips as cited in Martinez, 2016). In 2017, WPV accounted for approximately one-half of all fatal occupational injuries in hospitals in the United States (U.S.) (Arnetz et al., 2017). State hospitals have 154 injuries per 10,000 full-time employees (FTEs), while the overall state sector has 32.1 injuries per 10,000 FTEs. Private hospitals report 16.8 injuries per 10,000

FTEs, while the overall private sector reports 4.0 per 10,000 FTEs (Arnetz et al., 2017). From 1999 to 2014, there was a 76% increase in forensic patients in state hospitals (Wik, Hollen, & Fisher, 2020). Furthermore, the exact number of WPV is unknown mainly due to underreporting of events. In fact, only 20% to 60% of occurrences are reported (Grant, 2021). Healthcare workers grossly underreport WPV for many reasons, including the impression WPV comes with the job, believing the situation will not change, and fear of retaliation (Grant, 2021; Saragoza & White, 2016).

As previously mentioned, community meetings are one evidence-based way to address WPV. They are meant to be a safe space to encourage healthcare workers and patients to address concerns and have been shown to reduce WPV by up to 85% (Lanza et al., 2009; Lanza, 2017; Martinez, 2016). Community meetings act as a preventative measure for WPV by encouraging a united culture of safety and respect between patients and staff (Lanza, 2017). Although community meetings have been around since the 1940s, literature is scarce and often outdated. Lanza et al. (2016) explained many articles yielded beneficial results but failed to provide statistical data. This descriptive observational project compares data before and after the community meetings' re-implementation, including a review of unit rules, expectations of staff and patients, defining violence, and ways to access medication options to reduce anxiety and irritability.

Through community meetings, there is an opportunity to decrease the incidence of WPV in psychiatric inpatient hospitals. This project studied the impact of implementing a targeted WPV community meeting on the number of WPV incidents occurring in two inpatient psychiatric units of a large academic medical center located in an urban

metropolitan area. The Iowa Model for Evidenced-Based Practice (EBP) was selected to guide this project. The aim was to reduce the incidence of WPV by patients toward staff in the psychiatric units by 20% during a 90-day pilot period. The primary outcome measure of interest was the incidence of WPV from patient to staff. The question being addressed for this project: For adult patients aged 18-years and older admitted to an inpatient psychiatric unit, what is the effect of implementing a targeted WPV community meeting on WPV over a 90-day period compared to a general community meeting as conducted prior to its implementation?

Review of Literature

A comprehensive review of the current literature was conducted using Summon, CINAHL, and EBSCO databases. The review was conducted in two parts: (1) WPV in a healthcare setting and (2) community meetings. The keywords “*workplace violence*” AND “healthcare;” “psychiatry” OR “*mental health*” “*community meeting;*” AND *healthcare* AND “*behavioral health*” OR “psychiatry” were used to locate articles examining WPV and community meetings. Inclusion criteria included studies of peer-reviewed articles written in English, studies with participants 18-years of age and older, and studies on WPV, inpatient psychiatry, and healthcare. Exclusion criteria included articles written in a language other than English and studies with participants younger than 18-years of age. Twenty-eight peer-reviewed articles were selected, and 11 were retained for final review. Of the 11 articles, two were systematic reviews, one was a meta-analysis, four were reviews of studies, and four were expert opinions/observations.

In the healthcare setting, particularly in psychiatric units, WPV occurs often. In fact, nearly 20% of patients admitted to the acute psychiatric unit will commit WPV

(d'Ettoree & Pellicani, 2017; Khazaie et al., 2017). WPV is associated with risk factors and environmental factors. Risk factors include young adults, a diagnosis of schizophrenia, a history of substance abuse, and a history of violence (d'Ettoree & Pellicani, 2017; Khazaie et al., 2017). Environmental factors include long wait times, inadequate security, overcrowding, off shifts (night, weekend, and holidays), lack of de-escalation training, and lack of therapeutic activities (Halm, 2017; Niu et al., 2019).

