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An Intervention to Improve Nurses' Knowledge, Perceived Safety, and Confidence in Identifying and Managing Workplace Violence: A Translation of Evidence into Practice

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AN INTERVENTION TO IMPROVE NURSES' KNOWLEDGE, PERCEIVED SAFETY, AND CONFIDENCE IN IDENTIFYING AND MANAGING WORKPLACE VIOLENCE: A TRANSLATION OF EVIDENCE INTO PRACTICE

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Abstract

The Occupational Safety and Health Administration (OSHA) reports that over two million workers are victims of workplace violence (WPV) (Papa, 2013). Registered nurses are subjected to high risk for workplace violence from patients and visitors, with 25.5% reporting at least one victimization incident (Gillespie et al., 2013). Research indicates that WPV has a significant impact on nurses' quality of working life, job satisfaction levels, turnover rates and has also been shown to negatively impact efficiency and productivity (Gacki-Smith et al., 2009). ED nurses are at substantial occupational risk for workplace violence. Emergency departments have been identified as areas within the hospital in which the incidence of violence is moderately high, with nurses (67%) being most frequently being assaulted. Relative to other healthcare workers, emergency department (ED) staff face an exceptionally high risk for WPV, primarily due to open-door policies, a high volume of patients, and illness acuity.

The purpose of this Doctor of Nursing Practice (DNP) project was to develop, implement, and evaluate an online module to improve ED nurses' knowledge, perceived safety, and confidence in identifying and managing WPV. This project utilized a pre- and post-knowledge assessment with an educational intervention (i.e., the video presentation) delivered in an online format. Via an online platform, participants were asked for demographic information, completed pre-knowledge and safety and confidence assessments. Participants viewed an informational video, and post knowledge, safety, and completed confidence assessments. A brief evaluation of the project's video was also completed. The project took participants one and a half hours to complete, and a nursing continuing education certificate was awarded as an incentive to participate.

Change Theory has been utilized to explain interventions that improve nurses' perceptions of change in clinical practice. Change theory incorporates three concepts; driving forces, restraining forces, and equilibrium. Forces that push us in a director that results in a change to occur are driving forces. Change theory focuses on re-educating one's perceptions, beliefs, or attitudes. Lewin's change theory provided nurses with the direction in altering the old processes of dealing with violent patients to the new risk assessment method for potentially violent behavior (Shirey, 2013).

One hundred and nineteen possible participants responded to the survey invitation. Of the 119, 44 completed the project requirements; thus, 77 participants were excluded from all analyses resulting in a final sample of 44 (N= 44). The majority of the final sample were female 37 (84.1%), mostly employed in the acute care or inpatient setting 37 (84.1%), and were nurses 40 (90.9%). Participants reported experiencing WPV at least once a day 27.3% of the time, 13.6% monthly, and 15.9% a few times a year. Some participants 16 (36.4%) reported they felt WPV increased during COVID-19. A significance difference (p= 0.00) was demonstrated on the knowledge assessments, increasing knowledge following the educational intervention. Scores on the safety and confidence assessment were improved, but not significantly.

Project participants reported that 75% of the time, the incident of violence involved a patient, and 11.4% of the time involved a patient's family member. Participants further reported physical assaults 59.1% of the time, emotional assaults 68.2% of the time, and verbal assaults 45.5%. The Emergency Nurses Association reports that patients are the main offenders in all incidents of patient violence (97.8%) and visitor violence (92.3%), with the triage area (40.2%) being the most common area of WPV occurring.

This project demonstrated that healthcare workers benefited from this educational module to improve their knowledge about WPV; however, changes in perceptions of safety and confidence to manage WPV need further research, especially those working in the emergency department.

Acknowledgments

I cannot express enough thanks to the people who have made this Doctor of Nursing Project successful, and I would like to thank each of them. I am incredibly grateful for my committee mentor, Dr. Mary Bondmass, who has had a strong impact in mentoring me so successfully throughout this process. Her guidance, encouragement, knowledge, and collaboration have been invaluable over the last two years. She has helped me tremendously navigate graduate nursing education and guided me through challenges presented by the COVID-19 pandemic. Thank you for your patience, guidance, and exemplary leadership skills.

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Finally, I wish to express my gratitude to my family and friends who have continually cheered me on and pushed me throughout this program. My husband Zach, who has done so much in our home life to ensure my success, also acted as my statistical consultant on this project. Thank you, everyone, you have been the best support system, and I could not have done it without you.

Dedication

I wish to dedicate this project to my Dad, who always encouraged me to pursue the highest education level in my field, and to Lucy. She was the most incredible and uplifting nurse I had the pleasure of working with. I wish they were both here to see the project completion.

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Chapter I: Introduction

According to the World Health Organization, every individual has the right to a healthy and safe work environment. The National Institute for Occupational Safety and Health defines WPV as "violent acts, including physical assaults and threats of assaults directed toward a person at work or on duty." The Occupational Safety and Health Administration (OSHA) reports that over two million workers are victims of workplace violence (WPV) (Papa, 2013). The incidence of WPV within the healthcare industry is 3.8 times higher than all private sector industries. Registered nurses are subjected to increased risk for (WPV) from patients and visitors, with 25.5% reporting at least one victimization incident (Gillespie et al., 2013). Research indicates that WPV has a significant impact on nurses' quality of working life, job satisfaction levels, turnover rates and has also been shown to negatively impact efficiency and productivity (Gacki-Smith et al., 2009). In 2016, staffing, insurance, and medical care resulting from violence against hospital employees cost the hospital $429 million (Van Den Bos et al., 2017). According to Speroni et al. (2014), 76% of nurses had experienced verbal or physical WPV within the past year. Currently, it is a felony in 32 states to assault a healthcare worker. The Bureau of Labor and Statistics states that registered nurses account for 46% of all nonfatal assaults and violent acts related to WPV, resulting in registered nurses (RN) days away from work. Nonfatal assaults occurred more than double, with nurses being victims compared to other healthcare providers (BLS, 2015).

Problem and Significance

ED nurses are at substantial occupational risk for workplace violence. Emergency departments have been identified as areas within the hospital in which the incidence of violence is moderately high, with nurses (67%) being most frequently being assaulted. Relative to other

healthcare workers, emergency department (ED) staff face an exceptionally high risk for WPV, primarily due to open-door policies, a high volume of patients, and illness acuity. A nationwide survey was done in 2009, but the Emergency Nurses Association (ENA) resulted in more than 50% of nurses subjected to WPV by patients and more than 25% experiencing 20 or more acts of WPV last three years. The ENA (2011b) stated that WPV is a significant problem for nurses in the ED. In an extensive study of ED staff, nurses' perceptions of safety were lower than all other ED personnel types, supporting the fact that ED nurses experience higher rates of exposure to WPV than other healthcare workers (Jamshed et al., 2019).

