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# Preventing Violence, Harassment and Bullying Against Health Workers

Second Edition



## Disclaimer

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## Conflict of Interest

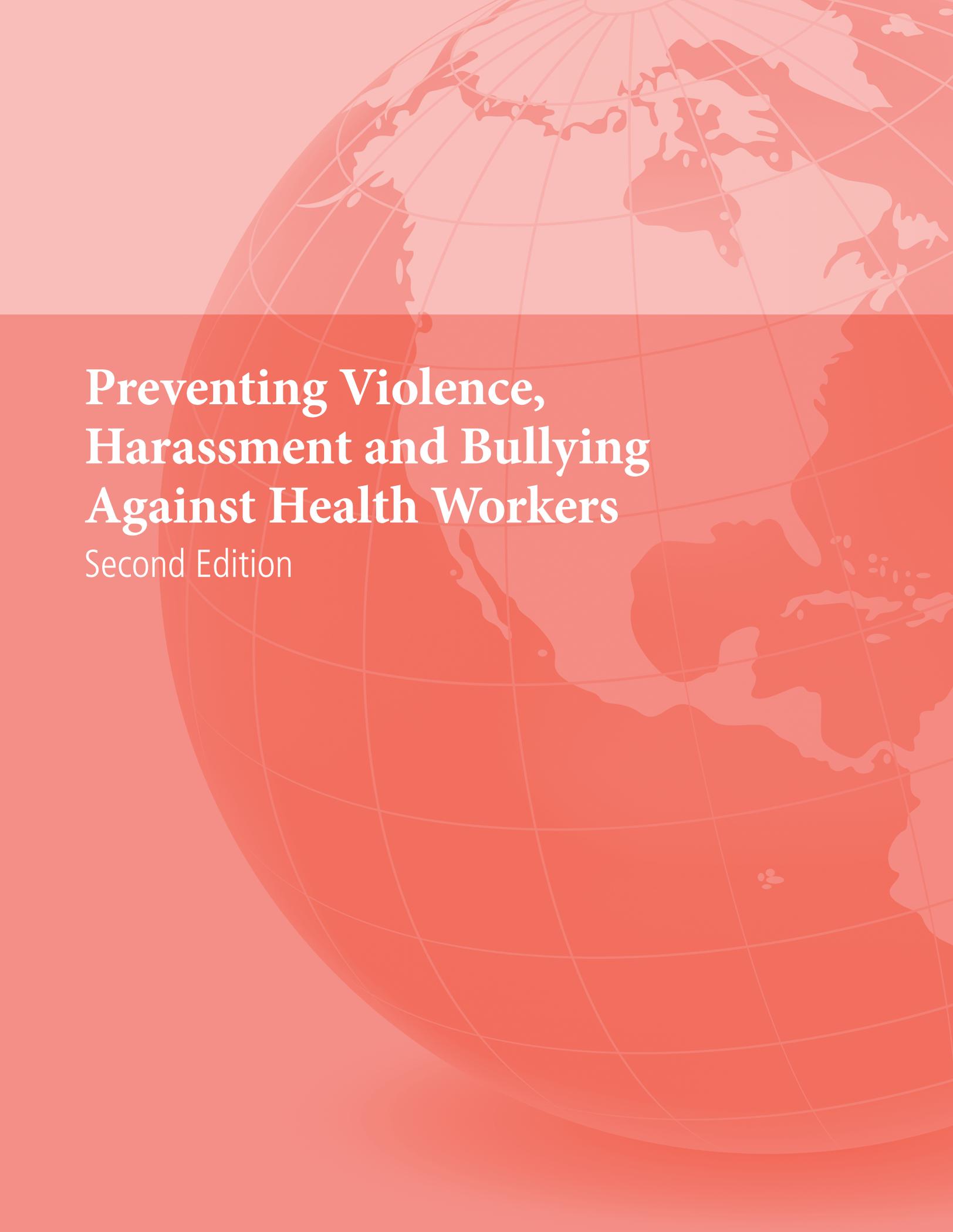
In the context of RNAO best practice guideline development, the term 'conflict of interest' (COI) refers to situations in which an expert panel member's financial, professional, intellectual, personal, organizational or other relationships may compromise their ability to independently conduct panel work. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the RNAO expert panel prior to their participation in guideline development work using a standard form (<https://rnao.ca/bpg/guidelines/workplaceviolence>). Expert panel members also updated their COI at the beginning of each guideline meeting. Any COI declared by an expert panel member was reviewed by the RNAO Best Practice Guideline Development and Research Team and expert panel co-chairs. No limiting conflicts were identified. See "Declarations of Conflicts of Interest Summary" at <https://rnao.ca/bpg/guidelines/workplaceviolence>.