Exposure to WPV has a detrimental impact on patients, staff, and the organization. Patients are adversely affected by WPV through reduced care quality, less staff able to safely care for them, and increased risk of medical errors (d'Ettoree & Pellicani, 2017; Grant, 2021; Niu et al., 2019). WPV negatively impacts staff through anger, fear, or anxiety; post-traumatic stress disorder; guilt, blame, and shame; and increased intent to leave the profession (d'Ettoree & Pellicani, 2017; Niu et al., 2019). Lastly, the organization is negatively impacted due to high staff turnover, decreased staff morale, unreceptive work environments, and economic burden from disability leave and reduced quality of care (d'Ettoree & Pellicani, 2017; Niu et al., 2019).

Community meetings have the potential to positively impact the patients, staff, and hospital as a whole. For community meetings to be impactful, successful, and meaningful, they must discuss unit rules, unit safety, a protocol for patients when they begin to feel a loss of control, problem-solving scenarios, violence reduction, and alternatives to violence (Lanza, 2017). Martinez's (2016) review of evidenced-based literature from 2009 to 2016 discovered that violence prevention community meetings decreased the incidence of violence by 85% among all shifts during a nine-week pilot study. In a seminal study, Lanza et al. (2009) highlighted the effectiveness of community

meetings when using a 20-week research design consisting of four phases. Phase one, pre-treatment, was a three-week period that allowed nursing staff to record violence as usual. Phase two, transition, was a four-week period during which nurses recorded violence and introduced the WPV community meetings. Here, different patterns of meetings were tested. Phase three, treatment, was a nine-week period during which the violence prevention community meetings were held twice a week, and staff continued to record violence. Lastly, Phase four, post-treatment, was a four-week period during which violence was recorded following the termination of the meetings. The results indicated that violence decreased by 89% (Lanza et al., 2009).

In an additional seminal study, Alnasser (2013) provided added support on the impact of community meetings from five studies to determine the purpose of community meetings in an inpatient psychiatric unit. Kisch et al. (1981) (as cited in Alnasser, 2013) noted patients are often uncertain about the purpose of community meetings. According to Winer and Klamen (1997) (as cited in Alnasser, 2013), community meetings should have an interpretative objective. They should focus on the relationship between staff and patients and the maladaptive ways patients can interpret staff, and they should be used to discuss these issues from the patient and staff perspectives. Also, the meeting creates an opportunity to increase medication compliance by educating the patients about psychotherapeutic and pharmacological interventions (Alnasser, 2013).

There are many ways to lead community meetings. According to Lanza (2017), community meetings should address disagreements, confusion, fears, and anger. When beginning the meetings, staff should introduce themselves, have everyone in attendance introduce themselves, and set ground rules to ensure the safety of everyone participating

in the community meetings. Topics in the meetings should include unit rules, what violence is, and what to do when you get angry (Alnasser, 2013; Lanza, 2017; Martinez, 2016). Lanza (2017) also recommended staff encourage patients to express appreciation and support. Staff should model respectful behavior to one another and patients. Alnasser (2013) explained that community meetings allow patients to reveal feelings towards staff and the meaning behind the feelings. The meetings allow staff and patients to address concerns, discuss both perspectives, and take feedback positively, thus decreasing overall tension in the unit (Alnasser, 2013). During the meetings, patients and staff are expected to pay attention, listen, participate, and voice feelings and concerns, allowing for discussions on how patients can work to avoid violence and with staff to minimize violence. Addressing the causes, consequences, and alternatives to violence is crucial, along with facts on violence and rumors about assaults (Lanza, 2017). Key elements of community meetings include consistency, stating unit rules, promoting the goal of violence reduction and the importance of safety, and patients and staff intermixed during the meeting (Lanza, 2017; Martinez, 2016).

Apart from being an effective way to decrease assaults, community meetings are cost-effective. The meetings are easy to teach and can be utilized when there is rapid turnover. Also, nurses and mental health technicians can conduct the meetings (Lanza et al., 2016). Community meetings can be a powerful tool for staff; however, research indicates that staff frequently lack the training needed to provide successful community meetings, often delegated and left to junior staff. The typical atmosphere reveals apathy and lack of interest with low attendance levels (Novakovic, 2011).

