A Quality Improvement Project to Enhance Emergency Nurse Workplace Violence Reporting

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Contribution to Emergency Nursing Practice

- Emergency nurses are at high risk of workplace violence, and nurse underreporting is highly prevalent in emergency departments.
- A feasible electronic reporting instrument, accessible via quick response code, can enhance nurse workplace violence reporting in the emergency department.
- Improving the capture of emergency nurse reporting can help nurse leadership and administration better understand workplace violence in the emergency department and take action.

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Abstract

Introduction: Workplace violence is a pervasive, perpetual, and underreported problem in the emergency department. Nurses experience devastating physical and psychological consequences owing to workplace violence exposure. Understanding workplace violence is challenging due to nurse underreporting. Improvement in capturing workplace violence cases can help drive data-informed, sustainable solutions to workplace violence prevention. The purpose of this project was to better capture the full extent of workplace violence in the emergency department through enhanced nurse workplace violence reporting.

Methods: In collaboration with emergency nurses and management, the project team used a multi-interventional approach and designed a feasible electronic reporting instrument to capture workplace violence events in real time by reducing nurse reporting barriers. Participating nurses accessed the instrument by scanning a quick-response code with their mobile phones. This code was strategically located on wall flyers and individual name badge stickers. Data were collected using Qualtrics software and analyzed using SPSS Statistics, which summarized the descriptive statistics.

Results: Two months after implementation, the electronic reporting instrument recorded 94 quick response code scans and 59 workplace violence reports, resulting in a 1080% increase in ED workplace violence reporting compared with the 2 months prior to implementation. The 59 workplace violence reports comprised 78% registered nurses, 19% emergency medical technicians, and 3% other health care workers. Workplace violence events were most frequent from 12:01 PM to 6:00 PM in treatment rooms (37%), triage (29%), waiting room (19%), behavioral health section (15%), and hallway (12%).

Discussion: A multi-interventional approach, coupled with a feasible, readily available electronic reporting instrument, enhanced ED workplace violence reporting and facilitated a better capture of ED workplace violence. Although nurse underreporting is still likely occurring, an emergence of

workplace violence data trends can provide data-driven solutions in workplace violence prevention. Continued efforts to reduce the barriers that inhibit reporting are needed to foster a safe and supportive culture surrounding workplace violence reporting.

Key words: Workplace violence; Emergency department; Emergency nurse; Underreporting; Reporting; Quality improvement

Introduction

PROBLEM DESCRIPTION

Workplace violence (WPV) in health care is a pervasive, perpetual, and underreported problem across United States health care facilities.[1-4] WPV is defined as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior occurring in the workplace—including verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors.[5,6] Type II WPV is the most common in health care and is defined as violence perpetrated by patients, families, or visitors toward health care employees.[5,7]

In a 2022 survey analysis, more than 2 nurses are assaulted every hour in the United States, most occurring in emergency departments and psychiatric units.[2] WPV worsened during the coronavirus disease 2019 pandemic (2020-2023) with 44% of nurses reporting physical violence and 68% reporting verbal abuse from their patients, visitors, or family members.[4] A more recent survey showed that more than 80% of nurses experienced at least 1 type of WPV in 2023.[8]

WPV has destructive and compounding effects on the nurse's physical and psychological health. Evidence has shown that WPV increases nurse absenteeism, job dissatisfaction, and intent to leave the profession, while also increasing the risk of post-traumatic stress symptoms and burnout.[9,10] After experiencing WPV, nurses may exhibit fear and anxiety within the workplace, degrading nurses' quality of care toward patients.[11,12] If nurses are in constant fear for their safety and distracted by aggressive and abusive patients/visitors, they cannot provide the highest quality of care to their patients. Furthermore, the financial impact on nurses owing to absence from work, health care costs, and legal fees takes its toll.

WPV is further complicated by underreporting. Underreporting of WPV is a severe problem because organizations may never know the true totality of the problem. The phenomenon of underreporting of WPV is not exclusive to the United States[3,4] and occurs worldwide.[13] Studies show as little as 6.5%,[14] 12%,[3] and 30%[15] of nurses will formally report WPV events. Emergency nurses often underreport WPV due to a misguided perception that it is an inherent part of their job.[16] Other barriers that hinder WPV reporting include time constraints, unawareness of how to report, lack of knowledge of what violence to report, fear of retaliation from perpetrators, fear of reprisal from management, and lack of support.[13,16,17] Underreporting limits the health care system's ability to adequately address WPV and leads to the misallocation of time, money, and resources.

