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## Auditing Workplace Aggression and Violence in the Emergency Department

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# **Auditing Workplace Aggression and Violence in the Emergency Department**

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Doctor of Nursing Practice with an emphasis in Leadership and Population Health

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### **Abstract**

**Problem:** Emergency Department (ED) staff are not reporting patient and visitor episodes of aggression and violence. The rate of violence per patient visit is unknown.

**Methods:** An observational, descriptive quality improvement project about Type I and II workplace aggression and violence (WAAV) reporting by ED staff and security consisted of education, an anonymous survey of the previous six months of WAAV, and a monthlong anonymous WAAV audit in a Midwestern ED.

**Results:** The survey response rate was 59% with 65% never reporting WAAV, 13% reporting all WAAV occurrences, 9% reporting some occurrences, and 13% usually not experiencing WAAV. The most significant reason for not reporting was the lengthy time involved in the reporting process. In 2021, there were 33,380 ED presentations and eight formal incident reports concerning Type I and II WAAV episodes for a rate of .02% of episodes per 100 visits. During the monthlong audit, staff completed 37 audits for a rate of 1.3 per 100 ED visits. Twenty-eight (76%) of reporters experienced aggression or violence and nine (24%) observed the episodes. Physical assaults were an element of eight audits, and verbal abuse was a component of 29 audits. Staff reported threatening behavior was an element of 21 events. No formal incident reports were completed.

**Implications for Practice:** The audit rate illustrated a more realistic picture of typical WAAV encountered in real time, so future safety efforts can measure improvement.

*Keywords:* workplace aggression and violence, incident report, audit, emergency department

### **Auditing Workplace Aggression and Violence in the Emergency Department**

Clinicians routinely encounter workplace aggression and violence (WAAV). The problem is an epidemic (Emergency Nurses Association [ENA], 2019), with a preponderance of international research describing the worldwide phenomenon. Mental health areas and emergency department (ED) staff face WAAV at higher rates than clinicians in any other setting (McGuire et al., 2021). Emergency departments (EDs) straddle the community and healthcare settings, servicing a wide swath of patients. The patients served include, but are not limited to, those in police custody, those with weapons, those with mental health diagnoses, those who are homicidal, victims of violent crimes—like gunshot wounds, victims of trauma, those who have suffered from overdoses, those with chronic diseases, those with myocardial infarctions and strokes, those with acute conditions like pancreatitis, and those who have no other place to seek routine care. Patient volume overload and limited capacity can cause long wait times in uncomfortably crowded quarters. These conditions increase the anxiety levels of patients, family members, and staff. The environment is ripe for altercations; the triage area is especially risky. ED episodes of WAAV are common and often severe (ENA, 2019). The ENA (2019) created a position paper about this issue.

The United States Occupational Safety and Health Administration (OSHA) defines WAAV as “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior” transpiring at an employment site (OSHA, n.d.). ED WAAV perpetrators include patients, family members, interlopers, and colleagues. In fact, the National Institute for Occupational Safety and Health divide WAAV into four classifications by the perpetrator-staff member relationship. In Type I, the employee and perpetrator have no relationship. Type II perpetrators are patients or visitors. Type III

perpetrators are colleagues, and Type IV are those with a personal relationship with the employee (American Nurses Association [ANA], 2019). This paper focuses on Types I and II. WAAV incidents negatively impact the physiologic and mental health of individual employees. Some episodes lead to injury, and some incidents traumatize clinicians. The high prevalence of WAAV adversely affects institutions' patient care, retention, organizational engagement, and staff members' desire to remain in the clinical arena. The exact financial costs are undeniably significant but difficult to measure due to the affected areas' scope and overlap with other organizational challenges (ENA, 2019). The Joint Commission [TJC] (2021) recognized this pervasive problem and is implementing WAAV standards in January 2022.

The ENA position paper (2019) describes another issue with WAAV: the lack of incident reporting. As many as 40% to 80% of nurses are not reporting encountered WAAV (ANA, 2019). Reasons for not reporting these episodes are abundant. Patient throughput is highly valued but conflicts with a time-consuming and complex reporting process. Episodes are challenging to categorize. Clinicians are undereducated about WAAV recognition, communication, prevention, de-escalation, and security-related actions. Additionally, clinicians do not understand institutions' policies. Institutions have an informal culture of ignoring incidents or excusing patients of abhorrent behavior related to their diagnoses. Furthermore, clinicians fear retribution and normalize WAAV as a job condition. (ENA, 2019; ANA, 2019; Hogarth et al., 2016; Mophet et al., 2019). The ENA (2019) advises institutions to clarify WAAV-related policies, bolster staff communication skills, make the reporting process efficient, and decrease the time involved in reporting to increase clinician uptake. In fact, TJC (2021) is requiring

hospitals to conduct ongoing system improvements for reporting, collecting data, and evaluating data as part of the 2022 standards.

A hospital serving a Midwestern metropolitan area and surrounding rural counties noticed an uptick in ED WAAV events without corresponding incident reporting compliance. The hospital has ongoing staff safety, WAAV prevention, and WAAV reduction initiatives. The ED had previously conducted a quality improvement (QI) project to increase staff reporting episodes. The earlier project included hanging a pareto chart in the ED and encouraged all staff to post incidents of verbal WAAV on the chart. ED leadership encouraged staff to call security for each episode of physical violence, and security took responsibility for filing most of the reports. Additionally, the hospital has a workplace violence committee. The committee created a behavior emergency response (BERT) team to de-escalate interactions before they become episodes of WAAV. The hospital did not have a behavioral health department and consequently did not have a mental health representative on the BERT team. The hospital was investigating proactive approaches to prevent staff from being injured by patients with confusion and dementia.

Furthermore, the health system safety team was focused on improving the backend of WAAV incident reporting. The reporting system made following and remedying incidents challenging. One reason was a report may have been duplicated three times if the subject falls into different categories, like patient safety, staff safety, and security; no feature within the system linked the separate entries together for accurate tracking and solution-finding. The focus on WAAV safety was an opportunity for frontline staff to collect data on accurate WAAV rates.

The recent uptick in WAAV incidents over the past six months in the ED offered an opportunity for another WAAV reporting quality improvement project. The purpose was to implement an ED staff audit to document WAAV occurrences in real time. The Knowledge-to-Action (KTA) Model provided a framework for the project (White, 2021). The aim was to quantify the gap between WAAV episodes and correlating incident reports. The project's primary outcome measure was to identify the number and types of WAAV events occurring. The secondary outcome measures were determining the ED staff's most severe barriers to completing incident reporting and increasing completed WAAV incident reports. The question for study was: In ED staff, what is the difference in completed WAAV audit rates per patient visits and completed WAAV incident report rates per patients visits during a six-week period?

### **Literature Review**

CINAHL, MEDLINE, Scopus, ERIC (Educational Resources Information Center) and the Cochrane Library were used to conduct the literature search. The initial English language search for academic literature between 2015 and 2021 included the following keywords and MeSH terms:

- clinicians or health professionals or nurses or physicians or hospital
- workplace
- aggression or violence
- emergency department or emergency room
- report

The search produced 72 results based on key terms, subject headings, and titles. The search expanded MeSH term *report* to *report or questionnaire or survey or prevalence or*

*incidence or cross-sectional* to produce 310 results. Exclusion criteria were *pediatrics or child or children, lateral violence or bullying or incivility, and coping or resilience or stress or satisfaction*. After employing inclusion and exclusion criteria, 173 relevant search results were produced. Articles were excluded if the focus was violence prevention, de-escalation, or interventions to decrease violence. Also, research occurring in psychiatric departments was excluded. Articles focusing on reporting incidence or prevalence and reporting barriers and enablers were included. Eleven publications were chosen to review the literature (Appendix A).

While we know healthcare WAAV is an epidemic, this problem was challenging to quantify. Most research related to the incidence and prevalence of this problem is retrospective, descriptive, and/or often cross-sectional. Much available data is from state, local, or organizational databases related to injury, security, or injury events. Retrospective data collected from reports likely underestimate the issue, whereas cross-sectional surveys are subject to recall bias. Clinicians who experienced WAAV or have strong feelings related to the issue may be more likely to participate in WAAV research. Regardless, this area of research does elucidate staffs' perspectives about reporting. Most qualitative explorative research in this area seeks to understand the obstacles and enablers to reporting.

