

A Violence Prevention and Preparedness Educational Intervention in Primary Care Clinics

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### Abstract

Violent acts of patients and/or visitors in the healthcare setting are an increasing problem that threatens the physical safety and psychological well-being of primary care office staff members and providers, as well as the levels of satisfaction, burnout, and turnover. The purpose of this pilot, quasi-experimental study was to determine if the evidence based educational intervention increased staff perception of workplace satisfaction, workplace safety, and knowledge of roles and responsibility in violent situations at a Federally Qualified Health Center (FQHC) with two locations in rural Missouri. The population for the study was a convenience sample of approximately 20 healthcare providers, including NPs, RNs, LPNs, MAs, and other direct patient contact staff. The outcomes measured were de-escalation knowledge level, perception of safety level, and workplace satisfaction level. The intervention did not statistically impact knowledge level or perception of safety level. Workplace satisfaction did improve statistically after the intervention. The time constraint of one hour was the greatest limitation to this study. Further research on this topic is recommended.

*Keywords:* education, nursing satisfaction, occupational stress, office nursing, primary health care, security, workplace violence, workplace violence prevention and control, quasi-experimental

### A Violence Prevention and Preparedness Educational Intervention in Primary Care Clinics

Healthcare facilities, including primary care offices, are locations for individuals and families to seek help when ill or vulnerable. Unfortunately, these locations have seen an increase in patients and families acting violently toward healthcare staff (El-Gilany, El-Wehady, & Amr, 2010; Powley, 2013; Whelan, 2008). Nurses and other healthcare providers have become exposed to violence more frequently, in one form or another, which has negative consequences to nurses as individuals and nursing as a profession (see Appendix A). In particular, physical violence and verbal abuse have serious ramifications, including increased turnover rates, decreased nursing satisfaction, and lower levels of psychological and physical health (El-Gilany, El-Wehady, & Amr, 2010; Oyeleye, Hanson, O'Connor, & Dunn, 2013; Tan, Lopez, & Cleary, 2015). Nurses and nursing staff should be provided the tools to prevent the escalation of verbal abuse to violence and be prepared if they are threatened with physical violence (Menendez, Gillespie, Gates, Miller, & Howard, 2012). Implementation of an educational program for employees that focuses on de-escalation techniques, roles and responsibilities, and incident reporting has been shown to improve staff's perception of knowledge, increase satisfaction, and increase perception of organizational support (Demir, Rodwell, & Flower, 2015; Ferns, 2012; Gillespie, Gates, & Farra, 2014; Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014; Itzhaki, et al., 2015; Tan, Lopez, & Cleary, 2015).

### **Significance**

The Bureau of Labor Statistics (BLS) reports data related to healthcare worker injuries and fatalities each year. The data from 2016 is currently unavailable, however, for the year 2015, there were 29 fatalities related to violence and other injuries by persons or animals (BLS, 2017a). Nineteen of the fatalities were characterized as homicides and 10 were suicides (BLS, 2017a). Of

the 19 homicides, three were caused by a relative or domestic partner of the victim and 12 were caused by co-workers (BLS, 2017a). One of the fatalities was characterized as caused by an assailant, suspect, or inmate (BLS, 2017a). The method of injury reported were 20 cause by gunshot and three caused by asphyxiation, strangulation, or suffocation (BLS, 2017a).

The data from 2015 shows an increase in fatalities compared to the 2014 data. The BLS reported for the year 2014, there were 8 fatal injuries that occurred in the ambulatory health setting and 7 that occurred in the hospital setting that were directly due to violence from persons or animals; nine of these were due to gunshot wounds (BLS, 2014a).

### **Economic Significance**

Violence in the healthcare setting may result in death, which costs both the individual's family and the healthcare system considerable financial ramifications. However, non-fatal injuries due to violence from patients or visitors that occur in healthcare facilities are also costly to both the institution and the individual injured. When individuals experience violence related injuries at work, days off work, as well as workman's compensation, financially impact the organization. In 2015, 4,670 healthcare workers were intentionally injured by persons or animals (BLS, 2017b). Per BLS data, healthcare patients caused 19,140 non-fatal injuries in 2015 (BLS, 2017b). In 2014, the BLS disclosed that healthcare workers were injured from violence related to persons or animals at an incident rate of 14.4 per 10,000 workers (BLS, 2015). Also, in 2013, the incidence of healthcare workers injured due to the acts of persons or animals was 19.3 per 10,000 workers (BLS, 2014b). In 2013 and 2014, the median days off work from the injury sustained at work was 6 days (BLS, 2014b; BLS, 2015).

**Policy Significance**

Due to the incidence of violence increasing in healthcare facilities, organizations must develop and maintain policies to protect their staff. Wolf, Delao, and Perhats (2014) found in their study that even when signs were in place that stated the organization would not tolerate violence in any way, nurses felt they had not seen those policies enforced. An overwhelming theme found in the literature was the lack of support when nurses did want to press charges against patients that had attacked them (Al-Bashtawy, 2013; Al-Omari, 2015; Wolf, Delao, & Perhats, 2014). Nurses reported responses from district attorneys and judges stating that they could press charges but nothing would happen, or that being attacked was simply part of working in the emergency room (Wolf, Delao, & Perhats, 2014).

The attitude of acceptance of violence in healthcare settings must change. Nationally, nurse advocates in the United States have been working to pass laws to protect nurses from violence. As of 2014, 30 states have made an attack on a healthcare worker a felony crime (Nelson, 2014). Nursing staff need to be taught to use their organization's incident reporting system, and additionally, need to feel empowered to report when they are assaulted (Ferns, 2012).

**Health System Significance**

Regardless of the demographics of the health system, organizations should place policies and safety measure in their facilities to discourage violence and increase the perception of safety and support by their staff. Blando, O'Hagan, Casteel, Nocera, and Peek-Asa (2013) found the implementation of security guard presence, metal detectors, security cameras, and panic buttons greatly increased the staff's perception of organizational support and safety in their workplace.

Health systems should weigh the costs of implementing similar interventions, while keeping in mind the cost of violence and nurse turnover to their healthcare organization (Al-Omari, 2015; Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013).

### **Local Issue**

This doctoral project was performed in a Federally Qualified Health Center (FQHC), with two primary health care clinics in rural Missouri. The clinics do not see a large amount of physical violence; however, staff have reported times when patients or families became verbally abusive. Although there are panic buttons at the front desk, the staff stated they are unsure if they even work. The clinics do have a paper incident reporting policy in place, but the system is not utilized by staff members. An overall health care system policy on personal safety and violence was non-existent. Lastly, staff have not received any training on de-escalation or roles and responsibilities in an active high risk situation.

### **Diversity Considerations**

Both locations of the project implementation were rural, underserved Missouri towns. As of July 2015, the population of the first location was 457 individuals, with a diversity index of 11, compared to the nationwide average of 60 (Missouri Home Town Locator, 2016a). The median household income in 2015 was \$28,249 (Missouri Home Town Locator, 2016a). Likewise, in 2015, the population of the other location was 440 people (Missouri Home Town Locator, 2016b). The racial diversity index was also quite low at 9, and the median household income was \$39,219 in 2015 (Missouri Home Town Locator, 2016b).

Within the clinic settings, the diversity present comes in the form of different levels of education, age, and job roles. There are two physicians and two advanced nurse practitioners at

the larger site, and one advanced nurse practitioner at the smaller site. An additional nurse practitioner divides his time between the two locations. Both clinics employ registered nurses (RN), licensed practical nurses (LPN), medical assistants (MA), and non-clinical clerical staff. The office manager and the Chief Executive Officer (CEO) work out of the larger clinic. The staff are of various ages, and many of the staff members are MAs or LPNs cross-trained for different roles, such as billing specialist and insurance assistance specialist, while performing patient care if needed in the clinic.

### **Problem and Purpose**

Physical violence and verbal abuse is a problem that healthcare workers face. As the Bureau of Labor Statistics and accounts from nurses have shown, injuries due to violence, both fatal and non-fatal, occur in the workplace of nurses and other healthcare staff while they attempt to provide care to patients, causing financial ramifications to both the organization and the individual (Wolf, Delao, & Perhats, 2014). Non-physical psychological damages have also been seen to occur after being faced with violence or verbal abuse. Healthcare staff have reported feelings of suspicion, anger, and resentment (Al-Omari, 2015; El-Gilany, El-Wehady, & Amr, 2010; Tan, Lopez, & Cleary, 2015). Decreased work satisfaction, decreased efficiency and performance, and increased job turnover related to high stress and burnout have been reported by studies focused on exposure to violence (El-Gilany, El-Wehady, & Amr, 2010; Oyeleye, Hanson, O'Connor & Dunn, 2013; Tan, Lopez, & Cleary, 2015).

### **Problem Statement**

The lack of training for staff to prevent or be prepared for violence in the workplace is a serious disservice to healthcare providers and negatively affects healthcare organizations (El-

Gilany, El-Wehady, & Amr, 2010; Oyeleye, Hanson, O'Connor, & Dunn, 2013; Tan, Lopez, & Cleary, 2015). Benefits have been shown to be associated with the implementation of de-escalation and team approach training and education focused on environmental safety, risk assessment, communication skills, and the importance of incident reporting in various studies focused on educational intervention for improvement of violence (Beech, 2008; Demir, Rodwell, & Flower, 2014; Ferns, 2012; Gillespie, Gates, & Farra, 2014; Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014). These benefits included a noted increase in employees' organizational support, increase in self-confidence in remaining safe and ability to protect oneself, an increase in perception of safety, and improvement in cognizance of staffs' rights (Beech, 2008; Demir, Rodwell, & Flower, 2014; Ferns, 2012; Gillespie, Gates, & Farra, 2014; Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014).

### **Intended Improvement**

The purpose of this doctoral project was to determine if the evidence-based education intervention increased staff level of workplace satisfaction, perception of workplace safety, and knowledge of roles, responsibilities, and de-escalation in violent situations. In particular, the focus for improvement was the implementation of an educational intervention set in the primary care setting with the population of advanced nurse practitioners, nursing staff, and other direct patient care staff.

### **Facilitators and Barriers**

#### **Facilitators**

The implementation of this doctoral study was met with enthusiasm. The office manager is a strong proponent for personal safety and de-escalation training and willingly acted as a

facilitator for the implementation of the education and any changes in policy that needed to occur. The CEO of the health center was also agreeable to the implementation of the education and supported the creation of a policy.

The project also gained the support of a member of the Centers for Disease Control and Prevention (CDC) task force on Healthcare Violence, Dr. Gordon Gillespie. Dr. Gillespie provided permission to use his tool to measure the intervention (see Appendix B). He also offered to be a resource for the project.

**Project economics.** Another facilitator in the implementation of the doctoral project was the economics of the project. Approximately 80 hours were spent by the student investigator in formulating the educational materials and the analysis of data. This time was worth approximately \$800 dollars. The other cost of the project was approximately \$100 for office supplies, such as printing. Lastly, as a motivator for completion of all three surveys, a \$5 gift card was provided to staff members when they completed the three-month follow-up survey. Cumulatively, the project is estimated to cost \$1083 in total (see Appendix C). However, the cost was anticipated to be low for the clinic, which is why the economics were considered a facilitator.

**Sustainability.** The educational component utilized the Centers for Disease Control and Prevention (CDC)'s online offering entitled *Workplace Violence Prevention for Nurses* (see Appendix D). Education also focused on the newly formulated policy which address violence prevention and preparedness in the clinics (see Appendix E). The online offering is free and available to the public. The clinic staff may continue to use the educational material at little or no cost to their budget.

## **Barriers**

Prior to the implementation of the project, the only barrier anticipated was a resistance to change in accordance to the new policy. Lewin's Change Model was chosen for this reason as one of the most important steps in implementing change is the "unfreeze" step, the time that staff must change from their current behavior (Levasseur, 2001; Lewin, 1943). For staff to understand the need for the unfreeze stage, a clear explanation of the purpose of the change in practice was needed for successful acceptance by the staff (Doody & Doody, 2011; Levasseur, 2001; Lewin, 1943). However, the only resistance encountered was from the CEO, who did not agree to including into the policy annual safety training for staff.

## **Review of the Evidence**

### **PICOT Question**

In formulation of this doctoral project, the following PICOT(S) question was developed: In nursing and other direct patient contact staff, does additional education increase de-escalation technique knowledge levels, perception of safety, and workplace satisfaction compared to pre-education knowledge levels and satisfaction during a 3-month study at a primary care office setting? The question was designed to follow the framework of other studies that have implemented educational interventions related to violence preparedness in healthcare settings, such as the studies by Demir, Rodwell, and Flower (2014) and Gillespie, Gates, and Farra (2014).

### **Search Strategies**

For the literature review, an extensive search was performed using the Cochrane Database of Systematic Reviews (CDSR), Cumulative Index to Nursing and Allied Health

Literature (CINAHL), PubMed, Psychology and Behavioral Sciences Collection, and Medline (Ovid). The key terms utilized were job satisfaction, nursing role, occupational stress, office nursing, primary healthcare, psychiatric nursing, safety, workplace aggression, workplace violence, and workplace violence prevention. Inclusion criteria for the literature review included studies focused on the workplace and English print. The satisfaction level had to relate to occupational satisfaction and not be related to quality of home life satisfaction. Studies were excluded from the search if they were non-English print, integrated reviews, or focused on sexual assaults, horizontal violence, or intimate partner violence.

The evidence included 15 non-experimental quantitative research studies and one experimental quantitative study (see Appendix F). There were also seven non-experimental qualitative studies and seven mixed method studies included in the synthesis of evidence. Four expert opinion articles were included due to the extensive discussion of the subtopics of the doctoral project. Of these studies, there was one Level 1, twenty Level 3, twelve Level 6, and four Level 7 (Melynk & Fineout-Overholt, 2015).

### **Synthesis of Evidence**

**Physical and verbal violence.** Violence is a broad category that includes verbal abuse, nonverbal abuse, physical abuse, sexual harassment, bullying, passive behaviors, and passive-aggressive behaviors (McNamara, 2010; Whelan, 2008). Unfortunately, a large number of healthcare workers, both globally and nationally, reported being exposed to violence when interviewed or studied. Seventeen studies were chosen in the literature review as resources. In Saudi Arabia, researchers found 28% of the 1,091 healthcare workers interviewed positively responded to being exposed to physical violence in the past year, and 52.4% reported being verbally abused (El-Gilany, El-Wehady, & Amr, 2010). Research of family practice physicians

in Canada found 98% of the physicians had been victims at least once in their career of some form of abuse (Miedema et al., 2010). Likewise, a study in Australia found general practitioners reported experiencing physical violence in the previous year at a rate of 59.3% and verbal abuse at the rate of 80% (Magin, et al., 2011). Spector, Zhou, and Che (2013) performed a meta-analysis and found that physical violence in the healthcare setting worldwide had an incident rate of 36.2% and was more common in emergency rooms, psychiatric facilities, and geriatric facilities located in Anglo areas of the world.

In the United States, Wolf, Delao, and Perhats (2014) interviewed 46 emergency room nurses that had experienced violent attacks from families or patients to gain their perspective on the violence and the ramifications of the violence. A study of RNs and LPNs in the state of Florida was performed by Small, Porterfield, and Gordon (2015), which reported 85% of the respondents had experienced verbal abuse in the previous year and 20% had experienced physical abuse in the previous year. Likewise, a study located in the United States' Midwest region looked at 7 hospital systems and found there were 214 reported physically violent events which had been reported by nurses or other direct patient care staff (Arnetz, et al., 2014).

