Workplace Violence Training and Prevention in Hospital-Based Healthcare: Implications for Nursing and the Interdisciplinary Team in the Hospital

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ABSTRACT

Purpose

The integrative review is designed to determine the effectiveness of implementing workplace violence (WPV) prevention programs in hospital settings. The WPV prevention programs will include various training and education, focusing on WPV from patient to staff. Healthcare workers are at an increased risk for encountering WPV due to various factors. The purpose is to inform best practice by evaluating and synthesizing findings from studies about the impact of WPV de-escalation programs in the hospital setting.

Introduction

Healthcare leaders must identify successful de-escalation strategies to incorporate to reduce WPV. Currently, very little is known relating to WPV in healthcare. This includes precursors to violent events, departments with higher rates of violence, effectiveness of de-escalation training, healthcare workers perceptions to WPV, confidence levels post de-escalation training, and methods to reduce WPV in healthcare. The aim will be to determine the effectiveness of de-escalation training in hospital settings and staff confidence in managing violent events.

Methodology

The integrative review will utilize the Whittemore and Knafl (2005) approach and design. An integrative review method of design was chosen for this project due to the acceptance of a variety of methodologies. These steps include problem identification, literature search, data evaluation, data analysis, and finally, presentation (Whittemore & Knafl, 2005). Each article will be apprised for a level and quality of literature utilizing the Johns Hopkins Nursing Evidence based Practice Research Appraisal Tool. The Johns Hopkins Nursing Evidence Based Practice Research Appraisal tool categorized articles first by level of evidence then by quality (Johns Hopkins University, n.d.). Finally, a PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) approach will be utilized to show the steps leading to the final included articles and studies. The PRISMA will guide readers in understanding how the final included articles are selected (Moher, Liberati, Tetzlaff, & Altman, 2009).

Results

A total of 10 articles were synthesized for the integrative review, three articles are qualitative, four are quantitative, and three are mixed method studies. Three of the articles discuss the effectiveness of various training and education programs to reduce WPV. Only two articles reduced the rates of WPV. The second aim was to determine staff's confidence level in managing WPV and the perception of WPV in healthcare. Nine articles address confidence and/or perception of WPV. Six articles showed evidence of improved confidence in managing and coping with WPV after an

intervention. Four of these articles utilized a standardized coping scale developed by Michael Thackrey in 1987 (Thackrey, 1987). Three articles implemented aggression management training courses to determine staff's perceptions to the effectiveness of aggression training. Overall, the aggression management courses indicated that staff attitudes did not improve with training, nor did staff's ability to emotionally cope with aggression.

Conclusions/Recommendations

WPV in healthcare is a global pandemic that will affect the future of healthcare and care delivery. Leaders must focus on three key aspects relating to WPV; a standardized coping scale to improve confidence in managing aggressive patients, increased de-escalation training utilizing education and simulation training, and developing a better understanding of the prevalence of WPV in healthcare. A multidisciplinary approach, with high emphasis on utilizing public safety, to understanding and reducing WPV would benefit healthcare leaders. As healthcare continues to grow, the need for a safe work environment must become a high priority.

INTRODUCTION

Workplace Violence has a significant impact in the healthcare systems. Healthcare is growing at an exponential rate. While healthcare is expanding into various components, the needs for healthcare workers are growing at the same rate. One of the top impacts of workplace violence is retention. Unfortunately, the retention rate for healthcare workers is rapidly declining. One of the reasons for the decline in retention is directly correlated with the increase in workplace violence. Hospitals have had a workforce turnover rate of 87.8% since 2014 (NSI Nursing Solutions, Inc., 2019). Increased turnover rates could be directly correlated to a potential increase in serious safety events impacting not only the patient but also the healthcare worker. This could result in new inexperienced staff, long work hours due to staffing issues, unsafe nurse to patient ratio, decrease staff satisfaction and more.

A direct positive correlation has been identified between increased job contentment and improved nurse retention (Robbins & Davidhizar, 2007). By ensuring a healthy work environment that protects healthcare workers from violence, healthcare systems will increase retention, increase patient safety, increase the quality of work, increase staff satisfaction, and thus increase patient satisfaction. Patient care will be improved by preventing healthcare workplace violence. This integrative review will analyze the effectiveness of incorporating workplace violence prevention programs in hospital - based settings.

