# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>WELCOME MESSAGE</td>
<td>2</td>
</tr>
<tr>
<td>CONFERENCE AT A GLANCE</td>
<td>3</td>
</tr>
<tr>
<td>May 11-13, 2012</td>
<td></td>
</tr>
<tr>
<td>POSTER LISTING</td>
<td>6</td>
</tr>
<tr>
<td>LOCAL RESTAURANT GUIDE</td>
<td>8</td>
</tr>
<tr>
<td>ORAL PRESENTATION ABSTRACTS</td>
<td>9</td>
</tr>
<tr>
<td>POSTER ABSTRACTS</td>
<td>20</td>
</tr>
<tr>
<td>ABSTRACT INDEX</td>
<td>31</td>
</tr>
<tr>
<td>ATTENDEE ROSTER</td>
<td>32</td>
</tr>
<tr>
<td>NOTES</td>
<td>36</td>
</tr>
</tbody>
</table>
Dear Participant,

We would like to personally welcome each of you to the National Conference for Workplace Violence Prevention & Management in Healthcare Settings. Workplace violence has been a problem for healthcare workers and employers for many years. Unfortunately, the published literature lacks clear guidance regarding effective interventions for the prevention, management, or recovery from workplace violence. Violence will continue to be a problem for employees, employers, and patients. This conference will provide an opportunity for workplace violence experts to disseminate scientific research on healthcare workplace violence and provide recommendations for minimizing workplace violence for healthcare providers and their patients.

We would like to give you an idea of what you can expect and what we hope to achieve over the next few days. There will be four keynote presentations, multiple oral/paper sessions, and three poster sessions over two days of the conference. There will also be a networking dinner on Friday evening and research interest group meetings on Saturday afternoon. The conference will close on Sunday with the highlighted panel discussion/consensus building session. The panel of experts will be available to answer your questions and respond to the state of the science related to workplace violence practice and research.

Before we close, we would like to thank each of your for attending our conference and bringing your expertise to this gathering. You, as healthcare providers and leaders, have the vision, the knowledge, the ability, and the experience to help us address the state of the science for workplace violence. Throughout this conference, we ask you to stay engaged, provide us evaluative feedback, and suggest questions for our panel of experts.

Sincerely,

Gordon Lee Gillespie, PhD, RN, FAEN
Conference Chair

Donna M. Gates, EdD, RN, FAAN
Conference Co-chair
**Friday, May 10**

8:00 – 8:30 am  REGISTRATION AND CONTINENTAL BREAKFAST .................................................. Outside Grand Ballroom

8:30 – 9:00 am  INTRODUCTORY REMARKS ................................................................................. Grand Ballroom, Salon AB

  *Greer Glazer, PhD, RN, FAAN,* Dean, University of Cincinnati College of Nursing, Cincinnati, Ohio
  *Gordon Lee Gillespie, PhD, RN,* Conference Chair, University of Cincinnati College of Nursing, Cincinnati, Ohio

9:00 – 10:00 am  OPENING KEYNOTE: **Paula Grubb, PhD,** Research Psychologist, CDC/NIOSH, Cincinnati, Ohio

  *Incivility in the Workplace*

10:00 – 10:15 am  BREAK ..................................................................................................................... North Pre-Function

**Epidemiology of Workplace Violence in Healthcare Setting**  Room, Salon AB

10:15 – 10:35 am  **Traci Galinsky, PhD,** Research Psychologist, Dart, NIOSH, Cincinnati, Ohio

  *Assaults of Workers by Patients in Home Health Care*

10:35 – 10:55 am  **Julie Shaw, RN, MSN, MBA, CEN,** Sr. Clinical Director, Emergency Services, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio

  *Staff Perceptions of Workplace Safety in a Pediatric Emergency Department*

10:55 – 11:15 am  **Marilyn Ridenour, BSN, MBA, MPH,** CDC/NIOSH, Morgantown, West Virginia

  *Shift Differences of Workplace Violence on Psychiatric Staff*

11:15 – 11:30 am  QUESTION AND ANSWER SESSION

11:30 – 11:45 am  BREAK ..................................................................................................................... North Pre-Function

**Concurrent Sessions**  Room, Salon C

11:45 am – 12:05 pm  **AnnMarie Papa, DNP, RN, CEN, NE-BC, FAEN,** Clinical Director, Emergency Nursing, Hospital of the University of Pennsylvania, Glenside, Pennsylvania

  *What is Violence? An International Perspective*

12:05 – 12:25 pm  **Ahlam Al-Natour, PhD (c),** University of Cincinnati College of Nursing, Cincinnati, Ohio

  *Violence Against Jordanian Nurses by the Intimate Partner or Family Member*

12:25 – 1:00 pm  QUESTION AND ANSWER SESSION

**Developing Our Human Resources for the Management of Workplace Violence**  Room, Salon AB

11:45 am – 12:05 pm  **Daniel Hartley, EdD,** Epidemiologist, Division of Safety Research, NIOSH, Morgantown, West Virginia

  *Workplace Violence Prevention On-Line Course: Research and Development*

12:05 – 12:25 pm  **Maryalice Nocera, MSN,** Project Director, Injury Prevention Research Center, University of North Carolina, Chapel Hill, North Carolina

  *Workplace Violence Prevention Training and the Prevalence of Physical Assault Among Home Health and Hospice Workers*

12:25 – 12:45 pm  **Peggy Berry, MSN, RN,** PhD student, University of Cincinnati College of Nursing

  *The Effects of Workplace Bullying on the Productivity of Novice Nurses*

12:45 – 1:00 pm  QUESTION AND ANSWER SESSION

1:00 – 2:30 pm  LUNCH ON OWN
WORKPLACE INCIVILITY AND BULLYING

2:45 – 3:05 pm  Shellie Simons, PhD, Assistant Professor Nursing, University of Massachusetts Lowell, Sharon, Massachusetts
   A Qualitative Study of Coping Strategies Used by Nurses Experiencing Bullying at Work

3:05 – 3:25 pm  Vicki Magley, PhD, Associate Professor, Psychology, University of Connecticut, Storrs, Connecticut
   Initial Evaluation of the Civility Among Healthcare Professionals (CAHP) Workshop

3:25 – 3:45 pm  Wendy Budin, PhD, RN-BC, FAAN, Director of Nursing Research, Nursing, NYU Langone Medical Center
   Relationships Among Verbal Abuse from Nurse Colleagues and Demographic Characteristics, Work Attributes and Work Environment of Early Career Registered Nurses

3:45 – 4:00 pm  QUESTION AND ANSWER SESSION

4:00 – 4:15 pm  BREAK.................................................................................................................. North Pre-Function

4:15 – 5:15 pm  KEYNOTE: David Yamada, Professor of Law and Director, New Workplace Institute
   Suffolk University Law School, Boston, Massachusetts ......................Grand Ballroom, Salon AB
   Workplace Bullying in Healthcare: Causes and Responses

5:30 – 6:30 pm  POSTER SESSION ......................................................................................... North Pre-Function

6:30 – 8:30 pm  DINNER ........................................................................................................... Grand Ballroom, Salon AB

SATURDAY, MAY 12

8:00 – 9:00 am  REGISTRATION AND CONTINENTAL BREAKFAST................................. North Pre-Function

8:00 – 9:00 am  POSTER SESSION ......................................................................................... North Pre-Function

9:15 – 10:15 am  KEYNOTE: Scott A. Bresler, PhD, Clinical Director, Division of Forensic Psychiatry,
   University of Cincinnati, Cincinnati, Ohio.........................................................Grand Ballroom, Salon AB
   Physical Violence Against Healthcare Workers

10:15 – 10:30 am  BREAK............................................................................................................. North Pre-Function

Concurrent Sessions

NOVEL APPROACHES FOR ADDRESSING WORKPLACE VIOLENCE

10:30 – 10:50 am  Judith Arnetz, PhD, MPH, Associate Professor, Department of Family Medicine and Public
   Health Science, Wayne State University School of Medicine, Detroit, Michigan
   Using Database Reports to Reduce Workplace Violence: Perceptions of Hospital Stakeholders

10:50 – 11:10 am  John-Robert Curtin, Founding Director, 4Civility Institute, Louisville, Kentucky
   Workplace Incivility, Harassment and Bullying in Healthcare Organizations: Practical Solutions to
   Create a Healthy Healthcare Environment

11:10 – 11:30 am  Adam Hill, MSN, Clinical Director, Division of Child and Adolescent Psychiatry,
   Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio
   Measurable Results: Reducing Staff Injuries on a Specialty Psychiatric Unit for Patients with
   Developmental Disabilities

11:30 – 11:45 am  QUESTION AND ANSWER SESSION
THE INTEGRATION OF THEORY TO PRACTICE FOR WORKPLACE VIOLENCE


Factors That Influence Perceptions of Personal Safety for Emergency Nurses: Development of a Valid Assessment Tool

10:50 – 11:10 am Linda Robinson, RN, Emergency Department, St. Elizabeth Healthcare, Edgewood, Kentucky

Workplace Violence Prevention: From a Fragmented to an Integrated Approach

11:10 – 11:30 am Ari Cowan, Co-Director, CAN International Institute, Bellevue, Washington

The Violence Integrative Prevention and Restoration Model: A Demonstrated, Evidence-Based, and Effective Approach for Preventing Violence in Health Care Settings

11:30 – 11:45 am QUESTION AND ANSWER SESSION

12:00 – 1:30 pm POSTER SESSION ................................................................. North Pre-Function

12:00 – 1:30 pm LUNCH................................................................. Salon AB

1:45 – 2:45 pm KEYNOTE: Donna M. Gates, EdD, RN, FAAN, Adjunct Professor, University of Cincinnati College of Nursing, Cincinnati, Ohio ...................................................... Grand Ballroom, Salon AB

Environmental Context of WPV

2:45 – 3:00 pm BREAK ................................................................. North Pre-Function

CONSEQUENCES OF WORKPLACE VIOLENCE

3:00 – 3:20 pm Tracy Whitaker, DSW, Director, Center for Workforce Studies, National Association of Social Workers, Washington, DC

I Can’t Believe This is Happening: Social Workers “Responses to Workplace Bullying”


The Reciprocal Influence Between Nurse Burnout and Patient Violence

3:40 – 4:00 pm Christina Purpora, RN, PhD, Assistant Professor, School of Nursing and Health Professions, University of San Francisco, San Francisco, California

Horizontal Violence and Its Relationship to Quality of Care

4:00 – 4:15 pm QUESTION AND ANSWER SESSION

4:15 – 5:30 pm RESEARCH INTEREST GROUP MEETINGS (E.G., BULLYING, INCIVILITY, ED VIOLENCE)...... Salon AB

5:30 DINNER ON OWN

SUNDAY, MAY 13

8:00 – 9:00 am LIGHT BREAKFAST

9:00 – 11:15 am PANEL DISCUSSION/CONSENSUS BUILDING REGARDING THE STATE OF THE SCIENCE FOR WORKPLACE VIOLENCE RESEARCH ........................................... Grand Ballroom, Salon AB

11:30 am – 12:00 pm CLOSING REMARKS, PROGRAM EVALUATIONS, POSTER/ABSTRACT AWARDS
Jeanine Goodin, MSN, CNRN, RN-BC, Associate Professor of Clinical, College of Nursing, University of Cincinnati, Cincinnati, Ohio
*Bullying, Brain Structure and Brain-Targeted Interventions*

Jacoba Leiper, MSN, CON, Professional Studies Team, University of North Carolina at Chapel Hill, Mebane, North Carolina
Disruptive Behavior Among Nurses on Medical Surgical Units: A Preliminary Qualitative Study

Peggy Berry, MSN, Coping Strategies of Nurses Following Bullying, College of Nursing, University of Cincinnati, Centerville, Ohio
Novice Nurse Coping Strategies Following Workplace Bullying

Susan Johnson, MN, RN, PhD student, School of Nursing, University of Washington, Olympia, Washington
Organizational and Regulatory Discourses of Workplace Bullying

Francesca Armmer, PhD, Chairperson, Nursing, Bradley University, Peoria, Illinois
Perceptions of Horizontal Violence in Staff Nurses and Intent to Leave

Purnima Gopalkrishnan, Graduate Student, Psychology, Bowling Green State University, Bowling Green, Ohio
Source of Incivility and Nurses? Safety Behaviors: POS as a Moderator

Sharon Stagg, DNP, Director, Shore Wellness Partners, Nursing, Shore Health System, Cambridge, Maryland
Survey Research Evaluation of a Workplace Bullying Program

Kiefah Awadal应该是ah, MSN, Department Nurse Educator, Center for Emergency Medicine-Adults, University Hospitals Case Medical Center, Cleveland, Ohio
Workplace Bullying and Structural Empowerment: An Emergency Department Nurses Assessment

Mary Alice Melwak, PhD, Quality Specialist Mattel Children's Hospital, Quality Management, UCLA Healthcare, Las Vegas, Nevada
Workplace Bullying and Lateral Violence: A Conceptual Model for Violence Awareness and Reduction

Tammy Mentzel, BS, Research Associate, College of Nursing, University of Cincinnati, Cincinnati, Ohio
An Intervention for Reducing Violence Against Healthcare Workers

Katie Koss, Nurse Manager, Pediatric Emergency Department, Monroe Carell Jr. Children's Hospital at Vanderbilt, Nashville, Tennessee
But They are Little- Why Should I be Scared?

Donna Gates, EdD, RN, FAAN, Adjunct Professor, College of Nursing, University of Cincinnati, Cincinnati, Ohio
Evaluation of a Comprehensive Violence Prevention Program in Emergency Departments
Jeffrey Beers, Clinical Risk Management and Patient Safety, University Hospitals Case Medical Center, Olmsted Falls, Ohio
*Family Centered Relationship Based Communication Guide*

Gina Kicos, BSN, RN, Emergency Department, Aultman Health Foundation, Canton, Ohio
“Stressed out?” (Secondary Traumatic Stress: An Educational Intervention for ED RN’s)

Anne Taylor, RN, Staff Nurse, Emergency Department, LewisGale Hospital Montgomery, Blacksburg, Virginia
*Violence in the Emergency Department: It is Not Part of the Job*

Lynn Schultz, BA, AD, RN, Staff Nurse, Emergency Department, Grant Medical Center, Canal Winchester, Ohio
*Violence Not Accepted Here*

**SATURDAY, MAY 12 • 12:00 PM - 1:30 PM**

Jeffrey Beers, Clinical Risk Management and Patient Safety, University Hospitals Case Medical Center, Olmsted Falls, Ohio
*Building a Critical Incident Management Team*

Gordon Gillespie, PhD, RN, Assistant Professor, College of Nursing, University of Cincinnati, Cincinnati, Ohio
*Environmental Risks for Workplace Violence in Cuban Healthcare Settings*

Jacoba Leiper, MSN, PhD student, University of North Carolina at Chapel Hill, Mebane, North Carolina
*Horizontal Violence Among Nurses: A Review of the Literature*

Kathy Cook, RN, MSN, Chief Nursing Officer, Nursing, St. Elizabeth Health Center, Youngstown, Ohio
*Help - I working in a Hostile Work Environment*

Christian Burchill, PhD, RN, CEN, Clinical Nurse IV, Emergency Nursing, University of Pennsylvania Health System, Philadelphia, Pennsylvania
*Results of a Staff Survey about Workplace Safety: Implications for one Academic ed Nursing Staff*

Saad Alghanim, King Saud University, Riyadh, Saudi Arabia
*Violence Exposure Among Health Care Professionals in the Saudi Public Hospitals*