**Workplace satisfaction.** Unlike violence in healthcare, workplace satisfaction has been a focus of research since the 1970s with studies by Locke (1976), Mobley, Horner, and Hollingsworth (1978), and Griffeth, Hand, and Meglano (1979) setting groundwork for future research. Eleven of the studies found in the literature review were related to this topic. Workplace satisfaction was studied in a psychiatric unit by Rump in 1979 but was not focused on how violence exposure impacted the satisfaction level. Research has shown a correlation between workplace environment and workplace satisfaction, with poor workplace satisfaction leading to increased turnover rate (Lambert, Hogan, & Barton, 2001; Oyeleye, Hanson,

O'Connor, & Dunn, 2013; Palmer, 2014). Low levels of workplace satisfaction in nurses have also been associated with increased absenteeism, job burnout, development of physical and psychological disease, and poor patient outcomes (Oyeleye, Hanson, O'Connor, & Dunn, 2013; Palmer, 2014).

Hamaideh (2011) found that over-exposure to violence can result in low workplace satisfaction. Research by Oyeleye, Hanson, O'Connor, and Dunn (2013) also revealed a relationship between the occurrence of workplace incivility and the level of job burnout experienced by nurses. Inversely, a positive workplace satisfaction level has been correlated with decreased occurrence of nursing turnover or burnout (Bingham, Valenstein, Blow, & Alexander, 2002). Itzhaki, et al. (2015) reported an increase in workplace satisfaction after implementation of education that focused on violence preparedness and the employment of security in the workplace.

**Education.** Although physical violence and verbal abuse are experienced frequently by nurses and other direct patient care staff throughout the world, there is a lack of training for staff in preparedness or prevention of violence (McNamara, 2010; Tan, Lopez, & Cleary, 2015). Three studies primarily focused on violence preparedness education, although many of the studies which focused on violence identified education as a needed intervention. If organizations do provide some form of training for staff, it is often limited to the psychiatric unit staff (Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013). Blando, O'Hagan, Casteel, Nocera, and Peek-Asa (2013) performed a study that looked at de-escalation knowledge and safety perception in emergency room nurses and psychiatric unit nurses. They found that psychiatric nurses had higher levels of knowledge and workplace satisfaction than their emergency room peers, although both units saw a large number of violent incidents. The difference was found in the

training of the nurses; the psychiatric nurses received onboarding and continuing education related to de-escalation and violence preparedness while the emergency room nurses did not (Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013).

All staff should be trained upon initial employment and receive continuing education on de-escalation techniques to prevent volatile situations from turning violent (Beech 2008; Gates, Gillespie, & Succop, 2011). In studies based in emergency rooms, Gillespie, Gates, and Farra (2014) and Gillespie, Gates, Kowalenko, Bresler, and Succop (2014) implemented evidenced based education which covered environmental safety, risk assessment, de-escalation and team approach, incident reporting, and communication skills. They used live and online education methods and found a large increase in knowledge immediately after and six months after implementation (Gillespie, Gates, & Farra, 2014; Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014). Menendez, Gillespie, Gates, Miller, and Howard (2012) also performed a similar implementation in an emergency room but also focused on educating the staff of their roles and responsibilities in a violent event, as many staff had reported uncertainty of their roles or the roles of other staff, such as security. These authors recommended that educational interventions should include any staff with direct patient contact and clearly outline roles and responsibilities of each individual (Menendez, Gillespie, Gates, Miller, & Howard, 2012).

**Employee Commitment.** Five studies discussed employee commitment. This phrase refers to the loyalty of staff members for their place of employment or their commitment to the organization. Rout (1999) was one of the first to identify the negative impact of low workplace satisfaction and violence in the workplace on the support staff held for the organization. If staff have low levels of loyalty for their organization, job turnover occurs when the staff members experience burnout (Alsaraireh, Griffin, Ziehm, & Fitzpatrick, 2014; Armstrong-Stassen &

Cameron, 2005; Schat & Frone, 2013). To improve the level of employee commitment to the organization, leaders should attend post-violent event debriefings, provide continuing education, and provide programs to assist staff members in coping with the violence they are faced with, as these interventions have been shown to improve staff support of the organization (Itzhaki, et al., 2015; Tan, Lopez, & Cleary, 2015). Lastly, the literature overwhelmingly reported nursing and other direct patient staff desired a zero-tolerance policy on violence and when leaders promote this environment, employee commitment and support of the organization has increased (Demir, Rodwell, & Flower, 2015; Itzhaki, et al., 2015; Menendez, Gillespie, Gates, Miller, & Howard, 2012; Tan, Lopez, & Cleary, 2015; Whelan, 2008).

### **Theory**

Hans Selye's General Adaptation Theory served as the framework for this study. Selye (1950) broke down the response to stressors into the stages of alarm, resistance, and exhaustion. He based these stages on his study of the endocrine system and described the theory as a complete body response, both physical and psychological (Selye, 1950). He formulated this theory during his experience as a medical resident when he observed the phenomenon of which all patients, regardless of their diagnoses, exhibited similar early signs of stress (Selye, 1950).

Key principles in Selye's theory include stress may be either positive (eustress) or negative (distress) and stress signs and symptoms are similar despite the type of stressors an individual is exposed to (Selye, 1950; Selye, 1955; Selye, 1976). Selye also theorized individuals that stay in the resistance stage too long experience exhaustion, but that the length of the resistance stage is based on individual conditioning. This can be directly correlated to the effect of exposure to violence on the healthcare provider and explains the reason repeated exposure to

violence has been shown to lead to nursing turnover and decreased satisfaction levels (see Appendix G) (Oyeleye, Hanson, O'Connor, & Dunn, 2013; Palmer, 2014).

## **Methods**

### **Internal Review Board and Site Approval**

The setting for the project does not have their own Internal Review Board (IRB). The University of Missouri Kansas City (UMKC) IRB approved the doctoral research study in September 2016 (see Appendix H). The study involved human subjects and was considered Human Subjects Research and IRB expedited research review category 7.

Approval from the primary care location's CEO and office manager was obtained in June 2016 (see Appendix I). Approval from the site was communicated to the student investigator's faculty mentors and permission was granted.

### **Ethical Issues**

Although the population of the sample did not involve patients, ethical considerations of the sample's rights were considered. After discussion with the office manager, the education was required for all nursing staff, medical assistants, and other direct patient staff, and optional for the advanced nurse practitioners. The physicians were not included in the required education. However, participation in the surveys for the project was optional. Participation was rewarded with the \$5 gift card at the time of completion of the final survey, but the final survey and the gift cards were in a private area so that participants could choose anonymously to take the gift without completing a survey. The responses of staff in the surveys remained anonymous and protected. As the student investigator has experienced violence in healthcare personally, there

existed potential author conflict of interest. Faculty mentor involvement and the office manager collaboration assisted in management of this conflict of interest.

### **Funding**

The student investigator applied for the Advanced Practice Nurses of the Ozarks scholarship for DNP students and did not receive the scholarship. The direct cost of the \$5 gift cards and the 80 hours of project time the student investigator was funded by the student investigator. The student investigator also covered the indirect cost of the gas for the drive to the two sites which were approximately 60 miles away.

### **Setting and Participants**

The setting for this study was at an underserved, rural Federally Qualified Health Center with two clinic sites in Missouri. The population of focus was the direct patient care staff at both locations. The sample was a convenience sample of nurse practitioners, nurses, and other direct patient care staff. The student investigator excluded the physicians and non-patient contact staff. Exclusion also included non-English speaking staff. Approximately 30 staff members were invited to be included into the convenience sample. Twenty-three individuals participated in the pre-test and educational intervention. Twenty-two individuals responded to the immediate post-test. Eleven of the responses to the three-month post-test were linked to previous responses, and four responses were unique and not linked to any previous participants with the unique identifier code.

### **Evidenced-based Intervention**

Two studies served as the framework for the evidenced-based intervention. Gillespie, Gates, and Farra (2014) and Gillespie, Gates, Kowalenko, Bresler, and Succop (2014) performed

studies that detailed their educational intervention and showed progress in knowledge and satisfaction. Although these studies were both set in emergency rooms, the format of the education was detailed and their measured outcomes were the same for this project. Both programs had two components: an online course and a live class (Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014; Gillespie, Gates, & Farra, 2014). The topics covered by the education were environmental safety, de-escalation, risk assessment, communication skills, team approach, and incident reporting (Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014; Gillespie, Gates, & Farra, 2014).

The educational intervention was delivered over four, one-hour “lunch and learn” sessions (see Appendix J). Content for the education was from the CDC’s *Workplace Violence Prevention for Nurses* free online program. Although the title implies the education is for nurses only, the objectives clearly outline the education is meant for all healthcare providers. The program focused on environmental safety, de-escalation, risk assessment, communication skills, team approach, and incident reporting as guided by Gillespie, Gates, and Farra (2014) and Gillespie, Gates, Kowalenko, Bresler, and Succop (2014). The office manager, the CEO, and the student investigator developed a policy that outlined clinic specific procedures related to safety and staff roles and responsibilities in a volatile situation. Printed versions of the new policy were provided to the staff members during the educational session.

During the one-hour “lunch and learn” sessions, the intervention began with a 30-minute online module, *Workplace Violence Prevention for Nurses*, presented via projector, which the student investigator controlled on the computer. Due to time, the entirety of the online module was not provided. The education covered Unit 1, Definition, Types, Prevalence; Unit 2, Workplace Violence Consequences; Unit 3, Risk Factors for Type 2 Violence; Unit 6,

Prevention Strategies for Nurses; and Unit 7, Intervention Strategies. The units are interactive and include lectures which were read by the student investigator, videos, and quizzes. The participants completed the module as a group, with the student investigator clicking responses on the computer. Due to discussion, actual time spent over the module was approximately 40 minutes. The next 5-10 minutes were spent in discussion over the new policy, which was handed out to every attendee. The plan was to role play for practice assigned roles in verbal and physical escalation situations to follow, but due to the time constraints this was not done and the office manager stated she would follow-up with the staff. The final 10 minutes were allotted for questions and answers for the office manager and the student investigator, and then for the immediate post-test completion.

### **Change Process**

The change model chosen for this research study was Lewin's Change Model. Many change models focus on patient behavior changes. However, for this study, the model needed to be applicable to change in a primary care setting and focused on the change of staff behavior. Lewin's Change Model contains three steps: Unfreeze, Change, and Refreeze (Cummings, Bridgman, & Brown, 2016; Lewin, 1943). One of the most important steps in the model is unfreeze in which the implementer of change must show the staff the importance of changing from current practices or behaviors (Levasseur, 2001; Lewin, 1943).

### **Evidenced-based Model**

The evidenced-based practice model utilized for this study was the Iowa Model of Evidenced-Based Practice. Like the change model, this evidenced-based practice model is aimed at implementing current evidenced-based guidelines into a clinical setting (White & Spruce,

2015). A benefit of this model is the focus on explaining current best practices to staff to help them understand the purpose of the change (Doody & Doody, 2011). This model also addressed the barrier of staff accepting the need for change in their current practice.

### **Study Design**

The design for this quasi-experimental study was a single group convenience sample with a pre-test, intervention, and post-test framework (see Appendix K). Details on the project were provided to the staff via email (see Appendix L). A consent form which informed the participant of the purpose and procedure of the project, and addressed confidentiality and voluntary participation was reviewed with the participants by the student investigator (see Appendix M). These consent forms were not signed, and participants understood participation in the surveys implied consent.

The pretest was offered immediately prior to the beginning of the educational intervention during the “lunch and learn” sessions which occurred October 24<sup>th</sup>, 25<sup>th</sup>, 26<sup>th</sup> and 27<sup>th</sup>, 2016. There was an immediate post-test after the educational intervention. Three months later, January 30<sup>th</sup> and February 1<sup>st</sup>, 2017, the student investigator returned to the project settings and provided a three-month follow-up post-test. The post-test was set in a private room with the gift card incentive which allowed individuals the privacy of choosing to not complete the final survey and still receive a gift card. A unique anonymous code, developed from details of participant demographics was asked for in each survey to link all three surveys. Data collection was performed October 2016 through February 2017, and data analysis occurred February through March 2017 (see Appendix N).

**Validity**

Due to the format of the proposed study, internal validity is high. Since the time frame of the study was relatively short, the participants were unlikely to be exposed to an event that would alter their results and interfere with the data gathered. It is highly likely any changes seen between the pre-and post-testing were due to the education intervention. The proposed study also has external validity and could be applied to primary healthcare settings regardless of demographics or populations. Although primary care offices may encounter verbal abuse or physical violence at different frequencies, training for preparedness is universal. The only changes to the study a clinic would need to make would be the clinic specific policy on how to handle a volatile situation. However, environmental safety, de-escalation, risk assessment, communication skills, team approach, and importance of incident reporting is universal.

**Measured Outcomes and Instrument**

The outcomes measured were de-escalation knowledge levels, perception of safety level, and workplace satisfaction level. The measurement instrument was used with permission from Dr. Gordon Gillespie (see Appendix O). The tool was adapted to change the location of the study from emergency room to primary care office. The tool was used by Gillespie, Farra, and Gates (2014). They did not publish the validity or reliability of the tool, but stated each item of the test was reviewed and deemed valid and reliable based on the feedback and revisions of a panel of experts on violence (Gillespie, Farra, & Gates, 2014). The modified tool had a total of 22 questions, with fourteen questions which addressed de-escalation knowledge.

Questions 17-22 were developed by the student investigator and had not been previously tested. Reliability was performed for the additional questions developed by the student

investigator with SPSS (see Appendix P). Questions 17 and 18 measured the workplace satisfaction level and had a Cronbach's alpha of .939. Questions 19 and 20 measured perception of safety level and had a Cronbach's alpha of .870.

### **Quality of Data**

The student investigator undertook methods to promote the quality of data. Permission to use the instrument was received from Dr. Gordon Gillespie, as discussed previously. A power analysis was not indicated due to the sample size being less than 30 individuals. Baseline data was gathered in the study and immediate post data occurred within the same hour, which promoted quality of data. Unfortunately, the two studies used as benchmarks were set in the emergency room and not in a primary care clinic.

### **Analysis**

To link responses, a personal identification code was used that did not identify the individual. Due to the small sample size, demographic information was not gathered. If demographic data had been gathered, the risk of breach of confidentiality would have increased. Analysis of the data was performed with SPSS and the statistical test performed was Wilcoxon-Matched pairs test for knowledge levels, perception of safety, and workplace satisfaction levels, as per the recommendation of the project's statistician provided by UMKC (see Appendix Q). The deidentified data analysis was performed by the student investigator and a statistician employed at a local hospital, with approval from faculty advisors.

## **Results**

### **Setting and Participants**

The research took place at two rural clinics. The “lunch and learn” sessions on October 24<sup>th</sup>, 25<sup>th</sup>, and 26<sup>th</sup> were at the larger location, and the session on October 27<sup>th</sup> was at the other site. Three months later, the immediate post tests were offered at the larger clinic on January 30<sup>th</sup> and at both locations on February 1<sup>st</sup>.

The participants of the study were staff members from both settings. The participants were from a variety of job roles including medical assistants, RNs, LPNs, nurse practitioners, and other direct patient care staff. The student investigator excluded the physicians and non-patient contact staff. Demographics were not collected due to confidentiality concerns. Twenty-five individuals attended the “lunch and learn” sessions.