The United States nursing industry has an estimated over 4 million Registered Nurses, with increasing job shortages due to numerous issues, one major issue being workplace violence (American Nurses Association). Jackson, Clare, and Mannix (2002), linked workplace violence to the recruitment and retention of nursing in the workforce. Their journal, Who Would Want to be a Nurse? Violence in the Workplace – a Factor in Recruitment and Retention, gathered evidence from multiple countries to prove that workplace violence in healthcare is an international dilemma. The consequences of not addressing the problem of workplace violence can result in decrease retention rates, decrease recruitment rates, increase in staff anxiety, increase in extended length of absences due to injury, decrease in quality of care delivered, increase in burnout (Jackson, Clare, & Mannix, 2002).

Evidence shows that nurses are suffering from post-traumatic stress disorders as a result of workplace violence (Rippon, 2000). A lack of complete understanding of the true magnitude of workplace violence in healthcare is in part due to the topic being under researched and under reported. In a real-time observation study conducted by Erickson & Williams-Evans (2000), Attitudes of Emergency Nurses Regarding Patient Assaults, “seven incidents were reported out of 686 observed occasions of violence or aggression” (Jackson, Clare, & Mannix, 2002). Violence in healthcare and the controversy of reporting stems from a belief “that being assaulted ‘goes with the job” (Erickson & Williams-Evans, 2000) from the majority of nurses surveyed by Erickson and Williams-Evans. Due to the lack of reporting, officially or unofficially, workplace

violence will continue to be under recognized as a leading cause of issues in healthcare. Healthcare leaders must formulate a systematic approach to address the prevention of workplace violence. Addressing workplace violence and implementing processes to create a safer work environment will directly correlate to an increase in retention. WPV training can decrease the incidence and severity of violent episodes through early intervention in potentially violent situations. Security staff and nursing personnel can partner on training and to support efforts to reduce WPV.

H.R. 1309 - Workplace Violence Prevention for Health Care and Social Service Workers Act was formed to mandate the Secretary of Labor to issue a standard that enforces healthcare and social service industry employers to develop and implement a workplace violence prevention plan (Courtney, 2019) Currently, there is no formal standard policy or process enforced to prevent nor deter workplace violence in the healthcare setting. State by State guidelines have previously been formed however few are enforced. For instance, Georgia's law only covers violence in the Emergency Department setting. (American Nurses Association, "Workplace Violence", 2019) Violence to healthcare workers occurs in all settings. While some units are at a higher frequency, we as a community cannot chose who to protect.

The Occupational Safety and Health Act of 1970 (OSH Act) is a guideline for states and hospitals to utilize to prevent workplace violence. This Act does not enforce states and hospitals to carry out the recommendations made. OSHA is a federal agency supported by the Department of Labor (DOL). However, the Occupational Safety and Health Administration (OSHA) is required to ensure that healthcare systems provide a safe environment for employees from serious hazards. (United States Government Accountability Office, 2016) Due to the increase in healthcare related violence, OSHA has increased its annual safety checks from 2010 to 2014 (United States Government Accountability Office, 2016). Healthcare related violence is not limited to fatalities, in fact, the majority of violence has resulted in non-fatal injuries. The Bureau of Labor Statistics (BLS) stated "between 2011 and 2013, workplace assaults ranged from 23,540 and 25,630 annually, with 70 to 74% occurring in healthcare and social service settings" (U.S. Department of Labor Occupational Safety and Health Administration, 2016). These statistics are only based on reporting individuals, there is a high potential that these are low numbers as violence in healthcare has historically been underreported. Workplace violence in healthcare is an underreported and minimized crisis that can greatly impact the future of healthcare.