Shellie Scribner, BSN RN CEN, Clinical Educator, Emergency Department, Grant Medical Center, Stoutsville, Ohio
*Violence Against Nurses and Other Health Care Personnel in an Urban Level I Trauma Center*
<table>
<thead>
<tr>
<th>Restaurant</th>
<th>Address</th>
<th>Phone #</th>
<th>Cuisine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ludlow Ave. Restaurants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habanero</td>
<td>358 Ludlow Ave.</td>
<td>513.961.6800</td>
<td>Latin-American cuisine</td>
</tr>
<tr>
<td>Ambar India</td>
<td>350 Ludlow Ave.</td>
<td>513.281.7000</td>
<td>Northern Indian cuisine</td>
</tr>
<tr>
<td>Proud Rooster</td>
<td>345 Ludlow Ave.</td>
<td>513.281.4965</td>
<td>American cuisine</td>
</tr>
<tr>
<td>Apna Indian Restaurant</td>
<td>341 Ludlow Ave.</td>
<td>513.861.6800</td>
<td>Indian cuisine</td>
</tr>
<tr>
<td>Graeter's</td>
<td>332 Ludlow Ave.</td>
<td>513.281.4749</td>
<td>Ice cream</td>
</tr>
<tr>
<td>China Kitchen</td>
<td>323 Ludlow Ave.</td>
<td>513.221.5333</td>
<td>Chinese - dine in or carryout</td>
</tr>
<tr>
<td>Thai Cafe</td>
<td>316 Ludlow Ave.</td>
<td>513.961.5678</td>
<td>Thai cuisine</td>
</tr>
<tr>
<td>Olives Lundlow Bar and Gille</td>
<td>342 Ludlow Ave.</td>
<td>513.221.4200</td>
<td>American cuisine</td>
</tr>
<tr>
<td>Arlin's</td>
<td>307 Ludlow Ave.</td>
<td>513.751.6566</td>
<td>Casual dining/bar - American cuisine</td>
</tr>
<tr>
<td>Skyline Chili</td>
<td>290 Ludlow Ave.</td>
<td>513.221.2142</td>
<td>Cincinnati style chili - dine in /carryout</td>
</tr>
<tr>
<td>Tinks Cafe</td>
<td>3410 Telford Ave.</td>
<td>513.961.6500</td>
<td>Casual dining - American cuisine</td>
</tr>
<tr>
<td>Dewey's Pizza</td>
<td>265 Hosea Ave.</td>
<td>513.221.0400</td>
<td>Casual pizza restaurant and bar</td>
</tr>
<tr>
<td><strong>With-in Walking Distance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cactus Pear</td>
<td>3215 Jefferson Ave.</td>
<td>513.961.7400</td>
<td>Casual Southwestern bistro</td>
</tr>
<tr>
<td>Marriott Kingsgate / Caminetto</td>
<td>151 Goodman Ave.</td>
<td>513.487.3835</td>
<td>Full service restaurant and bar</td>
</tr>
<tr>
<td>Chipotle</td>
<td>258 Stetson St.</td>
<td>513.559.9300</td>
<td>Mexican</td>
</tr>
<tr>
<td>Zoup</td>
<td>260 Stetson St.</td>
<td>513.221.1888</td>
<td>Soups, Salads</td>
</tr>
<tr>
<td>Subway</td>
<td>321 Albert Sabin Way</td>
<td>513.558.6668</td>
<td>Subs</td>
</tr>
<tr>
<td><strong>Clifton\West Clifton Restaurants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big Al's Sandwich Shop</td>
<td>2504 Clifton Ave.</td>
<td>513.569.0000</td>
<td>Casual dining -Italian cuisine</td>
</tr>
<tr>
<td>Cilantro Bistro</td>
<td>2510 Clifton Ave.</td>
<td>513.281.1732</td>
<td>Dine in or carryout / Vietnamese Bistro</td>
</tr>
<tr>
<td>Bruegger's Bakery</td>
<td>3317 Clifton Ave.</td>
<td>513.221.2243</td>
<td>Bagel bakery and restaurant</td>
</tr>
<tr>
<td>Chipotle</td>
<td>2507 W. Clifton Ave.</td>
<td>513.281.8600</td>
<td>Mexican</td>
</tr>
<tr>
<td><strong>Calhoun Restaurants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Papa Dino's Pizza</td>
<td>349 Calhoun St.</td>
<td>513.221.4747</td>
<td>Dine-in or carryout pizza</td>
</tr>
<tr>
<td>Bagel Brothers</td>
<td>347 Calhoun St.</td>
<td>513.221.4000</td>
<td>Bakery and deli</td>
</tr>
<tr>
<td>Uncle Woody's Tavern &amp; Eatery</td>
<td>339 Calhoun St.</td>
<td>513.731.2518</td>
<td>Casual, quiet neighborhood restaurant</td>
</tr>
<tr>
<td>Jimmy John's</td>
<td>335 Calhoun St.</td>
<td>513.751.9555</td>
<td>Dine in or carryout subs</td>
</tr>
<tr>
<td>Krishna Indian</td>
<td>313 Calhoun St.</td>
<td>513.961.2878</td>
<td>Carryout Indian cuisine</td>
</tr>
<tr>
<td>Five Guys Burgers</td>
<td>210 Calhoun St.</td>
<td>513.559.9900</td>
<td>Burgers and Hot Dogs</td>
</tr>
<tr>
<td>Potbelly Sandwich Works</td>
<td>210 Calhoun St.</td>
<td>513.961.1500</td>
<td>Dine-in or carryout sandwich shop</td>
</tr>
<tr>
<td>Buffalo Wild Wings</td>
<td>200 Calhoun St.</td>
<td>513.281.9464</td>
<td></td>
</tr>
<tr>
<td>Panera Bread</td>
<td>120 Calhoun St.</td>
<td>513.961.6300</td>
<td>Dine-in or carryout bakery / cafe</td>
</tr>
<tr>
<td>Toppers Pizza</td>
<td>345 Calhoun St.</td>
<td>513.475.9999</td>
<td>Pizza</td>
</tr>
<tr>
<td>Currito</td>
<td>22 Calhoun St.</td>
<td>513.281.1500</td>
<td>Dine-in or carryout Mexican-American</td>
</tr>
<tr>
<td>Yogurt VI</td>
<td>226 Calhoun St.</td>
<td>513.221.8200</td>
<td>Yogurt</td>
</tr>
<tr>
<td><strong>West McMillan Restaurants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adriatico's</td>
<td>113 W. McMillan St.</td>
<td>513.281.4344</td>
<td>New York-style carryout pizza</td>
</tr>
<tr>
<td>Pomodori's Pizzeria &amp; Trattoria</td>
<td>121 W. McMillan St.</td>
<td>513.861.0080</td>
<td>Wood-oven baked pizza</td>
</tr>
<tr>
<td>Lenhardt's</td>
<td>151 W. McMillan St.</td>
<td>513.281.3600</td>
<td></td>
</tr>
<tr>
<td>Arby's</td>
<td>180 W. McMillan St.</td>
<td>513.281.1528</td>
<td>Dine-in or carryout fast food</td>
</tr>
<tr>
<td>Chicago Gyros</td>
<td>200 W. McMillan St.</td>
<td>513.621.3828</td>
<td>Dine-in or carryout</td>
</tr>
<tr>
<td>Starbuck's Cafe</td>
<td>202 W. McMillan St.</td>
<td>513.241.7015</td>
<td>Coffee shop</td>
</tr>
<tr>
<td>King's Wok</td>
<td>203 W. McMillan St.</td>
<td>513.723.1999</td>
<td>Chinese cuisine</td>
</tr>
<tr>
<td>Red Pepper</td>
<td>204 W. McMillan St.</td>
<td>513.559.9229</td>
<td>Chinese cuisine</td>
</tr>
<tr>
<td>Penn Station</td>
<td>208 W. McMillan St.</td>
<td>513.961.7366</td>
<td>Dine-in or carryout subs</td>
</tr>
<tr>
<td>Jersey Mike's Subs</td>
<td>211 W. McMillan St.</td>
<td>513.421.6453</td>
<td>Dine-in or carryout subs</td>
</tr>
<tr>
<td>Thai Express</td>
<td>213 W. McMillan St.</td>
<td>513.651.9000</td>
<td>Carryout Thai carryout</td>
</tr>
<tr>
<td>Mediterranean House</td>
<td>235 W. McMillan St.</td>
<td>513.784.0144</td>
<td>Mediterranean cuisine</td>
</tr>
<tr>
<td>Baba Budans Bearcat Cafe</td>
<td>239 W. McMillan St.</td>
<td>513.221.1911</td>
<td>Casual cafe, music, food and spirits</td>
</tr>
<tr>
<td><strong>Vine St. Restaurants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martino’s on Vine</td>
<td>2618 Vine St.</td>
<td>513.221.8487</td>
<td>Casual dining &amp; bar; Italian</td>
</tr>
<tr>
<td>Gold Star Chili</td>
<td>2713 Vine St.</td>
<td>513.751.8841</td>
<td>Cincinnati-style chili</td>
</tr>
<tr>
<td>LaRosa’s Pizza</td>
<td>2717 Vine St.</td>
<td>513.861.7839</td>
<td>Italian</td>
</tr>
<tr>
<td>Papa John’s Pizza</td>
<td>2723 Vine St.</td>
<td>513.961.7272</td>
<td>Carryout pizza</td>
</tr>
<tr>
<td>Domino’s Pizza</td>
<td>2901 Vine St.</td>
<td>513.751.6262</td>
<td>Carryout pizza</td>
</tr>
<tr>
<td>Mecklenburg Gardens</td>
<td>302 E. University Ave.</td>
<td>513.221.5353</td>
<td>German cuisine</td>
</tr>
</tbody>
</table>
VIOLENCE AGAINST JORDANIAN NURSES BY THE INTIMATE PARTNER OR FAMILY MEMBER

Al-Natour, Ahlam, PhD (c), Nursing, University of Cincinnati, Cincinnati, OH, alnatoura@mail.uc.edu
Gordon Gillespie, University of Cincinnati

Intimate partner violence (IPV) in its different forms (physical, psychological, and sexual) is a hazardous problem existing internationally in varying degrees from as low as 10% to as high as 70%. The prevalence of IPV in Jordan ranges from 15% -47.5%. About 25% of nurses were physically or sexually abused and 22.8% psychologically abused in the United States. Although nurses are likely to be victims of IPV just as women are in the general community, there are no studies conducted in Jordan to estimate the prevalence of IPV among Jordanian nurses. So, the purpose of this study is to estimate the prevalence of physical, psychological, and sexual violence by intimate partners against Jordanian nurses. A cross sectional survey design was used to measure the problem of IPV with Jordanian nurses. The study instrument was the Women Abuse Screening Tool (WAST) and was used to measure the frequency of physical, psychological, and sexual IPV. A stratified random sampling strategy was used to recruit 125 nurses working in public and university hospitals and health centers at the city of Irbid, Jordan. Descriptive statistics were used to report the frequency of IPV. The study findings showed that about 11.5% of the married and 25% of the single Jordanian nurses were physically abused. Psychological abuse was experienced by 54.8% of the married and 68.2% of the single nurses. Sexual abuse occurred with 6.4% of the married and 8.3% of the single nurses. This study sheds light to the high percentage of Jordanian nurses experiencing IPV. Nurses experiencing IPV need the same support, interventions, and help offered to women in the community that report IPV in order to prevent the consequences of IPV over a nurses life.

USING DATABASE REPORTS TO REDUCE WORKPLACE VIOLENCE: PERCEPTIONS OF HOSPITAL STAKEHOLDERS

Arnetz, Judith, PhD, MPH, Associate Professor; Dept. of Family Medicine and Public Health Science, Wayne State University School of Medicine, Detroit, MI, jarnetz@med.wayne.edu
Lydia Hamblin, Wayne State University School of Medicine
Joel Ager, Wayne State University School of Medicine
Deanna Aranyos, Detroit Medical Center
Lynnette Essenmacher, Detroit Medical Center
Mark Upfal, Detroit Medical Center
Mark Luborsky, Wayne State University

Background: Violence towards hospital workers can adversely affect employee safety, health, work productivity, and the quality of care. However, hospitals lack practical and sustainable systems for workplace violence surveillance, risk assessment and prevention. In the first phase of an ongoing participatory action research project that aims to develop such a system, we explored key stakeholders’ perceptions of database-generated workplace violence incident reports.

Methodology: The setting for this project is a large, metropolitan hospital system with over 15,000 employees and a central database for reporting adverse workplace events, including incidents of violence. A focus group was conducted with 8 key hospital system stakeholders representing Human Resources, Security, Occupational Health Services, Quality & Safety, and Labor. The discussion was audiotaped, with one researcher facilitating the discussion and another responsible for documentation. A structured question guide was used to identify the group’s preferences and specifications for standardized, computerized reports of workplace violence data that will be generated by the hospital system’s central database. A recording of the 60-minute discussion was transcribed verbatim, processed as text, and analyzed by stepwise content analysis. One researcher read through the transcript and assigned codes for each type of response. This was repeated until the themes were distinct and no new themes appeared. A second researcher employed the same method, and categories were discussed until agreement was reached. A third researcher helped to condense the data and to construct a final inventory of main themes.

Findings: Five distinct themes emerged from the responses of the hospital stakeholders: Concerns, Etiology, Customization, Use, and Outcomes. While the main discussion of the focus group concerned content and format of incident reports, stakeholders brought up other points they were invested in, such as their concerns about this system and outcomes of the incidents. Concerns included underreporting and safeguarding employees as well as the organization. Etiology emerged as participants explained their need for details about the origin of the incidents and type of violence to better understand what happened. Customization concerned both how incident reports should be formatted as well as the preferred delivery method, consensus being electronic delivery via an access database where stakeholders could create their own, customized reports. In terms of Use, stakeholders wanted the incident reports to provide them with information such as trends and comparisons between and within units, in order to identify problem areas and establish violence management and prevention strategies. Outcomes included information on the results of reported incidents, such as discipline for perpetrators, care for victims, employee injury, and incident-related time off. In general, stakeholders were interested in seeing the big picture, i.e., reasons for incident occurrence; rates of occurrence; details regarding how, when, where and how often; consequences for the individual employee and/or the workplace; and organizational efforts that were employed to deal with the incident.

Conclusions: Exploring stakeholder views regarding workplace violence incident reports provided the researchers with concrete information on the preferred content, format, and use of workplace violence incident reports. Once they have been developed, reports generated by the hospital-system database will provide the foundation for hazard and risk assessment and violence prevention efforts in the next project phases.
THE EFFECTS OF WORKPLACE BULLYING ON THE PRODUCTIVITY OF NOVICE NURSES

Berry, Peggy MSN, RN, PhD student, University of Cincinnati College of Nursing, berrypa@mail.uc.edu
Gordon Lee Gillespie, University of Cincinnati College of Nursing
Donna Gates, EdD, University of Cincinnati College of Nursing
John Schafer, University of Cincinnati College of Nursing

Workplace bullying is not one incident but it is perceived as intentional, sustained, and repeated negative acts that belittle, humiliate, punish the target and it is meant to increase the targets social exclusion from the group. There is also a perceived power imbalance between the target and perpetrator of the actions. Workplace bullying behaviors are direct or indirect aggressive actions that attack the work or a person through verbal abuse (e.g., yelling, insults, teasing, gossip), belittling gestures (e.g., eye rolling, ignoring, terminating conversation by turning away), and unacceptable actions (e.g., sabotaging work, hiding equipment, withholding information vital to work assignment, assigning excessive work load purposely for employee failure). The purpose of this study was to determine the effects of workplace bullying on the work productivity of novice nurses. A cross-sectional survey design was used with a randomized sample of novice nurses from Ohio, Kentucky, and Indiana. Participants completed the Healthcare Productivity Survey, Negative Acts Questionnaire, and a demographic survey. Following Institutional Review Board approval, a postcard invitation was mailed to eligible participants. Data were collected via a secured web-based survey collector. Data were analyzed using descriptive statistics. Nearly half the sample reported experiencing bullying at work with a large proportion almost reporting decreased work productivity as a result of the bullying. We found that the greater the frequency of bullying, the greater the decline in their work productivity. Adverse workplace behaviors such as workplace bullying have a negative effect to work productivity. Interventions need to be done that protect novice nurses from experiencing decreased work productivity that may subsequently lead to job stress, anxiety, and errors in patient safety.

RELATIONSHIPS AMONG VERBAL ABUSE FROM NURSE COLLEAGUES AND DEMOGRAPHIC CHARACTERISTICS, WORK ATTRIBUTES AND WORK ENVIRONMENT OF EARLY CAREER REGISTERED NURSES

Budin, Wendy, PhD, RN-BC, FAAN, Director of Nursing Research, Nursing, NYU Langone Medical Center, New York, NY, wendy.budin@nyumc.org
Carol Brewer, University of Buffalo
Christine Kovner, New York University
Ying-Yu Chao, University of Buffalo

Aims: A culture of safety and quality depends on teamwork, communication and a collaborative work environment where no intimidating or disruptive behaviors should be tolerated. The most frequently reported disruptive behavior is verbal abuse. This study examined the relationships among levels of verbal abuse from nurse colleagues with demographic characteristics, work attributes and work environment of early career registered nurses (RNs).