LOCAL PROBLEM

In an academic medical center, WPV data revealed that the emergency department experienced a 150% rise in reported violent events and a 36% increase in team member injuries compared with the previous year. Moreover, the *Total Assault on Nursing Personnel Rate* in the emergency department consistently tracked above the National Database of Nursing Quality Indicators benchmark. Despite an ED zero-tolerance violence policy and a WPV prevention program, this emergency department was averaging approximately 2 WPV reports per month. Upon further investigation, a needs assessment revealed WPV underreporting and identified several barriers preventing staff from reporting. Emergency nurses experienced verbal or physical violence daily. However, it went unreported. Nurses stated they did not report WPV because they felt "nothing will change" and the reporting process was timely and complicated.

Needs Assessment

To identify effective strategies and appropriately use resources for project planning, a needs assessment survey was created and sent to all ED staff before project planning. The assessment sought to explore WPV prevalence, underreporting, and the barriers preventing staff from reporting. The voluntary, anonymous survey was sent out to all ED staff (N = 167) and recorded 34 responses with 17 of 34 respondents (50%) being emergency nurses. A total of 33 of 34 respondents (97%) experienced both verbal and physical violence in the emergency department, with 29% reporting

injury. Of the 97% respondents who experienced violence, 38% of respondents (13 of 34) reported >10 violent events in the last 90 days and only 6 WPV reports were electronically filed in the official hospital reporting system during that time frame. When staff were asked about the biggest barrier preventing them from reporting, the top responses resulted "nothing will change" (24%), "event was not severe enough" (21%), "part of the job" (15%), "electronic reporting system is time-consuming/complicated" (9%), "lack of time" (6%), "don't know how" (3%), "lack of leadership support" (3%), and no response (19%), with many of the same barriers found in the literature.[16,18,19] Moreover, >50% of respondents disclosed they report WPV to the charge nurse when not formally reporting.

AVAILABLE KNOWLEDGE AND RATIONALE

Current evidence supports the use of a practice improvement project using a multi-interventional approach aimed at enhancing WPV reporting. WPV education and awareness are essential to address the WPV reporting knowledge gap.[18-22] Multi-interventional approaches show enhancement of nurse WPV reporting.[18,22-25] By identifying and addressing key nurse barriers to WPV reporting, WPV reporting can improve.[19,20,26] Evidence also shows that the use of alternative reporting methods, such as paper-based reporting,[19,24] an audit approach,[25] a "dropbox,"[27] and electronic devices/mobile applications[21,28] can improve WPV reporting.

Several governing bodies and professional organizations recommend enhancement of health care WPV reporting processes, even capturing "near misses."[6,20,29] The American Nurses Association strongly recommends an electronic database that allows employees the option to anonymously report WPV incidents.[20] The revised Joint Commission standards guide hospitals in developing effective WPV reporting systems, data collection/analysis, and postincident strategies.[6] By reviewing and analyzing workplace data, trends emerge that will lead to making data-driven, informed decisions. Investigating the frequency and severity of incidents can further determine what interventions and resources are effective.

PROJECT AIM

The purpose of this quality improvement (QI) project was to better capture the full extent of WPV in the emergency department through an enhanced WPV reporting.

Methods

DESIGN

Using a Plan-Do-Study-Act QI design based on the Model for Improvement,[30] a team was formed to plan the project interventions and develop a new electronic reporting instrument. A needs assessment (as previously mentioned) was administered before project planning was underway to better inform the team in organizing interventions. Data was collected in real time as WPV reports were filed. Throughout the project, the team enagaged in informal conversations with clinical staff to gather feedback before, during, and after implementation.