Thomas et al. (2021) and Hogarth et al. (2016) both conducted descriptive, explorative research via focus groups, with the first study using a convenience sample and the second using a purposeful sample. Each study recruited fewer than 20 Australian ED nurses. Both studies found WAAV was underreported due to staff normalizing violence, the reporting process taking too long, and the complexity of the reporting



system. Hogarth et al. (2016) found nurses stated the “zero tolerance” policies were ignored. Nurses in Thomas et al.’s study (2021) described additional challenges: previous poor interactions with police, complicated perpetrators, and lack of visible organizational follow-up. Nurses in both studies stated they felt more encouraged to report after seeing organization efforts such as WAAV programs and learning about letters to perpetrators. Additional themes emerging from Hogarth et al.’s (2016) participants’ were that incident reports were completed when staff perceived the paperwork could serve as protection from potential complaints and after experiencing significant physical harm. This research revealed numerous recommendations to increase reporting, including quicker follow-up, and leadership showing immediate and sustained concern for staff members who experienced WAAV. Results also suggest that organizations could allow staff who submit WAAV incident reports to track the reports through the step-by-step backend process and to observe actionable interventions and the development of educational materials. This change would promote transparency and enhance staff members’ trust that reporting is worthwhile. Organizations could apply consequences consistently and include frontline staff in the organizational response. Clinicians routinely recommended making the reporting process simpler and more efficient (Thomas et al., 2021; Hogarth et al., 2016). Both studies were performed at a single institution on small groups (18 nurses and 15 nurses) and were subject to inherent bias. Participants may not have felt comfortable fully expressing their experiences or concerns in focus group settings (Thomas et al., 2021; Hogarth et al., 2016). However, the following study used the more private interview method and found similar results.

Morphet et al. (2019) performed interviews on a convenience sample of 15 members of safety, quality, and management staff from five United Kingdom urban high-risk hospital settings. While participants had a different vantage point from the previous studies, researchers nonetheless found underreporting prevalent due to a time-consuming, complex process. This study adds to the understanding of the backend of WAAV reporting. Incomplete fields slowed or halted the follow-up process, and duplicate reports were possible for a single episode. For instance, one incident could cause a both patient safety concern and an employee safety issue, which were reported separately. The safety, quality, and management professionals echoed the nurses' recommendations to increase reporting compliance, improve the systems' functionality, encourage staff to report, and share WAAV data with the staff (Morphet et al., 2019).

Cross-sectional surveys were most frequently employed to illustrate gaps between clinicians experiencing or observing WAAV and clinicians' propensity to report the incidents. Much research in this area concentrates on occurrences per clinician. Cho et al. (2020) conducted a survey of U.S. nurses with one year or less experience. The response rate was 36%, with authors collecting survey data from 799 nurses. Authors found 78.4% experienced verbal abuse, with 56.7% experiencing verbal abuse one to three times per month and 21.5% experiencing verbal abuse once per week. Clinicians employed in EDs, inpatient psychiatric units, and intensive care units encountered the greatest percentages of WAAV. Additionally, this survey found new nurses were more likely to report verbal WAAV from patients and visitors than colleagues (Cho et al. 2020). The findings are consistent with the literature. Byon et al. (2021) surveyed 373 U.S nurses from the Midwest and the South about verbal and physical violence from patients and visitors

between the months of February 2020 and May 2020, concurrent with the onset of the COVID-19 pandemic. More than 50% of the convenience sample were employed in EDs. Of responding nurses, 44% were exposed to physical WAAV at least once, with 28.1% experiencing these episodes two to three times. Caring for COVID-19 patients increased the likelihood of exposure to WAAV ( $p=.0003$ ). More than 50% of nurses working with COVID-19 populations were exposed to physical WAAV, whereas 30.1% of those caring only for other populations experienced these incidents. Sixty eight percent of nurses experienced verbal WAAV. Incident reporting compliance was low, with only 27.4% of nurses who experienced verbal or physical WAAV completing an incident report. In fact, 9.5% stated that completing WAAV incident reports was more difficult during COVID than before (Byon et al., 2021). This study used a convenience sample, with most of the nurses responding working in EDs. Likely all ED nurses, gateway clinicians to hospitals, cared for COVID-19 patients. Additionally, as Cho et al. (2020) reported, ED clinicians experience WAAV at the highest rates, which could account for the increased WAAV experienced by nurses caring for COVID-19 patients.

Three studies looked specifically at ED WAAV and compared rates to incident reports, one by self-report and two by incidents reports filed. Unlike the previous surveys, Nimthimathachoke and Wichienopparat (2021) reported a high response rate (87.5%) in their cross-sectional survey of 258 staff members in metropolitan EDs across several Thai institutions. Almost 90% of those surveyed suffered from WAAV, with 85.7% reporting psychological WAAV, 37.6% reporting physical WAAV, 24.8% reporting abrasions, and 13.5% reporting contusions. The frequency of WAAV incident reporting rates was higher than other studies with 35% of staff reporting every incident and 64% not reporting every

incident (Nimthimathachoke & Wichienopparat, 2021). McGuire et al. (2021) used a questionnaire to assess the frequency and nature of WAAV episodes for ED clinicians, other clinical team members, registration personnel, and security officers in a Midwestern city trauma center. Researchers compared the results of 261 completed surveys with incident report volume. Over the half-year, 86% of employees encountered verbal WAAV, and 37% of employees experienced physical WAAV according to survey data. Eleven incident reports were submitted during the six-month timeframe. The rates of WAAV incident reporting compared to self-reported survey data were 5% for verbal and 18% for physical. Of clinicians, other clinical staff, and registration, 69% responded “never” reporting WAAV (McGuire, 2021). Due to the design of the study—sending the survey to ED employees and other departments’ employees who were required to spend some time in the ED—researchers could not report a response rate. Copeland and Henry (2017) had a 63% response rate for their cross-sectional survey of ED staff in a U.S. suburban, shock and trauma center. Of 147 respondents, 88% encountered WAAV within the previous six months; 3% completed incident reports on all episodes. Fifty-three percent completed no incident reports. Ten formal incident reports were completed, and all reported episodes were patient-instigated.

Recommendations for increasing WAAV incident reporting compliance include remedying complex, time-consuming systems. Ramacciati et al. (2021) created a descriptive, observational, prospective cohort study to determine if simplifying the process would improve ED nurses’ perspectives about WAAV reporting, using the framework of factors determining engagement in patient safety incident reporting. Authors made reporting quicker and more efficient with the cell phone application

reporting method. Researchers recruited 184 nurses from 20 different Italian EDs; the submitted reports immediately were routed back to the reporting nurse's health organizations and clinical leadership for follow-up. Authors used a t-test for paired samples to assess whether a change in perspective about reporting occurred between the onset and end of the half-year study. A statistically significant difference ( $t(99) = .614, p < 0.0001$ ) in perspective on reporting was found, with little actual difference in the number of incidents reported. The number of incidents filed during the half-year was similar to the comparison year. A survey with a 59.4% response rate from nurse participants found 54% only experienced verbal WAAV, no one experienced only physical WAAV, 7.4% experienced both verbal and physical, and 38.6% experienced no WAAV (Ramacciati et al., 2021). More than 40% said the cell phone application made them more likely to complete incident reports, 55% were unchanged, and 1% had a reduced likelihood of incident report completion. This study shows that improving efficiency alone will not increase reporting rates.

Two other studies evaluated incident report data, which are completed in real time and less likely to be subject to bias than surveys. Kaeser et al. (2018) analyzed incident report data in retrospective, descriptive research evaluating WAAV incident reports over four years in a Swiss university hospital ED. The hospital had 159,388 patient presentations, and staff filed 84 reports, resulting in 5.3 incident reports for every 10,000 presentations. Authors concluded that WAAV most likely was under-reported (Kaeser et al., 2018). Richardson et al. (2018) confirmed these findings in their study assessing ED WAAV reporting in a New Zealand teaching hospital over a month by implementing an audit tool and comparing the results to standard incident reporting. The audit tool

collected reporter gender, profession, time at work, incident date, incident time, incident location, incident type or types, and incident description. Staff were encouraged to complete both the audit tool and standard practice incident reports. During the audit, the ED had 7,896 visits. Staff completed 107 audit forms, which noted if they experienced or observed WAAV, with 98 episodes of verbal and 19 episodes of physical WAAV reported at a rate of violence at 1.4 episodes per 100 patient visits. Not one WAAV incident report was completed during the audit month. The previous year, 29 ED WAAV incident reports were completed (Richardson et al., 2018). This prospective project effectively illustrates the gulf between WAAV experienced and WAAV reported in hospital systems.