### **Intervention Course, Actual**

The major components of the intervention were the “lunch and learn” sessions and the three-month follow-up. The “lunch and learn” sessions were planned to be a 1-hour event with 30 minutes devoted to the CDC online education, 10 minutes for policy discussion and role playing, and 10 minutes for questions and answers. The student investigator did not anticipate the time needed for completion of the pre- and post-test during this 1-hour period. In actuality, the pre-test took the participants approximately 10 minutes to complete, the educational information from the CDC lasted approximately 40 minutes, and the newly developed policy was briefly discussed for 3-5 minutes with few questions. The remaining 5-7 minutes were left for the staff to complete the immediate post-test, with many individuals taking up to 10 minutes, which

caused for a greater than one-hour event. This did not cause any complaint from the office manager or CEO.

The three-month follow-up was offered to staff on two occasions, January 30<sup>th</sup> and February 1<sup>st</sup> at the larger location, and once for the smaller clinic on February 1<sup>st</sup>. The student investigator spent multiple hours each day to allow staff the opportunity to collect their \$5 gift card and to complete the three-month post-test.

The “lunch and learns” were well attended. Twenty-five individuals attended the educational intervention. Twenty-three individuals participated in the pre-test. Two individuals were late to the session and the education had already begun; these individuals were excluded from the study group but listened to the education. Twenty-two individuals responded to the immediate post-test. Eleven of the responses to the three-month post-test were linked to previous responses, and four responses were unique and not linked to any previous participants with the unique identifier code.

### **Outcome Data**

**Knowledge levels.** The first outcome measured was the de-escalation knowledge level. The first 17 questions of the tool were graded as a percentile out of one-hundred. Wilcoxon Signed Ranks Test were performed and compared pre-test knowledge score and immediate post-test knowledge score, immediate post-test score and three-month knowledge score, and pre-test knowledge score and three-month knowledge score (see Appendix R). Pre-test knowledge  $n=23$ , immediate post-test knowledge  $n=22$ , and three-month knowledge  $n=15$ . Data analysis between the pre-test knowledge scores and the immediate post-test knowledge score found seven negative ranks, seven positive ranks, and eight ties, with a Z score of -0.96 and  $p=.924$ . Data

analysis between the immediate post-test knowledge score and the three-month knowledge score found three negative ranks, 6 positive ranks, and two ties, with a Z score of  $-.844$  and  $p = .399$ .

Lastly, data analysis between pre-test knowledge and three-month knowledge score resulted in three negative ranks, six positive ranks, and two ties, with a Z score of  $-1.379$  and  $p = .168$ . There was not a statistically significant change in knowledge levels.

**Workplace satisfaction levels.** Workplace satisfaction was measured based on responses to questions 17 and 18 on the tool. Composite results were used on the Wilcoxon Signed Ranks Tests. Data analysis between pre-test satisfaction and immediate post-test satisfaction resulted in zero negative ranks, seven positive ranks, and 15 ties, with a Z score of  $-2.46$  and  $p = .014$ . Data analysis which measured immediate post-test satisfaction and three-month satisfaction found one negative rank, three positive ranks, and seven ties, with Z score of  $-1.289$  and  $p = .197$ . Comparison between pre-test satisfaction and three-month post satisfaction results showed zero negative ranks, six positive ranks, and five ties, with a Z score of  $-2.232$  and  $p = .026$ . The Wilcoxon signed ranks showed that workplace satisfaction was statistically significant between pre-test and immediate post-test, as well as pre-test and three-month test. There were not significant changes between post-test and three-month post-test satisfaction levels.

**Perception of safety levels.** The last outcome measured was staff perception of safety. Questions 19 and 20 were analyzed as composite, and question 21 was measured individually. The Wilcoxon Signed Ranks Tests for pre-test perception of safety compared with immediate perception of safety resulted in five negative ranks, four positive ranks, and 13 ties, with a Z score of  $-.577$  and  $p = .564$ . The data analysis between immediate perception of safety and three-month perception of safety resulted in two negative ranks, two positive ranks, and seven ties, with a Z score of  $.000$  and  $p = 1$ . The data analysis between pre-test perception of safety and

three-month perception of safety found three negative ranks, four positive ranks, and four ties, with a Z score of  $-.264$  and  $p = .792$ .

Statistical analysis on question 21 was done with Wilcoxon Signed Ranks Tests which measured the results of all three tests. Data analysis of pre-test responses and immediate post-test found one negative rank, two positive ranks, and 19 ties, with a Z score of  $-.577$  and  $p = .564$ . The immediate post-test results compared to the three-month test resulted with two negative ranks, two positive ranks, and seven ties, with a Z score of  $.000$  and  $p = 1$ . Finally, data analysis performed with pre-test and three-month post-test responses found two negative ranks, two positive ranks, and seven ties, with a Z score of  $.000$  and  $p = 1$ . The results showed the educational intervention did not have a statistically significant impact on staff perception of safety.

**Missing data.** Although 25 staff members participated in the educational intervention, the pre-test sample  $n=23$  due to two individuals arriving late to the intervention and missing the pre-test. The immediate post-test  $n=22$ , with one participant returning a blank test. For the three-month post-test group,  $n=15$ ; however, four of the responses were unable to be linked with the unique identifier to previous responses and are missing in the statistics.

## Discussion

### Successes

The greatest success of this study was the finding of statistical significance related to the improvement in workplace satisfaction levels. These results suggest the economic investment of providing a paid “lunch and learn” session and the development of a policy to ensure the protection of staff was fruitful for the employer. As reported in the review of the literature, an

increased satisfaction level has been shown to decrease nurse burnout and decreased turnover (Bingham, Valenstein, Blow, & Alexander, 2002). Thus, by improving the staff satisfaction level, the study has likely decreased the rate of staff turnover.

### **Study Strengths**

The elements of the setting that provided support and context for the intervention would include the organizational culture, the staff members, and the leadership. Due to the organization's rural location and small size, the culture of the organization is very personable. The culture was open to change, which was an anticipated barrier. The staff members were very welcoming to the student investigator and provided respectful attention and interaction during the educational intervention. The participation on surveys was adequate for a pilot research study, with a good number of participants choosing to answer. The leadership was also very accommodating to the study, and the office manager replied to emails quickly and provided any support that was needed.

### **Results Compared to the Literature**

**Knowledge levels.** Although there were no direct benchmark studies found to compare the results of this study with, studies performed in other settings were used as the framework. Gillespie, Gates, and Farra (2014) and Gillespie, Gates, Kowalenko, Bresler, and Succop (2014) had statistically significant results which showed a large increase in knowledge levels. The knowledge levels in this project in primary care did not change significantly across the time of the project.

**Workplace satisfaction.** The findings of this project were consistent to the findings in the literature (Bingham, Valenstein, Blow, & Alexander, 2002). Itzhaki et al. (2015) and Tan,

Lopez, and Cleary (2015) reported continuing education on violence training had a positive impact on staff workplace satisfaction. The educational intervention and the development of a policy on staff safety resulted in statistically significant improvement in the satisfaction level of this organizations' staff members.

**Perception of safety.** There were no benchmark studies to compare with the data results of impact of the intervention on staff perception of safety. This study did not find statistical significance between the intervention and the responses of the surveys. Research studies have reported the high rates of violence which occur but did not report the perceived safety of the staff (Magin, et al., 2011; Miedema et al., 2010; Spector, Zhou, & Che (2013; Wolf, Delao, & Perhats, 2014).

### **Limitations**

#### **Internal Validity Effects**

Possible confounding factors did present during the implementation of the intervention. The Hermitage location had recently placed a protective barrier between the nurses' station and the hall which increased safety for staff from potentially violent patients and/or visitors prior to the intervention. This may have created a glass ceiling and affected the positive responses to perception of safety on the pre-test.

Personal exposure to violence, although not captured in demographic data, had the potential to confound the results related to perception of safety and de-escalation knowledge. During the education intervention, a few staff members shared personal exposure to violence examples. Having had a personal experience may have impacted an individual's responses. Also,

because the participants were different during each session, the same personal exposure stories were not shared at each session. This may have also impacted the data.

The potential for bias from the personal experiences of the student investigator related to exposure to violence in the healthcare setting were controlled. Although the student investigator portrayed a passion for staff safety in the educational intervention, personal experiences were not shared with any group of participants.

### **External Validity Effects**

The project as implemented would be generalizable for other primary care clinics. The CDC module, with the specific modules utilized, are generalizable to any primary health setting, regardless of geographic characteristics. The education was given in English, which would limit the usefulness of the CDC module to a non-English speaking staff member in another setting.

This particular policy developed could be used as a guide for other clinics who wish to develop a safety policy. However, the details of the policy written were specifically tailored to the project locations. If another location desired to implement this project, a new policy would need to be written for their organization.

### **Sustainability of Effects**

The only outcome improved by the implementation was workplace satisfaction. It is likely for this improvement to be weakened over time. Workplace satisfaction may be impacted through a variety of factors besides education related to violence. These other factors, such as changes in leadership or adjustments in pay or resources, may lead to a change in the level of satisfaction in the staff.

Unfortunately, the CEO did not see the importance of annual education and no plan to maintain the effects exists currently to the knowledge of the student investigator. The office manager did remark that she planned to review the policy in more detail with the staff and start holding event debriefings after high risk situations. This has not occurred to date.

### **Efforts to Minimize the Limitations**

Efforts were taken to minimize the limitations impact on application of results by the student investigator. As previously stated, the student investigator did not disclose any of the personal experiences of violence in healthcare to the participants in any session. Although it is unlikely this same educational intervention will be utilized by this site again, the concept of providing an annual “lunch and learn” session related to staff safety and violence prevention and preparedness is sustainable. By utilizing the CDC online offering, the clinic manager could assign the module to new staff for training.

## **Interpretation**

### **Expected and Actual Outcomes**

Based on the review of the literature, the student investigator anticipated improvements in all three outcomes measured. However, after implementation, the student investigator concluded that one hour was not enough time to make an impact in the knowledge level of staff on de-escalation techniques and roles and responsibilities in a violent situation. Thus, the student investigator was not surprised that knowledge levels were not significantly impacted.

Workplace satisfaction improved in the study as expected by the student investigator based on the findings in the literatures. The drop-off in the sample size may have impacted these findings however. Perhaps the individuals with lower satisfaction had a decrease desire to

participate in the three-month study. Perhaps the dissatisfied individuals quit or were fired. Unfortunately, several internal and external variables exist which could have altered this outcome.

The perception of safety outcome was not altered significantly as expected by the student investigator. A review of responses showed that most individuals marked high or moderately high feelings of safety on the pre-test which did not allow for improvement in their responses in the follow-up tests.

### **Intervention Effectiveness**

Although the “lunch and learn” was not enough time to improve the knowledge level of violence prevention and preparedness, the intervention did bring the topic to the attention of staff and began the conversation. This allowed the staff to see that their leadership felt the topic was important and that the safety of the staff members was important as well.

### **Intervention Revision**

Revisions recommended to this implementation would be to increase the time spent on the topic. One hour was not an adequate amount of time to discuss all the components of de-escalation and personal safety, as well as the review of policy and role playing. The format of the intervention should be altered either an all-day class or several “lunch and learn” sessions which focus on different aspects of violence prevention and preparedness. Annual education would also be recommended.

### **Expected and Actual Impact**

The cost of the intervention was anticipated to be low to the organization. However, the student investigator did not factor in the salaries of the employees while they ate, as the lunch hour was paid. The benefit of the “lunch and learn” format is that it does not impact patient care. The student investigator also anticipated providing staff with \$150 worth of gift cards. However, only 16 staff members took their incentive, which decreased the cost of the project for the student investigator.

### **Conclusions**

#### **Practicality of Intervention**

This pilot study was designed to be both useful and practical to implement. The intervention did not interrupt scheduled workflow or patient care. With implementation and the result of increase workplace satisfaction, both the staff and the health system benefitted.

#### **Further Study**

Further study on this topic is needed. Throughout the literature review, not a single study in the United States focused on an educational intervention to improve the prevention and preparedness of primary care health providers when faced with physical violence or verbal abuse. This pilot study showed that a “lunch and learn” session may improve workplace satisfaction, but was not adequate to impact knowledge levels. Further research on violence in primary care should be pursued.

**Dissemination**

The results of this study will be shared with faculty and students at UMKC in May 2016. Overall outcomes were also shared with the CEO and the office manager at the project site in April 2016. Results were sent to Dr. Gillespie, as he generously provided the tool for the study. The project proposal poster was shared at the Advanced Practice Nurses of the Ozarks 2016 Conference in November 2016, and a review of the literature manuscript was submitted to the *Journal of Doctoral Nursing Practice*.

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## Appendix A

## Definition of Terms

**General Adaptation Theory** – Non-nursing theory developed by Hans Selye (1950) that described the effects of stress on the body as a whole. Three stages alarm, resistance, and exhaustion.

**Organizational support** – The level of allegiance staff has toward their employer (Rout, 1999).

**Violence** – Includes verbal and non-verbal abuse, physical attacks, sexual harassment, bullying, passive and passive-aggressive behaviors (McNamara, 2010; Whelan, 2008)

Appendix B

Permission for Tool

**From:** Gillespie, Gordon  
**Sent:** Tuesday, April 19, 2016 2:01:14 PM  
**To:** Taylor, Jennifer K. (UMKC-Student)  
**Cc:** Gillespie, Gordon  
**Subject:** RE: Doctoral Project Focused on Violence in Primary Care

Attached is the pretest/posttest we used for those studies. Feel free to use and adapt as you would like. If you need anything else, just let me know.

Thanks, Gordon

Gordon Lee Gillespie, PhD, DNP, RN, CEN, CNE, CPEN, PHCNS-BC, FAEN  
Associate Professor  
Deputy Director, Occupational Health Nursing Program  
University of Cincinnati College of Nursing



## Appendix C

## Cost Table for Project

<b>Cost Table</b>	
<b>Education Development and Project Implementation</b>	\$800 (80 hours at \$10 per hour)
<b>Printing Supplies</b>	\$100
<b>\$5 Gift Card Incentive for Staff</b>	\$150 (approximately 30 staff)
<b>Travel Gas</b>	\$33
<b>Total</b>	<b>\$1083</b>

## Appendix D

## Intervention Material Outline

**Workplace Violence Prevention for Nurses  
CDC Course No. WB1865 - NIOSH Pub. No. 2013-155***Description*

The purpose of this course is to help healthcare workers better understand the scope and nature of violence in the healthcare workplace. Participants will learn how to recognize the key elements of a comprehensive workplace violence prevention program, how organizational systems impact workplace violence, how to apply individual strategies, and develop skills for preventing and responding to workplace violence. Content is derived from content experts and from the OSHA 2004 Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (OSHA 3148-01R 2004).

*Course Objectives*

At the conclusion of the session, the participant will be able to accomplish the following:

- Identify institutional environmental and policy risk factors for workplace violence.
- Recognize behavioral warning signs of violence in individuals.
- Employ communication and teamwork skills to prevent and manage violence.
- Identify appropriate resources to support injured healthcare workers.
- Take steps to implement a comprehensive workplace violence prevention program.

*Target Audience*

The Workplace Violence Prevention for Nurses is intended for the following healthcare professionals who desire an introduction to workplace violence prevention strategies:

- Registered Nurses
- Nurse Practitioners
- Physicians assistants
- Physicians
- Veterinarians
- Health Educators
- Nursing students
- Medical students

## Appendix E

## Clinic Policy

  
SYSTEM POLICY – EMPLOYEE SAFETY

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Submitted by:  Office Manager, LPN

Approved by: \_\_\_\_\_

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## PURPOSE:

The purpose of this policy is to implement safety strategies across both   locations. This policy will improve guidelines for staff to provide a safer environment for employees, patients, and visitors.

