ABSTRACT

Home health care (HHC) is one of the fastest growing sectors in health care with an expected 66% increase in growth and projected significant rise in HHC services. This results in an increase in demand of 109% for home health care registered nurses by 2020. Exposure to unsafe situations and incidents of violence have resulted in HHC nursing being the second most dangerous occupation with approximately 500,000 nurses becoming the victims of violent crimes in the workplace every year. Currently, there are no Federal mandates that require worker training to recognize or prevent workplace violence in HHC. This scholarly project is designed to examine the effect of workplace violence prevention (WVP) education and training program on HHC providers’ perception regarding assessing and preventing violence in the HHC environment. This quasi-experimental study used an investigator-created 31-question online survey comprised of six sections, which was validated by HHC industry experts. A convenience sample of 150 HHC providers from one HHC agency was invited to participate in this study. Inclusion criteria were: a) included: ≥ 18 years of age; b) currently employed as a HHC provider. Those who did not meet these criteria were excluded. HHC providers recruited were N=98 for the pre-test and N=80 for the post-test. More than one third (35.7%) of HHC providers reported experiencing workplace violence prior to the WVP training and 47.5% post-training. Unmatched
participant scores comparing topics presented in WVP training previous to this study’s training more than doubled the percentage who recognize and handle physically aggressive behavior (44.4% to 97.5%), verbally aggressive behavior (11.1% to 96.3%), self-defense (16.7 to 37.5%) and techniques for verbally deescalating (27.8% to 95%). HHC agencies have an obligation to provide employees with the tools necessary to identify unsafe work environments and provide education on handling situations that have the potential to escalate into violent encounters.
Dedication

I want to dedicate this scholarly project to Chance, Gage, and Grace Vaughn for without you all I am lost. You inspire me to become more than I am, and to continuously reach for the stars. You are everything to me.

To my amazing parents and siblings for believing in me and always supporting me in my endeavors.

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Chapter I – Introduction

Currently, health care accounts for more than 13.5 million jobs and is one of the largest industries in the United States (US). Home health care (HHC) is one of the fastest growing health care sectors representing more than 5.8% of US health care employment, and has a projected 66% increase in growth over the next 10 years (Gershon et al., 2008; Markkanen et al., 2007). This increased growth has resulted in a significant rise in HHC services and providers. There will be an estimated increased demand of 109% for HHC registered nurses specifically by the year 2020 (Canton et al., 2009). The initial growth in US HHC occurred following enactment of the Medicare program in 1965, which helped provide individuals with chronic disease, disabilities, or terminal illnesses the option to remain in their homes with skilled medical care provided (Lang, Edwards, & Fleiszer, 2008). In recent years, studies have attributed the intensified growth of the HHC industry to several factors: increasing costs of institutional healthcare; change of patient demographics; aging population; and, the increased prevalence of managed care organizations (Fazzone, Barloon, McConnel & Chitty, 2000; Markkanen et al., 2007).

In 2009, it was reported that exposure to unsafe situations and incidents of violence in the workplace resulted in home health nursing being the second most dangerous occupation in the US, following the first most dangerous occupation, law enforcement professionals (US Crime Statistics, 2010). The US Department of Justice estimates that approximately 500,000 nurses are the victims of workplace violence every year (Via Browning, Culver Clark, & Glick, 2013). However, the full extent of the incidents of violence against healthcare workers remains unknown because health care workers have a tendency to either consider it part of the job or feel...
peer and administrative pressure to tolerate verbal abuse and harassment (Fazzone et al., 2000; Mathiews & Salmond, 2013; McPhaul & Lipscomb, 2004; Zolnererek, 2015).

There are no Federally mandated requirements for HHC agencies to provide employees with training to recognize or prevent violence in the HHC workplace environment (Occupational Safety and Health Administration [OSHA] 2004; National Institute for Occupational Safety and Health [NIOSH], 2015; Lang et al., 2008). California is the only state that provides minimum training standards guidelines for HHC organizations and requires that employers have a comprehensive workplace violence prevention program; however, only 55% of 40 HHC agencies in California had recognized programs implemented and many of those were neither reviewed nor revised on a regular basis (Gross et al., 2013). Additionally, only 57% of the 40 agencies in California offered workplace violence prevention training to their employees and this training was provided inconsistently (Gross et al., 2013).

In Virginia, recent legislation HB1921/SB973, which has passed both the State Senate and House of Representatives, guarantees that all health care providers are equally protected, in any hospital setting or in other facilities that are providing emergency care. Until this legislation, only those health care professionals who worked in the Emergency Department were protected. The bill also requires the state Department of Health to work with professional associations and advocacy groups to formulate guidelines concerning the publication of information of legal consequences for battery on a healthcare provider and for the education and training of healthcare providers in violence prevention programs ("Protecting Health Professionals", 2017).

In the other states where training has not been mandated, a general disconnect exists between guidelines and policy development. Several agencies reported that they lacked policies,
procedures, and written standards for management of workplace violence and did not provide safety training for their staff. Other agencies reported that although they had policies in place to protect employees, only 15% of those agencies actually provided training (Fazzone et al., 2000; Gross et al., 2013; Mathews & Salmond, 2013). Because of the inconsistencies in agencies policies and procedures, providers were often unnecessarily exposed to unsafe environments because they not only received inadequate information on patient conditions, but also were provided minimal training on risk assessment or risk reduction strategies (Fazzone et al., 2000).

Sylvester & Reisner (2002) said it best: “Serving the community is the essence of home care. Being a victim to the environment is not.” (p. 71).

**Description of Problem**

The Occupational Safety and Health Administration (OSHA) defines workplace violence as any violent act that is directed towards a worker by any individual (2004). Violence could be perpetrated as employee-to-employee, patient-to-employee, or stranger-to-employee. These acts include verbal abuse, sexual advances, the threat of physical assault, and physical assault directed towards workers (OSHA, 2004). Exposure to violence in the HHC environment can be a dangerous and challenging occupational hazard for the health care professional. A health care professional or healthcare provider is “an individual who provides preventive, curative, promotional, or rehabilitative health care services in a systematic way to people, families or communities” (Berman, Snyder, & Frandson, 2016, pg. 118). For this paper, all future references to the term “provider” will encompass advanced registered nurse practitioners (ARNPs), registered nurses (RNs), licensed practical nurses (LPNs), physical therapists (PTs), physical therapy assistants (PTAs), occupational therapists (OTs), certified occupational therapy
assistants (COTAs), speech language pathologists (SLPs), medical social workers (MSWs), and home health aides (HHAs).

The absence of workplace violence prevention (WVP) programs, organizational protective policies, and lack of standardized industry regulations further contributes to workplace violence. These occupational hazards may be related to a healthcare culture that has been unwilling to acknowledge the idea that healthcare providers are at risk for workplace violence and the assumption that patient-centered violence is considered part of the job (McPhaul & Lipscomb, 2004).

**Significance of Problem**

Violence is a significant safety concern among HHC providers, especially because the majority of HHC providers are female (95%) (Canton et al., 2009; Markkanen et al., 2007). The influence that workplace violence can have in HHC is widespread and pervasive, with its damaging effects felt frequently in quality of patient care delivered and on staff morale. The damaging effects on providers include, but are not limited to: anxiety; fear; depression; decreased work performance; decreased job satisfaction; and a high employee turnover rate (Canton et al., 2009; Fazzone et al., 2000; Via Browning et al., 2013). These effects have been linked to HHC providers compromising patient care by visits being delayed or shortened, frequency of visits being reduced to minimize exposure, and providers refusing to conduct visits in communities perceived to be dangerous to their safety and well-being (Canton et al., 2009; Fazzone et al., 2000).

The HHC industry is especially susceptible to violence because the workplace is located within the confines of the patient’s home and not within a controlled institutionalized structure with security systems in place (Sylvester & Reisener, 2002). In an unpredictable and
unprotected HHC environment, the provider can face a variety of violent situations with patients, caregivers, or family members that may range from verbal abuse, threats of harm, physical assault, and homicide (NIOSH, 2015). HHC providers are placed in environments where they typically work unaccompanied without the advantage of customary safety measures that are common in the acute care setting, thus, placing them at greater risk to experience violence (Canton et al., 2009). HHC providers also face unique risk factors in the home that may increase the propensity for violence including presence of weapons, illegal use of drugs, and domestic violence. In addition, HHC providers are also at risk for violence from nefarious individuals in the surrounding neighborhood whose actions could include burglary, vandalism, and car theft (Canton et al., 2009; Gross et al., 2013, ¶ 2).

Canton et al. (2009) stated that “self-reported rates of violence in HHC have been documented with a prevalence ranging from 3% to 55%” (p. 365). However, the actual number of HHC providers who have been affected by workplace violence as the result of providing patient care is not actually known because nurses tend to tolerate verbal abuse and violence and do not formally report it (Mathews & Salmond, 2013).

HHC organizations have an obligation to focus on improving their practices regarding safety. In 2012, the Bureau of Labor and Statistics reported that approximately 66% of acts of violence occurred in the health care and social assistance industry workplace (2012). Health care providers have been assaulted, robbed, raped, and even murdered while performing their jobs.

Meeting the needs of the patients in a HHC organization, while maintaining the safety of the providers, can be a difficult balancing act. Provider concerns regarding the safety of a patient’s home are often overshadowed by the organization’s decision to continue to provide care despite concerns about employee safety. The problem is the lack of formal WVP education and
training provided to the HHC providers who are potentially at risk while providing care in patients’ homes.

It is crucial that HHC leaders recognize the risks that HHC providers may encounter on a daily basis and take action to keep them safe and protect them from harm. Providing HHC providers with the necessary tools through education and training to assess and circumvent workplace violence should be a fundamental aspect of the organization’s orientation and training program.

**Ethical Impact**

The field of ethics studies the fundamental principles of what is right and what is wrong ("Medical Ethics", 2017). There is scarcely an area in health care that does not have an ethical aspect associated with it and HHC is no exception. In the field of HHC, beneficence, nonmaleficence, and justice all play equally important roles in the provision of health care. Beneficence requires that providers of health care not only develop but maintain skills and knowledge by constantly updating their training, always considering the individual circumstances of patients, and consistently striving for the greatest benefit of the patient. Nonmaleficence requires that providers a do not prescribe or perform procedures that could harm the patient involved or other persons in society. Justice requires that the risks and rewards of any new or experimental treatments are equally distributed among all groups in society. Justice also requires that measures support the essence of current laws and are impartial to all persons involved ("Medical Ethics”, 2017).

In HHC, ethical issues arise when providers and administrators have to make decisions about whether or not to provide care to patients in areas or home environments that are
considered unsafe (Fazzone et al, 2000). HHC administrators must often decide if they provide care to a patient or is the safety risk to providers too high.

Beneficence is an act that is performed for the benefit of others, and, thus, beneficent actions can be taken to help avert or eliminate harms or to purely improve the circumstances of others (www.dictionary.com, n.d.). HHC providers are often asked by the organization’s management team to place the needs of the patients before their own. Providers often place themselves into situations and environments on a daily basis based on the premise that patients’ health care needs come first. In fact, HHC providers are often asked to return to homes where unsafe environments have been identified. This type of action on the part of HHS management team does not support beneficence for the HHC provider. Rather, the HHS management team needs to consider the benefits of both patient and provider in this type of situation.

As a health care provider, nonmaleficence requires that the provider has an obligation not to harm others. Challenges to promoting nonmaleficence include limiting patient-HHC provider visit times, as well as, decreasing number of visits related to care being delivered in environments that are considered unsafe. The reduction of the visits and amount of time spent with the patient can negatively affect patient outcomes.

Justice requires the HHC providers to provide patients with the health care services to which they are entitled. Specifically, inherent within the provision of health care there is a fundamental responsibility to treat all people equally, fairly, and impartially. For health care providers, the threat of violence and the fear for one’s own welfare can have a significant influence on their ability to deliver safe and effective care. Providers have been challenged to provide care to patients in environments where the crime statistics demonstrate a higher risk for violence, in environments after dark, and in neighborhoods where groups of individuals are
commonly seen “hanging around” (Fazzone et al., 2004, p.44). From the patient’s perspective, living in environments or neighborhoods that are deemed unsafe by HHC providers can reduce their access to basic healthcare. These challenges lead to challenging questions including when is the safest time to visit a patient and should a patient receive a different level of care because of where they live?

**Legal Impact**

Exposure to violence in the HHC sector can lead to numerous legal issues. For example, HHC providers may witness illegal activities when providing care in the home environment. These activities may include patients or family members engaging in the use or sale of illegal substances. Domestic violence and elder abuse or neglect may be discovered. Providers can also become witnesses to criminal acts requiring their providing information, and as needed, testimony against patients and/or family members.

Providers have verbalized concerns to administration in the HHC sector regarding their presence in a home where the patient or family is engaging in the use of marijuana and the impact that providing care for these patients could have on their random drug test results. Additionally, the HHC provider must know what legal and ethical obligations they have regarding reporting that a patient is selling their pain medications to pay their rent.