Given the significance, incidence, and prevalence of WPV amongst healthcare workers in general and ED nurses specifically, knowledge and risk assessment and confidence related to WPV need to be addressed and is, therefore, the focus of this project.

Purpose

The purpose of this Doctor of Nursing Practice (DNP) project was to develop, implement, and evaluate an online module to improve ED nurses' knowledge, perceived safety, and confidence in identifying and managing WPV. Although the module was specific to ED nurses, many components may be of value to any nurse or frontline healthcare workers because of the nature of the problem; therefore, any interested nurse or other healthcare workers were welcome to participate.

Chapter II: Literature Review

This chapter presents an extensive literature review related to violence and violence risk in the workplace generally, and specifically in the ED. A search of several databases was conducted to pursue studies within the last ten years; a few older articles were chosen from a historical perspective. The Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, OVID Nursing Journal, and Scopus databases were searched. Keywords included workplace violence, ED violence, violence in health care, nursing perception of violence, workplace safety, and violence risk assessment. This review's sections include scope and definitions, contributing factors, barriers, risk assessment, the need for violence prevention programs, and online delivery of continuing education.

Scope and Definitions

A review of the general literature indicates that WPV is a significant public health concern and has resulted in growing national attention (Gates et al., 2011). The National Institute for Occupational Safety and Health defines WPV as "an act of aggression directed toward persons at work or on duty, ranging from offensive or threatening language to homicide." Zhang et al. (2017) categorized WPV as physical violence (i.e., violence involving physical contact such as kicking, stabbing, and beating), verbal abuse (i.e., mistreatment through words), threats, sexual harassment, and bullying. The Emergency Nurses Association ENA recognized the potential for violence in the ED and developed a position statement that acknowledged that ED nurses are at significant occupational risk for WPV. The ENA reports that the WPV incidence rate in healthcare is 3.8 times higher than all private industries, with the emergency department (ED) being a highly susceptible area. The ENA suggests an increased emphasis on training nurses to recognize patient cues to identify potentially risky situations and focus on WPV

prevention rather than managing incidents (ENA, 2011a). Kowalenko et al. (2013) noted that due to the high prevalence of assaults and threats towards healthcare workers, there is a negative impact on stress, productivity, and healthcare workers' ability to perform their job. Kowalenko et al., further noted a significant issue in underreporting incidents to administrations due to the nurses' perception that it is "a part of the job." WPV impacts the nurses' ability to perform job duties, but nurses face other significant consequences. Hassankhani et al. (2018) found that workplace violence for nurses can result in nurses suffering from mental health risks, depression, anxiety and stress, unpleasant emotions, physical health risks, physical injuries, stress-related chronic conditions, sleeping problems, threats to professional integrity, loss of interest in work, low nursing interactions, disruptions in nursing care, threats to social integrity, disrupted family relationships, and daily activity impairment.

Contributing Factors

Factors contributing to nurses' perception of WPV include patient factors, environmental factors, and interactional factors. According to Angland et al. (2014), nurses' knowledge of factors that cause violence and aggression primarily included environmental and communication issues. Environmental factors include long waiting times, overcrowding, lack of space, insufficient security, and triage-related issues. Communication factors include interpersonal relationships, staff attitude, and fear, and vulnerability of patients. Angland et al. (2014) also found that patients blamed their perception of lack of communication from staff as the reason for aggression 36% of the time, where nurses perceived communication as the problem 15% of the time. It was determined that excellent communication skills and prevention training are reported to improve nurses' confidence in managing aggression in the ED (Angland et al., 2014). Gacki-Smith et al. (2009) found that assaults in the ED are a severe issue, and interventions and

prevention are critical. A commitment from hospital administrations, ED managers, and hospital security to improve ED nurses' safer workplace is needed (Gacki-Smith et al., 2009).

Barriers

There are many barriers to addressing WPV, including underreporting, nurses' perception that assaults are part of the job, and nurses' perceived lack of administrative support. Gacki-Smith et al. (2009) additionally note that nurses' perceived violence attributed to inadequate security, possession of weapons for patients of visitors, insufficient staffing levels, and lack of proper staff training in the reorganization and diffusion of potentially violent patients. It has been shown there is a direct association between the lack of workplace violence prevention programs and an increase in the risk of assaults, which consequently indicates a need for a comprehensive violence prevention program (Gacki-Smith et al., 2009). Challenging behavior is experienced regularly by ED nurses resulting in these nurses feeling intimidated and unsafe while working. Hyland et al. (2016) report a need for supported targeted educational programs to optimize safety and wellbeing.

Risk Assessment

Research has found the ED to be at higher risk for WPV compared to other settings within healthcare. The prevalence of ED WPV continues to be a pervasive problem encountered by all levels of EMS workers. WPV is a significant problem for the ED nurse and directly relates to negative stress experiences, decreased work productivity, and patient care quality. RNs were statistically more likely to be physically threatened than MDs/PA or LPN. (Kowalenko et al., 2013). Workplace violence contributes to staff stress, sick leave, turnover, burnout and limits the nurses' ability to provide quality care. Measures need to be implemented to reduce and manage WPV (Cabilan & Johnston, 2019).

A strategy that is gaining popularity in emergency medicine is the utilization of violence risk assessment tools. The purpose of risk assessment tools is to prevent suicide, prevent injury to healthcare workers, and de-escalate a patient before a violent act occurs. Violence risk assessment tools allow staff to initiate appropriate precautions and implement early interventions to reduce the impact of moderate to high-risk, nurse-patient encounters. However, current risk assessment tools used in the emergency setting predominantly focus on reaction to patient behaviors (Cabilan et al., 2019). Also involved in the use of violence risk assessment tools in the emergency setting is the early identification of high-risk behaviors and de-escalation techniques that reduced violence and protected staff and patients from potential injuries in the ED. Behaviors associated with high-risk for violence include staring/glaring, tone/increased volume, anxiety, mumbling, pacing, aggressive statements, belligerence, clenched fists, demanding attention, irritability, and hostility; the use of standardized violence risk assessment for early identification and de-escalation interventions may reduce violent behavior and decrease the risk of injury to healthcare workers (Calow et al., 2016).

The Broset Violence Checklist (BVC) is a six-item instrument used to identify patients who may become aggressive (Almvik et al., 2000). The BVC is primarily used in the psychiatric setting and demonstrated to be quick and easy to use in highly acute and busy environments. Clarke et al. (2010) found that during the implementation of the BVC on an inpatient psychiatric unit, there was an unusually low rate of aggressive incidents and reduction in seclusion protocols during the trial phase. The BVC scores can become a form of communication shorthand for staff inpatient handovers, transfers, and calls for assistance with possible utility in the ED. (Clarke et al., 2010). The Broset Violence Checklist (BVC) is one of the most studied violence risk assessment tools in the literature. Partridge and Affleck (2018) found that the use of the BVC in

the ED setting was able to recognize 16 of 35 violent patients correctly and 75% of patients who scored on the "physically threatening" BVC item went on the commit a violent act (Patridge & Affleck, 2018).