This QI project followed the Revised Standards for Quality Improvement Reporting Excellence.[31]

SETTING AND PARTICIPANTS

This project was conducted in a suburban emergency department with a patient census of approximately 70,000 patient visits per year. The emergency department is part of a Magnet-recognized, academic medical center located in the eastern United States. The 80-bed emergency department treats adult and child emergencies and encompasses a level 1 trauma center and an 8-bed section for behavioral and mental health emergencies. The potential participants included all emergency registered nurses (N = 112) working in the emergency department and were the focus of the project interventions.

INTERVENTIONS

Based on the findings in the needs assessment, the project team tailored specific project interventions to address the barriers to WPV reporting and uniquely created an alternative electronic-based reporting instrument.

Reporting Instrument

The new reporting instrument was developed using evidence-based literature.[3,19,20,28,32] The project team built the instrument in a sensitive data portal within Qualtrics (Qualtrics, Provo, UT), making it secure with no patient health information (PHI) contained. PHI was not included in the instrument owing to privacy and cyber security concerns because of personal use of mobile phones by participants. The instrument was only accessible by participants

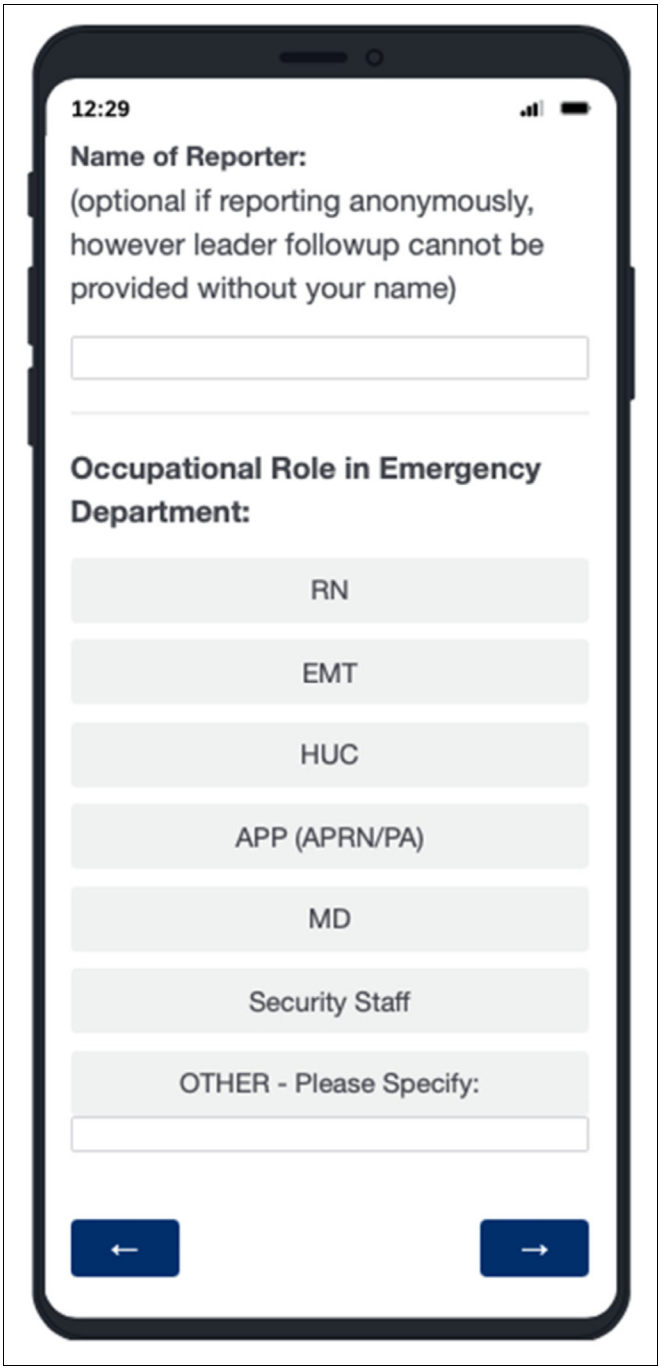


FIGURE 1

Reporting instrument items 1 and 2 displayed on mobile phone. RN, registered nurse; EMT, emergency medical technician; HUC, health unit coordinator; MD, doctor of medicine.

scanning a quick response (QR) code with a mobile phone, which then displayed the instrument items in Qualtrics. An example of instrument items 1 and 2 are shown in Figure 1. For a more detailed view of all instrument items in mobile phone view, see Supplementary Appendix. The instrument was created to address the nurse barriers to reporting such as anonymity, ease of access, and timeliness, which were identified in the literature and the needs assessment.[13,16,20,24] During a pilot test, the 11 items within the instrument (Table 1) were completed in 1 to 2 minutes, resulting in a short, fast, and feasible way to report WPV in real time. The new instrument was not intended to replace the current hospital's electronic reporting system, but rather to provide an alternative and simplified way to report events. Some but not all items resembled questions asked in the hospital's electronic WPV reporting system.