BACKGROUND

Healthcare leaders must identify successful de-escalation strategies to incorporate into the workplace to reduce workplace violence. This integrative review will evaluate literature themes from various de-escalation programs implemented throughout the world and the success rate in reducing workplace violence events and/or the healthcare team's confidence in handling violent situations. Currently there is very little knowledge relating to workplace violence in healthcare. This includes precursors to violent events, departments with higher rates of violence, effectiveness of de-escalation training, and

healthcare workers perceptions to workplace violence, confidence levels post de-escalation training, and methods to reduce workplace violence in healthcare. Security leaders and other healthcare leaders can partner with nursing to develop and implement training to support workplace violence prevention efforts. There is a high significance to better understanding workplace violence in healthcare and the impact workplace violence has for the future of healthcare delivery. The aim of this integrative review will be to determine the effectiveness of de-escalation training in the hospital setting in relation to the reduction of workplace violent events and staff confidence in managing violent events.

OBJECTIVES

The objective of this integrative review is to determine the effectiveness of implementing workplace violence prevention programs in hospital settings. The workplace violence prevention programs will include various training and education to hospital-based staff with a primary focus on workplace violence from the patient to staff. Healthcare workers are at an increased risk for encountering workplace violence due to various factors. This integrative review will assess the effectiveness of workplace violence prevention programs from several key points. The purpose of this integrative review is to inform best practice by evaluating and synthesizing findings from studies about the impact of workplace violence de-escalation programs in the hospital setting.

REVIEW QUESTIONS

The integrative review addresses two review questions:

1. Do workplace violence prevention education and training programs reduce incidents of workplace violence in the hospital setting?

2. Do workplace violence prevention programs help improve staff perception of and confidence in managing workplace violence incidents?

METHODS

This integrative review will utilize the Whittemore and Knafl (2005) approach and design. An integrative review method of design was chosen for this project due to the acceptance of a variety of methodologies. Integrative reviews are often thought of as the gold standard for nursing-based evidence-based studies. This integrative review will undertake several key steps prior to publication. These steps include problem identification, literature search, data evaluation, data analysis, and finally presentation (Whittemore & Knafl, 2005).

This integrative review will utilize the Kennesaw State University Database and Google Scholar, in combination with gray literature from the American Nurses Association,

Emergency Nurses Association, and political publications. All articles utilized in the review are published from January 2015- January 2020, allowing for the most up to date literature to be reviewed. Key search terms will include healthcare, workplace violence, emotional violence, physical violence, verbal violence, sexual violence, assault, prevention training, de-escalation, nurse, physician, healthcare worker, and hospitals. The key search terms will allow for variations of tense and spelling to account for a larger sample size review.

The articles will be reviewed based on title and abstract to ensure the appropriate include and exclusion criteria are met in the preliminary review. The inclusion criteria will include global studies, research studies, qualitative studies, mixed method studies, quantitative studies, healthcare workers, pre and post-test comparisons, published in English, primary sources, hospital-based departments, de-escalation training program implementation or education. The exclusion criteria will be limited to research articles in non-hospital settings, non-patient facing healthcare workers, studies without pre and post comparisons, and psychiatric units. As previously mentioned, each article will be reviewed based on a set of steps. The review will include the title, abstract, key terms, inclusion and exclusion criteria, and finally the entire article for inclusion into the final selected integrative review articles.

The management of selected articles will be maintained in an excel spreadsheet. The excel spreadsheet will include the management of bibliographies, the Johns Hopkins Nursing Evidence Based Practice Research Appraisal Tool and pertinent article details. The spread sheet includes several subsections for each article under review. The subsections for the bibliographies will include the APA reference, article title, authors, journal title, ISSN, publication date, volume, issue, first page, page count, accession number, DOI, and publisher. The subsections for the article details will include key terms, abstract, research study type, healthcare setting, sample size, de-escalation strategy or education, aim, methods, results, conclusions, and the Johns Hopkins Nursing Evidence Based Practice Research Appraisal Tool. Each article will be apprised for a level and quality of literature utilizing the Johns Hopkins Nursing Evidence based Practice Research Appraisal Tool. Finally, a PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) approach will be utilized to show the steps leading to the final included articles and studies. The PRISMA will guide readers in understanding how the final included articles are selected (Moher, Liberati, Tetzlaff, & Altman, 2009).