## Contact Information

**Registered Nurses' Association of Ontario**

158 Pearl Street, Toronto, Ontario M5H 1L3

Website: [www.RNAO.ca/bpg](http://www.RNAO.ca/bpg)



# **Preventing Violence, Harassment and Bullying Against Health Workers**

Second Edition

## Greetings from Doris Grinspun, Chief Executive Officer, Registered Nurses' Association of Ontario



The Registered Nurses' Association of Ontario (RNAO) is delighted to present the second edition of the healthy work environment best practice guideline (BPG) *Preventing Violence, Harassment and Bullying Against Health Workers*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day.

We offer our heartfelt thanks to the many stakeholders who make our vision for BPGs a reality. First, and most important, we thank the Government of Ontario that recognized early on RNAO's capacity to lead a program that has gained worldwide recognition and is committed to fund it. We also thank the co-chairs of the RNAO expert panel, Henrietta Van Hulle (Vice President, Client Outreach at the Public Services Health & Safety Association) and Dr. Gordon Gillespie (Professor and Deputy Director of the Graduate Occupational Health Nursing Program at the University of Cincinnati), for their invaluable expertise and stewardship of this BPG. Thank you to RNAO staff Giulia Zucal (Guideline Development Methodologist Co-Lead), Laura Ferreira-Legere (Former Guideline Development Methodologist Co-Lead), Erica D'Souza (Project Coordinator), Megan Bamford (Associate Director, Guideline Development and Evaluation), and the rest of the RNAO Best Practice Guideline Development and Research Team for their intense and expert work in the production of this BPG. Special thanks to the expert panel for generously providing their time, knowledge and perspectives to deliver a rigorous and robust evidence-based resource that will guide the education and practice of millions of health workers. We couldn't have done it without you!

Successful uptake of BPGs requires a concerted effort from educators, clinicians, employers, policy-makers, researchers, and funders. The nursing and health communities, with their unwavering commitment and passion for excellence in patient care, provide the expertise and countless hours of volunteer work essential to the development of new and next edition BPGs. Employers have responded enthusiastically by becoming Best Practice Spotlight Organizations (BPSO<sup>®</sup>), sponsoring best practice champions, implementing BPGs and evaluating their impact on patient and organizational outcomes. Governments at home and abroad have joined in this awesome journey. Together, we are building a culture of evidence-based practice that benefits all.

We invite you to share this BPG with your colleagues from nursing and other professions, with the patient advisors who are partnering within organizations, and with the government agencies with which you work. We have much to learn from one another. Together, we must ensure safe and healthy workplaces for nurses and all other health workers so that the public receives the best possible care every time they come in contact with us – making them the real winners of this great effort!

A handwritten signature in black ink that reads "Doris Grinspun". The signature is fluid and includes a long horizontal flourish at the end.

Doris Grinspun, RN, MSN, PhD, LLD (hon), Dr (hc), FAAN, O. ONT.  
Chief Executive Officer  
Registered Nurses' Association of Ontario

# Table of Contents

How to Use this Document . . . . .	5	BACKGROUND
Purpose and Scope . . . . .	6	
Interpretation of Evidence and Recommendation Statements . . . . .	11	
Summary of Recommendations . . . . .	14	
Best Practice Guideline Evaluation . . . . .	18	
RNAO Best Practice Guideline Development and Research Team . . . . .	23	
RNAO Best Practice Guideline Expert Panel . . . . .	24	
Stakeholder Acknowledgment . . . . .	26	
Organizing Framework for the System and Healthy Work Environments Best Practice Guidelines Project . . . . .	29	
Background Context . . . . .	33	
Recommendations . . . . .	36	RECOMMENDATIONS
Research Gaps and Future Implications . . . . .	85	
Implementation Strategies . . . . .	87	
References . . . . .	89	REFERENCES

# Table of Contents

APPENDICES	Appendix A: Glossary of Terms . . . . .	98
	Appendix B: RNAO Best Practice Guidelines and Resources that Align with this Best Practice Guideline . . . . .	105
	Appendix C: Best Practice Guideline Development Methods . . . . .	107
	Appendix D: Process for Best Practice Guideline and Systematic Review . . . . .	119
	Appendix E: Indicator Development Process . . . . .	123
	Appendix F: Risk Factors . . . . .	125
	Appendix G: STAMPEDAR Framework . . . . .	127
	Appendix H: Validated Risk Assessment Tools . . . . .	129
	Appendix I: Approaches to Education Delivery . . . . .	136
	Appendix J: Safewards Model . . . . .	140
	Appendix K: Communication Responses Lanyard Card . . . . .	143
	Appendix L: Workplace Health and Safety Survey Vulnerability Scale . . . . .	144
	Appendix M: Resources . . . . .	147
	Appendix N: Description of the Toolkit . . . . .	151
ENDORSEMENTS	Endorsements . . . . .	152
NOTES	Notes . . . . .	155