**Financial Impact**

The financial impact on patients, HHC providers, and payer sources can be immense. When HHC services are limited by the threat of violence, the patient must find an alternative source of care. Thus, patients may be forced to relinquish the option of receiving health care at home, thereby requiring them to secure services at another location that frequently requires a co-payment or to meet insurance deductibles. Often patients are required to be re-admitted to the
hospital, admitted to skilled nursing facilities, or go to outpatient service centers to receive care. Costs differ per provider and point of care. The cost per day for care received from a HHC nurse in the home is approximately $109 versus $3,383 for care received from a nurse during a hospital stay (Gershon et al., 2008). This impacts the HHC providers who may lose a revenue source because they can only bill for services that they provide. Eventually, the primary financial risk falls upon the insurance carrier as costly alternatives such as outpatient services and hospitalizations are frequently the resources utilized.

In 2004, OSHA published *Guidelines for the Prevention of Workplace Violence* in an attempt to increase the safety, security, and welfare of health care providers and social service workers. This included a nine-point framework for developing a comprehensive workplace education and training program (OSHA 2004; Vladutiu, Casteel, Nocera, Harrison, & Peek-Asa, 2016). There is a great diversity of workplace violence training provided across the healthcare industry. For example, for health care professionals working in the emergency department anywhere from 12 to 40 hours of workplace violence training is required compared to departments that require no training at all. In fact, currently, no national guidelines exist which require the workplace violence training of HHC providers and no national standards currently exist to regulate the environment in which HHC services are rendered (Lang et al., 2008).

Many HHC organizations do not exclude any areas of care, even areas in which crime rates are significantly higher than surrounding areas. In many HHC organizations concerns from both providers and administration have arisen regarding the safety and security of providers in the HHC setting. At the survey site for this project, reports have been received from providers who have encountered situations where they feel unsafe with patients, family members, and environments. These reports highlight exposure to unsafe home environments, increased
potential for verbal and physical abuse, and questionable workplace safety practices. The HHC industry brings risks unique to the workplace environment when compared to other health-related fields. Since the HHC workers work environment is that of the patient’s home, the environment is highly varied and less controlled than that of a traditional health care facility (Gross et al. 2013).

Although HHC organizations may be cognizant of the hazards faced by their providers in the various home environments, a comprehensive approach to provide and support workplace violence prevention policies may not be taken. Although many HHC organizations provide their employees with basic policies regarding safety and security, many times these policies are not consistently utilized and the implementation may be left up to the discretion of the providers (McPhaul et al., 2010). Currently, the organization where this researcher is employed has no formal workplace violence prevention policies and does not provide educational training to their staff to handle situations that are considered at risk or potentially violent. The aim of this scholarly project is to examine the effect of an education and training workplace violence prevention (WVP) program on HHC providers’ perception to assess and prevent violence in the HHC environment.

**PICOT Question**

The PICOT format is a “process in which clinical questions are phrased in a manner that yields the most relevant information from a search” (Melnyk & Fineout-Overholt, 2015, p. 609). This format, which identifies a population (P), an intervention (I), a comparison (C), an outcome (O), and a time frame (T), will be utilized as the basis for this study. Research demonstrates that violence occurs in all healthcare settings, but HHC providers face a unique set of risks and challenges. HHC providers are often placed in environments where they typically work
unaccompanied, devoid of the advantage of customary safety measures that are common in the acute-care setting, placing them at greater risk to experience violence. The influence that workplace violence can have in home health care is widespread and pervasive, with its effects felt frequently in patient care.

In order to address the effect of a WVP training program on HHC providers, the following clinical question was developed: In HHC providers, how does an educational and training program for WVP (compared to no education or training on WVP) affect HHC providers’ perceived ability to assess risk and prevent WPV during home health visits? The population was HHC providers. The intervention was a WPV prevention training program. The comparison was no WVP prevention program. The outcome was how the violence prevention training has affected the perception of HHC providers’ knowledge of violence prevention for their work environment. The timeframe was four weeks from initial training to final assessment.

**Frameworks to Guide Project**

Two frameworks were utilized in the development of this scholarly project, the first framework is the Stevens Star Model of Knowledge Transformation © (Appendix A) and was used as a guide with the PICOT question. The second framework, the Center for Disease Control’s Public Health Approach to Violence Prevention Model (Appendix B) is used as a guide for the intervention (workplace violence prevention education and training).

**The Steven’s Star Model**

The Stevens Star Model of Knowledge Transformation © (Appendix A) is based on “understanding the cycles, nature, and characteristics of knowledge” (Stevens, 2012, pg. 88). The Steven’s Star Model “places nursing’s previous scientific work within the context of evidence-based practice (EBP), serves as an organizer for examining and applying EBP, and mainstreams
nursing into the formal network of EBP” (Stevens, 2012, pg. 88). Additionally, it provides an outline for scientifically applying the EBP practice processes into operation.

The five point Star model explains the five major phases of knowledge transformation: discovery research, evidence summary, and translation to guidelines, practice integration, and process or outcome evaluation (Stevens, 2012).

**Star Point 1: Discovery Research**

During the discovery phase, knowledge is revealed through scientific inquiry and traditional research methodologies. This is generally the primary study, which builds the body of research about the clinical actions to be taken (Stevens, 2012).

**Star Point 2: Evidence Summary**

The Model’s “the knowledge generating phase”, is where the evidence summary is developed, and it is this extensive evidence summary that differentiates EBP from the former standard of research application (Stevens, 2012). During the evidence summary, the body of knowledge gained during the discovery phase is synthesized and summarized. The literature consistently identified that the HHC industry faced concerns regarding workplace violence, lack of reporting, inconsistent standards and training of staff, and the need for workplace violence prevention programs.

**Star Point 3: Translation to Guidelines**

The aim of the translation phase of the model is to provide a suitable and relevant set of summarized evidence, which is presented to clinicians in a format that allows them to account for time, cost, and care standards. Translation typically results in the development of clinical practice guidelines (CPGs), which assists in providing knowledgeable clinical decisions for the clinician, patient, and organization. CPGs which are evidence based clearly articulate the
relationship between the clinical recommendation and the strength of the evidence (Stevens, 2012).

The basis of the WVP education and training program was be the Nonviolent Crisis Intervention® (Crisis Prevention Institute website, n.d.). Training was provided through Crisis Prevention Institute (CPI) instructors. The CPI program has been used in institutionalized settings effectively for more than 35 years. This education and training program formed the foundation of the EBP intervention program. The program includes needed information to help define what types of violence can be encountered, what are threatening behaviors, identifying risk factors for these behaviors, and provides strategies on how to respond to threatening situations (Crisis Prevention Institute, 2016). The implementation of a comprehensive WVP program will provide HHC providers with the information and procedures necessary to effectively assess risk and circumvent violence. The challenge is in applying and appraising these policies and procedures to make certain that they are providing the intended protection for both staff and patients.

**Star Point 4: Practice Integration**

Practice integration occurs while changing the clinician and the organizational practices. It is probably the most familiar stage of the EBP process. It is during this stage that the factors that negatively and positively affect implementation and integration are identified on an individual and organizational basis. This is an integral part of the process, because without identifying possible barriers, integration and ultimately change could be affected (Stevens, 2012). The CPI non-violent intervention program is the basis of the WVP program at the survey site.
**Star Point 5: Process, Outcome Evaluation**

The final stage is evaluation. In EBP, numerous outcomes are measured and evaluated and the effect of the practice is identified by assessing patient health outcomes, provider and patient satisfaction, efficiency, efficacy, economic analysis, and the impact on health status (Stevens, 2012). The inclusion of an anonymous survey given prior to the WVP training program and again 2 weeks after successful completion of the course will help to evaluate the impact that the WVP training program has on the providers’ perception of their ability to assess and circumvent workplace violence. Future implementation of the education and training for the WVP program will be based on the evaluation of the outcomes from this intervention.

**The Public Health Approach to Violence Prevention Model**

The Public Health Approach to Violence Prevention Model, see appendix B, provides the theoretical framework to effectively establish the elements needed to build an effective WVP program. The Centers for Disease Control (CDC) currently utilizes this four-step approach to identify health problems, including violence, which affect populations to ask and answer the questions that are relevant to the issue. The four steps are as follows: define and monitor the problem; identify risks and protective factors; develop and test prevention strategies; and assure widespread adoption ("Public Health Approach," 2015).

**Step 1: Define and Monitor the Problem**

In the first step the problem is identified. The problem for this project was the lack of formal WVP education and training provided to the HHC providers who are potentially at risk while providing care in patients’ homes. In defining and monitoring the problem, data was collected which identified the types of violence that HHC providers encountered as well as their effects on employee safety, morale, and patient care. Some of the guiding questions focused on
the scope of the problem, where the problem is occurring, those parties affected by the problem, and how the problem affects the delivery of care ("Public Health Approach," 2015). On-going monitoring and evaluation will continue through the HHC agency to identify any additional needs for training or modification of the initial WVP training program.

**Step 2: Identify Risk and Protective Factors**

In the second step the reasons why violence is encountered in one home and not another will be examined. While identifying risk and protective factors it will be important to understand the elements that either place the HHC provider at risk for violence or protect them from violence. This helped to identify the focal points of the program and where prevention efforts should be focused. Some of the guiding questions focused on ascertaining the risk factors for HHC providers that increase the possibility of encountering workplace violence. Additionally, questions will also be asked of providers in the WVP survey at the beginning of the educational and training program to determine what providers feel are the protective factors currently in place that help to protect HHC providers from violence ("Public Health Approach," 2015).

**Step 3: Develop and Test Prevention Strategies**

During the third step prevention strategies will be developed and tested. An existing EBP program for violence prevention was identified and explored for its applicability towards implementation in the home environment. The Crisis Prevention Institute provides a non-violent approach to assessing and preventing workplace violence.

**Step 4: Assure Widespread Adoption**

If the results of the identified WVP education and training program are effective the program will be executed across the organization and all employees at the agency will be trained, even for those whom are not clinical, to assure widespread dissemination and implementation.
Continuing compliance will be accomplished through the application of new policies requiring that the WPV training program be completed at the time of hire for all employees and annually thereafter.

**Definition of Terms**

For the purposes of this study the following definitions and key terms will be utilized.

**Health Care Providers:** “A health professional or healthcare provider is an individual who provides preventive, curative, promotional or rehabilitative health care services in a systematic way to people, families or communities” (Berman et al., 2016, p. 136). The term “provider” will encompass advanced registered nurse practitioners (ARNPs), registered nurses (RNs), licensed practical nurses (LPNs), physical therapists (PTs), physical therapy assistants (PTAs), occupational therapists (OTs), certified occupational therapy assistants (COTAs), speech language pathologists (SLPs), medical social workers (MSWs), and home health aides (HHAs).

**Home Health:** Skilled care provided in the home environment by physicians, nurses, therapists, social workers, and ancillary staff.

**Occupational Safety:** concerned with the safety, health, and welfare of people engaged in work or employment (OSHA, 2004).

**Occupational Safety and Health Administration (OSHA):** the main Federal agency charged with the enforcement of safety and health legislation (OSHA, 2004).

**Physical assaults:** attacks including slapping, beating, rape, homicide, and the use of weapons or firearms (OSHA, 2004).

**Threats:** expressions of intent to cause harm (verbal, body language, written) (OSHA, 2004).

**Workplace Violence:** any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal
abuse to physical assaults and even homicide and can occur employee to employee, patient/family member to employee, or stranger to employee violence (OSHA, 2004; NIOSH, 2015).

**Workplace Violence Prevention Program:** a program developed to create clear policies of zero tolerance for workplace violence in order to effectively protect workers (OSHA, 2004).

**Summary**

In summary, this chapter defined and discussed the significance of the problem of workplace violence in HHC. Ethical, legal, and financial impacts were identified and discussed. A PICOT question was formed and frameworks to guide the scholarly project were identified. Industry specific terms were also identified and defined.
Chapter II - Review of the Literature

This purpose of this chapter is to address the processes involved in the review of the literature for the scholarly project. It will detail the search criteria and the databases accessed as well as the synthesis of the information found in relevant articles. Any similarities or themes found throughout the literature are identified and discussed in detail.

Introduction to Search Criteria

An electronic search was conducted of the Medical Literature Analysis and Retrieval System Online (PubMed MEDLINE), the Excerpta Medica Database (EMBASE) and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases. There was a minimal amount of research available within the past five years, thus, the criteria for inclusion were expanded to include published articles from June 2000 – June 2016. The following search terms utilized were: home care, home health care, nurses, occupational safety, physical assaults, threats, workplace violence, and violence prevention programs. The search was limited to the English-language and was supplemented with a manual search of all reference lists of the primary and secondary sources.