The Johns Hopkins Nursing Evidence Based Practice Research Appraisal tool will be used to evaluate the overall quality of the articles. The Johns Hopkins Nursing Evidence Based Practice Research Appraisal tool categorized articles first by level of evidence then by quality. There are three levels. The first is level one, which includes randomized control trial and experimental studies. The second level consists of quasi-experiments, this will be the primary level chosen for this integrative review. Finally, the third level is non-experimental. This integrative review will primarily consist of levels one and two. Next the Johns Hopkins Nursing Evidence Based Practice Research Appraisal tool evaluates the quality through a series of questions. There are three quality rating

scores. High quality, good quality, and low quality or major flaws. This integrative review will only utilize articles with high quality and good quality scores. Evaluating the level and quality of articles allows for the integrative review to establish “authenticity, methodological quality, informational value, and representativeness of available primary sources is considered and discussed in the final report” (Whittemore & Knafl, 2005).

DESCRIPTIVE RESULTS

A PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram was chosen for the data collection framework to display the search results (Moher, Liberati, Tetzlaff, & Altman, 2009). Figure 1 shows the progression of how articles were excluded and included.

The search resulted in 87 articles identified through the Kennesaw State University Library and 10 additional articles through Google Scholar, American Nurses Association, Emergency Nurses Association, and political news publications. Duplicate articles were removed resulting in 64 potential articles to be included in the integrative review. Articles were then screened by title, where 38 were then excluded. Finally, the author assessed the full articles for eligibility. Articles of poor quality, those that did not assess the effectiveness of implemented training to reduce workplace violence or assess the confidence level, and articles that consisted of incomplete trials were excluded. This resulted in a total of 10 articles to be synthesized for the integrative review. Three of the articles consist of qualitative studies, four are quantitate, and three are mixed method studies.

The integrative review was designed to evaluate current literature and review two key questions pertaining to workplace violence in healthcare. The first is the effectiveness of various training or education in the reduction of workplace violence. The second is effectiveness of various training or education in conjunction with staff’s perception or confidence level in managing workplace violence. Each of the ten articles addresses at least one of the key questions, if not both.

The author created a methodological matrix from the reviewed research articles (see table 1). The matrix is divided into five columns:

1. Study and location
2. Purpose
3. Level of evidence, quality, and design
4. Training methods
5. Major findings.

The research articles are then separated into three subgroups: qualitative, quantitative, and mixed methods. The matrix is utilized to synthesize the key areas in each research article.

EFFECTIVENESS TRAINING AND EDUCATION TO REDUCE WPV EVENTS

The selected research articles had to address at least one of the two integrative review questions for the integrative review. Three out of the ten articles selected in the integrative review discuss the effectiveness of various training and education programs to reduce workplace violence in the hospital setting. In reviewing the four articles, two used mixed methods of both training and education in their programs, while one research article only utilized education. The two articles that utilized mixed methods were from Arnetz, et al., (2017) and Baig, et al., (2018). Adams, et al., (2017) is the only article to utilize one method of education to reduce workplace violence rates.

Arnetz, et al., (2017), structured their research in reducing workplace violence in hospitals by utilizing a randomized controlled intervention on selected hospital units then compared the results to similar controlled units. The design was structured to give the intervention units pertinent information and data related to previous violence on their unit then develop individual action plans. The action plans covered three distinct strategic categories: environmental strategies, administrative strategies, and behavioral strategies. Many of the action plans indicated increased education to frontline staff in the behavioral and administrative strategies. The results of the research article indicate decreased rates of patient to staff violent incidences in the intervention units as compared to the control units.

Baig, et al., (2018), utilized mixed methods of training and education to reduce incidents of workplace violence in the hospital setting. Training and education in the research article included education and scenario-based role-playing simulation learning. The education and training were conducted over a single four-hour session. Baig, et al., (2018), found that the de-escalation training and education did not prove scientifically significant in the reduction of the frequency of violence as compared to the control group.