The Iowa Model for EBP allows clinicians to identify and address clinically significant areas by providing a step-by-step outline. This outline includes identifying the trigger, compiling evidence, and implementing an intervention (Dang et al., 2019). WPV has become a problem-focused trigger within the healthcare community. Implementing an evidence-based community meeting is a priority. Based on the literature review coupled with the increase of WPV at the identified facility, there was adequate data to conduct a pilot project utilizing a targeted WPV community meeting.

In summary, a targeted WPV community meeting has the potential to decrease the incidence of WPV substantially if appropriately performed. Overall, the tension in the unit can decrease by allowing staff and patients to address concerns, discuss both perspectives, and take feedback in a positive way (Alnasser, 2013). As mentioned earlier, successful community meetings should begin by reviewing unit policies and the unacceptability of violence. Then, meetings would allow for discussion on how patients can work together to avoid violence and work with staff to minimize violence by addressing the causes, consequences, and alternatives to violence (Lanza, 2017; Martinez, 2016).

Method

Design

This project used a descriptive observational design to evaluate the impact of a targeted WPV community meeting and was completed over three months from June 2021 through August 2021.

Setting

The project took place at a large academic medical center located in an urban metropolitan area. Two inpatient psychiatric units were utilized, one adult acute intensive unit and one adult/geriatric unit.

Sample

A convenience sample was used for this descriptive observational project. The acute intensive psychiatric unit holds up to 18 patients, and the adult/geriatric unit holds up to 18 patients. Consistently, there were 24 patients collectively on the units. Prior to the restructured community meeting, the meeting(s) had an attendance of eight to 10 patients from the two units combined. The inclusion criteria were patients aged 18-years old and older, mental health technicians, licensed practical nurses, registered nurses, and employees who have signed off on the community meeting training and agreement. The exclusion criteria were patients younger than 18-years old, student nurses, nursing interns, and employees who have not signed off on the community meeting training and agreement.

Procedure

A team of key stakeholders was formed, including the consulting nurse practitioner for the unit, the practice nurse specialist, and the graduate nursing student. The preliminary work for the project included the monthly stakeholders meeting from September 2020 to December 2020 to review guidelines and the information disseminated at the community meetings before restructuring. The community meeting was restructured from December 2020 to January 2021, and the format was approved in March. From April to May 2021, staff was trained on the restructured community

meeting, the violence prevention community meeting group completion sheet, and the assault datasheet. The implementation of the restructured community meeting started in June 2021, and data was collected through August 2021.

Data Collection

To ensure confidentiality, the data collected did not include any identifiers, such as name, medical records number (MRN), or address. The data instrument used to collect data on the assailant included legal status (voluntary versus involuntary), age, sex, assault type, result in injury, repeat assault, and the number of repeats (see Appendix A). Staff was educated on how to record community meetings and assault data. The community meetings were scheduled to be held every Tuesday and Thursday and recorded on the Violence Prevention Group Completion form (see Appendix B).

Approval Process

Approval was obtained from the Psychiatric Director of Patient Care and the Psychiatric Clinical Nurse Manager, the Doctor of Nursing Practice (DNP) committee, the hospital system's institutional review board (IRB), the University's IRB, and the Graduate School.

Results

Prior to implementing the targeted WPV community meeting, there were ($N=10$) physical assaults by patients toward staff from June through August 2020. Of all ($N=10$) physical assaults, 40% ($n=4$) were with injuries, and 20% ($n=2$) were by repeat assailants. Following the implementation of the targeted WPV community meeting from June-August 2021, there were ($N=5$) physical assaults by patients toward staff. Of all ($N=5$) physical assaults, 40% ($n=2$) were with injuries, and none were repeated assailants.