## How to Use this Document

This healthy work environment **best practice guideline** (BPG)<sup>G\*</sup> is a comprehensive document designed to support **health service organizations**<sup>G</sup> and academic institutions in creating and sustaining positive work environments. It provides resources for **evidence-based nursing practice**<sup>G</sup>. It is not intended to be a manual or “how-to” guide; rather, it is a tool to guide best practices and enhance decision-making for **nurses**<sup>G</sup> and other **health workers**<sup>G</sup>, as well as students who may experience, encounter or have knowledge of workplace **violence**<sup>G</sup>, **harassment**<sup>G</sup> and **bullying**<sup>G</sup> from **formal leaders**<sup>G</sup>, colleagues, visitors, persons or their **family**<sup>G</sup> receiving care. This BPG should be reviewed and applied in accordance with the needs of individual organizations, academic institutions or other practice settings. We recommend contextualizing its implementation with the needs and preferences of health workers and the persons and families accessing your organization and your health system. In addition, this BPG offers an overview of appropriate structures and supports for providing the best possible evidence-based care.

Nurses and other health workers, administrators and educators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, educational programs and tools to support safe and healthy workplaces and academic environments. Those in direct care will benefit from reviewing the **recommendations**<sup>G</sup> and the evidence that supports them. We particularly recommend that practice and academic settings adapt this BPG in formats that are feasible for daily use.

If your organization is adopting this BPG, we recommend that you follow these steps:

1. Read the Organizing Framework for the System and Healthy Work Environments Best Practice Guidelines Project section and familiarize yourself with the conceptual model for healthy work environments.
2. Assess your existing policies, procedures, protocols and **education**<sup>G</sup> programs in relation to the recommendations in this BPG.
3. Identify existing needs or gaps in your policies, procedures, protocols and educational programs.
4. Note the recommendations that are applicable to your setting and that can be used to address your organization’s existing needs or gaps.
5. Develop a plan for implementing or integrating recommendations, sustaining best practices and evaluating **outcomes**<sup>G</sup>.

Implementation resources, including the Registered Nurses’ Association of Ontario (RNAO) *Toolkit: Implementation of Best Practice Guidelines, Second Edition* (1), are available at [www.RNAO.ca](http://www.RNAO.ca). For more information, please see **Implementation Strategies** on p. 87.

All of the RNAO BPGs are available for download, free of charge, on the RNAO website at [www.RNAO.ca/bpg](http://www.RNAO.ca/bpg). To locate a particular BPG, search by keyword or browse by topic.

We are interested in hearing your feedback on this BPG and how you have implemented it. Please share your story with us at [www.RNAO.ca/contact](http://www.RNAO.ca/contact).

\* Throughout this document, terms that are marked with a superscript G (<sup>G</sup>) can be found in the **Glossary of Terms** (**Appendix A**).

# Purpose and Scope

## Purpose

RNAO BPGs are systematically developed, evidence-based documents that include recommendations on specific clinical, healthy work environment and health system topics, intended for nurses and other health workers in direct care positions, students, educators, administrators and executives, policy-makers, researchers and persons and families with lived experience. BPGs promote consistency and excellence in clinical care, administrative practices, policies and education, with the aim of achieving optimal health outcomes for people, communities and the health system as a whole.

This BPG replaces the RNAO BPGs *Preventing and Managing Violence in the Workplace* (2009) and *Workplace Health, Safety and Well-being of the Nurse* (2008) (2, 3). It is to be used to enhance the safety of health service organizations and academic institutions through the adoption of evidence-based practices. Safe and healthy work environments are an enabler for nurses and other health workers to optimize clinical outcomes for those receiving care. Such environments also optimize teaching and learning in academic settings.

For the development of this BPG, RNAO convened an expert panel consisting of a group of individuals with expertise and lived experience in workplace violence, harassment and bullying. The RNAO expert panel was interprofessional. It was comprised of individuals holding clinical, administrative, academic, security and student roles across a range of health service organizations, academic institutions, practice areas and sectors ranging from acute care, pediatrics, long-term care, home health care, mental health, primary care and family health teams. Workplace violence, harassment and bullying are prevalent in all sectors; consequently, the diversity of the expert panel is essential to address all areas where health workers and students can be at risk of encountering violence.

A systematic and comprehensive analysis was completed by the RNAO Best Practice Guideline Development and Research Team and the RNAO expert panel to determine the scope and priority recommendation questions for this BPG (see [Appendix C](#)).