Methods: Data are from the fourth wave of a national panel survey of early career RNs begun in 2006 (response rate for Wave 4 was 74%). Data were collected using an emailed and mailed survey. The final analytic sample included 1328 RNs. Descriptive statistics (i.e., means, percentages) were used to describe the sample, ANOVA to compare means with a Tukey correction, and Chi square to compare the categorical variables, with Bonferroni corrections for multiple comparisons.

Results: Nurses who reported higher levels of verbal abuse from nurse colleagues were more likely to be unmarried, work in hospital as compared to a non-hospital employment setting, and work in a non-magnet designated hospital or hospital on the magnet journey. Day shift nurses experienced a higher proportion of verbal abuse compared to evening and night shift nurses. Nurses who reported higher levels of verbal abuse from nurse colleagues also reported lower job satisfaction, organizational commitment, autonomy,intent to stay, and perceived unfavorable work environments including workgroup cohesion, lower supervisory and mentor support, and higher quantitative workload, and organizational constraints.

Conclusions: Data from this study provided support for the notion that early career registered nurses are potentially vulnerable to the effects of verbal abuse from nurse colleagues. More verbal abuse from nurse colleagues is seen in environments with unfavorable working conditions, and nurses working in such environments tend to have less favorable work attitudes. However, one cannot assume causality. It is unclear if poor working conditions create an environment in which verbal abuse is tolerated or if verbal abuse creates an unfavorable work environment. There is a need for the development and testing of evidence based interventions to deal with these issues.

FACTORS THAT INFLUENCE PERCEPTIONS OF PERSONAL SAFETY FOR EMERGENCY NURSES: DEVELOPMENT OF A VALID ASSESSMENT TOOL

Burchill, Christian, PhD, RN, CEN, Clinical Nurse IV, Emergency Department, University of Pennsylvania Health System, Philadelphia, PA, templephd@mac.com

Violent and abusive behavior committed by patients and family members against healthcare workers, and emergency nurses in particular, has been increasing in both amount and severity. In order to begin solving this problem, experts in the field recommend conducting an assessment of staff members in order to identify strengths, weaknesses, and suggestions for improvement. Currently, there is no valid and reliable assessment tool available in the literature that examines ED nurses’ perceptions of factors that influence personal safety in the workplace. A valid and reliable instrument would provide an effective and efficient way for ED managers and hospital administrators to address the problems...
THE VIOLENCE INTEGRATIVE PREVENTION AND RESTORATION MODEL: A DEMONSTRATED, EVIDENCE-BASED, AND EFFECTIVE APPROACH FOR PREVENTING VIOLENCE IN HEALTH CARE SETTINGS

Cowan, Ari, Co-Director, CAN International Institute, CAN International, Bellevue, WA, ari.cowan@compassionateactionnetwork.org

By combining a new, evidence-based, cognitive approach to violence response and prevention with effective environmental designs and administrative controls, healthcare practitioners and healthcare organizations can achieve outcomes that significantly reduce violence, improve the quality of patient care, lower risk, increase staff efficacy and on-the-job satisfaction, and elevate the quality of work life.

The Violence Integrative Prevention and Restoration (“PAR”) Model is a new, evidence-based, cognitive approach to violence response and prevention built upon a public health foundation. It is a significant departure from the traditional “punitive” and “defensive” models for dealing with violence. The PAR Model incorporates new thinking about and language for describing violence, provides a new framework for preventing and responding to violence, and presents an effective alternative to the commonly-used traditional punitive-based approaches for dealing with violence.

The PAR Model provides a framework within which a broad range of programs and practices can operate without the inhibiting barriers found in punishment-based approaches.

The PAR Model incorporates effective skills for dealing with the conflict continuum, from emotionally-charged and debilitating conflict to physical and emotional violence. By building a healthy “violence immune system” and treating the root drivers of violence before the onset of violent action, healthcare professionals can create a safer workplace and increase the value of their profession to those they serve.

Successfully demonstrated in a variety of settings (in schools, at a Level 5 Maximum Security prison, on the India-Pakistan border), the PAR Model incorporates recent developments in neuroscience, breakthroughs in conflict resolution, and a new definition of violence. The model integrates a broad range of diverse disciplines including social theory, the public health approach, developmental theory, evolutionary science (archeology, biology, etc.), psychology, neuroscience, and physiology. The Model also incorporates and integrates the concept of the “five bodes” — the physical, emotional, mental, environmental and the spiritual aspects of human existence.

This paper examines:

• The principal elements of the PAR Model.
• Key conflict resolution components that strengthen the impact of the model.
• Practical applications for high risk areas such as emergency rooms and psychiatric departments.

Applications in the following categories — Type I: Criminal Intent - Results while a criminal activity (e.g., robbery) is being committed and the perpetrator has no legitimate relationship to the workplace; Type II: Customer/client - The perpetrator is a customer or client at the workplace (e.g., health care patient) and becomes violent while being served by the worker; Type III: Worker-on-Worker - Employees or past employees of the workplace are the perpetrators; Type IV: Personal Relationship - The perpetrator usually has a personal relationship with an employee (e.g., domestic violence in the workplace).

• Implementation of PAR Model-based education in the healthcare setting.
• Resources that support continuing efforts to develop a violence-free workplace, including technology, research, and best practices.

The paper is authored and presented by:

Ari Cowan, Co-Director of the International Institute for Compassionate Cities; and Tony Belak and Karen Harrell Porter of the University of Louisville’s Office of the Ombuds. Their background information is available online.
Oral Abstracts

• Bullying is any activity that causes the target to experience negative feelings resulting in the bully receiving some sort of satisfying emotional reward;

• Leaders either do not recognize the detrimental effects of workplace incivility or they do not know how to productively manage it;

• Bullying negatively affects the human body and can cause cardiovascular problems, adverse neurological changes, immunological impairment, fibromyalgia, chronic fatigue syndrome, diabetes, and skin disorders;

• The most common bullying health effects are anxiety, irritability, depression, and post-traumatic stress disorder.

An Ombuds in a healthcare setting can be a valuable resource. Conflict is not a phenomenon, and we should expect it when two or more people interact in any enterprise or endeavor. It is a real part of our workplace, and it cannot be avoided. The Ombuds is the lightening rod of conflict and not only attracts people in conflict but seeks out those individuals who appear involved in disputes or disagreements at work. The key is to interact early before an interpersonal conflict spreads among other members of the group. Sometimes conflict cannot be seen, but it is felt in the form of anxiety, stress, discomfort, suspicion, mistrust, low morale, disharmony, and an emotional malaise. If left unresolved, this latent conflict will emerge as overt hostility, and the risk and cost to the organization is greatly enlarged. When trust exists in personal and professional relationships, almost everything else is easier and more comfortable to achieve, including problem solving and conflict resolution.

An Ombuds can be a form of risk management with the added benefit of allowing people with a problem to work it out in an early and meaningful manner, before it can get out of control or more difficult to manage. Almost every workplace has an unofficial Ombuds in that person who listens well and can give some advice or feedback to friends and colleagues. Even though it is difficult to measure the value of such interaction, one must assume it does have benefit since it repeats day after day in the workplace. To harness the benefits of intervention by a knowledgeable and competent person identified as the Ombuds in a confidential and privileged manner can be of large value to the workplace.

A civility and kindness system allows convenient and secure reporting of negative behavior to a designated person from any computer or hand held device that can reach the web. That person can then work through collaboration in a secure system that fully tracks all information inputted and documents actions taken. In addition to providing a private, safe and secure reporting system, the civility software provides the organization with a defendable record of activity that can prove invaluable in today’s litigious society.

ASSAULTS OF WORKERS BY PATIENTS IN HOME HEALTH CARE

Galinsky, Traci, PhD., Research Psychologist, DART, NIOSH, Cincinnati, OH, tgalinsky@cdc.gov
Amy Feng, NIOSH
Jessica Streit, NIOSH

Purpose: Few studies on violence against home health care (HHC) workers have been conducted to date. Previous studies have not differentiated between forms of violence (physical vs verbal) or perpetrators (patients vs others in the home). The goals of this study were to provide a sample of data indicating specifically rates of physical assaults by patients against workers, and to examine associations between potential risk factors and assaults.

Design: Convenience sampling was used to survey workers from 11 HHC agencies in Arkansas, California, Illinois, and Oregon.

Setting: Most of the surveys were administered in group sessions at HHC agencies; some surveys were mailed to workers who could not attend group sessions.

Participants: Response rate was 64%. Completed surveys were obtained from 535 home care aides, 83 certified nursing assistants, and 59 nurses.

Methods: A large, multi-topic survey was administered to participants. This report describes analyses of survey responses related to physical assaults of workers by their patients. The dependent variable was assault category (assaulted vs. not assaulted in past year). Multiple logistic regression analysis examined associations between several potential risk factors and assaults.

Results: 4.6% of the surveyed workers reported being assaulted one or more times during the previous year. Three factors were identified as significant predictors of assault, including routinely handling/lifting patients (OR=8.48, 95% CI: 1.89-37.94), having one or more patients with dementia (OR=4.31, 95% CI: 1.47-12.67), and perceiving threats of violence by others in/around patients’ homes (OR=4.45, 95% CI: 1.75-11.32). Assaults were not significantly associated with worker age, gender, race, job title, hours of work, or use of needles during patient care. Assaulted workers and workers who perceived threats of violence by others were significantly more likely to have shortened home care visits.

Implications: Patient-on-worker assaults and perceived threats of violence in HHC have negative consequences not only for workers, but are also associated with reduced quality of patient care in the form of shortened home care visits. Violence prevention should be kept in mind as well as ergonomic benefits when evaluating patient handling assistive devices. More detailed research is needed to confirm the present results and to evaluate methods for reducing assault risk.

Note: These data have been published previously in:
Purpose: Violence against healthcare providers is a pervasive issue in the United States. In the U.S., healthcare workers are nearly five times more likely to be victims of non-fatal violence than workers in all industries combined. While healthcare workers are not at particularly high risk for job-related homicide, nearly 60% of all nonfatal assaults occurring in private industry are experienced in healthcare. This presentation will discuss surveillance data, risk factors analysis, prevention strategies, and implementation techniques as they relate to workplace violence prevention in the healthcare setting. The information presented was used as the basis for development of a free on-line training course that will offer free continuing education credits to participants completing it.

Results/Outcomes: An on-line course that incorporates statistics that help the healthcare professional understand the scope and magnitude of workplace violence. Prevention of workplace violence is discussed from the perspective of the individual and the organization. Upon completion of the on-line course, healthcare workers will have an understanding of what elements are necessary to make a workplace violence prevention program effective. The prevention strategies discussed in the course can be applied in every healthcare facility.

Implications: Healthcare workers will have a free tool for accessing workplace violence prevention information. While they are learning methods to prevent violence and protect themselves in the workplace, they will also have an opportunity to earn continuing education units upon completion of the course.

MEASURABLE RESULTS: REDUCING STAFF INJURIES ON A SPECIALTY PSYCHIATRIC UNIT FOR PATIENTS WITH DEVELOPMENTAL DISABILITIES

Hill, Adam, MSN, Clinical Director, Division of Child and Adolescent Psychiatry, CCHMC, Florence, KY, Adam.Hill@cchmc.org
Nancy Daraiseh, CCHMC
Michael Lind, CCHMC

Topic: Injury reduction for nursing and other behavioral support staff through a quality improvement initiative.

Context: Children and adolescents with developmental disabilities and acute psychiatric crisis often present with severe aggressive behaviors which place staff at increased risk of injury in this specialty care setting. The frequency and severity of injuries to staff due to patient-related interactions were a concern to clinical staff and leaders.

Objective: To utilize quality improvement principles and interventions to reduce staff injuries on a specialized inpatient child/adolescent psychiatric unit.

Data Sources: The quality improvement initiative was executed within an inpatient psychiatric unit for patients with co-occurring developmental disabilities and psychiatric illness. Clinical leaders, internal and external, to the psychiatric division engaged frontline nursing clinicians in education, testing and sustainment of system principles, reliability design concepts, risk identification, mitigation planning and a preoccupation with failures. All interventions were determined by a team approach and carried out over a nine-month period.

Methods: Weekly run charts with raw data measures of all staff injuries and "days between"- reflecting OSHA recordable (increased severity), were utilized to guide interventions and measure outcomes. The run charts were annotated to reflect interventions tested and adopted across the chronological timeline of the initiative. The formal quality improvement initiative began in May 2011.

Results: Three months of structured and systematic intervention trial testing produced the first adopted interventions in August 2011. The following six months reflected a 73% reduction of staff injuries (baseline mean of 2.2 injuries per week down to 0.6 injuries per week). The overall severities of injuries were measured by being identified as “OSHA recordable” injuries. Between January and August 2011 there were eight OSHA recordable injuries with an average of 26.5 days between OSHA recordables. February 14, 2012 reflects 177 days since the last OSHA recordable.
INITIAL EVALUATION OF THE CIVILITY AMONG HEALTHCARE PROFESSIONALS (CAHP) WORKSHOP

Magley, Vicki, Ph.D., Associate Professor, Psychology, University of Connecticut, Storrs, CT, vicki.magley@uconn.edu
Benjamin M. Walsh, Ph.D., University of Illinois Springfield
Robert Trestman, M.D., Ph.D., Correctional Managed Health Care (CMHC)
Maureen Dinnan, The Health Assistance intervention Education Netwo

Purpose: The goal of the Civility Among Healthcare Professionals (CAHP) project is to develop and evaluate an intervention addressing disruptive behaviors (e.g., incivility) in healthcare organizations. Interventions such as the one proposed are particularly needed in light of Leadership Standard 3.15 recently passed by the Joint Commission on Accreditation of Healthcare Organizations that requires healthcare organizations to develop a code of conduct and processes for managing disruptive behaviors by physicians or individuals with clinical privileges.

Design: The intervention workshops were evaluated by examining change between pre- and post-training affective and utility reactions, attitudes, and knowledge.

Setting: Correctional Managed Health Care (CMHC) provides health care to all Connecticut incarcerated individuals.

Participants/Subjects: Participants were 201 employees from all divisions of CMHC: medical (nurses, doctors), mental health (social workers, psychiatrists), dental (dentists, dental assistants), and management (non-medical, support personnel). Participants were primarily female (74.3%) and Caucasian (71.9%). Although workshop attendance was mandatory, participation in the pre- and post-training surveys was voluntary.

Methods: A train-the-trainer model was used to create local experts on civility (Civility Coaches) who then hosted the workshops. Workshops were comprised of 1.5 hours of presentation of descriptive data about civility within CMHC (based on a prior data collection effort) and many opportunities for structured conversations around civility. Themes reiterated throughout the workshop included Empowerment and Community. As approved by IRB, participants completed a paper-and-pencil pre-training survey prior to the start of the CAHP civility workshop and a post-training survey immediately following the end of the workshop.

Affective and utility reactions indicated satisfaction with and perceived future usefulness of the workshops (four items; \( \alpha = .88 \)). Attitudes indicated the extent to which individuals do not tolerate the occurrence of workplace incivility (three items; \( \alpha = .88 \)). Both reactions and attitudes measures used a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree). Finally, knowledge assessed declarative knowledge acquired during the civility workshops (10 items scored 1 = correct and 0 = incorrect).

Participants received a laminated reminder card about the CAHP project to keep alongside their employee ID, as well as a “Civility Among Healthcare Professionals” pen.

Results/Outcomes: Participants had positive affective and utility reactions to the workshops (M = 6.01, SD = .85). High means were observed for attitudes towards workplace incivility both pre-training (M = 5.57, SD = 1.09) and post-training (M = 5.95, SD = .86). A paired-samples t-test indicated that post-training attitudes toward workplace incivility were significantly higher than pre-training attitudes toward workplace incivility, t(200) = -6.60, p < .001, d = .47, indicating that participants were significantly more intolerant of workplace incivility following the workshop. In addition, mean levels of knowledge about workplace incivility increased from 6.57 (SD = 1.52) before training to 7.91 (SD = 1.30) after training, and this difference was also statistically significant, t(200) = -13.75, p < .001, d = .97.

