Prevention Measures to Reduce Workplace Violence in the Acute Care Setting

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A DNP Project Manuscript
Submitted in Partial Fulfillment of the Requirements for the
Doctor of Nursing Practice Degree

School of Nursing, University of Maryland at Baltimore
May 2025

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Abstract

Problem: On an adult medical surgical unit in a mid-sized, community hospital in Maryland there has been an increase in Workplace violence (WPV) that has led to unfortunate injuries to staff providing care. Based on the event reporting system, there have been seven events where staff members were physically assaulted and six events involving nonphysical violence in the last year. **Purpose:** The purpose of this quality improvement project is to decrease WPV from patients against staff by implementing a clinical practice guideline**,** defining the use of 3 evidence-based tools: Broset Violence Checklist (BVC), Patient Treatment Agreements, and Behavioral Emergency Response Team (BERT) activation. A decrease in WPV will benefit the staff, the patients, and the organization. **Methods:** In the months preceding project implementation, the Quality Improvement Project Lead (QI-PL) assembled a team of invested stakeholders. The QI-PL developed a clinical practice guideline, gained stakeholder approval and provided education to all nurses. The guideline outlined that every patient admitted should be screened with the BVC to assess for potential violence. If a patient displays behavior that indicates potential violence, a patient treatment agreement should be completed. If a patient begins to escalate in behavior, a BERT should be activated to deescalate the situation, prior to a violent event occurring. **Results:** During the 15 weeks of project implementation, 100% of patients on the unit were screened with the BVC, no patient treatment agreements were completed, two BERTs were activated, and two WPV events were reported. **Conclusions:** Findings suggest high adherence with the clinical practice guideline despite limitations identified. Continued utilization of these evidence-based prevention measures is recommended because it has the potential to decrease the overall number of WPV events. *Keywords:* Workplace violence, prevention, prevention, acute care, screening

Prevention Measures to Reduce Workplace Violence in the Acute Care Setting

Workplace violence (WPV) is defined by the U.S. Department of Labor as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site" (United States Department of Labor, n.d.). Healthcare workers are five times more likely to experience WPV than workers overall (U.S. Bureau, 2020). At a community hospital in Maryland, on a medical surgical unit there has been an increase in incidents of WPV. Based on the employee injury and illness report and the event reporting system, there were seven WPV events in the last fiscal year where clinical staff were assaulted by patients which resulted in physical harm and six events involving non-physical violence. Prior to project implementation, staff on the unit unfortunately reported that they felt they lacked resources needed for prevention of WPV events.

The consequences of WPV are detrimental for the staff, patients, and the organization. For staff this can lead to not only physical injury, but burnout, job dissatisfaction, depression, substance abuse, and PTSD (Al-Qadi, 2021). For the patients, when violence occurs this often leads to use of chemical or physical restraints, security involvement, a longer inpatient stay, and poorer patient experiences (Al-Qadi, 2021). For the organization it leads to a financial burden for occupational health costs, cost of time of work, and the cost associated with hiring new staff to replace those who chose to resign. WPV in this acute care setting is complex and multifactorial; however, the root causes can be broken down into categories including patient factors, organizational factors, staff factors, policies and procedures, technology, environment, and resources available (see Figure 1). The purpose of this quality improvement (QI) project was to decrease WPV among patients against clinical staff on an inpatient, medical surgical unit by implementing a WPV prevention clinical practice guideline**.**

Available Knowledge and Specific Aims

An evidence search was completed to establish evidence-based tools shown to be effective in preventing workplace violence in the acute care setting. The goal of this literature review and appraisal was to make an evidence-based recommendation to determine if a practice change with the appropriate use of these resources would help to improve the clinical problem. A variety of databases were accessed including One Search, PubMed, CINAHL, and SCOPUS searching a combination of the keywords including workplace violence, violence, aggressive, Broset/Brøset violence checklist (BVC), screening, prevention, acute care, and risk assessment were used to locate high level, applicable research. Criteria such as peer reviewed journals and date of publication were used to narrow the search, after which a title review, abstract review, and full article review were conducted. See citation manager (Appendix A) of the searches and PRISMA Search Flow diagrams (Figure 2) to see evidence retrieval process. This literature search revealed three results including Broset Violence Checklist (BVC), patient treatment agreements and behavioral emergency response team (BERT) activation demonstrated the ability to positively screen for potential patient violence and decrease workplace violence events. All three of these interventions were available within the organization but not being utilized.

The Johns Hopkins evidence-based practice guidelines were used to determine the strength and quality of the evidence selected (Table 1). The evidence was either level II or level III and the quality was either A (high-quality) or B (good quality). While the initial search was for the use of the BVC, with the decision to expand the intervention to a bundle of interventions, additional literature was selected to support the use of the patient treatment agreements as well as the BERT activation. These research articles were therefore supplemented by lower levels of evidence (IV and V) including clinical practice guidelines, recommendations by nationally

recognized committees, and QI projects. This further reiterated the findings and supported the use of the identified interventions. After review, an evidence synthesis was conducted to compare, contrast, and draw conclusions (see Table 2). All evidence reviewed was completed in the acute care settings, on adult patients, and with a goal to address workplace violence. Given the strong level, high quality of the evidence, and consistent conclusions drawn amongst the literature recommendations can be made to support the use of this bundle in practice. The recommendation is to support the use of the BVC in practice to help recognize patients at high risk for violence, to utilize BERT to deescalate patients, and to complete patient treatment agreements to make patients aware of the code of conduct expected (Sharifi et al., 2020; Rajwani, Clark, & Montalvo, 2023; "Occupational Health", 2016).

Rationale

The Promoting Action on Research Implementation in Health Services (PARIHS) process framework is a widely used theoretical model that helps guide the implementation of evidence-based practices in healthcare settings. This framework suggests that successful implementation of research into practice is a function of the interaction of three key elements: evidence, facilitation and context. This framework was chosen to support this project because it aligned closely with the QI process.

For this QI project, evidence was gathered through a literature review, clinical experiences, and site data. Then, a plan was developed to establish the facilitation including appropriateness of the unit, overall purpose and goals, and the different roles needed. Finally, a thorough assessment was conducted to understand the context, including the culture of the unit and the leadership support. The PARIHS framework showed that with these three key elements

in place, there would be successful implementation (Ogrinc et al., 2022). See Figure 3 for framework diagram.

Methods

During planning, the culture and context of the hospital were assessed using the Context Assessment Index (CAI) (McCormack et al., 2009). The assessment showed that the hospital is committed to providing high-quality, compassionate care through strong teamwork. Guided by institutional values, it aims to grow as a trusted healthcare partner, advocate for the poor and marginalized, and collaborate to improve community well-being. The hospital is a part of a large academic medical system; however, the hospital itself is a relatively small 212-bed community setting. The hospital aligns their values with the overall healthcare system that they fall under, which are compassion, discovery, excellence, diversity, and integrity. The staff provide high quality patient care and there is a high level of respect across clinical disciplines. The institution encourages involvement, supports education, and promotes the use of evidence-based care. The unit provides care to adults with a variety of clinical presentations. Unit leadership was supportive and readily available to the staff. The CAI revealed high scores in all areas of culture, leadership and evaluation indicating a readiness for change, strong leadership presence, and support for evidence-based practice and change.

The initial processes surrounding WPV events were evaluated, and a plan was made based on the evidence review for the desired process (see Figure 4). Three process goals were developed. First 100% of patients that were admitted to the unit would be screened for the potential of violence with the Broset Violence Checklist in the electronic health record. Second, there would be an increased utilization of the BERT activation response. Finally, there would be increased utilization of the patient treatment agreements for patient's admitted to the unit

displaying violent behavior. The outcome goal for this project was that there would be a decreased number of WPV events on the unit. See GANNT chart (Figure 5) to display proposed project timeline and strategies planned for success. To achieve these goals, a unit-based clinical practice guideline was developed to utilize a triad of evidence-based tools for workplace violence prevention utilizing the literature found and feedback from the clinical staff. These guidelines provide a clear explanation of the three evidence-based practices that are available (BVC Checklist, BERT, and patient treatment agreements) and an explanation of how they should be utilized in practice. This explains that every patient should be screened with the use of the Broset violence checklist within EPIC to indicate a score for potential violence. If a patient is escalating in behavior that indicates potential violence, a BERT should be activated and a patient treatment agreement should be used if appropriate (Sharifi et al., 2020; Rajwani, Clark, & Montalvo, 2023;" Occupational Health & Safety Administration", 2016).

When planning implementation strategies and tactics to see success in this project, the "ABCDE" pneumonic was utilized which outlines accountability, buy-in, collaboration/communication, data collection, and education. For accountability, the project was implemented on only one unit. The project lead was present on the unit to provide education to the staff and perform data collection. For buy-in this included encouraging involvement with the staff, getting stakeholder buy in and manager support. For collaboration and communication, this involved being present on the unit, actively communicating with stakeholders, and asking staff for feedback. For data collection, this was completed by the project lead via EPIC chart audits, reports from stakeholders, and communication with the staff. Finally, education was extremely important in the success of the project. The project lead provided multimodal forms of education

to the staff including attending the unit staff meetings, individual conversations, and printed materials displayed on the unit (see Appendix B).

Measures

Several measures were gathered to track success of the process and outcome goals. The process measures of adherence with completion of BVC screening tools, patient treatment agreements and BERT activations were tracked by the QI-PL on a weekly basis via electronic health record chart audits. The charge nurses on the unit were also educated to contact the QI-PL if a patient treatment agreement was completed so that none were missed. All BERT activations were verified by an electronically generated report. BVC adherence was calculated by looking at the total number of patients that were screened with the BVC divided by total number of patients admitted to the unit. Patient treatment agreements completed and BERTs that are activated were just looked at as a whole number since they were only to be used when clinically necessary, when a patient was displaying inappropriate or potentially violent behavior. Finally, the outcome measure of WPV events that occurred on the unit were tracked weekly via communication with the unit manager and verified by the reports of the event reporting system from the safety coordinator. All measures were entered into REDCap via the data collection tools created by the QI-PL (See Appendix C).

The project measures were individually tracked and analyzed throughout this process. It is important to acknowledge that patients who display violent behavior can come and go circumstantially and times violence doesn't always occur. Considering this common cause versus special cause circumstances, it is important to track all these metrics because even if violence does not occur throughout this time, the increased use of the tools available would show a positive clinical practice change based on these guidelines.

Analysis

The data for this QI project including the three process measures and the outcome measure were quantitative methods. Each measure was tracked weekly by the QI project lead and displayed via a weekly run chart for weeks one through fifteen. Displaying this data via a run chart allowed for the QI-PL to see the mean of the data, to assess for any trends, shifts, or runs, and to monitor if the goals were being met. As seen on the run charts, most of the data for all the measures fall on the median or only one point off then back to the median. Because of this, no shifts, trends or runs within this data can be appreciated (see Figures 6-9). ("Institute for Healthcare Improvement", 2019). It also provided the opportunity for the project lead to identify and take any necessary action if there was a trend in the data counter to project goals. For example, if a significant drop in the Broset Violence checklist completion was noted, the QI-PL would recognize this change, assess the situation, provide more education, or any alternate methods to get the project back on track to meeting its goals. While the QI- PL did track data regarding education completed, baseline knowledge of staff members, and asked for feedback from the staff throughout implementation, there was no qualitative data collected or measured for this project.

Ethical Considerations

Prior to project implementation, the QI-PL obtained Non-human Subject's Research determination from the Human Research Protections Office (HRPO) of the University of Maryland School of Medicine. When the project leader was completing chart audits, confidentiality was maintained by collecting data in a secured room and only the information needed for data collection relevant to this project was viewed. This included completion of the Broset Violence Checklist within flowsheets, a search for any BERT documentation, and the

media tab would be accessed if a patient treatment agreement was completed. Given that most of the collected data did not require patient protected health information, patient privacy and confidentiality was protected. In the data that did require patient protected health information, the least amount of information necessary was collected. The data was stored via REDCap which is a password protected and encrypted web-based database visible only by those who are given access. It should be noted that the QI-PL is an employee of hospital medical system; however, does not work for the specific hospital where the project occurred. Because the intervention took place for all nurses practicing on the unit and the practice guideline was to be used on every patient admitted to the unit, it was easier to ensure equity and inclusion. There are no other conflict of interests or ethical considerations.

Results

Throughout the 15 weeks of project implementation, data was collected by the QI project lead and tracked on a weekly basis, displayed via run charts (See Figures 6-9). There was no missing data during the 15 weeks of implementation. The first process goal of 100% of patients admitted to the unit would be screened for potential for violence with the Broset Violence Checklist was achieved. Data collection revealed that this goal was met because all 617 patients that were admitted to the unit during this time were screened with the Broset Violence Checklist within the EHR at least once during their unit stay. There was an organizational decision to make the use of this screening tool part of the admission documentation for patients which was an unintended facilitator which supported this goal being met. The screening tool was more easily accessible and with increased education to the staff of its importance to the staff, helped to ensure adherence with the use of this tool.

The second process goal was that there would be an increased utilization of the BERT

activation response. There were two BERTs activated during weeks one and eleven of implementation. There was no change in utilization as compared to the data prior to implementation and therefore, this process goal was not met. Although the data does not show a major change, qualitatively there did seem to be a better awareness of the resource available to the staff and a better understanding of appropriate usage of BERT activation prior to having to activate a code green response (indicating active violence).

The final process goal was that there would be an increased utilization of the patient treatment agreements for patient's admitted to the unit displaying violent behavior. The data collected during this time revealed that no patient treatment agreements were completed; therefore, this process goal was not met.

Finally, the outcome goal was to reduce the number of WPV events on the unit. There were two WPV events reported during weeks two and four of the project implementation. Compared to the average number of events reported during the previous fiscal year, this represents a meaningful reduction. As such, the outcome goal was successfully achieved, indicating positive progress toward creating a safer and more supportive work environment.