SCOPE: 

## DEFINITIONS:

Direct patient contact staff: Staff that interacts with patients directly, such as receptionist, schedulers, and billing staff

Nursing staff: Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Medical Assistants (MAs)

Physical violence – Attack onto another individual's person, not limited but including kicking, biting, hitting, punching, and scratching

## POLICY:

- A. During operating hours, there should be at least two individuals in the building.
- B. During operating hours, the only doors unlocked are to be the entrance doors in each location.
- C. After operating hours, all external doors should remain locked.
- D. If a situation arises where the behavior of a person causes disruption to the normal operation of the clinic (loud arguing, cursing, yelling, or destruction of property, and no weapon is displayed, the response should be for the staff member(s) to implement verbal de-escalation while another employee alerts the Office Manager or the supervisor available at that time.
- E. If the situation arises where the behavior of a person becomes physically destructive to property or other persons, staff should remove other patients and/or visitors from the area.
- F. Staff is to call 911 if an individual becomes physically destructive to property, physically violent to other persons, or threatens persons with a weapon, regardless of whether the weapon is seen by staff.
- G. If a patient seems mentally unwell, staff should keep the patient in the lobby and call for the Office Manager or the supervisor available at that time for guidance.
- H. If staff members are injured by patients or by visitor, the administration of the clinic supports the staff member in pressing legal charges.

- I. If a patient becomes a threat to his/her own person staff will call EMS/and or Law Enforcement. They will be placed in an exam room; a staff member will stay with them if it is felt to be safe. If not a staff member will remain outside the door until EMS or Law Enforcement arrives on scene.
- J. An affidavit will be filled out by the staff member that heard the comments from the patient directly.
- K. If the patient is not willing to go with the ambulance crew and an affidavit has been filled out, law enforcement will be called.
- L. If the patient begins to act violently, although there is an affidavit in place, staff should not detain the individual as their safety may be compromised.
- M. An incident report will be filled out when a person is injured on the property of either [REDACTED] clinic.

PROCEDURE:

- A. Appropriate employee response to physical violence or the threat of physical violence may differ depending on location.
- B. General Instructions-
  - 1. If person(s) in lobby area becomes threatening or violent, staff should inform patients in rooms to stay calm and to stay in their room.
  - 2. If a patient becomes a threat to his/her own person staff will call EMS/and or Law Enforcement. They will be placed in an exam room; a staff member will stay with them if it is felt to be safe. If not a staff member will, remain outside the door until EMS or Law Enforcement arrives on scene.
  - 3. An affidavit will be filled out by the staff member that heard the comments from the patient directly.
  - 4. If the patient is not willing to go with the ambulance crew and an affidavit has been filled out, law enforcement will be called.
  - 5. If the patient begins to act violently, although there is an affidavit in place, staff should not detain the individual as their safety may be compromised.
  - 6. An incident report will be filled out when a person is injured on the property of either [REDACTED] clinic.
  - 7. An incident report will be filled out when a person is injured on the property of either [REDACTED] clinic.
  - 8. Alert other areas of the building as soon as it is safe to do so.
- C. Specific Locations:
  - i. Billing Department- Will keep the entrance door locked at all times. If a person should enter the billing department without permission and refuses to leave, one staff member will call 911 and one staff member will call the front desk to alert them of the situation when it is safe to do so.
  - ii. Behavioral Health- [REDACTED] location- If a person in the lobby area or therapy office becomes threatening or violent, staff will activate the panic button to alert [REDACTED]

County Sheriff's Department. Isolate the person until Law Enforcement and/or EMS arrives. An affidavit will be filled out by staff involved in the incident. Alert other areas of the building as soon as it is safe to do so.

- iii. [REDACTED] Location- If a person in the lobby area or therapy office becomes threatening or violent, staff will call 911. Isolate the patient in a room until Law Enforcement or EMS arrives. Staff will advise all other patients to stay in their exam rooms until the threat is over. If at any time the patient's behavior compromises the safety and welfare of staff and other patients allow the patient to leave the building and report this to Law Enforcement. An affidavit will be filled out by staff involved in the incident. An incident report will be filled out when a person is injured on the property of either [REDACTED] clinic.
- iv. Administrative Area – If a person becomes threatening or violent to staff, the 911 will be called to alert [REDACTED] County Sheriff's Department. De-escalation tactics will be attempted while awaiting Law Enforcement. Do not attempt to keep the person there. Alert other areas of the building as soon as it is safe to do so.

Evacuation of the clinic should be done when there is a weapon threat or at discretion of the Office Manager, the CEO, and/or Law Enforcement. Evacuation routes depend on location. Follow the evacuation map for appropriate area. Evacuation routes are posted in each location

ROLES:

- A. In an active violent situation, multiple roles will need to be filled. Staff should assume the role which is not being filled at the time.
  - a. An individual to inform patients to stay in exam rooms
  - b. An escort for evacuation, if needed
  - c. An individual to call 911
  - d. An individual to document events
  - e. An individual to notify the ambulance staff, administrative staff, the Behavioral Health Clinic, and any other staff in the building
  - f. If there is a risk of the situation not being contained to the clinic, the [REDACTED] Clinic must notify the adjoining pharmacy of threat

## Appendix F

Synthesis of Evidence Table

First author, Year, Title, Journal	Purpose	Research Design <sup>1</sup> , Evidence Level <sup>2</sup> & Variables	Sample & Sampling, Setting	Measures & Reliability (if reported)	Results & Analysis Used	Limitations & Usefulness
<b>Subtopic: Violence</b>						
Tan (2015). Nursing management of aggression in a Singapore emergency department: A qualitative study. Nursing & Health Sciences.	RNs' management of violent patients in an ER in Singapore	Qualitative, non-experimental. Level 6. Variables: demographics, assessment of aggression, nursing interventions, communication skills, education and training, de-escalation and physical restraint skills, post-aggressive incident support and follow up.	Convenience sample of 10 RNs in ER of public Singapore. RNs had to work less than 3 months in an ER.	Interviewed on their perceptions of aggression. Tool adapted with permission from previous research. Reliability not reported.	Verbatim transcriptions with coding for systematic data analysis.	Limitation: Small sample size in the ER. Usefulness: Recommends further research on aggressive encounters for nursing staff.
Al-Omari (2015). Physical and verbal workplace violence against nurses in Jordan. International Nursing Review.	To research the occurrence of physical and verbal violence in hospitals in Jordan and its relationship to demographics.	Cross-sectional correlation study. Level 3. Variables: physical and psychological workplace violence, anxiety about violence at workplace and some demographic variables	Convenience sample of nurses in Jordan hospitals. Total number of respondents: 468	Tool from International Labour Office (ILO), International Council of Nurses (ICN), WHO and Public Services International (PSI). Cronbach's alpha between 0.73 and 0.90	SPSS 20.0. Descriptive, correlation statistics and logistic regression statistics.	Usefulness: Variables are the same as in this author's research project. Project shows that violence is an issue in Jordan. Limitations: Location in Jordan and takes place in hospitals.
Arnetz (2015). Understanding patient-to-worker violence	Identification of reasoning behind	Qualitative content analysis. Level 6.	Total number of 214 incidents	Data gathered from central reporting	Results coded into categories for data analysis.	Usefulness: Discussed violence by patients

<p>in hospitals: a qualitative analysis of documented incident reports. Journal of Advanced Nursing</p>	<p>completion of incident reports by employees after violence from patients.</p>	<p>Variables: Violence by patients toward health care workers, occupational hazards, and episodes of violence.</p>	<p>reported in 2011 in American hospital system.</p>	<p>system. Dependability/reliability from 3<sup>rd</sup> author not involved in the coding process.</p>		<p>toward health care workers. Provided qualitative examples of experiences with violent patients. Limitations: Hospital setting. Level 6.</p>
<p>Itzhaki (2015). Exposure of mental health nurses to violence associated with job stress, life satisfaction, staff resilience, and post-traumatic growth. International Journal of Mental Health Nursing,</p>	<p>To study relationship between mental health nursing and violence, job stress, resilience, and post-traumatic growth related to satisfaction</p>	<p>Quantitative non-experimental descriptive study. Level 3. Variables: Physical and verbal violence, job stress, life satisfaction, and post-traumatic growth”.</p>	<p>Mental health nurses (118) in a mental health hospital in Israel.</p>	<p>Tool developed for the study that was pilot tested with 13 nurses from different mental health wards.</p>	<p>SPSS 21.0 Pearson correlation coefficients, t-tests, and Linear regression.</p>	<p>Usefulness: analyzed result of exposure to violence. Limitation: setting in mental health center in Israel.</p>
<p>Spector (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. International Journal of Nursing Studies.</p>	<p>Quantitative review of violence divided into setting, source, and world location.</p>	<p>Quantitative systematic review. Level 1. Variables of violence, setting, source, and world region.</p>	<p>A total of 136 articles provided data on 151,347 nurses from 160 samples. Nursing violence articles were found using CINAHL, Medline, and PsycInfo database.</p>	<p>Three authors coded the data collected from the articles.</p>	<p>Meta-Analysis. Article provides extensive tables with many results, including standard deviation.</p>	<p>Physical violence was most prevalent in emergency rooms, geriatric, and psychiatric facilities. Physical violence and sexual harassment were most prevalent in Anglo countries, and the source was most commonly patients. Limitations was some studies did not code all</p>

						the variables the authors were researching. Details of the statistical approach is also lacking.
Small (2014). Disruptive behavior within the workplace. Applied Nursing Research.	Analysis the incidence of violence that impacted nurses in healthcare and how organizational procedures responds	Quantitative, non-experimental . Level 3. Variables of verbal, electronic or e-mail abuse or physical abuse.	LPN, RN, and APRN in Florida. 3,067 total participants . The authors sent the survey request to every licensee in FL but not all responded.	Online questionnaire with 21 questions about exposure to disruptive behavior. Reliability not disclosed.	SPSS. Chi Square Test.	Limitations: The author suspect there was a likelihood since the survey was self-respond, there was a greater chance in individuals that had been victims of disruptive workplace behavior responded over those not abused. Usefulness: Verbal abuse was most common. Evidence of high burnout rate.
Lowth (2014). Issues in personal safety. Practice Nurse.	To discuss risk of workplace risk of a practice nurse.	Opinion of expert. Level 7. Variables: Workplace injuries and direct patient risks.	No Research	No Research	No Research	Limitations: Set in the UK. Level 7. Usefulness: looks at primary care setting or “practice nurses”
Wolf (2014). Nothing changes, nobody cares: Understanding the experience of emergency nurses	Research experiences of ER nurses in US related to their exposure to violence	Qualitative descriptive exploratory design. Level 6. Variables: Environmental, cue recognition,	sample consisted of 46 emergency nurses	written narratives submitted by e-mail	Analysis was performed by identifying themes in the data	Usefulness: Graphic personal accounts of violence occurring in the US. Limitations:

physically or verbally assaulted while providing care. JEN: Journal of Emergency Nursing		personal, assault				Setting in ER.
Al-Bashtawy, M. (2013). Workplace violence against nurses in emergency departments in Jordan. International Nursing Review	Factors related to workplace violence in the ER in Jordan.	Quantitative Cross-section non-experimental . Level 3. Variables: Types of violence, personal demographics, policies and procedures, and safety training.	Convenience sample of 227 nurses in Jordan hospital ERs.	Tool was developed for this study by review of literature. Experts validated tool. Reliability established with Cronbach's alpha coefficient 0.80	SPSS 14. Chi-square testing & odds ratio	Usefulness: Research related to violence, education, and policies and procedures. Limitations: Setting in ER in Jordan.
Powley (2013). Reducing violence and aggression in the emergency department. Emergency Nurse	To apply Gribbs reflective cycle on violent incident in the ER	Expert opinion. Level 7. Variables: Mental Health, Nursing Student, Alcohol dependence, Violence	No Research	No Research	No Research	Usefulness: Discusses the need for training for nursing students to be prepared for violence. Limitation: Focused on nursing student rather than staff.
Magin (2011). Occupational violence in general practice: a whole-of-practice problem. Results of a cross-sectional study. Australian Health Review.	Review occupational violence experiences of general practitioners and staff	Cross-sectional non-experimental qualitative study. Level 6. Variables: Prevalence of violence, staff apprehension and perception of control over violence.	Participants were general practitioners and supports staff. Network of Research General Practices in New South Wales Australia. 125 questionnaire replies received.	Participation packet containing 31-item questionnaire . alpha of 0.05, 95% CI	Univariate analyses of demographic factors was by t-test, Mann-Whitney, Chi-square or Fisher's Exact Test as appropriate.	Limitation: Demographics of Australia differ than the U.S. Usefulness: All staff included in office settings. Statistical analysis provided.

<p>Gates (2011). Violence against Nurses and its Impact on Stress and Productivity. Nursing Economic\$</p>	<p>Violence related to the productivity and development of PTSD in ER nurses</p>	<p>Mixed methods ex non experimental study. Level 6. Variables:</p>	<p>ER nurses members of the Emergency Nurses Association in U.S. Sample of 3,000 with 264 surveys returned</p>	<p>Impact of Events Scale-Revised and Healthcare Productivity Survey. Internal consistency (0.79-0.91). sensitivity (74.5) specificity (63.1)</p>	<p>Descriptive and bivariate statistics SPSS, 17</p>	<p>Usefulness: patient violence and its effect on nursing staff. Limitations: Occurs in ER.</p>
<p>Schat (2011). Exposure to psychological aggression at work and job performance: The mediating role of job attitudes and personal health. Work &amp; Stress</p>	<p>to investigate the relations between psychological aggression at work and two forms of job performance (task performance and contextual performance ) and potential mediators of these relations</p>	<p>Quantitative non-experimental . Level 3. Variables: job performance, workplace aggression, stress, job attitudes, personal health</p>	<p>national probability sample of US workers (N=2376)</p>	<p>random digit dialed telephone survey Reliability was .79. Job satisfaction was assessed using a five-item facet free scale developed for the 1977 Quality of Employment Survey Reliability was .80 for job satisfaction, .87 for organizational commitment, and .91 for overall job attitude</p>	<p>Taylor linearization Mplus software chi-square statistic comparative fit index (CFI), Tucker-Lewis index (TLI), and the root mean square error of approximation (RMSEA).</p>	<p>Usefulness: linked aggression and job performance . Limitations: not limited to health care.</p>
<p>Miedema (2010). Prevalence of abusive encounters in the workplace of family physicians. Canadian Family Physician.</p>	<p>Canadian family physicians' career exposure to violence</p>	<p>Mixed methods. Level 3. Variables: Demographics, different types of abuse, frequency of abuse, and policies.</p>	<p>3802 College of Family Physicians of Canada were sent surveys N=774.</p>	<p>survey in English and French Telephone interviews</p>	<p>Spss. chi(2) analysis. 90% of practitioners had been abused by patients.</p>	<p>Limitations: Canadian and limits to physicians. Usefulness: Discusses policies and also found that physicians practicing in small towns had higher violence.</p>