Ramacciati & Giusti (2020) identified the need for training and partnership with nursing and security personnel to partner to improve WPV incidents in the Emergency room. Education and training to increase knowledge and promote partnership of nursing and security staff has the potential to reduce WPV incidents. In addition, education can provide clarity in roles and responses to WPV for nursing and security which will support a safer environment.

Adams, et al., (2017), only utilized an education approach to reduce workplace violence events in the hospital setting. The education was provided daily in-person on the units over the course of four months in 2013. All staff were educated at the same times each day, one session for day shift, one session for night shift staff. The education had four main focuses: assessment, planning, implementation, and post incident. A comparison of pre-intervention and postintervention showed a reduction in the frequency of workplace violence events on the units.

STAFF CONFIDENCE AND PERCEPTION OF WPV

The other aim of this integrative review was to determine staff's confidence level in managing workplace violence and the perception of workplace violence in healthcare. Of the ten research articles, nine articles speak to confidence and/or perception of workplace violence. Seven of the eight research articles utilized workplace prevention programs that incorporated multiple education techniques: simulation, video, power points, etc. Only one workplace violence prevention program utilized one educational method.

Six articles showed evidence of improved confidence in managing and coping with workplace violence after an intervention. These six articles are from Baig, et al., (2018), de la Fuente & Schoenfisch, (2019), Heckemann, et al., (2016), Jeong & Lee, (2020), Mitchell, et al., (2020), and Story, et al., (2020). Four of these articles utilized a standardized coping scale developed by Michael Thackrey in 1987 (Thackrey, 1987). The coping scale is frequently referred to as Confidence in Coping with Patient Aggression Instrument (CCPAI) or Self- Confidence in Coping with Patients' Assault Scale. Baig, et al., (2018), de la Fuente & Schoenfisch, (2019), and Story, et al., (2020), utilized the Coping with Patient Aggression Instrument. Jeong and Lee, (2020), utilized the Self-Confidence in Coping with Patients' Assault Scale to standardize the results. All six articles utilized multiple educational methods to improve confidence in managing and coping with workplace violence.

The articles by Heckermann, et al., (2016), Coneo, et al., (2019), and Adams, et al., (2017), indicated no scientific improvement to staff perception or attitude in the management of workplace violence post intervention training. Heckerman, et al., (2016), Coneo, et al., (2019), and Adams, et al., (2017), implemented aggression management training courses to determine staff's perceptions to the effectiveness of aggression training. Overall, the aggression management courses indicated that staff's attitudes did not improve with training, nor did staff's ability to emotionally cope with aggression in the workplace.

DISCUSSION

The aim of this integrative review is to inform best practice by evaluating and synthesizing findings from studies about the impact of workplace violence de-escalation programs in the hospital setting. This integrative review will evaluate themes identified from the various research articles, as well as limitations from the research. Workplace violence has been proven to impact healthcare. There is great potential for nursing and security to partner to work towards reducing the risk of WPV. Security personnel often have knowledge and expertise in the training and intervention in prevention and intervention of violent situations. These personnel can be strong partners for nursing and other healthcare workers through training, support, and education. The articles addressed one or both of the review questions surrounding workplace violence in healthcare. The review questions include discussing effectiveness in de-escalation

training in reducing workplace violence, as well as staff perceptions to management of violent events after de-escalation training.

Themes

A leading theme was the utilization of the standard coping scale tool to help improve confidence in managing aggressive patients. A common tool utilized in several studies was developed by Michael Thackrey (Thackrey, 1987). The Confidence in Coping with Patient Aggression Instrument (CCPAI) is a widely known tool to help standardize subjective responses relating to specific questions. This tool is used to measure the confidence staff have in managing aggressive and violent patients. The research articles that utilized the CCPAI showed significant increase in confidence managing aggressive and violent patients post de-escalation training (Thackrey, 1987). The surveys utilize an 11-point Likert Scale over ten standardized questions. Shaw (2015) did not utilize an intervention nor the CCPAI to evaluate staff's perception to workplace violence in emergency departments. However, Shaw (2015) findings did show concerning results of staff's perception of a lack of safety protocols and procedures within the department and healthcare.