Implications: These results provide initial evidence of the effectiveness of the CAHP civility workshops. Additional evaluations are planned to assess the long-term impact on CMHC’s civility climate.

WORKPLACE VIOLENCE PREVENTION TRAINING AND THE PREVALENCE OF PHYSICAL ASSAULT AMONG HOME HEALTH AND HOSPICE WORKERS

Nocera, Maryalice, MSN, Project Director, Injury Prevention Research Center, University of North Carolina, Chapel Hill, NC, mnocera@email.unc.edu
Carri Casteel, University of North Carolina at Chapel Hill
Catherine Vladutiu, University of North Carolina at Chapel Hill
Corinne Peek-Asa, University of Iowa

Background: Home care workers are exposed to violence associated with the provision of care to aggressive and disoriented patients. They work in uncontrolled settings, where threats also come from high-crime neighborhoods and patients’ homes. Little is known about the workplace violence prevention (WVP) training offered to workers. The purpose of this study is to describe training workers receive and how this training affects the prevalence of assaults.

Methods: Home care workers (n=272) from 40 branches in Northern California were interviewed about the WVP training they receive and completed a survey about their experiences with violence. Descriptive analyses were used to examine training characteristics and the prevalence of violent events. Binomial regression analyses were used to examine the association between worker characteristics, training characteristics and the prevalence of physical assault.

Results: About half of the workers reported receiving new-hire (48%) or ongoing (44%) WVP training. Verbal assault was the most common type of violence reported over a one-year period (69%), followed by sexual harassment (26%) and physical assault (16%). Workers who did not receive WVP training had a higher prevalence of physical assault (PR=1.10, 95% CI=0.61-2.01).
Workers who were less than 50 years of age, minority race, home care aides or those hired on contracts had a higher prevalence of physical assault.

Conclusions: Less than half of the workers received WVP training. However, findings suggest that training may be beneficial for reducing the prevalence of assaults. Therefore, working with employers to increase the availability of training programs could improve worker safety.

WHAT IS VIOLENCE? AN INTERNATIONAL PERSPECTIVE

Papa, AnnMarie, DNP,RN,CEN,NE-BC,FAEN, Clinical Director, Emergency Nursing, Hospital of the University of Pennsylvania, Glenside, PA, ampapa109@hotmail.com
Gordon Gillespie, University of Cincinnati College of Nursing

Workplace violence against healthcare providers is a significant problem garnering international attention. The World Health Organization defines workplace violence as: Incidents where staff are abused, threatened, or assaulted in circumstances related to their work. While workplace violence is a known problem in the United States, there are no data available to compare the rate of violence in the United States to that of a socialist neighbor, specifically the country of Cuba.

The purpose of this descriptive study was to identify if workplace violence was an issue in Cuba and what strategies were in place to mitigate the issue and protect healthcare providers. Data were collected using confidential field observations and interviews with Cuban nationals.

Cuban nationals reported that workplace violence did not exist in the same manner or degree as it does in the United States. Participants further reported that there is a strong respect for the nursing profession in Cuba. Nurses are highly valued for their contribution to the health system and to Cuban society. In fact, the role of the nurse was identified as being central to the overall function of the Cuban health system. Workplace violence is not viewed as burdensome in Cuba as it is in the United States. The Cuban nurses relayed that patients often get angry or upset with their course of treatment or prognosis, but they expressed that they felt very comfortable with their ability to diffuse the situation, and call on the resources available to help the patient and/or family to deal with the crisis. They believed that aggression during stressful situations was an expected part of the disease/symptom management process.

In the United States long waits, the influence of drugs and alcohol, and behavioral health issues are key indicators that fuel workplace violence. These factors did not seem to occur in Cuba, and may be a factor in the reported low incidence of workplace violence. Citizens and patients were commonly seen waiting for care; however, no violent outbursts were observed. Narcotic medications are rarely prescribed and when they are the patient must report to the physician’s office or they are delivered to their residence on a daily or weekly basis.

Cuban healthcare providers can provide valuable information to the United States health policy experts and administrators. Dramatic redesign of the system and approach to violence is needed to increase the safety of U.S. healthcare workers and patients.

HORIZONTAL VIOLENCE AND ITS RELATIONSHIP TO QUALITY OF CARE

Purpora, Christina, RN, PhD, Assistant Professor, School of Nursing and Health Professions, University of San Francisco, San Francisco, CA, cmipurpora@usfca.edu
Mary A. Blegen, University of California, San Francisco
Nancy A. Stotts, University of California, San Francisco

Purpose: Some nurses suffer personal consequences from their experiences with horizontal violence including strained coworker relationships, while others imply that horizontal violence jeopardizes patient safety. Yet, no known empirical evidence exists that describes the relationship among horizontal violence, peer relations, and the quality of care. Three hypotheses based on a horizontal violence and quality and safety of patient care model were tested: (1) horizontal violence and peer relations are inversely related, (2) horizontal violence and the quality and safety of patient care are inversely related, and (3) horizontal violence and adverse events are positively related. Additionally, the relationship of nurse and work characteristics to horizontal violence, peer relations, and quality and safety were determined.

Design: Descriptive, model testing.

Setting: California, USA.

Participants/Subjects: A random sample of registered nurses (RNs) (n=175) was drawn from the California Board of Registered Nursing’s mailing list. RNs working as staff nurses in hospitals, who were willing to share views in a survey, and consented to participate were included.

Methods: Eligible RNs participated either online or with a paper survey. The Negative Acts Questionnaire-Revised measured horizontal violence, behavior directed between colleagues that disrespects and harms the recipient. A peer relations subscale measured the extent that coworker relationships are supportive. Earlier work was used to develop scales to measure quality and safety and adverse events. Quality of care is the degree to which the care delivered to patients meets their needs. Patient safety is preventing and avoiding harm while delivering care. Adverse events are injuries resulting from care delivery. Bivariate and multivariate analyses tested study hypotheses. A Committee on Human Research approved the study.

Results/Outcomes: This study begins to describe the relationship between horizontal violence, peer relations, and quality of care. Hypotheses were supported. Bivariate correlations showed an inverse relationship between horizontal violence and peer relationships (r=-.640; p = .000), an inverse relationship between horizontal violence and quality and safety (r= -.469; p=.000), and...
a positive relationship between horizontal violence and adverse events \(r = .442; p = .000\). In multivariate analyses controlling for nurse and work characteristics, horizontal violence contributed significantly in predicting peer relationships (unstandardized coefficients) \(B = -.084, p = .000\), the quality and safety of patient care \(B = -.672, p = .000\), and adverse events \(B = .428, p = .000\).

When peer relations was added in the final step of the hierarchical regression model, findings suggested that peer relationships had a significant role in the impact horizontal violence had on quality and safety but not on adverse events. Nurse characteristics and hospital characteristics were not related to other variables. Clinical area contributed significantly in predicting the quality and safety of care and adverse events but not peer relationships.

Implications: Horizontal violence does affect peer relations and the quality and safety of patient care as perceived by participating nurses. More research is needed to gather evidence of these relationships in other populations of RNs and to develop ways nurses can address horizontal violence at work.

SHIFT DIFFERENCES OF WORKPLACE VIOLENCE ON PSYCHIATRIC STAFF

Ridenour, Marilyn, BSN, MBA, MPH, CDC/NIOSH, Morgantown, WV, dvn7@cdc.gov
Scott Hendricks, CDC/NIOSH

Purpose: Psychiatric staff experience aggression frequently. The objective of our study was to determine the shift differences of workplace violence (verbal and physical aggression) against psychiatric staff.

Design: An intervention evaluation was conducted over 21 weeks with three time periods which are as follows: pre-treatment (weeks 1-3), treatment (weeks 4-18), and post-treatment (weeks 19-21).

Setting: Eight acute locked psychiatric sites in the United States.

Participants/Subjects: Participants were 262 nursing staff at 8 acute locked psychiatric sites within the Veterans Health Administration. Human Subject Review Board approval was obtained. The 8 sites were randomly assigned to the control group (no change in community meetings) or intervention group (conducted community meetings that discussed violence during the treatment time period).

Methods: Nursing staff were given a two lever clicker to record verbal and physical aggression (person and property) as they worked their shift. Standard definitions for verbal and physical aggression by the Modified Overt Aggression Scale were utilized. At the end of their shift, nurses would fill out the daily incident log on the number of clicked verbal aggression, the number of clicked physical aggression, type of aggression, the level of aggression, who the target was, circumstances surrounding the aggression and their emotional response to the aggression. Hours that the staff worked was collected for the whole study period. Analyses compared patient aggression over the 3 time periods for each of the shifts for the two study groups. Aggression rates are calculated in terms of incidence per nurse per year (2000 hours = 1 full time employee).

Results/Outcomes: The evening shift had the highest verbal aggression rate for the treatment time period (31.39) in the intervention group; the highest physical aggression rates for the pre-treatment (19.05), treatment (13.80), and post-treatment (9.39) time periods in the intervention group, and the highest total aggression rates for the pre-treatment (64.59), treatment (38.21), and post-treatment (24.34) time periods in the intervention group. The night shift had the highest verbal aggression rate for the pre-treatment time period (56.63) in the control group; and for the post-treatment time period (17.83) in the intervention group.

Implications: The evening shift had the highest rates for verbal aggression, for physical aggression, and for total aggression in the majority of the pre-treatment, treatment, and post-treatment time periods. Future research should focus on factors such as nurse-patient ratio and amount of patient activities that could improve aggression for the evening shift staff.

WORKPLACE VIOLENCE PREVENTION: FROM A FRAGMENTED TO AN INTEGRATED APPROACH

Robinson, Linda, RN, Registered Nurse, Emergency Department, St. Elizabeth Healthcare, Edgewood, KY, linda.robinson@stelizabeth.com
Theresa Vistor, St. Elizabeth Healthcare
Michael Kraft, St. Elizabeth Healthcare
Joseph Rectenwald, St. Elizabeth Healthcare
Lisa Blank, St. Elizabeth Healthcare

Purpose: Violence in the community is spilling into the emergency departments (EDs) across the nation. The U.S. Department of Justice (2009) reported an estimated frequency of 4 violent crimes per 1000 employed persons in the workplace (approximately 572,000 crimes). Approximately 10.2% of these crimes were against people in the medical field. Prior to publication of The Joint Commission Sentinel Event Alert (2010) Preventing violence in the health care setting, one healthcare facility was at the forefront addressing this issue. This presentation will describe the impact of an emergency department workplace violence awareness/prevention program that started with a violent triage incident in 2003 and led to a system-wide multidisciplinary approach to the problem.

Design: The project began with a survey of staff nurses in one emergency department to determine their perceptions of workplace violence. Subsequent to that, a system-wide multidisciplinary committee was convened to address the issue of workplace violence and to implement changes based on the literature and expert consensus.
Setting: The project occurred in a large healthcare system with 1236 licensed beds and 6500 associates. The system includes four hospital based and one free-standing emergency department that had 208,590 visits in 2011.

Participants: The survey participants included nurses, ED technicians, and clericals who were employed in an emergency department in an urban setting. Participants on the multidisciplinary committee consist of representatives from Nursing, Security, Safety, Patient Safety, Risk Management, Registration, Social Services, Employee Health, Human Resources, and the Employee Assistance Program.

Methods: A survey of staff experiences and perceptions regarding violence in the work setting was conducted. The survey solicited information about personal encounters with violent episodes and their feelings about the safety of their work environment. Additionally, a security analysis of the site was completed that incorporated input from local law enforcement. Interventions included formation of a multidisciplinary workplace violence committee, enhanced physical security, staff education, development of a reporting tool, post-incident debriefings, flagging violent patient charts while maintaining confidentiality, de-escalation and secure training, and increased security presence. Education emphasized that with heightened awareness and early intervention, violent situations may be avoided, diffused and/or better managed.

Outcomes: This comprehensive approach has resulted in increased reporting of violence, a strong relationship with law enforcement, and workplace violence prevention as a consideration in facility space design. Awareness, as measured by the number of staff completing a computer-based learning module, increased from 72 completions in 2005 to 4,620 in 2011. Importantly, in 2011, an Emergency Department nurse testified before the state senate on this topic and at her urging legislation was introduced to increase the penalty for assault of emergency department healthcare workers.

Implications: A multidisciplinary and community approach to health-care violence is effective in addressing issues of healthcare violence. The involvement of state and local law enforcement is imperative in order to ensure safety, enforce the law, and make changes that directly affect the amount of violence in the hospital and the community it serves.

STAFF PERCEPTIONS OF WORKPLACE SAFETY IN A PEDIATRIC EMERGENCY DEPARTMENT

**Shaw, Julie**, RN, MSN, MBA, CEN, Sr. Clinical Director, Emergency Services, Cincinnati Children’s Hospital Medical Center, julie.shaw@cchmc.org

Purpose: A patient with an undiscovered gun in the pediatric emergency department (ED) created stress and anxiety for staff, highlighting a need for improvements to decrease risks for patient/family driven violent events and to address staff fears.

Design: Mitigation efforts could be costly and lengthy to implement so an understanding of the greatest needs from the perspective of staff was sought to direct interventions. An electronic, anonymous, 18 question survey was developed. Demographic, single option multiple choice, forced ranking, and narrative response questions were included.

Setting: The study organization is a large pediatric, not for profit, magnet system in the Midwest United States. Emergency services are provided in an urban level 1 trauma center with 90,000 visits annually and a freestanding, suburban, community ED with 35,000 visits annually. Three urgent care centers in suburban locations see 25,000 patients annually combined.

Participants: Survey distribution included about 400 staff from all sites. Major job categories included physicians, nurses, respiratory therapists, patient care assistants, paramedics, child life specialists, and clerical staff. All emergency services staff was invited to participate. Responses were not independently identifiable. Inclusion/exclusion was by self-selection.

Methods: The survey was distributed simultaneously to all participants by the senior nursing leader for all emergency services in the organization via corporate email during the last week of December, 2010, with a 2 week response deadline. The survey included 3 demographic questions and 3 questions to examine perceptions of both concern for safety and of fear while at work. A forced ranking rated potential security risks in order of concern importance. Opportunity to add risks not previously identified was provided. Four questions for the urban campus examined perceptions about the presence of a local police department officer. Five questions examined perceptions about the presence of organization based security officers. Response counts for multiple choice questions determined the percentage of positive responses for each defined choice. Narrative responses were themed by a single reviewer and validated by 2 additional reviewers. This was a safety improvement project and was not reviewed by the organizational Institutional Review Board.

A QUALITATIVE STUDY OF COPING STRATEGIES USED BY NURSES EXPERIENCING BULLYING AT WORK

**Simons, Shellie**, PhD., Assistant Professor, Nursing, University of Massachusetts Lowell, Sharon, MA, shellie_simons@uml.edu

Objective: The aim of this study is to explore nurses’ perception of being bullied at work and to examine strategies that nurses who were bullied used to ameliorate the bullying behavior.

Background: There have been an increasing number of recent studies investigating either bullying or related phenomenon but only a very few pose evidence based research to reduce or eliminate the problem. Despite the current shortage of nurses and the evidence that bullying affects whether nurses stay in their jobs, there has been little research to develop strategies and effective interventions to reduce and eliminate the problem.
**Oral Abstracts**

Methods: A qualitative descriptive design was used to explore the question, “What strategies did you use to cope with or stop the bullying?” A purposive sample included eighteen registered nurses in Massachusetts who self-identified as being targets of bullies. Interviews were audio taped, transcribed and entered into NVIVO 9 for analysis. The text was then interpreted using conventional content analysis methodology.

Results: Nurses used a variety of coping strategies to deal with bullying that included direct confrontation, knowing agency’s policies, keeping a diary and reporting the behavior to a supervisor. A few of the nurses stated that the bullying got better over time but others reported that the bullying did not end until the bully or the target transferred or left their job.

Implications: Despite the increase in research related to bullying among nurses, there remains a paucity of research-based evidence related to interventions designed to effectively eliminate this pervasive problem that has plagued the nursing workplace for much of the past seventy-five years. The successful strategies used by nurses in this study will be useful in developing interventions that can be tested so that health care agencies can adopt evidence-based practices that work.