Every assault involved a patient whose admission status was involuntary ($N=15$, 100%). The age of the assailants ranged from 23 to 74-years of age, and the average age for assailants was 44.13-years old. There were seven male assailants and eight female assailants. Although the number of male assailants to female assailants was nearly equal, there were some notable differences. Male assailants ranged from 30-74-years old, and most men assaulting staff tended to be older than the female assailants, ranging from 60 to 69-years old. On the other hand, women assailants ranged from 24-52-years old, and most women assaulting staff tended to be younger, ranging from 20-29-years old. Out of ($N=15$) assaults from pre-and post-implementation, 13.3% ($n=2$) involved a male patient injuring staff, while 26.7% ($n=4$) involved a female patient injuring staff. As data suggests, women were twice as likely to injure staff members than men during the evaluation period. A Fisher's Exact Test was performed to compare repeat assaults and assaults with injuries pre-and post-intervention. The p -value for results of injury ($p=.706$) and p -value for repeat assaults ($p=.429$) showed not to be statistically significant. Although the project was found not to be statistically significant, the project proved to be clinically significant, with a 50% reduction in WPV.

Discussion

This project intended to implement a targeted WPV community meeting to include unit rules and safety, a protocol for losing control, problem-solving scenarios, coping skills, and alternatives to violence. The intervention reduced the incidence of WPV by 50%, from ten to five incidents.

Despite a significant reduction in the incidence of WPV, there were still several limitations that existed, including the resignation of the Psychiatric Clinical Nurse

Manager and one Assistant Nurse Manager, and another Assistant Nurse Manager stepping down. The loss of management resulted in a lack of force to drive the project. Also, there was a staffing shortage of nurses and mental health technicians, which resulted in one unit being closed and two units being capped for a safe nurse-to-patient ratio. The loss of management and the staffing shortage affected the consistency of the meetings. The meetings would be performed during random hours, and there were weeks the meetings were missed. Lastly, the small sample size was unable to test for statistical significance. Despite these limitations, strengths were gleaned from this project, including a meaningful Violence Prevention Community Meeting script for all staff to follow. Also, a safe space was created for staff and patients to address concerns. Recommendations for future studies include a clear definition of assaults, noting the reason for the assault, assessing over a 6-month period, collecting patient diagnoses, offering interventions at least three times a week during scheduled times, implementing the community meetings on pediatric psychiatric units, and training new staff on demographic factors that put a patient at risk for assault.

Conclusion

Although the project's impact was not statistically significant due to its small sample size, it was clinically significant, with a 50% violence reduction after implementation. The results suggest a more extended timeframe of data collection with a larger sample size could show a statistical significance and provide more support for the clinical significance. Violence Prevention Community Meetings are essential in a climate where workplace violence is prevalent. Every organization should consider supporting these meetings in order to protect their staff and patients. The community meetings

provide the patient with an environment where their concerns are heard. These meetings support the decrease of WPV by encouraging a shift within the culture by setting a climate for respect between patients and staff, ultimately creating a space for a safer environment. Through these community meetings, patients, staff, and organizations have an opportunity to address challenges associated with WPV. The organization also benefits from the effectiveness of community meetings by increasing staff morale or job satisfaction, improvement in patient care quality and care outcomes, and cost savings.