Simulation training and education to strengthen staff's confidence and competence in managing aggressive patients is another key theme from the research articles. In the majority of the research articles, simulation training and education was utilized in the de-escalation training programs. The simulation training and education allowed for staff to analyze, learn, and understand key points in managing escalating patients, preventative measures, and de-escalation techniques in a controlled environment. Simulation training allowed for staff to learn in a controlled environment without endangering themselves or patients.

One of the final key themes identified in the research articles is the magnitude and prevalence of workplace violence throughout healthcare on a global scale. Each research article's data spoke to workplace violence in their organization. This key theme can associate workplace violence in healthcare as a pandemic problem. If healthcare does not remedy the safety issues and concerns raised by frontline staff, healthcare will continue to suffer staffing shortages, increased workman's compensation claims, and decreased quality care delivery to patients.

Limitations

The integrative review has numerous limitations. This integrative review only reviewed articles from the previous five years to better understand recent advances made in the research surrounding workplace violence in healthcare. The integrative review did utilize a global search, however, there remained a limited number of articles applicable to the integrative review topics. Further limitations in this integrative review are related to the lack of published articles and research in the field of workplace violence in healthcare. The integrative review also incorporated a variety of quality rated articles that might not have been included if more articles were available for review.

Implications

The implications from this integrative review result in a need for increased research and interest surrounding workplace violence in healthcare. Future studies should evaluate the effectiveness of de-escalation strategies in reducing the rates of workplace violence, establish a best practice in de-escalation training, and staff's perceptions to workplace violence in healthcare. Studies should also focus on their countries or local governments stance on preventing workplace violence in healthcare. Healthcare systems must lean on their governments the importance of preventing workplace violence in healthcare and the potential outcomes associated if workplace violence continues to be overlooked as a serious pandemic in healthcare.

CONCLUSIONS

Workplace violence in healthcare is a global pandemic that will affect the future of healthcare and care delivery. Research is needed to determine the magnitude and prevalence workplace violence has in healthcare. Anonymous surveys, that ensure staff are safe from repercussions, are highly encouraged to determine accurate data surrounding workplace violence in healthcare. As healthcare continues to grow, the need for a safe work environment becomes a higher priority. An estimated 1 in every 4 nurses have been assaulted during their career. The workplace violence epidemic that is affecting healthcare can be correlated as one of the leading factors to increased turnover rates. The 2019 National Health Care Retention & RN Staffing Report stated that hospitals have had an average turnover rate of 87.8% of its workforce since 2014 (NSI Nursing Solutions, Inc., 2019). Healthcare leaders must address the incidences of workplace violence and create a standard for a safe work environment. Due to the current limited data, leaders must focus on ways to increase data. A preliminary focus for building a zero-tolerance environment is through understanding ways to create an environment of reporting. Through reporting, leaders will better understand the prevalence of workplace violence and the impact on healthcare (American Nurses Association, 2019). Healthcare workers deserve the right to work in a safe environment and as leaders it should be our primary focus to help achieve that goal.