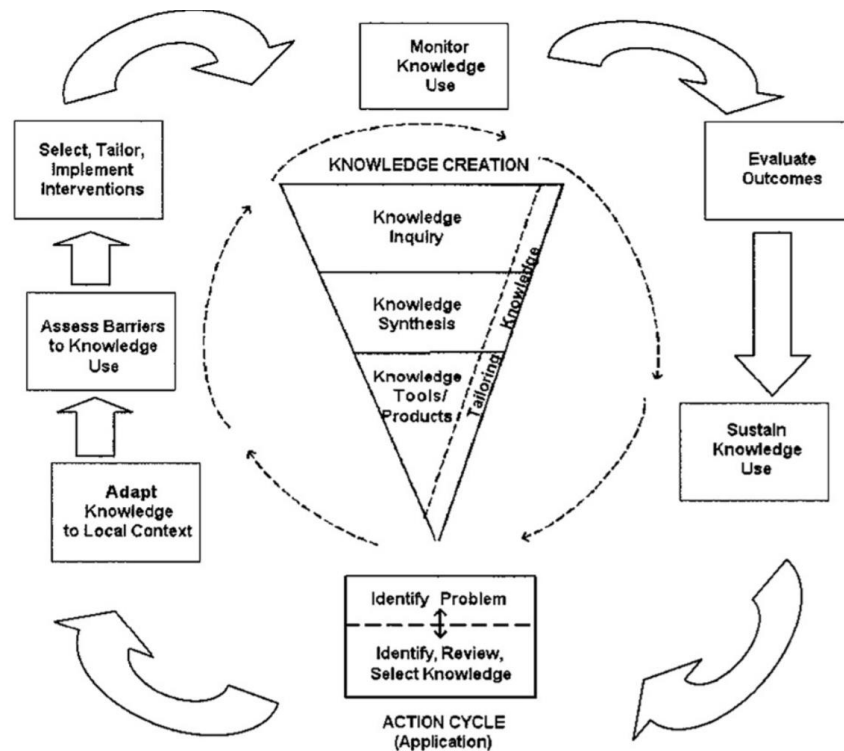
The data is overwhelming with WAAV incidence on the rise for ED staff in the United States and around the world. Even if survey data over-estimates prevalence and severity by double, WAAV is too common. Reporting compliance does not match occurrence rates, with staff reporting as infrequently as less than 1% of episodes (Richardson et al., 2018). Time-consuming, complex systems deter reporting, as do clinicians normalizing WAAV behaviors. Other hurdles are nontransparent processes, staff not believing organizations stand behind their policies, and staff perceiving their efforts as in vain. Without data that accurately represents incidents, how can leaders measure the effectiveness of prevention and reduction interventions? Incidence assessments need to be performed in real time to determine how many incidences go unreported in relation to patient visits.

This WAAV reporting project encompassed security and other staff who may not be familiar with evidence-based practice implementations. The KTA Model (White,

2021; see Figure 1) was ideal due to the framework's simplicity. Instead of using verbiage about "practice," KTA refers to "action" to promote participation from clinical and nonclinical staff alike. The seven steps correspond to the QI initiative. Though the framework is shaped like a pyramid standing on its point, KTA has a continuous feedback loop to learn and incorporate new information. The framework emphasizes the iterative process of refining implementation based on local knowledge, local barriers, monitoring, and evaluation (White, 2021). This loop was imperative to refining the project.

**Figure 1**

*Knowledge to Action Model*



*Note:* From Straus, S., Tetroe, J., & Graham, I. (2009). Knowledge translation is the use of knowledge in health care decision making. *Journal of Clinical Epidemiology*, 64(1).

<https://doi.org/10.1016/j.jclinepi.2009.08.016>

As the project director (PD) sought stakeholder input and approval, the PD learned of local and systemwide efforts to improve WAAV reporting. The three-part project was revised to complement the employee safety team's existing effort. The initial survey was based on lengthy questionnaires created by hospital associations, and the education was based on WAAV definitions, policies and procedures. Stakeholder feedback and continued literature exploration led to less time-consuming examples. The survey was redesigned to focus on Type I and II violence experienced and reporting hurdles, and this questionnaire was completely different from the original tools. The first project iteration approved by the hospital chief nursing officer was a new incident report tool. However, the system already invested in improving the current incident reporting system, *Riskconnect*, the organization's information system for reporting both patient and employee safety events. A continued literature search revealed Richard et al.'s (2018) audit, which was more efficient than the current reporting system and had the benefit of real-time data collection. ED staff helped modify types of violence collected according to WAAV they experienced. For instance, one physician recounted several episodes of microaggression and requested *racial* and *gender slurs* be added to the audit. Several cycles into KTA, the project had been redesigned to concentrate on determining rates of WAAV, so future WAAV reporting QI can evaluate efficacy.

## **Methods**

### **Design**

This QI project used an observational, descriptive design. Data was collected through survey (Appendix B), audit (Appendix C), and WAAV incident report review. Data collected included the barriers to submitting incident reports, types of WAAV encountered, and quantity of WAAV episodes per audit and per incident report.



**Setting**

This project occurred in an ED that serves a Midwestern county and borders several rural counties with 33,380 patient presentations in 2021. Approximately 4% of the hospital's patients were uninsured and 50% had Medicaid or Medicare. The ED is a Level I Critical Diagnosis STEMI Center and Level I Stroke Center.

**Sample**

The potential survey sample consisted of staff employed by the emergency department and security, including 92 employees. The potential audit sample was comprised of staff assigned to the ED who witnessed WAAV during a six-week timeframe. The survey and audits were anonymous.

**Approval Processes**

The organization's Institutional Review Board (IRB) and University of Missouri—St. Louis's (UMSL's) IRB determined that the project did not constitute human subjects research Appendices D & E). The survey and audits were designed to minimize the risk of linking incidents to specific people and did not collect personal identifying information. The surveys were electronic and only available via QR code. The audits were available in two formats, electronically and via paper. Paper audits were collected in a locked box, placed in the security office, located in the ED. Individual responses for both the survey and the audit were available only to the doctoral student PD leading the project.

**Data Collection Analysis**

The survey was designed to be completed quickly, and the audit form was modified from Richardson et al.'s (2018) tool according to staff and leadership input.

Formal, written permission to modify the audit tool was obtained from the corresponding author of Richardson et al. (2018) (Appendix E). All data collection was anonymous. The survey was only available electronically via Qualtrics, did not collect internet protocol (IP) addresses and was accessed via QR code. The survey was seven questions long with five multiple choice questions and two questions where respondents chose all that applied (Appendix B). Survey respondents indicated their profession from 11 options, perceptions of their own WAAV tolerance related to their colleagues, WAAV experiences from a list of 20 options (i.e., threatened, bitten, stabbed, etc.), and hurdles to reporting from a list of 13 options (i.e., nobody was hurt, I am concerned about patient satisfaction scores, etc.). The anonymous audits were available in two formats, electronically and via paper, for individual staff preference and convenience (Appendix C). The electronic audits did not collect IP addresses. Staff were able to access the electronic, Qualtrics-based audit via QR code. Paper audits were available in the ED security office by the secured box. The audit was six questions long, with multiple choice and choose-all-that-apply questions. Audit data included the reporter's profession. The audit collected information about the WAAV incident: day of week, six-hour time blocks (i.e., 0000-0600), WAAV location (i.e., triage, waiting room, West side, etc.), and WAAV type (i.e., sworn at, pinched, spat on, etc.), and an indication if the reporter witnessed or experienced the violence. The number of WAAV incident reports submitted during 2021 and during the audit period also was provided by the systemwide employee safety director.

Descriptive statistics were used to analyze staff responses to surveys, the rates of WAAV per 100 ED patient presentations, and barriers to reporting.

## **Procedure**

During January 2022, ED staff and security officers were educated by the PD on the definitions of Type I and II WAAV, the organization's WAAV policies, reporting policies, the audit process, and accessing the survey and audit. Teaching sessions were in discussion format, occurring during staff meetings and huddles. During a 21-day period in February 2022, staff were provided the survey QR code through email and posters in the ED breakroom. Staff could voluntarily access and complete the seven-question anonymous survey. The audit implementation period began in March 2022 and lasted four weeks. Staff members were asked to complete audits if they witnessed or experienced WAAV. The anonymous, minute-long, multiple-choice and choose-all-that-apply, six-question audit was available via QR code posted throughout the ED and in a paper format to accommodate individual preferences. A secure locked collection box for paper audits was placed in a designated safe location inside security's office in the ED. The paper audits were collected once a week and stored in a locked cabinet on another healthcare campus until data was entered in the excel spreadsheet. Staff members also were encouraged to complete incident reports. After four weeks of data collection, the PD transferred Qualtrics and paper data into an Excel spreadsheet for descriptive analyses.

## **Results**

There were 54 respondents completing the survey about their experience with Type I and II WAAV over the previous six months, with a 59% response rate. Nurses were the largest group of staff completing the survey (n=19, 35%) and completed the most audit tools (see Table 1). Twenty staff members (37% of respondents) perceived their tolerance level to WAAV as higher than their colleagues. Thirty staff members

(56%) rated their tolerance as the same, and four (7%) rated their tolerance as less than their co-workers. Seven staff members (13%) reported all episodes. Five staff (9% of respondents) reported some, 35 (65%) reported none, and 7 (13%) usually did not experience violence. Forty staff members (74%) responded that violence was part of the job.

**Table 1**

*Survey and Audit Respondents*

Profession	Respondents by profession			Responses by profession	
	N	n	%	n	%
Nurses	47	19	35	24	54
Care technicians	13	9	17	4	11
Advanced practice providers	7	3	6	1	3
Physicians	12	7	13	0	0
Security	10	9	17	8	22
Administrative staff	3*	6	11	0	0
<b>Total</b>	<b>92</b>	<b>54</b>		<b>37</b>	

*Note:* \*Three care technicians also work as secretaries and may have chosen the administrative staff option as their survey profession.