The inclusion criteria were defined to include home health care providers (e.g., nurses, home health aides, medical social workers), threats (e.g., verbal, body language, written), physical assaults (e.g., hitting, beating, rape, homicide) workplace violence (e.g., physical violence, harassment, intimidation, bullying), and violence prevention programs. Included publications were required to report on violence, victims, health care or social services programs. Studies were excluded if they if they were non-English, were published prior to June 2000 and did not address safety or violence in the home health care setting.
A search was conducted in MEDLINE PubMed using the following terms: home care, home health care, nurses, occupational safety, physical assaults, threats, workplace violence, and violence prevention programs resulting in 844,474 articles. Using the same criteria as above, a search was conducted incorporating the use of the Boolean operator AND as a limiter, which resulted in 15 articles. These articles included cohort studies and case reports.

Using EMBASE a search was conducted using the same terms resulting in 344,122 articles. Using the same criteria as above, a search was conducted incorporating the use of the Boolean operator AND as a limiter which resulted in seven articles being found. These articles included cohort studies, case reports, and a systematic review.

Using CINAHL, and the same terms resulted in 513,039 articles. The same search process was conducted using the Boolean operator AND as a limiter, which resulted in 18 articles being found. These articles included qualitative research, cohort studies, retrospective cohort studies, and case reports.

A manual search was completed of the reference lists from the primary and secondary articles which resulted in three articles being found.

Each study was appraised individually for its quality and level of evidence and then as a body of evidence utilizing the LEGEND (Appendix C).

**Critique and Synthesis of Previous Evidence**

From 43 studies retrieved and reviewed, 10 primary sources and one secondary source, a meta-synthesis systematic review, were included as relevant as they met inclusion criteria and also elements of the PICOT question. Six of the 10 primary articles used a qualitative study design (Fazzone et al., 2000; Gross, Peek-Asa, Nocera, & Casteel, 2013; Markkanen et al., 2007; Mathiews & Salmond, 2013; McPhaul & Lipscomb, 2004; and four used a mixed method study
design (Canton et al., 2009; Gershon et al., 2008; Lang, Edwards, & Fleiszer, 2008; Lang et al., 2015). Each of the articles received a rating per the Cincinnati Children Hospital (Let Evidence Guide Every New Decision) LEGEND rating system (Appendix C). Evidence was found to be from studies that used a qualitative design, and whose results were both clinically important and consistently reported. Minor exceptions were made for studies that may have been limited by a smaller study size. In general, the results are free from serious flaws in research design, and researcher bias.

Two of the articles identified that further research was needed to identify gaps in the current practices and barriers to implementation of comprehensive WVP programs (Canton et al., 2009; Lang, Edwards, & Fleiszer, 2008). Seven of the primary articles consistently identified that the home health care industry faced concerns regarding workplace violence, lack of reporting, inconsistent standards and training of staff, and the need for workplace violence prevention programs (Fazzone et al., 2000; Gross, Peek-Asa, Nocera, & Casteel, 2013; Markkanen et al., 2007; Mathiews & Salmond, 2013; McPhaul & Lipscomb, 2004; Vladutiu, Casteel, Nocera, Harrison, & Peek-Asa, 2016). Four of the primary articles used a mixed method study design (Canton et al., 2009; Gershon et al., 2008; Lang, Edwards, & Fleiszer, 2008; Lang et al., 2015).

**Concerns Regarding Workplace Violence**

“Workplace violence is a concept with ambiguous boundaries” (McPhaul & Lipscomb, 2004, para. 8). OSHA reported that mainstream media tends to focus its attention on reports of workplace violence that end in life-threatening injury or even homicide; however, serious but non-fatal injuries comprise much of workplace violence incidents (2004). In 2013, Gross et al., defined workplace violence as acts of physical and psychological violence or abuse, bullying,
sexual harassment, and racial harassment. Workplace violence specific to the home health industry is a rising concern as the HHC work environment presents unique risks for workplace violence as providers typically work by themselves in patients’ homes which are uncontrolled with highly varied settings. HHC providers work without the benefit of security measures seen in institutionalized settings (Canton et al., 2009; Fazzone et al., 2000; Gross, Peek-Asa, Nocera, & Casteel, 2013; NIOSH, 2015).

HHC providers encounter a range of physical and psychosocial hazards in their work environment. Across the body of literature risk factors were reported that increase the incidence of workplace violence in the home setting included the following hazards: violent or unstable patients or family members, illicit drug use, alcohol and prescription drug abuse, weapons present in the home, domestic violence, presence of aggressive animals (Canton et al., 2009; Fazzone et al., 2000; Gross et al., 2013; NIOSH, 2015). Additionally, HHC providers are at risk from environmental influences external to the home. Many neighborhoods or surrounding communities are hazardous to the providers where reports of robbery, car theft, and vandalism have been reported as well as gangs or gang-related activities (McPhaul & Lipscomb, 2004; Gross et al., 2013; Vladutiu et al., 2016).

Increasing violence and fear for personal safety has had a significant impact in the delivery of healthcare in the US, including the ability of providers to deliver safe and effective healthcare in all settings (Gershon et al., 2008; Lang, Edwards, & Fleiszer, 2008; Lang et al., 2015; Markkanen et al., 2007). And while violence committed by patients may be unintentional, the harm it causes is outweighed by the lack of intent as exposure to violence has been linked with adverse physical and emotional consequences for health care providers (Canton et al., 2009). A history of provider exposure to violence in the workplace has been associated with
poor job satisfaction and reduced retention rate leading further to staff shortages in the healthcare industry (Canton et al., 2009; Gross et al., 2013; “OSHA” 2004).

Lack of Reporting

The rates of non-fatal results are highest in the healthcare and social service related fields (Runyan, Zakocs, & Zwerling, 2000, “OSHA” 2004); however, the full extent of the incidents of violence against healthcare workers remains unknown as health care workers tend to either consider it part of the job or feel peer and administrative pressure to tolerate verbal abuse and harassment (Fazzone et al., 2000; Mathiews & Salmond, 2013; McPhaul & Lipscomb, 2004; Zolnlerek, 2105). However, it has been identified that nurses who work in non-standard health care environments such as HHC are less inclined to report work-related injuries out of loyalty and sense of duty to the patient and thresholds for violent behavior are often offset by the client and caregiver needs (Lang et al., 2015; Markkanen et al., 2007; Mathiews & Salmond, 2013). Nurses currently comprise the largest group of health care providers and more than 80% of them have reported that they been assaulted in some way while on the job (Zolnlerek, 2105).

Inconsistent Standards and Training of Staff

Currently, no national guidelines exist requiring the training of HHC providers nor are there any national standards which regulate the environment in which home health care services can be rendered (Lang et al., 2008). In 2004, OSHA published guidelines for the prevention of workplace violence in an attempt to increase the safety, security, and welfare of health care and social service workers, which included a nine-point framework for developing comprehensive training program recommendations for developing WPV training programs. Across the healthcare industry WVP training provided ranges from extensive for health care professionals working in the emergency department to almost non-existent for those working in a HHC setting.
Many HHC providers reported that the quality of training they received from their employer was inadequate in relation to the situations they encountered (McPhaul & Lipscomb, 2004). In 2015, NIOSH developed and recommended the implementation of a workplace violence training program specifically for HHC providers addressing safety in the home workplace environment. The program includes needed information to help define what types of violence are encountered, what are threatening behaviors, identifying risk factors for these behaviors, and providing strategies on how to respond to threatening situations (NIOSH, 2015; OSHA, 2004)

Need for Workplace Violence Prevention Programs

“All employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious harm” (OSHA, 2004, p. 7). As guidance, OSHA has stated that their guidelines are neither new standards nor new regulations, that they are meant to be advisory and informational. The intention of OSHA is that employees use their guidelines in the workplace to remain safe and for employers to develop effective WPV programs (OSHA, 2004; Sylvester & Reisener, 2002). These guidelines recommend that all employees, which includes supervisors and managers, be trained at least annually. Importantly, new hires should receive orientation and WPV training prior to doing their jobs or receiving patient care assignments.

The evidence shows that to effectively ensure the safety and security of HHC providers, employers must develop a comprehensive and effective workplace violence prevention program (Canton et al., 2009; Gross et al., 2013; McPhaul & Lipscomb, 2004; Sylvester & Reisener, 2002; Vladutiu et al., 2016). “Threats, harassment, and violence cannot be ignored behind closed doors. The open door ideal is essential to the transparency of the visit; where
professionals help protect each other using tools, assessments, and communication” (Mathiews & Salmond, 2013, p. 318).

Current literature is consistent in its recommendation that HHC organizations “take an integrated evidence-based approach to implementing a comprehensive policy for assessment and mitigation of violence in home” (Chmielewski & Abbey, 2012). Canton et al. (2009) recommended that policies and practices are developed and implemented that build the foundation and provide support for an organization that focuses on ensuring a safe and secure environment for their employees as well as their patients (p. 372).

**Rationale for Project**

The US National Institute for Occupational Safety reported that workplace violence is preventable (NIOSH, 2015). As HHC providers are usually alone when visiting patients, home health care agencies should be more concerned about improving safety practices based on the provider’s exposure to high risk situations and environments ("U.S. Crime Statistics," 2010). Persistent inaction from organizations can have detrimental effects on employees leading to chronic provider underreporting of encounters of violence. HHC agencies have an obligation to provide their employees with the tools necessary to identify work environments that are potentially unsafe and to provide education on handling situations that have the potential to escalate into violent encounters.

The prevalence of violence in the HHC setting remains problematic; however, studies have shown that the inclusion of a violence prevention program demonstrates awareness of the problem, commitment to the employees’ safety, a desire to improve the working conditions and could lead to increased employee job satisfaction and retention (Canton et al., 2009; Sylvester & Reisener, 2002.
Summary

This chapter addressed the processes that were utilized in the review of the literature. Detailed search criteria was provided as well as the databases search which resulted in the identification of 43 studies that were retrieved, reviewed, and appraised. Ultimately 11 articles were met the search criteria and were relevant to the PICOT question. The four themes that evolved from the literature were identified as concerns regarding workplace violence, lack of reporting, inconsistent standards and training of staff, need for workplace violence prevention programs. These areas were discussed in detail and formed the basis of the rationale for the scholarly project.
Chapter III - Methods

The purpose of this chapter is to describe the steps involved and the preparation that was necessary to conduct the scholarly project. It will discuss the study site and the resources required to effectively administer the survey tool developed to answer the PICOT question. Additionally, the study design and implementation plan will be discussed in detail providing timelines and resources that were be utilized. The project sponsor and tools necessary to complete the study along with the protocol for subject recruitment will be explained, the process for protection of the participants, as well as, the processes for the development of the survey tool.

Human Subjects Review

When conducting any research project, the protection of human subjects is of utmost importance and cannot be compromised. The principal investigator (PI) successfully completed the Collaborative Institutional Training Initiative (CITI Program) for Biomedical (Biomed) and Social-Behavioral-Educational (SBE) research. All participants were provided with an informed consent for an anonymous survey prior to participation in the study. The consent included information that the study was being conducted by a Georgetown University Doctorate of Nursing Practice student to measure the effect that the implementation of a WVP education and training program has on the HHC providers’ ability to ascertain and circumvent violence in the HHC workplace environment. It emphasized that participation in the study was entirely voluntary and that the participant could choose not to participate at all or to leave the study at any time and that regardless of their decision, there would be no effect on their relationship with the researcher or any other consequences. The participants’ continuation with the link to the survey denoted consent (Appendix D). All the data collected was stored on the secure sockets later (SSL) encrypted Survey Monkey™ database and access was provided only to the PI. The
anonymous survey response functionality was utilized to ensure all participants could not be identified. Pre- and post-surveys were unmatched.

If any of the participants felt that they were suffering negative effects from the WVP program (i.e. sensitivity to a previous domestic or workplace violence issue), they were able to excuse themselves from the survey at any time and a referral to the Employee Assistance Program, which offers counseling, would be provided to them by the HR representative.

As the PI was currently working at the scholarly project site in a supervisory position several steps were taken to avoid bias. The PI provided the materials (i.e. the survey and five dollar Starbucks incentive cards) necessary for the scholarly project; however, the PI recused herself from any meetings regarding the training, recruitment, anonymous consent instructions, or survey completion process. Those tasks were completed by representatives from the HR Department. In addition, the two trainers from the HR department completed a course from CPI, which certified them as trainers for the non-violence prevention program.

The proposal was submitted to the Georgetown University IRB for review and an exempt approval was received on April 12, 2017 (Appendix E). Following approval from the IRB, the WVP education and training program was implemented the last week of April of 2017.

**Design and Implementation**

This project utilized a translational research study design with a pre- and post-test. According to Woolf, translational research “seeks to close the gap and improve quality by improving access, reorganizing and coordinating systems of care, helping clinicians and patients to change behaviors and make more informed choices, providing reminders and point-of-care decision support tools, and strengthen the patient-clinician relationship” (2008, p. 211).
In order to complete the initial WPV education and training in one day the actual course was modified to exclude traditional healthcare facility scenarios, as they were not relevant to the HHC environment. This resulted in the WPV education and training course to be six hours in length. The organization opened the training to all clinical providers regardless of their employment status (i.e. full-time, part-time, per-diem, and subcontractors) and the number of sessions was based on the total attendees registered. The implementation plan offered the organization’s clinical providers with a six-hour WVP training program.