AUTHORS

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APPENDIX 1

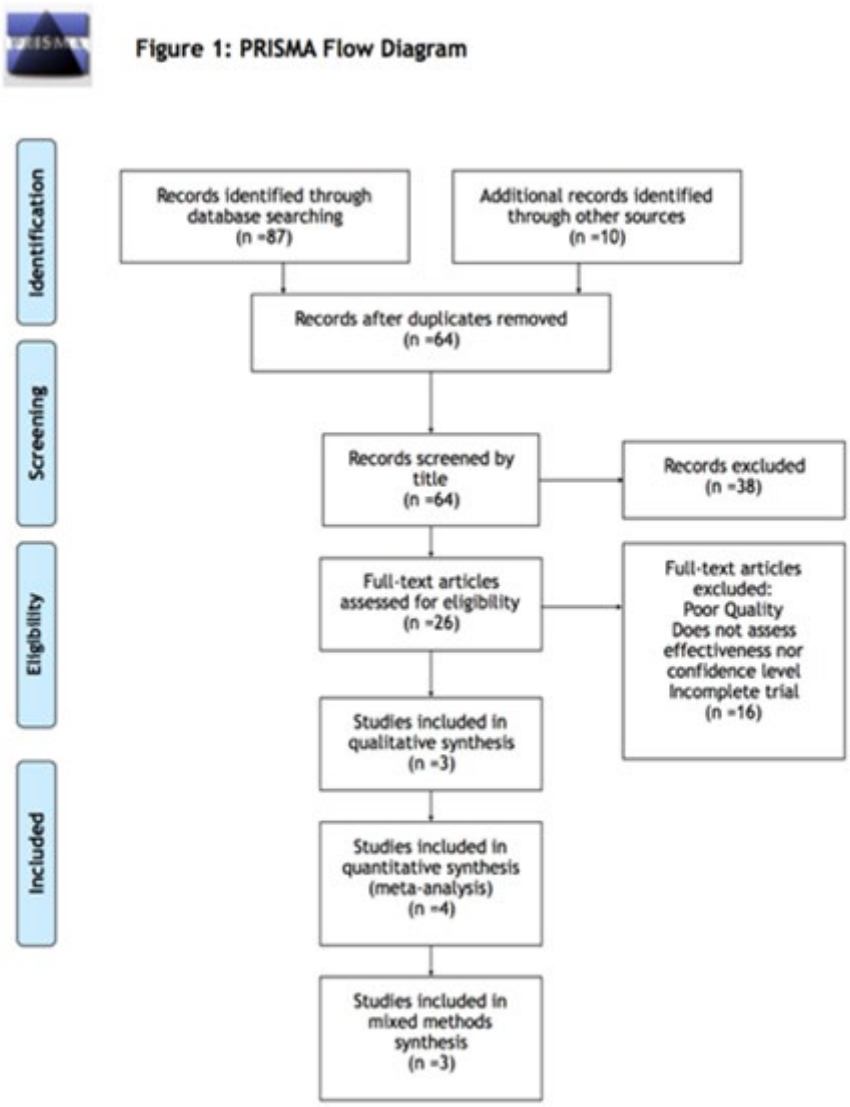
Figure 1: PRISMA Flow Diagram
Identification
Screening
Eligibility
Included
Records identified through database searching (n =87)
Additional records identified through other sources (n =10)
Records after duplicates removed (n =64)
Records screened by title (n =64)
Records excluded (n =38)
Full-text articles assessed for eligibility (n =26)
Full-text articles excluded: Poor Quality Does not assess effectiveness nor confidence level Incomplete trial (n =16)
Studies included in qualitative synthesis (n =3)
Studies included in quantitative synthesis (meta-analysis) (n =4)
Studies included in mixed methods synthesis (n =3)
From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097
For more information, visit www.prisma-statement.org.

APPENDIX 2

Table 1: Review of Literature

Study and Location	Purpose	Level of Evidence, Quality and Design	Training Methods	Major Findings
Qualitative				
Heckemann, et al., 2016 (Switzerland)	To evaluate nurses' perspectives of knowledge and skills learned from an aggressive management training course.	Level III, good quality. Descriptive qualitative interview study of seven nurses pre and post training.	8.5 hours theory then 3.5 hours practice training scenarios	Aggressive management improved nurses' skills and knowledge, however, emotional impact unchanged.

Mitchell, et al., 2020 (Australia)	To evaluate a simulation-based program and its effectiveness to understand participants confidence managing aggressive clinical situations.	Level III, high quality. Proof of concept study for the management of clinical aggression (MOCA) utilizing the Kirkpatrick framework to assess training. 140 total participants completed pre and post-survey questionnaires.	Two-hour simulation training in addition to the management of clinical aggression training.	Improved confidence scores in staff who encountered aggressive patients during the 3-6 months post training.

Story, et al., 2020 (United States)	To evaluate the impact of workplace violence in a hospital setting and to evaluate the effectiveness of a workplace violence prevention training program in connection to nurses' confidence and perceptions in managing violence and aggression.	Level III, high quality. Quality improvement project utilized "Confidence in Coping with Patient Aggression" (CCPA) to evaluate the effectiveness of the workplace violence prevention training program. Forty-three participants completed the required pre and post training surveys.	Single two-hour training session.	Improved skills in recognizing aggression and management of aggressive situations.