THE RECIPROCAL INFLUENCE BETWEEN NURSE BURNOUT AND PATIENT VIOLENCE

**Taylor, Melissa, MPH, RNC, CEN, Registered Nurse, Emergency Nurses Association/Trihealth, Cincinnati, OH, mrs smith7@att.net**

Purpose: Emergency nurses are regularly exposed to psychosocial risk factors for burnout syndrome, including workloads of high intensity that integrate seriously ill patients, with those who are violent, abusive and extremely demanding. This paper reports a review conducted to examine the influence that, both, nurse burnout and patient violence have on each other.

Design: Narrative Literature Review.

Setting: Emergency Departments.

Participants/Subjects: Registered nurses, employed full or part time in emergency departments, who have regular and frequent contact with patients, families and visitors. Although all clinicians working in emergency departments can experience high degrees of stress, symptoms of burnout and some form of patient violence, only nurses were the subject of this literature review.

Methods: A comprehensive literature search was conducted using the search engines of OVID, Medline, Pubmed, PsycArticles and Google Scholar. Keyword searches included caring, burnout, compassion fatigue, cognitive resilience, workplace violence, emergency department violence, patient aggression, reciprocal influence, and narrative literature review. The reference lists of published studies and online reports were also reviewed. The papers retrieved used quantitative and qualitative approaches and were examined for relevance. Data from relevant papers were synthesized. This review is organized beginning with general epidemiology and theories regarding Nurse caring, stress and burnout. The review progresses to workplace violence theory, statistics, patient perceptions of nurse caring behaviors, and discussion of linguistic, environmental, and behavioral triggers of violent interactions between nurses and patients.

Results/Outcomes: A number of articles published between 1988 and 2011, met the inclusion criteria and corresponded to the purpose of this review. Although the term “burnout,” was first coined in 1974 by psychologist Dr. Herbert J. Freudenberger, literature from the late 1980’s and beyond was included because of the increase in reported violence against emergency nurses during that period.

Implications: Although patient violence against emergency nurses can be unforeseen and unpredictable, both nurses and patients report some linguistic, environmental and behavioral triggers of violent interactions. Emergency nurses experiencing burnout may express themselves in language and manner indicating lack of empathy, concern or caring toward patients and families. They identify repeated and intense encounters with hostile, violent patients and families as a source of stress contributing to symptoms of burnout. Reciprocally, violent patients often attribute the cause of their behavior to nurse behaviors, language or tone that they perceive as uncaring, condescending, patronizing or insulting, during their time of stress and illness. Both quantitative and qualitative studies indicate a reciprocal influence between nurse burnout and patient violence. More research is needed regarding the effect of multipronged approaches designed to support the psychological and emotional needs of nurses, and to reduce patient violence.
BACKGROUND: This study examined the perception of bullying work relationships for social workers, the ability of social workers to construct effective coping responses to perceived workplace bullying, and the factors influencing social workers’ coping responses to perceived workplace bullying.

METHODS: This nonexperimental, cross-sectional project used a mixed-methods research design. The quantitative data were gathered through the use of a mailed questionnaire, and the qualitative data resulted from semi-structured individual interviews conducted in person with two self-identified targets of bullying. The quantitative sample consisted of 300 social workers from the metropolitan, Washington, DC area. Private practitioners, students and retirees were excluded to limit the sample to those who were most likely to be actively employed at least 30 hours per week within an organizational setting during the preceding year. Of 171 surveys that were returned, (54%), 111 cases (35%) met the criteria for inclusion in the study.

RESULTS: Nearly three of five social workers (58%) in the sample reported being the recipients of demeaning, rude, and hostile workplace interactions more than once in the previous year. Most targets of bullying were men (59%), between 27 and 50 years of age (58%), had master’s degrees (98%), and were Caucasian/White (75%). Although targets were most likely to work in government agencies/military and mental health outpatient organizations (19% and 18% respectively); bullying was also a problem for social workers in inpatient health, hospice and nursing home settings (7%). More than a third of targets (35%) held a direct service role (clinical/direct practice), whereas almost a third (29%) identified their role as administration or management. Supervisors, colleagues, subordinates, and clients were all identified as bullies. Women were more than twice as likely to be identified as bullies as were men.

CONCLUSIONS: The findings from this study strongly suggest that workplace bullying may be an issue for social workers and social work practice. Social work clinicians and administrators need to be prepared to recognize and address abusive behaviors from clients, colleagues, subordinates, and supervisors, particularly in host settings.
PERCEPTIONS OF HORIZONTAL VIOLENCE IN STAFF NURSES AND INTENT TO LEAVE

Ammer, Francesca, PhD, Chairperson, Nursing, Bradley University, Peoria, IL, faa@bradley.edu
Charlotte Ball, Bradley University

The environment in which nurses practice is a diverse one. Nurse-to-nurse interactions within this environment may often be perceived as hostile. The influence of such an environment clearly impacts job satisfaction and retention. The purpose of this descriptive correlational study was to describe registered nurses’ experiences with horizontal violence and examine the relationship between horizontal violence and intent to leave. Roberts Oppression Theory served as the theoretical framework for the study. A sample of 300 registered nurses from a midwestern hospital received the Briles’ Sabotage Savvy (BSSQ), Intent to Turnover (MOAQ), and Demographic questionnaires. Analysis of findings was based upon a 38% response rate with 104 completed data sets. Results indicated that horizontal violence had been experienced by nurses of all ages and degrees of experience. The four major examples of horizontal violence identified were: Being held responsible for coworkers’ duties; Reprimanded or confronted in front of others; Failure to be acknowledged or confronted in front of others; and Untrue information about you being passed or exchanged. Correlations from BSSQ and MOAQ results indicated a significant, positive relationship between perceptions of horizontal violence and intent to leave. Additionally, correlation results indicated that the longer nurses were employed the more likely they were to perceive themselves as victims of horizontal violence and younger nurses indicated more of a willingness to leave a position in relationship to perceived horizontal violence than older nurses. While longitudinal study may be indicated, it is further important that nurse administrators strategically plan to initiate activities to address the ultimate impact of perceived horizontal violence; job satisfaction and retention. Mentoring, the ongoing assessment of organizational climate, and zero tolerance for horizontal violence are just a few of the workplace strategies that may effectively address the challenges of perceived horizontal violence and curb the likelihood of intent to leave.

WORKPLACE BULLYING AND STRUCTURAL EMPOWERMENT: AN EMERGENCY DEPARTMENT NURSES ASSESSMENT

Awadallah, Kiefah, MSN, Department Nurse Educator, Center for Emergency Medicine-Adults, University Hospitals Case Medical Center, Cleveland, OH, kiefah.awadallah@uhhospitals.org
Deborah Lindell, Case Western Reserve University

The literature regarding workplace bullying (and related terms) and structural empowerment within the nursing field has recently been a topic of interest. Despite the lack of focused research in the field of Emergency Nursing with respect to workplace bullying and structural empowerment, there is insightful information about workplace bullying and structural empowerment and the effects of the latter on nurses in other nursing fields. There is need for an investigation into the extent of workplace bullying and empowerment among Emergency Nursing. This study will describe the extent of workplace bullying and structural empowerment among ED nurses. Descriptive correlational study by convenience sampling. System hospital Emergency Departments in rural and urban settings in the Midwest U.S. Identified Emergency Department (ED) Nurse. Inclusion criteria include any Active Emergency Department Nurses with an Employment status of full-time, part-time or pm. Exclusion criteria include Retired or terminated ED nurse, Float pool RN. Protection of human subjects will be maintained by concealing any to personal identification. Demographic data sheet will be utilized to gain insight into the ED population (Age, gender, Education, years as a nurse, and years as an ED nurse). Negative Acts Questionnaire-Revised (NAQ-R II) is the tool to measure bullying based 23 questions written in behavioral terms and answered on a 5-point Likert scale (1 for “never” to 5 for “daily”). Nowhere does the questionnaire refer
to the term bullying. The higher the score indicates a higher incidence of occurrence of workplace bullying. Conditions for Work Effectiveness Questionnaire-II (CWEQ-II) is the tool to measure structural empowerment. Concepts to be studied are Power (Formal power, informal power) and Access (opportunity structures, information power structures, support power structures, resources power structures). A 19 questions that measures Kanter’s empowerment structures (3 questions for the 4 structures of access to opportunity, information, support and resources, 3 questions for formal power and 4 questions for informal power). Variables include Workplace Bullying and Structural Empowerment. Workplace bullying is theoretically defined as “a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation wherein the target of bullying has difficulty in defending himself or herself against these actions. We will not refer to a one-time incident as bullying” (Einarsen, & Hoel, 2001). Kanter’s more clearly defined structural empowerment as four structural factors (access to information, access to information, access to support and access to resources) within the work environment that have a greater impact on employee work attitudes and behavior (1977). IRB pending approval. Results/Outcomes: research in progress cannot discuss data at this point. Implications: Projected outcomes of this study can be inferred that there is a moderate to high onset of workplace bullying among ED nurses. Also, it can be anticipated that ED nurses may find structural empowerment components low to moderate.

BUILDING A CRITICAL INCIDENT MANAGEMENT TEAM

Beers, Jeffrey, Clinical Risk Management and Patient Safety, University Hospitals Case Medical Center, Olmsted Falls, OH, jeffrey.beers@Uhhospitals.org
Julia Skarbinski, UHCMC
Kim Bixentine, University Hospitals

Increasing national recognition of the need for crisis support for health care practitioners, coupled with our own experiences, has prompted University Hospitals to develop our own Critical Incident Management Team program for our staff and physicians. Our Critical Incident Management Team is available to provide support – either immediately or any time after an event – to practitioners involved in an incident that results in an adverse patient outcome. Such events may be the result of practitioner error, health care system delivery issues, complications of medical or surgical care or a devastating course of a patient’s illness. They may include events designated as “sentinel events” or “critical events” in UH policy or in Joint Commission Requirements, or cases that result in litigation.

Members of the CIMT are volunteers – physicians, nurses and licensed social workers – who have received in-depth training in critical incident management. The CIMT member will set up a time to meet with the practitioner. These can be one-on-one or group debriefing sessions.

Every conversation between a CIMT member and practitioner is privileged and confidential. Ohio law recognizes that communications between a CIMT member and an individual receiving crisis services is privileged from disclosure in litigation.

The Director of Patient Safety and Risk Management coordinates this program under the auspices of the Patient Care Nursing and Medical Outcomes (PCNMO, a combined function of the Chief Medical Officer and Chief Nursing Officer).

Launched in the 3rd quarter of 2010, UH has reached more 100 practitioners through this team.

FAMILY CENTERED RELATIONSHIP BASED COMMUNICATION GUIDE

Beers, Jeffrey, Clinical Risk Management and Patient Safety, University Hospitals Case Medical Center, Olmsted Falls, OH, jeffrey.beers@Uhhospitals.org
Julia Skarbinski, UHCMC

University Hospitals follows a “Relationship Based Care” delivery model. This model is holistic and inter-disciplinary. It places the patient at the center of all medical, nursing and ancillary assessment, planning, implementation and evaluation of care. This includes the family or significant others as a patient system.

Most all of our patient’s families and visitors are interacting with the patient, hospital staff and physicians in typical social dialog exchange. The family’s needs are being addressed and the family is expressing satisfaction regarding the resolved needs.

Individuals may use different coping methods when dealing with the stress of illness.

At times, family members may have reactions to the stress of illness that are disruptive to the patient’s plan of care.

The Family Centered Relationship Based Communication Guide is a communication tool designed to provide supportive guidelines when family relationships are not responding to our usual skill set. In these situations the Algorithm will help the practitioner to identify what actions to take and offers recommendations for family reactions. It empowers the bedside providers to take definitive action when needed.

There are four categories. An assessment of the family may place the family member in any of the categories or their actions may escalate through the algorithm:

- Receptive
- Requires attention
- Concerning
- Urgent
Poster Abstracts

Once a problem is identified – the algorithm serves as a tool to bring support services to the family quickly and to report certain escalating families to nursing and physician leadership, risk and legal.

Summary of Communication Guide / Algorithm:

1. Recognize the patient as the center of care.

2. Recognize the family as a significant component or “system” of the patient’s treatment and plan of care. Family / visitor assessment is as much a component of the daily exam or assessment as any other system i.e. neuro, cardiac, GI and etc.

3. Consistent assessment and documentation of the family / visitor are necessary as a component of the medical exam and nursing assessment.

4. Expeditiously creating and implementing an interdisciplinary plan to meet family needs that are identified. Involving multiple services readily to fulfill the medical/nursing family intervention plan.

5. Reassessing and recognizing when the plan is not effective and creating a new plan.

6. Notifying management and administrative service as a support to the interdisciplinary clinical team that are at the bedside interacting with the patient and family / visitor.

7. Creating verbal and written contracts and agreements when needed regarding communication, behavior and interactions between the family and healthcare team.

8. Empowering the bedside providers to implement the healthcare team plan of care.

NOVICE NURSE COPING STRATEGIES FOLLOWING WORKPLACE BULLYING

Berry, Peggy, MSN, Coping Strategies of Nurses following Bullying, College of Nursing, University of Cincinnati, Centerville, OH, berrypa@mail.uc.edu
Gordon Gillespie, University of Cincinnati

Purpose: The purpose of this study was to identify the frequency of workplace bullying and the impact of bullying on novice nurses’ work productivity.

Design: A cross sectional web-based survey design

Setting: Novice nurses from Ohio, Kentucky, and Indiana

Participants/Subjects: 197 novice registered nurses (less than 2 years since nursing graduation responded to a postcard invitation

Methods: Novice nurses (n=197; 91.4% female, 8.6% male) in practice less than two years completed the Healthcare Productivity Survey, Negative Acts Questionnaire, and a demographic survey.

Results/Outcomes: 72.6% of novice nurses (n=147) reported a workplace bullying event within the previous month with 57.9% (n=114) the direct targets and another 14.7% (n=29) witnessing the workplace bullying behaviors. Using a weighted Negative Acts Questionnaire score, 21.3% (n=43) of novice nurses were bullied over a six month period. When asked if bullied over the past six months, almost 55% of NNs (54.7%, n=88) reported repeated, targeted workplace bullying with 55.3% reporting no workplace bullying. Workplace bullying acts were primarily perpetrated by more experienced nursing colleagues (59.4%, n=117). Further, work productivity regression modeling was significant and novice nurse productivity was negatively impacted by workplace bullying (r=-.322, p=.045).

Implications: Workplace bullying continues in the healthcare environment and negatively affects bullied novice nurses’ productivity by affecting cognitive demands and ability to handle/manage workload. Healthcare facilities should continue to measure workplace bullying in the work environment after policy implementation and eliminate negative behaviors through root cause analysis to correct environmental factors associate with workplace bullying.

RESULTS OF A STAFF SURVEY ABOUT WORKPLACE SAFETY: IMPLICATIONS FOR ONE ACADEMIC ED NURSING STAFF

Burchill, Christian, PhD, RN, CEN, Clinical Nurse IV, Emergency Department, University of Pennsylvania Health System, Philadelphia, PA, templephd@mac.com

One of the first recommendations to those wishing to tackle the issue of abusive and violent behavior in emergency department is to conduct an assessment of the staff’s suggestions on strengths, weaknesses, and improvements. A survey instrument was developed from a review of the literature, consultation with experts in the field, and discussions with clinical emergency nurses. Content validity was achieved from national experts (CVI=0.98). Use of this instrument for quality improvement purposes at an urban academic medical center was granted by the university’s IRB. An email invitation with a link to an online version of the survey was sent to all 109 emergency nursing staff members (80 RNs & 29 ED technicians). Participation assumed consent. Response rates were high (78% RN & 62% ED technicians). A review of the results showed that, in general, nurses were slightly more concerned with their safety and safety-related factors than the ED technicians. There were two key findings: 1.) Confidence in hospital administration and ED physician support for reporting violent or abusive behavior was dramatically low; and, 2.) Both groups agree that status or job title plays a key role in the degree to which senior hospital administrators would respond and that violence committed against a physician would garner greater respect from administration. Data from the results of this survey continue to be used by both ED and hospital administration in order to address this problem.
St. Elizabeth Health Center is a Level 1 trauma Center in an urban setting. We are proud to announce that we just received re-signation for our Magnet Status in December of 2011. We were the first hospital in the state of Ohio to receive Magnet Designation in 2001. Our Progressive Intermediate Care has historically been the unit that had a higher level of acuity and a poor nursing image in the hospital. In 2009 their nurse to patient ratio was adjusted to acknowledge this high acuity. However the care giver stress and poor staff engagement continued. This unit scored low on the NDNQI survey in 2010. The Patient Satisfaction scores for this unit were well below the benchmarks, and the employee turnover was at 17.5% for the year. The need to look deeper into what was causing a low staff engagement became a priority. Staff nurses were communicating with nursing leadership and Hospital Administration regarding what they described as a hostile work environment. With the assistance of an interdisciplinary team approach, focus groups were held and problem resolution began to take place. Successful outcomes include decreasing the turnover rate from 17.5% to 4.5% in one year. There was an improvement in Gallup engagement scores from an Overall Mean by 0.37. The most impressive increase was the Gallup question- My supervisor or someone at work cares about me went up 0.81. The patient satisfaction scores for overall rating for this unit went up in all categories from 2010 to 2012 based on Press Ganey results. The NDNQI re-survey will take place in May 2012.