McNamara (2010). Workplace violence and its effects on patient safety. Association of Operating Room Nurses Journal.	Discuss types of workplace violence.	Opinion of expert. Level 7. Variables: Intimidation, verbal or physical threats, physical attack, property damage, and sexual harassment.	No research.	No Research.	No research.	Usefulness: Address the impact of violence on nursing and patient safety. Limitation: Expert opinion. Does not focus on primary care setting.
El-Gilany (2010). Violence against primary health care workers in Al-Hassa, Saudi Arabia. Journal of Interpersonal Violence	Bring attention to the frequency and seriousness of violence against primary care providers	Quantitative, non-experimental . Level 3. Variables: Physical violence, psychological violence, victim based results, coping mechanisms	Al-Hassa, Saudi Arabia primary health care (PHC) workers. A total of 1,091.	self-administered questionnaire developed by ILO/ICN/WHO/PSI. Reliability not provided.	SPSS 11, chi-square test. Wald logistic regression analysis	Usefulness: Thorough discussion of violence in healthcare. Limitations: Saudi Arabia setting
Whelan (2008). The escalating trend of violence toward nurses. JEN: Journal of Emergency Nursing	To explore nurse safety and violence.	Expert opinion. Level 7. Variables: Workplace safety, nurse safety, violence.	No Research	No Research	No Research	Usefulness: Explanation of correlation with job satisfaction and workplace safety. Limitation: opinion. Canada.
<b>Subtopic: Workplace Satisfaction</b>						
Alsaraireh, (2014). Job satisfaction and turnover intention among Jordanian nurses in psychiatric units. International Journal of Mental Health Nursing	Explore relationship between satisfaction and turnover	A quantitative descriptive, correlational, cross-sectional design. Level 3. Variables: Job satisfaction and turnover.	154 Nurses in the psychiatric units of the Jordanian National Mental Health Center.	The Minnesota Job Satisfaction Questionnaire (MSQ) – shortform, Cronbach’s alpha of 0.91. Modified version of the	SPSS, 17 independent-sample t-test were used. One-way ANOVA.	Usefulness: Shows correlation between job satisfaction and turnover. Limitation: Mental health hospital and Jordan. Does not

				Withdrawal Cognition Scale (WCS). reliability score of 0.79		address violence as a variable.
Palmer (2014). Nursing retention and satisfaction in Ecuador: Implications for nursing administration. Journal of Nursing Management.	Relationship between environment , satisfaction, and turnover	Mixed methods. Level 3. Variables: Nursing satisfaction, turnover, and selected organization characteristics.	88 nurses in a 900 bed welfare hospital in Ecuador.	Nursing Work Index Cronbach's alpha 0.960	SPSS, surveys were scored with means and standard deviations from each question. Qualitative were translated and categorized.	Usefulness: May use Nursing Work Index tool in my study. Subtopics are same as my PICOT. Limitations: setting in Ecuador hospital.
Oyeleye (2013). Relationship of workplace incivility, stress, and burnout on nurses' turnover intentions and psychological empowerment. Journal of Nursing Administration.	Relationship between stress, burnout, environment , and incivility	Quantitative non-experimental . Level 3. Variables: Workplace incivility, stress, burnout, turnover intentions, total years of nursing experience, and RN education levels.	Convenience sample of nurses from 2 community hospitals and 1 tertiary hospital in the Midwestern United States. N=61	5 Tools: Perceived Stress Scale, Maslach Burnout Inventory, Uncivil Workplace Behaviors questionnaire , Workplace Incivility Scale, Spreitzer Psychological Empowerment Scale. Reliability provided for most tools.	SPSS, 20.0. P value of .05	Usefulness: Many variables discussed. Takes place in the United States. Limitations: Takes place in the hospital setting. Does not discuss violence in particular in relation to nursing turnover.
Hamaideh (2011). Burnout, Social Support, and Job Satisfaction among Jordanian Mental Health Nurses. Issues in Mental Health Nursing	Relationship between burnout and job satisfaction	Mixed methods, non-experimental study. Level 6. Variables: Burnout, social support, job satisfaction, and demographic variables.	181 mental health nurses from mental health units in Jordan	Maslach Burnout Inventory, Social Support Scale, Job Satisfaction Scale, and demographic and work-related variables	SPSS Pearson and Spearman Correlation Coefficients. Significance level $p < 0.05$ . Multiple linear regression analysis	Usefulness: Through discussion of job satisfaction. Limitations: takes place in Jordan.
Ward (2011). Mental health nursing and	Feminist view of women in	Qualitative, non-experimental	13 female RNs employed	interviews, focus groups	thematic analysis with	Usefulness: Found a direct

stress: Maintaining balance. International Journal of Mental Health Nursing	mental health nursing and their experiences	. Level 6. Variables: Workplace culture, stress management, professional well-being.	in a mental health unit		coding of answers.	correlation between stress and job satisfaction Limitation: Setting in Australia and in mental health facility
Mullenbach (2010). Professional issues. Senior nursing students' perspectives on the recruitment and retention of medical-surgical nurses.	View of senior BSN students in leadership course on recruitment and retention to Med-Surg nursing units	Qualitative, experimental . Level 6. Variables: recruitment strategies and retention strategies.	UK senior baccalaureate nursing students	Assignment of leadership course	Statistics not provided	Usefulness: Discussion on nurse retention and turnover effects Limitations: Does not discuss violence. Takes place in UK.
Armstrong-Stassen (2005). Concerns, Satisfaction, and Retention of Canadian Community Health Nurses. Journal of Community Health Nursing	Satisfaction of Canadian community health care RNs and what affects their decision to stay in the position	Quantitative cross-sectional descriptive field study. Level 3. Variables: 17 concerns related to community health nursing such as dealing with difficult clients and uncooperative family members, and time for client care.	(n=386), homecare (n=410), and CCAC (n=248)	job satisfaction scales developed by Spector (1997) and Cammann, Fichman, Jenkins, and Klesh (1983)	SPSS. Multivariate analysis of covariance (MANCOVA) with tenure (job, agency, nurse) and work status as covariates	Usefulness: job satisfaction. Limitation: Takes place in Canada and is focused on community health nursing.
Rosberg (2004). Work environment and job satisfaction. Social Psychiatry and Psychiatric Epidemiology.	psychometric properties Working Environment Scale-10 (WES-10)".	Quantitative, non-experimental . Level 3. Variables: satisfaction of working on mental health ward, patients and staff, how	640 staff members on 42 wards for psychotic patients.	WES-10 survey. Cronbach's alpha.	Factor Analysis with varimax rotation.	Limitation: Older study. Setting in a psychiatric ward. Usefulness: High level study. Possible tool for my study.

		long the respondents had worked and expected to continue to work at the ward.				
Bingham (2002). The Mental Health Care Context and Patient Characteristics: Implications for Provider Job Satisfaction. Journal of Behavioral Health Services & Research	Aspects associated with provider job satisfaction and how administration can impact satisfaction	Quantitative non-experimental . Level 3. Variables: Provider characteristic , patient characteristic , job satisfaction, and patient illness severity.	Patients and staff in 18 units in 12 Veteran Affairs Medical Centers	a survey of job satisfaction related to administration	Hierarchical Linear Modeling (HLM) one-way analysis of variance (ANOVA). Bonferroni’s adjustment for multiple tests	Usefulness: Discussed job satisfaction and organizational support. Limitations: Older research. Limited to VA facilities.
Lambert (2001). The impact of job satisfaction on turnover intent: a test of a structural measurement model using a national sample of workers. The Social Science Journal.	“To examine the causal process of employee turnover using a national sample of adult workers”.	Quantitative, non-experimental . Level 3. Variables: demographic characteristics, work environment measures, job satisfaction, turnover intent, and alternative employment opportunities .	“1515 respondents from the 1977 Quality of Employment Survey by Quinn and Staines (1979)”.	1977 Quality of Employment Survey. Cronbach’s alpha reliability coefficient.	Two-Step approach. Lisrel 8 with estimation technique of Maximum Likelihood.	Limitation: older study. Usefulness: Ground breaking study on job satisfaction.
Rout (1999). Stress and job satisfaction among primary care professionals. Journal of Interprofessional Care	Relationship between stress and job satisfaction	Mixed methods, non-experimental . Level 3. Variables: Demographics, job stressors, job satisfaction, mental health, Type A behavior, Health behavior, and coping checklist.	81 Primary Care Professionals in the northwestern UK interviewed . 128 Receptionists, 51 practice managers, and 119 nurses were then surveyed	Questionnaire on 7 variables	Statistics not provided	Usefulness: Primary care focus on satisfaction and stress. Limitations: Does not address violence, date, and takes place in UK

Rump (1979). Size of psychiatric hospitals and nurses' job satisfaction. Journal of Occupational Psychology	size of mental hospital correlated to nurses satisfaction	Quantitative, Non experimental . Level 3. Variables: hospital size, job satisfaction, communication, organizational support	three psychiatric hospitals in Adelaide, South Australia. 325, 251 and 43 in the respective groups	116-item questionnaire commissioned by the Director of the South Australian Mental Health Services	SPSS. Chi-square analysis or Analysis of Variance. Two-tailed tests of significance were used, at the 0-05 level	Usefulness: Through look at nursing satisfaction. Provides history to problem. Limitation: Date limits applicability of results. Violence is not discussed.
<b>Subtopic: Education</b>						
Gillespie (2014). A workplace violence educational program: A repeated measures study. Nurse Education in Practice.	Implementation of educational program and the impact on knowledge	Quasi-experimental . Level 3 descriptive. Variables of teaching methods, online or classroom.	120 emergency department employees.	Online and classroom educational intervention. Baseline test, post-test, and six months post-test.	Analysis of variance. results indicated a significant time effect, Wilk's $\Lambda = .390$ , $F(2, 118) = 26.554$ , $p < .001$ , $\eta^2 = .310$ .	Placed in the emergency room. Study concluded that the availability of the education either online or in class improved learning outcomes.
Gillespie (2014). Implementation of a Comprehensive Intervention to Reduce Physical Assaults and Threats in the Emergency Department. Journal of Emergency Nursing.	Implementation of educational program in the ER focused on violence	Quasi-experimental . Level 3. Variables violent event rates before and after the workplace violence intervention.	3 intervention and 3 comparison emergency departments.	Monthly surveys for 18 months.	Descriptive statistics. Analysis of variance.	Placed in the emergency room. Study hypothesis not significantly supported but 2 intervention sites had significant decrease in workplace violence.
Beech (2007). Aggression prevention training for student nurses: Differential responses to training and the interaction between theory	aggression prevention and management training program for nursing students	Quantitative experimental . Level 3. Variables: Demographic factors, Knowledge, attitudes, confidence,	Three cohorts of UK student nurses. N=243	Three page purposely designed questionnaire to measure variables.	Chi Square, One way Anova. Spss. Bivariate analysis using independent sample t-tests.	Usefulness: Shows that education related to violence de-escalation and policies has positive outcomes.

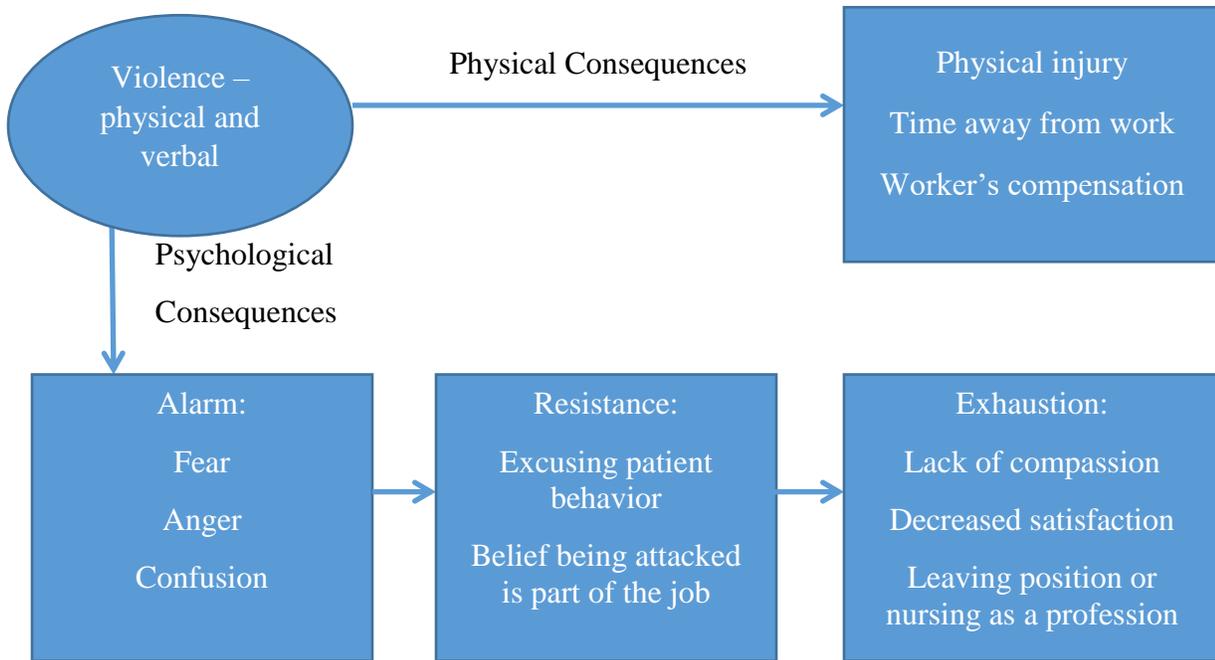
and practice. Nurse Education in Practice		self-assessed competence.				Limitation: UK setting and in student nurses.
<b>Subtopic: Organization Support</b>						
Demir (2014). Antecedents and Consequences of Workplace Aggression in the Allied Health Context. Social Work in Health Care	Impact of workplace aggression on healthcare workers	Quantitative, non- experimental . Level 6. Variables: Job satisfaction Bullying, Psychological distress, Organizational commitment	134 allied health professionals at a large Australian health care organization	scale developed by Brayfield and Rothe NA (PANAS) developed by Watson, Clark, and Tellegen The Cronbach's alpha coefficient for NA was .83.	Levene statistic. ANCOVA	Usefulness: Variable of Job Satisfaction and organizational commitment . Limitations: Based in Australia.
Blando (2013). Impact of hospital security programmes and workplace aggression on nurse perceptions of safety. Journal of Nursing Management	Perception of safety of nurses	Mixed methods non experimental . Level 6. Variables: Job experience, Perceptions of safety and violence experience, Perceptions of the units workplace violence programs	Nurses in NJ and California n=457	a cross- sectional written survey	Fisher's exact tests	Usefulness: Variables of workplace violence and violence support correlate. Limitation: Does not address nursing satisfaction.
Ferns, T. (2012). Recording violent incidents in the emergency department. Nursing Standard	Discuss incident reporting usage	Retrospective mixed methods study. Level 6. Variables: Documentation, emergency department, violence, and incident reporting.	ER staff for 2 years in large hospital	documentary analysis of violent incident reports retrospectively	Interview transcribed by author	Usefulness: Organizational policies. Limitations: Does not address job satisfaction.
Menendez (2012). Emergency	The purpose of this study is to	Qualitative, non- experimental	Convenience sample of 31 health	Interview of participants regarding	Modified constant comparative	Limitations: Convenience and small

<p>department workers' perceptions of security officers' effectiveness during violent events. Work.</p>	<p>describe ED workers' views of security officers' effectiveness during actual events of verbal and/or physical violence</p>	<p>. Level 6. Variables (1) a need for security officers, (2) security officers' availability and response, (3) security officers' presence or involvement, (4) security officers' ability to handle violent situations, (5) security officers' role with restraints, and (6) security officers' role with access</p>	<p>care workers for urban pediatric ED in the Midwestern U.S.</p>	<p>workplace violence with transcripts. Reliability was established by auditing transcripts. No numerical data given.</p>	<p>analysis process with coding scheme.</p>	<p>sample. Usefulness: Not limited to nursing staff and included physicians, nurses' aides, respiratory therapist etc.</p>
<p>Laschinger (2012). The influence of personal dispositional factors and organizational resources on workplace violence, burnout, and health outcomes in new graduate nurses: A cross-sectional study. International Journal of Nursing Studies</p>	<p>To test model Six Areas of Worklife Model on new graduate nurses</p>	<p>Quantitative non-experimental . Level 3. Variables: Worklife, bullying, burnout, psychological capital, physical and mental health.</p>	<p>165 Ontario nurses with on year or less experience in nursing. Not limited to type of health care setting.</p>	<p>Psychological Capital Questionnaire, Areas of Worklife Scale, Negative Acts Questionnaire Revised.</p>	<p>Descriptive statistics and Cronbach alpha reliability estimates were conducted using SPSS version 18.0</p>	<p>Usefulness: discussed work environment's effect on mental health. Limitation: Setting in Canada.</p>

Appendix G

Theory to Application Diagram:

Modified Theory Based on Selye’s Stress Adaption Theory (1950)



Physical violence from the patient experienced by the nurse may have a two-part consequence. First, the nurse may experience physical injury. Secondly, the psychological consequences mirror Selye’s General Adaptation Syndrome (1950), with the nurse experiencing the stages of alarm, resistance, and exhaustion.