WPV Awareness Bundle

As a part of a multi-interventional approach, exclusive only to emergency nurses, a WPV awareness bundle was introduced 1 month after implementation of the WPV reporting instrument. Infographics were distributed to all emergency nursing staff via electronic mail with the support of emergency nurse leadership. The infographics included educational information on what constitutes WPV and the importance of WPV reporting, which addressed the WPV reporting knowledge gap.[18-21,24,26] Customized, promotional ink pens branded with the phrase "REPORT Workplace Violence" were also distributed among clinical nursing staff, aligned with a similar study.[24] WPV flyers were strategically posted around the emergency department in nurse high-traffic areas such as bathrooms, nursing stations, break room, and visual management board. The flyers served as a reminder to report and displayed the QR code to access the new reporting instrument. Nurse badge stickers ($1'' \times 1''$) (Figure 2), displaying the QR code, were created and disseminated to nursing staff, increasing the accessibility to report anytime and anywhere. The project team formed a strong partnership with the emergency charge nurses to champion the new reporting process. Charge nurses encouraged nursing staff to report all WPV at the change of shift huddles. The project team lead performed ED rounds once a week during implementation, talking with nursing staff about WPV and inquiring feedback about the new reporting instrument. After a WPV report was filed, the

TABLE 1
Reporting instrument items

Item	Answer choices
1. Name of Reporter: (optional if reporting anonymously, however leader follow-up cannot be provided without your name)	(free text box)
2. Occupational Role in Emergency Department: (Select one):	☐RN ☐EMT ☐HUC ☐APRN/PA ☐MD ☐Security ☐Other
3. Workplace Violence Type: (Select all that apply):	☐Physical Assault w/o Injury Physical Assault w/ Injury ☐Verbal Abuse/ Threats (i.e. shouting, offensive/profane/ vulgar language, verbal/written threats leading to fear for your safety) ☐Property Damage ☐Bullying, ☐Sexual Comments/ Gestures ☐Unwanted Sexual Physical Contact ☐Other
4. Did Physical Contact Occur w/ Perpetrator? (includes objects or bodily fluids thrown at you)	☐Yes | ☐No
5. Did Physical Injury Occur from Event? (ie, scratch, bruise, abrasion, sprain, strain, etc.)	☐Yes | ☐No
6. Perpetrator Relationship to You (the reporter):	☐Patient ☐Visitor/Patient's Family Co-worker ☐Contractor/ Vendor ☐Supervisor/Adm. ☐Student ☐Other
7. Location of Event (Select all):	☐Waiting Room ☐Triage ☐Rapid Medical Evaluation ☐Behavioral Health/Psych. ☐Trauma ☐Treatment Room ☐Hallway ☐Other
8. Date/Time the Event Occurred:	Date (mm/dd/yyyy): | Time: (24-hr time):
9. Resources/Interventions Used During Event (Select all):	☐Security Called ☐Physical Restraints ☐Pharm./Medication Restraints ☐De-escalation Techniques ☐Physician Team Paged/Called ☐Other
10. Were Any Weapon/ Object(s) Used By The Perpetrator During Event?	☐N/A ☐Gun ☐Knife ☐Bodily Fluids ☐Furniture ☐Medical Equipment ☐Other
11. Brief Description of The Event and How It Was Handled: [Please do NOT include patient health information (PHI)]	(free text box)

emergency nurse manager responded with follow-up and resources. Follow-up occurred only if the reporter annotated their name on the filed report owing to the option of anonymity.

