2024

Healthcare Workers' Perception of Workplace Violence

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A Project
Submitted in Partial Fulfillment of the Requirements for the
Degree of Master of Science in Nursing
College of Nursing and Health Sciences
Mississippi University for Women

COLUMBUS, MISSISSIPPI
July 2024

Graduate Committee Approval

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DEDICATION

This research project is dedicated to those who have been my constant source of support, inspiration, and love. To my beloved children, Alex and Brooklyn, whose smiles and laughter provide endless joy and motivation. Your curiosity and zest for life remind me daily of the importance of perseverance and the pursuit of knowledge. To my loving husband, Zachary, whose unwavering support and encouragement have been the bedrock of my journey. Thank you for standing by me through every challenge and celebrating every achievement with me. To my wonderful parents, Stacey and Jesse, who instilled in me the values of hard work, dedication, and the importance of education. Your love, sacrifices, and belief in me have made this accomplishment possible. And most importantly, to our Lord and Savior, whose guidance and grace have illuminated my path. Your presence in my life has given me the strength and faith to pursue and complete this endeavor. Thank you all for your unconditional love and support. This work is a testament to your incredible influence on my life. – Rachael Flynn

First and foremost, I would like thank God for blessing me despite my shortcomings. Thank you, God, for your daily grace and mercy. Thank you for not allowing the things I thought I wanted but allowing the things I needed that you had planned for me. Thank you for having a bigger vision for me than I had for myself. I cannot thank you enough. In everything that I do, I keep a few bible verses in mind to stay encouraged in those challenging times. “For I know the plans I have for you, declares the Lord, plans to prosper you and not to harm you, plans to give you a hope and a future.” -Jeremiah 29:11. Romans 8:31 says, “If God is for us, who can be against us?” Lastly, Deuteronomy 31:6 says, “Be strong and courageous. Do not be frightened, and do not be dismayed, for the Lord your God is with you wherever you go.”

I would like to dedicate this research project to my family. Alaysia, thank you for being so patient with me while I constantly studied and had less time for you. You took it like a champ like you have done every other time I have been in school. We did it again. I hope that I have shown you what hard work and dedication exemplify with God on your side. I pray you know that you can do anything you put your mind to. Anything worth having will not come easy; know that you can and will do it with God. To the rest of my family, thank you for helping me with whatever I needed whether it was being there for Alaysia, transporting her, donating to the many fundraisers, or whether it was just prayers. I thank you for it all. None of it went unnoticed; I greatly appreciate it because you did not have to do it. I love each one of you with everything in me. Again, thank you from the bottom of my heart.

I want to say thank you, Dr. Kemp, and our committee chair for your guidance throughout this research project. We could not have done it without you. Thank you, Dr. Kemp, for advising me, listening, and giving me constructive criticism when needed. Lastly, I would like to thank my preceptors, Tara Enlow, FNP-C, Britny Owens, FNP-C, and Stephanie Stegall, FNP-C, for being the absolute best mentors, and thank you for encouraging me. I could not have done it without you guys. -Brandy Montgomery

First, I would like to thank God for his grace and mercy, which has been my guiding light. His steadfast presence has seen me thorough every challenge ,and for that I'm thankful. This research is dedicated to my beloved husband, Lamonta, whose unwavering support and love have been my greatest strength. You have been the greatest provider for our family and took on a lot throughout this past year. To my precious son, Landon, your joyful spirit and endless curiosity inspire me every day. Your beautiful

smile was a major reason for your mother to keep pushing through this program. To my incredible parents, your sacrifices and endless encouragement has made this journey possible. Thank you all from the depths of my heart for your support and love. – Tyesha Pringle

This research project is dedicated to every employee that works in direct patient care. As people who have dedicated their lives and careers to ensuring others are taken care of, each of you deserve to have an advocate that will defend your right to protection against violence. I truly pray this study will shine a light on the unacceptable tolerance workplace violence has forced upon each of you. May God bless you and protect you as you serve others with the same serving love of Christ. -Anna Decker

ACKNOWLEDGEMENTS

I would like to sincerely thank Dr. Lindsay Kemp, my committee Chair and Advisor, who guided and mentored me throughout my research project. Dr. Kemp is truly a student advocate, dedicating countless extra hours and consistently placing student needs above her own to ensure we get the most out of our educational endeavors. Her unwavering support, insightful feedback, and exceptional guidance have been instrumental in completing this research. This project would not have been possible without her invaluable help and dedication. Thank you, Dr. Kemp, for your extraordinary commitment to my academic and personal growth.

I want to express my heartfelt gratitude to Dr. Rebecca Johnston, DNP, FNP-C, who served as my preceptor during my research project. Her constant support, inspiring influence, and caring nature have been instrumental in my academic journey. Not only has she been a great friend, but her mentorship has been invaluable to me. Dr. Johnston has guided and encouraged me and allowed me to conduct my research in her clinic, showing an unwavering belief in my capabilities. Her deep dedication to her patients and teaching has had a profound impact on my personal and professional development. I can't thank Dr. Johnston enough for her exceptional mentorship and enduring support throughout this experience. - Rachael Flynn

ABSTRACT

Healthcare workers are increasingly becoming victims of workplace violence and a loss of personal resources due to poor awareness, training, and intervention regarding workplace violence. According to research completed by Rajabi et al. (2020), healthcare workers are estimated to experience workplace violence nearly sixteen times more than other professional groups of employees. This issue can lead to decreased attendance, job performance and satisfaction, and job retention significantly affecting patient care. The purpose of this study was to evaluate the perception, preparedness, and effects of workplace violence among healthcare workers. The researchers conducted a quantitative, descriptive study utilizing a questionnaire that focused on the sample population's demographics, perception of workplace violence, preparedness within the facility of employment, and direct effects of workplace violence contributing to healthcare burnout. This study was voluntary, and the survey was distributed via email along with a QRL code shared through social media and placed in participating healthcare settings throughout Mississippi. After data collection, the data was subjected to analyses using SPSS 27 and a chi-square test analysis to analyze the relationship between the specific variables studied. The results of this study showed that most healthcare workers perceived workplace violence as having a detrimental effect on their view of the workplace environment. This perception was significantly influenced by their job role and the healthcare setting in which Registered Nurses (RN)/Licensed Practical Nurses (LPN) and those in hospitals reported more negative impacts.

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Chapter I

Workplace violence in healthcare is an issue across the globe that continues to be undermined and poorly scrutinized. Healthcare workers are estimated to experience workplace violence nearly sixteen times more than other professional groups of employees (Rajabi et al., 2020). Workplace violence is defined as a threat or performance of physical force, verbal harassment or intimidation, or other behaviors that are threatening or disruptive (OSHA, n.d). Those working in the nursing profession have reported a de-sensitization to workplace violence due to accepting that such violence is common in healthcare (Spencer et al., 2023).

Due to poor awareness, training, and intervention regarding workplace violence, healthcare workers are increasingly becoming the victims of workplace violence and a loss of personal resources. The Conservation of Resources theory defines the personal characteristics of resources as pertaining to an individual's traits or coping skills that may be lost or threatened and lead to stress (Hobfoll, 1989). The threat or actual loss of healthcare workers' personal resources due to workplace violence contributes to burnout and poor retention in healthcare facilities (Prapanjaroensin et al., 2017). Burnout and poor retention leads to healthcare workers decreasing attendance, performance, and job retention.

Problem Statement

Poor policies and protocols regarding workplace violence prevention and intervention lead to decreased healthcare workers' long-term satisfaction and performance and significantly affect patient care.

Statement of Purpose

This study aimed to evaluate the perception, preparedness, and effects of workplace violence among healthcare workers. Workplace violence among healthcare workers can directly impact an individual's physical and mental well-being, thus affecting job satisfaction, performance, and overall patient care.

Significance of the Study

This research study evaluated the perception, preparedness, and adverse effects of workplace violence among healthcare workers. Recognition of employee perception, preparedness, and effects of workplace violence would evaluate how healthcare workers perceive violence and differentiate between types of violence that they may be experiencing. This study would also provide potentially valuable analyses of healthcare worker preparedness. The researchers questioned if healthcare workers are prepared for potential violent events within their facility and confident in the implementation of recommendations. Finally, the researchers aimed to identify healthcare burnout related to experienced violence. Researchers hypothesized that healthcare workers have minimal preparation, are unconfident in reaction to a violent threat, and experience lasting effects of violence in healthcare, thus contributing to decreased job satisfaction, increased burnout, and inadequate patient care.

Conceptual Framework

As previously mentioned, the Conservation of Resources (COR) theory defines how the threat or loss of specific resources to an individual can lead to stress. The four primary resources are described as objects, personal characteristics, conditions, or energies (Hobfoll, 1989). Resources of the COR model are further explained as objects

relating to the presence of physical items (shelter and clothing), personal characteristics pertaining to individual traits or coping skills, conditions referring to structures or states (social relationships or status), and energy relating to valuable skills or abilities that reap benefits such as knowledge or money (Prapanjaroensin et al., 2017).

From a theoretical perspective, Hobfoll (1989) expressed that individuals would try to have abundant resources, even in the absence of stressors, to resist future losses. However, when individuals lack a surplus in resources to resist a loss, a loss spiral may occur, eliciting psychological distress and poor chances of success. The COR model explains that individuals develop long-term expectations with an investment of resources, whereas an increased investment of resources should elicit more excellent compensation or outcomes. When a significant investment of resources is given with poor returns or outcomes, loss is perceived, which usually entails depression. The COR theory highlights the effort of individuals to possess, conserve, and increase valuable resources to anticipate or resist losses or stress (Hobfoll, 1989).