Discussion

The key findings of this QI project are that there was high adherence to the clinical practice guideline when it was necessary. There is potential for a significant positive impact if the appropriate use of the tools continues. It was positively received by staff due to minimal overall changes and a demonstrated effort by leadership to improve their safety and wellbeing. There are some limitations in completing data collection on workplace violence because the findings could be largely circumstantial based on the population that happens admitted to the unit during that particular time. For that reason, it is hard to provide a direct correlating relationship to the

intervention and the results collected. Additionally, the data collection design was that the QI-PL completed manual chart audits at least every three days to collect data for Broset violence checklist completion because an electronic report was unable to be accurately generated from the EHR. Given that there were many patients, and this was a tedious process, increasing the risk for human error to have affected these results.

According to the Joint Commissions new and revised workplace violence prevention standards for hospitals, the financial impact of workplace violence in healthcare can be significant. The impact of healthcare costs range from around $109,000 annually for nurse injuries to more than $330,000 in a single hospital system. These figures exclude the broader effects, such as psychological trauma, fear, job dissatisfaction among staff, and additional patient-related costs (Arnetz, 2022). Given these potential costs of continued acts of violence from patients against employees, with an intervention that is little to no financial cost to the organization, the return on investment of implementation this clinical practice guideline and taking these steps that focus on prevention is incredibly high. Not only is it financially favorable, but this is also a highly sustainable practice given that there is no significant change to nursing workflow, no significant increases in documentation, and no additional staff members are needed to ensure this role. The additional work needed for patient treatment agreements and BERT interventions are only to be used when applicable in the case of escalating behavior or violence. Education should be provided to all clinical staff, and the tools should be readily available and utilized in all inpatient units.

It is important to reflect on whether the results of this project align with the results initially found in the literature. The literature suggests that the Broset Violence Checklist is highly predictive of potential patient violence and studies suggest screening patients upon admission to

mitigate this risk of violence. The results of this QI project do align with the current published literature given elevated scores for patients that required BERT activation and for those involved in WPV events. For the use of BERT activation, the literature suggests that activating a BERT when a patient's behavior is escalating toward violence, decreases WPV events occurring. In reviewing the information on the two BERTs activated, both were without a subsequent WPV event being reported demonstrating that the results of this project do align with what the current literature suggests. For patient treatment agreements, the literature indicates that completing a patient treatment agreement helps to outline a treatment plan, provides education on what behavior is acceptable, and has the potential to decrease WPV events. What was found on this unit during implementation was that the WPV that is occurring is primarily among a population of primarily elderly patients that suffer from some sort of cognitive deficit such as dementia or a psychiatric condition. Patient treatment agreements require the patient to be actively involved in their plan of care and being able to sign a document expressing their understanding. In this case, this population of patients was unable to complete this agreement. Finally, when looking at the outcome goal of decreasing WPV events overall, the published literature implies that utilizing the three prevention tools on an inpatient unit should decrease the amount of WPV, aligning with the results of this QI project.

Conclusion

WPV has become an increasing concern in healthcare, drawing attention from the media, professional organizations, legal experts, and health systems. This growing focus highlights the importance of research and quality improvement efforts aimed at reducing WPV. The results of this quality improvement project demonstrates a positive trend and is the first step necessary in

improving this issue. This intervention is highly sustainable and could be easily spread from this unit to a hospital wide standard.

Although there was success in implementation, continued attention and quality improvement is needed. There were limitations that should be assessed further and opportunities for expansion of quality improvement moving forward. Staff should be commended for completing the Broset Violence Checklist; however, completion of the tool alone is not enough to stop the violence. This is the first step in establishing the risk but ensuring that there are actions taken based off these scores and tracking appropriate steps taken would be an opportunity for expansion of this QI project. Additionally, there should be continued investigation to find alternative prevention measures for the population unable to complete patient treatment agreements requiring support from the staff and leadership to ensure that fixing this problem remains a priority. Ongoing ownership and measurement are necessary for its continued success.

Implementing this guideline provides numerous benefits: early identification of at-risk patients, heightened awareness of prevention strategies, de-escalation interventions, and more. Most importantly the continued use of the clinical practice guideline is recommended for WPV prevention measures because there are potential better outcomes for the staff, the patients and the organization.

References

Arnetz J. E. (2022). The Joint Commission's new and revised workplace violence prevention standards for hospitals: A major step forward toward improved quality and safety. *Joint Commission Journal on Quality and Patient Safety*, *48*(4), 241–245. https://doi.org/10.1016/j.jcjq.2022.02.001

Hvidhjelm, J., Berring, L. L., Whittington, R., Woods, P., Bak, J., & Almvik, R. (2023). Short-term risk assessment in the long term: A scoping review and meta-analysis of the Brøset Violence Checklist. *Journal of Psychiatric and Mental Health Nursing, 30*(4), 637–648. https://doi.org/10.1111/jpm.12905

Institute for Healthcare Improvement. (2019). Run Chart Rules Reference Sheet. https://www.ihi.org/sites/default/files/lms/legacy/education/IHIOpenSchool/Courses/Documents/11_RunChartRulesReferenceSheet.pdf

McCormack, B., McCarthy, G., Wright, J., Slater, P., & Coffey, A. (2009). Development and testing of the Context Assessment Index (CAI). *Worldviews on Evidence-Based Nursing*, *6*(1), 27–35. https://doi.org/10.1111/j.1741-6787.2008.00130.x

Meehan, T., de Alwis, A., & Stedman, T. (2017). Identifying patients at risk of inpatient aggression at the time of admission to acute mental health care. What factors should clinicians consider? *Advances in Mental Health, 15*(2), 161–171. https://doi.org/10.1080/18387357.2016.1259001

Occupational Safety and Health Administration. (2016). Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. https://www.osha.gov/sites/default/files/publications/osha3148.pdf

Ogrinc, G.S., Headrick, L.A., Barton, A.J., Dolansky, M.A., Madigosky, W.S., & Miltner, R.S.

(2022). *Fundamentals of Health Care Improvement: A Guide to Improving Your Patients' Care, 4th Edition 9781635852714*). Oakbrook Terrace, IL: The Joint Commission and Institute for Healthcare Improvement. ISBN: 978-1-63585-272-1

Partridge, B., & Affleck, J. (2018). Predicting aggressive patient behaviour in a hospital emergency department: An empirical study of security officers using the Brøset Violence Checklist. *Australasian Emergency Care, 21*(1), 31–35. https://doi.org/10.1016/j.auec.2017.11.001

Rajwani, A., Clark, N., & Montalvo, C. (2023). Understanding best practices in implementation of behavioral emergency response teams through a scoping review. *Journal of the American Psychiatric Nurses Association, 29*(5), 375–388. https://doi.org/10.1177/10783903221114335

Quinn, J. M., & Koopman, J. M. (2023). Violence risk assessment in the emergency department. *Journal of Emergency Nursing, 49*(3), 352. https://doi.org/10.1016/j.jen.2023.02.006

Sarver, W. L., Radziewicz, R., Coyne, G., Colon, K., & Mantz, L. (2019). Implementation of the Brøset Violence Checklist on an Acute Psychiatric Unit. *Journal of the American Psychiatric Nurses Association, 25*(6), 476–486. https://doi.org/10.1177/1078390318820668

Senz, A., Ilarda, E., Klim, S., & Kelly, A.-M. (2021). Development, implementation, and evaluation of a process to recognise and reduce aggression and violence in an Australian emergency department. *Emergency Medicine Australasia*, *33*(4). https://doi.org/10.1111/1742-6723.13702

Sharifi, S., Shahoei, R., Nouri, B., Almvik, R., & Valiee, S. (2020). Effect of an education

program, risk assessment checklist and prevention protocol on violence against emergency department nurses: A single center before and after study. *International Emergency Nursing, 50,* N.PAG. https://doi.org/10.1016/j.ienj.2019.100813

Zicko, C. J. M., Schroeder, L. R. A., Byers, C. W. S., Taylor, L. A. M., & Spence, C. D. L. (2017). Behavioral Emergency Response Team: Implementation Improves Patient Safety, Staff Safety, and Staff Collaboration. *Worldviews on evidence-based nursing*, *14*(5), 377–384. https://doi.org/10.1111/wvn.12225

Table 1
Evidence Review Table

Citation #1: Senz, A., Ilarda, E., Klim, S., & Kelly, A.-M. (2021). Development, implementation, and evaluation of a process to recognise and reduce aggression and violence in an Australian emergency department. *Emergency Medicine Australasia*, *33*(4). https://doi-org.proxy-hs.researchport.umd.edu/10.1111/1742-6723.13702
Level: III - B

Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
The purpose of this study was to develop an approach to recognize and respond to occupational violence and aggression (OVA). The intervention included routine use of the Brøset Violence Checklist for all ED patients integrated with a score-based notification and response framework. This was gathered into what was called the BOC (Behaviors of Concern) chart. The present study evaluated the impact of the new process on staff knowledge, perceptions, and confidence regarding OVA in the emergency department and the rate of security events related to OVA.	Research; Prospective, Observational study	The study was completed in the emergency department of a metropolitan teaching hospital in Australia with an annual census of adult patients of approximately 40 000. Data on 250 adult patients was collected in each of the pre-and-post point-prevalence data sets.	**Control Protocol:** Not applicable. Intervention in this study was applied to all participants and compared on a pre and post intervention basis. Treatment fidelity also not applicable in this case given that all patients were screened with the same tool. **Intervention Protocol:** To avoid bias for certain patient cohorts, the BOC chart was commenced on arrival into the treatment area for all patients (including those with dementia, confusion, and cognitive impairment) and completed on a regular	**Dependent Variable:** The outcomes of interest were changes in nursing staff knowledge, perceptions, and confidence regarding OVA in ED, and the **rate of security responses to OVA** before and after implementation of the process. **DV Measure:** The dependent variables were measured through before-and-after survey of nursing staff (knowledge, perceptions, confidence, safety, and incidence/experience of OVA), a before-and-after point prevalence study comparing the proportion of violence risk assessments completed,	**Statistical Results:** There were statistically significant improvements in confidence in, and performance of, risk screening, as well as perception of organizational support, but no change in confidence to prevent violence or feelings of safety. Documented risk of violence assessment increased from 30% to 82% ($P < 0.0001$). For the subset of patients with a mental health or drug and alcohol presentations, the proportion with a documented BVC increased from 54% to 100%. Use of the BVC and its associated response matrix resulted in a statistically significant reduction in unplanned OVA-related

			and ongoing basis at the same time as other vital signs (every hour).	and through a comparison of the rate of security responses to OVA (code grey activation) before and after implementation.	security responses. **Conclusions:** A process including routine OVA risk assessment and a notification and response framework reduced unplanned security events due to OVA and increased staff confidence in recognition and proactive management of OVA.
Citation #2: Sharifi, S., Shahoei, R., Nouri, B., Almvik, R., & Valiee, S. (2020). Effect of an education program, risk assessment checklist and prevention protocol on violence against emergency department nurses: A single center before and after study. *International Emergency Nursing, 50,* N.PAG. https://doi-org.proxy-hs.researchport.umd.edu/10.1016/j.ienj.2019.100813 **Level**: II - A					
Purpose or Hypothesis	**Type of Evidence and Research Design**	**Sample (population, size, setting)**	**Intervention Procedures**	**Primary Outcome/Measures**	**Results Conclusions**

The purpose of this study was to evaluate the effects of an education program, risk assessment checklist and preventive protocol on violence against emergency department nurses.	Research; Prospective, Quasi – experimental study	Research was completed in the emergency department of Tohid Hospital located in Sanandaj, Iran in 2016. The study population included all nurses in the emergency department of the hospital. Inclusion criteria required nurses, undergraduate and graduate, voluntary participation in the study and had at least 3 months' experience in the ED. Exclusion criteria included not following the study protocol and being transferred to other wards during the study. After inclusion and exclusion criteria considered, 37 participants entered the study.	**Control Protocol:** Not applicable. Intervention in this study was applied to all participants and compared on a pre and post intervention basis. Treatment fidelity also not applicable in this case given that all patients were screened with the same tool. **Intervention Protocol:** All participants attended a 4-hour workshop, which was held on 2 consecutive days to maximize participation in the study. Following this education, the risk assessment checklist and preventive protocol were put in the patient medical record for each hospitalized patient in the ED. At the time of admission, a checklist was filled in for the patient or his or her companion, and the possibility of violence in the patient or the companion was assessed. The preventative protocol	**Dependent Variable:** Amount of violence within the emergency department before and after implantation. As well as type of violence, perception of violence and reaction to violence when it does occur. **DV Measure:** Data were collected using paper-based tools which included demographic characteristics (13 items), Incident report form (The Staff Observation Aggression Scale-Revised (SOAS-R) and national questionnaire for analyzing workplace violence (17 items).	**Statistical Results:** The mean score of violence before the intervention was 8.4 and after the intervention it was 2.7, which was statistically a significant difference ($p < 0.0001$). In addition, there were significant differences in the mean frequency of verbal abuse ($p < 0.0001$), assessment of workplace security ($p = 0.006$), fear of injury ($p < 0.02$) and type of reaction to violence ($p < 0.01$) before and after the intervention among the nurses. **Conclusions:** Using the BVC risk assessment checklist and preventive protocol can reduce the experience of violence and verbal abuse, which is the most common form of violence for emergency department nurses. Using this checklist and preventive protocol when patients arrive in emergency departments is recommended.

			was then applied based on the obtained results of checklist.		