DATA COLLECTION AND ANALYSIS

WPV data using the reporting instrument were collected for 2 months in Qualtrics software (Qualtrics, Provo, UT). The project lead transferred pertinent WPV data from Qualtrics into the hospital's electronic reporting system for organizational tracking. The data transfer process took 15 to 30 minutes on days reports were filed within the instrument. The process measures included total QR code scans from ED staff and the location/times of WPV events. The outcome measure was the total number of ED WPV events reported using the new instrument.

Data analysis was performed using IBM SPSS Statistics (Version 29.0) (IBM Corp, Armonk, NY). Descriptive statistics were summarized in frequencies and percentages.

ETHICAL CONSIDERATION

The institutional review board determined the project to be nonhuman subjects research, exempt from oversight. No PHI or identifiers were collected. Employee data were removed when analyzed. Participation in this project to report WPV was completely voluntary.



FIGURE 2
Nurse badge sticker. RN, registered nurse.

Results

Two months after implementation, the reporting instrument accumulated 94 QR code scans, 35 incomplete reports, and 59 complete reports. The 59 WPV reports (N = 59) comprised 78% registered nurses, 19% emergency medical technicians, and 3% other health care workers (HCWs) (Table 2). Verbal abuse/threats (83%) were found to be the highest type of violence in the instrument, followed by physical violence (11%), physical violence with injury (1%), and sexual assault/harassment (1%). Patients were found to be the main perpetrator of violence. WPV events were most frequent from the hours of 12:01 PM to 6:00 PM, located in treatment rooms (37%), triage (29%), waiting room (19%), behavioral health section (15%), hallway (12%), and trauma (0.2%). The most commonly used interventions were de-escalation techniques (66%) and security team (56%) (Table 2).

The percent increase in WPV reporting using the new reporting instrument (N = 59) was notable, resulting in an overall 1080% increase in ED WPV reporting compared with the 2 months before implementation. The historical trends of ED total WPV counts, including data from both the new reporting instrument and the hospital's electronic reporting system, are presented in Figure 3. Forty-seven percent of WPV reports were filed using the option of anonymity and 53% provided their name. Five reports (1%) were filed outside the hospital's geographic location. After removing extreme outliers (8 of the 59 WPV reports), the

TABLE 2
Reporting instrument variable frequencies

Characteristic	n	%
QR code scans	94	
Incomplete reports	35	
Complete reports	59	
Occupational role		
Registered nurse	46	78
EMT	11	19
Other (HUC, security)	2	3
Types of violence*		
Verbal abuse/threats	49	83
Physical violence	6	10
Physical violence with injury	3	1
Sexual assault/harassment	3	1
Perpetrator of violence		
Patient	52	88
Patient's family/visitor	7	12
Location of event*		
Treatment room	22	37
Triage	17	29
Waiting room	11	19
Behavioral health section	9	15
Hallway	7	12
Trauma	1	0.2
Time of day		
1:00 AM-6:00 AM	14	24
6:01 AM-12:00 PM	9	15
12:01 PM-6:00 PM	27	46
6:01 PM -12:00 AM	9	15
Interventions/resources used*		
De-escalation techniques	39	66
Security called	33	56
Provider team called	18	31
Pharmacological restraints	9	15
Physical restraints	3	5

EMT, emergency medical technician; HUC, health unit coordinator; QR, quick response.
Sample size N = 59.
* Multiple responses allowed for variable.