The COR theory was utilized to research the prevalence of poor protocols regarding workplace violence prevention in healthcare and the adverse effects on job satisfaction and performance. The researchers formed research questions that utilize COR theory examples of resources to compare the responses of healthcare workers to the hypothesis. Utilizing this conceptual framework, the researchers hypothesized that healthcare workers' perceptions of workplace violence decrease job satisfaction due to the lack of policies and protocols for prevention and repercussions. The researchers assumed that negative perceptions of workplace violence by healthcare workers would ultimately

cause stress and potentially lead to a spiral according to the loss of resources forementioned by the COR theory.

Research Questions

(1) How do healthcare workers perceive workplace violence?

(2) Are healthcare workers confident in their ability to respond to a violent situation based on facility protocols and guidelines?

(3) What effects has workplace violence had on healthcare workers?

Hypothesis

The researchers hypothesized that healthcare workers have little preparation, are unconfident in reaction to a violent threat, and experience lasting effects of violence, thus contributing to decreased job satisfaction, increased burnout, and inadequate patient care. The researchers predicted that the majority of healthcare workers have experienced workplace violence and are not adequately equipped to handle workplace violence due to the lack of protocols in healthcare facilities.

Definition of Terms

Healthcare Workers – "A healthcare worker is one who delivers care and services to the sick and ailing either directly as doctors and nurses or indirectly as aides, helpers, laboratory technicians, or even medical waste handlers" (Joseph & Joseph, 2016). The operational definition of Healthcare Workers (HCWs) includes all individuals working in healthcare facilities providing direct or indirect patient care. This includes nurses, nurse practitioners, nursing assistants, physicians, physician assistants, registered dietitians, pharmacists, pharmacy technicians, medical assistants, physical therapists,

physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, laboratory technicians, and medical waste handlers.

Adequately – an adverb defined as "to an adequate or sufficient degree or extent" (Merriam-Webster, n.d.).

Adequately, the operational definition should be a response of greater than 50%.

Equipped – a verb meaning "to make ready: prepare" (Merriam-Webster, n.d.). The operational definition of equipped is having the necessary resources, training, and support.

Handle – "to have overall responsibility for supervising or directing or to act, behave, or respond in a certain way when directed" (Merriam-Webster, n.d.)

The operational definition for "handle" is when at least 70% of healthcare workers report that they can effectively manage incidents of workplace violence.

Workplace violence – any act or threat of physical violence, harassment, intimidation, or other threatening, disruptive behavior from patients, patient's family members, external individuals, and hospital personnel. It includes physical, sexual, and psychological assaults *(Workplace Violence/End Nurse Abuse,* 2018). The operational definition of workplace violence is any act or threat of physical violence, harassment, intimidation, disruptive behavior, or verbal abuse toward healthcare workers (HCWs).

Healthcare facilities – places that provide health care. Healthcare facilities include hospitals, clinics, outpatient care centers, and specialized care centers, such as birthing centers and psychiatric care centers (A.D.A.M. Medical Encyclopedia, n.d.).

The operational definition of a healthcare facility includes hospitals, clinics, school settings, urgent care centers, rehabilitation centers, nursing homes/long-term care facilities, specialized outpatient services, and outpatient surgery centers.

Protocol – a detailed scientific or medical experiment, treatment, or procedure plan (Merriam-Webster, n.d.). The operational definition of a protocol is a predefined and structured set of procedures or guidelines designed to respond to workplace violence.

Experience – a noun that means something personally encountered, undergone, or lived through (Merriam-Webster, n.d.) The operational definition for experience is any situation where a healthcare worker is exposed to actions or threats of physical harm, verbal abuse, intimidation, harassment, or other forms of aggressive behavior within the healthcare facility. Experience encompasses both direct involvement in violent incidents and indirect exposure through witnessing violence or being aware of threats within the workplace.

Majority – a noun that means a number or percentage equaling more than half of a total (Merriam-Webster, n.d.).

The majority operational definition means 70% or greater of healthcare workers have experienced workplace violence.

Assumptions

It was expected that the participants would provide honest and truthful evaluations. The questionnaire was also assumed to be designed to obtain dependable responses, and participants would completely comprehend the questions presented. The population had been sufficiently studied, as theoretical saturation was achieved.

Limitations of the Research Project

The study's limitations included a smaller number of respondents because healthcare workers often viewed workplace violence as inevitable and not a significant concern. Another limitation was reduced response rates from healthcare workers who did not check or respond to their emails. When asked for volunteers, some employees had experienced workplace violence but did not want to participate for personal reasons. Some healthcare workers felt they were too busy to respond to emails. This did not portray the accuracy of workplace violence.

Summary

The survey completed by healthcare workers in Mississippi aimed to evaluate how many have experienced workplace violence, their perception of workplace violence, and whether they felt prepared during the event. The survey was also designed to evaluate whether healthcare workers were aware of policies and procedures regarding workplace violence and whether they felt safe and secure in the event of workplace violence. This chapter discusses the significance of workplace violence, education, and theory.

Chapter II

This research study aimed to investigate the perception, preparedness, and effect of workplace violence on healthcare workers. The current study's researchers analyzed and critiqued academic journals, peer-reviewed articles, and other evidence-based articles to develop a broader insight into workplace violence in healthcare. This chapter outlines a theoretical framework and twelve sources of related literature that correlate with workplace violence in healthcare. The researchers disclosed the conceptualizations,

empirical evidence, interpretations, and associations of each source of related literature below.

Conceptual Framework

Gaining insight into workplace violence in healthcare exposed the perceptions and negative effects such violence had on healthcare workers. The Conservation of Resources (COR) theory was developed as an original stress model describing the intrinsic nature of retaining, protecting, and building resources. Furthermore, threats or actual loss of such resources valuable to individuals led to stress and a spiral. The creator of the COR theory proposed that the model would refine testing, comprehension, and direction for additional stress and stress resistance research (Hobfoll, 1989).

To understand the COR theory, resources were identified as subjects that individuals value while making efforts to procure more. The four primary subjects are described as objects, personal characteristics, conditions, or energies (Hobfoll, 1989). Primary subjects of the COR model are further explained as objects relating to the presence of physical items (shelter and clothing), personal characteristics pertaining to individual traits or coping skills, conditions referring to structures or states (social relationships or status), and energy relating to valuable skills or abilities that reap benefits such as knowledge or money (Prapanjaroensin et al., 2017). However, when individuals lack a surplus in resources to resist a loss, a loss spiral may occur, eliciting psychological distress with poor chances of success (Hobfoll, 1989).

Prapanjaroensin et al. (2017) conducted a review of literature study to scrutinize the COR theory as an explanation for burnout in nursing. The COR theory explains stress as an individual's response to threats of losing resources, actual loss of resources, or an

investment of resources without the ability to replenish them. When healthcare workers are exposed repeatedly to work-related loss or stress, exhaustion, overwhelm, and burnout occur. Several COR theory resources are associated with burnout in nursing when faced with repetitive stress or loss. Condition resources in nursing, such as feelings of inferiority or irritation and difficulty sleeping, serve as significant risk factors for burnout. Personal characteristic resources such as poor coping or support contribute to burnout as well as loss of energy resources by working long hours or having time constraints. The COR theory conceptualizes and rationalizes burnout in nursing but also serves as a tool to strategize against burnout. To improve nursing retention and decrease burnout, it is imperative that organizations develop solutions and strategies to protect the resources valued by nurses and prevent recurring loss (Prapanjaroensin et al., 2017).

The current study's researchers utilized the COR theory resources to assess the perception, preparedness, and effects of workplace violence on healthcare workers rather than single subjects such as nurses. Understanding that stress is modeled by a loss of object, personal characteristic, conditional, or energy resources (Hobfoll, 1989) and work-related mental stress causes burnout (Prapanjaroensin et al., 2017), healthcare workers were evaluated on their perception and preparedness for workplace violence and how the loss of resources, according to the COR theory, affected them.

Review of Related Literature

Article I

Spencer et al. (2023) performed a comprehensive and systematic literature review to assess the causes of underreporting of workplace violence (WPV) among nurses. The review was based on nineteen published quantitative studies from the past ten years

(January 1, 2011, to March 24, 2022) regarding global nursing perspectives of workplace violence. The purpose of the study was to scrutinize and summarize recent literature regarding the rationale for nurses underreporting healthcare WPV perpetrated by patients or visitors. The authors hypothesized that by understanding the causes of underreporting WPV, healthcare leaders may take measures to address the problem. The research question developed stated, "Why do nurses underreport patient or visitor-perpetrated WPV?" and the authors proposed light would be shed on the phenomenon of underreporting through analyses of selected studies as well as interventions and recommendations.

Spencer et al. (2023) utilized the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guideline to design the systematic review and various electronic databases to identify articles containing words related to workplace violence in healthcare and underreporting. Of the nineteen articles reviewed, sixteen were deemed high quality and three were deemed acceptable after quality appraisal through the Scottish Intercollegiate Guidelines Network (SIGN) checklist. The articles deemed high quality were conducted in Indonesia, the USA, China, Jordan, and Saudi Arabia, to name a few (Spencer et al., 2023).

The categories developed to rationalize the underreporting of workplace violence by nurses are broken down into subcategories and then again into specific factors. For the initial nursing category, seventeen articles contributed and highlighted rationales such as negative perceptions among nurses, fear, lack of knowledge about reporting workplace violence, etc. The second category pertained to management, in which seventeen articles aided in rationales such as nurses being unsatisfied with outcomes, lacking support to

report, and culture. The final category related to the organization, in which four articles exposed the lack of policies and procedures, reporting systems, and training programs. The authors recommended that nurses and organizations should address the rationales for underreporting as outlined and provide actionable procedures, resources, and support for nursing staff (Spencer et al., 2023).

The current research built upon this review was a quantitative study conducted to further assess the perception and preparedness of healthcare workers against workplace violence. Spencer et al. (2023) summarized negative perceptions, lack of policies and procedures, and lack of training programs as rationales for underreporting workplace violence. The current researchers aimed to correlate the mentioned rationales to the research study's findings, summarizing the effects of workplace violence against healthcare workers.