Workplace Violence Prevention Programs

There were few workplace violence prevention programs identified in the literature, thus creating a need to develop and implement such programs. Elements of workplace violence prevention programs should include risk assessment strategies, establishing and maintaining safe environments, risk communication, violent events responses, recordkeeping, surveillance, and post-incident care (Gillespie et al., 2013). Available data suggest workplace violence is a common and inevitable occupation hazard resulting in manifestations of burnout among nurses, including emotional exhaustion, depersonalization, decreased personal efficacy, and diminished job satisfaction. Processes that mediate workplace violence's impact need to be implemented in the ED setting to reduce workplace violence incidents and decrease nurse burnout (Vrablik et al., 2019). Current WPV prevention programs are geared toward administration and organizational assessment. Items include the presence and availability of security, policies and procedures for when a violent event occurs, unit environmental considerations, and recordkeeping. This project program is focused on the education and implementation of tools to be used at the staff RN level. RNs will be educated on the BVC and provided evidence-based interventions to be implemented based on the BVC score.

Online Delivery of Continuing Education

Web-based learning is not limited to but primarily includes online and offline computer-based learning, virtual simulations, E-learning, and mobile learning. Web-based learning is a cost-efficient and convenient way to provide sufficient access to learning domains and

information. Due to these resources' increased availability, online education delivery is as effective as traditional face-to-face instruction (Kang & Seomun, 2018).

Nursing education is rapidly changing and needs to meet the demands of learners and meet healthcare staffing needs. By accepting more nursing students, educational programs are utilizing different nursing education programs, which has led to an increase in the use of online nursing programs (Abuatiq, 2019). The flexibility and resource-rich nature of online learning encourage nurses to use online learning for continuing education. Online learning is widely used for professional development and training nursing skills and is recognized as an effective approach for enhancing nursing knowledge. Online education empowers nurses to simultaneously balance their own learning needs and workloads (Wu, Chan, Tan, & Wang, 2018).

There has been shown equal effectiveness of web-based teaching modalities for continuing education compared to face-to-face delivery. There is also a lower cost for healthcare providers and employers using web-based teaching. (Maloney et al., 2012). Internet-based methods of delivering nurses' continuing education seem to be as effective as the face-to-face method (Khatony et al., 2009). This project was initially planned to be delivered in a face-to-face format at several Las Vegas Hospital's EDs, and a smaller sample was anticipated. However, given the social distancing required in our COVID-19 health environment, this project will now be open to licensed nurses within the United States and other healthcare workers. They also may be affected by WPV. Furthermore, online delivery allows reaching larger audiences of nurses without utilizing further resources. ED nurses will serve as a subpopulation of interest and will be analyzed separately and in aggregate.

Summary

Violence in the ED is common, with an underlying normalization of this phenomenon. Contributing factors and multiple barriers were identified, and research indicates a significant negative impact of WPV on nurses and their ability to perform their job. While there are WPV risk assessment tools available, few data on WPV programs were found in the literature. Risk assessment tools differ from WPV programs in that they provide a standard in which healthcare providers evaluate individuals for potential violence. Workplace violence prevention programs incorporate risk assessment strategies, establishing and maintaining safe environments, risk communication, violent events responses, recordkeeping, surveillance, and post-incident care (Gillespie et al., 2013). Workplace violence prevention programs may decrease WPV; however, further research on interventions that identify and reduce high-risk situations is needed.

Needs Assessment

Recent research has documented the incidence of WPV within the healthcare setting. The Bureau of Labor Statistics (BLS, 2015) has been considered a reputable source for occupational injury data. When evaluating data between HC violence and other industries, it was noted that there is a higher incidence of nonfatal occupational illness and injuries related to HC assaults compared to all other sectors (BLS, 2015). However, the BLS data did not distinguish between patient care areas (i.e., ED vs. other inpatient units). Currently, the predominance of research on violence in the ED focuses on the screening and risk assessment of intimate partner violence and ED workplace violence. While several tools are used to recognize and risk-stratify patients prone to high risk for violent behaviors, they are primarily specific to the mental health population. Many of these tools have been validated, yet few have been used in the ED setting. ED practitioners must now assess patients for potential risks, even though the assessment tools have

not effectively prevented violence in the ED. There is a need for research and quality improvement programs, such as in this DNP project, to apply these screening tools specific to the ED.

The statistics confound ED nurses' experiences and the disproportionate incidences of WPV with patients and visitors (Speroni et al., 2014). According to a survey by the ENA, 70 percent of emergency nurses report being hit and kicked while on the job. The ENA has conveyed that patients were the main offenders in all incidents of patient violence (97.8%) and visitor violence (92.3%), with the triage area (40.2%) being the most common area of WPV occurring. The ENA published a report of the Emergency Department Violence Surveillance (EDVS) study, which reported patient violence was reported by 12.1% of participants, and 42.5% of those responding noted they have also been subjected to visitor violence exclusively (ENA, 2011). The above literature and WPV statistics provide the need for increasing ED nurses' knowledge, risk assessment, and confidence in addressing WPV.

Chapter III: Theoretical Underpinnings

This chapter presents two theories that guided this Doctor of Nursing Practice (DNP) project. A brief overview of Lewin's Change Theory (Schein, 1996) and Hans Selye's General Adaptation Theory was discussed concerning this DNP project's development and implantation. In addition to the research literature presented in Chapter 2, Change Theory and General Adaptation Theory were used to guide this project, determine and explain variables of interest, and create an online educational module related to WPV. Changes occur to organizational patterns when healthcare providers implement evidence-based practices into the clinical setting.

Lewin's Change Theory

Change Theory has been utilized to explain interventions that improve nurses' perceptions of change in clinical practice. Change theory incorporates three concepts; driving forces, restraining forces, and equilibrium. Driving forces are forces that push in a direction that causes change to occur. Restraining effects are forces that counter driving forces. Therefore, restraining forces hinder change by directing the person in the opposite direction. These cause a shift in the equilibrium, which opposes change. The three critical stages of Lewin's change theory include unfreezing, change, and freezing; all three must be achieved to drive change successfully.

Change theory focuses on re-educating one's perceptions, beliefs, or attitudes. Lewin's change theory will provide nurses with guidance in changing the old processes of dealing with violent patients to the new risk assessment method for potentially violent behavior (Shirey, 2013). Unfreezing is essential for change and sustained freezing to occur. This new method requires creating a situation in which change is considered necessary by investigating facts and evaluating restraining and driving forces (Lewin, 1948). During the unfreezing stage, the process

involves demonstrating that the current way of doing something is substandard, and there is a need for change to be made to improve something. In WPV, the unfreezing stage is critical and must be accomplished before nurses can start implementing change in their practice and start the refreezing stage. Related to this DNP project, nurses will progress through these stages as they unfreeze current practice models that lack pre-assessment of potentially violent patients, change their practice by implementing the Broset Violence Checklist, and freeze with the practice model, which incorporates an updated violence risk assessment.