The focus of the training was on Nonviolent Crisis Intervention®. This program was developed by the Crisis Prevention Institute (CPI) and is currently used in hospitals, mental health care facilities and educational systems throughout the US (Crisis Intervention Institute website, n.d.). The program training focused on risk management, prevention and deceleration strategies, and decision-making tools and matrices. The Human Resources (HR) Department of the HHC organization where the study was conducted identified two employees who were sent to a formal CPI instructor training course which provided them with the skills necessary to teach the CPI program and authority to issue completion certificates.

Volunteer recruitment was done through the HR department through flyers posted at the entrances, exits, and break rooms (Appendix F).

Project Sponsor and Resources

The project sponsor for was organization where the researcher was employed. The principal investigator (PI) is a doctoral student who is employed in a supervisory role at the organization where the study was conducted. Thus, the PI recused herself from the implementation of the educational training program and did not participate in the delivery of the
pre- or post-testing. Any incentives were provided through representatives of the HR Department.

The current Board of Directors (BOD) of the organization provided this investigator full access to all resources within the organization as well as access to their external contractors that may have been of benefit to the study. The organization allowed the use of its physical location for training sessions and agreed to adjust employees’ schedules to accommodate the training time. The organization provided laptop computers to facilitate the completion of the surveys and the employee conference/training room was made available to the study participants.

Subject Recruitment and Population

This translational research study utilized a convenience sample (N=150). The target population was HCC providers, who care for patients in the home setting. The accessible population is the current HHC providers who are employed through and were recruited from one HHC organization where the researcher is employed. Currently the organization employs over 150 HHC providers who work in varied home environments in the Central Florida area. Inclusion criteria were: a) ≥ 18 years of age; b) functioning in the role of HHC provider; and c) provide care to patients in the patient’s home environment. The study population was comprised of males and females in positions from the following disciplines: home health aides (HHAs), licensed practical (LPNs), registered nurses (RNs), social workers (MSWs), certified occupational therapy assistants (COTAs), occupational therapists (OTs), physical therapy assistants (PTAs), physical therapists (PTs), and speech language pathologists (SLPs), and advanced registered nurse practitioners (ARNPs).

The sample was recruited using flyers (Appendix E). A representative from the HR Department of the organization ensured that all eligible providers received an informed consent
script during the orientation for the educational training program for WVP (Appendix D). This letter informed the WVP training program participants about the study and asked them if they would like to volunteer to participate. Flyers with key information about the study was posted two weeks prior to the educational training program on all entrance and exit doors of the organizational offices and in common areas/breakrooms. Email messages (and if necessary email reminders) were also be sent to eligible participants who opted to participate via Survey Monkey™

**Procedures and Timeline**

The implementation of this project was conducted in April 2017. The WVP training timeline was scheduled for training sessions to be conducted two times a week for eight consecutive weeks in order to keep the class size at 12 individuals or less. Two additional weeks were allotted to accommodate for overruns on time or unanticipated schedule changes.

The participants that agreed to voluntarily participate in the survey were asked to complete the survey via Survey Monkey™ at the beginning of the CPI education and training program. CPI training was then provided to all registrants regardless of their decision to participate in the study or not. After the WVP training session was completed invitations to take the post-training survey with associated links were sent out by the HR Department to all participants 14 days after completion of the training program through Survey Monkey™. Participants were also sent reminders by the HR Department to complete the survey after seven days and again at 10 days.

**Data Collection**

Survey Monkey™ was utilized to collect data as the organization currently utilized this website for survey distribution. The six-hour training course was provided at the corporate office of a HHC organization located in central Florida. The course occurred in the employee training
or workshop room where computers were available for the completion of the survey. At the start of the training session the participants were given the option by the instructors to participate in a WPV survey regarding HHC violence and prevention. If they chose to participate in the study, the instructors provided participants with a link to the anonymous survey on Survey Monkey™ to complete the WPV survey (pretest) prior to the education and training session. It is important to note that no identifiable information was collected. If providers chose to participate an HR department representative followed up with an identical WPV survey (posttest) for them to complete 2 weeks after the training program. As an incentive to complete both surveys a five dollar Starbucks™ gift card was provided by the HR Department after the participant reported completion of the second survey.

**Instruments, Tools, Validity, and Reliability**

After assessing the existing tools in the literature, the researcher decided that no instruments existed that assessed the areas of interest so a pre- and post-training survey was developed by this researcher. Based on the construct of the WVP education and training program adapted from CPI, the survey focused on participants’ knowledge, attitudes, and perceptions of workplace violence and WVP training. The purpose of the instrument was to identify potential risk factors and other issues related to the safety of home health care providers and workplace violence training. The instrument was first reviewed by five members of the nursing faculty at Georgetown University who provided comments that required minimal modification to the original instrument. Three questions were removed from the survey as it was felt after further review that they could potentially be used as identifiers. Therefore, the participants were not asked their gender, ethnicity, or educational level.
The survey was then sent to three HHC experts who validated the instrument for relevance and clarity using a content validity index (CVI) form which resulted in a CVI rating of 1.0 (Polit & Beck, 2012). While reliability of this instrument has yet to be established, the survey was piloted amongst clinicians who would not be included in the survey prior to implementation. It was concluded that the survey was accessible on the internet and the software logic applications were functioning appropriately.

**Workplace Violence Prevention (WVP) Survey**

The pre- and post-training instrument (Appendix G) is divided into six sections. These sections include: demographics, defining workplace violence, potential risk factors, incidents and reporting, workplace violence training, and recommendations. There are a total of 31 questions and it is estimated that completion time for the survey is 15 minutes or less.

Section I, the Demographic section includes six questions related to demographical information of the participants; such as, current working status, how long they have worked as a healthcare professional, how long they have work in the HHC industry, and previous area of clinical work experience.

Section II is the Defining Workplace Violence section and contains six multiple choice questions related to the participant’s knowledge or perception of workplace violence. Questions were asked to obtain the providers prospective of what workplace violence is and their level of acceptance of violence in the workplace.

Section III is the Potential Risk Factors section. It contains three items related to the participant’s personal experiences in providing care to patients in the HHC environment. These items are formatted as multiple choice questions and were asked to obtain the providers perception of safety risks in the HHC workplace environment.
Section IV is the Incidents and Reporting section which contains five items related to the participant’s knowledge of the organizations policies and procedures and the participant’s experience with workplace violence and reporting. The items are formatted as yes or no questions with the option on one to provide a narrative, these were asked to ascertain the provider’s experiences with workplace violence and reporting.

Section V is the Workplace Violence Training section and contains 12 items measuring the participant’s knowledge, attitudes, and perceptions of dealing with several different types of workplace violence. These items are formatted as forced choice questions in order to obtain the providers comfort level in dealing with situations that could have a potential to develop into violence.

Section VI, the Recommendations section, has one open-ended question asking the provider’s perception of the three most important issues that should be addressed in a workplace violence prevention training and education program.

**Outcome Measurements and Data Analysis Plan**

The outcomes being measured for this study were the changes in the providers’ perception of their own preparedness and ability to recognize and circumvent violence.

The chi-square test is used in pre/post studies when the samples are unmatched. As training was provided to a company employee the study wanted to know whether the WVP training had any impact on the employee; however, the employee’s anonymity was the foremost concern so the pre and post education and training surveys remained unmatched.

A biostatistician was consulted to determine the appropriate statistical testing for this project.
The business plan incorporates both direct and indirect costs. The project budget (Appendix H) allocated costs to five specific sections: project design, project development, project delivery, project management, and other costs. Each section includes specific items such as materials required, man hours necessary, and estimated costs.

**Section 1: Project Design**

The project design section includes project specifications, project architecture referencing the structure of the WVP program, and design specifications regarding survey development. Meetings with the project mentor have been incorporated as well as anticipated contact with experts. While no cost has been associated with this, an account of hours has been allocated at 80 hours.

**Section 2: Project Development**

The project development section includes materials needed, man hours required and associated costs for instructor training certification through CPI, software procurement, hardware procurement, training materials, volunteer participant recruitment, and training schedule development.

The budget allotted for $13,890 to cover the expected costs associated with course training $8550, employee wages $3840, and travel $1500.

The study procured and developed existing software available. Survey Monkey™ was utilized to collect data as the organization currently utilizes this website for survey activity. Because of this there was no cost associated with utilizing the software. However, there was a cost associated with the development of the survey on the website and associated administration of the survey. Four hours was allotted for this with a cost of $80.
Computers with associated hardware and training facilities were provided by the organization at no charge.

CPI training manuals were purchased, at the cost per workbook of $1.10 for a quantity of 100, which equated to $220 to cover the employees. There was additional merchandise available for purchase; however, the organization decided that they would not purchase any additional products such as bags, quick reference cards, DVDs. Additionally, four hours were allotted for the training material packets to be assembled at a cost of $80.

Volunteer recruitment was done by the HR department through flyers and invitations inserted into paycheck envelops. A materials fee of $10 was budgeted as well as six hours of employee time. Six hours allotted for the completion of this task were at a cost of $120 (6 hours x $20 per hour).

The development of a training schedule was done by a representative from the HR department. Sixteen hours were allotted for the completion of this task at a cost of $320 (16 hours x $20 per hour).

**Section 3: Project Delivery**

The delivery of this training program was during work hours. The organization paid the employees for attendance and participation in this training program. A combined total of 1,152 hours was allotted for the completion of this task with a cost of $26,392.

In addition, to encourage the study participants to complete the post-training survey a $5 Starbucks gift card was offered as an incentive and was provided by the HR department when the provider self-reported completion of the second survey, this item accounted for $1500.
**Section 4: Project Management**

The project management section included project progress meetings and reports by the HR department which were scheduled bi-weekly during the 8-week training period. Eight hours were allocated for this with an expected cost of $160.

**Section 5: Other Costs**

Data collection was conducted through Survey Monkey™, 4 hours were allocated with a cost of $80.

Additional resources included a biostatistician to assist with the data analysis. The cost was determined to be $100.

Reporting of results to the organizations BOD was allocated for 2 hours with an associated cost of $160.

**Summary**

In Summary, this section provided information regarding the steps that were involved and the preparation that was necessary to effectively prepare for the scholarly project. The study site, sponsor support, participant recruitment, and the resources required were discussed in detail. Additionally, the survey tool development and the CVI were described. The protection of the participants, the storage of data, and the tools that were utilized to assure anonymity were explained. A detailed business plan described project-related costs was presented.
Chapter IV – Evaluation of Results

The purpose of this chapter is to report and analyze the data collected during this DNP scholarly project. Information is presented in tables and summaries and is in response to questions asked about the following topics: demographics, defining workplace violence, potential risk factors, incidents and reporting, workplace violence training, and recommendations. This data provides the researcher with the information of the effectiveness of a WVP education and training program on HHC provider’s ability to assess and circumvent workplace violence in the HHC setting. Furthermore, it provides direction for future studies.

Analysis of Data

A total of 114 home health care providers who attended the WVP education and training were invited to participate in a pre- and post-education and training survey. Participation was voluntary and 98 eligible providers (86%) choose to participate in the pre-survey and 80 (81.6%) participants in the post survey. None of the participants excused themselves from the training. Those that choose not to participate provided no explanation for non-participation.

The surveys were anonymous with no link between pre and post survey results. Therefore, all pre- post comparisons were done using chi squared tests of independence. Because the groups were treated as if they were independent, a higher rate of Type I errors could result because the standard errors based on independent groups are larger than the standard errors based on dependent groups. Therefore, the alpha was increased to .01 and the p values <.001.

Descriptive statistics were reported for each of the following sections of the questionnaire: demographics, defining workplace violence, potential risk factors, incidents and reporting, and workplace violence training.
The IBM SPSS Statistics for Windows, Version 24.0. Armonk, NY: IBM Corp. analysis demonstrated a statistical significance in the awareness of risk factors and handling of potentially violent situations in the home health environment.

**Demographics and Work History**

The demographic data was requested to identify the participation population and ascertain if any results could be linked to central issues such as age or sex. There were no significant differences in the age, sex, or years of experience between those who completed the survey pre-training and those who completed it post-training. The majority (65%) of participants were female and were between the age of 20 – 50 (70.1%). More than 68% stated that they had worked as a health care professional for 3 – 15 years and 80% reported working in the home health industry for more less than 10 years. Table 1 summarizes the demographic characteristics.

<table>
<thead>
<tr>
<th>Table 1. Demographic characteristics</th>
<th>Pre Training</th>
<th>Post Training</th>
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<tbody>
<tr>
<td></td>
<td>(n = 98)</td>
<td>(n = 80)</td>
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<tr>
<td>n</td>
<td>%</td>
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</tr>
<tr>
<td>Female</td>
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<td></td>
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<td></td>
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<tr>
<td>20-30</td>
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<td>Time worked in Healthcare Profession in Any Capacity</td>
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Table 1. Demographic characteristics (Cont.)