Article II

Najafi et al. (2018) performed a first-time qualitative study in Iran uncovering the predisposing factors and consequences of workplace violence based on perceptions of nurses as victims of such violence. This study was deemed significant in that documentation of such events would improve by identifying factors contributing to workplace violence, as well as policies and interventions to prevent recurrence. The qualitative nature of the study allowed for open-ended questions including, “Would you please describe the sequence of events that occurred when you were a victim of violence by patients and/or their relatives, colleagues, and/or supervisors/physicians?” which was then followed up by, “How did the violence affect you?”.

Nine public and private hospitals in Tehran, Iran, were utilized to conduct unstructured interviews with twenty-two nurses with at least six months of experience. The unstructured interviews were digitally recorded, persisting for 30-75 minutes each, with the majority of the nurses being females aged 26-41 with 4-19 years of experience. Each of the nurses interviewed was required to sign a written informed consent form explaining the voluntary nature of the study and confidentiality, with the opportunity to regress at any time (Najafi et al., 2018).

The study categorized the predictors of workplace violence into five categories and the consequences into two categories. Each category was further broken down into subcategories to provide concise examples related to the main category. The antecedents of workplace violence included unmet expectations of patients/relatives, inefficient organizational management, inappropriate professional communication, factors related to nurses, and factors related to patients, patients' relatives, and colleagues. The consequences of workplace violence were summarized as individual-familial consequences and destructive career consequences. The authors discussed the adverse effects of workplace violence on nurses' careers along with the effects on individual and familial levels (Najafi et al., 2018).

The interest in uncovering the prevention and intervention of workplace violence was relevant to the current research, in which Najafi et al. (2018) disclosed nurses' negative feelings toward their profession and insecurities regarding the workplace. The study reviewed served as a great foundation and tool for the further investigation of the perception and preparedness among healthcare workers regarding workplace violence.

Article III

Tuominen et al. (2023) performed an empirical research study investigating patient violence toward social and healthcare workers and its effect on staff well-being. The authors discussed the lack of research on healthcare workers' well-being at work and leadership after a patient or client perpetrated violence was experienced. The research questions utilized were stated as follows:

> What kind of violence do clients and patients commit against social and healthcare staff? What kinds of connections does violence have on the well-being and the implementation of work of the staff? What kind of support do nurses expect to receive from their leader when they encounter workplace violence by patients or clients? How do leaders consider their opportunities to support their staff, and what measures do they take? (Tuominen et al., 2023).

The study was conducted utilizing a five-stage integrative review method, which included phases to identify the research problem, search and select data using the PRISMA 2020 checklist, quality appraise studies found on electronic databases, extract and analyze data from articles published between 2015 and 2021, and synthesize the results. The demographics of the twenty-one articles reviewed included sample sizes ranging from 13-4125 participants, thirteen countries (primarily Asia, Australia, North America, and Europe), and a combination of qualitative and quantitative studies, cross-sectional studies, correlational studies, and a quantitative questionnaire survey (Tuominen et al., 2023).

The study's results were categorized by connections of workplace violence to well-being, work performance, and commitment of nurses at work. The connections of

workplace violence to well-being at work and work ethic were described in ten studies and discussed that workplace violence reduced psychological, emotional, and physical well-being while at work while limiting work performance and commitment. Eighteen studies illustrated the perceptions and expectations healthcare workers subject to workplace violence had toward behaviors or actions among leaders. Healthcare workers reported disappointment and dissatisfaction when discussing leaders. Leaders responded to the experience of workplace violence by reporting feelings of stress and ethical conflict as they were responsible for the safety of patients and healthcare workers (Tuominen et al., 2023).

The review conducted by Tuominen et al. (2023) supported the researchers' intent to explore perceptions, preparedness, and the effect of workplace violence on healthcare workers. The study highlighted several articles that congruently disclosed healthcare worker attitudes and perceptions about leader involvement in workplace violence with an incentive to investigate further solutions to mitigate the issue. Discussion of executive management's involvement in preventing and managing workplace violence gave a stronger foundation for the current research by expanding the pool of participants to healthcare workers, managers, and leaders.

Article IV

Spelten et al. (2020) article titled "Organizational Interventions for Preventing and Minimizing Aggression Directed Towards Healthcare Workers by Patients and Patient Advocates." The article investigates organizational interventions targeting the reduction of aggression towards healthcare workers. The researchers thoroughly discuss the background and significance of their study, underlining a critical issue of aggression

confronted by healthcare professionals, a problem with effects on worker well-being and patient care quality. The article also clearly identifies the research problem: aggression towards healthcare workers. The research question points out the need for effective interventions to prevent and minimize workplace aggressions.

Although not directly, the article successfully points out the study's research questions. The authors' primary focus is identifying organizational interventions that effectively reduce patient or patient-advocate aggression toward healthcare workers. Although explicit hypotheses are absent from the research article, the research questions provide a guideline for investigating the efficacy of the interventions to address workplace aggression.

The study searched multiple electronic databases and included findings from seven studies conducted in various healthcare settings, enhancing the generalizability of findings. It focused on healthcare workers and their peers who experienced patient aggression, aligning with the research question. The study used randomized controlled trials (RCTs) or controlled before and after studies (CBAs) to investigate organizational interventions to prevent aggression. Participants' numbers were mentioned, but details about sampling methods were lacking, and the study could benefit from providing more information on these techniques to enhance methodological transparency. Additionally, the study employed standard Cochrane methods for data collection and analysis, including independent information extraction and Risk of Bias assessment by a minimum of two review authors per study, promoting data reliability and quality assessment. The study focused on measuring episodes of non-harmful aggression as dependent and independent variables, categorizing interventions based on the Haddon Matrix to assess

their impact before, after, and during aggression. The search period for relevant studies was clearly outlined, spanning from inception to May 25, 2019. The study used a random effect model for meta-analysis and grade to evaluate evidence quality, both essential in systemic reviews. However, the specific instruments or tools for data collection within each study were not mentioned, which would aid in evaluating primary research quality.

The study presents statistical findings, including effect sizes, confidence intervals and risk ratios for different interventions and phases, with interpretations consistent with the data. For example, it reports that humor therapy did not show clear evidence of reducing overall aggression in a nursing home setting, and this finding is interpreted accordingly. The study concludes that various interventions may reduce aggression while acknowledging the evidence's limitations. Additionally, the study appropriately suggests the need for more research in this area given the limitations of the existing evidence.

This article is relevant to students' research as it establishes a basis for understanding the impact of organizational interventions on workplace aggression in healthcare settings. This article systematically classifies interventions, which can aid in identifying future strategies and directly addresses themes of workplace aggression and interventions to lessen it. The evaluation of different interventions' impact on aggression may align with the research questions. The article also highlights deficiencies in the existing literature, particularly in studies focusing on the post-event phase of the Haddon Matrix, offering a foundation for framing research agendas. The article also showcases disparities in intervention efficiency across different stages and healthcare environments.

Article V

Kim et al. (2021) conducted a study in a hospital setting to explore nurses' experiences of workplace violence and its connection to emotional exhaustion and perceptions of patient safety. Workplace violence was defined as physical and threatening assaults, with statistics showing a significant increase in such incidents toward healthcare providers, particularly nurses. The study highlighted that physical aggression by patients or family members was a common form of workplace violence directed at nurses. Despite these challenges, the experience of workplace violence is often under-reported. The study identified negative impacts of workplace violence, including job dissatisfaction and symptoms of traumatic experiences. While the article did not explicitly mention a specific theoretical framework, it emphasized the need for intervention to reduce workplace violence in the healthcare setting.

Kim et al. (2021) uses three research questions to guide their study. The first explores the characteristics of violent actions in the workplace and the extent of underreporting (Kim et al., 2021). This research question aims to understand the nature and extent of workplace violence incidents by examining the underreporting of such incidents. The second research question seeks to understand whether there is a link between workplace violence experienced by nurses, emotional exhaustion, and patient safety. The third research question identified asks how workplace violence can affect how emotional exhaustion is perceived and impacts on patient outcomes. The research questions guide the researchers in achieving the purpose of the study.

The study used a cross-sectional analysis and data from hospital staff in a healthcare institution in the southeastern United States. The researchers collected data

from 3601 hospital staff in 2017 using an anonymous survey, with 1781 responses being from nurses. The survey included items to measure emotional exhaustion, workplace violence, and patient safety over three months. Emotional exhaustion was measured using the Maslach Burnout Inventory (MBI) subscale, workplace violence was assessed through physical and verbal violence, and patient safety was evaluated through using the Hospital Survey on Patient Safety Culture (HSOPS). The study also compared self-reported data with incident reports (EIR and HPR) to assess the underreporting of workplace violence and validate the accuracy of incident reports in healthcare settings.

The study found that verbal abuse towards nurses from patients or visitors was more common than physical violence. It also showed that all forms of workplace violence were certainly linked to nurses' emotional exhaustion, with verbal abuse from patients being a strong predictor of emotional exhaustion. The research highlighted the negative impact of workplace violence on patient safety and suggested addressing verbal abuse, improving reporting systems, and enhancing coping strategies for nurses. The authors recommended further research into factors contributing to workplace violence and developing strategies to stop violence.

Kim et al.'s study is essential to the current research as it provides critical knowledge on the effects of workplace violence on healthcare professionals. This knowledge is the basis of the research. The study also suggests exploring the effects that emotional exhaustion has on patient safety and patient outcomes. This recommendation addresses an aspect this research plan to investigate, providing a clear path for further inquiry. Finally, the article provides insights into using surveys, which designs the study.