This presentation will provide a successful process for transforming a nursing unit from a disruptive hostile environment to one that demonstrates the true picture of our Professional Practice Model. Staff and leadership worked together to address bullying and the outcome has been a significant increase in employee and patient satisfaction.

Quick termination of 4 employees identified numerous times as the “leaders” took place. This was followed by one on one counseling with 8 additional individuals that were identified as participating in the bullying but were not the “leaders”. Several staff sessions held to build accountability and ownership. The outcome was a Code of Conduct that all staff signed. Nursing Leadership was addressed as well.

The turnover rate on this unit has decreased to 4.5%. The response for a job posting inhouse previous to this transformation was consistently zero, experienced in house staff would not apply to work on this unit. All new hires had to come from out of house. Twelve months after the beginning of this transformation, there is a list of inhouse nurses applying to come to this unit. This is a true testament to the positive environment and the change in the image of nursing that exists on this unit.

Background: Violence against healthcare workers is a serious and growing problem for employees and hospitals. There is a lack of published articles that provide administrators with guidance regarding strategies to use when implementing violence prevention programs in the hospital setting. Action research provided the opportunity to plan, implement and evaluate a new multi-component violence prevention program with three hospital emergency departments. The implementation was guided by evidence and partnerships between academicians and clinicians at three emergency departments. Formative and summative program evaluation of the program provided important data to support ongoing revisions and improvements.

Program objectives: 1) Implement and sustain a comprehensive violence prevention program with stakeholder input, 2) Evaluate how employees rated on-line and classroom education, 3) Identify how a sample of employees rated the violence prevention program and 4) Describe ED managers’ evaluation of the violence prevention program and each of its components.

Methods: The project took place at three hospital EDs in the Midwest. One of the participating hospitals was an urban Level 1 trauma center, one was an urban hospital and one was a suburban hospital. The Level 1 trauma hospital had separate psychiatric and adult-only EDs. The urban and suburban EDs provided care for all types of patients including children and psychiatric patients. Whereas the project was aimed at the entire ED, direct care providers, including nurses, physicians, and patient care assistants were specifically targeted for risk reduction and evaluation. Both qualitative and quantitative data was collected to evaluate the objectives.

Results: The level of implementation and sustainability was based on the setting with the smaller, suburban ED have the greatest success. Overall the managers rated the program as successful and valued the partnership. The believed the most important component was the environmental changes and the classroom education. Employees’ evaluation of the overall program varied by occupation and setting. Nurses at the small suburban hospital ED rated the program the highest. Fidelity to the program was also highest at the suburban hospital. Employees rated the classroom education higher than the on-line education. Employees felt that the most important component of the violence prevention program was surveillance and monitoring and the least important was policies and procedures.

Summary/Conclusion: The program evaluation provides new information for administrators, managers and staff who want to plan a comprehensive program to improve the safety of their workplaces. Ongoing efforts to reduce violence will require a
One mechanism shown to increase the occupational safety from events of workplace violence has been the environmental structure of the work setting. However, the environmental context varies greatly among healthcare settings. The purpose of this presentation is to differentiate the environment of Cuban healthcare settings in relation to U.S. healthcare settings and businesses in the U.S. and Cuba. A qualitative, descriptive design was used for this study, which received Institutional Review Board approval prior to data collection. Data were collected through observations and in-depth interviews conducted while the PI was in Cuba serving as part of a research delegation to evaluate the delivery of healthcare in Cuba. Data were collected while visiting select healthcare settings including a cardiac hospital, regional hospital, rehabilitation center, emergency department, and private practice clinic. Observations and interviews were documented on a field notes guide. Digital pictures were taken to provide a visual representation of the data. Data were analyzed using NVivo-9 qualitative management software. Overall, Cuban hospital settings have easy access similar to those in the U.S.; however, at least for one setting, the facility could potentially be accessed illegally around the clock given the 16 inch unsecured portals in the exterior wall. On the other hand, Cuban private practice clinics are potentially more secure than those of the U.S. with their use of a large perimeter fence that can be locked closed when the clinic is closed. Minimal barriers were seen in any Cuban healthcare setting that could stop illegal entry from persons that may be seeking to harm healthcare workers. This is very different from the U.S. where corridors are labeled “Staff Only” or have a keycard required to gain entry. No closed circuit television cameras were seen in any Cuban healthcare setting including the large regional hospital, in contrast to U.S. urban hospital settings where cameras are more common, especially in high risk areas such as the emergency department. Corridors were also dimly lit, which has been shown to increase one’s risk for workplace violence. The only Cuban healthcare setting with security personnel posted at an entrance was at the maternity home. This too is very different from U.S. hospital-based settings, where security personnel are seen in parking areas, lobbies, and/or the emergency department. Multiple differences were observed between U.S. and Cuban healthcare settings in relation to fostering environmental safety. While Cuban settings may appear to place the healthcare worker at greater risk for workplace violence, the rate of violence is nearly nonexistent. Reducing the rate of workplace violence in the U.S. may require community level cultural change versus focusing solely on the work environment.

BULLYING, BRAIN STRUCTURE AND BRAIN-TARGETED INTERVENTIONS

Goodin, Jeanine, MSN, CNRN, RN-BC, University of Cincinnati College of Nursing, Cincinnati, OH, jeanine.goodin@uc.edu
Dianne Felblinger, University of Cincinnati

Workplace Bullying has been associated with increased stress, anxiety, depression, low self-esteem, and sleep disturbances, all of which are associated with alterations in the brain. This presentation will provide a literature-based definition of bullying and an in-depth overview of brain changes associated with symptoms of bullying. Brain structure and function will be discussed with attention to the areas of the brain that provide a link between dysregulation and the associated clinical and biochemical responses. As the study of brain alterations becomes increasingly main-stream, it is important to document modifications in brain physiology as a basis for measuring the impact of bullying interventions. The research on brain function has focused largely on the prefrontal cortex, the gray matter in the primary and secondary visual cortex, the amygdala, and the hippocampus. The neuroendocrine function of the hypothalamic-pituitary-adrenal axis has also received attention by investigators. Each of these areas of the brain will be discussed in conjunction with novel and brain-targeted types of bullying interventions. These interventions can provide the foundation for continued social neuroscience research.

SOURCE OF INCIVILITY AND NURSES? SAFETY BEHAVIORS: POS AS A MODERATOR

Gopalkrishnan, Purnima, Graduate Student, Psychology, Bowling Green State University, Bowling Green, OH, purnimg@bgsu.edu
Steve Jex, Bowling Green State University
YoundAH Park, Bowling Green State University

Purpose: Hospitals are characterized by high stress and high stakes decision making. This study looks at how organizational support can mitigate the negative impact of incivility from various sources on nurses’ safety behaviors.

Design: Mail-in survey design was used using a list of all the registered nurses in the state of Ohio. Approximately 2000 participants were randomly sent the survey. Participants were also sent a postcard reminder two weeks after the initial mailing and offered incentives for participation.

Setting: Most participants worked full-time in a hospital setting and dealt with 11 patients on average during their work hours.

Participants: Participants were mostly female (90%) and Caucasian. The average age was 37.32 (SD = 10.13).

Method: Survey packets contained an informed consent letter, the survey and a pre-stamped business return envelope. Study materials were approved by the IRB at BGSU. Participants were
Poster Abstracts

assured confidentiality of their responses. The following scales were used:

Incivility from nurses, supervisors, physicians and patients, families and visitors was measured using 34 items from the Nurse Incivility Scale (NIS) (Guidroz et al., 2007) and participants responded on a 5 point scale (from “strongly agree” to “strongly disagree”) Coefficient α ranged from .81 to .94 depending on the source of incivility.

POS was measured using an 8 item scale (Eisenberger et al., 1986) with the response scale ranging from 1 to 7 (“strongly disagree” to “strongly agree”) and α=.97.

Safety compliance and participation was measured using an 8 item frequency scale (Griffin & Neal, 2000) with responses ranging from 1 to 5 (“never” to “almost always”).

We also collected demographic information such as nurses’ age, sex, race, tenure, number of patients handled etc.

Results: Correlations showed that the relations between sources of incivility and safety behaviors were significant and in the expected direction. Moderated regression analyses showed that POS significantly moderated the relationship between incivility from other nurses and physicians and safety compliance (β = -.712, p < .05 and β = -.742, p < .05 respectively). We also found that POS almost moderated the relationship between incivility from physicians and safety participation (β = -.441, p < .10).

Implications: Incivility from physicians seems to have the most impact on nurses’ safety behaviors. Nurses work closely with physicians and there is a great amount of trust and responsibility shared between these individuals in the hospital environment. Therefore, it is likely that incivility from physicians may have the most detrimental effects on nurses’ work behaviors (in particular safety behaviors) as a result of being pre-occupied with such negative interactions. This suggests that it is important for physicians to be aware of their own behaviors as a way to not just maintain safe work environments for nurses and patients, but also for themselves. However, the perception of a supportive and caring work environment can mitigate these negative effects. Therefore, hospitals and healthcare organizations should not only consider training physicians in regulating their behaviors, but also have programs and policies in place that show support and care for the staff’s well-being.

ORGANIZATIONAL AND REGULATORY DISCOURSES OF WORKPLACE BULLYING

Johnson, Susan, MN, RN, PhD student, School of Nursing, University of Washington, Olympia, WA, slj6@u.washington.edu

Workplace bullying has been identified as an occupational stressor that occurs in health care settings. Targets of bullying often report feeling powerless to end bullying without outside assistance. However, they report that when they seek help from their managers, they either get no response, or the response they get is not helpful. Some targets report that managerial and organizational responses actually exacerbate the problem. Witnesses of workplace bullying confirm that managerial and organizational responses to workplace bullying are often ineffective.

Managers operate within organizations, and their actions are influenced by the discourses of these organizations. Organizational discourses have the potential to influence nursing managers’ discourses in several ways. How an issue is discussed within an organization will influence the manner in which managers think about and respond to a given situation. For example, if an organization does not have a discourse of WPB, it will be difficult for managers to talk about WPB, and to initiate disciplinary actions against perpetrators of bullying.

Organizational discourses can be found in documents that organizations produce, such as informational pamphlets, policies and procedures, and codes of conduct. Organizational discourse is closely tied to the discourse of regulatory agencies, since they pay attention to issues that are important to these agencies, even when there is no legal mandate to do so. In the case of hospitals in Washington State, where this study is being conducted, these entities include The Joint Commission, the Occupational Health and Safety Administration (OSHA), and the Washington State Department of Labor and Industries (L&I).

The purpose of this study, which is part of a larger study on managerial and organizational discourses of workplace bullying, is to explore discourses of workplace bullying of hospitals and agencies that regulate these hospitals. The ultimate goal is to understand how these affect managers’ responses to workplace bullying.

The study used discourse analysis to describe discourses of workplace bullying found in documents produced by hospitals and regulatory agencies (The Joint Commission, OSHA, L&I). Organizational documents that were examined include employee codes of conduct, codes of ethics, policies and procedures, and informational pamphlets. Documents were obtained from hospital communication departments, human resources, and safety departments. However, when there is no legal mandate to do so. In the case of hospitals in Washington State, these documents are often vague and open to interpretation. The findings of this study suggest that one solution to the problem of workplace bullying is for organizations to work in conjunction with front line managers to change their discourse on workplace bullying.

Preliminary findings suggest that lacking a clear regulatory mandate, the discourse on workplace bullying varies from organization to organization. The terms used vary widely, as do descriptions of and solutions to the problem. The language in organizational documents is often vague and open to interpretation. The findings of this study suggest that one solution to the problem of workplace bullying is for organizations to work in conjunction with front line managers to change their discourse on workplace bullying.
Poster Abstracts

“STRESSED OUT?” (SECONDARY TRAUMATIC STRESS: AN EDUCATIONAL INTERVENTION FOR ED RN’S)

Kicos, Gina, BSN, RN, Emergency Department, Aultman Health Foundation, Canton, OH, GLorenzo@aultman.com

Background: Secondary Traumatic Stress (STS) is the emotional stress that comes from repeatedly caring for traumatically suffering patients. It is already known that the occurrence of STS is elevated among Emergency Department Registered Nurses in the United States and around the world. Most of the current professional research studies have only looked at the prevalence of STS, but not interventions. It is recommended that an educational intervention on STS be implemented in order to see the effect on STS scores. Also, Self-Care is correlated positively to high STS prevalence; therefore Self-Care should be examined as well.

Purpose: This study serves as an assessment of STS scores among ED RN’s before and after an educational intervention. It looks at Self-Care in addition to STS scores. This study hypothesized that an educational intervention would lower STS scores and also would serve to identify Self-Care needs for future education.

Study Setting: 55 bed ED at an acute care hospital located in NE Ohio. 14 ED RN’s with at least 6 months of experience in the ED participated.

Findings: Among categories of Intrusion, Avoidance, and Arousal: Avoidance showed the highest statistical significance within the 3 STS categories. All levels decreased 1 week after the educational intervention. Also, Areas of Self-Care that proved to be the highest scores were: eating healthy, noticing inner experiences, staying in contact with important people, and taking time to chat with co-workers. The lowest Self-Care scores were: getting massages, writing in a journal, Re-reading favorite books/movies, meditating, and negotiating needs.

Implications: This study serves as a baseline for utilizing an educational intervention in improving STS scores among ED RN’s. It also helps identify areas of Self-Care that are lacking and can be improved upon in the future in order to decrease STS.

BUT THEY ARE LITTLE - WHY SHOULD I BE SCARED?

Koss, Katie, Nurse Manager, Pediatric Emergency Department, Monroe Carell Jr. Children’s Hospital at Vanderbilt, Mount Juliet, TN, katie.koss@vanderbilt.edu

Pediatric Emergency Departments have not been highlighted as a dangerous workplace environment. However, some of the same violence risks are as prevalent, if not more prevalent, in this unique setting. This session will present information on monitoring staff’s perception of security, scripting for patients and families, and action items to increase security while still maintaining a family centered care model.

DISRUPTIVE BEHAVIOR AMONG NURSES ON MEDICAL SURGICAL UNITS: A PRELIMINARY QUALITATIVE STUDY

Leiper, Jacoba, MSN, PhD student, UNC CH, Mebane, NC, leiper@email.unc.edu

Background: Disruptive behavior (DB) is a term used in health care to describe a wide variety of hurtful, unhelpful, hostile, and intimidating behaviors that occur among health care workers. DB most commonly consists of various degrees of verbal and physical abuse. The Joint Commission considers DB to be such a problem that it called for the creation of a Code of Conduct aimed at stopping disruptive and inappropriate behaviors among health care professionals, effective January 1st, 2009.

The consequences of DB are significant. The nurse may experience emotional (e.g., anger, frustration, fear), physical (e.g., nausea, headaches, cardiac arrhythmias), psychological (e.g., depression, burnout, substance abuse), and social (e.g., isolation, strained relationships) effects. These consequences impact the organization and in turn contribute to decreased patient safety, quality of care, productivity, adverse patient outcomes, a negative work environment, and increased absenteeism and staff turnover.