Verbal WAAV was reported most frequently. The top three types of verbal WAAV reported as having occurred in the past six months were cursed at (n= 42, 78%), verbal intimidation (n=36, 67%), and threatened (n=32, 59%) (see Table 2).

Physical WAAV was reported less frequently. The top three types of physical WAAV reported in the last six months are being hit (n=10, 19%), grabbed (n=10, 19%), and being spit on (n=8, 14%). It is important to note that one reported experiencing sexual assault (see Table 2).

**Table 2**

*Workplace Aggression and Violence Type as Reported on Survey or Previous Six Months and Monthlong Audit*

WAAV type	WAAV type within previous six month		WAAV type during monthlong audit	
	n	%	n	%
Verbal WAAV				
Racial slur	16	30	0	0
Gender slur	17	32	4	11
Sexual language harassment	24	44	1	3
Cursed/sworn at	42	78	21	57
Verbally intimidated	36	67	24	65
Threatened	32	59	21	57
Physical WAAV				
Pinched	4	7	0	0
Hair pulled	0	0	0	0
Scratched	4	7	0	0
Bitten	2	4	1	3
Hit	10	19	5	14
Hit by thrown objects	3	6	1	3
Kicked	3	6	0	0
Grabbed	10	19	5	14
WAAV sexual in nature, or related to body fluids				
Harassed by genitalia	5	9	4	11
Spit on	8	15	0	0
Voided on/at	1	2	2	5
Assaulted with body fluids	4	7	1	3
Sexually assaulted	1	2	0	0
Other				
Other	3	6	1	3

Survey respondents were asked two questions about factors preventing reporting. The most prevalent hurdles were the time-consuming process (n=27, 50%), part-of-the-job rationale (n=24, 44%), nobody-was-hurt rationale (n=21, 38%), lack of follow-up (n=16, 30%), and the complexity of the reporting process (n=15, 28%). Staff also identified the most significant reporting hurdle (see Table 3). The most frequently cited

hurdles deemed most significant were the time-consuming process (n=9, 17%), nobody-was-hurt rationale (n=9, 17%), and part-of-the-job reasoning (n=8, 15%) (see Table 3).

**Table 3**

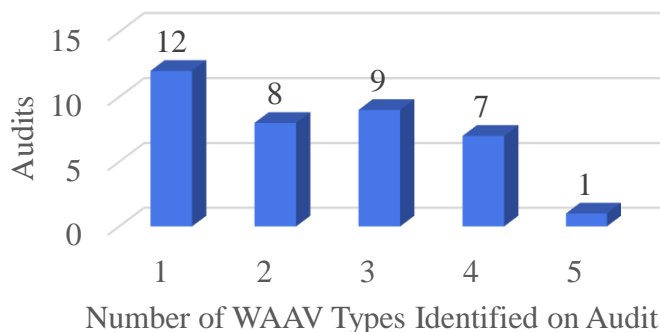
*Incident Reporting Hurdles: Barriers and Most Significant Barriers*

Barriers	Reported Barrier		Most Significant Barrier	
	n	%	n	%
Part of job	24	44	8	15
Nobody hurt	21	38	9	17
Time	27	50	9	17
Complex	15	28	1	2
Follow-up not communicated	16	30	2	4
Peer perception	1	2	1	2
Nobody else does	10	19	3	6
Fear retaliation	2	4	5	9
Patient satisfaction scores	1	2	0	0
Not supported	6	11	5	9
Do not know how	8	15	3	6
Reported all incidents	8	15	6	11
Did not experience WAAV	5	9	6	11
No answer	0	0	1	2

In 2021, there were 33,380 ED presentations; there were eight formal incident reports concerning Type I and II WAAV episodes in the ED for a rate of .023% episodes per 100 visits. Between March 9, 2022 and April 8, 2022, there were 2,773 ED presentations and no formal incident reports. During the same timeframe, participating staff completed 37 audits for a rate of 1.3 per 100 ED visits. Twenty-eight (76%) reporters experienced WAAV, whereas nine (24%) observed the episodes. Twelve audits identified only one WAAV type, whereas 25 identified two through 5 types (see Figure 1). Verbal abuse was a component of 29 audits; threatening behavior was an element of 21 events. Physical assault of at least-but not limited to one type (i.e., hit, bitten, etc.) was a component of eight audits. Body fluids, including urine, were elements of three occurrences, and there were four (11%) genitalia exposure events. Of the nine locations listed on the audit, the West side of the unit experienced 14 (38%) and triage experienced 11 (29%) of these occurrences. Most events happened between 6 a.m. and 12 p.m. (n=12, 32%) and 6 p.m. and 12 a.m. (n=15, 41%). Tuesday (8, 22%) and Wednesday events (n=22, 30%) were more common than Friday (n=6, 16%), Saturday (1, 2%), or Sunday (n=2, 5%) (see Table 4).

### Figure 1

*Number of Workplace Aggression and Violence (WAAV) Types Identified on Audits*



**Table 4**

*Emergency Department (ED) Workplace Aggression and Violence (WAAV) Episodes by Location and Timeframe during Audit*

Location	n	%	Day	n	%	Timeframe	n	%
Parking lot	0	0	Monday	3	5	0000-0600	7	19
Outside	0	0	Tuesday	8		0600-1200	12	32
ED entrance				8				
Triage	11	30	Wednesday	11	22	1200-1800	3	8
Waiting room	1	3	Thursday	6	30	1800-000	15	41
West side	14	38	Friday	6	16			
East side	2	5	Saturday	1	16			
Rapid medical exam area	3	8	Sunday	3				
Radiology bay	0	0						
Other	6	16						

### Discussion

The survey yielded responses comparable to those found in other research and QI projects. Fifty-six percent of survey respondents perceived their tolerance level the same as their colleagues and 37% as higher, while Copeland and Henry (2017) found 70% of participants perceiving similar tolerance levels and 18% as higher. Copeland and Henry noted 64% adhered to the part-of-the-job reasoning, and our survey found a commiserate rate with the same belief at 74%. Of the staff who responded to have reported all WAAV occurrences, all were security guards. Excluding security professionals, ED staff did not routinely report Type I and 2 WAAV. Staff may be less likely to file incident reports on events that seem normal to them, with 15% reporting normalization of WAAV as the most significant reporting barrier. During this QI, charge nurses voiced the concern that many staff refrained from completing the audits because of the view that *nothing ever*



*changes*. Complexity was cited as a hurdle by 28% of respondents and is closely related to reporting being too time-consuming. Thirty percent of respondents cited that follow-up was not communicated, and 11% did not feel supported. While only 4% thought fear of retaliation was a barrier, 9% identified this factor as the most significant hurdle (see Table 3). WAAV follow-up and staff support offer opportunities for leadership to build culture around safety.

One barrier stood out as the most significant: the time necessary to complete incident reports. Richardson et al. (2018) and our QI project overcame this barrier. Staff readily used the abbreviated audit format. In fact, many staff members asked if the hospital could switch to the less time-consuming audits. Ramacciati et al. (2021) made formal incident reporting more efficient but did not see an increase in reports. In contrast to Ramacciati et al.'s (2021) half-year study of incident reporting in 184 nurses from 20 EDs, both our QI project audit and Richardson et al.'s (2021) audit were less lengthy with shorter implementation periods and smaller sample sizes. Additionally, all audits were anonymous, whereas for Ramacciati's nurse respondents, anonymity was an option. Likewise, anonymity is an option for routine incident reporting. Ramacciati et al.'s (2021) findings are a cautionary tale for a hospital whose only WAAV reporting action plan is simplifying and shortening the process. As reporting solutions are explored, merely decreasing the clinician time investment, may not fix the problem.

The audit rate illustrated a more realistic picture of typical WAAV encountered in real time. Type I and II WAAV episodes were underreported, as noted in EDs worldwide (ENA, 2019). The QI initiative provided insight into the gap between episodes and formal reporting in the ED. Another interpretation is that WAAV incidents are on the rise

in this ED. The likely explanation is both are occurring: WAAV is underreported and on the rise in this ED. Richardson's et al.'s (2018) audit documented a rate of WAAV at 1.4 occurrences per 100 patient visits. Our audit revealed a strikingly similar rate of 1.3 episodes per 100 patient visits, while the 2021 incident reports showed 0.023 occurrences per 100 patient visits. The actual difference between episodes of violence during the monthlong audit and incident reports was at least 37 audits, compared to no formal incident reports. Eight formal ED WAAV incident reports were filed throughout the year of 2021. In contrast eight assaults with a physical component—including biting, hitting, and grabbing—were noted in the monthlong audit. These occurrences are stressful, and staff members bear substantial collective trauma, contributing to dissatisfaction and turnover.