<table>
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<th>Time in Home Health Industry</th>
<th>Pre Training (n = 98)</th>
<th>Post Training (n = 80)</th>
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<tr>
<td>11 to 15 years</td>
<td>16</td>
<td>16.3</td>
</tr>
<tr>
<td>16 to 20 years</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>5</td>
<td>5.1</td>
</tr>
</tbody>
</table>

The question was asked “In which of the following areas have you previously worked.” Providers (n=98) responded acute rehabilitation (14.3%), assisted living (18.4%), home health care (65.3%), hospital (34.7), long term care (13.3%), outpatient therapy (8.0%), physician’s office (11.2%), skilled nursing facility (29.6%), other (5.1%), and none (4.1%). The percentages may add to more than 100 because respondents could give more than one answer.

Defining Workplace Violence

As individuals differ, it was important to obtain the providers perspective of how they define workplace violence. Participants were asked “What is workplace violence?” From pre-training (n=98) to post training (n=80), participants were able to define workplace violence as bullying (88.8% to 90.0%), intimidation (86.7% to 87.5%), physical violence (100.0% to 98.8%), psychological violence (91.8% to 91.3%), racial harassment (86.7% to 90.0%), sexual harassment (90.8% to 92.5%), and/or verbal abuse (88.8% to 92.5%). Percentages added to more than 100 because respondents could give more than one answer. It was noted that there were no noteworthy differences in the percentage of participants who marked any of the definitions of violence from pre to post training.
The acceptance of workplace violence pre and post education and training showed no significant difference in the percentages of those who said workplace violence should NOT be accepted pre (92.9%) and post (96.3%), $\chi^2(1) = 1.927, p = .165$.

The question was asked “In the home health care environment I feel that workplace violence is accepted”. From pre-training ($n=98$) to post training ($n=80$), there were no significant differences in the percentages of those who said that violence was accepted by their coworkers (32.7% to 43.8%), managers (13.3% to 8.8%), or organization (6.1% to 5.0%).

The question was asked “In the home health care environment I feel that I am treated with dignity and respect by: other employees, by management, by patients, by the patents families”. From pre-training ($n=98$) to post training ($n=80$), there were no significant differences in the percentages who said they were treated with dignity and respect by employees (82.7% to 86.3%), managers (85.7% to 92.5%), patients (80.6% to 81.3%), or patients’ families (72.4% to 76.3%) from pre to post training.

**Potential Risk Factors**

Questions were asked to obtain the providers perception of potential risk factors encountered in the home health environment pre and post WVP education and training. Based on the post training survey WVP education and training appeared to significantly increase the awareness of many potential risk factors. Because of the increased risk of having high Type I errors, an alpha of .01 rather than .05 was used. With a .01 cut-off for significance, the awareness of the following potential safety risks was increased significantly by the training: car obstructed, inadequate lighting, and physical restraint. There were increases in the percentages who recognized each of the possible safety risks from pre to post training. Table 6 demonstrates the comparison of awareness of possible safety risks pre and post training.
Table 2. Comparison of participant awareness of possible safety risks pre and post education and training.

<table>
<thead>
<tr>
<th></th>
<th>Pre Training (n = 98)</th>
<th>Post Training (n = 80)</th>
<th>( \chi^2(2) )</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animals</td>
<td>82.7</td>
<td>92.5</td>
<td>3.796</td>
<td>.051</td>
</tr>
<tr>
<td>Car obstructed preventing leaving</td>
<td>64.3</td>
<td>83.8</td>
<td>8.473</td>
<td>.004</td>
</tr>
<tr>
<td>Guns</td>
<td>81.6</td>
<td>91.3</td>
<td>3.375</td>
<td>.066</td>
</tr>
<tr>
<td>Gang activity</td>
<td>75.5</td>
<td>87.5</td>
<td>4.097</td>
<td>.043</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>79.6</td>
<td>92.5</td>
<td>5.884</td>
<td>.015</td>
</tr>
<tr>
<td>Inadequate lighting</td>
<td>75.5</td>
<td>92.5</td>
<td>9.073</td>
<td>.003</td>
</tr>
<tr>
<td>Inappropriate touch by patient</td>
<td>78.6</td>
<td>90</td>
<td>4.218</td>
<td>.040</td>
</tr>
<tr>
<td>Inappropriate touch by family member(s)</td>
<td>77.6</td>
<td>88.8</td>
<td>3.841</td>
<td>.050</td>
</tr>
<tr>
<td>Isolated location</td>
<td>73.5</td>
<td>88.8</td>
<td>6.510</td>
<td>.011</td>
</tr>
<tr>
<td>Physically restrained by patient or family member</td>
<td>72.4</td>
<td>88.8</td>
<td>7.254</td>
<td>.007</td>
</tr>
<tr>
<td>Physical harm</td>
<td>81.6</td>
<td>93.8</td>
<td>5.748</td>
<td>.017</td>
</tr>
<tr>
<td>Vandalism</td>
<td>71.4</td>
<td>85.0</td>
<td>4.656</td>
<td>.031</td>
</tr>
<tr>
<td>Verbal abuse by patient to family member(s)</td>
<td>84.7</td>
<td>95.0</td>
<td>4.907</td>
<td>.027</td>
</tr>
<tr>
<td>Verbal abuse by family member(s) to patient</td>
<td>82.7</td>
<td>93.8</td>
<td>5.007</td>
<td>.025</td>
</tr>
<tr>
<td>Verbal abuse by patient to provider</td>
<td>80.6</td>
<td>93.8</td>
<td>6.517</td>
<td>.011</td>
</tr>
<tr>
<td>Verbal abuse by family member(s) to provider</td>
<td>80.6</td>
<td>92.5</td>
<td>5.156</td>
<td>.023</td>
</tr>
<tr>
<td>Weapons other than guns</td>
<td>74.5</td>
<td>86.3</td>
<td>3.776</td>
<td>.052</td>
</tr>
<tr>
<td>No Safety Risks</td>
<td>0.0</td>
<td>1.3</td>
<td>1.219</td>
<td>.269</td>
</tr>
</tbody>
</table>

Using an alpha of .01, there were significant increases in the reports of exposure to gang activity, inadequate lighting, and isolated location from pre to post training. Increased recognition of inadequate lighting as a hazard and isolated location may have contributed to the higher reporting of experiencing them. Table 3 shows the comparison of safety risks experienced from pre to post training.
Table 3. Comparison of participant experienced safety risks pre and post education and training.

<table>
<thead>
<tr>
<th>Safety Risk</th>
<th>Pre Training (n = 98)</th>
<th>Post Training (n = 80)</th>
<th>χ²(2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animals</td>
<td>40.8</td>
<td>51.3</td>
<td>1.934</td>
<td>.164</td>
</tr>
<tr>
<td>Car obstructed preventing leaving</td>
<td>20.4</td>
<td>23.8</td>
<td>0.287</td>
<td>.592</td>
</tr>
<tr>
<td>Guns</td>
<td>7.1</td>
<td>12.5</td>
<td>1.463</td>
<td>.226</td>
</tr>
<tr>
<td>Gang activity</td>
<td>10.2</td>
<td>26.3</td>
<td>7.885</td>
<td>.005</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>20.4</td>
<td>28.8</td>
<td>1.673</td>
<td>.196</td>
</tr>
<tr>
<td>Inadequate lighting</td>
<td>22.4</td>
<td>48.8</td>
<td>13.526</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Inappropriate touch by patient</td>
<td>11.2</td>
<td>15.0</td>
<td>0.558</td>
<td>.455</td>
</tr>
<tr>
<td>Inappropriate touch by family member(s)</td>
<td>3.1</td>
<td>6.3</td>
<td>1.043</td>
<td>.307</td>
</tr>
<tr>
<td>Isolated location</td>
<td>24.5</td>
<td>47.5</td>
<td>10.274</td>
<td>.001</td>
</tr>
<tr>
<td>Physically restrained by patient or family member</td>
<td>1.0</td>
<td>3.8</td>
<td>1.494</td>
<td>.222</td>
</tr>
<tr>
<td>Physical harm</td>
<td>1.0</td>
<td>2.5</td>
<td>0.582</td>
<td>.446</td>
</tr>
<tr>
<td>Vandalism</td>
<td>5.1</td>
<td>6.3</td>
<td>0.109</td>
<td>.741</td>
</tr>
<tr>
<td>Verbal abuse by patient to family member(s)</td>
<td>37.8</td>
<td>52.5</td>
<td>3.879</td>
<td>.049</td>
</tr>
<tr>
<td>Verbal abuse by family member(s) to patient</td>
<td>35.7</td>
<td>52.5</td>
<td>5.056</td>
<td>.025</td>
</tr>
<tr>
<td>Verbal abuse by patient to provider</td>
<td>45.9</td>
<td>58.8</td>
<td>2.904</td>
<td>.088</td>
</tr>
<tr>
<td>Verbal abuse by family member(s) to provider</td>
<td>44.9</td>
<td>51.3</td>
<td>0.712</td>
<td>.399</td>
</tr>
<tr>
<td>Weapons other than guns</td>
<td>6.1</td>
<td>12.5</td>
<td>2.190</td>
<td>.139</td>
</tr>
<tr>
<td>No Safety Risks</td>
<td>23.5</td>
<td>16.3</td>
<td>1.423</td>
<td>.233</td>
</tr>
</tbody>
</table>

There were no significant differences from pre to post training in responses made to safety hazards.

**Incidents and Reporting**

Participants were asked about their knowledge of the organizations policies and procedures and their experiences with workplace violence and reporting. Pre-training results indicated that 61 (62.2%) participants said that they were aware of their current home care
agency’s policies regarding workplace violence, while results of the post-training survey demonstrated that 78 (97.5%) of respondents reported that they were aware of their current home care agency’s policies regarding workplace violence.

Of the participants surveyed after receiving training 38 (47.5%) reported that they had encountered workplace violence in the home healthcare environment. Of the 38 who encountered violence, 33 (86.8%) reported it to their manager. Twenty-eight (84.8%) of those who reported the violence, felt the report was handled appropriately.

When asked to describe the encounter attributed to workplace violence several individuals described encounters with animals. For example, one participant explained

“I have had several incidences over the years - most involve people’s pets. Patients don't think that there animals are capable of attacking because they are "so sweet" but I have noticed that animals think they are protecting their owners and therefore tend to be more aggressive.”

A second concern that emerged when discussing workplace violence encounters that involved inappropriate sexual advances towards home health care providers.

“I was taking care of a patient when he grabbed me by the back of the head and tried to push my head into his groin area while yelling at me that I needed to take care of him "completely", he began yelling profanities and grabbed my hair as I pulled away. I was able to get free and grabbed my bag to leave, as I was exiting the house the patients daughter was apologizing and said "he's just old and confused he didn't mean it", I told her I was leaving and she started screaming at me that I was abandoning her father and that as I nurse I should show more compassion. She called my supervisor to complain that I was incompetent and ill-trained to deal with patients.”
A third concern was relating to the illegal sale of drugs in a patient’s residence.

“I visited a patient that was selling his pain medication to individuals. While I was there we were interrupted several times by people coming to the door and buying his medications.”

Concern relating to verbal abuse arose.

“I didn't really think of it as workplace violence - but I had a patient who was very verbally abusive to her husband - constantly calling him names and telling him he was stupid - he just ignored her and explained she was the nicest person before she had a stroke and now she can be mean - but he said it wasn't her fault she didn't mean it.”

Another participant reported

“I had a patient become very upset with me when I was calling the MD because the patients BS was extremely high > 500 - they became agitated - screaming obscenities at me and accusing me of trying to conspire with their family to place them in a "death home" they blocked my path out of the house and refused to move until I called the doctor back and told him I was lying that everything was just fine. I ended up calling 911 and having the police intercede.”

Concerns regarding the impact that workplace violence can have on the delivery of care can be seen in the pre training survey \( n=98 \), as 32.7% of the providers reported that they had left a patient visit and 35.7% had refused further visits for a patient at some point in their careers. Surprisingly enough 27.6% of those surveyed reported that they took no action.
Workplace Violence Prevention Education and Training

The pre-training survey of identified that 18.4% (n=18) of those surveyed had received any workplace violence prevention education and training. Of those that had received training, they reported it had been conducted in the following work environments: acute rehabilitation 1 (5.6%), assisted living 4 (22.2%), home health care 5 (27.8%), hospital 8 (44.4%), long term care 2 (11.1%), outpatient therapy 0 (0.0%), physician’s office 0 (0.0%), skilled nursing facility 2 (11.1%), and other areas 1 (5.6%). Percentages added to more than 100 because respondents could give more than one answer.

Of those who had received education and training, 8 (44.4%) reported that it covered recognizing and handling physically aggressive behavior, 2 (11.1%) reported that it covered recognizing and handling verbally aggressive behavior, 3 (16.7%) reported that it covered self-defense, and 5 (27.8%) reported that it covered techniques for verbally de-escalating the situation. The post training survey results identified that 97.5% (n=80) reported receiving workplace violence prevention training. Of those who had received training, 78 (97.5%) reported that it covered recognizing and handling physically aggressive behavior, 77 (96.3%) reported that it covered recognizing and handling verbally aggressive behavior, 30 (37.5%) reported that it covered self-defense, and 76 (95.0%) reported that it covered techniques for verbally de-escalating the situation.