Article VI

Barros et al. (2022) explore the susceptibility of healthcare workers to workplace violence. The article explores the likelihood for healthcare professionals to encounter various manifestations of violence, such as verbal abuse, threats, and physical assault. This aggression may be from patients, patient's families, or even fellow colleagues within the healthcare environment. The authors assert that workplace violence impacts the physical and mental well-being of healthcare workers while also undermining their professional efficacy and satisfaction. The introduction effectively describes workplace violence as a global public health concern that requires immediate consideration. The introduction does not mention of the theoretical framework guiding the study.

Barros et al. (2022) clearly defined their research questions and hypotheses, focusing on the correlations between psychosocial risk factors and workplace violence experienced by healthcare workers. The hypotheses aligned with the research questions, predicting greater communication about intimate partner violence in intervention clinics reduction in violence incidents, enhancement of connection to communities, perception of a safer work environment, and improved overall health for healthcare workers in intervention clinics compared to usual care. These hypotheses helped to guide and quantify the study’s objectives.

Barros et al. (2022) conducted research on intimate partner violence among healthcare workers in Portugal. They collected demographic information from 276 healthcare workers, including nurses, physicians, healthcare assistants, and administrative assistants. The study used established tools such as the Conflict Tactics Scale-2 and the CDC's Healthy Days Core Module, to assess intimate partner violence and the

participants, health, and well-being. However. The authors noted limitations including the lack of information about the study's parameters, such as the timetable for data collection and the overall duration of the study.

Barros et al. (2022) presented statistical findings and their interpretations. The interventions group of clinicians showed significantly higher rates of IPV inquiry compared to the usual care group, confirming the first hypothesis. They also found that

there were no notable declines in adverse outcomes over time, leading to the dismissal of the overarching hypothesis. The study also acknowledged that both groups enhanced safety practices, although specific statistical finding were lacking.

Regarding the applicability of the findings, Barros et al. (2022) center on the screening of intimate partner violence in family practice clinics. The prioritization of implementing comprehensive systems of care for intimate partner violence in healthcare settings closely aligns with the student's research interests and objectives. In this context, the article bears significant relevance to the student's research, which centers around IPV screening in family practice clinics. The emphasis on integrating IPV care systems into healthcare environments closely aligns with the student's research interests and objectives. The study's findings and recommendations about the significance of regular screening and intervention for IPV can supply valuable insights for the student's research design and objectives.

Article VII

According to Otachi et al. (2022), workplace violence has been and continues to be an ongoing problem in healthcare. The purpose of this study was to research underlying factors associated with workplace violence. Demographic, work-related, and

behavioral factors, different disciplines, and work setting were examined during this study. According to the American Association of Occupational Health Nurses, "Workplace violence is a serious hazard and is the leading cause of occupational disability, morbidity, and mortality in the U.S. workforce. Workplace violence reduces employee motivation and engagement, resulting in increased absenteeism and employee burnout (Otachi et al., 2022). According to the Occupational Safety and Health Administration, "it has been estimated that approximately 75% of healthcare workers report regular workplace violence." Results of this study indicated that workplace violence is an issue that continues to worsen. This study did not have a clear theoretical framework.

Otachi et al. wanted to know if there was a significance between discipline, work setting, workers' demographics, work-related and behavioral factors, and exposure to workplace violence. The researchers sought to raise awareness of how often workplace violence occurs and the fact that it occurs too often without consequences. Participants were asked whether they had witnessed or experienced workplace violence (Otachi et al., 2022).

This study was conducted using a secondary analysis of cross-sectional data that was obtained from an electronic survey administered to healthcare workers in an academic medical center in which was comprised of four hospitals, inpatient and outpatient settings, which totaled 9000 healthcare workers. It utilized a correlational design to examine the associative factors related to workplace violence. Study participants were a voluntary sample of healthcare workers that included physicians, advanced practice providers, nurses, certified nurse assistants, social workers,

psychologists, therapists, and administrative staff. This secondary analysis stemmed from data that was obtained in an earlier study that examined compassion fatigue, burnout, and secondary traumatic stress among healthcare professionals. Participants, which totaled 1006, were invited to participate in the study via email between November 2018 through April 2019 (Otachi et al., 2022). They were sent an electronic survey in which they could participate anonymously. The healthcare variables included work-related variables such as disciplines, different work settings, shift worked such as days or nights, length of time worked in a particular location, length of time practiced in discipline, etc.; demographic variables such age, that being at least 18 years of age, gender, sexual orientation, marital status, etc.; and behavioral variables such as length of sleep in a twenty four hour period, quality of sleep, alcohol use, etc. (Otachi et al., 2022).

Based on the study conducted, more than half of the participants (54.5%) witnessed (23.8%) or experienced (30.7%) workplace violence with psychiatric (45.1%) and emergency (44.1%) services having reported the highest experience of workplace violence. (Otachi, Robertson, & Okoli, 2022). Although the study did show the significance of workplace violence amongst the different variables used, the authors found that the statistical results could have been affected due to some professional disciplines and workplace settings that were not included as participants. According to Otachi, Robertson, and Okoli, 2022, despite the limitations, the study found important demographic, work-related, and behavioral correlations that may speak to research, policy, and practice interventions to assess and address risks for workplace violence by implementing policies and procedures.

Article VIII

Small et al. performed a study for the purpose of determining the frequency and reporting of workplace violence incidents among home healthcare workers. Workplace violence is a significant occupational hazard for home healthcare workers as well as other healthcare workers. Healthcare workers often underreport workplace violence. According to Small et al. (2023), workplace violence is defined as the "act or threat of violence ranging from verbal abuse to physical assaults directed toward persons at work or on duty". It includes acts of incivility, sexual harassment, and verbal and physical aggression. According to the Bureau of Labor Statistics, nonfatal injuries, verbal abuse and near misses are not reported. The Haddon Matrix theoretical framework guided this research study. The Haddon Matrix framework contains two dimensions that combine public health constructs of host-agent vector environment as the objects of change based on interventions that can be used by the host to protect themselves from harm (Small et al., 2023).

Small et al. (2023) used three questions in this study. The three questions consisted of: "How often are home healthcare workers experiencing workplace violence?", "In what ways have you (home healthcare workers) experienced workplace violence?", and lastly, "If you experienced workplace violence, did you (home healthcare workers) report it?" Small et al. (2023) wanted to conduct a study to show factual numbers of victims of workplace violence to show there is a problem.

This study used a cross-sectional research design and survey tool to estimate the reporting and frequency of workplace violence occurrences. This study stemmed from a Haddon Matrix guided study that was conducted among healthcare workers in Southwest

Ohio in April 2020. There were two partnering sites for this study, both located in Southwestern Ohio. Small et al. (2023) The first site was a home healthcare agency and the second site included home care agencies that were registered with the Ohio Department of Medicaid. The study used a 76-item tool used to collect data that was analyzed using percentages, standard deviations, frequencies, and means. It contained questions that were categorized in categories such as threats of violence, sexual and verbal abuse, and physical assault from patients, patient's family members, visitors, coworkers, supervisors, or intimate partners. The study was conducted over a series of 12 months measuring incidents of workplace violence and why or why not workplace violence was reported.

Following analysis, 86% of home healthcare workers were female. The analysis revealed that 28.3% of home healthcare workers experienced verbal abuse when the aggressor was the patient, 17.4% when the aggressor was a patient's family member, and 10.9% when the aggressor was an intimate partner (Small et al., 2023). Major reasons the participants did not report were 6.5% felt like no action would be taken, 6.5% felt like the incident was not that big of a deal, and 4.3% felt like it was just what came along with the territory. The study also revealed that workplace violence was more common when the vector or aggressor was the patient. Verbal abuse and physical assault were underreported when the vector or aggressor was an intimate partner. Although workplace violence is experienced in home healthcare, all vectors were not well displayed or represented due to the setting of home healthcare. Findings from this study show that when the aggressor is an intimate partner, personal relationship workplace violence does not exist in the home care environment (Small et al., 2023). Further investigation is recommended to fully

understand underreporting in this population. Another recommendation would be to conduct the study at another time because the results of the study may have been affected by the timing of the study.

Article IX

Beam et al. (2022) performed this study for the purpose of investigating the types and frequency of workplace violence experienced by radiologic technologists and to identify which technologists using specific imaging modalities are at increased risk. The term violence refers to harm that can be physical, verbal, or psychological. Workplace violence is prevalent in many areas of the hospital; however, the authors of this study wanted to zoom in on the radiology department. Violence in the workplace is an increasingly problematic issue worldwide. According to the U.S. Bureau of Labor Statistics, 15% of work-related accidents are caused by violence. The World Health Organization (WHO) defines workplace violence as any situation in which the person is the subject of abuse, threats or attacks in circumstances related to their work or professional activity, having their safety, well-being or health threatened explicitly or implicitly (Beam et al., 2022). There was no theoretical framework identified.

Beam et al. (2022) used five guiding research questions for this study: What types of violence are technologists exposed to clinically? How often do violent events occur against technologists? Are there imaging modalities and locations at higher risk for violence? Are violent events being reported? Is education provided on how to handle violent events at work?

This study was conducted using a mixed-methods approach investigating the prevalence of workplace violence including the types and frequency per modality to

which technologists are exposed daily. The American Society of Radiologic Technologists (ASRT) housed more than 157,000 members from various regions in the United States. In October 2020, a random sample of 10,000 members of ASRT were sent an electronic survey through an embedded link via email. The link was accessible for two weeks. It was voluntary and anonymous; if completed, it would be consent for researchers to use the collected data (Beam et al., 2022). The survey was designed through the research electronic data capture web application Redcap. The survey questions were developed by evaluating several survey tools that also were tailored to the research questions. It included the Likert scale, multiple select, yes-no, forced-choice questions, questions related to participant's background information, experiences with violence, and reporting and education. The research also included an optional qualitative question at the end of the survey (Beam et al., 2022).