The triage area has been the epicenter of much ED WAAV (ENA, 2019). A nurse and care technician are routinely assigned to triage, which is in the ED entrance, and the two are the only staff in this area at the hospital where this project occurred. Frequently, one will be pulled away for tasks throughout the department, leaving a lone staff member in the entrance vulnerable to WAAV. In fact, the hospital where this project occurred is initiating a security presence during limited times in triage to increase clinician safety. This project identified the West side of the unit as an additional area of concern. The West side contains two trauma rooms and is where behavioral health patients are roomed. Moreover, the ED shuts down the East side during low volume, while the West side remains open. This area has higher, more constant patient volumes than the other areas and is populated with more staff, which may explain the tendency for WAAV occurring here.

Leadership buy-in from nursing, medicine, and security, as well as staff liaisons to educate and discuss each step at meetings and huddles facilitated this implementation. Many of the nursing and care technician staff were not permanent and rotated through the department, which was an implementation limitation. Of course, our QI was performed in a specific ED, surveys and audits were not randomized, and the findings are not generalizable.

### **Recommendations**

The hospital system leadership has followed this QI project closely, identified WAAV as a priority, and been responsive to both the emerging literature and the project. The system safety team is simplifying the incident reporting process and removing the need for multiple reports when someone is injured. This change should decrease the incident reporting input time and complexity, an area for potential improvement identified in the QI project. Moreover, the team is building an electronic medical record section to improve the identification of patients with a WAAV history. The build includes an agitation protocol. Finally, the safety team is developing a WAAV debriefing form to help staff and leaders alike understand how the event transpired and to prevent future occurrences. Adding a step seems to conflict with a barrier identified by staff—time. This is not so. During the QI project, staff recounted WAAV stories to the PD and their colleagues. With each education session, more staff shared their experiences until dozens of WAAV episodes were described in vivid detail. Most likely, staff members were compelled to discuss their experiences because it was evident that someone was listening and interested in their safety. Leaders should use active listening and explore solutions during WAAV incident debriefings to engage staff. This new requirement is an

opportunity for leaders to demonstrate concern for staff safety and address the barriers related to the lack of communication about follow-up, lack of support, and retaliation fears. Moreover, this measure will involve staff in problem-solving. These efforts will address some of the issues detected in the local QI project, as Thomas et al. (2021) found that visible follow-up, from showing immediate concern to updating staff victims about the ongoing investigation, can increase formal incident reporting.

Anonymity seemed to contribute to audit compliance; in contrast, a follow-up investigation is more challenging when incident reporters do not identify themselves. Future surveys should address the role of anonymity in WAAV reporting. This QI gives insight to site-specific recommendations. Concealed firearms are legal in this state (Guns to Carry, 2020). Eight physical incidents per month could escalate into occurrences involving weapons, even guns. Administration may consider buoying security's presence in both the triage area and the West side. Other considerations are installing a metal detector and equipping security officers with carry firearms, as officers currently have tasers. Other system hospitals have metal detectors, and some security in other hospitals in the same system do carry firearms.

Related topics of exploration emerged. Security voiced frustrations with clinicians *not doing their job* and reporting WAAV. Another security concern was clinicians had a variety of expectations, with some clinicians desiring officers to overwhelm perpetrators and others preferring standby assistance. Some clinicians commented they were dissatisfied about security being unwilling to take measures to prevent staff from WAAV, while others said they felt safe with the security's balance of de-escalation and a hands-on approach. Security already has been incorporated into the start-of-shift huddle. These

conversations demonstrate an opportunity for better collaboration between security and the ED. Leadership should consider facilitating ongoing dialogue between the departments and establishing a protocol, so all employees are on the same page about WAAV safety measures. This discourse also could occur during the system-instituted debriefings.

The ANA (2019) stated that healthcare WAAV has reached an epidemic level. With 37 WAAV audits in a month's time, the problem is substantial for this ED with employee safety and psychological well-being being threatened every day. Administrative incrementalism in combating ED WAAV should be discouraged. Small measures, spaced apart, like developing committees, hanging signs, and tinkering with current processes may be viewed as band aids for this violence epidemic. These actions may be viewed as conflicting with the ENA's (2020) and ANA's (2019) recommendation for a zero-tolerance to violence and likely will contribute to staff turnover.

While the system as a whole supports WAAV QI, the PD approached three hospitals before finding a site. These efforts are difficult to prioritize at the institutional level. If the system is supportive, why might a hospital balk at these programs? Perhaps leaders had concerns about the perception by stakeholders (potential or current employees, patients, and donors) or utilization of data against them by plaintiff's attorneys, unions, or liability insurers. Courageous leadership is necessary to move past potential fears and demonstrate to staff that safety is paramount.

### **Conclusion**

Hospital staff regularly endure Type I and II WAAV, and EDs are one of the most at-risk units. Most WAAV incidents go unreported, which makes finding solutions to

escalating violence challenging. Much of the literature is retrospective, is in survey format, and focuses on rates of violence per clinician. In order to address WAAV, organizations need to have a clear depiction about real time violence rates per patient visit. A monthlong audit verified this ED was experiencing more violence than was formally reported at a rate of 1.3 WAAV occurrences to 100 patient visits. This rate, more descriptive data, and hurdles to reporting as identified by staff will help build a foundation for measuring safety efforts.