## Appendix H

## IRB Approval



UMKC  
5319 Rockhill Road  
Kansas City Missouri  
TEL: 816 235-5927  
FAX: 816 235-5602

**NOTICE OF NEW APPROVAL**

Principal Investigator: Nancy Willis-Smith  
379 SW 123rd Lane  
Mindenmines, MO 64769

Protocol Number: 16-310  
Protocol Title: A Violence Prevention and Preparedness Educational Intervention in Primary Care Clinics  
Type of Review: Designated Review

**Date of Approval: 09/19/2016**  
**Date of Expiration: 09/18/2017**

Dear Dr. Willis-Smith,

The above referenced study, and your participation as a principal investigator, was reviewed and approved by the UMKC IRB. You are granted permission to conduct your study as described in your application.

- Your protocol was approved under Expedited Review Regulatory Criteria at 45 CFR 46.110 or 21 CFT 56.110 under Category #7 as follows: Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

- Your protocol was approved for a waiver of documentation of consent under regulatory criteria at 45 CFR 46.117(c) having met either of the following criteria:

1. That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or
2. That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

In cases in which the documentation requirement is waived, you may be required to provide subjects with a written statement regarding the research.

**Attachments Include:**

Letter of Approval Taylor Jennifer  
Taylor UMKC Project Approval Letter  
Modified Measurement Tool Gillespie  
Permission to use tool  
Methods of Jennifer Taylor Paper Modified  
Recruitment script Jennifer Taylor  
Consent form Approved Version 09.08.16



UMKC  
5319 Rockhill Road  
Kansas City Missouri  
TEL: 816 235-5927  
FAX: 816 235-5602

This approval includes the following documents:

**Attachments**

The ability to conduct this study will expire on or before 09/18/2017 unless a request for continuing review is received and approved. If you intend to continue conduct of this study, it is your responsibility to provide a Continuing Review form prior to the expiration of approval.

This approval is issued under the University of Missouri - Kansas City's Federal Wide Assurance FWA00005427 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under the Board's Assurance, please do not hesitate to contact us.

There are 5 stipulations of approval:

- 1) No subjects may be involved in any study procedure prior to the IRB approval date or after the expiration date. (PIs and sponsors are responsible for initiating Continuing Review proceedings).
- 2) All unanticipated or serious adverse events must be reported to the IRB.
- 3) All protocol modifications must be IRB approved prior to implementation unless they are intended to reduce risk. This includes any change of investigator.
- 4) All protocol deviations must be reported to the IRB.
- 5) All recruitment materials and methods must be approved by the IRB prior to being used.

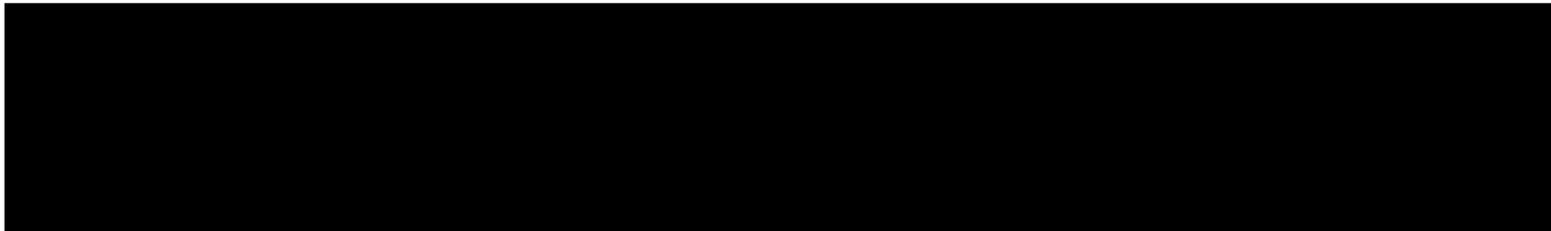
Please contact the Research Compliance Office (email: [umkcirb@umkc.edu](mailto:umkcirb@umkc.edu); phone: (816)235-5927) if you have questions or require further information.

Thank you,

Cynthia Thompson  
UMKC IRB

Appendix I

Permission for Project Site

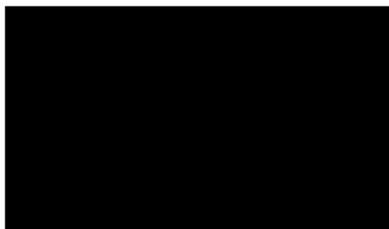


June 10, 2016

To Whom It May Concern:

My name is [REDACTED] Clinic Manager. I manage the medical locations for our Federally Qualified Health Center. This letter is to give approval for Jennifer Taylor, DNP student at UMKC, to use our facility as the site for her Violence Education Project. This project will begin in 2016 and continue until May of 2017. I expect that this project will be very beneficial for our staff. Thank you for allowing us this opportunity to work with Jennifer on this project. If you have any questions, please let me know.

Sincerely,



Appendix J  
Logic Model

Rev. 7/09, 1/2015  
[http://www.uwex.edu/ces/lmcourses/interface/coop\\_M1\\_Overview.htm](http://www.uwex.edu/ces/lmcourses/interface/coop_M1_Overview.htm)  
 Logic-Model Worksheet  
 content revisions by Lyla Lindholm for DNP Project. Not to be placed on web for public use.  
 For UMKC DNP coursework only.

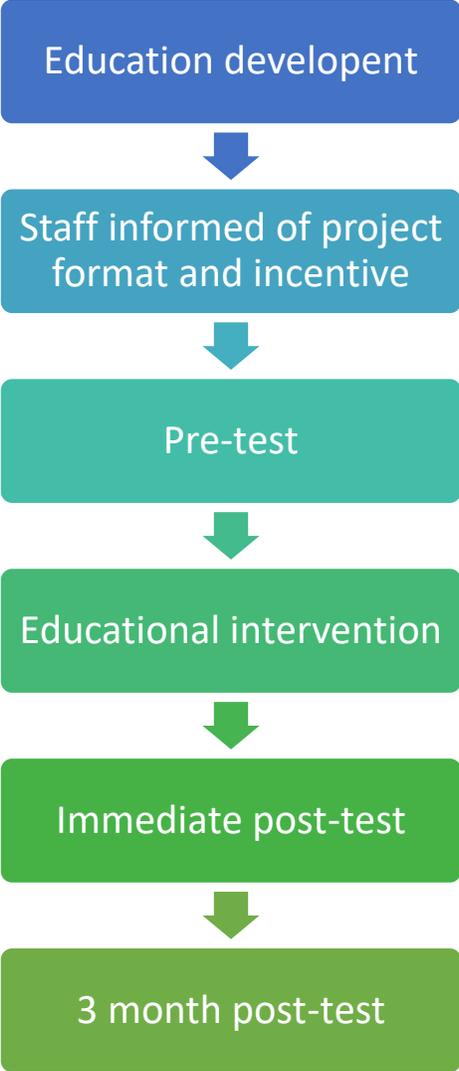
**Student:** Jennifer Taylor

**PICOTS:** In nursing and other direct patient contact staff, does additional education increase de-escalation technique knowledge levels, perception of safety, and workplace satisfaction compared to pre-education knowledge levels and satisfaction during a 3-month study at a primary care office setting?

Inputs	Intervention(s) Outputs		Outcomes -- Impact		
	Activities	Participation	Short	Medium	Long
<p><b>Evidence, sub-topics</b>                      Violence-                      Physical violence                      Verbal abuse                      Workplace                      Satisfaction –                      Decreased turnover                      Nursing burnout                      Reported satisfaction                      Education –                      De-escalation techniques                      Role and responsibilities                      Organizational                      Support –                      Policies and procedures                      Increased perception of safety</p> <p><b>Major Facilitators or Contributors</b>                      CDC task force on workplace violence.</p> <p><b>Major Barriers or Challenges</b>                      Lack of U.S. studies in primary care.</p>	<p><b>EBP intervention which is supported by the evidence in the Input column</b>                      Education focused on de-escalation and roles and responsibilities when safety is at risk.</p> <p><b>Major steps of the intervention</b>                      Pretest                      Education via CDC program and policy                      Posttest</p>	<p><b>The participants (subjects)</b>                      Staff of primary care clinic</p> <p><b>Site</b>                      2 rural clinics</p> <p><b>Time Frame</b>                      Fall Semester 2016</p> <p><b>Consent Needed or other</b>                      Obtained</p> <p><b>Person(s) collecting data</b>                      Jennifer Taylor</p> <p><b>Others directly involved</b>                      Staff and Advanced Practitioners at site</p>	<p><b>(Completed as student)</b></p> <p><b>Outcome(s) to be measured with valid &amp; reliable tool(s)</b></p> <p>Tool to measure satisfaction as related to safety in the workplace and knowledge of prevention and preparedness</p> <p><b>Statistical analysis to be used</b>                      Wilcoxon-Match pairs</p>	<p><b>(after student DNP)</b></p> <p><b>Outcomes to be measured</b></p>	<p><b>(after student DNP)</b></p> <p><b>Outcomes that are potentials</b></p>

Appendix K

Intervention Flow Diagram, Procedure



## Appendix L

## Recruitment Material

Will send via email:

My name is Jennifer Taylor and I am a nurse practitioner student at UMKC. I am performing my doctoral research project at your clinic locations, with permission from your CEO and office manager. The focus of my research is to see if providing an educational offering on violence prevention will impact levels of violence prevention knowledge, perception of safety, and workplace satisfaction levels. A policy addressing the procedures that should be followed at the [REDACTED] locations has also been developed and education will be provided on the changes. The education will be provided over a 1-hour lunch and learn, which the office manager will arrange. She will contact those required to attend the education with details on which lunch they will attend.

Although the education will be mandatory for certain positions at [REDACTED], the participation in a pre-test, post-test, and a 3-month post-test are optional. Responses to the surveys will remain anonymous. If a participant completes all three surveys, a \$5 gift card to Casey's will be gifted.

Thank you for considering participation in the surveys. I look forward to working with you during the educational offering.

## Appendix M

**CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY**

## A Violence Prevention and Preparedness Educational Intervention in Primary Care Clinics

**Introduction**

You are being asked to volunteer for a research study. This study is being conducted at the [REDACTED] Primary Care Clinics.

The researcher in charge of this study is Dr. Nancy Willis-Smith. While the study will be run by her, other qualified persons who work with her may act for her. The student investigator of the research is Jennifer Taylor.

The study team is asking you to take part in this research study because you are an employee with patient contact at [REDACTED]. Research studies only include people who choose to take part. Please read this consent form carefully and take your time making your decision. The student researcher and/or the office manager will go over this consent form with you. Ask her to explain anything that you do not understand. This consent form explains what to expect: the risks, discomforts, and benefits, if any, if you consent to be in the study.

**Background**

The research will take place at each [REDACTED] clinic. The subjects being asked to participate are advanced practice nurses, registered nurses, licensed practical nurses, medical assistants, and other direct patient contact staff. Three surveys will be given throughout the study. The education provided is required per the office manager.

**Purpose**

The purpose of this research study is to see if providing staff with education about violence prevention, de-escalation techniques, roles and responsibilities in high risk situations, and policies and procedures will improve staff knowledge and perception of safety. Researchers have performed studies in emergency rooms, in which an educational intervention was provided to the staff, with results of increased knowledge levels of de-escalation techniques and roles and responsibilities in a high risk situation (Gillespie, Gates, & Farra, 2014; Gillespie, Gates, Kowalenko, Bresler, & Succop, 2014; Menendez, Gillespie, Gates, Miller, & Howard, 2012). Research studies are not available for the primary care setting.

You will be one of about 30 subjects in the study at [REDACTED]. About 30 subjects total will take part across all the places working on this study.

### **Study Procedures and Treatments**

The office manager has divided the staff required to attend the education into four different “lunch and learn” events. If you decide to participate in the study, a pre-test will be given to you before the education. After the pre-test, an educational session will occur. Immediately after the educational session, a post-test will be given to those who have decided to participate in the study. Approximately three months after the education session, the last survey will be distributed to staff whom have decided to participate.

If you agree to take part in this study, you will be involved in this study for approximately three months. The first obligation will take approximately 1 hour. The follow-up information gathered in the survey will take you approximately 5-10 minutes three months after the education.

When you are done taking part in this study, you will still have access to the educational information.

### **Possible Risks or Side Effects of Taking Part in this Study**

Possible risks associate with taking part in this study include emotional distress at discussing the possibility of violence at your workplace.

The survey responses will be anonymous, but the data results will be shared with the office manager and the Chief Executive Officer at [REDACTED]

### **Possible Benefits for Taking Part in this Study**

Benefits to you may include increase knowledge in de-escalation techniques and roles and responsibilities. You may experience improved workplace satisfaction and perception of safety.

In the future, other people may benefit from the information about the use of education for violence prevention in the primary care setting.

### **Costs for Taking Part in this Study**

There is no cost to the subject for taking part in this study. You will not have to pay for the education provided during this study.

### **Payment for Taking Part in this Study**

There will be a \$5 gift card to Casey’s General Store following the three-month survey, which will complete the study participation.

### **Alternatives to Study Participation**

If you choose not to participate in the study, you will not participate in the surveys before and after the education. The education may still be required based on your job role and at the discretion of the office manager at [REDACTED]

### **Confidentiality and Access to your Records**

The results of this research may be published or presented for scientific purposes. You will not be named in any reports of the results. Your surveys may be shown to the Institutional Review Board (IRB) (a committee that reviews and approves research studies), or other governing agencies. This is to prove which study procedures you completed and to check the data reported about you. The study team will keep all information about you confidential as provided by law, but complete confidentiality cannot be guaranteed.

If you leave the study or are removed from the study, the study data collected before you left may still be used along with other data collected as part of the study.

### **Contacts for Questions about the Study**

You should contact the IRB Administrator of UMKC's Adult Health Sciences Institutional Review Board at [REDACTED] if you have any questions, concerns or complaints about your rights as a research subject. You may call the researcher Dr. Willis-Smith at [REDACTED] if you have any questions about this study. You may also call her if any problems come up.