Beam et al. (2022) only had 193 responses of the 10,000 surveys emailed for a response rate of 1.9%. 78.2% of those respondents were women, and 21.8% were men. Fifty-eight percent were in the hospital setting, 25.9% in a clinic setting, and 13% reported other. Seventy-nine percent were practicing, and 3.1% were unemployed or no longer working in that profession. Thirty-one percent worked in adult radiography, 20.2% in computed radiography, 12.4% in mammography, 10.4% in adult ED radiography, 6.2% in cardiovascular interventional, 5.2% in radiation therapy, 4.7% in magnetic resonance imaging, 1% nuclear medicine, 0.5% pediatric ED radiography, and 7.8% reported as other. The outcomes of this study revealed that patients and visitors committed most types of workplace violence. Fifty percent had been hit, bitten, name-called, harassed, threatened, verbally intimidated, or had their hair pulled. Fifty-six

percent had been called a name by a visitor, 68% had been verbally intimidated by patients, 60% by physicians, and 54% by visitors. The most common types of workplace violence occurring one to three times per month were name-calling by patients (18.8%), verbal intimidation by patients (16.5%) sexual harassment by patients (10.2%), and name-calling by visitors (12.1%). The survey results also revealed that 62.9% of technologists had been instructed to report their encounters with workplace violence, whereas 37.1% had not been instructed to report. Sixty percent reported based on the severity of the workplace violence, 7.7% reported all violent incidents, 21% reported some of the incidents, and 40.6% did not formally report the incidents. When asked about education, 9.8% had never received an education, 25.2% had completed an educational course more than 12 months ago, 38.5% within the past four to twelve months, and 26.6% less than four months ago (Beam et al., 2022). Workplace violence creates an undesirable working environment, leading to negative implications for the healthcare worker and the patient. As indicated by the results of this study, there is an opportunity for improvement in education and reporting practices. It also revealed consistency in verbal abuse and intimidation not only from visitors and patients but also from other healthcare professionals. This might warrant a need for specific education on reporting and managing verbal intimidation and abuse (Beam et al., 2022). According to Beam et al., workplace violence as it relates to radiologic technologists warrants further investigation. Additional research might help identify how workplace violence affects radiologic technologists' attendance at work and their opinions on future employment, an evaluation of specific content in education courses might help identify how technologists are instructed to handle verbal and physical abuse, and lastly future investigation might

demonstrate how failing to report workplace violence affects employee education due to difficulty determining recurrent themes and identifying appropriate methods to reduce violent incidents (Beam, et al., 2022).

Article X

Tomagová et al. (2020) performed a cross-sectional study to identify the incidence of workplace violence against nurses in healthcare facilities in the Czech Republic and Slovakia, its sources, ways of dealing with violence against nurses, the intensity of nurse's psychological problems as a result of their experience of workplace violence, and to describe the differences in the monitored data items between nurses in these two countries. The research questions and hypotheses for the study were not clearly stated in the body of the article. Is workplace violence significant for nurses would be the most important question in this study. The evident purpose the researcher sought to achieve was that workplace violence has adverse psychological effects on nurses. Finally, healthcare facilities lack the necessary management and prevention of workplace violence.

Tomagová et al. (2020) research sample consisted of 526 nurses working in the selected healthcare settings within two participating countries: the Czech Republic and Slovakia. The Slovakia sample consisted of 200 nurses from different healthcare facilities, including two selected hospitals, an outpatient clinic, and two home care agencies in the Middle Slovakia Region. The Czech Republic sample comprised 326 nurses from two selected hospitals in the Moravian-Silesian Region. The inclusion criteria for the sample were: registered nurse, working in a selected setting for at least one year of clinical experience, and consent with the research participation. The use of

Strengthening the Reporting of Observational Studies in Epidemiology checklist was used in this cross-sectional study. The researchers administered a paper-and-pencil questionnaire to the nurses from the selected healthcare facilities from June 2016 to November 2016. World Health Organization (WHO), the International Labor Office (ILO), the International Council of Nurses (ICN), and Public Services International (PSI), Geneva 3 Workplace Violence in Health Sector Country Case Study – Questionnaire was used for data collection. Only five main sections of the questionnaire were used: Personal and workplace data (16 items), Physical workplace violence (20 items), Psychological workplace violence (12 items), Opinions on workplace violence (3 items), and health sector employer (2 items) but bullying/mobbing, sexual harassment, and racial harassment were excluded (Tomagová et al., 2020). Tomagová et al. (2020) used the Chi-square test to determine the associates between variables. A p-value of < 0.05 was considered significant. Descriptive statistical characteristics were calculated and analyzed using the statistical program Statistical Package for the Social Sciences 18.0.

Following analysis, 29% of Slovak nurses report they are moderately concerned about violence in the workplace, and 35.5% of Czech nurses are slightly concerned about violence in the workplace. In this study, 69.8% of Slovak nurses reported a lack of institutional procedure for violence incident reports in the workplace, and 75.6% of Slovak nurses marked the “no” answer to the question concerning the existence of support in the workplace for reporting workplace violence incidents. Regarding physical workplace violence, 17.5% of Slovak and 17.7% of Czech nurses experienced this in the past twelve months of practice, with 97.1% of the physical attacks being patient-initiated for the Slovak and 96.5% patient-initiated for the Czech. A statistically significant

difference was found in the intensity of the psychological response to physical and verbal violence between the Czech and Slovak nurses; the nurses reported greater intensity of monitored psychological problems because of experiencing physical and verbal workplace violence. As 20% of the Slovak nurses and 53.3% of the Czech nurses reported the incident of physical workplace violence to their supervisor. In the case of the incidents of psychological violence against nurses, the nurses in Slovakia preferred a passive solution to this situation compared to the nurses in Czech. Such an incident was reported to the supervisor by 16.7% of the nurses in Slovakia and 34% in Czech (Tomagová et al., 2020). The current research aims to build on the findings of Tomagová et al. This study will provide further evidence to inform practice. Tomagová et al. highlight the prevalence of workplace violence, a global phenomenon studied in Central Europe. The current research study in Mississippi will provide additional evidence to support the previous findings.

Article XI

Hamzaoglu and Türk (2019) performed a cross-sectional study to identify the prevalence of physical and verbal abuse directed against healthcare workers and to determine how these workers react in situations where physical and verbal abuse exists. There were three research questions for this study. The first question was, what is the prevalence of physical and verbal abuse directed against health care workers? Secondly, the apparent question the researchers sought to ask was: how do these workers react in situations where physical or verbal abuse exists? Finally, the last research question pertaining to this study was: What was the satisfaction of the healthcare workers

regarding the attitudes of their managers toward the evaluation of physical and verbal abuse?

Participants were selected randomly; e-mails, including the link to questionnaires, were sent to 250 healthcare workers, and shared with their colleagues. All individuals participated voluntarily after receiving the questionnaire via e-mail. Online responses were collected and delivered to the researchers as an anonymous spreadsheet file. The sample size for data analysis was 447, which consisted of 167 doctors, 274 midwives/ nurses/emergency medical technicians (EMT), and 6 that had no direct contact with patients. A standardized, confidential questionnaire, "Workplace Violence in the Health Sector Country Case Study Questionnaire," developed by ILO/ICN/ WHO/PSI, was first translated into Turkish and then used. Cronbach's alpha test was applied by selecting the appropriate questions, and the internal consistency value of the questionnaire was found to be 0.74%. The participants were divided into two groups to make a comparison. One group consisted of doctors and the other consisted of allied health personnel (nurses, midwives, and EMTs). Data was analyzed using SPSS version 18, and a chi-square independence test was used to determine whether there was a significant relationship between 2 or more categorical variables. Frequency distributions are presented as percentages, and a P value below .05% was considered significant.

Almost half of the participants in the study have encountered physical abuse, and nearly all the participants have experienced verbal abuse. A total of 40.7% of doctors and 34.3% of midwives/nurses/EMTs reported exposure to physical violence, and 94.6% of doctors and 85.4% of midwives/nurses/EMTs reported verbal abuse. The majority of the violence reported, 86.8% of doctors and 75.3% of the other group, including

midwives/nurses/EMTs believe the incident could have been prevented. Many of the participants (81.1% exposed to physical violence and 80.8% exposed to verbal abuse) report that abuse is typical in their workplaces. These rates of violence do not significantly differ in terms of working hours and the profession of the health care workers (P>.05%). However, in comparison by gender and departments, the rate of exposure to physical violence is drastically higher for men as well as for workers in the emergency department or ambulance services (P¼.007, P<.001). Many incidents were reported, 62.1% of verbal abuse and 48.2% of physical violence; the participants stated that nothing happened when they reported the incident. The participants who were exposed to violence (71.3% physical abuse and 83.2% verbal abuse) did not even report it, as they emphasized that they believed that reporting the violence would be of no benefit. Surprisingly, 72.7% of all participants stated that their managers supported the official notification of workplace violence. However, most of the participants who were truly exposed to physical violence and verbal abuse were not satisfied with the efforts of their managers during the evaluation process of physical violence (86.0%) and verbal abuse (86.2%) (Hamzaoglu & Türk, 2019).

The Hamzaoglu and Türk (2019) study is relevant to the current study for several reasons. According to previous research, workplace violence against healthcare workers is a grave global issue that has significant negative impacts on their well-being. The increasing prevalence of this problem has sparked greater interest in the topic, and the findings indicate that the existing measures to prevent such incidents are inadequate. The current researchers will further investigate, build on, study, analyze, and propose solutions to this obstacle.

Article XII

Legesse et al. (2022) conducted a cross-sectional study to assess the prevalence of workplace violence and its associated factors among nurse professionals working in public hospitals in Eastern Ethiopia. The study involved six public hospitals in Harari Regional State and Dire Dawa City Administration, with a sample size of 620 nurse professionals selected through a simple random sampling technique. The research question was not clearly stated, but this study's apparent purpose was to assess the prevalence of workplace violence and its associated factors among nurse professionals working at public hospitals.