Hans Selye's General Adaptation Theory

General Adaptation Theory consists of a three-stage setoff physiological process that prepares or adapts the body for danger. Selye (1950) discovered and broke down these stages into (1) alarm, (2) resistance, and (3) exhaustion. This theory suggests a living organism's ability to adapt to its environment and changes in its surroundings. The alarm reaction is the first stage of general adaptation syndrome (GAS), followed shortly after a stressful event where the body is prepared for a fight or flight response. The resistance stage is where the body attempts to adapt to the new situation. The final stage of GAS is exhaustion, where the body tries to repair itself if the original threat has passed (Selye, 1950).

Selye (195) theorizes that when individuals stay in the resistance stage too long, they experience exhaustion. This resistance explains the effect of repeated exposure that violence has on healthcare providers. Repeated exposure to violence has been shown to increase nursing turnover and decrease job satisfaction (Oyeleye et al., 2013; Palmer, 2014). Physical and verbal abuse from a patient experienced by the RN can have two-part consequences, consisting of physical and psychological effects. Real results can include bodily injury, taking time away from work, and worker's compensation. Psychological consequences mirror Selye's General

Adaptation Syndrome (1950) and progress through the three stages of alarm, resistance, and exhaustion. For example, in the alarm stage, RNs may have fear, anger, and confusion. In the resistance stage, RNs may excuse patient behavior or believe that violence is part of the job. In the exhaustion stage, RNs may experience a lack of compassion, decreased job satisfaction, reduced quality of patient care, and the resignation of position or, worst-case scenario or retire from the profession.

Chapter IV: The Project: Methods and Procedure

The purpose of this DNP project was to develop, implement, and evaluate an online module to improve ED Nurses' knowledge, perceived safety, and confidence in identifying and managing WPV. Although the module was specific to ED nurses, many components were thought to be of value to any nurse or frontline healthcare worker because of the nature of the problem; therefore, any interested nurses or other healthcare workers were welcome to participate.

This chapter describes how the workplace violence educational module was developed, implemented, and evaluated for this DNP project. Included below are the setting and design, population and sample, procedures with timeline, measures, instruments, and data analysis. Possible risks and threats and project evaluation are also addressed.

Setting and Design

This project was implemented via a web-based application called SurveyMonkey®. The web-based modality was determined to be most beneficial due to social distancing barriers imposed by Nevada governmental orders related to the COVID-19 pandemic. The design utilized was a pre-and post-knowledge assessment of an educational intervention (i.e., the video presentation). Participants completed the project at their leisure, any place or site of their preference.

Population and Sample

This project's population of interest were registered nurses over the age of eighteen and licensed to practice in the United States; however, other interested healthcare workers could participate if they wished. Recruitment was done primarily through Nevada Nurses Association via email invitation. Participants voluntarily responded to email invitations sent out from email

invitation sent by the Nevada Nurses Association. Participants were also recruited using social media contacts and word-of-mouth.

Procedures and Timeline

After receiving the approval of the student's Graduate Advisory Committee, IRB approval from UNLV was obtained. After that, the sequential/simultaneous procedures and timeframes through the project's completion are listed below.

- Development of a pre-and post-knowledge assessment and an educational video related to WPV (September and October 2020).
- Development of the SurveyMonkey® website (October 2020), which included:
    - an informed consent page
    - a demographic collection page
    - a pre-intervention knowledge assessment page
    - pre-intervention perceived safety and confidence assessment pages
    - an inserted link to a video presentation and links to supplemental materials
    - a post-knowledge assessment page
    - post-intervention safety and confidence assessment pages
    - a program evaluation page
    - an embedded link to download the continuing education certificate
- Obtained email lists from various sources (and set up social media sites) for participant recruitment (September and October 2020)
- Data were collected over six weeks (October and November)
- Analysis of data (December 2020 through February 2021)

- Completion of results, discussion, and conclusions for chapters V and VI
- Final project defense (March 23, 2021)

Outcome Variables and Instruments

This project's outcomes were knowledge about workplace violence, perception of workplace safety, and confidence in managing workplace violence. To measure knowledge, the student developed a WPV knowledge assessment related to the information presented in the educational video. The Workplace Violence Safety Scale and the Workplace Violence Confidence Scale (Gates et al., 2011) were used to measure safety and confidence.

The Workplace Violence Safety Scale is a three-item Likert scale survey. The three items ask the participant about their current feelings of safety while working in the ED. The Safety Scale addressed how safe the participant felt while working in the ED and whether they thought they would be injured from an assault within the next six months. Participants responded on a scale of 1-10, with one being 'strongly disagree' and ten beings 'strongly agree' (Gates et al.2011). Responses were then converted to a safety score.

The Workplace Violence Confidence Scale is a four-item Likert scale survey. The four items asked the participant to describe how confident they are in handling patients and visitors who become aggressive and rate their ability to manage violent patients or visitors. Questions were answered on a 1-10 scale, with one being 'not confident' and ten being 'extremely confident.'

Both the safety and confidence instruments have documented good face and content validity with high internal reliabilities (Cronbach $\alpha > 0.9$). In previous work, the safety scale's alpha was 0.75 and 0.95 for the confidence scale (Gates et al., 2011). Gates et al. (2011) operationalized physical assaults to include hitting with a body part, slapping, kicking, punching,

pinching, scratching, biting, pulling hair, hitting with an object, throwing an object, spitting, beating, shooting, stabbing, squeezing, and twisting. Physical threats included actions, statements, and written or nonverbal messages, conveying physical injury threats, which were severe enough to cause one to feel unsettled and unsafe.

Data Analysis

Descriptive statistics, including frequencies and percentages, were used to analyze and present demographic data and the individual item responses on the pre-and post-assessments. Scores for knowledge assessments were calculated using correct responses out of the number of possible items. A paired t-test for match samples was used to analyze the pre-and post-knowledge assessment scores.

While this DNP work is a quality improvement change project and not considered formal research, clinical significance (change in knowledge, perceived safety, and confidence) versus statistical difference was the desired endpoint; however, statistical analysis was conducted as described above.

Resources

Limited resources other than the student's time were needed for this project. The student's advisory Chair provided the use of the SurveyMonkey® application.

Risks and Threats

The project's participation was voluntary and not associated with the participants' place of employment. Risks related to participants were considered to be minimal. Participants might have had some minor psychological discomfort in completing the knowledge assessment if they felt unsure about their answers or felt uneasy about their safety risk of WPV.

The project's primary risk was the possible lack of participation due to the project not being a mandatory organizational requirement. Project threats further included participants' not completing all of the required portions of the project. To mitigate the risk, continuing education credits were offered to encourage full participation through completion.