Citation #3: Quinn, J. M., & Koopman, J. M. (2023). Violence Risk Assessment in the Emergency Department. *Journal of Emergency Nursing, 49*(3), 352. https://doi-org.proxy-hs.researchport.umd.edu/10.1016/j.jen.2023.02.006

Level: III - B

Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
The specific aims of this study were to evaluate the use of the Broset Violence Checklist in an emergency department setting to record incidents of violence or potential for violence in real-time, record the interventions that nurses used, and track the reporting of such incidents.	Research; Prospective, Non-experimental research	Study was conducted in a 390-bed community hospital in a suburb of a large midwestern city. Started in March 2020 and continued for 8 weeks. Staff nurses from the adult emergency department were invited to participate. After considering criteria, a total of 65 nurses were eligible to participate in project.	**Control Protocol:** Not applicable. Intervention in this study was applied to all participants. Treatment fidelity also not applicable in this case given that all patients were screened with the same tool. **Intervention Protocol:** Paper BVC scoring sheets were made available on each of the 3 adult pods of the emergency department. Nurses were asked to start a BVC scoring sheet on any patient that would score at least a 1 and record hourly scores until the patient was discharged or the score returned to 0. Nurses were	**Dependent Variable:** Workplace violence events **DV Measure:** Information gathered from the hospital reporting system. Serial assessments were compared with prior scores to trend risk of violence over time. Chi-square analysis was completed to assess the associations between BVC score categories and each independent variable.	**Statistical Results:** During the 8-week-long intervention, 3.5 incidents occurred per week as compared to 3.3 incidents per month for the previous 18 months, as reported to the hospital tracking system. **Conclusions:** The BVC was successfully used to identify patients with potential for physical violence. The interventions that nurses implemented when faced with an incident of potential violence that demonstrated statistical significance included offering comfort measures, answering patient questions and concerns, and applying restraints. No statistical significance was found with alerting the charge nurse, maintaining a

			instructed to begin to implement interventions for scores of ≥1 and document which interventions were implemented to address the behavior. The types of interventions used also were recorded on the scoring sheet.		buddy system, using a sitter, involving security, and providing sedative, antipsychotic, or anxiolytic medication. Incidents were under-reported to the hospital reporting system compared to the data of incidents from use of the BVC in real time.

Citation #4: Partridge, B., & Affleck, J. (2018). Predicting aggressive patient behaviour in a hospital emergency department: An empirical study of security officers using the Brøset Violence Checklist. *Australasian Emergency Care, 21*(1), 31–35. https://doi-org.proxy-hs.researchport.umd.edu/10.1016/j.auec.2017.11.001

Level: III – A

Purpose or Hypothesis	**Type of Evidence and Research Design**	**Sample (population, size, setting)**	**Intervention Procedures**	**Primary Outcome/Measures**	**Results Conclusions**
This study was the first to evaluate the statistical utility of the Broset Violence Checklist (BVC) when administered by a security officer in a hospital emergency department (ED).	Research; Prospective, empirical study	Study completed in a public (223 bed) hospital in metropolitan Southeast Queensland, Australia, over a two-month period. The sample included 2064 emergency department patients that were assessed using the violence checklist.	**Control Protocol:** Not applicable. Intervention in this study was applied to all participants. Treatment fidelity also not applicable in this case given that all patients were screened with the same tool. **Intervention Protocol** For a two-month period between mid-July and	**Dependent Variable:** Workplace violence events **DV Measure:** Data of workplace violence events was gathered from security case reports.	**Statistical Results:** Violent patients were around 71 times more likely to score BVC ≥ 3 than non-violent patients. **Conclusions:** The BVC has good sensitivity, specificity, and predictive value in this setting. Using the BVC may help to implement measures that mitigate the impact of

			mid-September in 2016, the hospital trialed having a Protective Services Officer (security officer) assigned specifically to the ED. Patients attending the ED during these hours were assessed for their risk of violence upon presentation to triage by the ED security officer using the BVC.		violent patients in the ED, or ideally, implement procedures that prevent violence towards ED workers in the first place.

Citation #5: Meehan, T., de Alwis, A., & Stedman, T. (2017). Identifying patients at risk of inpatient aggression at the time of admission to acute mental health care. What factors should clinicians consider? *Advances in Mental Health, 15*(2), 161–171. https://doi-org.proxy-hs.researchport.umd.edu/10.1080/18387357.2016.1259001

Level: III - A

Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
The aim of this study was to identify, at the time of admission, predictors of aggression in adults admitted to acute mental health care.	Research; prospective, nonexperimental research	The study was conducted at the acute inpatient admission facility within the National Institute of Mental Health (NIMH) in Sri Lanka. The present study was conducted across the four male and four female acute admission units (n = 8). Each unit has 40 beds with an occupancy rate of 85%. The study looked at only adult patients. The mean age of the study sample (n	**Control Protocol:** Not applicable. Intervention in this study was applied to all participants. Treatment fidelity also not applicable in this case given that all patients were screened with the same tool. **Intervention Protocol:** Adult patients (n=350) consecutively admitted to the National Institute of Mental Health (NIMH) in Sri Lanka	**Dependent Variable:** Aggressive behavior within 72 hours of admission **DV Measure: D**ata collectors were trained in the use of the data collection tools by one of the authors and instructed to follow up each patient admitted for a period of 72 hours; Details of each incident were substantiated by the data collectors from accounts of the incident in the patient's medical	**Statistical Results:** In the final model, we included the BVC total score (completed on or close to admission). Again, the model was highly significant ($\chi^2 = 135.89$, $p < .001$) with the Cox and Snell R^2 increasing to 33.4% and 88% of cases correctly classified. The inclusion of the BVC score added significant incremental validity to the variables included in

		= 350) was 43.2 years (s.d. = 13.5) and 67.2% were male. The mean duration of mental illness in the group was 12.1 years (s.d. = 10.1) and 83.3% had a previous admission (during their lifetime) to hospital for mental health problems. The most common diagnostic categories included schizophrenia (47.2%) and bipolar disorder (28.5%).	were assessed for a wide range of dispositional, historical, contextual, and clinical factors associated with inpatient violence. Clinical factors were assessed using the Brief Psychiatric Rating Scale (BPRS), and risk of aggression using the Brøset Violence Checklist (BVC). All 350 patients were followed for 72 hours post-admission and observed for aggression using the Overt Aggression Scale.	record. Recruitment continued until a final sample of 350 patients (based on power analysis) had been obtained.	models 1 and 2. For every one-point increase in the BVC total score, the odds of aggression increased fourfold (OR = 4.06, 95% CI: 2.74–6.02). The BVC total score emerged as the most significant predictor of inpatient violence. **Conclusions:** Of all the risk factors considered at the time of admission, the BVC total score was the strongest predictor of aggression following admission. Indeed, the BVC was a more robust predictor of aggression in the post-admission period than a history of aggression preceding admission and psychopathology as measured by the BPRS. The finding supports the use of structured risk assessments for monitoring the risk of aggression in patients during the initial 72 hours post-admission.

Citation #6: Sarver, W. L., Radziewicz, R., Coyne, G., Colon, K., & Mantz, L. (2019). Implementation of the Brøset Violence Checklist on an Acute Psychiatric Unit. *Journal of the American Psychiatric Nurses Association, 25*(6), 476–486. https://doi.org/10.1177/1078390318820668

Level: III - B

Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
The primary aim of the study was to evaluate routine integration of a validated violence checklist to deter- mine relationship among BVC scores and incidence of violence. Secondary aims of the study were to compare BVC scores between those requiring high-level nursing interventions and those not requiring high-level nursing interventions for violence, and to investigate the impact of BVC scores on length of stay and 30-day readmission rates.	Research; Retrospective, non-experimental	The study included all patients admitted over a 3-month period to 20-bed adult inpatient psychiatric unit in a Midwest hospital. Inclusion criteria were all patients admitted to the adult inpatient psychiatric unit during the study dates. There were no exclusion criteria as nurses completed the BVC on all patients admitted during the study dates as routine care. Study dates included were March 1, 2014, through May 31, 2014. The total sample size was 222 patients.	**Control Protocol:** Not applicable. Screening with BVC took place for every patient. Treatment fidelity also not applicable in this case given that all patients were screened with the same tool. **Intervention Protocol** All nursing staff (approximately 20 registered nurses [RNs]) were trained on use of the BVC prior to beginning the study through a video session provided by the authors of the BVC. Following training, RNs obtained BVC score on all patients on admission and continued to complete the checklist every day until the patient was either discharged or transferred per routine care.	**Dependent Variable:** Incidence of violence **DV Measure:** Retrospective chart reviews. Logistic regression was performed to identify predictors of violence based on admission BVC scores, using evidence of violence and BVC scores over time as time-dependent covariates.	**Statistical Results:** Findings indicate there was a 3.4 times greater risk of violence for every additional point on BVC scores on admission (odds ratio = 3.4, 95% confidence interval [2.29, 5.08], $p <$ .0001) **Conclusions:** Efforts toward early identification and management of agitation and disruptive behavior is encouraged. Results showed increased risk of violence with every additional point on BVC on admission; further attention should be paid to these patients on admission when using violence screening tools.

Citation #7: Hvidhjelm, J., Berring, L. L., Whittington, R., Woods, P., Bak, J., & Almvik, R. (2023). Short-term risk assessment in the long term: A scoping review and meta-analysis of the Brøset Violence Checklist. *Journal of Psychiatric and Mental Health Nursing, 30*(4), 637–648. https://doi.org/10.1111/jpm.12905

Level: III - B					
Purpose or Hypothesis	**Type of Evidence and Research Design**	**Sample (population, size, setting)**	**Intervention Procedures**	**Primary Outcome/Measures**	**Results Conclusions**
The purpose of this research was to identify current knowledge on the BVC and guide clinicians and researchers toward the next steps in using this tool in clinical practice to prevent **violence** in healthcare settings.	Research; Systematic review with meta-analysis	Sixty-two studies conducted in 23 countries were included in the research. **Inclusion criteria:** Published 1995 or after, includes the words Brøset, Broset, BVC or Brø(o)set Violence Checklist, includes modified versions, More than just a description/ statement of the properties of BVC or previous research, can be a description of use with practice in any way (within and beyond psychiatry), any country, any language, any publication format (book chapter, conference abstract, poster, report, guideline, thesis, etc.) **Exclusion criteria:** Thesis with articles published, conference paper linked to a full article, not available, policy paper, BVC just mentioned, no BVC data reported, reviews	A scoping review approach with a meta-analysis supplement was adopted to broadly identify and map available evidence on the BVC and provide specific estimates of predictive validity in different contexts.	**Dependent Variable & Measures:** This study examined various aspects of practical implementation of the BVC in these settings including usability, implementation practices and clinical utility. An extensive meta-analysis was completed.	**Statistical Results:** With the help of the meta-analysis, we found the combined AUC from all the included studies was 0.83 and ranged from 0.69 to 0.98 across these studies. This combined AUC value is at an excellent level. **Conclusions:** The BVC combines high predictive validity and good clinical utility across a wide range of settings and cultures. It should continue to be incorporated into routine practice in mental health services focused on preventing violence and coercion.

		existing BVC data only			
Citation #8: Rajwani, A., Clark, N., & Montalvo, C. (2023). Understanding Best Practices in Implementation of Behavioral Emergency Response Teams Through a Scoping Review. *Journal of the American Psychiatric Nurses Association, 29*(5), 375–388. https://doi-org.proxy-hs.researchport.umd.edu/10.1177/10783903221114335 **Level**: III - B					
Purpose or Hypothesis	**Type of Evidence and Research Design**	**Sample (population, size, setting)**	**Intervention Procedures**	**Primary Outcome/Measures**	**Results Conclusions**

This scoping review seeks to highlight the best practices and limitations of BERT use with adult populations in hospital settings to guide future implementation across academic medical centers.	Research; systematic review	After inclusion and exclusion criteria applied; 10 articles were included for systematic review. **Inclusion criteria:** 2000-2020 English Studies Adults Studies that focus on behavioral teams-based response to broad categorization of patient activity in hospital-based settings **Exclusion criteria:** Studies outside noted time period Non-English Children Studies focused on medical responses, articles that only briefly mention behavioral response teams Psychiatry-specific BERTS BERTs in non-hospital settings	**Control Protocol:** Implementation of BERT in every study included in the review **Intervention Protocol:** Non- applicable in this case. A systematic review was completed.	**Dependent Variable & Measure:** While the outcome of interest in the majority of the studies included in this review is reducing assaults directed at staff, it is clear that by using BERTS to reduce assaults directed at staff, medical centers and the health care system can directly impact staff satisfaction, and both directly and indirectly improve patient outcomes.	**Results & Conclusions:** BERTS are effective at reducing assaults directed at staff and are associated with increased staff satisfaction. Using a proactive process to identify high-risk patients for disruptive behavior in conjunction with a team-based response to behavioral emergencies, academic medical centers can decrease the use of physical restraints and increase staff satisfaction leading to a higher quality of care.

Citation #9: Zicko, C. J. M., Schroeder, L. R. A., Byers, C. W. S., Taylor, L. A. M., & Spence, C. D. L. (2017). Behavioral Emergency Response Team: Implementation Improves Patient Safety, Staff Safety, and Staff Collaboration. *Worldviews on evidence-based nursing*, *14*(5), 377–384. https://doi.org/10.1111/wvn.12225

Level: V - A

Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
The purpose of this research was to determine how implementation of a BERT affects staff and patient safety and to examine nursing staffs' level of knowledge, confidence, and support in caring for psychiatric patients and patients exhibiting behavioral emergencies	Quality Improvement	The BERT protocol was piloted on one medical surgical unit for 5 months and expanded to two additional units for 3 months.	**Control Protocol:** Not applicable, no randomization **Intervention Protocol:** A behavioral emergency response team protocol was created using evidenced-based protocols that have been shown to be effective in reducing the number of occurrences of workplace violence.	**Dependent Variable:** The research looked at multiple variables – the main variable being assaults against staff. Th study also looked at restraint use and staff perception of safety **DV Measure:** Violent evident incidences, Pre and post implementation surveys	**Statistical Results:** The BERT responded to 17 behavioral emergencies. The number of assaults decreased from 10 (pre) to 1 (post); security intervention decreased from 14 to 1; and restraint use decreased from 8 to 1. MS staffs' level of BERT knowledge and rating of support between MH staff and their staff significantly increased. Both MS and MH nurses rated the BERT as supportive and effective. **Conclusions:** A BERT can assist with deescalating behavioral emergencies and improve staff collaboration and patient and staff safety.