The research used a structured and pretested self-administered questionnaire that included questions on socio-demographic and occupational characteristics, physical and psychological workplace violence, and health sector employer-related issues. The researchers collected data using EpiData 3.1 and analyzed it using SPSS version 28. Twenty-three explanatory variables were present, 11 had a p-value < 0.25 in bivariate analysis, and then they were included in multivariable logistic regression analysis. The Hosmer-Lemeshow goodness-to-fit model was applied to test the multivariate fitness, and the result was 0.446. The statistically significant association was declared using Adjusted Odds Ratio (AOR) with a 95% Confidence Interval (CI) at a P value of less than 0.05.

The study revealed that 75.6% of nurses reported being worried about workplace violence, and 59.7% were not knowledgeable of the presence of reporting procedures for workplace violence attempts or incidents. The prevalence of workplace violence against nurses in the last twelve months was 64.0%, and those working in surgical, psychiatric, and medical wards, as well as emergency units, were more likely to encounter violence

than those working in specialized units. Nurses who witnessed physical violence were five times more likely to experience violence than those who did not. The main offenders in all types of workplace violence were the patients themselves and their relatives.

The Legesse et al. (2022) study is relevant to the current study for several reasons. This study showed that nurses who are worried about violence in the workplace are more likely to experience mental disorders. This article provided a foundation for one of the current research questions “Do healthcare facilities have protocols to protect healthcare workers from workplace violence?” as more than half, 59.7% of nurses, were not aware of any reporting procedure of workplace violence attempts or incidents.

Summary

Workplace violence against healthcare workers has become a common occurrence and requires management and prevention policies in healthcare facilities. This issue has been studied for several decades now, and it is imperative to find solutions to prevent violence from affecting healthcare professionals, quality of care, and patient satisfaction. Evidence-based research is essential in advising policies that can help prevent and control workplace violence. In this regard, academic journals, peer-reviewed articles, and other sources were analyzed to understand workplace violence in healthcare. The literature reviews focused on evaluating the perception, preparedness, and effect of workplace violence on healthcare workers. The theoretical framework used the Conservation of Resources (COR) theory to better understand workplace violence. The researchers assessed healthcare workers' perception and preparedness for workplace violence and how the loss of resources, according to the COR theory, affected them. All twelve articles

suggest the need for further investigation into workplace violence against healthcare workers.

Chapter III: Design and Methodology

The purpose of this study was to evaluate the perception, preparedness, and effects of workplace violence among healthcare workers. Workplace violence among healthcare workers can directly impact the individual's mental and physical well-being, thus affecting job satisfaction, performance, and overall patient care. This study aimed to determine the perception, preparedness, and negative effects of workplace violence among healthcare workers. This study provided a potentially valuable analysis of healthcare worker preparedness and the effects of workplace violence that influence job satisfaction and patient care.

Design of the Study

The researchers of this study used a descriptive quantitative study to determine the preparation, preparedness, and long-term effects of workplace violence. The survey distributed to healthcare workers includes questions that focus on the sample population's demographics, perception of workplace violence, preparedness within the facility of employment, and direct effects of workplace violence contributing to healthcare burnout. The survey was distributed using convenience sampling by the research group via email along with a QRL code shared through social media and placed in participating healthcare settings throughout Mississippi. The use of descriptive quantitative studying was relevant to this research due to the time restraint in which the research group had to complete this project.

Setting for the Research

The research questionnaires were distributed to healthcare facilities throughout Mississippi. Examples include hospitals, home health agencies, clinics, rehabilitation centers, urgent care centers, nursing homes, and schools. In addition, individuals distributed the survey to various healthcare facilities through email, QRL code, participating facilities, and social media platforms.

Population and Sample

The research group targeted a population of healthcare workers in Mississippi. The sampling population was narrowed to the geographic location for convenience. researchers assumed that a diverse representation of healthcare workers completed the questionnaire.

Methods of Data Collection

The research was implemented by developing a proposal and questionnaire that was presented and approved by the Institution Review Board (IRB) at MS University for Women. After approval, the proposal was presented to healthcare facilities and healthcare workers for approval of distribution and participation. The survey was delivered to participants throughout Mississippi via email, social media platforms, and a QRL code placement in breakrooms of healthcare facilities.

Instrumentation

The questionnaire comprised demographic data, knowledge and perceptions of workplace violence, and preparedness within the employment facility. The survey was administered directly to healthcare professionals, including doctors, nurse practitioners (NP), registered nurses (RN), certified nursing assistants (CNA), licensed practical nurses

(LPN), social workers, nutritionists, and therapists. The therapists surveyed encompassed a range of specialties, including physical therapists, occupational therapists, speech therapists, and mental health therapists who provide counseling and psychological support to patients dealing with various mental health issues. There were no identifying questions asked of the healthcare workers, such as name, date of birth, or location. The closed-ended questions varied between multiple-choice, forced multiple-choice, and dichotomous questions. The survey included instructions that only completed surveys would be used and that surveys should be completed and returned by March 1, 2024. No incentives were used for cooperation from healthcare facilities or providers.

Methods of Data Analysis

The effectiveness of this research problem will be determined by statistical analysis of completed questionnaires. Data from the completed questionnaires will be stored electronically, transferred to an Excel spreadsheet, and sent to a professional statistician for analysis. A professional statistician will perform statistical analysis using SPSS 27. A chi-square test analysis will also be performed on the questionnaire results to analyze the relationship between the specific variables studied.

Summary

This study evaluated the perception, preparedness, and effects of workplace violence among healthcare workers in healthcare facilities throughout Mississippi. The study was conducted using a questionnaire that was distributed via email, social media platforms and QRL code placement in participating healthcare facilities. Completed survey results along with thank you notes were sent out to participants. The effectiveness of this research problem was determined by statistical analysis of the completed

questionnaires. Data from completed questionnaires were stored electronically, transferred to an Excel spreadsheet, and sent to a professional statistician for analysis using SPSS 27. A chi-square test analysis was also performed to analyze the relationship between the specific variables studied.

Chapter IV: RESULTS

The study was designed to evaluate the perception, preparedness, and effects of workplace violence among healthcare workers. Workplace violence among healthcare workers can directly impact an individual's physical and mental well-being, thus affecting job satisfaction, performance, and overall patient care. The researchers assumed that workplace violence is a significant issue for healthcare workers and impacts their perceptions and experiences within the workplace. The researchers also assumed that the availability and effectiveness of policies and training might influence healthcare workers' confidence and preparedness in dealing with violent situations. Additionally, the researchers assumed that experiencing workplace violence could affect the levels of burnout among healthcare workers. The researchers sough specifically to answer the following questions: 1. How do healthcare workers perceive workplace violence? 2. Are healthcare workers confident in their ability to respond to a violent situation based on facility protocols and guidelines? 3. What effects has workplace violence had on healthcare workers?

The methodology for this study was an electronic survey to collect data from 209 healthcare providers, with 207 useable responses. The data was first compiled in Microsoft Excel and subsequently analyzed using IBM SPSS statistical software. Analysis involved descriptive statistics, chi-square tests, and cross-tabulations to examine

differences in perceptions, confidence, and burnout related to workplace violence across various demographic factors.

Profile of Study Participants

A quantitative study was used to obtain data for the current research study. The survey questionnaire was designed to evaluate the perception, preparedness, and effects of workplace violence among healthcare workers. The study involved 209 healthcare providers, yielding 207 usable survey responses, aiming to understand perceptions of workplace violence among healthcare workers, their confidence in responding to violent situations, and the impact of such violence on their professional lives. The majority of respondents were females, predominantly Caucasian, and most worked as registered nurses or licensed practical nurses in hospital settings. The respondents' tenure varied, with having worked between one to five years. A significant portion reported experiencing physical violence, and an even larger percentage had encountered verbal violence from patients or their families. These experiences had a notably negative impact on their workplace perceptions, which indicates a detrimental effect. Furthermore, while 63.3% of respondents acknowledged the existence of policies and training related to handling workplace violence, only 30.4% felt confident in these measures, and a mere 42.5% believed the training adequately prepared them for such incidents. Additionally, the prevalence of burnout was highlighted, with 59.9% reporting some degree of burnout prior to experiencing violence, which increased to 85% post-incident, indicating a significant adverse effect on their professional well-being. The data provides critical insights into the challenges faced by healthcare workers and underscores the need for

improved support and training to manage workplace violence effectively. Knowledge and personal testimonies were asked of the participants.

Statistical Results

The majority of healthcare workers perceive workplace violence as having a detrimental effect on their view of their workplace environment. This perception is significantly influenced by their job role and the healthcare setting, with RNs, LPNs, and hospital-based staff reporting more negative impacts. These findings underscore the need for targeted interventions to address and mitigate workplace violence, particularly in high-risk areas such as hospitals and among nursing staff.

How do healthcare workers perceive workplace violence?

To address the first research question, which explored how healthcare workers perceive workplace violence, we conducted a detailed analysis of the responses to survey question nine. This question specifically asked participants to rate the impact of workplace violence on their perception of their work environment. The survey revealed that 74.9% of respondents indicated that experiencing workplace violence had a negative effect on their view of the workplace. This substantial majority highlights the pervasive nature of workplace violence and its significant impact on healthcare professionals' morale and job satisfaction.

Data was further analyzed by subdividing the responses based on demographic factors and conducting a chi-square analysis. Categories with small frequencies were consolidated to enhance the effectiveness of the analysis. The key findings include significant differences in perceptions based on job roles and healthcare settings.

Specifically, RNs and LPNs reported significantly more negative perceptions of the workplace compared to other roles ($\chi 2$ (6, N = 207) = 17.381, p = .008). Additionally, respondents working in the hospital setting experienced more negative perceptions than those in other healthcare settings ($\chi 2$ (6, N = 207) = 20.260, p = .002).