Project Evaluation

The project's evaluation was done using the standard continuing education evaluation used by the Nevada Nurses Association (NNA) as an approved provider of continuing nursing education by the Nevada State Board of Nursing.

Sustainability of the Project

After the final defense of this project (anticipated spring 2021 semester), the entire project will be donated to the NNA. The NNA will offer it to Nevada nurses in their free online library of continuing education. Additional analysis may be conducted between six and nine months after the donation, and any other available data will be used for a possible manuscript. Posting on the NNA's website will provide sustainability for as long as the information is current, and a manuscript may result in even further dissemination.

Chapter V: Results

The purpose of this Doctor of Nursing Practice (DNP) project was to develop, implement, and evaluate an online module to improve ED nurses' knowledge, perceived safety, and confidence in identifying and managing WPV; this purpose was achieved. This chapter will describe the project's specific results, including the sample's demographics and the pre- and post-comparisons of the project's outcome variables of knowledge, safety, and confidence.

Sample Demographics

One hundred and nineteen possible participants responded to the project's invitation. Of the 119, forty-four completed all of the project requirements; thus, 77 participants were excluded from all analyses, resulting in a final sample of 44 (n= 44). The majority of the final sample was female 37 (84.1%), mostly employed in the acute care or inpatient setting 37 (84.1%), and nurses 40 (90.9%). Table 1 presents a detailed description of additional sample characteristics.

Participants were surveyed on workplace violence experiences, perception of COVID-19 impact on workplace violence, and organizational communication regarding workplace violence. Table 2 presents a detailed description of incidents of workplace violence. Table 3 shows a detailed description of the perception of the impact of COVID-19 on workplace violence. Table 4 presents a detailed description of the perception of organizational responses to workplace violence.

Table 1: Sample Characteristics

Sample Characteristics		
Age	n=40	
	Mean/SD	35.92±11.87
	Median	32.50
	Mode	32
	Min	20
	Max	71
Nurse years	n=39	
	Mean/SD	12.33±12.698
	Median	8.00
	Mode	5
	Min	0
	Max	52
Gender	Frequency	Percent
Female	37	84.1
Male	6	13.6
ED Year Experience	n=18	
	Mean/SD	9.89±12.150
	Min	1
	Max	49
Primary Workplace	Frequency	Percent
Academia	1	2.3
Inpatient (Hospital or Nursing facility)	37	84.1
Occupational Health	1	2.3
Out-patient	5	11.4
Employment Status		
Full-time	33	75.00
Part-time	4	9.1

Sample Characteristics		
Per-diem	6	13.6
Student	1	2.3
Highest level of education	Frequency	Percent
ASN	5	11.4
BSN	26	59.1
MSN	6	13.6
DNP	3	6.8
N/A	4	9.1
Specialty		
Emergency	12	27.3
Surgical Services	5	11.4
Critical Care	5	11.4
Med-Surg	2	4.5
Primary care	2	4.5
Psychiatric	2	4.5
Other	16	36.4
Other Healthcare Provider		
Certified Nursing Assistant (CNA)	1	2.3
Doctor of Osteopathic Medicine (DO)	1	2.3
Phlebotomist	1	2.3
Physical Therapist	1	2.3

Table 2: Experience of Violence

Experience of Violence		
Direct involvement in the incident of WPV within the last year	Frequency	Percent
Yes	28	63.6
No	16	36.4
Physical Assault		
Physical assault – e.g., kicking, punching, spitting, biting, pushing, pulling, cutting, stabbing	26	59.1
Emotional Assault		
Emotional assault -- e.g., bullying, manipulation, intimidation ▪ Sexual assault -- e.g., harassment, stalking	30	68.2
Verbal Assault		
Verbal assault -- e.g., threats, blaming, name-calling, unwanted contact	20	45.5
The individual commits an act of violence		
Employee/Coworker	3	6.8
Patient	33	75.0

Experience of Violence		
Patient's family member	5	11.4
How often do you see or experience violence at your workplace?	Frequency	Percent
A few times a year	7	15.9
At least once a day	12	27.3
Monthly	6	13.6
Never	4	9.1
Once a year or less	6	13.6
Weekly	9	20.5
Did you report your experience with WPV?		
Yes	28	63.6
No	13	29.5

Table 3: Perception of COVID-19 on WPV

COVID-19 Impact on WPV		
	Frequency	Percent
Increased	16	36.4
Decreased	4	9.1
I do not know	9	20.5
No change	14	31.8

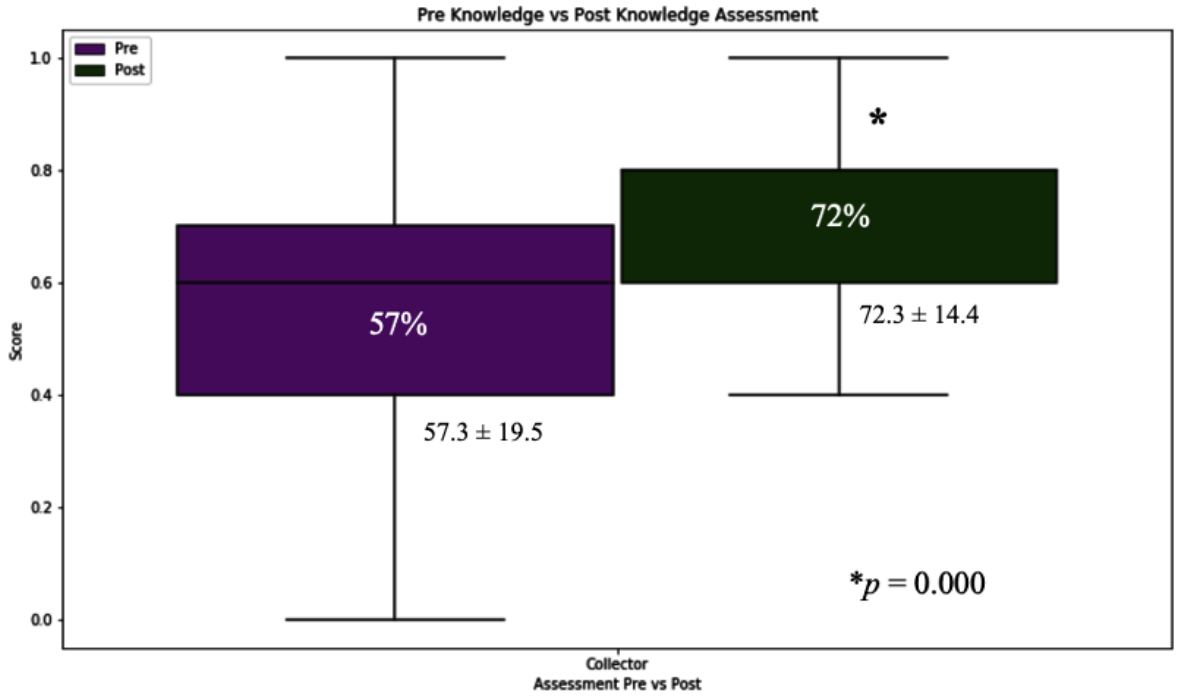
Table 4: Perception of organizational response to WPV