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## Appendix A

### Literature Matrix

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
Author(s), Date, Title, Journal Information, doi	Purpose & Outcome Measures or Goals (Aims)	Sample & Setting	Study Design & Interventions	Results, Strengths/Weaknesses, Limitations, & Recommendations
<b>Qualitative</b>				
<p>Hogarth, K., Beattie, J., &amp; Morphet, J. (2016). Nurses' attitudes towards the reporting of violence in the emergency department. <i>Australasian Emergency Nursing Journal</i>, 19(2), 75-81. <a href="https://doi.org/10.1016/j.aenj.2015.03.006">https://doi.org/10.1016/j.aenj.2015.03.006</a></p>	<p><b><u>Purpose</u></b> To determine facilitators to, hurdles for, and attitudes about nurses reporting workplace violence in the emergency department</p> <p><b><u>Outcome Measures</u></b> WAAV reporting facilitators, hurdles, and perceptions of reporting</p>	<p><b><u>Participants</u></b> Purposeful sampling of 15 emergency nurses</p> <p><b><u>Setting</u></b> Metropolitan ED in Melbourne, Australia. ED with 42 beds and 113 fulltime nurses</p>	<p><b><u>Design</u></b> Phenomenological approach to determine facilitators and barriers to reporting WAAV during 2 focus-group sessions</p> <p><b><u>Intervention</u></b> None</p>	<p><b><u>Results</u></b></p> <p><b><u>Barriers</u></b> WAAV underreported d/t -Normalization of WAAV -Incident reporting system complex and takes too long -No physical harm/verbiage not considered violence/aggression -Not encouraged to report -Attitude that “zero tolerance policy” not enforced</p> <p><b><u>Facilitators</u></b> -Protection from potential complaints -Feedback about process and organization response</p> <p><b><u>Strengths</u></b> -Fully explored the idea that nurses understanding of what constituted violence contributed to reporting of WAAV</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				<p>-showed link between reporting practices and perceptions of incident reporting system</p> <p><b><u>Weaknesses</u></b> Sample size and bias</p> <p><b><u>Limitations</u></b> -15 is a small sample size -Volunteers (inherent bias possible) -Focus group-not private for full expression</p> <p><b><u>Recommendations</u></b> -Involving nurses in organizational response and plans may increase reporting. -Increase efficiency/utility of computer-based WAAV incident reporting -Clinician teaching on what constitutes violence -design participatory action research for ED WAAV</p>
<p>Morphet, J., Griffiths, D., &amp; Innes, K. (2019). The trouble with reporting and utilization of workplace violence data in health</p>	<p><b><u>Purpose</u></b> To assess reporting, monitoring and utilization of workplace violence/aggression against clinicians</p> <p><b><u>Outcome Measures</u></b></p>	<p><b><u>Participants</u></b> -Convenience sampling from safety/quality/management staff from environments considered to be at increased risk for violence -15 of 22 participated</p>	<p><b><u>Methods</u></b> Descriptive, exploratory (qualitative research)</p> <p><b><u>Design</u></b> Loosely organized, explorative interviews</p>	<p><b><u>Results</u></b> -underreporting, -variable guidance/instruction about reporting process, -coding inconsistencies -staff accepting workplace violence. -reporting took too much time</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
<p>care. <i>Journal of Nursing Management</i>, 27(3), 592-598.  <a href="https://doi.org/10.1111/jonm.12717">https://doi.org/10.1111/jonm.12717</a></p>	<p>-method of collecting WAAV data          -how data used</p>	<p><b>Setting</b>          5 urban UK health centers</p>	<p><b>Interventions</b>          None</p>	<p>-time-consuming, complex reporting system          -incomplete incident report fields in completed reports          -duplicate reports possible for single incident i.e. violence may have caused a patient safety and employee safety issue</p> <p><b>Strengths</b>          With one publicly funded health system, the UK has more standardization of workplace violence reporting processes. This study strengthens the recurring themes: reporting is too time consuming,          -WAAV is a normal part of the job.          -This qualitative study adds breadth to the topic.</p> <p><b>Limitations</b>          -only 15 staff members interviewed          -explored many aspects affecting frontline reporting through a midline staff members</p> <p><b>Recommendations</b>          -more efficient functional reporting systems will increase reporting.          -encourage staff to report. -share data with staff</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
<p>Thomas, B., McGillion, A., Edvardsson, K., O'Meara, P., Van Vuuren, J., &amp; Spelton E. (2021). Barriers, enablers, and opportunities for organizational follow-up of workplace violence from the perspective of emergency department nurses: a qualitative study. BMC Emergency Medicine, 21(1). <a href="https://doi.org/10.1186/s12873-021-00413-7">https://doi.org/10.1186/s12873-021-00413-7</a></p>	<p><b><u>Purpose</u></b> Determine obstacles and facilitators to WAAV</p> <p><b><u>Outcome Measures</u></b> Determine hurdles, enablers, opportunities according to predetermined categories: individual: professionals and perpetrators, social perspective, health institutional perspective, financial and political perspectives, and</p>	<p><b><u>Participants</u></b> Convenience sample of 18 ED nurses</p> <p><b><u>Setting</u></b> Urban Australian hospital ED</p>	<p><b><u>Methods</u></b> Descriptive, exploratory, qualitative research</p> <p><b><u>Design</u></b> Two focus groups, using COREG guidelines to evaluate themes</p> <p><b><u>Interventions</u></b> None</p>	<p><b><u>Results</u></b></p> <p><b><u>Barriers</u></b> -lack of reporting -previous poor interactions with police -complicated perpetrators -WAAV occurs often -experience time/complexity reporting hurdles -do not observe organizational follow-up.</p> <p><b><u>Facilitators</u></b> -Staff members being physically harmed -previous organizational initiative around violence -letters to perpetrators</p> <p><b><u>Opportunities</u></b> -keep psychiatric patients from ED -educate community -enforce rules for violators -show security footage Make reporting less complex -provide staff feedback about process Strengths</p> <p><b><u>Strength</u></b> categories of themes from individual to political</p> <p><b><u>Recommendations</u></b></p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				<p>-follow-up: immediately                      -show concern to staff who encountered or observed WAAV,                      -provide long-term support to those staff,                      allow staff to see report turned into future planning.                      -quick, effective, and leadership-endorsed reporting system necessary to enable leadership to then follow up. Hurdle: inconsistently applied consequences</p> <p><b><u>Limitations</u></b>                      Limited pool of subject from one hospital and one profession.</p>
<b>With Incident Report Data</b>				
<p>Kaesler, D., Guerra, R., Keidar, O., Lanz, U., Moses, M., Kobel, C., Exadaktylos, A. K., Ricklin, M. E. (2018) Verbal and nonverbal aggression in a Swiss university emergency room: A descriptive study. <i>International Journal of Environmental Research and Public Health</i>, 15(7). 1423. <a href="https://doi.org/10.3390/ijerph15071423">https://doi.org/10.3390/ijerph15071423</a></p>	<p><b><u>Purpose</u></b>                      Analyze incidence report data on the reasons for the incident, the time of day, the manner of violence, the consequences, and the migratory background of the aggressor</p> <p><b><u>Outcome Measures</u></b>                      -characteristics of incidents                      -number of reports filed</p>	<p><b><u>Participants</u></b>                      Incidence reports reviewed</p> <p><b><u>Setting</u></b>                      University hospital ED in Byrne, Switzerland.</p>	<p><b><u>Methods</u></b>                      Retrospective, descriptive study, evaluating incidence reports over 4 years.</p> <p><b><u>Design</u></b>                      Researchers reviewed WAAV ED incident reports from pts = or &gt;16 years</p> <p><b><u>Intervention</u></b>                      None</p>	<p><b><u>Results</u></b>                      -83 reports filed over 4 years                      -159,388 pts presentations                      -.005%                      -4.5 of every 10,000 presentations resulted in a WAAV report                      -17-25 episodes/year                      -Male&gt;female                      -16-30 y/o                      -more likely at night                      -r/t substance use or psychiatric dx, or migratory                      53% perpetrators received letter about behavior</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				<p>-7.2% requested by hospital to leave premises            -21.7 involuntary admission to psychiatric unit</p> <p><b><u>Strengths</u></b>            -reviewed incident report content            -no data available related to pt wait times and other environmental factors that may elicit inappropriate behavior</p> <p><b><u>Limitations</u></b>            -WAAV was likely under-reported</p> <p><b><u>Recommendations</u></b>            -Adopt efficient, simple reporting system            -Staff development around reporting</p>
<p>Richardson, S. K., Grainger, P. C., Ardagh, M. W., &amp; Morrison, R. (2018). Violence and aggression in the emergency department is under-reported and under-appreciated. <i>New Zealand Medical Journal</i>, 131(1476), 50-58.  <a href="https://pubmed.ncbi.nlm.nih.gov/29879726/">https://pubmed.ncbi.nlm.nih.gov/29879726/</a></p>	<p><b><u>Purpose</u></b>            Assess WAAV reporting and staff perceptions about reporting</p> <p><b><u>Outcome Measures</u></b>            -Completed WAAV audit forms            -completed WAAV incident reports            -type of WAAV</p>	<p><b><u>Participants</u></b>            ED staff</p> <p><b><u>Setting</u></b>            New Zealand teaching hospital with 90,000 visits/year</p>	<p><b><u>Methods</u></b>            Prospective audit of WAAV</p> <p><b><u>Design</u></b>            1-month implementing audit and comparing to standard incident reporting</p> <p><b><u>Intervention</u></b>            Audit form about WAAV incident</p>	<p><b><u>Results</u></b>            Total visits-7,896 (1.2% visits include WAAV OR 1 WAAV incident per 100 visits)            Audit forms-107            Incident reports-0 (security reports-21)            Verbal abuse-98            Verbal threat 22            Physical threat 21            Physical assault 19            Previous year 2013-only 29 reports filed</p>



CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				<p><b><u>Strengths</u></b>                      -Real-time data collection less subject to bias than recall methods                      -demonstrated scope of WAAV reporting problem</p> <p><b><u>Limitations</u></b>                      -Did not research reasons for not reporting but described literature and mentioned anecdotal evidence                      -perpetrator information was not collected                      -did not explore hurdles with reporting process</p> <p><b><u>Recommendations</u></b>                      Create permanent group to monitor and improve ED WAAV                      -address clinician feedback about incident reporting</p>
<b><u>Survey</u></b>				
Copeland, D., & Henry, M. (2017). Workplace violence and perceptions of safety among emergency department staff members: Experiences, expectations, tolerances, reporting, and recommendations. <i>Journal of Trauma</i>	<p><b><u>Purpose</u></b>                      -assess relationships between witnessing/experiencing violence to reporting to tolerance to expectations to attitudes about safety</p> <p><b><u>Outcome Measures</u></b>                      Of interest measure-reporting barriers                      -barriers to reporting</p>	<p><b><u>Participants</u></b>                      Survey sent to 235 ED staff                      147 (63%) responded</p> <p><b><u>Setting</u></b>                      Suburban Level 1 Shock Trauma center with 48,000 patients/year</p>	<p><b><u>Methods</u></b>                      Retrospective, descriptive</p> <p><b><u>Design</u></b>                      Cross-sectional survey over previous 6 months</p> <p><b><u>Intervention</u></b>                      None</p>	<p><b><u>Results</u></b>                      -129/147 (88%) reported experiencing violence in previous 6 months                      -5 or 3% of clinicians experiencing WAAV reported all episodes                      -37 or 25% reported some episodes                      -53% did not report 1 episode                      -Standout categories were verbal from pts 94.7%, name-calling from</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
<p><i>Nursing: The Official Journal of the Society of Trauma Nurses</i>, 24(2), E1-E2.  <a href="https://doi.org/10.1097/JTN.0000000000000279">https://doi.org/10.1097/JTN.0000000000000279</a></p>	<p>-relationships of variables to reporting behaviors</p>			<p>pts 64.6%, threats 59.2%, lawsuit threats 55.8%,          -Between 23.5% and 26.5% reported physical violence, spitting, grabbing, and sexual innuendo          -staff most often cited that no physical harm resulting was reason for not reporting          -correlation btwn “part of the job” outlook and not reporting          -10 formal incident reports filed and all pt-instigated WAAV</p> <p><b><u>Strengths</u></b>          Assessing relationship between attitudes and reporting</p> <p><b><u>Limitations</u></b>          -recall bias          -single site study</p> <p><b><u>Recommendations</u></b>          -staff do not report based on institutional definitions of violence but based on their own perceptions and culture</p>
<p>Ramacciati, N., Guazzini, A., Caldelli, R., &amp; Rasero, L. (2021). User-friendly system (A smartphone app) for reporting violent</p>	<p><b><u>Purpose</u></b>          Evaluating whether easy, phone-application-based WAAV reporting system increased reporting</p>	<p><b><u>Participants</u></b>          318 Italian nurses responded to survey          318 signed on to use application</p>	<p><b><u>Methods</u></b>          Cross-sectional, descriptive, observational, prospective, and multisite for 6 mos</p> <p><b><u>Design</u></b></p>	<p><b><u>Results</u></b>          T1-Questionnaire          102/189 nurses exp. verbal          0/189 physical          14/189 both verbal and physical          73/189 no violence</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
<p>incidents towards emergency nurses in the emergency department: An Italian multicenter study. <i>Medicina Del Lavoro</i>, 112(1), 68-81.  <a href="https://doi.org/10.23749/mdl.v112i1.9984">https://doi.org/10.23749/mdl.v112i1.9984</a></p>	<p><b><u>Outcome Measures</u></b>  Assess whether nurses found application easy  Did application improve attitude toward reporting WAAV  Did more nurses report WAAV</p>	<p>184 responded to first and second surveys</p> <p><b><u>Setting</u></b>  184 nurses from multiple EDs in Italy 20 emergency departments</p>	<p>Paired t-test  T0-T1  -Exposure to violence in previous 6 mos  -did they report-  -why they did not report  -observations of WAAV trends</p> <p><b><u>Interventions</u></b>  Simple phone-application to report WAAV nurses use to report and report automatically goes to management and organization</p>	<p>83/189 more likely to report violence with app  104/189 unchanged  2/189 reduced likelihood</p> <p>Not an outcome, but the reported filed were similar between observation period and study period. There was however, a statistically significant (but not a large average difference) change in reported (by nurse participant assessment) for from onset to end.</p> <p><b><u>Strengths</u></b>  Only cell-phone reporting study  Testing user-friendly reporting methods</p> <p><b><u>Limitations</u></b>  attrition, potential of Hawthorne effect: participants reporting more d/t extra attention on under-reporting WAAV. Unvalidated survey used. The isolated creation of a new system cannot change behavior.</p> <p><b><u>Recommendation</u></b>  It takes more enablers  Develop tool to measure sustainability</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
<p>McGuire, S. S., Mullan, A. F., &amp; Clements, C. M. (2021). Unheard victims: Multidisciplinary incidence and reporting of violence in an emergency department. <i>Western Journal of Emergency Medicine</i>, 22(3), 702-709. <a href="https://doi.org/10.5811/westjem.2021.2.50046">https://doi.org/10.5811/westjem.2021.2.50046</a></p>	<p><b><u>Purpose</u></b> Determine WAAV incidence in ED for ½ year timeframe</p> <p><b><u>Outcome Measures</u></b> -incidence of verbal abuse via survey -incidence or physical abuse via survey -compare survey data to formal incident reports</p>	<p><b><u>Sample</u></b> Large, Level 1 urban U.S. Midwestern ED</p> <p><b><u>Setting</u></b> 261 clinicians, techs, phlebotomists, radiology, registration and security</p>	<p><b><u>Methods</u></b> Descriptive, prospective study -Likert, multiple-choice survey questions -# physical abuse incident reports -# verbal abuse incident reports</p> <p><b><u>Design</u></b> -frequency counts, with confidence intervals -odds ratios -percentages -group comparisons chi-squared tests -gender and experience comparisons-2-sided Wilcox rank sum test and Kruskal-Wallis test</p> <p><b><u>Intervention</u></b> None</p>	<p><b><u>Results</u></b> -11 verbal abuse reports (5% of questionnaire) -18 physical abuse reports (18% of questionnaire) [ED sees approximately 78,000 patients annually -76 nurses reported experiencing verbal abuse [via survey] (95%), with security guards only reporting a higher percentage. -39 (49%) nurse reported physical assault -86% staff experience verbal WAAV -37% experienced physical WAAV -Almost 7 or every 10 staff members-excluding security staff report violence -69%-excluding security—responded that they NEVER report</p> <p><b><u>Strengths</u></b> -# of participants -variety of departments/genders/ages for comparison -comparison to incident reports</p> <p><b><u>Weaknesses</u></b> -subjective violence interpretations -recall bias</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				<p><b><u>Limitations</u></b>            -inclusion of many disciplines made determining survey response rate impossible            -performed at only one institution</p> <p><b><u>Recommendations</u></b>            -incentivize reporting            -research differences in female and male reporting</p>
<p>Nimthimathachoke A., &amp; Wichienopparat, W. (2021). High incidence of workplace violence in metropolitan emergency departments of Thailand: A cross-sectional study. Archives of Academic Emergency Medicine, 9(1), e30. <a href="https://doi.org/10.22037/aaem.v9i1.1140">https://doi.org/10.22037/aaem.v9i1.1140</a></p>	<p><b><u>Purpose</u></b>            Assess WAAV rates/types</p> <p><b><u>Outcome Measures</u></b>            -psychological violence            -physical            -incidences or abrasion            -incidences of contusion            -whether staff member reported every violent episode            -didn't report every incident</p>	<p><b><u>Participants</u></b>            295 Thai ED staff sent survey            258 completed (87.5 response)</p> <p><b><u>Setting</u></b>            9 EDs in Thailand's Bangkok Metropolitan Administration</p>	<p><b><u>Methods</u></b>            Retrospective, descriptive</p> <p><b><u>Design</u></b>            Cross-sectional, anonymous questionnaire</p> <p><b><u>Intervention</u></b>            None</p>	<p><b><u>Results</u></b>            228 (88.4% experienced violence)            -psychological violence 218 (85.7%)            -physical 93 (37.6%)            -incidences or abrasion 64 (24.8%)            -incidences of contusion (35 (13.5%)            -whether staff member reported every violent episode (82 (35%)            -didn't report every incident 165 (64%)</p> <p>Younger, nurses, and those in most urban areas, and during evening shift most likely to experience WAAV</p> <p><b><u>Strengths</u></b>            -Multi-institutional survey            -Good survey response rate</p> <p><b><u>Limitations</u></b></p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				<p>No authors did not mention # of visits or correlate episodes with pt ED presentations -subject to recall bias</p> <p><b>Recommendations</b> Encourage real-time episode reporting -analyze episodes -remedy any environmental issues that provoke WAAV -use QI to improve situation</p>
<p>Byon, H. D., Sagherian, K., Kim, Y., Lipscomb, J., Crandall, M., &amp; Steege, L. (2021). Nurses' experience with type II workplace violence and underreporting during the COVID-19 pandemic. <i>Workplace Health and Safety</i>, <a href="https://doi.org/10.1177/21650799211031233">https://doi.org/10.1177/21650799211031233</a></p>	<p><b>Purpose</b> Evaluate verbal violence toward nurses during pandemic</p> <p><b>Outcome Measures</b> -verbal WAAV prevalence -physical WAAV prevalence</p>	<p><b>Participants</b> Convenience sample of 373 U.S. nurses-mostly from Midwest or South across units in the hospital &gt;50% worked in EDs</p> <p><b>Setting</b> U.S hospitals</p>	<p><b>Methods</b> Retrospective, descriptive</p> <p><b>Design</b> Cross-sectional survey data over WAAV experience between February and May 2020.</p> <p><b>Intervention</b> None</p>	<p><b>Results</b> -44.4% exp. physical assault -67.8% exp verbal assault -exp verbal and physical violence: nurses with COVID pts &gt;nurses without COVID patients -18 nurses in care of COVID pts exp verbal violence &gt; 5 times and 67 exp verbal violence &gt; 5 times <u>-9.5% reported increased difficulty reporting WAAV during COVID than previously</u></p> <p><b>Strengths</b> -focus</p> <p><b>Limitations</b> -nonrandom sampling-cannot generalize -recall bias -homogenous group responded</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				<p>-unable to determine rate of response</p> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>-first step-make reporting easier</li> <li>-support legislative action for protecting clinicians</li> <li>-organizations developing comprehensive protection plans</li> </ul>
<p>Cho, H., Pavek, K., &amp; Steege, L. (2020). Workplace verbal abuse, nurse-reported quality of care and patient safety outcomes among early-career hospital nurses. <i>Journal of Nursing Management</i>, 28(6), 1250-1258. <a href="https://doi.org/10.1111/jonm.13071">https://doi.org/10.1111/jonm.13071</a></p>	<p><b>Purpose</b> Evaluate verbal violence experience of nurses with 1-year experience or less</p> <p><b>Outcome Measures</b> -differences with experiencing verbal aggression of this clinician population -associations with verbal WAAV or type II violence -also found incidence of patient/family member perpetrated violence</p>	<p><b>Participants</b> 799 U.S. nurses with 1 year or less experience. 3,780 approached, 1,171 completed survey, 380 excluded [NUMBERS DO NOT ADD UP]</p> <p><b>Setting</b> U.S 20 metropolitan and 1 rural community across 14 states</p>	<p><b>Methods</b> Descriptive, qualitative</p> <p><b>Design</b> Cross-sectional survey data analysis, Likert-style or multiple choice</p> <p><b>Intervention</b> None</p>	<p><b>Results</b></p> <ul style="list-style-type: none"> <li>-Almost 80% experienced verbal abuse</li> <li>never 172/799 21.6%</li> <li>-1-3x/month 541 56.7%</li> <li>-1/week or more 173 21.7%</li> <li>-males&gt;females</li> <li>-verbal violence from physicians: younger nurses&gt; older</li> <li>-from patients: age 30s&gt;20s</li> <li>-EDs, inpatient psych and intensive care units most verbal aggression</li> </ul> <p><b>Strengths</b> -focus of new nurses across states and care spectrums</p> <p><b>Limitations</b> -poor calculations, poor response rate 36%</p> <p><b>Recommendations</b> -preventing nurses from being verbally assaulted will lead to</p>