Citation #10: Occupational Safety and Health Administration. (2016). Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. https://www.osha.gov/sites/default/files/publications/osha3148.pdf

Level: V - B

Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
This evidence is through a national recognized organization to provide thorough guidance on workplace violence prevention for healthcare workers in a variety of settings.	Nonexperimental; Opinion of nationally recognized expert(s) based on experiential evidence based on research	Guidelines; not applicable	**Control & Intervention Protocol:** Not applicable, no randomization	Dependent variable & measures not applicable as this is not research based evidence; These guidelines have considered all research and have drawn strong conclusions to provide recommendations surrounding best practice for workplace violence prevention.	**Conclusions:** This literature provides in depth explanation of measures that should be taken to prevent workplace violence in healthcare settings including the hospital setting. These guidelines support the use of making the policies and procedures of the organization clear and available, and developing written plan of action when patients are “acting out”.

Table 2
Evidence Synthesis Table

Project Title: Reducing Workplace Violence in the Acute Care Medical Surgical / Telemetry Unit at University of Maryland St. Joseph Medical Center			
PICOT: Will the development of a clinical practice guideline on workplace violence prevention that utilizes a triad of resources (the Broset Violence Checklist (BVC) within EPIC, behavioral emergency response team (BERT), and patient treatment agreements), lead to a decrease in workplace violence events from patients against clinical staff on the 7th floor adult medical-surgical telemetry unit at St. Joseph Medical Center.			
JHNEBP Model Level	**Total Number of Sources**	**Author and Quality Rating of each study**	**Synthesis of Findings**
Level 1 Experimental study · Randomized Controlled Trial (RCT) · Systematic review of RCTs with or without meta-analysis			
Level II Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis	1 Quasi-experimental study) (Sharifi et al., 2020)	Sharifi et al - A	This study took place in the emergency department. This study was quasi-experimental unlike the others; however, it looked at the same dependent variable being violence. It found that the BVC tool had good sensitivity, specificity, and predictive value and drew the same conclusion that the BVC may help to implement measures that mitigate the impact of violent patients which was similar to the findings of all the other level 3 studies discussed.
Level III Non-experimental study · Systematic review of a combination of RCTs,	5 non-experimental / observational studies	Partridge & Affleck – A Quinn & Koopman –	Three of the studies (Senz et al, Quinn & Koopman and Partridge & Affleck) took place in the emergency department, while two (Sarver

quasi-experimental, and non-experimental studies, or non-experimental studies only, with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis	1 systematic review with meta-analysis 1 systematic review without meta-analysis (Partridge & Affleck, 2018; Quinn & Koopman, 2023; Senz et al., 2021; Meehan, Alwis & Stedman, 2017; Sarver et al., 2019; Hvidhjelm et al., 2023; Rajwani, Clark, & Montalvo, 2023)	B Senz et al – B Meehan, Alwis & Stedman – A Sarver et al – B Hvidhjelm et al – B Rajwani, Clark, & Montalvo - B	et al and Meehan, Alwis & Stedman) were completed in the acute/inpatient psychiatric setting. Partridge, B., & Affleck was different than the others in that it was a security officer upon arrival that was completing the checklist as opposed to nurses in all the other studies. While the settings which they were completed were different and one study used a different role to complete the tool, they all analyzed the same Broset violence checklist, used only adult patients, looked at violence/aggression as the dependent variable, and the studies drew the same conclusions supporting the use of the tool. Unlike the 5 others, Hvidhjelm et al was a retrospective systematic review with meta-analysis (all others were prospective and non-experimental / observational research) which was described as the largest review looking at the use of the BVC checklist. This too drew the same conclusions as the previous research discussed which was that the BVC was highly reliable in recognizing potential for violence and was recommended for use in prevention. It also noted that the tool was easily utilized across a variety of settings and cultures. Citation 8 (Rajwani, Clark, & Montalvo, 2023) looks at another tool being, the implementation of the behavioral emergency response team (BERT) to reduce violence against staff members. This research similarly to others for BV took place in the emergency department.

			Based on the findings of this study, this intervention is recommended for de-escalation of incidents before violence occurs.
Level IV Opinion of respected authorities and/or reports of nationally recognized expert committees/consensus panels based on scientific evidence			
Level V Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports · Opinion of nationally recognized expert(s) based on experiential evidence	1 quality improvement study (Zicko et al., 2017) 1 citation of an Opinion of nationally recognized expert(s) based on experiential evidence (“Occupational Safety and Health Administration”, 2016)	Zicko et al – A Occupational Safety and Health Administration - B	Zicko et al looked at the use of the Behavioral Emergency Response Team (BERT). While the level of evidence was lower, it was high quality and drew the same conclusions as citation 8 (Rajwani, Clark, & Montalvo, 2023). This supports the findings of higher-level research in that the use of BERT is effective in reducing WPV and improving safety of patients and staff. This study therefore helps to support the recommendation for the use of BERT in clinical practice. Occupational Safety and Health Administration supports the use of a patient treatment agreement because it makes the policies and procedures clear, explains the zero-tolerance policy of the organization and establishes guidelines for patients that are “acting out”.
Overall Quality Rating w/rational and Recommendation: **B; good and consistent evidence to support a practice change**			