Purpose: The purpose of this study was to explore nurses’ perceptions and meanings of disruptive behavior in the context of the organization. The aim was to collect preliminary data to guide a future research approach to build a theoretical model representative of disruptive behavior among nurses in the hospital work environment.

Research question: How do nurses understand the circumstances and contexts under which disruptive behavior among nurses occur?

Method: A grounded theory approach was used. Data was collected using semi-structured interviews with open ended questions.

Sample: The participants included Registered and Licensed Practice Nurses working in two medical surgical units in a large teaching hospital who experienced disruptive behavior from another nurse. Since this was a preliminary study the sample size was small; four volunteer participants.

Data analysis: Open coding was the primary method of analysis; concepts were identified and categorized into themes. Constant comparison and memo writing took place throughout the data collection and analysis process.

Results: Four major themes emerged: high levels of stress, lack of teamwork, unaddressed personality conflicts, and ineffective managerial style. Narrative examples support the themes. An initial basic model that illustrates when DB occurs among nurses was developed by grouping the most prevalent concepts that support the themes together.
HORIZONTAL VIOLENCE AMONG NURSES: A REVIEW OF THE LITERATURE

Leiper, Jacoba, MSN, PhD student, UNC CH, Mebane, NC, leiper@email.unc.edu
Jennifer Leeman, UNC CH

Background: Horizontal violence is a term used in the nursing literature to describe a wide variety of negative behaviors that occur among nurses. Horizontal violence (HV) and its effects have been reported for more than 30 years. Common examples include various degrees of verbal (e.g., shouting, criticizing), physical (e.g., pushing, blocking doorway), sexual (e.g., harassment, assault), and work-related (e.g., sabotage, reporting without cause) violence.

Objective: The objective of this literature review was to summarize findings on violence among nurses with a focus on prevalence, antecedents, and consequences.

Method: We searched PubMed and the Cumulative Index to Nursing and Allied Health Literature for reports of empirical studies published between July 2001 and May 2010. Search terms included “nurses” and “disruptive behavior,” “horizontal violence,” “lateral violence,” “bullying,” “incivility,” “interpersonal conflict,” and “verbal and physical abuse.” We also searched reference lists of included articles and used Google Scholar to do direct name searches for work by leaders on this topic. After applying inclusion and exclusion criteria, 22 publications were included in the review. The sample includes quantitative (n = 21) and qualitative (n = 1) studies. The majority of quantitative studies (n = 20) were cross-sectional. One study was longitudinal. We extracted and summarized data according to guidelines outlined by Whitmore and Knafl (2005).

Results: Prevalence: The prevalence of violence among nurses was high. Overall, studies reported that 17 – 80% of nurses either witnessed or experienced horizontal violence. Antecedents: A variety of triggers to violence were identified. In quantitative studies, authors identified organizational (workload, skill mix, time constraints, organizational climate, role ambiguity, etc.); demographic (type of nursing unit, age, sex, level of education, years’ experience, nationality, etc.); and environmental antecedents (noise levels, type of neighborhood, etc.). In qualitative studies, authors identified power relationships, the formation of alliances among nurses, misuse of authority, poor communication, organizational tolerance of the behavior, and internalization of the behavior by new nurses. Consequences: The effects of violence among nurses were evident on multiple levels. Nurses experienced psychological, emotional, physical, and social consequences. These, in turn, impacted the organization in terms of patient safety and mortality, nursing productivity, retention, and satisfaction, and organizational climate.

Discussion: Horizontal violence among nurses is a multifaceted, complex problem. Violence does not occur due to one specific antecedent or in isolation, but due to the confluence of circumstances and contexts within an organization. In addition to consequences for nurses and organizations, the profession of nursing is greatly affected since the existence of violence among nurses undermines nursing’s ethic of caring and professional status. To manage or suggest effective solutions, a greater understanding of why and how horizontal violence occurs is needed.

WORKPLACE BULLYING AND LATERAL VIOLENCE: A CONCEPTUAL MODEL FOR VIOLENCE AWARENESS AND REDUCTION

Melvak, Mary Alice, PhD, Quality Specialist Mattel Children’s Hospital, Quality Management, UCLA Healthcare, Las Vegas, NV, mmelvak@mednet.ucla.edu

Bullying and lateral violence continue the aggressive assault on healthcare workers, the work environment, and ultimately patient safety. Toxic workplace behaviors such as bullying and lateral violence adversely affect multiple fundamental facets of unit culture and markers of quality patient care. Workplace bullying and lateral violence are complex, multilayered phenomena that contribute to moral distress, dysfunctional and harmful work environments, and adverse patient outcomes.

The current and increasing complexity of healthcare systems presents escalating challenges to organizational leaders to address the origins and the effects of toxic workplace cultures. Understanding organizational and theoretical complexities of bullying and lateral violence is paramount to implementing change initiatives that reduce both overt and covert toxic behaviors and affect the ethical climate of healthcare units. Leaders must reverse the cycle of toxic work environments through deliberate interventions that increase the level of communication, collaboration, and respect among their members.

Leadership and staff expertise, values, experience, expectations, and positive behaviors must be grounded in a practice environment infused with both awareness and a template for action to assess violence levels and adapt quickly to bullying patterns that affect clinical excellence, care, cost-effectiveness, critical thinking, empowerment of staff, and professional growth.

The purpose of this review is to describe a conceptual model for bullying and lateral violence that addresses negative behavior etiologies as well as treatment measures and strategies to overcome barriers to effect culture change in hospitals. Significant contemporary perspectives stress the multiple levels of determinants of organizational culture change. We utilize key types of theory concepts such as change theory, situational awareness, social influence theory, and transformational leadership as the foundation for leadership interventions. Moral distress, ethical climate and levels of organizational distress are discussed with the ecological model serving as the framework for multiple level pathways for leadership initiatives.

The model addresses the central issue of organizational culture change and organizational transformation and the relationship
to optimizing a productive and healthy work environment as a reduction strategy to diminish the detrimental effects of bullying and lateral violence. A conceptual foundation for understanding bullying, lateral violence is delineated with a synthesis of the evidence regarding patterns and effects of theory regarding sustaining culture change to effectively reduce levels of bullying and lateral violence.

In addition, the conceptualization illustrates the viability, utility, and challenges of using theory-based interventions to initiate and evaluate effects on bullying and lateral violence in hospitals. This review concludes by identifying cross cutting themes and important future directions for bridging the gap between theories, practice, and research. Response patterns that are evidence-based are discussed along with competencies for positive culture change for staff and leadership.

A cultural change schema for bullying and lateral violence management process is embedded within the model for unit and organizational level leadership. The review concludes with suggested strategic management strategies and associated risks inherent establish a change-oriented organization with the capacity for safe and healthy work environments.

**AN INTERVENTION FOR REDUCING VIOLENCE AGAINST HEALTHCARE WORKERS**

**Mentzel, Tammy**, BS, Research Associate, College of Nursing, University of Cincinnati, Cincinnati, OH, tammy.mentzel@uc.edu

**Donna Gates**, University of Cincinnati

**Gordon Gillespie**, University of Cincinnati

**Terry Kowalenko**, University of Michigan

**Ahlam Al-Natour**, University of Cincinnati

Workplace violence against healthcare workers is a serious and growing problem. In addition to the significant stress workplace violence causes healthcare workers, violence has been shown to have a considerable impact on the care provided to patients and families. Successful interventions to reduce and manage violence against healthcare workers will need to incorporate a multi-component, collaborative approach. An intervention study was funded by the United States’ National Institute for Occupational Safety and Health (NIOSH) to develop and test the effectiveness of a multi-component intervention to prevent physical violence against emergency department (ED) workers and reduce the negative consequences of violence. The intervention was developed and implemented using an action research model. This presentation will describe the methods used to partner with the hospitals to develop and implement the project, describe the formative and summative evaluation, and discuss the challenges encountered during the process. Six EDs were enrolled; three intervention sites and three control sites. Focus groups were held with hospital managers, employees and patients at the intervention sites to gather information regarding their beliefs about the violence and to identify strategies that they believed would be beneficial and sustainable in their work settings. Workplace violence policies and procedures from ten hospitals were collected and reviewed to ensure development of comprehensive documents. After consulting with workplace violence experts, a gold standard for policies and procedures was developed by the research team. Meetings with intervention sites were held to review, revise and tailor the gold standard workplace violence policies and procedures for successful implementation. An environmental assessment was conducted at each intervention site with subsequent recommendations made to managers based on the assessments. Education and training consisted of two different strategies. First, all employees were required to take web-based modules focusing on workplace violence definitions, consequences of workplace violence, risks for violence, general interventions to prevent violence, protective environmental controls, non-confrontational presence, recognition of escalating behaviors, effective communication for de-escalating violence, early intervention, coordinated team approach during a violent event, and safe work environments after a violent event. Second, two hour tabletop training sessions were held to reinforce the content of the web-based training modules and the new policies and procedures. A train-the-trainer approach was used for the table-top training sessions; ED employees were trained to conduct the training with the rest of their employees. Challenges included differences in priorities, lack of support from physicians and other disciplines, legal concerns from administration, management and personnel changes, and issues arising with accreditation and differences in focus (research versus project), and timelines. Developing an effective and sustainable intervention to reduce violence against healthcare workers requires a multi-component, collaborative approach that involves all stakeholders, written policies and procedures, environmental assessments, and education and training.

**VIOLENCE NOT ACCEPTED HERE**

**Schultz, Lynne**, BA, AD, RN, Staff Nurse, Emergency Department, Grant Medical Center; Canal Winchester, OH, schultzlynn3@aol.com

**Traci Jackson**, Grant Medical Center

**Teresa Poliseno**, Grant Medical Center

Purpose: The purpose of this project was to create a zero tolerance policy directed to protect patients, employees, visitors, property, and medical staff in the Emergency Department (ED).

Design: The project is part of an interventional phase to address violence in the Emergency Department. The project emerged after a survey revealed a high prevalence of violence and minimal acknowledgement of administrative support for a zero tolerance policy.

Setting: Level 1 trauma center with over 80,000 patient visits during 2011.

Participants: The following groups or individuals participated in the development and implementation of the policy: Unit Shared Governance Team, Clinical Manager, Quality Outcomes Manager, Chief Nursing Officer (CNO), ED Peer Group, Protective
Methods/Process: The stimulus for this project was two simultaneous issues that occurred in January of 2011: a serious safety event against a staff nurse and participation in a survey measuring ED violence experiences and perceptions. The project accelerated in May 2011 when the survey findings revealed that the majority of participants did not believe that the hospital and ED administrators were committed to eliminating workplace violence (68.6% and 60.8% respectfully). An individual member from the Shared Governance Council drafted a zero tolerance policy after an intensive search for a zero tolerance policy in this state’s hospital system and found that none were available. The Quality Outcomes manager then edited and revised the policy to fit the format to other hospital policies. The first administrative group that reviewed the policy was the Patient Safety Council that asked for revisions in wording and inclusion of additional definitions. The revised policy was then reviewed by the hospital wide system wide Emergency Peer Group. The group made additional suggestions and decided that the policy should be implemented and evaluated in one ED before it is implemented system wide. The policy was reviewed by Protective Services and Risk Management to address specific content for the Threat Assessment Team. The policy was approved by Protective Services, Risk Management, and the Legal Team before returning to the system wide Peer Group for final review. The ED CPIT reviewed the policy with the CNO’s request for additional clarification of written communication of patient’s rights in relationship to the new policy. The policy was revised and submitted to the CNO for approval in February 2012.

Implications: The project team will present their findings to hospital administration and staff nurses from the remaining units for hospital wide adoption.

VIOLANCE AGAINST NURSES AND OTHER HEALTH CARE PERSONNEL IN AN URBAN LEVEL I TRAUMA CENTER

Scribner, Shellie, BSN RN CEN, Clinical Educator, Emergency Department, Grant Medical Center; Stoutsville, OH, sscribne@ohiohealth.com
Pamela Huff RN CEN, Grant Medical Center
Paula Renker Ph.D. RN, Grant Medical Center

Purpose: Violence against nurses and other health care personnel in Emergency Departments (ED) is gaining national attention. Organizations such as The Joint Commission and the Emergency Nurses Association (ENA) have lent their support to the issue by making it priorities for research, policy development, and accreditation. The purpose of this study was twofold: 1) To compare ED nursing personnel experiences with violence and perceptions of workplace safety with national benchmarks and 2) To identify their perceptions of factors that precipitate and diminish violence in the ED.

Design: This abstract reports Time 1 findings of a prospective quasi-experimental study whose purpose is to minimize violence in the ED. The findings from Time 1 are presented descriptively.

Setting: This research study took place in an urban Level I trauma center emergency department at a hospital in the Midwest.

Participants/Subjects: The final sample consisted of 52 nurses, paramedics, and patient support assistants. Although offered, no surveys were received from unit clerks in the department. The survey was not offered to physicians, physician assistants, or nurse practitioners in the ED.

Methods: The descriptive study used a survey developed by the Emergency Nurses Association (ENA) for their national study (Gacki-Smith, et al., 2009) to measure violence against ED nurses with nurses and nursing assistants at an urban Level I Trauma center. Survey items were in multiple formats, including open-ended items. Analyses conducted on quantitative items included descriptive statistics, t-tests and chi-square analyses while open-ended items were analyzed using Cresswell’s (2007) generalized approach for qualitative inquiry.

Results/Outcomes: The final sample consisted of 52 nurses and staff (82% RN) with a mean of 7.6 years experience in the ED. Other than age, demographic characteristics of the sample mirrored Glacki-Smith, et al.‘s national study. Participants in this study revealed that they were often unsure of the types of security controls used in the ED to protect them. When compared to findings for nurses from high population, urban EDs, participants in this study experienced daily or weekly higher levels of physical violence (study 39.2%, national sub-group 13.4%) and verbal abuse (study 68%, national 43.8%). Participants identified cynicism, collaboration, concerns for customer service, consequences, and consistency as factors that can exacerbate or diminish violence in the ED.

Implications: Findings from this study are being used to develop specific strategies to address violence concerns in the department. Some of the changes in progress include new mandatory staff training, a zero-tolerance policy, and a new visitor policy. Staff is to be re-surveyed 18 months from the original survey to evaluate changes in perception of workplace safety and precipitating factors.
Background: According to a 2007 United States nursing survey, 31% of the participants reported being bullied at work. Nationally, 70% of nurses leave their jobs as a result of workplace bullying (WB). With the excessive costs to orient and replace nurses, the profession cannot afford to lose nurses to bullying.

Purpose: The purposes of this study were to determine the prevalence of WB and if a cognitive rehearsal program improved WB management knowledge and decreased WB.

Design: This was a quasi-experimental study employing a behavioral intervention.

Methods: This study consisted of three parts: (a) an internet-based WB survey assessing the frequency of bullying behaviors, (b) WB knowledge testing before and after the two-hour cognitive rehearsal training program, and (c) an internet-based survey evaluating the usage of the behavioral technique six months after the intervention.

Findings: Of the 62 medical and surgical nurses at two affiliated rural hospitals eligible to participate, 20 completed the survey and 15 joined the training program. From the WB survey, 80% of the nurses had experienced WB. Nursing peers were identified as the major source of WB. Frequently reported bullying behaviors included ignored achievements and contributions, work life made difficult, and ignored.

Immediately following the cognitive rehearsal training program, nurses’ knowledge about WB significantly increased. Additionally, nurses were significantly more agreeable that they had observed bullying, had bullied others, and they felt adequately prepared to handle WB.

For the six-month follow-up, ten of the 15 medical and surgical nurses who participated in one two-hour cognitive rehearsal training program completed the follow-up survey. The results from the survey show that 50% of the nurses had witnessed bullying since attending the cognitive rehearsal training program. Some of the bullying behaviors witnessed by the nurses included backbiting, nonverbal innuendos, verbal affront, and undermining activities. Also, nursing peers were most frequently the target for workplace bullying. Additionally, the majority of nurses stated their ability to identify bullying improved and 70% of the participants changed their own behavior following the training program. Further, 70% of the registered nurses declared their ability to intervene in bullying improved; however, only 16.7% responded to bullying when it happened. In addition, 40% of the nurses felt their experiences with bullying over the last 6 months decreased. Lastly, when the nurses were asked for recommendations to reduce workplace bullying, education of staff regarding bullying was a common theme.