No statistically significant differences were found in perceptions based on gender, race/ethnicity, or employment duration. The lack of significant differences in these categories could be attributed to the small sample sizes within certain demographic groups. These results highlight the substantial impact of workplace violence on healthcare workers' perceptions, particularly among nurses and those working in hospital environments. The findings underscore the need for targeted interventions and support mechanisms to address and mitigate the adverse effects of workplace violence in these settings.

Q9: How has experiencing workplace violence by a patient/family member affected your perception of the workplace?	**None**	**Somewhat Negatively**	**Negatively**	**Very Negative**
OVERALL	**25.1%**	**42.0%**	**23.7%**	**9.2%**
Gender (χ^2 (1, 6 = 207) = 10.385, p = .109)				
Female	26.0%	42.3%	22.4%	9.2%
Male	11.1%	33.3%	55.6%	0.0%
Race/Ethnicity (χ^2 (6, N = 207) = 6.755, p = .344)				
Caucasian	24.4%	39.8%	26.7%	9.1%
African American	28.6%	53.6%	7.1%	10.7%
Other	33.3%	66.7%	0.0%	0.0%
Job Description (χ^2 (6, N = 207) = 17.381, p = .008)				
RN/LPN	18.5%	43.8%	26.0%	11.6%
Physician/Advanced Provider	32.4%	47.1%	17.6%	2.9%
Other	51.9%	25.9%	18.5%	3.7%
Healthcare Area (χ^2 (6, N = 207) = 20.260, p = .002)				
Hospital	18.1%	38.6%	30.7%	12.6%
Clinic	40.0%	51.4%	5.7%	2.9%

Other	33.3%	44.4%	17.8%	4.4%
Employment Duration (χ^2 (9, N = 207) = 13.998, p = .122)				
Less than a year	23.8%	38.1%	28.6%	9.5%
1-5 years	16.0%	42.0%	29.6%	12.3%
5-10 years	26.8%	48.8%	12.2%	12.2%
Greater than 10 years	35.9%	39.1%	21.9%	3.1%

Table 1. *Chi-square analysis of question 9 by demographic variable.*

Are healthcare workers confident in their ability to respond to a violent situation based on facility protocols and guidelines?

Confidence in handling workplace violence is low among healthcare workers, particularly those in hospital settings. This indicates a need for improved training and clearer communication of available policies. To address research question two, survey question 11 was analyzed to assess healthcare workers' confidence in responding to workplace violence based on facility protocols and guidelines. The analysis revealed that only 30.4% of respondents reported being confident in their ability to handle such situations.

Further examination of the responses by demographic factors, using chi-square analysis, showed a significant difference in confidence levels based on the healthcare area ($\chi 2$ (4, N = 207) = 15.808, p = .003). Respondents working in hospitals reported the lowest levels of confidence. However, no statistically significant differences were found in confidence levels based on gender, race/ethnicity, job description, or employment duration. The absence of significant differences in these categories might be attributed to small sample sizes within certain demographic groups.

These findings underscore the need for improved training and clearer communication regarding facility protocols to enhance healthcare workers' confidence in handling workplace violence, particularly in hospital settings. Addressing these gaps is essential for ensuring a safer and more supportive work environment for healthcare professionals. Additionally, implementing regular assessments and feedback mechanisms can help continuously refine these protocols and training programs, ensuring they remain effective and responsive to the evolving challenges faced by healthcare workers.

Q11: How confident are you in the policies or trainings available for preventing, addressing, or resolving an incident regarding workplace violence by a patient/family member?	**Confident**	**Not Confident**	**I am unaware of policies or training available**
OVERALL	**30.4%**	**45.4%**	**30.4%**
Gender (χ^2 (4, N = 207) = 4.748, p = .314)			
Female	31.1%	43.9%	25.0%
Male	11.1%	77.8%	11.1%
Race/Ethnicity (χ^2 (4, N = 207) = 9.044, p = .060)			
Caucasian	27.8%	47.2%	25.0%
African American	50.0%	35.7%	14.3%
Other	0.0%	33.3%	66.7%
Job Description (χ^2 (4, N = 207) = 7.704, p = .103)			
RN/LPN	30.8%	47.9%	21.2%
Physician/Advanced Provider	20.6%	38.2%	41.2%
Other	40.7%	40.7%	18.5%
Healthcare Area (χ^2 (4, N = 207) = 15.808, p = .003)			
Hospital	28.3%	55.1%	16.5%
Clinic	34.3%	25.7%	40.0%
Other	33.3%	33.3%	33.3%
Employment Duration (χ^2 (6, N = 207) = 3.907, p = .689)			
Less than a year	28.6%	47.6%	23.8%
1-5 years	24.7%	45.7%	29.6%
5-10 years	31.7%	46.3%	22.0%
Greater than 10 years	37.5%	43.8%	18.8%

Table 2. *Chi-square analysis of question 11 by demographic variable.*

What effects has workplace violence had on healthcare workers?

Workplace violence significantly contributes to increased burnout among healthcare workers, particularly affecting RNs/LPNs and those in hospital settings. This highlights the critical need for interventions to support healthcare workers in managing stress and preventing burnout. Providing access to mental health resources, such as counseling and stress management programs, can be vital in mitigating the adverse effects of workplace violence. Additionally, fostering a culture of support and open communication within healthcare facilities can help in early identification and intervention for those at risk of burnout.

To answer research question three, the analysis focused on the change in burnout among healthcare workers (Questions 13 and 14), particularly in response to workplace violence. The survey revealed that 36.7% of respondents reported an increase in burnout after experiencing workplace violence. This issue is notably prevalent among RNs/LPNs and those working in hospital settings, highlighting the urgent need for targeted interventions to support healthcare workers in managing stress and preventing burnout.

Further investigation into the demographics of respondents and their experiences with burnout was conducted using chi-square analysis. Significant differences in burnout changes were observed based on job description ($\chi 2$ (4, N = 204) = 10.006, p = .040), with RN/LPN respondents more frequently reporting increased burnout compared to other roles. Additionally, there was a significant difference based on healthcare area ($\chi 2$ (4, N = 204) = 9.055, p = .060), with hospital workers experiencing higher burnout rates than those in other settings.

No statistically significant differences were found in burnout changes based on gender, race/ethnicity, or employment duration, which might be attributed to small sample sizes within certain demographic categories. These findings emphasize the critical need for implementing support systems and interventions to mitigate burnout among healthcare professionals, particularly those in high-risk roles and settings.

Calculated value: Change in burnout (Q14-Q13)	**Burnout decreased**	**Burnout remained the same**	**Burnout increased**
OVERALL	**5.3%**	**56.5%**	**36.7%**
Gender (χ^2 (4, N = 204) = 5.067, p = .280)			
Female	5.7%	58.0%	36.3%
Male	0.0%	33.3%	66.7%
Race/Ethnicity (χ^2 (4, N = 204) = 5.680, p = .224)			
Caucasian	4.6%	55.5%	39.9%
African American	10.7%	64.3%	25.0%
Other	0.0%	100.0%	0.0%
Job Description (χ^2 (4, N = 204) = 10.006, p = .040)			
RN/LPN	5.5%	51.0%	43.4%
Physician/Advanced Provider	3.0%	78.8%	18.2%
Other	7.7%	65.4%	26.9%
Healthcare Area (χ^2 (4, N = 204) = 9.055, p = .060)			
Hospital	4.7%	51.2%	44.1%
Clinic	3.0%	75.8%	21.2%
Other	9.1%	61.4%	29.5%
Employment Duration (χ^2 (6, N = 204) = 10.811, p = .094)			
Less than a year	0.0%	55.0%	45.0%
1-5 years	2.5%	50.6%	46.8%
5-10 years	7.3%	58.5%	34.1%
Greater than 10 years	9.4%	65.6%	25.0%

Table 3. *Chi-square analysis of change in burnout by demographic variable.*

The findings underscore the pervasive issue of workplace violence in healthcare settings and its substantial impact on healthcare workers' perceptions and burnout levels.

The research findings of this limited study indicates there is a clear need for enhanced policies, training, and support systems to address and mitigate these issues effectively.

Chapter V: IMPLICATIONS

Workplace violence among healthcare workers is an undermined and poorly scrutinized nodus affecting the prosperity of healthcare worldwide. Poor policies and protocols regarding workplace violence prevention and intervention lead to decreased healthcare workers' long-term satisfaction and performance and significantly affects patient care. This research study aimed to evaluate the perception, preparedness, and negative effects of workplace violence by surveying healthcare workers in Mississippi with questions that also evaluated workplace burnout as a consequence of the violence experienced. The researchers hypothesized that workers had little preparation, were unconfident in reaction to a violent threat, and experienced lasting effects of violence thus contributing to decreased job satisfaction, increased burnout, and inadequate patient care. This chapter will comprehensively discuss the outcomes of the results, limitations to the study, and final remarks to encourage further research and action against workplace violence.

Discussion of Findings

The study aimed to understand healthcare workers' perceptions of workplace violence, their confidence in responding to such incidents, and the impacts on their well-being. The researchers did not meet their goal of 400 participants. The analysis of survey responses from 207 healthcare workers revealed that a significant majority had experienced both physical (72.0%) and verbal (89.9%) violence. These incidents had a notably negative impact on their perception of the workplace, with 74.9% reporting some

level of negative impact. Particularly, RN/LPNs and those working in hospitals reported more negative perceptions compared to their peers in other roles and settings.

Regarding confidence in handling violent situations, only 30.4% of respondents felt confident in the existing policies and training. This low confidence was more pronounced among hospital workers, with no significant difference observed across other demographic factors. This suggests a critical gap in the effectiveness and perceived adequacy of the current training programs and protocols. The effects of workplace violence extended to increased burnout among healthcare workers. Before experiencing violence, 59.9% of healthcare workers reported feeling some level of burnout. After an incident of violence, this number increased to 84.9%, with 36.7% of respondents noting a significant rise in their burnout levels. RN/LPNs and hospital workers again reported higher increases in burnout, indicating that these groups are particularly vulnerable to the adverse effects of workplace violence.