Figure 1

Root Cause Analysis

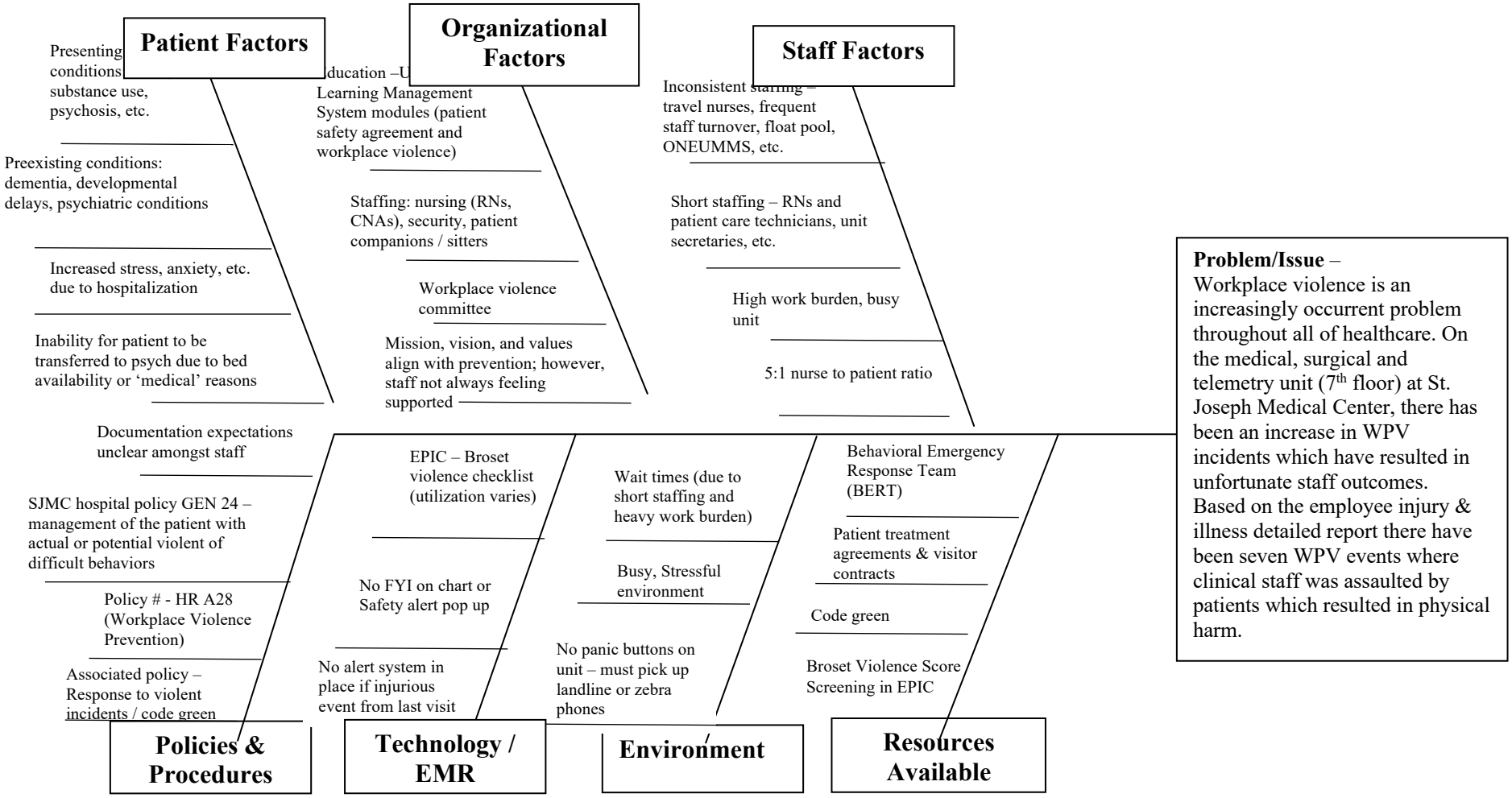


Figure 1

Root Cause Analysis

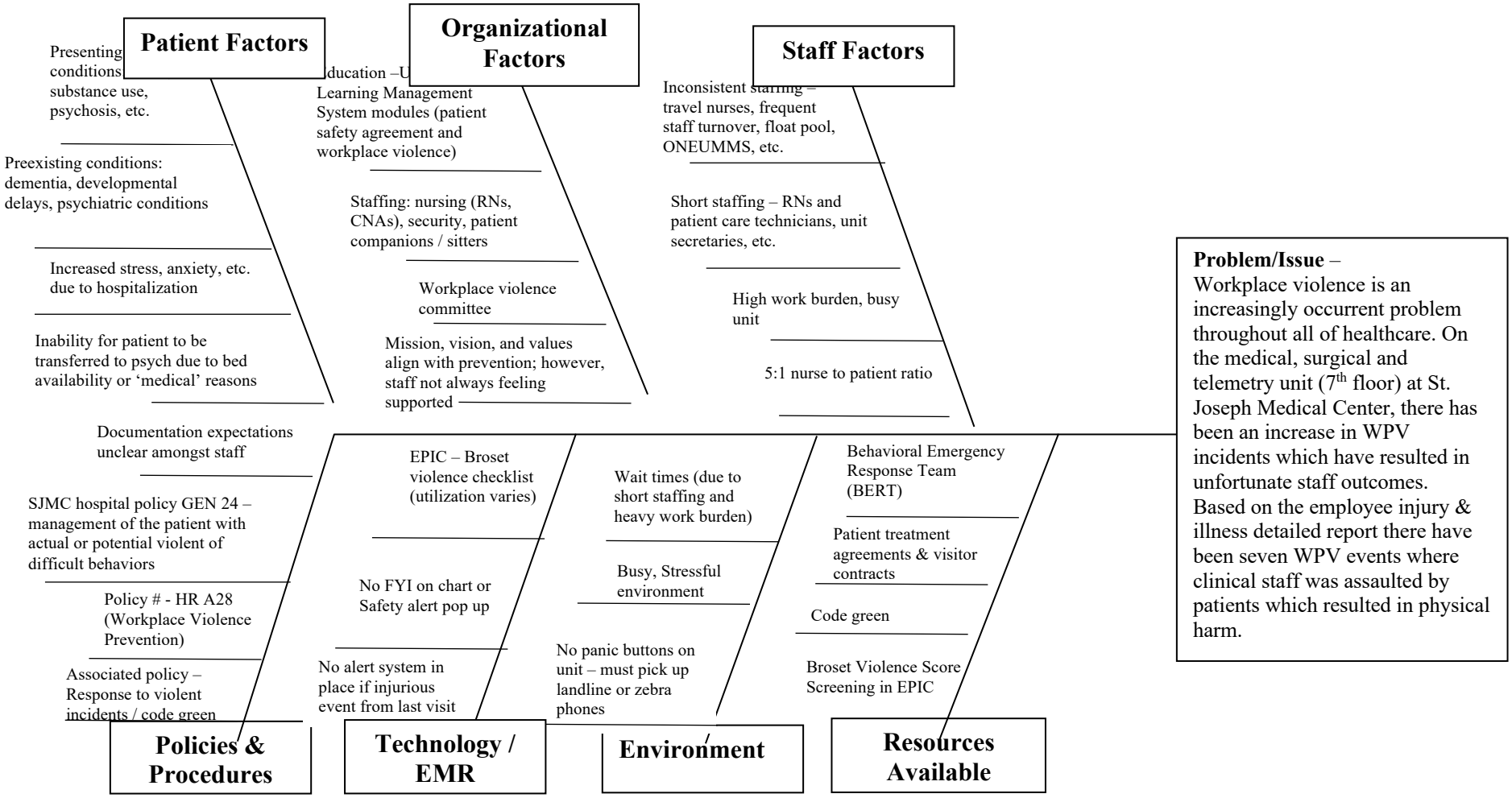


Figure 2
PRISMA Evidence Selection Flow

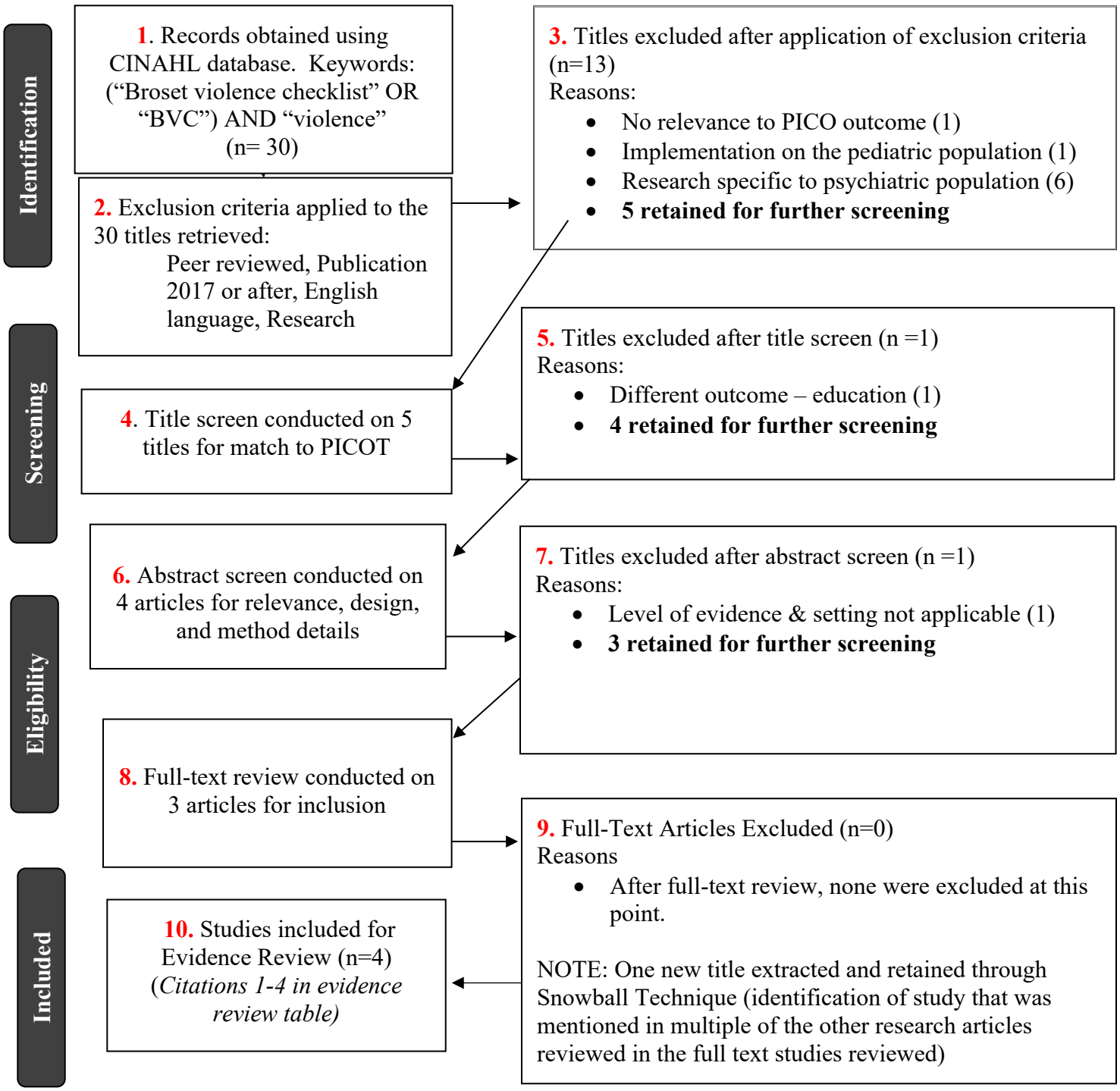


Figure 2.1. Evidence search and retrieval using CINAHL database.

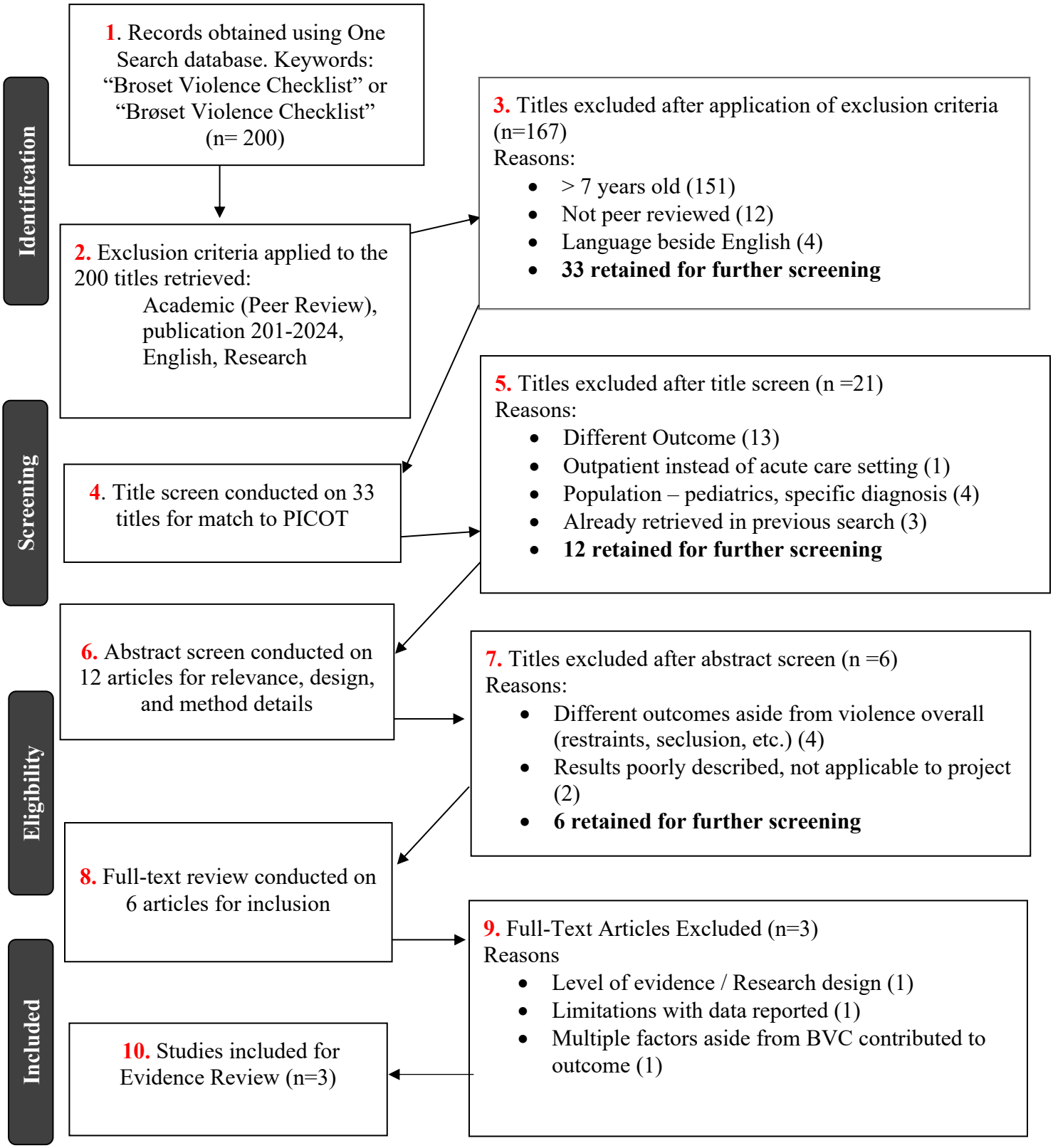
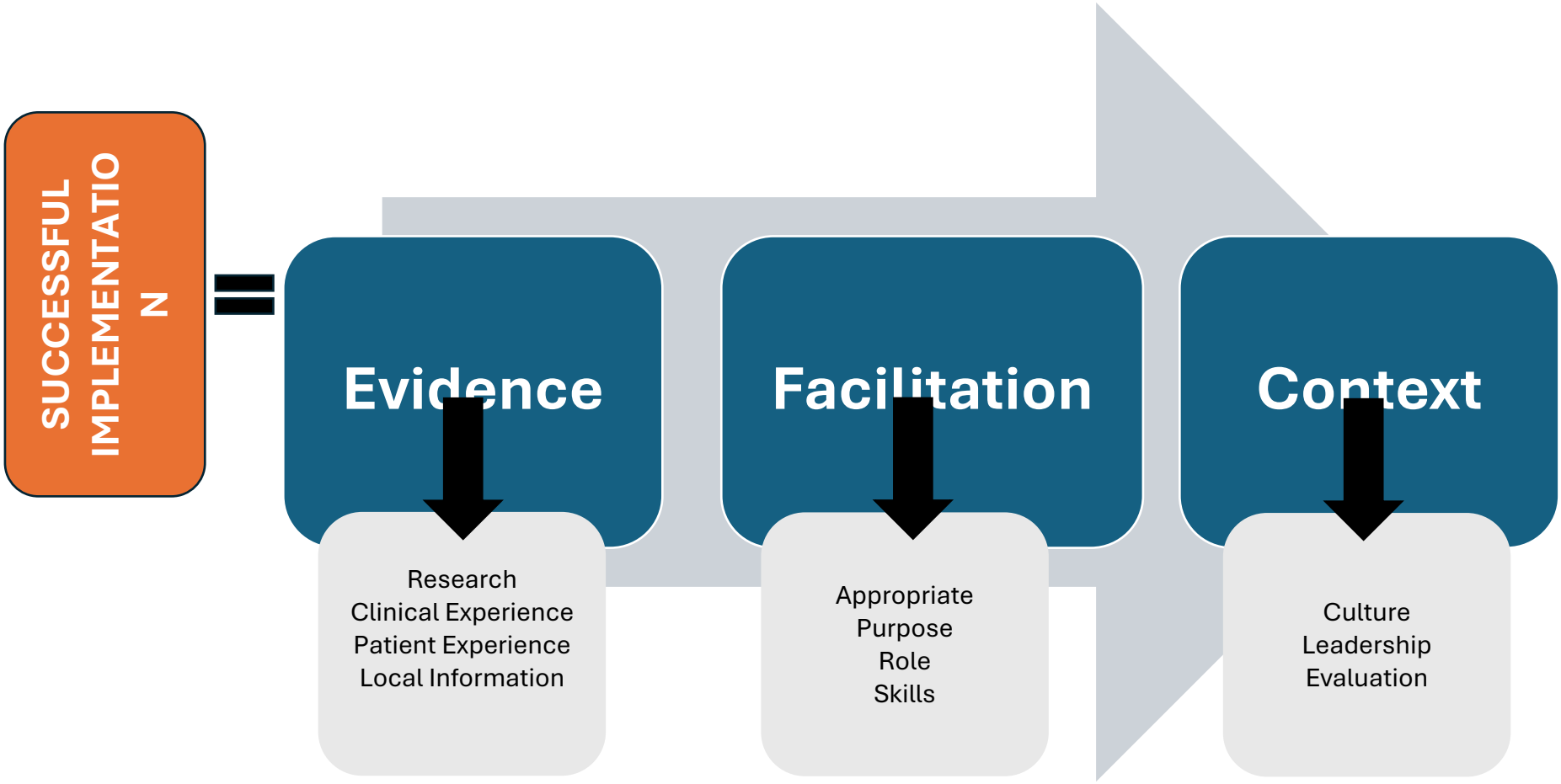


Figure 2.2. Evidence search and retrieval using One Search database.

Figure 3
Theoretical Framework to Support Quality Improvement Initiative



Note. Diagram displaying Promotion Action on Research Implementation in Health services (PARIHS) theoretical framework for workplace violence DNP project.