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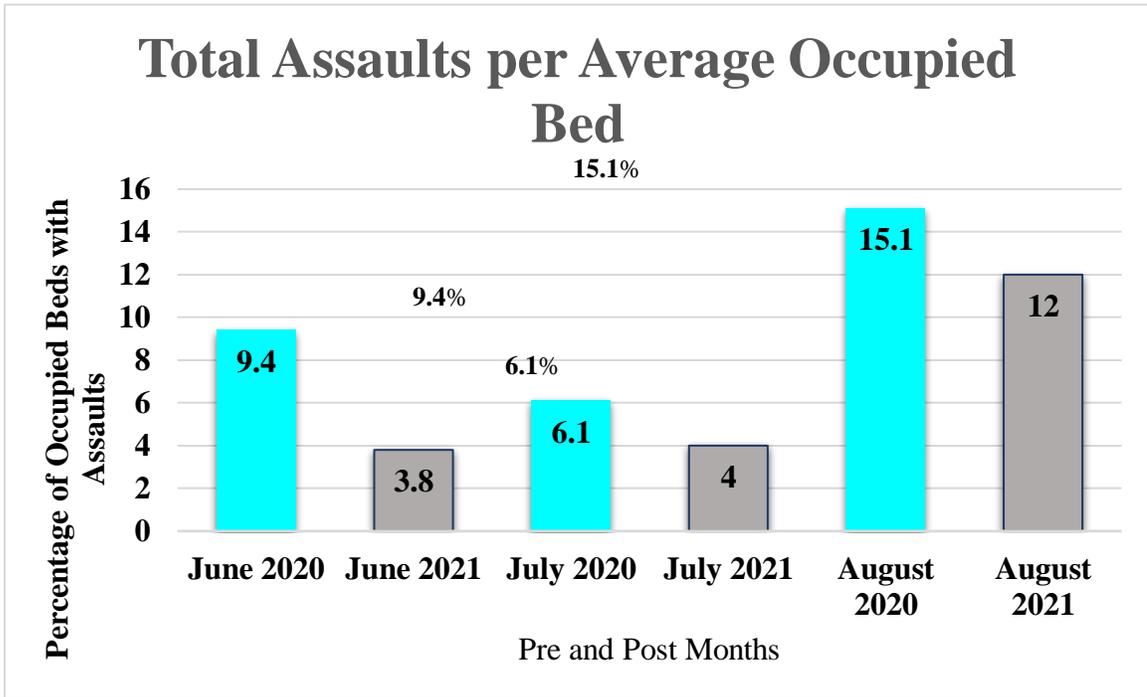
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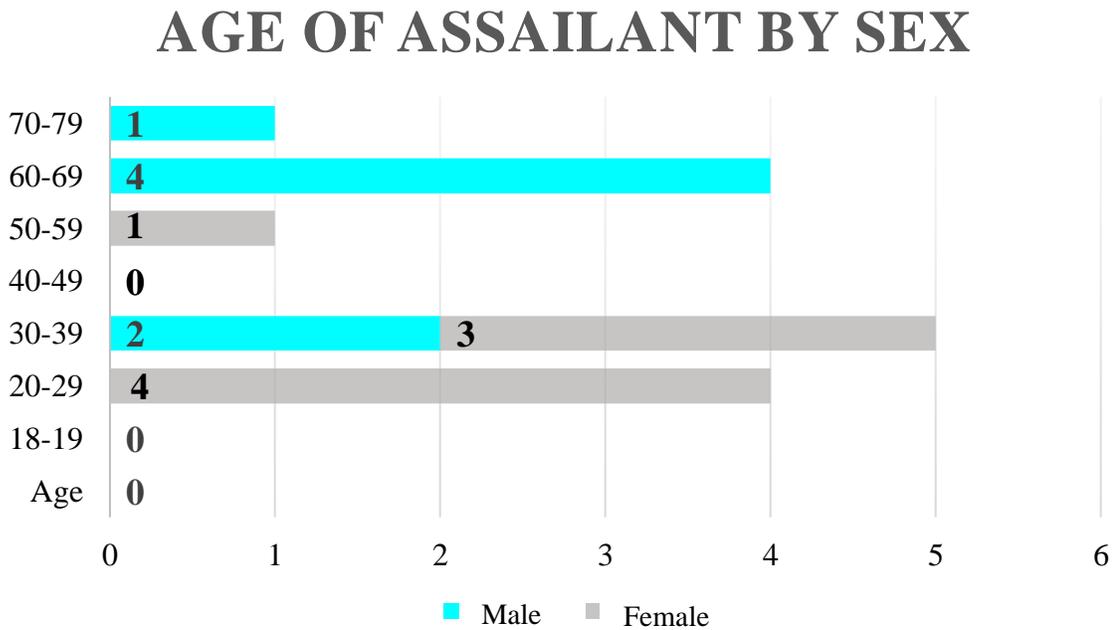
Appendix C

Figure 3. Total Assaults per Average Occupied Bed



Appendix D

Figure 4. Assaults by Age and Sex



Appendix E

Figure 5. Percentage of Injuries per Sex of Assailants