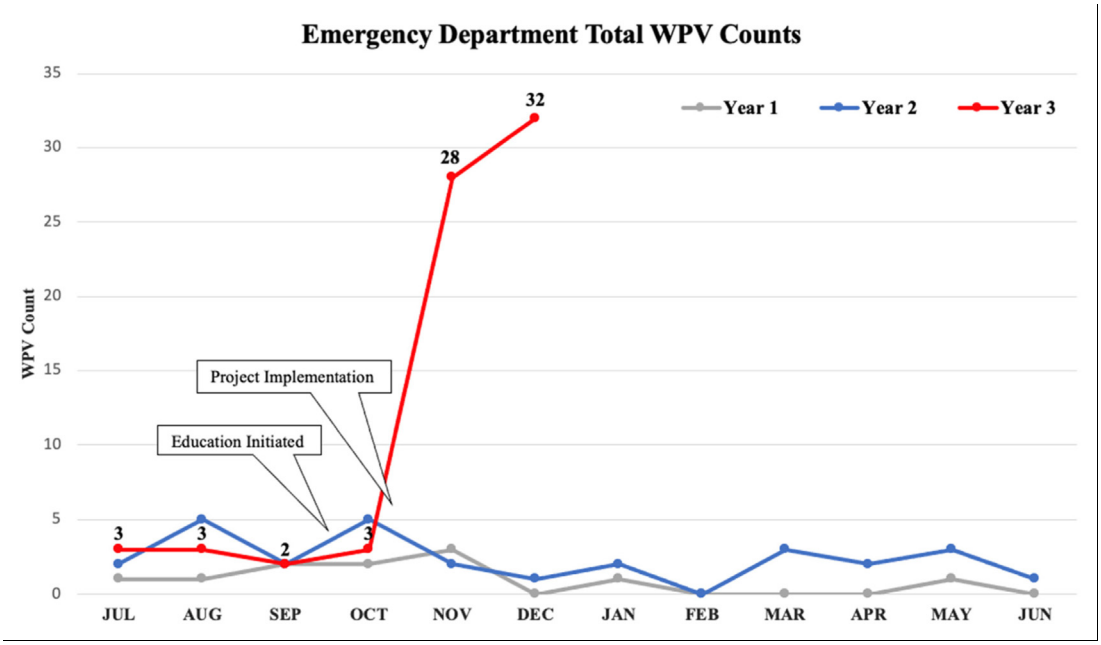


FIGURE 3
ED total WPV counts. WPV, workplace violence.

median time of instrument completion was 5 minutes and 20 seconds. There was overwhelming positive support from emergency nurses and ED leadership in support of the reporting instrument. Nurses expressed "feeling heard" by nursing leadership.

Discussion

WPV adversely affects ED staff and clinicians. The QI project focused solely on increasing WPV reporting among emergency nurses. Most of the WPV reports (78%) were completed by emergency nurses. However, 22% of reports were filed by HCWs, including emergency medical technicians, health unit coordinators, and a hospital security officer, who felt empowered to use the reporting instrument despite not directly receiving the awareness bundle education. This underscores the importance of providing all ED HCWs with a feasible WPV reporting process.

REPORTING INSTRUMENT

The data retrieved from the instrument align with previously published findings regarding WPV reporting. The instrument found verbal abuse (83%) to be the highest type of violence, followed by physical violence (11%), consistent with recent literature[4,33] WPV events were most frequent in the afternoon (12:01 PM-6:00 PM), located in treatment rooms (37%), triage (29%), and the waiting room (19%). Notably, the triage area is colocated with the waiting room in this specific emergency department. Combining triage and the waiting room percentages (48%), which becomes the highest location of ED WPV, aligns it with a previous study.[34] Accurately knowing the location and times of ED WPV allows leaders to make data-informed solutions to mitigate future WPV events.

Despite timeliness mentioned as a barrier to nurse reporting,[13,16] participants' average reporting time for instrument completion was 5 minutes and 20 seconds after removing 8 outliers. Some reports were filled out in their entirety but never submitted. In these situations, the instrument timer continued to run, resulting in the removal of outliers. The project team anticipated the time to be approximately 2 minutes in the early project planning and testing stage. The last question of the reporting instrument, which asked for a "brief description of the event and how it was handled" (Table 1), was thought to have consumed most reporters' time.

Undoubtedly, including anonymity within the reporting instrument improved WPV reporting. With 47% of reports being anonymous, 53% of ED staff wanted

acknowledgment and follow-up by leadership in leaving their name. There is an opportunity to explore further what drives the need to report anonymously. Fear of reprisal or reprimand from employers is a barrier that prevents nurses from reporting WPV,[8,13,35] which could be a potential culprit for staff preferring anonymity.