Figure 4
Current Versus Desired Workflow

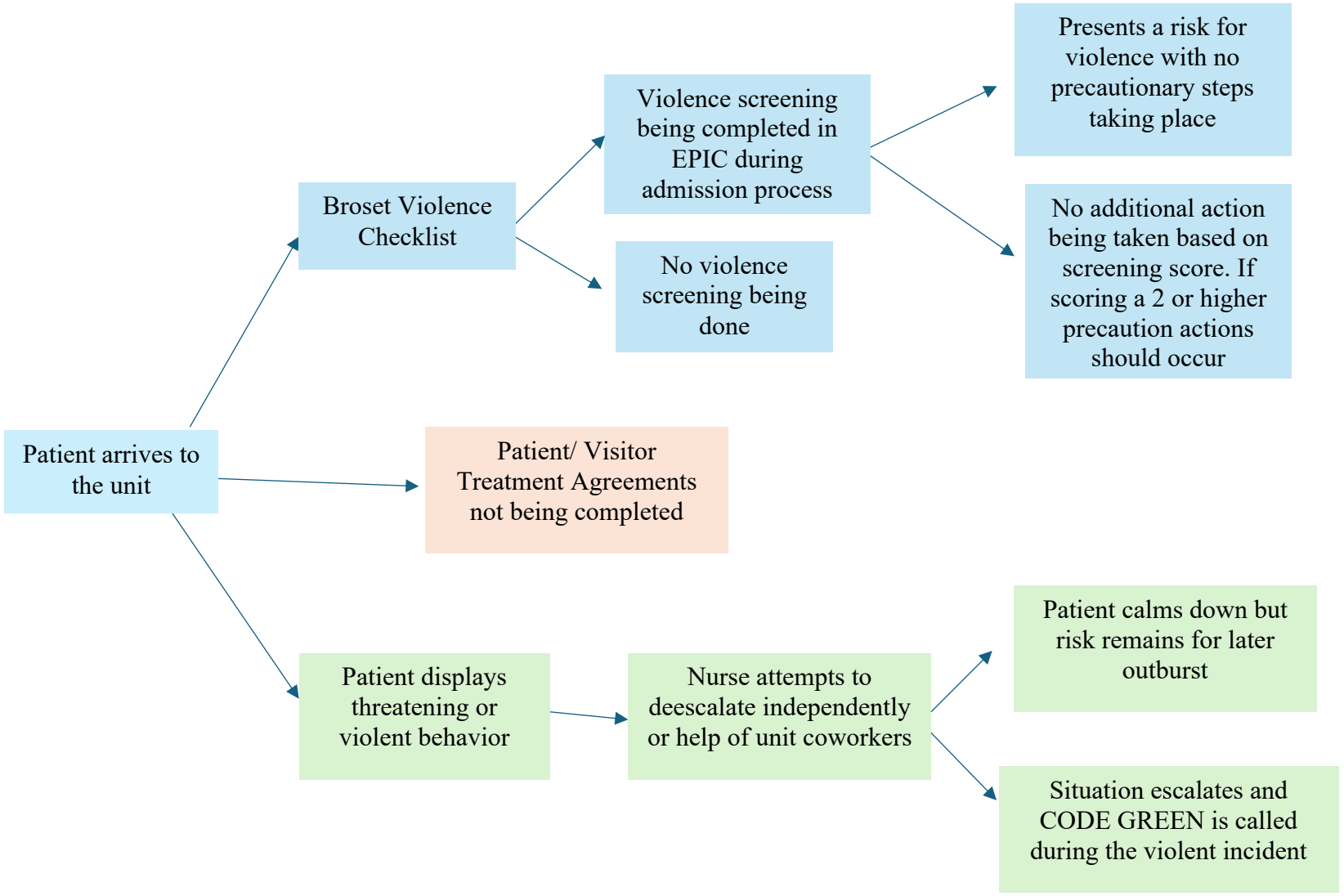


Figure 4.1 Map of current process relevant to problem issue

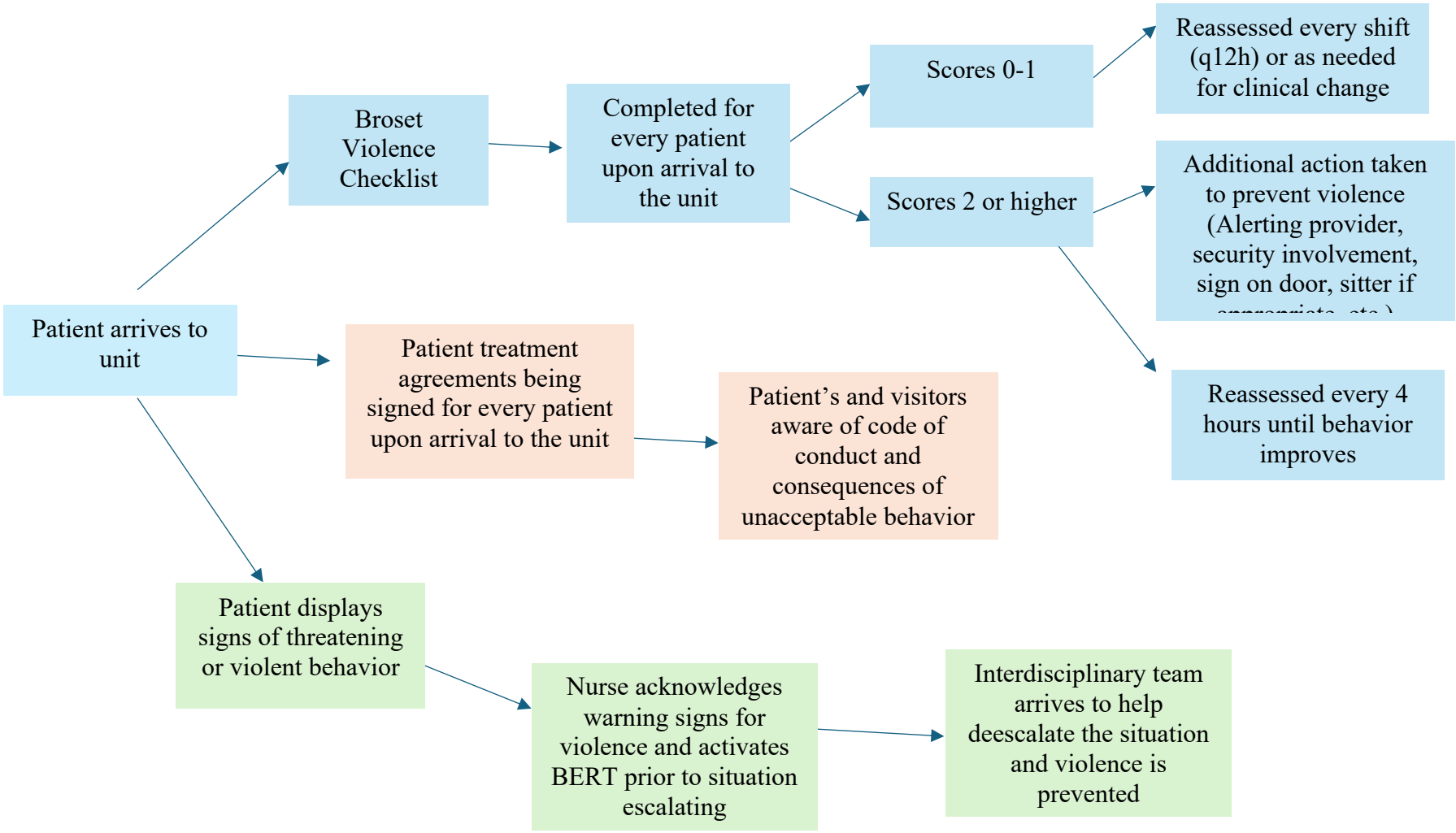
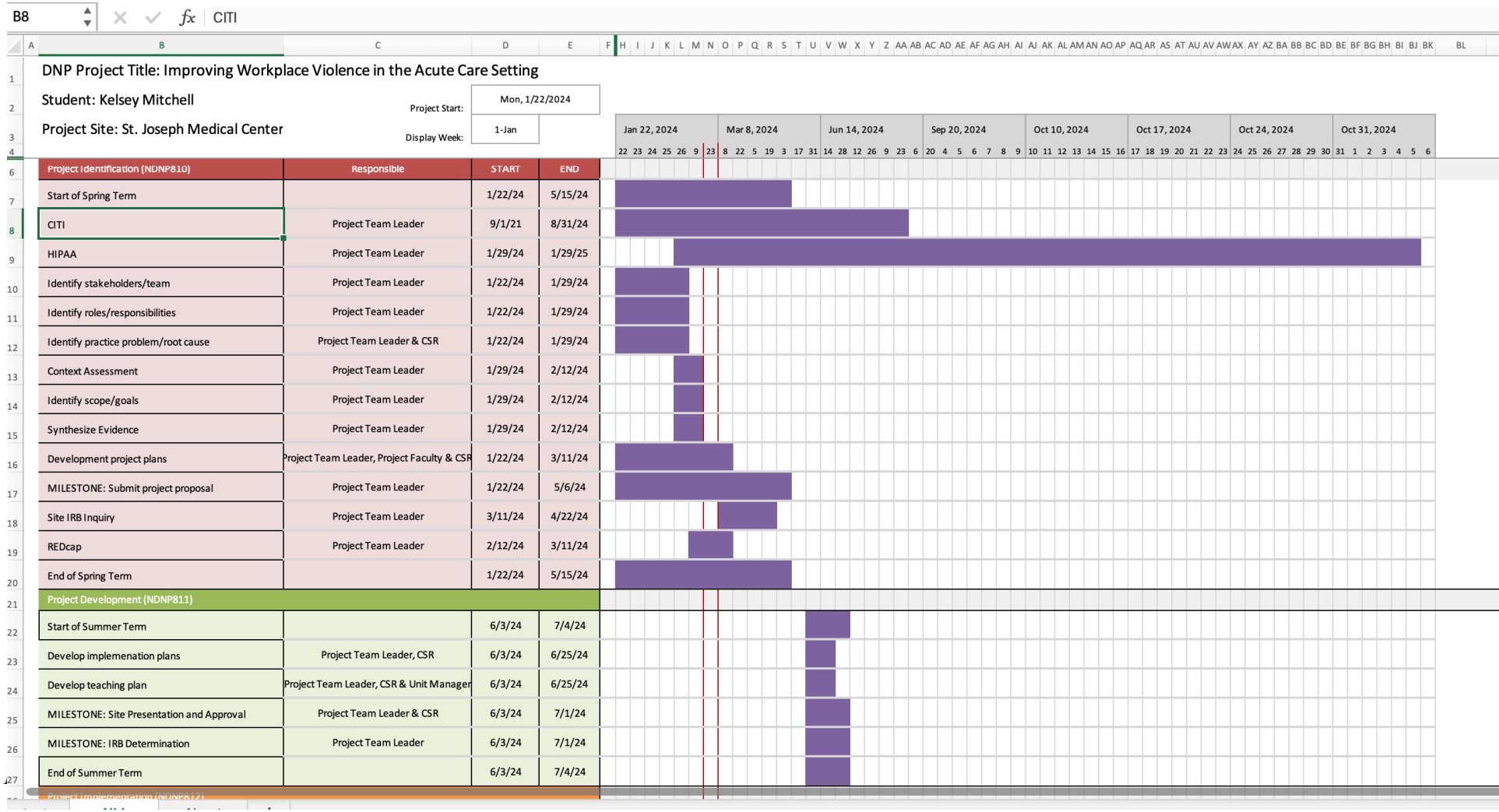


Figure 4.2 Map of desired process relevant to problem issue

Figure 5

GANTT Chart: DNP Project Timeline



DNP Project Title: Improving Workplace Violence in the Acute Care Setting

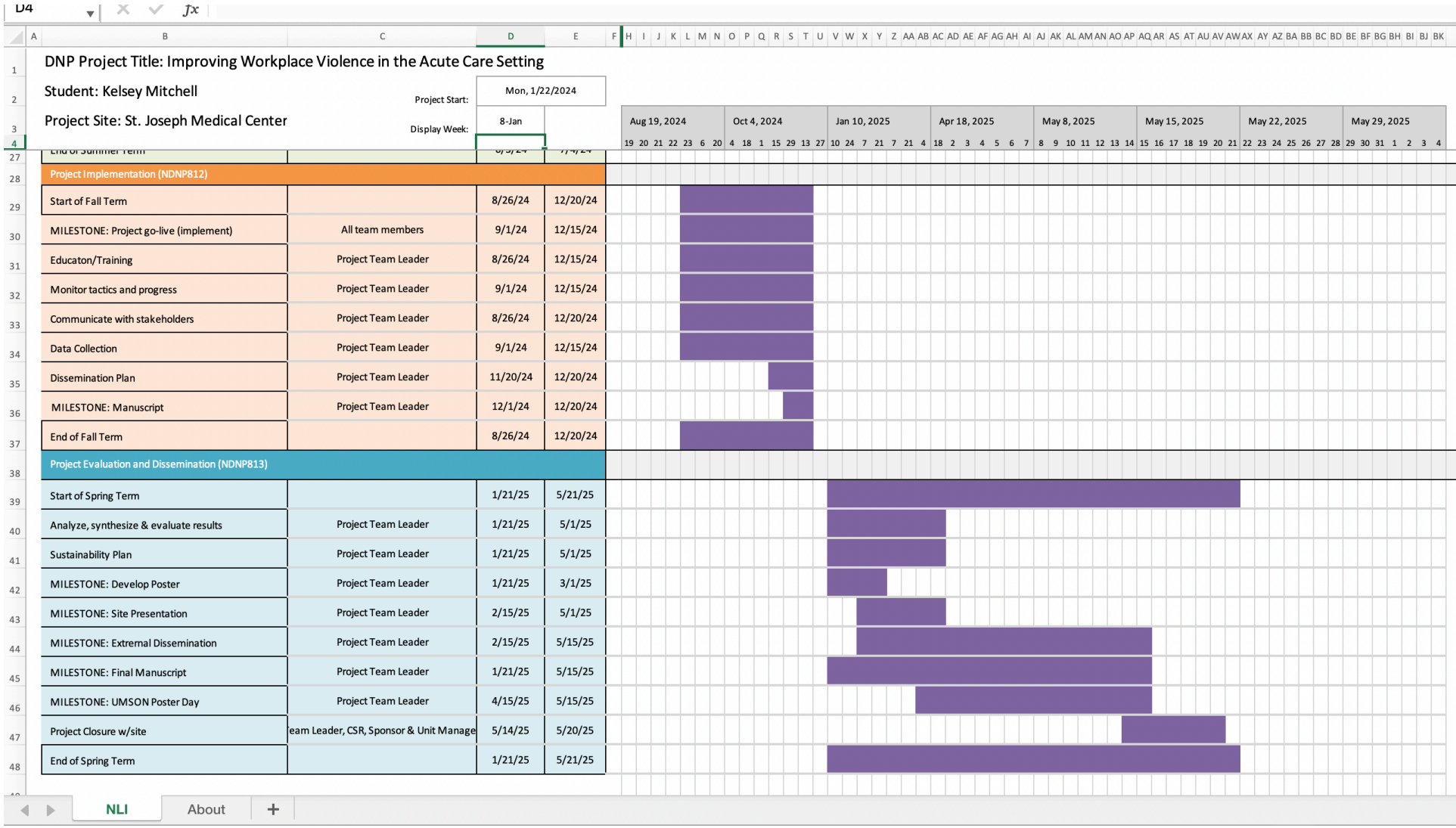
Student: Kelsey Mitchell

Project Site: St. Joseph Medical Center

Project Start: Mon, 1/22/2024

Display Week: 1-Jan

Project Identification (NDNP810)	Responsible	START	END
Start of Spring Term		1/22/24	5/15/24
CITI	Project Team Leader	9/1/21	8/31/24
HIPAA	Project Team Leader	1/29/24	1/29/25
Identify stakeholders/team	Project Team Leader	1/22/24	1/29/24
Identify roles/responsibilities	Project Team Leader	1/22/24	1/29/24
Identify practice problem/root cause	Project Team Leader & CSR	1/22/24	1/29/24
Context Assessment	Project Team Leader	1/29/24	2/12/24
Identify scope/goals	Project Team Leader	1/29/24	2/12/24
Synthesize Evidence	Project Team Leader	1/29/24	2/12/24
Development project plans	Project Team Leader, Project Faculty & CSR	1/22/24	3/11/24
MILESTONE: Submit project proposal	Project Team Leader	1/22/24	5/6/24
Site IRB Inquiry	Project Team Leader	3/11/24	4/22/24
REDcap	Project Team Leader	2/12/24	3/11/24
End of Spring Term		1/22/24	5/15/24
Project Development (NDNP811)			
Start of Summer Term		6/3/24	7/4/24
Develop implemenation plans	Project Team Leader, CSR	6/3/24	6/25/24
Develop teaching plan	Project Team Leader, CSR & Unit Manager	6/3/24	6/25/24
MILESTONE: Site Presentation and Approval	Project Team Leader & CSR	6/3/24	7/1/24
MILESTONE: IRB Determination	Project Team Leader	6/3/24	7/1/24
End of Summer Term		6/3/24	7/4/24
Project Implementation (NDNP812)			