### **Voluntary Participation**

Taking part in this research study is voluntary. If you choose to be in the study, you are free to stop participating at any time and for any reason. If you choose not to be in the study or decide to stop participating, your decision will not affect any care or benefits you are entitled to. The researchers or sponsors may stop the study or take you out of the study at any time

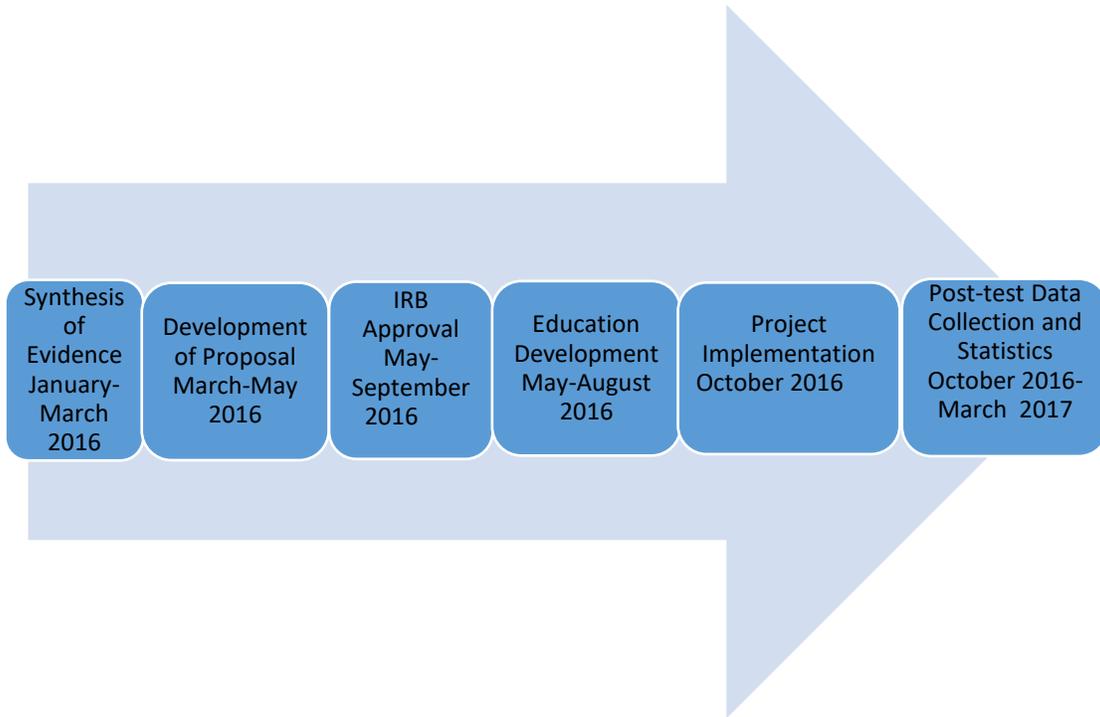
- if they decide that it is in your best interest to do so,
- if you experience a study-related injury,
- if you no longer meet the study criteria, or
- if you do not comply with the study plan.

They may also remove you from the study for other administrative or medical reasons. You will be told of any important findings developed during the course of this research.

You have read this Consent Form or it has been read to you. You have been told why this research is being done and what will happen if you take part in the study, including the risks and benefits. You have had the chance to ask questions, and you may ask questions at any time in the future by calling Dr. Willis-Smith at [REDACTED]. By complete the survey, you have implied that you consent to participating in the study.

Appendix N

Project Timeline Flow Model



Appendix O

Adapted Measurement Tool Provided by Dr. Gordon Gillespie

Tool in private domain.

Appendix P

Reliability of Added Questions

Perception of Safety Reliability SPSS:

**Reliability**

**Scale: ALL VARIABLES**

**Case Processing Summary**

		N	%
Cases	Valid	11	40.7
	Excluded <sup>a</sup>	16	59.3
	Total	27	100.0

a. Listwise deletion based on all variables in the procedure.

**Reliability Statistics**

Cronbach's	
Alpha	N of Items
.870	3

Workplace Satisfaction Reliability SPSS:

**Reliability**

**Scale: ALL VARIABLES**

**Case Processing Summary**

		N	%
Cases	Valid	11	40.7
	Excluded <sup>a</sup>	16	59.3
	Total	27	100.0

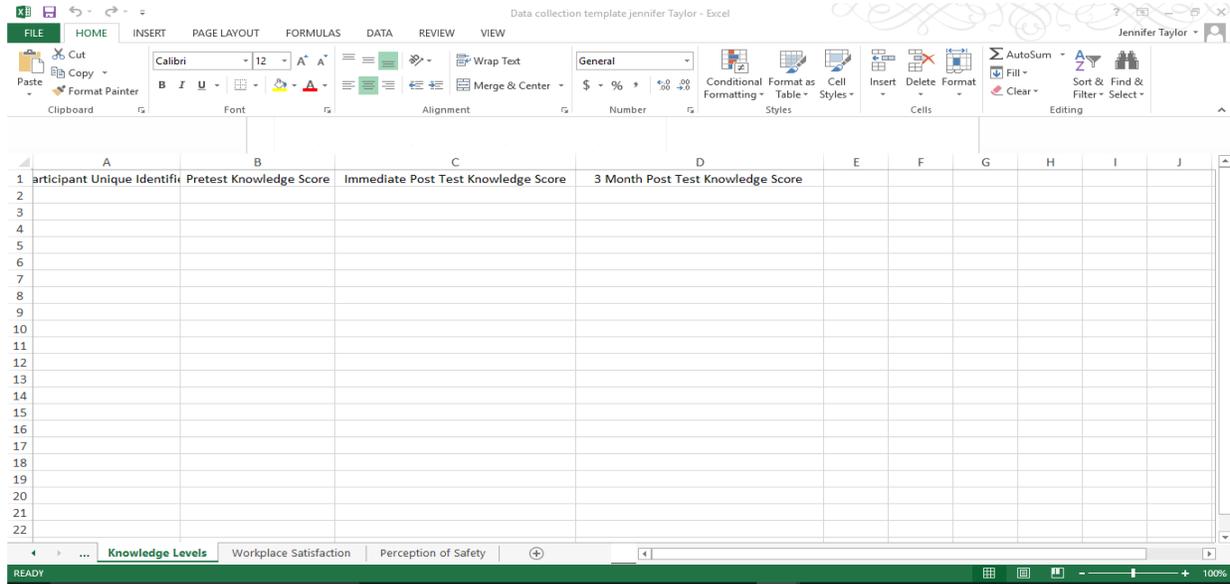
a. Listwise deletion based on all variables in the procedure.

**Reliability Statistics**

Cronbach's	
Alpha	N of Items
.939	3

Appendix Q

Data Collection Spreadsheet



	A	B	C	D	E	F
1	Participant Unique Identifier	Pretest Workplace Satisfaction Level	Immediate Post Test Workplace Satisfaction Level	3-Month Post Test Workplace Satisfaction Level		
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						

	A	B	C	D
1	Participant Unique Identifier	Pretest Perception of Safety Level	Immediate Post Test Perception of Safety Level	3- Month Post Test Perception of Safety Level
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

Appendix R

Statistics

Knowledge Levels

**NPar Tests**

**Descriptive Statistics**

	N	Mean	Std. Deviation	Minimum	Maximum
PretestKnowledgeScore	23	61.6848	13.09715	31.25	87.50
ImmediateKnowledgeScore	22	62.5000	13.22313	37.50	87.50
ThreeMonthKnowledgeScore	15	63.7500	15.16281	37.50	87.50

**Wilcoxon Signed Ranks Test**

**Ranks**

		N	Mean Rank	Sum of Ranks
ImmediateKnowledgeScore - PretestKnowledgeScore	Negative Ranks	7 <sup>a</sup>	7.29	51.00
	Positive Ranks	7 <sup>b</sup>	7.71	54.00
	Ties	8 <sup>c</sup>		
	Total	22		
ThreeMonthKnowledgeScore - ImmediateKnowledgeScore	Negative Ranks	3 <sup>d</sup>	5.17	15.50
	Positive Ranks	6 <sup>e</sup>	4.92	29.50
	Ties	2 <sup>f</sup>		
	Total	11		
ThreeMonthKnowledgeScore - PretestKnowledgeScore	Negative Ranks	3 <sup>g</sup>	3.67	11.00
	Positive Ranks	6 <sup>h</sup>	5.67	34.00
	Ties	2 <sup>i</sup>		
	Total	11		

- a. ImmediateKnowledgeScore < PretestKnowledgeScore
- b. ImmediateKnowledgeScore > PretestKnowledgeScore
- c. ImmediateKnowledgeScore = PretestKnowledgeScore
- d. ThreeMonthKnowledgeScore < ImmediateKnowledgeScore
- e. ThreeMonthKnowledgeScore > ImmediateKnowledgeScore
- f. ThreeMonthKnowledgeScore = ImmediateKnowledgeScore
- g. ThreeMonthKnowledgeScore < PretestKnowledgeScore
- h. ThreeMonthKnowledgeScore > PretestKnowledgeScore
- i. ThreeMonthKnowledgeScore = PretestKnowledgeScore

**Test Statistics<sup>a</sup>**

	ImmediateKnowledge Score - PretestKnowledgeScore	ThreeMonthKnowledge eScore - ImmediateKnowledge Score	ThreeMonthKnowledge eScore - PretestKnowledgeScore
Z	-.096 <sup>b</sup>	-.844 <sup>b</sup>	-1.379 <sup>b</sup>
Asymp. Sig. (2-tailed)	.924	.399	.168

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

**Workplace Satisfaction Levels**

**NPar Tests**

**Descriptive Statistics**

	N	Mean	Std. Deviation	Minimum	Maximum
PretestSatisfactionScale	23	3.6739	.82032	2.00	5.00
ImmediateSatisfactionScale	22	3.9091	.88151	2.00	5.00
ThreeMonthSatisfactionScale	15	3.9667	.66726	3.00	5.00

**Wilcoxon Signed Ranks Test**

**Ranks**

		N	Mean Rank	Sum of Ranks
ImmediateSatisfactionScale - PretestSatisfactionScale	Negative Ranks	0 <sup>a</sup>	.00	.00
	Positive Ranks	7 <sup>b</sup>	4.00	28.00
	Ties	15 <sup>c</sup>		
	Total	22		
ThreeMonthSatisfactionScale - ImmediateSatisfactionScale	Negative Ranks	1 <sup>d</sup>	1.50	1.50
	Positive Ranks	3 <sup>e</sup>	2.83	8.50
	Ties	7 <sup>f</sup>		
	Total	11		
ThreeMonthSatisfactionScale - PretestSatisfactionScale	Negative Ranks	0 <sup>g</sup>	.00	.00
	Positive Ranks	6 <sup>h</sup>	3.50	21.00
	Ties	5 <sup>i</sup>		
	Total	11		

a. ImmediateSatisfactionScale < PretestSatisfactionScale

b. ImmediateSatisfactionScale > PretestSatisfactionScale

- c. ImmediateSatisfactionScale = PretestSatisfactionScale
- d. ThreeMonthSatisfactionScale < ImmediateSatisfactionScale
- e. ThreeMonthSatisfactionScale > ImmediateSatisfactionScale
- f. ThreeMonthSatisfactionScale = ImmediateSatisfactionScale
- g. ThreeMonthSatisfactionScale < PretestSatisfactionScale
- h. ThreeMonthSatisfactionScale > PretestSatisfactionScale
- i. ThreeMonthSatisfactionScale = PretestSatisfactionScale

**Test Statistics<sup>a</sup>**

	ImmediateSatisfaction Scale - PretestSatisfactionScale	ThreeMonthSatisfactionScale - ImmediateSatisfactionScale	ThreeMonthSatisfactionScale - PretestSatisfactionScale
Z	-2.460 <sup>b</sup>	-1.289 <sup>b</sup>	-2.232 <sup>b</sup>
Asymp. Sig. (2-tailed)	.014	.197	.026

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

Perception of Safety Levels

**NPar Tests**

**Descriptive Statistics**

	N	Mean	Std. Deviation	Minimum	Maximum
PretestPerceptionSafetyScale	23	4.5000	.42640	3.50	5.00
ImmediatePerceptionSafetyScale	22	4.4318	.47045	3.50	5.00
ThreeMonthPerceptionSafetyScale	15	4.3667	.66726	3.00	5.00

**Wilcoxon Signed Ranks Test**

**Ranks**

		N	Mean Rank	Sum of Ranks
ImmediatePerceptionSafetyScale - PretestPerceptionSafetyScale	Negative Ranks	5 <sup>a</sup>	5.40	27.00
	Positive Ranks	4 <sup>b</sup>	4.50	18.00
	Ties	13 <sup>c</sup>		
	Total	22		
ThreeMonthPerceptionSafetyScale - ImmediatePerceptionSafetyScale	Negative Ranks	2 <sup>d</sup>	2.50	5.00
	Positive Ranks	2 <sup>e</sup>	2.50	5.00

	Ties	7 <sup>f</sup>		
	Total	11		
ThreeMonthPerceptionSafetyScale - PretestPerceptionSafetyScale	Negative Ranks	3 <sup>g</sup>	4.17	12.50
	Positive Ranks	4 <sup>h</sup>	3.88	15.50
	Ties	4 <sup>i</sup>		
	Total	11		

- a. ImmediatePerceptionSafetyScale < PretestPerceptionSafetyScale
- b. ImmediatePerceptionSafetyScale > PretestPerceptionSafetyScale
- c. ImmediatePerceptionSafetyScale = PretestPerceptionSafetyScale
- d. ThreeMonthPerceptionSafetyScale < ImmediatePerceptionSafetyScale
- e. ThreeMonthPerceptionSafetyScale > ImmediatePerceptionSafetyScale
- f. ThreeMonthPerceptionSafetyScale = ImmediatePerceptionSafetyScale
- g. ThreeMonthPerceptionSafetyScale < PretestPerceptionSafetyScale
- h. ThreeMonthPerceptionSafetyScale > PretestPerceptionSafetyScale
- i. ThreeMonthPerceptionSafetyScale = PretestPerceptionSafetyScale

**Test Statistics<sup>a</sup>**

	ImmediatePerceptionS afetyScale - PretestPerceptionSafe tyScale	ThreeMonthPerceptio nSafetyScale - ImmediatePerception SafetyScale	ThreeMonthPerceptio nSafetyScale - PretestPerceptionSafe tyScale
Z	-.577 <sup>b</sup>	.000 <sup>c</sup>	-.264 <sup>d</sup>
Asymp. Sig. (2-tailed)	.564	1.000	.792

- a. Wilcoxon Signed Ranks Test
- b. Based on positive ranks.
- c. The sum of negative ranks equals the sum of positive ranks.
- d. Based on negative ranks.