Quantitative				
Adams, et al., 2017 (Australia)	To evaluate the effectiveness of clinical education in recognizing patients with high risk for violence and to reduce the number of violent events.	Level II, good quality. A pre and pos-training 1-5 Likert Scale questionnaire utilized to assess staff's confidence and perceived capability to prevent and manage workplace violence. A population sample of 65 pre and 73 post-training scores were utilized in the study.	Daily education in pre-shift huddles included hypothetical situations. Four key areas were educated to staff: assessment, planning, implementation during a crisis, and post incident.	Education decreased violent incidents by 45%. However, confidence and capability score did not increase post education.

Arnetz, et al., 2017 (United States)	To evaluate the effects of randomized controlled interventions to reduce workplace violence in type II violence.	Level I, good quality. Forty-one units across seven hospitals placed into intervention and control groups. Intervention unit groups developed action plans based on data.	Intervention groups developed action plans in three categories: environmental strategies, administrative strategies, and behavioral strategies.	Intervention groups had significantly lower risks for events and injuries as compared to the control group over a six-month period of time.

de la Fuenta, et al., 2019 (United States)	To evaluate nurses' confidence in managing aggressive patients post behavior management training	Level II, high quality. A five-hospital health system conducted pre and post-training surveys utilizing the Confidence in "Coping with Patient Aggression" (CCPA). A total of 75 participants were utilized in training, while only 31 participated in the surveys.	4-hour in person training program Management of Aggressive Behavior (MOAB).	Significant improvement of nurses' confidence in managing aggressive patients post training.

Jeong, et al., 2020 (South Korea)	To develop, implement and evaluate a violence prevention program for nursing students. The programs goals include improving communication self-efficacy, problem focused coping style, emotion focused coping style, and the ability to cope with violence.	Level II, high quality. Quasi-Experimental research using nonequivalent control group with a pre and post-test design of 45 students.	Two groups, control group and experimental group. Experimental group participated in eight sessions including simulation over four weeks. The control group participated in a 120 minute lecture in the first and only session.	Significant improvement in post-training scores for the experimental group in problem-focused coping style, emotion-focused coping style, and observation assessments of students ability to cope with violence.

Mixed Methods				
Baig, et al., 2018 (Pakistan)	To evaluate the effectiveness of de-escalation training to prevent verbal and non-verbal violence.	Level III, good quality. Quasi-experimental study with mixed method design. Two similar hospitals participated in the study. The control and intervention group consisted of 77 participants each. Confidence levels were measured utilizing the "Confidence in Coping with Patient Aggression Instrument" (CCPAI) scale	The intervention group were given a four-hour de-escalation training session. The training consisted of four key topics: Understanding violence and stress, escalation and de-escalation of violence, management of post-traumatic stress disorder, and patient-communication protocol.	Significantly higher CCPAI scores for the intervention group in comparison to the control group.

Coneo, et al., 2020 (Uganda)	To evaluate the effectiveness of the RESPECT training program on staff's perceptions of causes and management of patient aggression	Level III, good quality. Mixed methods convergent design. Sample size of 90 participated in pre and post-training analysis tool and interviews. The analysis tool used was the "Management of Aggression and Violence Scale" (MAVAS)	Four-day RESPECT training course. The program is comprised of 70% prevention, 20% de-escalation, and 10% reactive strategies.	Significant effect of staff's perception of causative factors and management of aggression post RESPECT training.

Shaw, 2015 (United States)	To understand pediatric emergency department staff's perceptions to workplace violence risk which will help determine improvements needed to reduce risks and staff fear.	Level III, good quality. Descriptive, non-experimental design. Surveys were sent to staff in two EDs and three urgent care centers. The surveys utilized a Likert Scale and narrative response questions.	Survey centered on four topics: work-based demographics, perceptions of security fears and concerns, local police department presence, and hospital security staff presence.	Significant evidence shows staff have concerns and fear regarding personal safety at work to some degree. Researchers recommended implementing a workplace violence prevention program in all hospitals.