Organization WPV		
Does management communicate information to employees about incidents of workplace violence prevention efforts at the hospital?	Frequency	Percent
Yes	22	50.0
No	20	45.5
Is there a written violence prevention policy at your hospital?	Frequency	Percent
Yes	38	86.4
No	5	11.4
Are there clearly established procedures and expectations for violence prevention at your hospital?		
Yes	31	70.5
No	12	27.3

Outcome Variable: Knowledge

Participants in this project completed pre-and post-knowledge assessments to determine change before and after viewing the educational video (i.e., the project's intervention). The student developed the knowledge assessment based primarily on the evidence available in the literature. The knowledge assessment was comprised of five questions. Each question was valued at one point, with a possible score of five equaling 100%. There was a significant (p= 0.00) improvement on the post-knowledge assessment (Figure 1).

Figure 1 Pre- and Post-Knowledge Assessment Scores (N=44)



Outcome Variables: Safety & Confidence

Participants also completed safety and confidence assessments. The Workplace Violence Safety Scale is a three-item Likert scale survey. The three items ask the participant about their current feelings of safety while working in the ED. The Safety Scale addresses how safe the participant felt while working in the ED and whether they thought they would be injured from an assault within the next six months. Participants responded on a scale of 1-10, with one being 'strongly disagree' and ten being 'strongly agree'; item responses were added to achieve a total score (Gates et al., 2011).

The Workplace Violence Confidence Scale is a four-item Likert scale survey. The four items ask the participant to describe how confident they are in handling patients and visitors who become aggressive and rate their ability to manage violent patients/visitors. Participants responded on a scale of 1-10, with one being 'not confident' and ten being 'extremely confident'; item responses were added to achieve a total score

Slight improvement was found in both the safety (16.63 ±3.87 vs 17.08 ± 3.78) and confidence (24.53 ± 10.06 vs 25.05 ± 10.73) scores, but the change was not significant. A post hoc power analysis indicated the effect size for the safety and confidence assessments was small (0.11) and an N of 67 (compared to the current N = 44) would have been needed to have 0.80 power to find differences between the pre- and post-assessments, if they were truly different; therefore, the possibility of a Type II error (false negative) was present in this project's evaluation of safety and confidence.

Program Evaluation

Program evaluation responses were mainly positive. Table 5 displays a detailed description of the program's evaluation items and responses.

Table 5: Program Evaluation

Program Evaluation			
Evaluation Item	Strongly Agree	Agree	Neutral
Were the presentation objectives clear	24(54.5)	14(31.8)	1(2.3)
My personal learning objectives were met	22(50.0)	15(34.1)	2(4.5)
The content was appropriate for the intended audience	25(56.8)	13(29.5)	1(2.3)
The visual aids and oral presentation clarified the content	24(54.5)	14(31.8)	1(2.3)
Teaching methods were appropriate for the subject matter	21(47.7)	17(38.6)	1(2.3)
The speaker Kayla Sullivan was knowledgeable in the content area	24(54.5)	15(34.1)	

Results presented as number of participants (#) and percent of respondents (%)

Chapter VI: Discussion and Conclusion

This chapter includes the discussion about this DNP project's clinical relevance, addresses the problem and further research implications, implications for practice, relates the results of the project to evidence and theory, and considers the potential for sustainability and dissemination of these results.

Clinical Relevance

This DNP project is clinically relevant to any registered nurse or healthcare provider, regardless of where they work. Currently, the predominance of research on violence in the ED focuses on the screening and risk assessment of intimate partner violence and ED workplace violence. While several tools are used to recognize and risk-stratify patients prone to high risk for violent behaviors, they are primarily specific to the mental health population. Many of these tools have been validated, yet few have been used in the ED setting. Project results show that 63.6% of participants had direct involvement in an incident of WPV within the last year. ED practitioners must now assess patients for potential risks, even though the assessment tools have not effectively prevented violence in the ED. There is a need for research and quality improvement programs, such as this DNP project, to apply these screening tools specific to the ED. This project demonstrated the knowledge about WPV can be improved with education, but further assessments, with larger sample sizes, are needed to determine if perceptions of safety and confidence can be improved with education.

ED nurses' experience and the disproportionate incidences of WPV with patients and visitors (Speroni et al., 2014). Project participants reported that 75% of the time, the incident of violence involved a patient, and 11.4% of the time, involved a patient's family member. According to a survey by the ENA, 70 percent of emergency nurses report being hit and kicked

while on the job. Project participants reported physical assaults 59.1% of the time, emotional assaults 68.2% of the time, and verbal assaults 45.5%. The ENA has conveyed that patients were the main offenders in all incidents of patient violence (97.8%) and visitor violence (92.3%), with the triage area (40.2%) being the most common area of WPV occurring. The above literature and WPV statistics provide the need for increasing ED nurses' knowledge, risk assessment, and confidence in addressing WPV. However, as indicated by this project's post hoc power analysis, larger samples or an increase effect size, may be needed if statically significant changes are the desired outcome and the probability of a Type II error eliminated.

Limitations

The project's limitations included a small sample size, and there was a more significant percentage of female respondents than males. The sample size of this study included 44 participants. When a small sample size occurs, the project's limitations consist of reducing the power of the study and increasing the margin of error. For this project, the issues related to sample size could have resulted from non-response, where some subjects do not have the opportunity to participate in the survey. The time-frame of data collection could have impacted the number of participants who were able to participate. If the data-collection time frame was extended, it could have resulted in a larger sample size.

The nursing field is a predominantly female-driven workforce. Females encompass 91% of the United States nursing workforce. The majority of respondents in this project were female, which could have impacted this project's result, considering the majority of the nursing workforce is female. The possibility that results were skewed, having primarily female respondents and their perception of workplace violence compared to males.

Addressing the Problem and Further Research

Project participants responded that 27.3% experienced WPV at least once a day, 13.6% experienced WPV monthly, and 15.9% experienced WPV a few times a year. Risk assessment instruments differ from WPV programs in that they provide a standard in which healthcare providers evaluate individuals for potential violence. Workplace violence prevention programs incorporate risk assessment strategies, establishing and maintaining safe environments, risk communication, violent events responses, recordkeeping, surveillance, and post-incident care (Gillespie et al., 2013). Workplace violence prevention programs may decrease WPV; however, further research on interventions that identify and reduce high-risk situations is needed. Addressing violence related to screening and prevention strategies may be a promising component of increasing nurses' perception of violence and confidence in managing violent patients, although not statistically determined in this project.