**NPar Tests**

**Descriptive Statistics**

	N	Mean	Std. Deviation	Minimum	Maximum
PretestPerceptionSafetyLevel21	23	4.3913	.58303	3.00	5.00
ImmediatePerceptionSafetyLevel21	22	4.4545	.59580	3.00	5.00
ThreeMonthPerceptionSafetyLevel 21	15	4.2000	.86189	2.00	5.00

**Wilcoxon Signed Ranks Test**

**Ranks**

		N	Mean Rank	Sum of Ranks
ImmediatePerceptionSafetyLevel21 - PretestPerceptionSafetyLevel21	Negative Ranks	1 <sup>a</sup>	2.00	2.00
	Positive Ranks	2 <sup>b</sup>	2.00	4.00
	Ties	19 <sup>c</sup>		
	Total	22		
ThreeMonthPerceptionSafetyLevel21 - ImmediatePerceptionSafetyLevel21	Negative Ranks	2 <sup>d</sup>	2.50	5.00
	Positive Ranks	2 <sup>e</sup>	2.50	5.00
	Ties	7 <sup>f</sup>		
	Total	11		
ThreeMonthPerceptionSafetyLevel21 - PretestPerceptionSafetyLevel21	Negative Ranks	2 <sup>g</sup>	2.50	5.00
	Positive Ranks	2 <sup>h</sup>	2.50	5.00
	Ties	7 <sup>i</sup>		
	Total	11		

- a. ImmediatePerceptionSafetyLevel21 < PretestPerceptionSafetyLevel21
- b. ImmediatePerceptionSafetyLevel21 > PretestPerceptionSafetyLevel21
- c. ImmediatePerceptionSafetyLevel21 = PretestPerceptionSafetyLevel21
- d. ThreeMonthPerceptionSafetyLevel21 < ImmediatePerceptionSafetyLevel21
- e. ThreeMonthPerceptionSafetyLevel21 > ImmediatePerceptionSafetyLevel21
- f. ThreeMonthPerceptionSafetyLevel21 = ImmediatePerceptionSafetyLevel21
- g. ThreeMonthPerceptionSafetyLevel21 < PretestPerceptionSafetyLevel21
- h. ThreeMonthPerceptionSafetyLevel21 > PretestPerceptionSafetyLevel21
- i. ThreeMonthPerceptionSafetyLevel21 = PretestPerceptionSafetyLevel21

**Test Statistics<sup>a</sup>**

	ImmediatePerceptionS afetyLevel21 - PretestPerceptionSafe tyLevel21	ThreeMonthPerceptio nSafetyLevel21 - ImmediatePerception SafetyLevel21	ThreeMonthPerceptio nSafetyLevel21 - PretestPerceptionSafe tyLevel21
Z	-.577 <sup>b</sup>	.000 <sup>c</sup>	.000 <sup>c</sup>
Asymp. Sig. (2-tailed)	.564	1.000	1.000

- a. Wilcoxon Signed Ranks Test
- b. Based on negative ranks.
- c. The sum of negative ranks equals the sum of positive ranks.

Appendix S

Evidenced Based Practice Project Guideline Checklist

**UMKC Doctor of Nursing Practice  
EBP Project Scholarly Paper, Guidelines  
Final DNP Project, Spring 2017**

**Sections**                      **Description of Content** (proposal content not shaded; additional final project content is shaded, 25 to 30 pages in body of paper)

<p><b>Title (2 points)*</b></p> <p><i>Word count per APA</i></p>	<p>Indicates the population, EBP quality improvement intervention, and measured outcome.</p>	<p><b>Included: Y, N, NA, comment</b> Y_____</p>
<p><b>Abstract (5) Key Terms</b></p> <p><i>2/3 page, 250-word maximum</i></p>	<p>Summarizes the key project components sequentially: introduction of topic indicating significance, purpose, study design, population with number with setting, EBP intervention, outcome(s) measured, results, and implications to nursing or healthcare or impact to society.</p>	<p>__Y__ (8 items)</p>
<p><b>title heading on 1<sup>st</sup> page (1)</b></p> <p><b>Significance (Economic, Policy, Health System) (1)</b></p> <p><b>Local Issue (1)</b></p> <p><b>Diversity Considerations (1)</b> <i>2 pages for this section</i></p>	<p>(The support for the reason to do this project.)</p> <p>Introduces the specific problem or system dysfunction.</p> <p>Provides the current information and evidence about the problem. (economic, policy, and/or health system).</p> <p>Describes the nature and severity of the problem or system dysfunction within the local project setting.</p> <p>Presents diversity content associated with the population and/or local project setting.</p>	<p>__Y__</p> <p>_____</p> <p>Y</p> <p>__Y__</p> <p>__Y__</p>
<p><b>Problem, Purpose</b></p> <p><b>Problem Statement (1)</b></p>	<p>(The clearly defined problem, purpose of the EBP intervention, and factors for success)</p> <p>States concisely the primary current problem and any secondary problems.</p>	<p>Y</p> <p>_____</p>

<p><b>Intended Improvement with Purpose (1)</b></p> <p><b>Facilitators &amp; Barriers (2)</b></p> <p><i>1 page for this section</i></p>	<p>Identifies the current trigger for the change and why the change is important now.</p> <p>Concludes with primary and any secondary purpose statement(s).</p> <p>Identifies the project facilitators (support systems, stakeholders or shareholders, champions) and the potential barriers to the change.</p> <p>Discusses the project economic component as a facilitator or barrier.</p> <p>Discusses potential for sustainability of the intervention during and after the project.</p>	<p>__Y__ __Y_</p> <p>___Y</p> <p>___Y</p> <p>___Y</p> <p>___Y</p>
<p><b>Review of the Evidence</b></p> <p><b>PICOTS (1)</b></p> <p><b>Search Strategies (1)</b></p> <p><b>Evidence, Sub-Topics (6)</b></p> <p><i>3-4 pages for this section</i></p>	<p>(The existing evidence for this DNP project)</p> <p>States precisely the primary PICOTS and any secondary PICOTS question.</p> <p>Identifies the literature search strategies (broad to focused with direct application to project) including (a) databases, (b) search terms and inclusion time period of publications, and (c) results of search by study design and by level of evidence [Melnik] with numbers</p> <p>Presents the synthesis and integration of the evidence (studies and guidelines) that support the problem, intervention, and outcome measurement. At least 3 sub-topics with a total of 15 – 20 studies including evidence based guidelines</p>	<p>___Y</p> <p>__Y__ (all items)</p> <p>___Y_</p>
<p><b>Theory (2)</b></p> <p><i>1/2 page</i></p>	<p>Discusses the theory with concepts and addresses application to the project and intervention.</p> <p>Discusses application of the theory in studies similar to the project.</p>	<p>___Y</p> <p>___</p>

<p><b>Methods</b></p>	<p>(The components of the project. Provides information for others to replicate the evidence based change)</p>	
<p><b>IRB Approval, Site Approval, Ethical Issues, Funding (2)</b> <i>½ page</i></p>	<p>States specific IRB approval and site agreement.</p> <p>Discusses ethical considerations of privacy, protection including research vulnerable population, and author conflicts of interest.</p> <p>Addresses management of the ethical concerns.</p> <p>Addresses funding.</p>	<p><u>  </u>Y<u>  </u></p> <p><u>  </u>Y<u>  </u></p> <p><u>  </u>Y<u>  </u></p> <p><u>  </u>  Y</p>
<p><b>Setting &amp; Participants (1)</b> <i>½ page</i></p>	<p>Describes the setting, specifics of the participants with inclusion and exclusion criteria, sampling method, and expected number.</p>	<p><u>  </u>Y</p>
<p><b>EBP Intervention (2)</b> <i>2 pages</i></p>	<p>States the EBP intervention.</p> <p>Details the intervention steps (recruitment, intervention sequence including time and participant involvement and who conducts) so others can replicate.</p>	<p><u>  </u>  Y</p> <p><u>  </u>  Y</p>
<p><b>Change Process, EBP (2)</b> <i>½ page</i></p>	<p>Discusses the change theory with processes to promote change and EBP model or framework to support the project.</p>	<p><u>  </u>Y<u>  </u> (change) <u>  </u>Y<u>  </u> (EBP )</p>
<p><b>Study Design (1)</b> <i>1/3 page</i></p>	<p>Identifies the study design for measuring impact of the EBP intervention on primary outcome and any secondary outcomes.</p>	<p><u>  </u>  Y</p>
<p><b>Validity (1)</b> <i>½ page</i></p>	<p>Describes aspects of the project that address internal validity (integrity of the data) and external validity (generalization)</p>	<p><u>  </u>  Y</p> <p><u>  </u>  Y</p>
<p><b>Outcomes (1)</b> <i>¼ page</i></p>	<p>States the primary outcome and any secondary outcome of the EBP intervention which includes anticipated degree and direction of impact of the EBP intervention on the outcome.</p>	<p><u>  </u>  Y<u>  </u></p>
<p><b>Measurement Instrument(s) (2)</b> <i>½ - 1 page</i></p>	<p>Identifies and discusses the instrument to measure each outcome of the EBP intervention including tool validity and reliability.</p>	<p><u>  </u>Y<u>  </u></p>

<p><b>Quality of Data (1)</b> <i>1/2 page</i></p> <p><b>Analysis Plan (Statistical) (2)</b> <i>1/2 page</i></p>	<p>Addresses procedures associated with participant completion of the instrument.</p> <p>Discusses permission for use of the instrument.</p> <p>Explains methods to promote quality of data h including a) power analysis of number of participants, b) baseline data and post data with time length of data collection, and c) comparison to published benchmark data.</p> <p>Provides statistical methods to draw inferences from the data which includes pre-post data and demographics, if later applies.</p>	<p>Y____ _Y____</p> <p>__Y__</p> <p>____Y_</p> <p>____Y</p>
<b>Results</b>		
<p><b>Setting &amp; Participants (5)</b> <i>1/2 page</i></p> <p><b>Intervention Course, Actual (5)</b> <i>1/2-1 page</i></p> <p><b>Outcome Data by Sub-Topic (10)</b> <i>1 page</i></p>	<p>Reports the time frame, setting, and participants involved.</p> <p>Describes participant data.</p> <p>Reports the major components of the intervention and the associated time periods.</p> <p>Addresses the number of participants at key points.</p> <p>Presents the data with statistical analysis for each measured outcome.</p> <p>Includes summary of missing data.</p>	<p>____Y</p> <p>____Y</p> <p>____Y</p> <p>____Y</p> <p>____Y</p> <p>____Y</p>
<b>Discussion</b>		
<p><b>Successes, Most Important (4)</b> <i>1/2 page</i></p> <p><b>Study Strengths (2)</b> <i>1/2-1 page</i></p>	<p>States and describes the most important successes in the study outcomes.</p> <p>Describes elements of the setting (for example, geography, resources, organizational culture, staff, and leadership) that provided support and context for the intervention.</p> <p>Discusses degree of success in implementing the intervention components.</p>	<p>____Y</p> <p>____Y</p> <p>____Y</p>

<p><b>Results Compared to Evidence in the Literature (2)</b> <i>1 page</i></p>	<p>Compares and contrasts the study results with relevant findings from specific published studies.</p>	<p><u>  Y  </u></p>
<b>Limitations</b>		
<p><b>Internal Validity Effects (1)</b></p>	<p>Discusses possible sources of confounding factors, bias, and imprecision in EBP intervention processes and collection of data that could affect the study outcomes.</p>	<p><u>  Y  </u></p>
<p><b>External Validity Effects (2)</b></p>	<p>Address factors (participant characteristics, setting characteristics) that could affect generalizability</p>	<p><b>Y</b>_____</p>
<p><b>Sustainability of Effects and Plans to Maintain Effects (1)</b></p>	<p>Addresses potential for observed gains to weaken over time and plans for maintaining improvement.</p>	<p><u>  Y  </u></p>
<p><b>Efforts to Minimize the Study Limitations (1)</b> <i>2-3 pages this section</i></p>	<p>Reviews the efforts to minimize limitation impact on application of results.</p> <p>Assesses the effect of limitations on interpretation and application of findings.</p>	<p><u>  Y  </u></p> <p>_____ <b>Y</b> _____</p>
<b>Interpretation</b>		
<p><b>Expected &amp; Actual Outcomes (2)</b></p>	<p>Addresses expected results, unexpected results, problems, and failures.</p> <p>Explores possible reasons for differences between observed and expected outcomes.</p>	<p><u>  Y  </u></p> <p><b>Y</b>_____</p>
<p><b>Intervention Effectiveness (inferences) (2)</b></p>	<p>Draws inferences consistent with the strength of the study data about causal mechanisms (components of the intervention, support context factors, type of setting) that assisted with the intervention’s effectiveness.</p> <p>Addresses the types of settings in which the study intervention is most likely to be effective.</p>	<p><b>Y</b>_____</p> <p><u>  Y  </u></p>

<p><b>Intervention Revision (1)</b></p> <p><b>Expected and Actual Impact to Health System, Costs, and Policy (2)</b></p> <p><b>Opportunities, other</b> <i>2 pages for this section</i></p>	<p>Suggests intervention modifications that might improve attainment of the outcomes.</p> <p>Highlights the expected impact and the actual impact of the EBP intervention on health system, policy, and cost.</p> <p>Reviews study estimated costs and actual cost of the intervention and study.</p> <p>Discusses the potential for the economic sustainability of the intervention.</p> <p>Discusses current funding sources for the study.</p> <p>As applies, optional.</p>	<p>___Y</p> <p>___Y</p> <p>___Y</p> <p>___Y</p> <p>___Y</p>
<p><b>Conclusions</b></p> <p><b>Practical Usefulness of Intervention (2)</b></p> <p><b>Further Study of Intervention (1)</b></p> <p><b>Dissemination (1)</b> <i>1 page for this section</i></p>	<p>Discusses overall practical usefulness of the EBP intervention.</p> <p>Addresses further implementation and outcome studies of the EBP intervention.</p> <p>Presents dissemination.</p>	<p>__Y__</p> <p>___Y_</p> <p>___Y</p>
<p><b>References (4)</b></p>	<p>Presents a minimum of 20 research studies including evidence based guidelines. All cited within body of paper. May have additional references: e.g., grey literature, professional organization guidelines which may not be derived from high evidence level research, other. Excludes general references such as textbooks. Use primary sources.</p>	<p>___Y</p>
<p><b>Appendices (all cited within body of paper, sequence appendices as introduced in paper)</b></p> <p><b>Cost Table for Project (1)</b></p>		<p>__Y__ (cost)</p>

<p><b>Definition of Terms (1)</b></p>		<p>___Y_ (terms)</p>
<p><b>Synthesis of Evidence Table (specific to project) (1)</b></p>		<p>___Y_ (table)</p>
<p><b>Theory to Application Diagram (1)</b></p>		<p>___Y_ (theory)</p>
<p><b>Logic Model (1)</b></p>		<p>_Y___ (Logic)</p>
<p><b>Project Timeline Flow Graphic (1)</b></p>		<p>_Y___ (timeline)</p>
<p><b>Intervention Flow Diagram (1)</b></p>		<p>__Y__ (intervention)</p>
<p><b>Intervention Materials (example-education program)</b></p>		<p>Y___ (materials)</p>
<p><b>IRB Approval Letter(s), if applies **</b></p>		<p>_Y___ (IRB)</p>
<p><b>IRB Approved Consent or Informational Letter, if applies</b></p>		<p>___Y_ (consent)</p>
<p><b>Measurement Tool(s), if applies</b></p>		<p>___Y___ (tools)</p>
<p><b>Permission(s) for Tool(s), if applies</b></p>		<p>___Y___ (tools)</p>
<p><b>Data Collection Template (1)</b></p>		<p>___Y___ (permission)</p>
<p><b>Statistical Analysis Results Table(s) (4)</b></p>		<p>___Y_ (collection)</p>
<p><b>Other Tables</b></p>		
<p>This checklist completed by student</p>		<p>_Y___ (results, analysis)</p>

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\*total points = 100 points

\*\* if applies, then must be present to receive paper grade

Appendix T

UMKC SoNHS Proposal Approval Letter



July 24, 2016

Members of UMKC Institutional Review Board  
University of Missouri-Kansas City  
Kansas City, MO 64108

UMKC IRB,

This letter serves to provide documentation regarding Jennifer Taylor's Doctor of Nursing Practice (DNP) Project proposal. Ms. Taylor obtained approval for her project proposal, A Violence Prevention and Preparedness Educational Intervention in Primary Care Clinics, from the School of Nursing DNP faculty committee on July 24, 2016.

If I can provide any further information, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Susan J. Kimble".

Susan J. Kimble, DNP, RN, ANP-BC, FAANP  
Clinical Associate Professor  
DNP Programs Director  
UMKC School of Nursing and Health Studies  
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