NURSE UNDERREPORTING

Nurse underreporting complicates estimating the true prevalence of WPV in the emergency department, which makes it a crucial barrier to WPV prevention.[3,4,13] Emergency nurses often operate in high-stress, fast-paced environments with numerous interruptions, which may have resulted in 35 incomplete reports. We excluded the 35 incomplete reports from the data analysis. However, it is essential to highlight the gap between the number of QR code scans (94) and incomplete reports (35) compared with complete reports (59). Despite improvements in accessibility and timeliness of reporting, it seemed that WPV events were still underreported. In addition, informal staff feedback during clinical walkthroughs revealed that WPV nurse underreporting was still occurring in the emergency department.

There may be other approaches available to explore WPV prevalence, which can highlight nurse underreporting in the emergency department. One approach may be analyzing ED security team response calls. This approach could elucidate a more accurate picture of WPV despite an environment of perpetual nurse underreporting. Another approach may be to analyze ED violence risk assessment tools, such as the Brøset Violence Checklist. Quinn and Koopman[36] found this to be an ideal opportunity to illuminate the prevalence of ED WPV in the midst of underreporting, enabling leaders to make informed staffing and safety decisions.

EMERGENCY CHARGE NURSE PARTNERSHIP

Partnering with emergency charge nurses and nursing management was integral to the success of this project. Charge nurses are the eyes and ears of the emergency department. The project's needs assessment pointed to more than 50% of ED staff reporting WPV to the charge nurse while not formally filing a report. Charge nurses are key stakeholders in any unit change process, especially WPV reporting. The proactive engagement of charge nurses in advocating for WPV reporting and the immediate responsiveness of the nurse manager upon receiving WPV reports were paramount. Successful WPV prevention programs, including WPV reporting and organizational follow-up, require effective leadership to promote inclusivity, support, and respect.[23,26,37] Concordant with our project experience, charge nurses and nursing management were critical in creating and providing that environment to support WPV reporting.

Limitations

The project was limited to a single emergency department in the eastern United States over a short duration. The reporting instrument developed by the project team was not a validated questionnaire. However, it mirrored some but not all questions in the hospital's electronic reporting system. In addition, underreporting may continue to occur despite the project's improvement efforts and the instrument's inability to remove all reporting barriers. Furthermore, anonymous reports can be considered a barrier owing to the absence of providing organizational follow-up and resources from an employee assistance program. Finally, excluding PHI in the reporting instrument made it challenging to add electronic health record behavioral flags, a devoted practice for situational awareness and promoting workplace safety in this emergency department.

Implications for Emergency Nurses

This project highlights the value of creating an accessible and timely process for reporting WPV, actively supported by nurse leadership. WPV reporting can provide valuable and actionable data, but reporting must occur to reveal those trends. Lack of data hinders the development of effective and sustainable solutions for preventing workplace violence.

Organizational leaders, including the chief nurse officer and nurse managers, must foster a safety culture that breeds acceptance and support in reporting WPV. Transparent and open communication demonstrates effective feedback and positive reporting outcomes, which mitigate a reporting barrier of "nothing will change." Moreover, nurse leaders also have an opportunity to explore ED walkthroughs, also known as Gemba walks, to foster dialogue among emergency nurses and address staff reasons for reporting anonymously. An ED visual management board may help track WPV data, showing support and creating further awareness toward WPV reporting.

Conclusion

A feasible electronic reporting instrument, alleviating key reporting barriers, enhanced WPV reporting in the emergency department. WPV reporting via QR code allowed nurses easier accessibility to report in real time, thus positively affecting nurse underreporting. A multi-interventional awareness bundle improved collaboration across emergency nursing staff, which brought attention to WPV events, team communication, and leadership follow-up. Emergency nursing management and charge nurses fostered a supportive environment encouraging WPV reporting.

This project emphasizes the ability of ED teams to increase WPV reporting. Accurate reporting allows for targeted solutions that may ultimately enhance nurse well-being. Directed action by organizational leaders can positively affect nurse wellness, thus potentially reducing nurse turnover and mitigating the emotional toll following WPV events. The pervasiveness of WPV events in the emergency department requires a concerted effort to be fully understood and become the never events nurses deserve.

Author Disclosures

Conflicts of interest: none to report.

The views expressed herein are those of the authors and do not reflect the official policy or position of the United States Army Medical Center of Excellence, United States Army Training and Doctrine Command, Department of the Army, Department of Defense, or United States government.

Supplementary Data

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