Participants were asked “What safety risks do you believe might exist when providing care in patient’s homes?” Pre and post education and training results indicate that there was a significant increase in the awareness of many possible safety risks. Because of the risk of having high Type I errors, an alpha of .01 was used rather than .05. With a .01 cut-off for significance, the awareness of the following potential safety risks was increased significantly by the training:
car obstructed ($p = .004$), inadequate lighting ($p = .003$), and physical restraint ($p = .007$). There were increases in the percentages who recognized each of the possible safety risks from pre to post training.

Using an alpha of .01, there were significant increases in the reports of exposure to gang activity, inadequate lighting, and isolated location from pre to post training. Increased recognition of inadequate lighting as a hazard and isolated location may have led to the higher reporting of experiencing them.

At pre-training survey ($n=18$), of those who had received training, 8 (44.4%) reported that it covered recognizing and handling physically aggressive behavior, 2 (11.1%) reported that it covered recognizing and handling verbally aggressive behavior, 3 (16.7%) reported that it covered self-defense, and 5 (27.8%) reported that it covered techniques for verbally de-escalating the situation. The post training survey ($n=80$), of those who had received training, 78 (97.5%) reported that it covered recognizing and handling physically aggressive behavior, 77 (96.3%) reported that it covered recognizing and handling verbally aggressive behavior, 30 (37.5%) reported that it covered self-defense, and 76 (95.0%) reported that it covered techniques for verbally de-escalating the situation.

Education and training significantly increased the comfort level of providers in handling all the situations presented. Participants ($n=98$) pre education and training reported that 30.9% of them were uncomfortable when a patient becomes verbally aggressive, 35.1% of them were uncomfortable when a family member becomes verbally aggressive, 52.6% of them were uncomfortable when a patient becomes physically aggressive, 43.4% of them were uncomfortable when a family member becomes physically aggressive, 40.6% of them were uncomfortable using self-defense with a patient, 62.9% of them were uncomfortable using self-
defense with a family member, 10.9% of them were uncomfortable using verbal de-escalation with a patient, and 20.6% of them were uncomfortable using verbal de-escalation with a family member. Table 4 compares the comfort level in participants’ pre and post education and training.

**Table 4. Comparison of participant comfort level in handling aggressive situations pre and post training.**

<table>
<thead>
<tr>
<th></th>
<th>Comfortable Pre (n=98) %</th>
<th>Comfortable Post (n=80) %</th>
<th>$\chi^2(2)$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient becomes verbally aggressive</td>
<td>69.1</td>
<td>96.2</td>
<td>20.723</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Family member becomes verbally aggressive</td>
<td>64.9</td>
<td>96.2</td>
<td>25.251</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Patient becomes physically aggressive</td>
<td>47.4</td>
<td>79.5</td>
<td>18.813</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Family member becomes physically aggressive</td>
<td>56.6</td>
<td>78.2</td>
<td>26.807</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Using self-defense with a patient</td>
<td>59.4</td>
<td>80.8</td>
<td>26.580</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Using self-defense with a family member</td>
<td>37.1</td>
<td>79.5</td>
<td>31.505</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Using verbal de-escalation with patient</td>
<td>89.1</td>
<td>96.2</td>
<td>7.147</td>
<td>.008</td>
</tr>
<tr>
<td>Using verbal de-escalation with family member</td>
<td>79.4</td>
<td>97.4</td>
<td>12.822</td>
<td>&lt; .001</td>
</tr>
</tbody>
</table>

**Findings and Outcomes**

The pre and post education and training surveys remained anonymous throughout the survey, as a result the groups were unmatched. While there was no statistically significant changes between pre and post WVP education and training surveys regarding the identification of workplace violence, the consistency in which providers 87.5 to 100% were able to identify workplace violence was encouraging. The addition of the open ended question provided a perspective into the challenges that HHC providers face on a daily basis and allows them to
voice concerns. The results of the training demonstrated a statistically significant increase in the awareness of possible safety risks as well as an increase in the comfort in handling all the situations presented.

Summary

The results and evaluation of the data collected provided valuable information and insight into the work environment of the HHC provider. It has given insight into implementing a WVP education and training program. The independent chi squared test provided both statistically significant and clinically significant information. This data demonstrated the effectiveness of a WVP education and training program on home health care providers' ability to assess and circumvent workplace violence in the home health care setting.
Chapter V – Discussions and Conclusions

The purpose of this chapter is to discuss the findings of this DNP scholarly project; the limitations encountered; and the future implications regarding practice, education, research, and policy dissemination; and recommended areas of further study.

Discussion of Findings

As reported by the Bureau of Labor and Statistics in 2016, healthcare providers working in healthcare settings are more than 16 times more likely to encounter workplace violence than any other type of service personnel, and they are four times more likely to be hurt because of workplace violence (WPV) resulting in more work absences than all employees in other sectors. An unsafe working environment is detrimental to a healthcare provider’s ability to provide safe and effective quality care. Workplace violence can manifest itself through various forms including verbal and emotional abuse, harassment, unwelcome sexual advances, threats of physical violence, and physical assault. Data that was collected and analyzed as part of the study will be useful in helping to ensure that employees and administration will view planned WPV education and training interventions as acceptable, relevant, comprehensive, and practical.

Major Themes

The purpose of this study was to provide a better understanding of the effect that a WPV education and training program has on the HHC provider’s perception to assess and prevent violence in the HHC environment. Several major themes emerged during this study. These themes illustrate how a lack of reporting can impede organizational, educational, and procedural issues required to enhance provider safety; how concerns regarding workplace violence on personal safety and patient care and outcomes; how inconsistent standards and training of staff can affect the provider perception of their ability to assess and prevent violence; and the need to
implement policy to require that workplace violence prevention and training is mandated for all HHC providers.

**Lack of Reporting Impeding Organizational, Educational, and Procedural Issues Required to Enhance Provider Safety**

Accurate baseline statistics are required in any study to ascertain the true extent of the problem and effectively assess the progress of the strategies implemented to reduce workplace violence. Occurrences of workplace violence, in all categories, continue to be grossly underreported. This is partly due to a pervasive culture in health care that does not want to acknowledge that providers are at risk for workplace violence and who continue to accept that violence is “part of the job.”

In 2016, Phillips offered that the “broken windows” principle, which is a criminal-justice theory that explains that neighborhood indifference toward low-level crimes actually creates an environment that is conducive to the development of more serious crime. This principle can also apply to workplace violence. Phillips also inferred that when verbal abuse and low-level battery are consistently tolerated one is basically inviting more serious forms of violence (2016).

May & Grubb (2002) found that many nurses accepted that violence was a fundamental aspect of their occupation and thought that reporting instances of workplace violence would be inefficient and time consuming. Additionally, because they feel it may be interpreted as a professional failure, HHC providers may not access support for violent incidents in the workplace (Roche, Diers, Duffield, & Catling-Paull, 2010). Because of this, it is probable that workplace violence in the health care settings is more than likely underestimated.

In order to create a more secure work environment it is important that agency administrators and managers participate in taking steps to create a more secure work
environment. For example, implementing WVP education and training program to foster a culture of encouragement for reporting workplace violence incidents.

**Concerns Regarding Workplace Violence on Personal Safety and Patient Care and Outcomes**

OSHA considers those employees who provide services in isolated or high-crime areas, those who work alone or in small groups, and those who have extensive contact with the public as high-risk providers who may be more likely to encounter workplace violence (OSHA, 2004). Frequent instances of workplace violence can have both direct and indirect negative consequences on staff and patients alike, including compromised patient care.

It is imperative that there is general understanding of the effect that experiencing workplace violence has on the healthcare provider themselves. The HHC industry as a whole and HHC agencies specifically, must provide appropriate and suitable support to their employees. Providing ongoing resources, like WVP education and training, helps to ensure that the provider feels safe, respected, and valued.

**Inconsistent Standards and Training of Staff Can Affect the Provider’s Ability to Assess and Prevent Violence**

Without standardized education and training requirements, it will continue to remain problematic for researchers to equate data, measure interventions, and detect progressive changes. While the use of current legal definitions of assault, aggravated assault, and battery help to enable accurate collaborative work among researchers, law enforcement personnel, and legislators, the lack of consistent standards for WVP education and training in HHC remains a significant concern.
The development of a suitable program intended to avert workplace violence necessitates the attention to issues that involve not only individual workers, but include law-enforcement officials and health care organizations to effectively assess and identify weaknesses and generate solutions. Each program’s content should preferably be designed to address personalized patient populations; patient care requirements; staff responsiveness and willingness to learn; and organizations available resources (Papa & Venella, 2013).

It is essential that healthcare providers have the appropriate education and training aimed at recognizing, diffusing, and deescalating violent behaviors. Effective strategies for individual workers that have been suggested to reduce workplace violence include training in aggression de-escalation techniques and training in self-defense. Additionally, skillful communication plays a part in de-escalating violent incidents and assists with conflict resolution (Papa & Venella, 2013).

**Need to Implement Policy to Require That Workplace Violence Prevention and Training is Mandated for all HHC Providers**

Current guidelines and provider education regarding techniques used in conflict resolution and management of aggressive behaviors are inadequate (Gates et al., 2011). Additionally, providers identified during the study that they desired recurrent educational opportunities that provided them with specific strategies aimed at de-escalating situations with patients and family and focused on avoiding or resolving conflicts.

Post education and training results demonstrated that there was a significant increase in the reports of exposure to gang activity, inadequate lighting, and isolated location from pre to post training. Additionally, there was an increased awareness of inadequate lighting as a hazard and isolated location may have led to the higher reporting of experiencing them. Participation in
the education and training program significantly increased the comfort in handling all the situations presented.

Limitations

The probability of response bias was increased because of the use of a non-random convenience sample. As an example, participants who agreed to complete both the pre- and post-tests may have regarded the WVP education and training program more positively than those who did not.

The sample size was small and confined to one agency in one geographic location. The sample demographics were representative of the Central Florida HHC providers only and findings may not be generalizable to all HHC agencies across the United States.

Administration of a pre-test may have had an impact on participants' knowledge regardless of their participation in the training program. The use of a self-reported questionnaire may have resulted in response bias. Because this study only measured participants’ attitudes and did not measure behavior, the evaluation did not include any long-term gains the WPV education and training program may have provided.

Implications for Practice, Education, Research, and Policy Dissemination

Implications for Practice

One important factor to reduce workplace violence in HHC is a commitment by administrators, managers, and providers to ensure a safer workplace. As reported by the participants in this study, support by administration is essential in providing the emotional and legal support necessary to remove any barriers that could affect the reporting of incidents of violence. HH agencies and providers need to work on being proactive as they consider ways to mitigate workplace violence.
The HR Department should be actively involved to ensure that the organization’s current policies and procedures are in use and correctly implemented. Their practice should incorporate consistent follow-up with individuals that report workplace violence incidents and to provide annual WVP education and training to providers.

Health care organizations that are ready and willing to ensure safe and secure working environments for their employees may initially do so by adopting simple procedures to ensure workplace violence incident-reporting. These policies and procedures need to provide protection to complainants from reprisal, ensure comprehensive WVP education and training programs are provided, and support the application of cost-effective and evidence-based solutions. Attention to increasing provider safety and reducing workplace violence must be the focus for HH agencies going forward.

**Implications for Education**

For a WVP educational training program to be successful, providers need to be educated and trained on relevant issues, which include skills for managing violent behavior. For example, education on how to assess the various environments and to identify patients and family members who may be predisposed toward violent behavior. One way that this can be accomplished is by training employees in a multidisciplinary forum.

Aligning the educational course content with the needs and culture of individual organizations is key. Annual in-services and continuing education and training programs should focus on communication skills, in particular those used throughout workplace violence encounters, and to teach providers to observe and successfully manage such incidents. All employees, administrators to providers, need to be familiar with their roles and responsibilities.
when a workplace violence incident occurs. Additionally, they should know what type of support or response to expect from other team members.

The study also provides nurse educators with some additional understanding into developing workplace violence prevention plans. A recommendation would be that WVP education and training be incorporated into curriculum during undergraduate studies to prepare nursing students and provide them with the necessary tools to confront and manage violence when they graduate and enter the work force more fully prepared.

**Implications for Research**

There is little research available on the efficacy of a workplace violence educational and training program, especially for HHC providers. This lack of research creates a need to evaluate this problem in the clinical setting. Additionally, it would assist health care providers in developing effective instruction and appropriate interventions.

Further studies need to evaluate the impact that a WVP education and training program has on provider practice. Further surveys are indicated to assess providers' attitudes and the effect of a WVP education and training program.