Implications for Practice

This DNP project provided a way to educate nurses and healthcare workers or nurses WPV. The results displayed a significant increase in knowledge of WPV. The changes in knowledge validate participating in annual WPV education and training, even though perceptions of safety and confidence were not shown to have changed significantly. The project's online nature is advantageous for nurses and healthcare workers to complete education and training on their own time. Workplace violence prevention programs may play a crucial role in the prevention of violence for healthcare providers. There were few workplace violence prevention programs identified in the literature, thus creating a need to develop and implement such programs. Elements of workplace violence prevention programs should include risk assessment strategies, establishing and maintaining safe environments, risk communication, violent events

responses, recordkeeping, surveillance, and post-incident care (Gillespie et al., 2013). Available data suggest workplace violence is a common and inevitable occupation hazard resulting in manifestations of burnout among nurses, including emotional exhaustion, depersonalization, decreased personal efficacy, and diminished job satisfaction (Vrablik et al., 2019).

Also, this training is accessible to any individual who has internet access, including all persons within the healthcare industry. Since WPV is a common practice in the healthcare setting, offering education to the population expresses interest in improving knowledge of WPV.

Dissemination of Results and Sustainability

The entire project will be donated to the Nevada Nurses Association who will post in their free online library of continuing education. Additional analysis may be conducted between six and nine months after the donation, and any other available data will be used for a possible manuscript. Posting on the Nevada Nurses Association's website will provide sustainability for as long as the information is current. Opportunities for submitting this information to journals concerned with nursing, emergency medicine, and WPV will be targeted to disseminate this information.

Conclusion

ED nurses are at substantial occupational risk for workplace violence. Emergency departments have been identified as areas within the hospital in which the incidence of violence is moderately high, with nurses (67%) being most frequently being assaulted. Relative to other healthcare workers, emergency department (ED) staff face an exceptionally high risk for WPV, primarily due to open-door policies, a high volume of patients, and illness acuity. The ENA (2011b) stated in its Emergency Department Violence Surveillance Study that WPV is a significant issue for nurses in the ED. In an extensive study of ED staff, nurses' perceptions of

safety were lower than all other ED personnel types, which supports the fact that ED nurses experience higher rates of exposure to WPV than other healthcare workers (Jamshed et al., 2019). It has been shown there is a direct correlation between the lack of workplace violence prevention programs and an increase in the risk of assaults, which consequently indicates a need for a comprehensive violence prevention program (Gacki-Smith et al., 2009). The early identification of high-risk behaviors and de-escalation techniques reduced violence and protected staff and patients from potential injuries in the ED. The use of standardized violence risk assessment for early identification and de-escalation interventions may reduce violent behavior and decrease the risk of injury to healthcare workers (Calow et al., 2016)

Appendix A

Demographic Survey

I realize there are multiple genders, and I do not wish to exclude anyone. I have listed three options below for simplicity, and I did not want to leave any gender identification option out. Please feel free to indicate other (and describe) or feel free to choose not to answer.

- ◯ Male
- ◯ Female
- ◯ I choose not to answer
- ◯ Other (please specify)

What is your age (please provide a number only e.g. 35)

How many years have you been a nurse (please provide a number of years and/or months if applicable - If you are newly graduated, please put 0 for years and 0 for months.)
If you are not a nurse, please mark NA

- Years
- Months
- NA

Primary workplace

- ◯ In-patient (Hospital or Nursing facility)
- ◯ Out-patient
- ◯ Academia
- ◯ Other (please specify)

Do you work in the emergency department?

- ◯ Yes
- ◯ No
- ◯ Sometimes
- ◯ I am a new grad and have not start working anywhere yet
- ◯ Other (please specify)

Emergency Experience: If you work in the Emergency Department, how many years of experience do you have on that unit? Mark NA if not applicable to you

Number of years of Emergency Experience	
NA	

Do you work full-time, part-time, per diem, or other?

- ◯ Full-time
- ◯ Part-time
- ◯ Per-Diem
- ◯ Other (please specify)

Was your original nursing program in the United States or from elsewhere in the world? (If you are not a nurse, mark NA)

- ◯ Yes, my original nursing program was in the United States
- ◯ NA
- ◯ Other (please specify)

If you work for a hospital system, please indicate which. Select NA if you do not work for a hospital system.

- ◯ Dignity Health
- ◯ HCA
- ◯ UMC (this includes the hospital and all out-patient facilities)
- ◯ UHS
- ◯ Other (please specify)
- ◯ Carson Tahoe
- ◯ Prime Health Care
- ◯ NA

What is your highest level of education in nursing?

- ◯ LPN
- ◯ Associate Degree
- ◯ BSN
- ◯ MSN
- ◯ DNP
- ◯ PhD in nursing
- ◯ N/A (you do not hold a nursing degree)

What is your highest level of education not in nursing (put NA if not applicable)?

What do you consider your specialty in nursing (A generalist is a specialty)

If you are not a registered nurse, which healthcare position do you hold?

- ◯ Respiratory Therapist (RT)
- ◯ Registered Dietician (RD)
- ◯ Doctor of Medicine (MD)
- ◯ Doctor of Osteopathic Medicine (DO)
- ◯ Emergency Medical Technician (EMT)
- ◯ Paramedic
- ◯ Certified Nursing Assistant (CNA)
- ◯ Physical Therapist (PT)
- ◯ Pharmacist
- ◯ Social Worker
- ◯ Physician Assistant
- ◯ Speech Therapist
- ◯ Occupational Therapist
- ◯ Phlebotomist

Other (please specify)

Appendix B

Violence Survey

In the last year, have you been directly involved in an incident(s) of workplace violence within this organization?

- ◯ Yes
- ◯ No

If yes, did that incident(s) include any of the following? Select all that apply.

- ☐ Physical assault – e.g. kicking, punching, spitting, biting, pushing, pulling, cutting, stabbing
- ☐ Emotional assault -- e.g. bullying, manipulation, intimidation ▪ Sexual assault -- e.g. harassment, stalking
- ☐ Verbal assault -- e.g. threats, blaming, name-calling unwanted contact

In your experience indicate the individuals who most often commit the act of violence in the workplace violence incident

- ◯ Patient
- ◯ Patient's family member
- ◯ Visitor (non-family member)
- ◯ Employee/coworker

How often do you see or experience violence at your workplace?

- ◯ At least once a day
- ◯ Weekly
- ◯ Monthly
- ◯ A few times a year
- ◯ Once a year or less
- ◯ Never

If you saw or experienced a violent incident at work, did you report it?

- ◯ Yes
- ◯ No

Does management communicate information to employees about incidents of workplace violence prevention efforts at the hospital?

- ◯ Yes
- ◯ No

Is there a written violence prevention policy at your hospital?

- ◯ Yes
- ◯ No

Are there clearly established procedures and expectations for violence prevention at your hospital?

- ◯ Yes
- ◯ No

Do you feel incidents of workplace violence increased or decreased at your organization since COVID-19?