DNP Project Title: Improving Workplace Violence in the Acute Care Setting

Student: Kelsey Mitchell

Project Site: St. Joseph Medical Center

Project Start: Mon, 1/22/2024

Display Week: 8-Jan

Project Implementation (NDNP812)			
Start of Fall Term		8/26/24	12/20/24
MILESTONE: Project go-live (implement)	All team members	9/1/24	12/15/24
Educaton/Training	Project Team Leader	8/26/24	12/15/24
Monitor tactics and progress	Project Team Leader	9/1/24	12/15/24
Communicate with stakeholders	Project Team Leader	8/26/24	12/20/24
Data Collection	Project Team Leader	9/1/24	12/15/24
Dissemination Plan	Project Team Leader	11/20/24	12/20/24
MILESTONE: Manuscript	Project Team Leader	12/1/24	12/20/24
End of Fall Term		8/26/24	12/20/24
Project Evaluation and Dissemination (NDNP813)			
Start of Spring Term		1/21/25	5/21/25
Analyze, synthesize & evaluate results	Project Team Leader	1/21/25	5/1/25
Sustainability Plan	Project Team Leader	1/21/25	5/1/25
MILESTONE: Develop Poster	Project Team Leader	1/21/25	3/1/25
MILESTONE: Site Presentation	Project Team Leader	2/15/25	5/1/25
MILESTONE: Extremal Dissemination	Project Team Leader	2/15/25	5/15/25
MILESTONE: Final Manuscript	Project Team Leader	1/21/25	5/15/25
MILESTONE: UMSON Poster Day	Project Team Leader	4/15/25	5/15/25
Project Closure w/site	eam Leader, CSR, Sponsor & Unit Manage	5/14/25	5/20/25
End of Spring Term		1/21/25	5/21/25

Figure 6

Run chart to display the percentage of patients screened with the Broset Violence Checklist

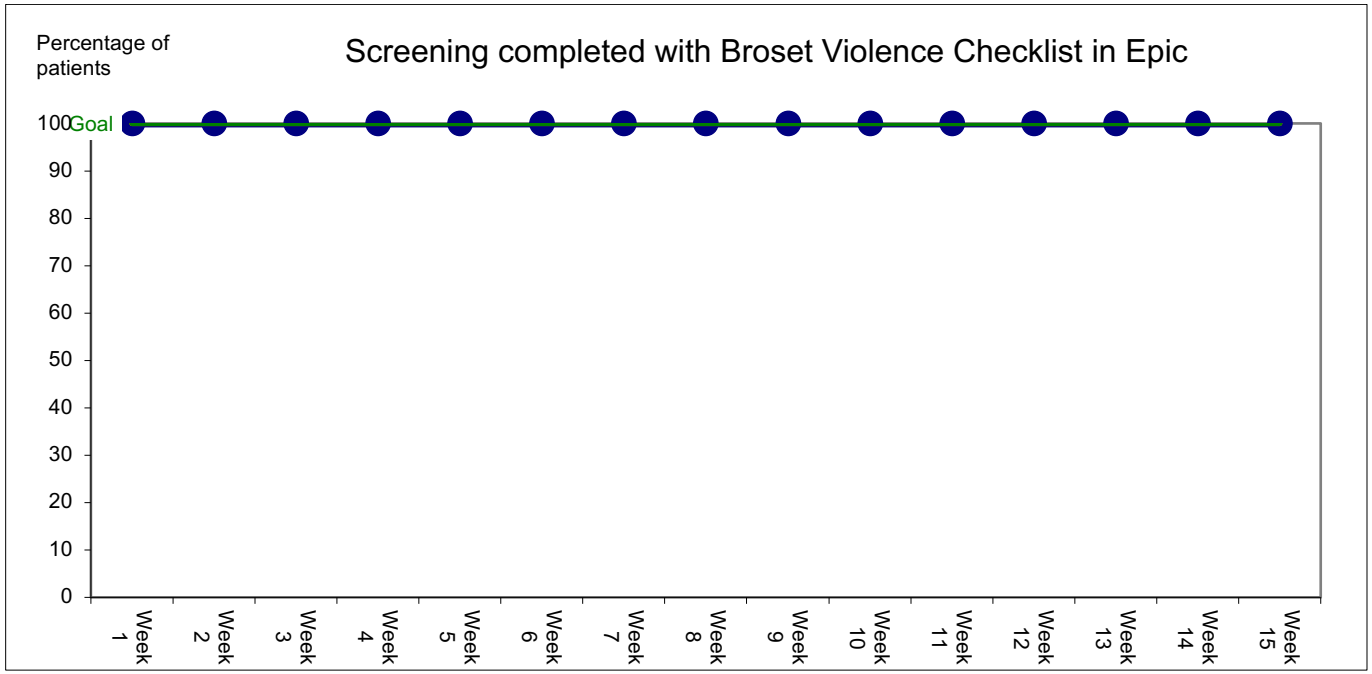


Figure 7

Run chart to display the number of BERTs activated on the unit each week

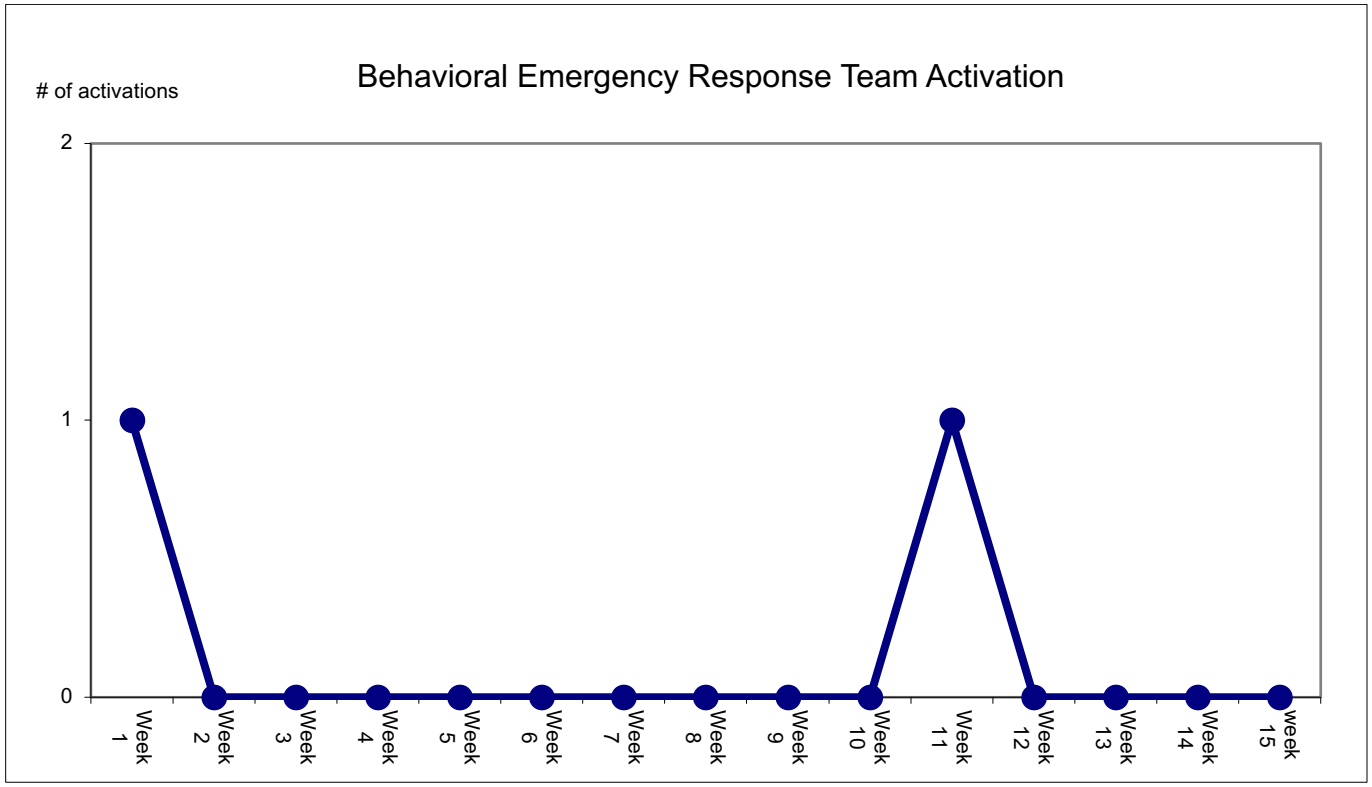


Figure 8

Run chart to display the number of patient treatment agreements completed on the unit each week

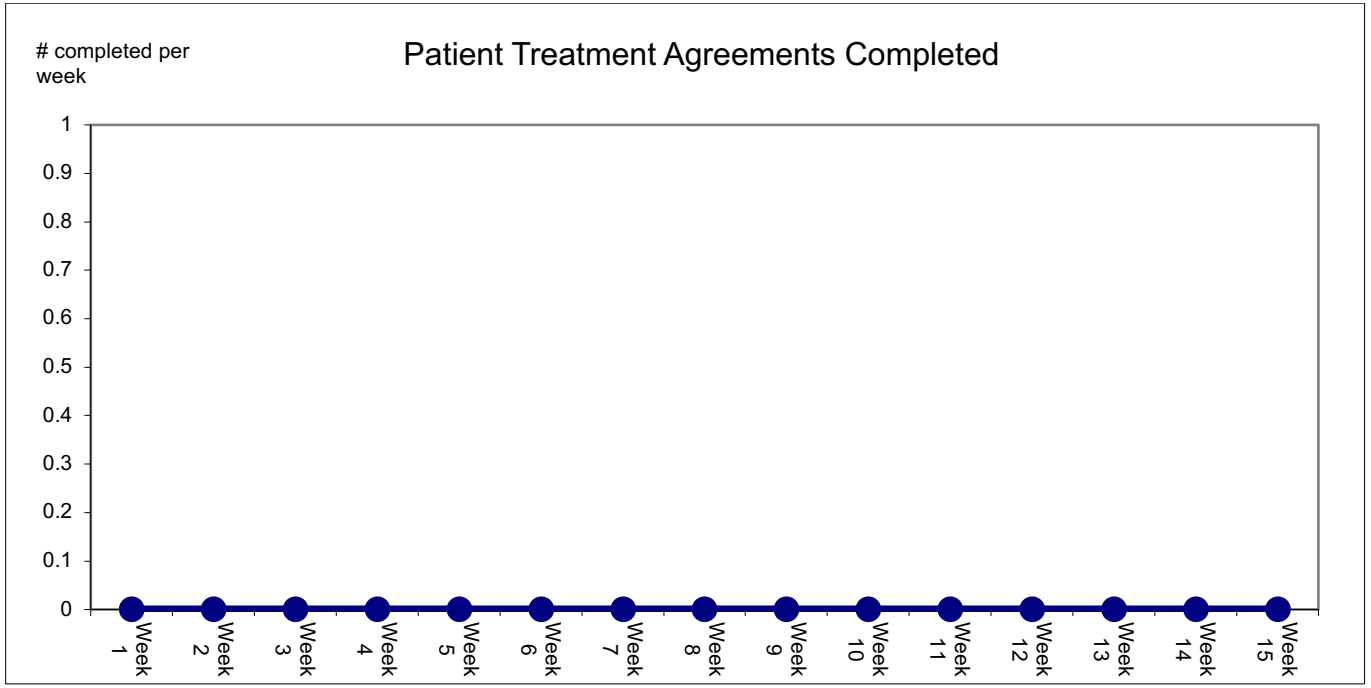
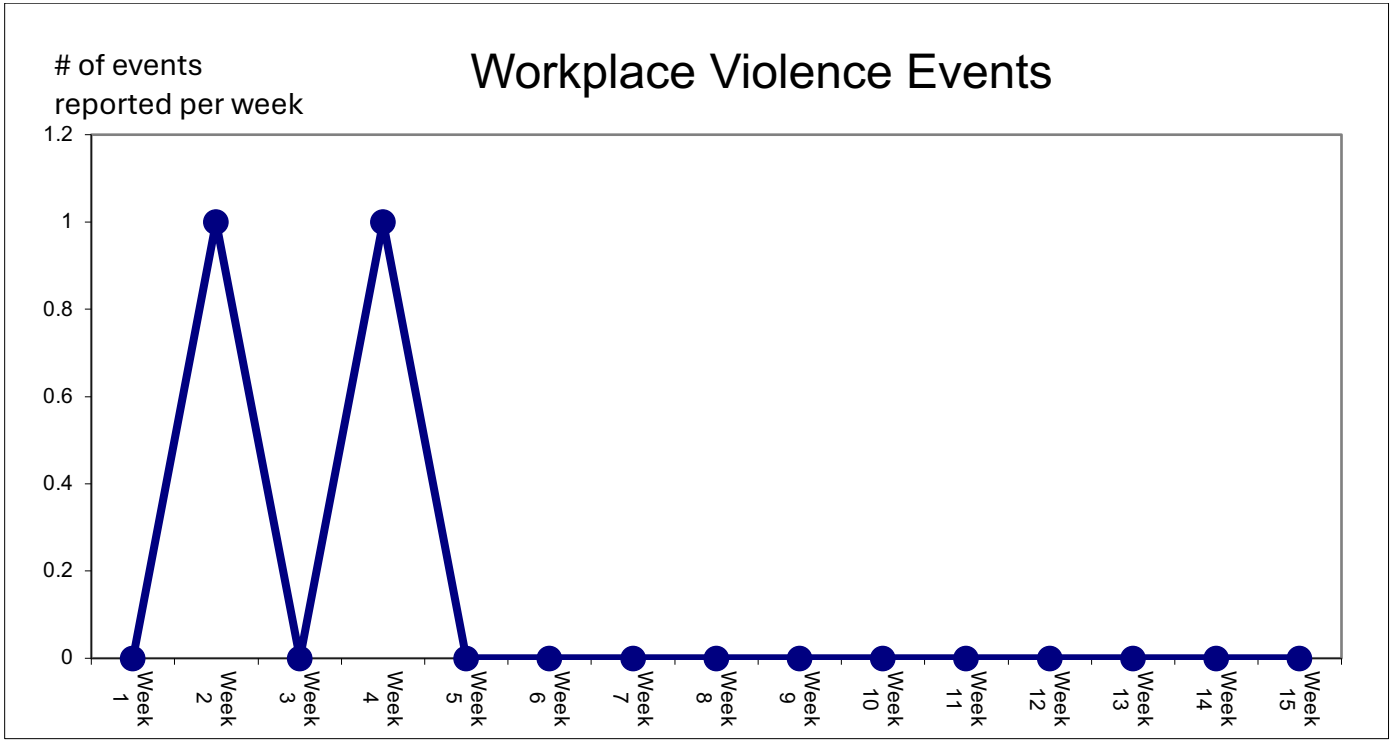