Chi-square analyses highlighted significant differences in perceptions and burnout changes based on job roles and healthcare areas but not on gender, race/ethnicity, or employment duration. This points to the need for targeted interventions for specific roles and settings rather than broad, uniform approaches. Addressing the unique stressors and challenges faced by different healthcare professionals can enhance the overall well-being and job satisfaction of the workforce. Additionally, continuous monitoring and assessment of these interventions can ensure they remain effective and adapt to the evolving needs of healthcare workers.

In conclusion, this study reveals the widespread nature and profound impact of workplace violence on healthcare workers, particularly those in high-risk roles and

settings like hospitals. The findings highlight critical gaps in existing training and policies, as well as the substantial increase in burnout among affected staff. To foster a safer and more supportive work environment, healthcare facilities must implement comprehensive, effective violence prevention and response strategies, particularly targeting vulnerable groups such as RN/LPNs and hospital employees. Addressing these issues is essential not only for the well-being of healthcare workers but also for maintaining a stable and efficient healthcare system.

Limitations

The limitations of the study consisted of time constraints, geographic size, and fearful participation due to topic sensitivity. The duration of data gathering consisted of three weeks which isolated the pool of participants primarily to full-time healthcare workers. However, due to social media promotion, this limitation was not considered a heavy burden to the study outcomes. The study's target geographic location of Mississippi may have restricted the variations in perceptions due to the similar culture of individuals residing in one state. Multi-state or national expansion would have positive impact on the number of participants as well as the diversity in perceptions and cultures. Healthcare workers' vulnerability of responses and reservation to disclose perceptions of workplace violence may have hindered full participation, especially in those who are no longer affiliated with the same organizations or harness resentment toward their experience.

Implications

The data collected aimed to understand healthcare workers' perceptions of workplace violence and their confidence in responding to such incidents. The impact on

well-being was congruent with the assumed hypothesis that workers had preparation, were unconfident in reaction to a violent threat, and experienced lasting effects such as decreased job satisfaction and increased burnout. The statistical significance of an increase in reported burnout after experiencing workplace violence demands an action plan from facility administrators to preserve healthcare worker retention and wellbeing.

The COR theory, utilized as theoretical framework for survey questions, was appropriate and ultimately foreshadowed the anticipated outcomes that workplace violence caused stress and a loss of resources for healthcare workers.

Summary of Findings

The 16-question survey was answered completely by 207 individuals. Data from 207 usable survey responses revealed that a significant majority of respondents were female (94.7%), Caucasian (85.0%), and predominantly worked as RNs/LPNs (70.5%) in a hospital setting (61.4%). The findings indicated that 72.0% of respondents experienced physical violence and 89.9% encountered verbal violence in the workplace, with 74.9% reporting a negative impact on their perception of the workplace. Confidence in existing policies and training was low, with only 30.4% of participants feeling confident in their facility's polices and training, and only 42.5% believing that these measures prepared them adequately. Burnout rates were also notable, with 36.7% of respondents reporting an increase in burnout after experiencing workplace violence. Detailed chi-square analyses showed significant differences in perceptions and burnout changes based on job description and healthcare area, with hospital workers and RNs/LPNs reporting more negative experiences and higher burnout rates. These findings highlight the pervasive

issue of workplace violence in healthcare settings and the need for more effective policies and support systems to protect healthcare workers and reduce burnout.

Overall, the findings underscored a pressing need for more effective training and policies tailored to the needs of high-risk groups such as RN/LPNs and hospital workers. The significant impact on mental health and job satisfaction necessitates immediate action to mitigate workplace violence and support affected staff adequately. By prioritizing the development of comprehensive support systems and preventative measures, healthcare institutions can create a safer and more resilient work environment. Collaboration between management, staff, and policymakers will be crucial in implementing these changes effectively.

Recommendations

Future research should focus on developing and assessing the effectiveness of comprehensive training programs designed to better prepare healthcare workers for dealing with workplace violence. Additionally, further research should investigate the specific factors contributing to the lack of confidence among healthcare workers in existing policies and training, particularly in hospital settings. Exploring the role of leadership and administrative support in mitigating workplace violence and its impact on staff could provide valuable insights. Research should also consider longitudinal studies to understand the long-term effects of workplace violence on burnout and mental health among healthcare workers. It would be beneficial to include a more diverse sample to explore potential differences across various demographic groups. Implementing mixed-methods approaches could enhance the understanding of qualitative experiences alongside quantitative data. Lastly, investigating the efficacy of different intervention

strategies, including debriefing and counseling post-incident, could provide evidence-based recommendations for improving employee support and safety.

Conclusions

In conclusion, this study revealed the widespread nature and profound impact of workplace violence on healthcare workers, particularly those in high-risk roles and settings such as hospitals. The findings highlighted critical gaps in existing training and policies, as well as the substantial increase in burnout rates among affected staff. To foster a safer and more supportive work environment, healthcare facilities must implement comprehensive, effective violence prevention and response strategies, particularly targeting vulnerable groups such as RN/LPNs and hospital employees. Addressing these issues is essential not only for the well-being of healthcare workers but also for maintaining a stable and efficient healthcare system.

Appendix A: IRB Exempt Form

DATE: February 23, 2024

TO: Dr. Lindsay Kemp

FROM: Dr. Candy Grant, IRB Chair *C.G.*

CC: Anna Decker, Rachael Flynn, Brandy Montgomery, Tyesha Pringle

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Research Title: Healthcare Workers' Perception of Workplace Violence

The Mississippi University for Women IRB Committee has determined that your research is exempt under 45 CFR 46.101 (b)(4). The research obtains data using a survey and the identity of the human subjects cannot be readily ascertained.

If any changes are made to the study, the Committee must be notified. If the project is still running twelve months after the date of this memo, please be advised that we will need an update for our files.

Best wishes with your research!

Appendix B: Consent Letter

Dear Potential Participants,

I hope this letter finds you well. We are graduate students from Mississippi University for Women. We invite you and your colleagues to participate in an important research study focusing on workplace violence among healthcare workers in Mississippi.

This survey is for healthcare workers in the state of Mississippi.

Workplace violence is a major problem that affects healthcare professionals in different work environments such as hospitals, clinics, and long-term care facilities. The aim of our study is to gain a better understanding of the occurrence, characteristics, and consequences of workplace violence incidents that healthcare workers face.

Participation in the survey is entirely voluntary. All responses will be kept confidential and anonymized to ensure privacy and confidentiality. Your participation in this survey will serve as consent. The survey will take approximately 5-10 minutes to complete, and your input will provide valuable insight.

To participate in the survey, please click on the following link: https://muw.qualtrics.com/jfe/form/SV_4Sg9Th4x6wHMhbU.

Or you can scan the QR code below:

We greatly appreciate your time and cooperation in this research endeavor.

Thank you for your consideration, and we look forward to your participation.

-Anna Decker, Rachael Flynn, Brandy Montgomery, Tyesha Pringle

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Mississippi University for Women
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Appendix C: Research Questions/Questionnaires

1. **What is your gender?**
   Female
   Male
   Other

2. **What is your race/ethnicity?**
   Caucasian
   African American
   Hispanic
   Other

3. **What is your job description?**
   Medical Technician, Nurse Technician, Student
   RN/LPN
   Physician/Advanced Practice Provider
   Housekeeping
   Dietary
   Other _____

4. **In what area of healthcare are you primarily employed?**
   Hospital
   Clinic

5. **How long have you been employed at your primary hospital/clinic?**
   Less than a year
   1-5 years
   5-10 years
   Greater than 10 years

6. **Have you experienced *physical* violence (*hitting/kicking/pushing/scratching/spitting*) from a patient/family member in the workplace?**
   Experienced
   Not Experienced

7. **Have you experienced *verbal* violence (*yelling/screaming/using profanity*) from a patient/family member in the workplace?**
   Experienced
   Not Experienced

8. **How many times have you encountered workplace violence by a patient/family member in the past 12 months?**
   Never
   Weekly

Monthly

9. **How has experiencing workplace violence by a patient/family member affected your perception of the workplace?**
   None
   Somewhat negatively
   Negatively
   Very negative

10. **Are there policies or trainings available regarding patient/family member perpetrated workplace violence that you are aware of?**
    Yes
    No

11. **How confident are you in the policies or trainings available for preventing, addressing, or resolving an incident regarding workplace violence by a patient/family member?**
    Confident
    Not Confident
    I am unaware of policies or training available

12. **If you have experienced workplace violence from a patient/family member, how did your preparedness impact your perception of the workplace?**
    Positive impact. Policies/Trainings available prepared me to effectively handle the situation.
    Negative impact. Policies/Trainings available/not available did not prepare me to effectively handle the situation.

13. **Prior to experiencing workplace violence by a patient/family member, what was your perception of burnout in the workplace?**
    No Burnout
    Some Burnout
    Heavy Burnout

14. **After experiencing workplace violence by a patient/family member, what was your perception of burnout in the workplace?**
    No Burnout
    Some Burnout
    Heavy Burnout

15. **If you experienced burnout in the workplace after experiencing workplace violence by a patient/family member, did you receive education/training/debriefing after the event?**
    Yes. I did receive education/training/debriefing after the event.
    No. I did not receive education/training/debriefing after the event.
    No. I did not report the event.

16. **If you did/did not receive education, training, or debriefing after a workplace violence by patient/family member event, how did such impact your perception of burnout?**
    Positive effect. Education/training/debriefing decreased my perception of burnout
    No effect. Education/training/debriefing did not affect my perception of burnout
    Negative effect. Education/training/debriefing increased my perception of burnout

If you have experienced workplace violence and would like to share your experience or leave comments or concerns, please feel free to do so below. Thank you for participating in this survey!

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