- ◯ Increased
- ◯ Decreased
- ◯ No Change
- ◯ I do not know

Appendix C

Pre and Post Knowledge Assessment

What are the reasons workplace violence is under-reported? Select all that apply.

- [ ] Fear of being blamed for the incident
- [ ] Belief violence is apart of the job
- [ ] Belief that reporting the incident is futile
- [ ] Belief that the incident is too minor to report
- [ ] Fear of jeopardizing one's job or position

Which of the following can workplace violence be categorized as? Select all that apply.

- [ ] Physical
- [ ] Verbal
- [ ] Active
- [ ] Passive
- [ ] Direct
- [ ] Indirect

Which of the following occupational factors increases the risk of employees experiencing workplace violence?

- ◯ Lack of security
- ◯ Working nighttime hours
- ◯ Working in a geographically isolated area
- ◯ Easy public accessibility
- ◯ Long waiting times
- ◯ All of the above

What is a potential consequence of witnessing workplace violence for healthcare workers and clinicians?

- ◯ Burnout
- ◯ Compassion fatigue
- ◯ Loss of social interest
- ◯ Primary traumatization

According to The Occupational Safety and Health Administration (OSHA) how many reports of victims of workplace violence are there?

- ◯ 375,000
- ◯ 2,000,000
- ◯ 870,000
- ◯ 1,655,000

Appendix D

Workplace Violence Safety Scale

Workplace Violence Safety Scale

Directions: The following three items will ask you about your current feelings of safety while working in the ED. Please circle **a number** that best describes your level of agreement with each of the following statements.

1. I feel safe (free from violence) when working in ED.

1	2	3	4	5	6	7	8	9	10
Strongly disagree									Strongly agree

2. I think there is a good chance of being injured from an assault by a **patient** while working in the ED during the next 6 months.

1	2	3	4	5	6	7	8	9	10
Strongly disagree									Strongly agree

3. I think there is a good chance of being injured by a **visitor** while working in the ED during the next 6 months.

1	2	3	4	5	6	7	8	9	10
Strongly disagree									Strongly agree

Appendix E

Workplace Violence Confidence Scale

Workplace Violence Confidence Scale

Directions: The following four items ask you to describe how confident you are in handling patients and visitors who become aggressive. Please circle **a number** that best describes your level of confidence in the following items.

1. Your ability to manage a patient's or visitor's ***agitation or verbal aggression***?

1	2	3	4	5	6	7	8	9	10
Not confident									Extremely

2. Your ability to manage patients or visitors who become ***verbally abusive*** to you?

1	2	3	4	5	6	7	8	9	10
Not confident									Extremely

3. Your ability to manage patients or visitors who ***physically threaten*** you or your co-workers?

1	2	3	4	5	6	7	8	9	10
Not confident									Extremely

4. Your ability to manage patients or visitors who become ***physically violent*** towards you or your co-workers?

1	2	3	4	5	6	7	8	9	10
Not confident									Extremely

Appendix F

IRB Approval

UNLV Biomedical IRB - Exempt Review
Exempt Notice

DATE:	October 12, 2020
TO:	Mary Bondmass, PhD
FROM:	Office of Research Integrity - Human Subjects
PROTOCOL TITLE:	[1658271-2] An Intervention to Improve Nurses' Knowledge, Perceived Safety, and Confidence in Identifying and Managing Workplace Violence: A Translation of Evidence into Practice
ACTION:	DETERMINATION OF EXEMPT STATUS
EXEMPT DATE:	October 12, 2020
REVIEW CATEGORY:	Exemption category # 2

Thank you for your submission of Revision materials for this protocol. This memorandum is notification that the protocol referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46.101(b) and deemed exempt.

We will retain a copy of this correspondence with our records.

PLEASE NOTE:

Prior to publishing the Social Media Ads and sending the recruitment emails to potential participants, please include the Prinicipal Investigator's name and contact information for someone on the research team.

Upon final determination of exempt status, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI - HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials.

If your project involves paying research participants, it is recommended to contact Carisa Shaffer, ORI Program Coordinator at (702) 895-2794 to ensure compliance with the Policy for Incentives for Human Research Subjects.

Any changes to the application may cause this protocol to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced protocol has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI - HS of its closure.

If you have questions, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 702-895-2794. Please include your protocol title and IRBNet ID in all correspondence.

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Curriculum Vitae

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LINCENSURE/CERTIFICATIONS:

Nevada RN License 85881
BLS Healthcare Provider CPR & AED Certification
ACLS Healthcare Provider
PALS Healthcare Provider
TNCC Trauma Nursing Core Certification
ENPC-Emergency Nursing Pediatric Certification

EDUCATION:

DATE	INSTITUTION	FIELD OF STUDY	DEGREE
2010-2013	San Diego State University	Psychology	BA
2014-2015	Marian University	Nursing	BSN
2016-2019	Chamberlain College	Nursing Education	MSN
2019-2021	UNLV	Nursing Leadership	DNP

ACADEMIC EXPERIENCE:

DATE	POSITION	INSTITUTION, CITY, STATE
2019-2020	Part-time instructor	UNLV, Las Vegas, Nevada
2020-Present	Lecturer	UNLV, Las Vegas, Nevada

EXPERIENCE OTHER THAN ACADEMIC TEACHING:

DATE	TITLE	UNIT
2015-2016	Registered Nurse	Medical Intensive Care unit
2016-2019	Registered Nurse	Emergency Department
2019-Present	Registered Nurse	PACU
2018-2020	Registered Nurse	Outpatient Surgery
2015-2019	Registered Nurse	Aesthetic Medicine/Medical Spa

HONOR SOCIETIES/ACADEMIES:

ORGANIZATION
Sigma Theta Tau International, the Honor Society of Nursing
National Student Nurses Association
National Honor Society of Psychology

Emergency Nurses Association
American Association of Critical Care Nurses

HONORS AND AWARDS:

DATE	AWARD
2018	Finalist- March of Dimes Southern Nevada Nurse of the Year- Emergency Medicine
2018	Nominee- Southern Nevada Nurse of the Year- Critical Care & Emergency Services
2019	School of Nursing Graduate Scholarship
2020	Tony & Renee Marlon Scholarship
2021	UNLV Access Grant

RESEARCH, CREATIVE ACCOMPLISHMENT, AND SCHOLARSHIP:

Baderm T., Cooks, C., Grewal, A., Sullivan, K. (2019). Factors that Influence Student Clinical Judgement & How CDI's can Help Students Develop their Clinical Judgement Skills. Presented at Summerlin Hospital Medical Center, Las Vegas.

Sullivan, K. (2020). An Intervention to Improve Nurses' Knowledge, Perceived Safety, and Confidence in Identifying and Managing Workplace Violence: A Translation of Evidence into Practice. Presented online via Nevada Nurses Association.