Conclusion: From this evidenced-based study, several nursing implications for practice were identified. First, the nursing staff should attend a cognitive rehearsal program that has been found to decrease WB. Second, staff nurses need to be aware of their personal behaviors which are considered bullying. Third, since many nurses were unable to speak up during the bullying situations after attending the program, other methods to manage WB need to be explored.

VIOLENCE IN THE EMERGENCY DEPARTMENT: IT IS NOT PART OF THE JOB

Taylor, Anne, RN, CEN, Emergency Department, LewisGale Hospital Montgomery, Blacksburg, VA, julie.mcelwee@hcahealthcare.com
Adam Berger, LewisGale Hospital Montgomery
Susan Huffman, LewisGale Hospital Montgomery

With the increase of violence in society, Emergency Departments are also experiencing an increase in violence. Emergency Department violence is defined as verbal and/or physical action with the intent to inflict injury to another. Nursing staff struggle to maintain safety for themselves, patients and visitors. This daily struggle has led to decreased staff satisfaction, morale and retention and an increase in absenteeism. On a personal level, there is an increase in anger, depression, professional distraction and apathy towards work. Personal physical injury of a staff member may lead to a loss of income, and in some cases, permanent disability.

This study reflects the HCA and Lewis Gale Hospital Montgomery commitment to maintaining a safe work environment. A quasi-experimental one-group only pre-test post-test design was employed to determine the effectiveness of a non-violent crisis intervention program on perceived staff competence and sense of safety. Using an Emergency Nurses Association questionnaire on workplace violence, Emergency Department nursing staff were surveyed to identify safety concerns present in their daily work setting. Staff then received 8 hours of training in Non Violent Crisis Intervention, including the importance of appropriately reporting incidences of violence. Findings will be presented that identify the effectiveness of this intervention to provide Emergency Department staff with the skills needed to defuse potentially violent situations and increase a sense of safety in the work setting.
Abstract Index

ALGHANIM, SAAD .......................................................... 20
AL-NATOUR, AHLAM .................................................. 9
ARMMER, FRANCESCA .............................................. 20
ARNETZ, JUDITH ....................................................... 9
AWADALLAH, KIEFAH ................................................ 20
BEERS, JEFFREY ......................................................... 21
BERRY, PEGGY .......................................................... 10, 22
BUDIN, WENDY .......................................................... 10
BURCHILL, CHRISTIAN .............................................. 10, 22
COOK, KATHY ............................................................ 23
COWAN, ARI .............................................................. 11
CURTIN, JOHN-ROBERT ............................................. 11
GALINSKY, TRACI ....................................................... 12
GATES, DONNA ........................................................ 23
GILLESPIE, GORDON ............................................... 24
GOODIN, JEANINE ..................................................... 24
GOPALKRISHNAN, PURNIMA ................................... 24
HARTLEY, DANIEL ................................................... 13
HILL, ADAM .............................................................. 13
JOHNSON, SUSAN ...................................................... 25
KICOS, GINA ............................................................. 26
KOSS, KATIE ............................................................. 26
LEIPER, JACOBA ........................................................ 26, 27
MAGLEY, VICKI .......................................................... 14
MELWAK, MARY ALICE ........................................... 27
MENTZEL, TAMMY .................................................... 28
NOCERA, MARYALICE ............................................... 14
PAPA, ANNMARIE ...................................................... 15
PURPORA, CHRISTINA .............................................. 15
RIDENOUR, MARILYN .............................................. 16
ROBINSON, LINDA ..................................................... 16
SCHULTZ, LYNN .......................................................... 28
SCRIBNER, SHELLIE ................................................... 29
SHAW, JULIE ............................................................. 17
SIMONS, SHELLIE ....................................................... 17
STAGG, SHARON ....................................................... 30
TAYLOR, ANNE .......................................................... 30
TAYLOR, MELISSA ...................................................... 18
WHITAKER, TRACY .................................................... 19
<table>
<thead>
<tr>
<th>Attendee Roster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahlam Al-Natour</td>
</tr>
<tr>
<td>University of Cincinnati</td>
</tr>
<tr>
<td>Cincinnati, OH</td>
</tr>
<tr>
<td><a href="mailto:alnatoas@mail.uc.edu">alnatoas@mail.uc.edu</a></td>
</tr>
<tr>
<td>Sheila Allen</td>
</tr>
<tr>
<td>PCA</td>
</tr>
<tr>
<td>CCHMC</td>
</tr>
<tr>
<td>Cincinnati, OH</td>
</tr>
<tr>
<td><a href="mailto:faithfulsheila@yahoo.com">faithfulsheila@yahoo.com</a></td>
</tr>
<tr>
<td>Judy Arnetz</td>
</tr>
<tr>
<td>Associate Professor</td>
</tr>
<tr>
<td>Wayne State University SOM</td>
</tr>
<tr>
<td>Detroit, MI</td>
</tr>
<tr>
<td><a href="mailto:jarnetz@med.wayne.edu">jarnetz@med.wayne.edu</a></td>
</tr>
<tr>
<td>Kiefah Awadallah</td>
</tr>
<tr>
<td>Department Nurse Educator</td>
</tr>
<tr>
<td>University Hospital Case Medical Center</td>
</tr>
<tr>
<td>Cleveland, OH</td>
</tr>
<tr>
<td><a href="mailto:kiefah.awadallah@uhhospitals.org">kiefah.awadallah@uhhospitals.org</a></td>
</tr>
<tr>
<td>Nancy Bailes</td>
</tr>
<tr>
<td>RN</td>
</tr>
<tr>
<td>Saint Agnes Medical Center</td>
</tr>
<tr>
<td>Clovis, CA</td>
</tr>
<tr>
<td><a href="mailto:nan4me@att.net">nan4me@att.net</a></td>
</tr>
<tr>
<td>Charlotte Ball</td>
</tr>
<tr>
<td>Assistant Professor</td>
</tr>
<tr>
<td>Bradley University</td>
</tr>
<tr>
<td>Peoria, IL</td>
</tr>
<tr>
<td><a href="mailto:jthies@bradley.edu">jthies@bradley.edu</a></td>
</tr>
<tr>
<td>David Bartos</td>
</tr>
<tr>
<td>Chief of Police</td>
</tr>
<tr>
<td>VA Medical Center</td>
</tr>
<tr>
<td>Cincinnati, OH</td>
</tr>
<tr>
<td><a href="mailto:david.bartos@va.gov">david.bartos@va.gov</a></td>
</tr>
<tr>
<td>Jeffrey Beers</td>
</tr>
<tr>
<td>Manager Clinical Risk Mtg</td>
</tr>
<tr>
<td>University Hospitals Case Medical Center</td>
</tr>
<tr>
<td>Cleveland, OH</td>
</tr>
<tr>
<td><a href="mailto:jeffrey.beers@UHhospitals.org">jeffrey.beers@UHhospitals.org</a></td>
</tr>
</tbody>
</table>
Attendee Roster

Traci Galinsky
Res Psychologist-SR SCI Office
NIOSH
Cincinnati, OH
zd7@cdc.gov

Dulcey Griffith
Registered Nurse
Children's Hospital
Amelia, OH
dulcey.griffith@cchmc.org

Mary Ann Hulme
Dir/Principle Advisor Accred
UH Case Medical Center
Cleveland, OH
maryann.hulme@uhhospitals.org

Renee Garbark
Nurse Educator
Wright Patterson Medical Group
WPAFB, OH
renee.garbark@wpafb.af.mil

Paula Grubb
Research Psychologist
National Institute for Occupational
Safety and Health
Cincinnati, OH
pla4@cdc.gov

Traci Jackson
violence not accepted here
Grant Medical Center
Columbus, OH
tbrinkman2@yahoo.com

Donna Gates
Adjunct Professor
University of Cincinnati
Cincinnati, OH
donna.gates@uc.edu

Dan Hartley
Epidemiologist
NIOSH
Morgantown, WV
dsh3@cdc.gov

Steve Jex
Professor of Psychology
Bowling Green State University
Bowling Green, OH
sjex@bgsu.edu

Gordon Gillespie
Assistant Professor
University of Cincinnati
Cincinnati, OH
gordon.gillespie@uc.edu

Adam Hill
Clinical Director
Cincinnati Children's Hospital Medical
Center
Cincinnati, OH
adam.hill@cchmc.org

Susan Johnson
PhD candidate
University of Washington
Olympia, WA
sjj6@uw.edu

Greer Glazer
Dean
University of Cincinnati
Cincinnati, OH
greer.glazer@uc.edu

Mary Hill
SW - Suicide Prev Case Mngr
VA Medical Center
Cincinnati, OH
mary.hill4@va.gov

Gina Kicos
ED RN
Aultman Hospital
Canton, OH
gmkicos652010@yahoo.com

Jeanine Goodin
Associate Professor
UC College of Nursing
Cincinnati, OH
jeanine.goodin@uc.edu

Karen Howard
Nurse Director
Hasbro Children's Hospital
Brimfield, MA
khoward3@lifespan.org

Katie Koss
Nurse Manager
Monroe Carell Jr. Children's Hospital at
Vanderbilt
Nashville, TN
katie.koss@vanderbilt.edu

Purnima Gopalkrishnan
Graduate Student
Bowling Green State University
Bowling Green, OH
purnimg@bgsu.edu

Pamela Huff
Clinical Nurse Educator
Grant Medical Center
Columbus, OH
phuff@ohiohealth.com

Kobie Leiper
University of North Carolina at Chapel
Hill
Mebane, NC
leiper@email.unc.edu

Carol Green
RN CEN
Clement J. Zablocki VA Medical Center
Milwaukee, WI
carol.green2@va.gov

Sadie Hughes
Director NNU
VA Medical Center
Cincinnati, OH
sadie.hughesyoung@va.gov

Anna Leslie
Nurse Coordinator
St. Mary's Medical Center
Evansville, IN
aleslie@stmarys.org
Lori Locke
Administrative Director-Psych
University Hospitals Case Medical Center
Cleveland, OH
lori.locke@UHhospitals.org

Christine Luca
Instructor of Clinical
University of Cincinnati
Cincinnati, OH
lucace@ucmail.uc.edu

Kristine Luke
Registered Nurse
Saint Agnes Medical Center
Clovis, CA
klukern@gmail.com

Vicki Magley
Associate Professor
University of Connecticut
Storrs, CT
vicki.magley@uconn.edu

Alison McLeish
University of Cincinnati
Cincinnati, OH
mcleisan@ucmail.uc.edu

Tammy Mentzel
University of Cincinnati
Cincinnati, OH
Tammy.Mentzel@uc.edu

Pat Moore
Secretary/Treasurer - Safety
VA Medical Center
Cincinnati, OH
patricia.moore@va.gov

Eugenio Moura
Registered Nurse
Rhode Island Hospital
Cumberland, RI
epfm71@gmail.com

Joyce Muni
Lake Forest, IL
joyce.muni1860@gmail.com

Massa Nnadi
Nurse Educator
The James Cancer Hospital and Solove Research Institute
Columbus, OH
massa.nnadi@osumc.edu

Maryalice Nocera
Program Director
University of North Carolina
Chapel Hill, NC
mnocera@email.unc.edu

Andrea Padach
Nurse Manager
St. Elizabeth Health Center
Youngstown, OH
Andrea_Padach@hmis.org

AnnMarie Papa
Clinical Director
Hospital of the University of Pennsylvania
Glenside, PA
ampapa109@hotmail.com

Lisa Pixley
UVA Medical Center
Charlottesville, VA
angsxJ4@yahoo.com

Teresa Poliseno
violence not accepted here
Grant Medical Center
Columbus, OH
poliseno1@yahoo.com

Karen Porter
Coordinator
University of Louisville
Louisville, KY
karen.porter@louisville.edu

Christina Purpora
Assistant Professor
University of San Francisco
San Francisco, CA
cmpurpora@usfca.edu

Marilyn Ridenour
Nurse Epidemiologist
NIOSH
Morgantown, WV
dvn7@cdc.gov

Jasmine Robinson
Care Coordinator
VA Medical Center
Cincinnati, OH
jasmine.robinson@va.gov

Linda Robinson
Registered Nurse
St. Elizabeth Healthcare
Edgewood, KY
linda.robinson@stelizabeth.com

Brian Rogers
Registered Nurse
University of Kentucky HealthCare
Lexington, KY
bsroge2@uky.edu

Lynn Schultz
RN
Grant Medical Center
Columbus, OH
schultzlynn3@aol.com

Shellie Scribner
Clinical Educator
Grant Medical Center
Columbus, OH
sscribne@ohiohealth.com

Julie Shaw
Sr. Clinical Director
Cincinnati Children’s Hospital Medical Center
Liberty Township, OH
julie.shaw@cchmc.org
<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Title</th>
<th>Organization/Location</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shellie Simons</td>
<td>Assistant Professor</td>
<td>University of Massachusetts Lowell, Sharon, MA</td>
<td><a href="mailto:shellie_simons@uml.edu">shellie_simons@uml.edu</a></td>
</tr>
<tr>
<td>Carolyn Smith</td>
<td>CBOC Nurse Manager</td>
<td>Cincinnati Children's Hospital Medical Center, Cincinnati, OH</td>
<td><a href="mailto:carolyn.smith@cchmc.org">carolyn.smith@cchmc.org</a></td>
</tr>
<tr>
<td>Sharon Stagg</td>
<td>Director</td>
<td>Shore Health System, Cambridge, MD</td>
<td><a href="mailto:sstagg@shorehealth.org">sstagg@shorehealth.org</a></td>
</tr>
<tr>
<td>Cherie Swirles</td>
<td>RN</td>
<td>Adrian, MI</td>
<td><a href="mailto:cswirles@gmail.com">cswirles@gmail.com</a></td>
</tr>
<tr>
<td>Anne Taylor</td>
<td>RN</td>
<td>LewisGale Hospital Montgomery, Blacksburg, VA</td>
<td><a href="mailto:anne.taylor@hcahealthcare.com">anne.taylor@hcahealthcare.com</a></td>
</tr>
<tr>
<td>Harold Taylor</td>
<td>Employee Health Nurse</td>
<td>McCullough-Hyde Memorial Hospital, Oxford, OH</td>
<td><a href="mailto:jwynn@mhmh.org">jwynn@mhmh.org</a></td>
</tr>
<tr>
<td>Melissa Taylor</td>
<td>Clinical Staff RN</td>
<td>TriHealth, Cincinnati, OH</td>
<td><a href="mailto:mrsmith7@att.net">mrsmith7@att.net</a></td>
</tr>
<tr>
<td>Anne Tepe</td>
<td>RN</td>
<td>CCHMC, Cincinnati, OH</td>
<td><a href="mailto:anne.tepe@cchmc.org">anne.tepe@cchmc.org</a></td>
</tr>
<tr>
<td>Tracy Whitaker</td>
<td>Dir. Social Work Practice</td>
<td>National Association of Social Workers, Washington, DC</td>
<td><a href="mailto:twhitaker@naswdc.org">twhitaker@naswdc.org</a></td>
</tr>
<tr>
<td>Scott Wuest</td>
<td>CBOC Nurse Manager</td>
<td>VA Medical Center, Cincinnati, OH</td>
<td><a href="mailto:scott.wuest@va.gov">scott.wuest@va.gov</a></td>
</tr>
<tr>
<td>Jan Wynn</td>
<td>Employee Health Nurse</td>
<td>McCullough-Hyde Memorial Hospital, Oxford, OH</td>
<td><a href="mailto:jwynn@mhmh.org">jwynn@mhmh.org</a></td>
</tr>
<tr>
<td>David Yamada</td>
<td>Professor of Law &amp; Director</td>
<td>Suffolk University Law School, Boston, MA</td>
<td><a href="mailto:dyamada@suffolk.edu">dyamada@suffolk.edu</a></td>
</tr>
</tbody>
</table>
Thank You To Our 2012 Conference Sponsors

CDC-NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

EMERGENCY NURSES ASSOCIATION (ENA)

UNIVERSITY OF CINCINNATI COLLEGE OF NURSING

Funding for this conference was made possible (in part) by the cooperative agreement award number 1R13OH010135-01 from the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.