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING	METHODS / DESIGN	RESULTS / LIMITATIONS / RECOMMENDATIONS
				better outcomes for patients and longevity for clinicians



## Appendix B

### Workplace Aggression and Violence Anonymous Survey

1. Professional group that best describes you (choose one):
  - Registered nurse
  - Patient care tech
  - Advanced practice provider
  - Attending physician
  - Resident physician
  - Secretary
  - Social worker
  - Administration
  - Scribe
  - Security
  - Registration
  - Other
  
2. In general, do you perceive your tolerance to patients'/visitors' aggression/violence as (choose one):
  - Higher than your coworkers
  - About the same as your coworkers
  - Less than your coworkers
  
3. Research has shown that staff members feel like verbal and physical aggression/violence is an expected part of the job. Do you agree?
  - I agree
  - I disagree
  
4. In the past 6 months, have you experienced any of the following from patients/visitors at work (choose all that apply)?
  - Racial slur
  - Gender slur
  - Harassed with sexual language/innuendo
  - Verbally intimidated
  - Threatened
  - Sworn/cursed at
  - Harassed by genitalia exposure
  - Pinched
  - Hair pulled
  - Bitten
  - Scratched

- Hit (e.g., punched, slapped)
  - Hit by thrown objects
  - Kicked
  - Grabbed/pushed/shoved/pulled
  - Shot/shot at
  - Stabbed
  - Sexually assaulted
  - Spit on/at
  - Voided on/at
  - Assaulted with body fluids (urine, feces, blood, etc)
  - Other \_\_\_\_\_
5. Did you report these incidents in *Riskconnect* (choose one)?
- Yes, all of them
  - Yes, some of them
  - None of them
  - NA
6. If you experienced episodes of verbal or physical aggression or violence, and you did not report them, what prevented you from reporting them (check all that apply)?
- It is part of the job.
  - Nobody was hurt.
  - Reporting is time-consuming.
  - Reporting is complicated.
  - The follow-up often is not communicated to the frontline.
  - I am concerned about how I would be perceived by my peers.
  - Nobody else reports these incidents.
  - I am afraid of retaliation.
  - I am concerned about patient satisfaction scores.
  - Reporting is not supported.
  - I do not know how to report.
  - I reported all incidents.
  - I did not experience any incidents.
7. If you experienced episodes of verbal or physical aggression or violence, and you did not report them, what prevented you from reporting the incident the most (check one)?
- It is part of the job.
  - Nobody was hurt.
  - Reporting is time-consuming.
  - Reporting is complicated.

- The follow-up often is not communicated to the frontline.
- I am concerned about how I would be perceived by my peers.
- Nobody else reports these incidents.
- I am afraid of retaliation.
- I am concerned about patient satisfaction scores.
- Reporting is not supported.
- I do not know how to report.
- I reported all incidents.
- I did not experience any incidents.

## Appendix C

### Anonymous Workplace Aggression and Violence Audit Tool

Adapted from Richardson, S. K., Grainger, P. C., Ardagh, M. W., & Morrison, R. (2018). Violence and aggression in the emergency department is under-reported and under-appreciated. *New Zealand Medical Journal*, 131(1476), 50-58.  
<https://pubmed.ncbi.nlm.nih.gov/29879726/>

1. Professional group that best describes you (choose one):
  - Registered nurse
  - Patient care tech
  - Advanced practice provider
  - Attending physician
  - Resident physician
  - Secretary
  - Social worker
  - Administration
  - Scribe
  - Security
  - Registration
  - Other
2. Incident day of week:
  - a. Sunday
  - b. Monday
  - c. Tuesday
  - d. Wednesday
  - e. Thursday
  - f. Friday
  - g. Saturday
  - h. Sunday
3. Timeframe
  - a. 00:00-06:00
  - b. 06:00-12:00
  - c. 12:00-18:00
  - d. 18:00-00:00
4. Incident location (choose one):
  - a. Parking lot
  - b. Outside ED entrance
  - c. Triage
  - d. Waiting room
  - e. West side
  - f. East side
  - g. RME (rapid medical exam area)

- h. RAD (radiology) bay
    - i. Other \_\_\_\_\_
5. Did you (choose one):
  - a. Experience the aggression/violence
  - b. Observe the aggression/violence
6. Incident (choose all that apply):
  - Racial slur
  - Gender slur
  - Harassed with sexual language/innuendo
  - Verbally intimidated
  - Threatened
  - Sworn/cursed at
  - Harassed by genitalia exposure
  - Pinched
  - Hair pulled
  - Bitten
  - Scratched
  - Hit (e.g., punched, slapped)
  - Hit by thrown objects
  - Kicked
  - Grabbed/pushed/shoved/pulled
  - Shot/shot at
  - Stabbed
  - Sexually assaulted
  - Spit on/at
  - Voided on/at
  - Assaulted with body fluids (urine, feces, blood, etc)
  - Other \_\_\_\_\_

*Note:* Adapted from Richardson, S. K., Grainger, P. C., Ardagh, M. W., & Morrison, R. (2018). Violence and aggression in the emergency department is under-reported and under-appreciated. *New Zealand Medical Journal*, 131(1476), 50-58.  
<https://pubmed.ncbi.nlm.nih.gov/29879726/>

## Appendix D

### University of Missouri-St. Louis Internal Review Board (IRB) Letter



February 04, 2022

Dear Michelle Parmentier (MU-Student),

The IRB reviewed your QI Questionnaire to project #2082728-QI entitled "Auditing Workplace Aggression and Violence (WAAV) in the Emergency Department (ED)" and made the following determination:

**QI Determination: The project has been determined to be a quality improvement activity not requiring IRB review.**

If you have any questions regarding this determination, please feel free to contact our office at 314-516-5972 or email [irb@umsl.edu](mailto:irb@umsl.edu).

**Approval to Conduct QI Activity:** It is your responsibility to ensure approval from an authorized person in the organization/location/area you plan to conduct your QI activity.

**Note Regarding Publications:** It is appropriate to disseminate and replicate QI/program evaluation successes, including sharing the information external to an organization. This may include presentations and publications. The mere intent to publish the findings does not require IRB review as long as the publication does not refer to the activity as research.

Thank you,  
UMSL Institutional Review Board

## Appendix E

### Audit Permissions

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**From:** Parmentier, Michelle (MU-Student) <michelle.parmentier@mail.umsl.edu>  
**Sent:** Tuesday, 19 October 2021 10:13 AM  
**To:** Sandra Richardson <Sandra.Richardson@cdhb.health.nz>  
**Cc:** Dean-Baar, Susan <deanbaars@umsl.edu>; Magnuson, Nancy M. <magnusonn@umsl.edu>; Borgan, Judi <Judi.Borgan@ssmhealth.com>  
**Subject:** Emergency Department Violence Audit [EXTERNAL SENDER]

Dear Dr. Richardson,

You published the manuscript, "Violence and aggression in the emergency department is under-reported and under-appreciated," in the *New Zealand Medical Journal*. It is important work, as you and your coauthors establish rates of emergency department violence in real-time.

My colleagues and I are conducting quality improvement on emergency department violence and aggression reporting. We wanted to replicate your audit--with a few modifications to appease our institution--on a U.S. urban emergency department. Can we have permission to use and modify the audit? Proper acknowledgment will be included within the proposal, final paper, and manuscript (if we publish).


If you agree to provide us with permission, please sign this correspondence electronically, and send it back to us so we can include this communication in our publication submission materials.

We appreciate your consideration of our permissions request.

Thank you so much,

Michelle Parmentier, BSN, RN  
Susan Dean-Baar, PhD, RN, CENP, FAAN  
Nancy Magnuson, DSN, FNP, RN  
Judi Borgan, JD, CHRC

By signing below, I warrant that I have the right to grant the permission requested in this correspondence, and that I provide you with that permission.

Signature: 

Date: 21.10.21