**Policy Dissemination**

There is no simple solution to ending workplace violence in the HHC setting. Policy makers need to be encouraged to pass legislation regarding the need to require WPV education and training programs and facilities need to be encouraged to develop policies. Providing WVP education and training programs are important strategies and realistic starting points to addressing workplace violence. Additionally, the DNP needs to be competent and prepared to articulate this concern as they work together with employers to appraise and decrease risks to employees while developing appropriate institutional level policies.
While laws that are intended to prevent violence in the health care workplace have been implemented in only a few states, legislators could assess the efficacy of such laws and consider the adoption of those that have been effective in mitigating workplace violence.

The results of this study will help policy makers formulate policies and strategies on workplace violence. Administrators and Nurse Managers must design an effective intervention plan and implement effective strategies to prevent workplace violence.

This study provides healthcare providers, managers, administrators, researchers, educators, organizations and policy makers with evidence regarding interventional programs relating to workplace violence and their importance in decreasing workplace violence in the health care environment.

In 2012, The American Nurses Association (ANA) petitioned OSHA to “require employers to develop workplace violence prevention programs that would include employee involvement; risk assessment and surveillance; environmental, architectural, and security controls; and training and education” (American Nurses Association [ANA], 2012, p.2). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Community Health Accreditation Partner (CHAP) could assume responsibility to do the same.

Important strategies to consider include increased advocacy for state legislation; developing and implementing facility policies; and providing education with provider practice. To protect vulnerable healthcare providers, all states should be encouraged to consider enacting legislation that makes battery against a health care worker a felony offense. In addition to legislative changes, it is crucial that solutions to dealing with the problem involve an understanding of the issue, employees are provided with appropriate and effective education, and that anyone involved in an incident of workplace violence feel safe and supported.
Many organizations have zero tolerance policies, but these policies must be appropriately applied and enforced. These policies must be utilized consistently and reviewed at least annually.

**Recommendations for Practice and for Further Study**

It is imperative that the prevention and management of violence in the home health environment be a priority for administrators and managers of HH agencies. Workplace violence should never be accepted or considered as part of the job. Additionally, WVP policies and procedures are needed, and should ideally focus on the security of the workplace environment, reporting of incidents, and developing WPV education and training for all employees and managers (Gates, Gillespie, & Succop, 2011).

The effectiveness of the education and training program was evident in the results obtained through this study and that it significantly improved providers attitudes towards the prevention of patient aggression.

**Summary**

HHC employees, just like all other workers, have a right to be safe on the job and currently in the HHC industry in the US they are not. Studies regarding the lack of workplace violence education programs for HHC have been published and recommendations have been made since 2004 and yet no significant progress has been made to resolve the concerns identified. Although legislators may well consider enacting more severe penalties for violence against health care workers due to the special class of offense, the reality is that providers are being beaten, raped, robbed, and even murdered because they have been inadequately trained in WVP. Thus, the HHC industry needs to focus workplace violence as the primary HHC worker issue that needs resolution.
Appendix A

Stevens Star Model of Knowledge Transformation
Appendix B

Center for Disease Control Public Health Model
Appendix C

Cincinnati Children’s Hospital Medical Center LEGEND Tool

![LEGEND Diagram](image)

**Source:** Reprinted with permission from Cincinnati Children’s Hospital Medical Center.
Appendix D

Informed Consent Script

IRB #
Title: EDUCATION AND TRAINING FOR THE PREVENTION OF VIOLENCE IN THE HOME HEALTHCARE WORKPLACE ENVIRONMENT

Page 1

ANONYMOUS SURVEY

You are invited to participate in a research study titled PREPARATION AND PREVENTION OF VIOLENCE IN THE HOME HEALTHCARE WORKPLACE ENVIRONMENT. This study is being conducted by a Georgetown University Doctorate of Nursing Student to measure the effect that the implementation of a workplace violence prevention training program has on the HHC providers' ability to assess risk and circumvent violence during home health visits.

Participation in this study is entirely voluntary at all times. You can choose not to participate at all or to leave the study at any time. Regardless of your decision, there will be no effect on your relationship with the researcher or any other consequences.

You are being asked to take part in this study because you are home health care provider.

If you agree to participate, you will be asked to fill out 2 surveys about workplace violence and the provided training program. These surveys should take around 10-15 minutes to complete. The surveys will be administered via Survey Monkey® with the initial survey being collected at the start of training and final survey being collected 2 weeks after training has concluded.

All of your responses to this survey will remain anonymous and cannot be linked to you in any way. No identifying information about you will be collected at any point during the study, and your survey will be identified only with a random number. Once you submit your completed survey, there will be no way to withdraw your responses from the study because the survey contains no identifying information.

Study data will be kept in digital format in a secure database at Survey Monkey®. Access to digital data will be protected encrypted passwords. Only system administrators will have access to the data.

There are no risks associated with this study. While you may not experience any direct benefits from participation, information collected in this study may benefit others in the future by helping to identify if the affects that a workplace violence prevention training program has on the HHC providers' ability to assess risk and circumvent violence during home health visits.

If you have any questions regarding the survey or this research project in general, please contact the principal investigator Becky Mitchell-Vaughn, via email at bcm56@georgetown.edu.

If you have any questions about your rights as a research participant, please contact the Georgetown University IRB at (202) 687-1506 or irb@georgetown.edu.

By completing and submitting this survey, you are indicating your consent to participate in this study.

Doctorate of Nursing
Practice Student
Georgetown University
Appendix E

Georgetown University IRB Approval Letter

Georgetown University Institutional Review Board

Date: 4/12/2017
To: Becky Mitchell-Vaughn
From: Michael Orgulza
Institutional Review Board
IRB#: 2016-1178
Title: Education and Training for the Prevention of Violence in the Home Health Care Workplace Environment
Exemption Granted Date: 4/12/2017
Action: Initial Review - Exempt

Attachments being reviewed:

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<td>BMV CV.docx</td>
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</table>

The above referenced project was deemed to be exempt from review by the Institutional Review Board on 4/12/2017 with the following category:
2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, or achievement), survey procedures, interview procedures, or observation of public behavior.

NOTE: Except as noted above, this exemption applies to all such research involving ADULT subjects unless BOTH of the following conditions apply:

(a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects (NOTE: Codes constitute identifiers);

AND

(b) Any disclosure of the subjects’ responses outside of the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, or reputation.

NOTE: This exemption applies to research involving CHILDREN EXCEPT that (i) research involving survey or interview procedures with children is NOT EXEMPT, and (ii) research involving observation of the public behavior of children is NOT EXEMPT if the investigator(s) participate(s) in the actions being observed.

This exemption is in accordance with Title 45 of the Code of Federal Regulations Part 46.102
(d) "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge" as well as Part 46.102 (f) "a living individual about whom an investigator (whether professional or student) conducting research obtains (1) data through intervention or interaction with the individual or (2) identifiable private information".

Please refer to the above mentioned date and protocol number when making inquiries concerning this protocol.

Georgetown University IRB
Robert Wood Building, Annex
Washington, DC 20057
(202)687-4636 Telephone
(202)687-1917 Answering
COMING SOON

Nirvana Health Services will be conducting training for nonviolent crisis intervention for all home health care providers who work with the organization (Full-Time, Part-Time, and Subcontract Employees)

Training will be conducted during the months of February and March 2017 and take place at Nirvana Health Services corporate offices located in Altamonte Springs, Florida. There is no cost to participate. Lunch will be provided.

Initial training will consist of a 6 hour course that focuses on the following areas:

- Defining workplace violence and aggression
- Behavioral responses in crisis situations
- How positive interpersonal behaviors affect interactions
- Verbal de-escalation techniques
- Risk assessment and reduction
- Non-physical approaches to prevent behaviors
- Professional values
- Decision-making matrix

A Crisis Prevention Institute training certificate will be provided to all participants upon successful completion of the course.

To register please contact Shirley Pond at (407) 647-5008 x 313 or spond@nirvanahealthservices.com.
# Appendix G

## Workplace Violence Prevention (WVP) Survey

The purpose of this questionnaire is to identify potential risk factors and other issues related to the safety of home health care providers and workplace violence training.

Instructions: Please answer the following questions to the best of your knowledge. There are no right or wrong answers. Most importantly is that you answer honestly. This survey will take about 5-10 minutes to complete. Thank you so much for your time.

## I. DEMOGRAPHIC INFORMATION

* 1. Are you currently working as a healthcare professional in the home healthcare industry?
  - [ ] Yes
  - [ ] No

* 2. What is your gender?
  - [ ] Female
  - [ ] Male

## I. DEMOGRAPHIC INFORMATION
3. What is your age in years?

- < 20
- 20-30
- 31-40
- 41-50
- 51-60
- > 60

Workplace Violence Prevention (WVP) Survey

I. DEMOGRAPHIC INFORMATION

4. How long have you worked as a healthcare professional in any capacity?

- < 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- > 20 years
* 3. What is your age in years?
   - < 20
   - 20-30
   - 31-40
   - 41-50
   - 51-60
   - > 60

Workplace Violence Prevention (WVP) Survey

I. DEMOGRAPHIC INFORMATION

* 4. How long have you worked as a healthcare professional in any capacity?
   - <1 year
   - 1-2 years
   - 3-5 years
   - 6-10 years
   - 11-15 years
   - 16-20 years
   - >20 years
* 5. How long have you worked in the home health industry, with this organization, or any other?
   - 1-2 years
   - 3-5 years
   - 6-10 years
   - 11-15 years
   - 16-20 years
   - >20 years

**Workplace Violence Prevention (WVP) Survey**

**I. DEMOGRAPHIC INFORMATION**

* 6. In which of the following areas have you previously worked? (Check all that apply.)
   - Acute Rehabilitation
   - Assisted Living
   - Home Health Care
   - Hospital
   - Long Term Care
   - Outpatient Therapy
   - Physician’s Office
   - Skilled Nursing Facility
   - None
   - Other (please describe):

**Workplace Violence Prevention (WVP) Survey**

**II. DEFINING WORKPLACE VIOLENCE**
5. How long have you worked in the home health industry, with this organization, or any other?
   - 1-2 years
   - 3-5 years
   - 6-10 years
   - 11-15 years
   - 16-20 years
   - >20 years

Workplace Violence Prevention (WVP) Survey

I. DEMOGRAPHIC INFORMATION

6. In which of the following areas have you previously worked? (Check all that apply.)
   - Acute Rehabilitation
   - Assisted Living
   - Home Health Care
   - Hospital
   - Long Term Care
   - Outpatient Therapy
   - Physician's Office
   - Skilled Nursing Facility
   - None
   - Other (please describe):

Workplace Violence Prevention (WVP) Survey

II. DEFINING WORKPLACE VIOLENCE
7. What is workplace violence? (Check all that apply)
   - Bullying
   - Intimidation
   - Physical Violence
   - Psychological Violence
   - Racial Harassment
   - Sexual Harassment
   - Verbal Abuse
   - Other (please describe)

Workplace Violence Prevention (WVP) Survey
II. DEFINING WORKPLACE VIOLENCE

8. I feel that workplace violence in the home health care environment:
   - Should be accepted as part of the job by the provider.
   - Should not be accepted as part of the job by the provider.

Workplace Violence Prevention (WVP) Survey
II. DEFINING WORKPLACE VIOLENCE

9. In the home health care environment I feel that workplace violence is accepted: (Check all that apply.)
   - As part of the job by my coworkers.
   - As part of the job by my manager.
   - As part of the job by my organization.
   - Not applicable

Workplace Violence Prevention (WVP) Survey
7. What is workplace violence? (Check all that apply)

- Bullying
- Intimidation
- Physical Violence
- Psychological Violence
- Racial Harassment
- Sexual Harassment
- Verbal Abuse
- Other (please describe)

Workplace Violence Prevention (WVP) Survey

II. DEFINING WORKPLACE VIOLENCE

8. I feel that workplace violence in the home health care environment:

- Should be accepted as part of the job by the provider.
- Should not be accepted as part of the job by the provider.

Workplace Violence Prevention (WVP) Survey

II. DEFINING WORKPLACE VIOLENCE

9. In the home health care environment I feel that workplace violence is accepted: (Check all that apply.)

- As part of the job by my coworkers.
- As part of the job by my manager.
- As part of the job by my organization.
- Not applicable
II. DEFINING WORKPLACE VIOLENCE

* 10. In the home health care environment I feel that workplace violence is not accepted: (Check all that apply.)
   - [ ] as part of the job by my coworkers.
   - [ ] as part of the job by my manager.
   - [ ] as part of the job by my organization.
   - [ ] Not applicable

Workplace Violence Prevention (WVP) Survey

II. DEFINING WORKPLACE VIOLENCE

* 11. In the home health care environment I feel that I am treated with dignity and respect by: (Check all that apply.)
   - [ ] Other employees
   - [ ] By management
   - [ ] By patients
   - [ ] By the patients’ families
   - [ ] Not applicable
II. DEFINING WORKPLACE VIOLENCE

10. In the home health care environment I feel that workplace violence is *not* accepted: (Check all that apply.)
   - [ ] as part of the job by my coworkers.
   - [ ] as part of the job by my manager.
   - [ ] as part of the job by my organization.
   - [ ] Not applicable

Workplace Violence Prevention (WVP) Survey

II. DEFINING WORKPLACE VIOLENCE

11. In the home health care environment I feel that I am treated with dignity and respect by: (Check all that apply.)
   - [ ] Other employees
   - [ ] By management
   - [ ] By patients
   - [ ] By the patients' families
   - [ ] Not applicable
* 12. In the home health care environment I do not feel that I am treated with dignity and respect by: (Check all that apply.)