Figure 9

Run chart to display the number of workplace violence events reported on the unit each week



Appendix A

Citation Manager

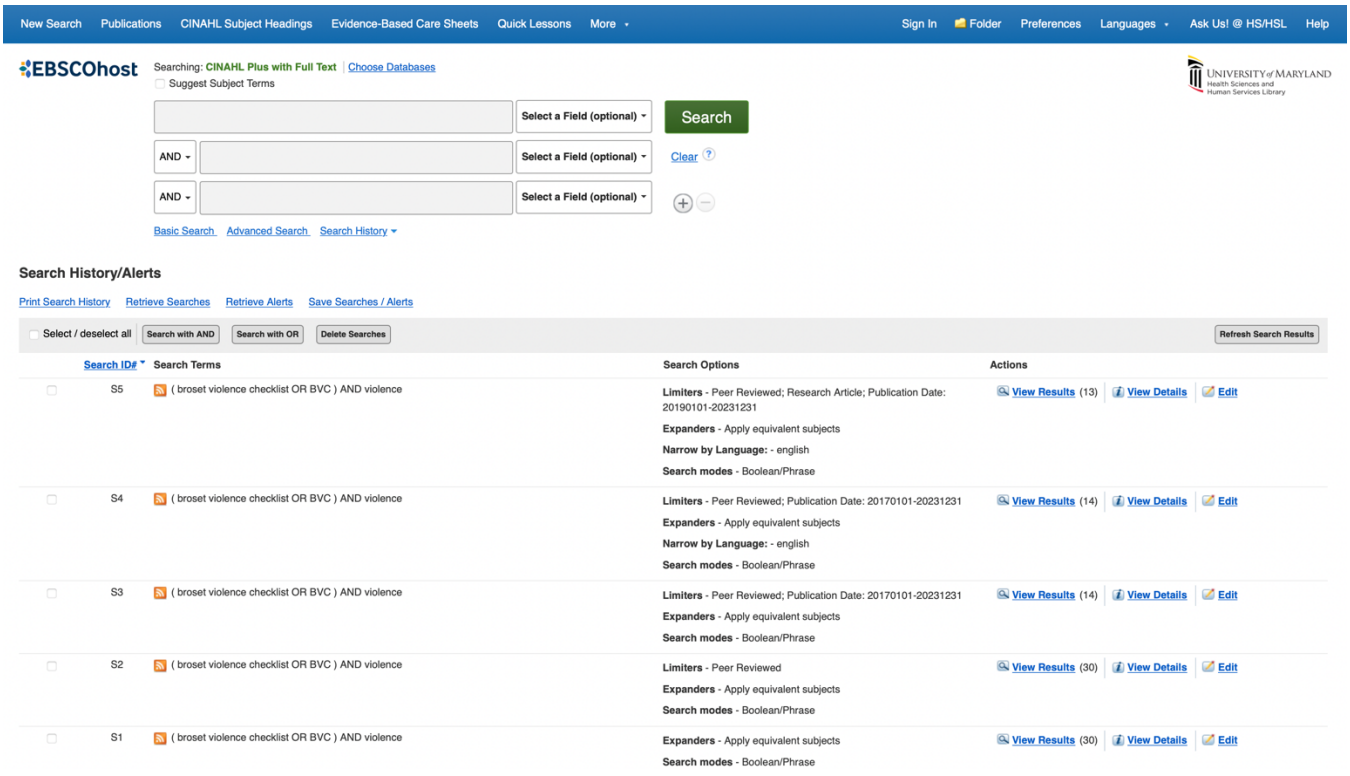


Figure A1. Evidence search using CINAHL database via HSHSL.

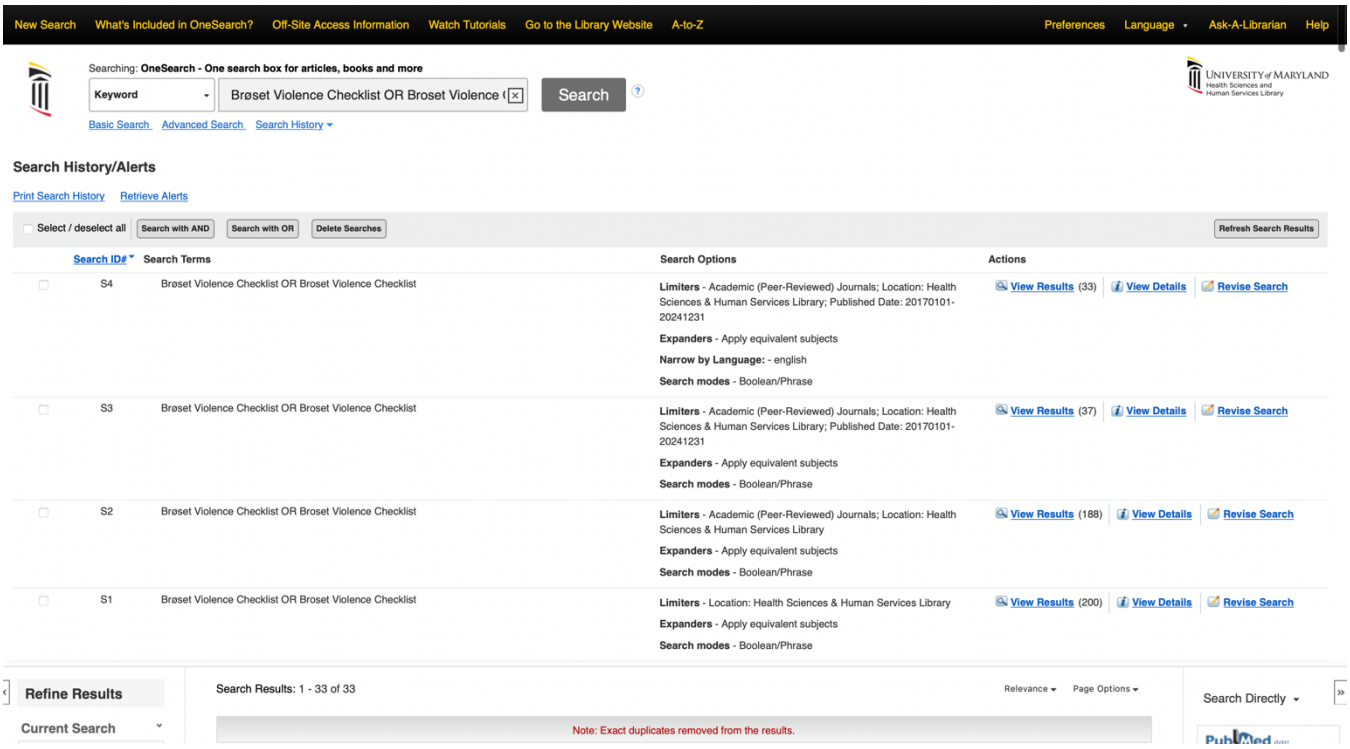


Figure A2. Evidence search using One Search via HSHSL.

Appendix B

Figure B. Example of once visual handout that was created by QI-PL and placed on unit to help with education and reminders to the nursing staff

Appendix C

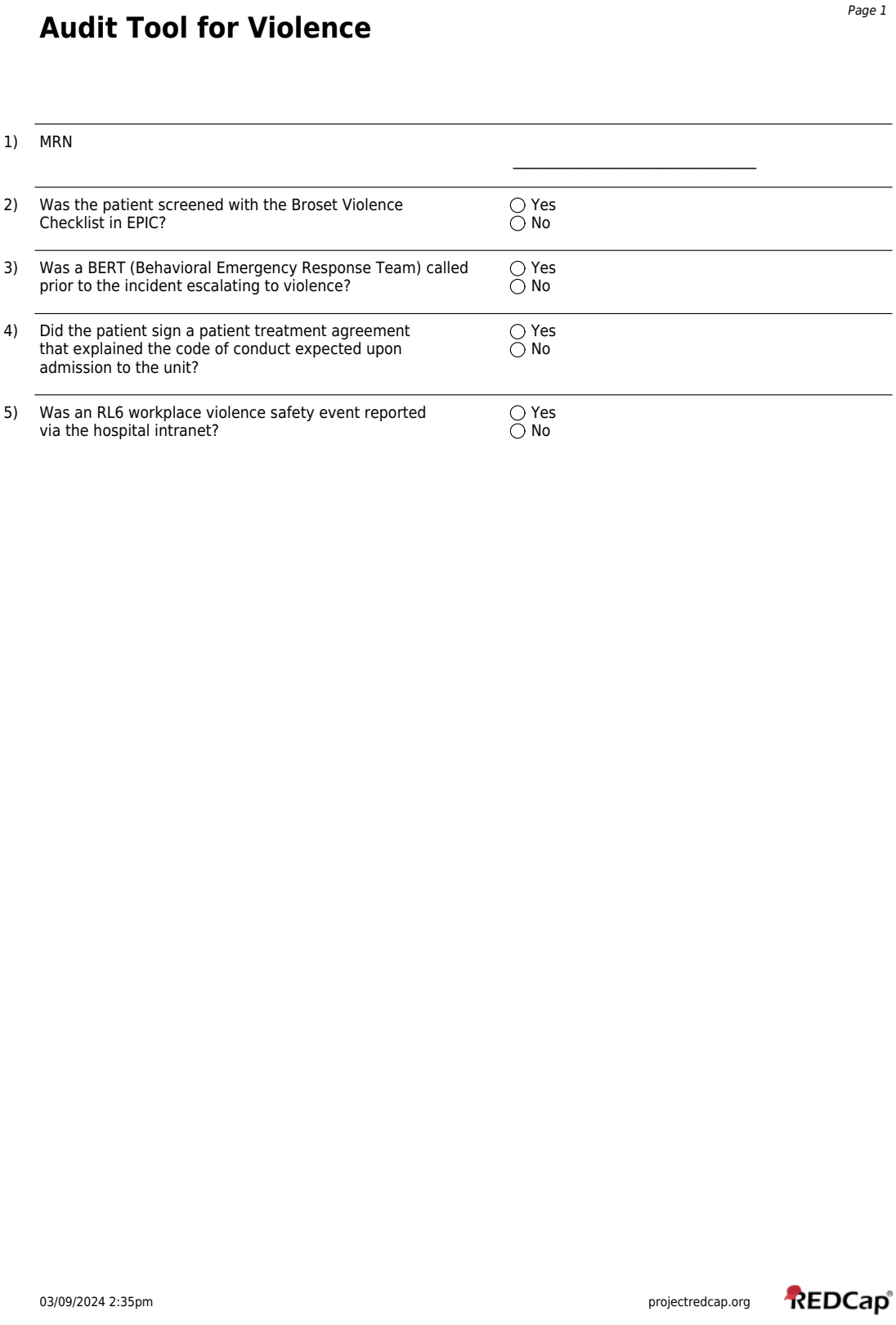
REDcap Broset Violence Checklist

Broset Violence Checklist

Please complete the checklist based on patients clinical presentation

1)	Confused	◯ Yes ◯ No
2)	Irritable	◯ Yes ◯ No
3)	Boisterous	◯ Yes ◯ No
4)	Verbal Threats	◯ Yes ◯ No
5)	Physical threats	◯ Yes ◯ No
6)	Attacking objects	◯ Yes ◯ No

Figure C1. Broset Violence Checklist available in EPIC.



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Audit Tool for Violence

1)	MRN	_____
2)	Was the patient screened with the Broset Violence Checklist in EPIC?	◯ Yes ◯ No
3)	Was a BERT (Behavioral Emergency Response Team) called prior to the incident escalating to violence?	◯ Yes ◯ No
4)	Did the patient sign a patient treatment agreement that explained the code of conduct expected upon admission to the unit?	◯ Yes ◯ No
5)	Was an RL6 workplace violence safety event reported via the hospital intranet?	◯ Yes ◯ No

03/09/2024 2:35pm projectredcap.org REDCap

Figure C2. Audit tool to establish compliance with clinical practice guidelines in the event that violence did occur.