- [ ] Other employees
- [ ] By management
- [ ] By patients
- [ ] By the patients’ families
- [ ] Not applicable

Workplace Violence Prevention (WVP) Survey

III. POTENTIAL RISK FACTORS
* 12. In the home health care environment I do not feel that I am treated with dignity and respect by: (Check all that apply.)

☐ Other employees
☐ By management
☐ By patients
☐ By the patients' families
☐ Not applicable

Workplace Violence Prevention (WVP) Survey

III. POTENTIAL RISK FACTORS
* 13. What safety risks do you believe might exist when providing care in patients' homes? (Check all that apply.)

- Animals
- Car obstructed by person or object resulting in inability to leave area.
- Guns
- Gang activity.
- Illegal drugs.
- Inadequate lighting.
- Inappropriate touch by patient to clinician (i.e., sexual advances).
- Inappropriate touch by family members to clinician (i.e., sexual advances).
- Isolated location
- Physically restrained by patient or family member.
- Physical harm
- Vandalism
- Verbal abuse by patient to family member(s).
- Verbal abuse by family member(s) to patient.
- Verbal abuse by patient to home health care provider.
- Verbal abuse by family member(s) to home health care provider.
- Weapons (excluding guns).
- None
- Other: ____________________________

Workplace Violence Prevention (WVP) Survey

III. POTENTIAL RISK FACTORS
* 13. What safety risks do you believe might exist when providing care in patients' homes? (Check all that apply.)

☐ Animals
☐ Car obstructed by person or object resulting in inability to leave area.
☐ Guns
☐ Gang activity.
☐ Illegal drugs.
☐ Inadequate lighting.
☐ Inappropriate touch by patient to clinician (i.e., sexual advances).
☐ Inappropriate touch by family members to clinician (i.e., sexual advances).
☐ Isolated location
☐ Physically restrained by patient or family member.
☐ Physical harm
☐ Vandalism
☐ Verbal abuse by patient to family member(s).
☐ Verbal abuse by family member(s) to patient.
☐ Verbal abuse by patient to home health care provider.
☐ Verbal abuse by family member(s) to home health care provider.
☐ Weapons (excluding guns).
☐ None
☐ Other:

Workplace Violence Prevention (WVP) Survey

III. POTENTIAL RISK FACTORS
* 14. What safety issues have you personally been exposed to when providing care in patients’ homes?
   (Check all that apply.)
   □ Animals
   □ Car obstructed by person or object resulting in inability to leave area.
   □ Guns
   □ Gang activity
   □ Illegal drugs
   □ Inadequate lighting
   □ Inappropriate touch by patient to clinician (i.e. sexual advances)
   □ Inappropriate touch by family members to clinician (i.e. sexual advances)
   □ Isolated location
   □ Physically restrained
   □ Physical harm
   □ Vandalism
   □ Verbal abuse by patient to family member(s)
   □ Verbal abuse by family member(s) to patient
   □ Verbal abuse by patient to home health care provider
   □ Verbal abuse by family member(s) to home health care provider
   □ Weapons (excluding guns)
   □ None
   □ Other: 

Workplace Violence Prevention (WVP) Survey

III. POTENTIAL RISK FACTORS
* 14. What safety issues have you personally been exposed to when providing care in patients' homes? (Check all that apply.)

- Animals
- Car obstructed by person or object resulting in inability to leave area.
- Guns
- Gang activity
- Illegal drugs
- Inadequate lighting
- Inappropriate touch by patient to clinician (i.e. sexual advances)
- Inappropriate touch by family members to clinician (i.e. sexual advances)
- Isolated location
- Physically restrained
- Physical harm
- Vandalism
- Verbal abuse by patient to family member(s)
- Verbal abuse by family member(s) to patient
- Verbal abuse by patient to home health care provider
- Verbal abuse by family member(s) to home health care provider
- Weapons (excluding guns)
- None
- Other:  

---

Workplace Violence Prevention (WVP) Survey

III. POTENTIAL RISK FACTORS
15. What safety measures have you used when feeling unsafe while providing care in patients' homes? (Check all that apply.)

- Called police
- Called supervisor
- Having family present during visit or using staff escorts
- Left the visit
- Lights left on for next provider
- Previous training techniques
- Rearranged time of visit
- Refused future visit
- Requested animals be removed
- Used buddy system
- Used chemical deterrent (e.g., pepper spray or mace)
- None
- Other (please specify)

Workplace Violence Prevention (WVP) Survey

IV. INCIDENTS AND REPORTING

16. Are you aware of your current home care agency's policies regarding workplace violence?

- Yes
- No
15. What safety measures have you used when feeling unsafe while providing care in patients' homes? (Check all that apply.)

- Called police
- Called supervisor
- Having family present during visit or using staff escorts
- Left the visit
- Lights left on for next provider
- Previous training techniques
- Rearranged time of visit
- Refused future visit
- Requested animals be removed
- Used buddy system
- Used chemical deterrent (e.g., pepper spray or mace)
- None
- Other (please specify)

Workplace Violence Prevention (WVP) Survey

IV. INCIDENTS AND REPORTING

16. Are you aware of your current home care agency's policies regarding workplace violence?

- Yes
- No
17. Have you ever encountered workplace violence in the home healthcare environment?

- Yes
- No

18. If yes, please describe the incident.

19. If you encountered workplace violence in the home healthcare environment did you report it to your manager?

- Yes
- No

20. If you reported it, do you feel as though the report was handled appropriately?

- Yes
- No
17. Have you ever encountered workplace violence in the home healthcare environment?

☐ Yes
☐ No

Workplace Violence Prevention (WVP) Survey

18. If yes, please describe the incident.

[Blank space]

Workplace Violence Prevention (WVP) Survey

IV. INCIDENTS AND REPORTING

19. If you encountered workplace violence in the home healthcare environment did you report it to your manager?

☐ Yes
☐ No

Workplace Violence Prevention (WVP) Survey

IV. INCIDENTS AND REPORTING

20. If you reported it, do you feel as though the report was handled appropriately?

☐ Yes
☐ No

Workplace Violence Prevention (WVP) Survey

V. WORKPLACE VIOLENCE TRAINING
21. Have you ever been provided with a workplace violence prevention training program?

- [ ] Yes
- [ ] No

### V. WORKPLACE VIOLENCE TRAINING

22. If yes, in which work environment? (Check all that apply.)

- [ ] Acute Rehabilitation
- [ ] Assisted Living
- [ ] Home Health Care
- [ ] Hospital
- [ ] Long Term Care
- [ ] Outpatient Therapy
- [ ] Physician’s Office
- [ ] Skilled Nursing Facility
- [ ] Not applicable
- [ ] Other:
  
  __________________________

### V. WORKPLACE VIOLENCE TRAINING
21. Have you ever been provided with a workplace violence prevention training program?

☐ Yes

☐ No

**Workplace Violence Prevention (WVP) Survey**

**V. WORKPLACE VIOLENCE TRAINING**

22. If yes, in which work environment? (Check all that apply.)

☐ Acute Rehabilitation

☐ Assisted Living

☐ Home Health Care

☐ Hospital

☐ Long Term Care

☐ Outpatient Therapy

☐ Physician’s Office

☐ Skilled Nursing Facility

☐ Not applicable

☐ Other:

[Blank space for other input]
23. What did the Workplace Violence Training Program include? (Check all that apply.)

- Recognizing and handling verbally aggressive behavior
- Recognizing and handling physically aggressive behavior
- Self-defense
- Verbal de-escalation techniques
- Not applicable
- Other: ____________________________

Workplace Violence Prevention (WVP) Survey
V. WORKPLACE VIOLENCE TRAINING

* 24. How comfortable do you feel handling a situation where a patient has become verbally aggressive?  

- Very Uncomfortable  
- Uncomfortable  
- Comfortable  
- Very Comfortable

Workplace Violence Prevention (WVP) Survey
V. WORKPLACE VIOLENCE TRAINING

* 25. How comfortable do you feel handling a situation where a family member has become verbally aggressive?  

- Very Uncomfortable  
- Uncomfortable  
- Comfortable  
- Very Comfortable
23. What did the Workplace Violence Training Program include? (Check all that apply.)
  ○ Recognizing and handling verbally aggressive behavior
  ○ Recognizing and handling physically aggressive behavior
  ○ Self-defense
  ○ Verbal de-escalation techniques
  ○ Not applicable
  ○ Other:

**Workplace Violence Prevention (WVP) Survey**

**V. WORKPLACE VIOLENCE TRAINING**

* 24. How comfortable do you feel handling a situation where a patient has become verbally aggressive?
  ○ Very Uncomfortable
  ○ Uncomfortable
  ○ Comfortable
  ○ Very Comfortable

**Workplace Violence Prevention (WVP) Survey**

**V. WORKPLACE VIOLENCE TRAINING**

* 25. How comfortable do you feel handling a situation where a family member has become verbally aggressive?
  ○ Very Uncomfortable
  ○ Uncomfortable
  ○ Comfortable
  ○ Very Comfortable
V. WORKPLACE VIOLENCE TRAINING

* 26. How comfortable do you feel handling a situation where a patient has become physically aggressive?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

Workplace Violence Prevention (WVP) Survey

V. WORKPLACE VIOLENCE TRAINING

* 27. How comfortable do you feel handling a situation where a family member has become physically aggressive?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

Workplace Violence Prevention (WVP) Survey

V. WORKPLACE VIOLENCE TRAINING

* 28. How comfortable do you feel using self-defense measures (i.e. physical holds) with a patient?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable
V. WORKPLACE VIOLENCE TRAINING

26. How comfortable do you feel handling a situation where a patient has become physically aggressive?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

Workplace Violence Prevention (WVP) Survey

V. WORKPLACE VIOLENCE TRAINING

27. How comfortable do you feel handling a situation where a family member has become physically aggressive?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

Workplace Violence Prevention (WVP) Survey

V. WORKPLACE VIOLENCE TRAINING

28. How comfortable do you feel using self-defense measures (i.e. physical holds) with a patient?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

Workplace Violence Prevention (WVP) Survey
V. WORKPLACE VIOLENCE TRAINING

29. How comfortable do you feel using **self-defense measures** (i.e. physical holds) with a **family member**?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

**Workplace Violence Prevention (WVP) Survey**

V. WORKPLACE VIOLENCE TRAINING

30. How comfortable do you feel employing **verbal de-escalation** techniques with a **patient**?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

**Workplace Violence Prevention (WVP) Survey**

V. WORKPLACE VIOLENCE TRAINING

31. How comfortable do you feel employing **verbal de-escalation** techniques with a **family member**?
   - Very Uncomfortable
   - Uncomfortable
   - Comfortable
   - Very Comfortable

**Workplace Violence Prevention (WVP) Survey**
V. WORKPLACE VIOLENCE TRAINING

* 29. How comfortable do you feel using self-defense measures (i.e. physical holds) with a family member?
- Very Uncomfortable
- Uncomfortable
- Comfortable
- Very Comfortable

Workplace Violence Prevention (WVP) Survey
V. WORKPLACE VIOLENCE TRAINING

* 30. How comfortable do you feel employing verbal de-escalation techniques with a patient?
- Very Uncomfortable
- Uncomfortable
- Comfortable
- Very Comfortable

Workplace Violence Prevention (WVP) Survey
V. WORKPLACE VIOLENCE TRAINING

* 31. How comfortable do you feel employing verbal de-escalation techniques with a family member?
- Very Uncomfortable
- Uncomfortable
- Comfortable
- Very Comfortable
V. WORKPLACE VIOLENCE TRAINING

* 32. In my current job while providing care in patients' homes I feel safe:

   - All of the time
   - Most of the time
   - Some of the time
   - None of the time

Workplace Violence Prevention (WVP) Survey

VI. RECOMMENDATIONS

* 33. What are the three most important issues that you feel should be addressed in a workplace violence prevention training program for home health care?

1. 
2. 
3. 
## Appendix H
### Project Budget

### Source of Project Cost - WVP Training

<table>
<thead>
<tr>
<th>PROJECT TASKS</th>
<th>LABOR HOURS</th>
<th>LABOR COST ($)</th>
<th>MATERIAL COST ($)</th>
<th>TRAVEL COST ($)</th>
<th>OTHER COST ($)</th>
<th>TOTAL PER TASK</th>
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<td>Develop Project Specifications</td>
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Bibliography


American Nurses Credentialing Center [ANCC]. (n.d.). http://www.nursecredentialing.org


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