## Scope

To determine the scope and organization of this BPG, the RNAO Best Practice Guideline Development and Research team took the following steps:

- reviewed the RNAO BPGs *Preventing and Managing Violence in the Workplace* (3) and *Workplace Health, Safety and Well-being of the Nurse* (2);
- conducted two **scoping reviews**<sup>G</sup> of the literature to determine existing research on bullying among health workers in organizations; and
- consulted with the expert panel co-chairs and the entire expert panel in May 2017.

These steps informed the scope of this BPG. This BPG is applicable to all health service organizations and academic institutions, and it can be utilized by all health workers and students who may experience, encounter or have knowledge of workplace violence, harassment and bullying from formal leaders (such as management and faculty), colleagues, visitors, persons and their families.

Specifically, the BPG will address how to recognize, prevent, and manage violence, harassment and bullying in the workplace. It will focus on the following areas:

- risk assessment tools and strategies;
- organizational policies, procedures, requirements and responsibilities;
- educational approaches and strategies;
- implementation strategies and tools for organizations;
- evaluation criteria; and
- future research opportunities and gaps in knowledge.

## Key Concepts Used in this Best Practice Guideline

**Bullying:** Repeated and persistent behaviours that can include social isolation, creating or spreading rumours, engaging in excessive or unjustified criticism, intimidating a person, physically abusing or threatening abuse, and withholding job responsibilities (4). In a health service organization or academic institution, bullying can occur: (a) towards health workers from persons; (b) between colleagues; (c) between students and health workers; and (d) between formal leaders and health workers.

**Education:** Obtaining theoretical knowledge and cultivating the ability to use critical thinking and decision-making skills. Education includes three continuous and fluid levels: awareness, training for specific needs and competency-based skills, and specialization (5). Education should be tailored to the scope of practice of the health worker and their role within the organization.

**Formal leader:** Refers to a person in a formal leadership position, including managers, supervisors, clinical educators, faculty and administrators.

**Harassment:** Comments or behaviours that are unwelcome and persistent, including sexual harassment (6). Remarks, jokes or innuendos that demean, ridicule, intimidate or offend a health worker or student are considered examples of workplace harassment. In a health service organization or academic institution, harassment can occur: (a) towards health workers from persons; (b) between colleagues; (c) between students and health workers; and (d) between formal leaders and health workers.

**Health worker:** Defined as “all people engaged in actions whose primary intent is to enhance health” (7). This includes regulated health professionals (e.g., registered nurses, registered practical nurses, physicians, social workers and physiotherapists), unregulated health workers (e.g., personal support workers, physician assistants and outreach workers) and additional support staff (e.g., patient transportation workers, dietary staff and volunteers) who come into contact with persons receiving care and their families. Students enrolled in a health worker program are included in this definition when they enter a clinical placement.

**Health service organization:** Any health setting or workplace where a health worker provides care to persons and/or families and practices within their scope (e.g., acute care, home health care, primary care, community care or long-term care). Violence, harassment and bullying can occur in any health service organization, and the applicability of the recommendations is not limited to acute care unless otherwise stated.

**Horizontal violence:** Violence, harassment or bullying directed at colleagues who are of equal level within an organization. Depending on the literature, horizontal violence can also be referred to as “lateral violence” (8). The most common example of horizontal violence is harassment, including verbal abuse, threats, intimidation, criticism, humiliation and exclusion (9).

**Person:** An individual with whom a health worker has established a therapeutic relationship for the purpose of partnering for health. Replaces the terms “patient,” “client” and “resident,” which are used across health service organizations (10). The term “person” will not only include an individual in the health system, but also their family (e.g., parents, caregivers, friends and substitute decision-makers) (11, 12). Exceptions to the use of this term occur when discussions in the literature (e.g., studies or reports) use alternative terms (e.g., patient, client or resident).

**Student:** An individual currently enrolled in any health worker education program who is receiving education or training in an academic institution and/or skills lab setting. The term is not used to describe students practicing during a clinical placement (see definition for “health worker”).

**Vertical violence:** Violence, harassment or bullying that occurs between colleagues who are at unequal levels within an organization (9).

**Violence:** The use, or attempted use, of physical force against a person that causes, or could cause, physical injury. Sexual aggression, verbal statements, non-verbal behaviours, or acts that are reasonably interpreted as a threat of physical force that can lead to physical harm are also considered violence (24). In health service organizations, the most prevalent type of workplace violence is from the person receiving care or their family (25). Examples of workplace violence include: verbal threats, threatening notes, shaking a fist in the worker’s face, hitting/trying to hit a worker or throwing an object at a worker (24). Exceptions to the use of this term throughout this BPG occur when discussions in the literature (e.g., studies or reports) use alternative terms (such as “aggression”).

It is important to note that violence from a person receiving care, their family or a visitor can be the result of behavioural and psychological symptoms of an illness (e.g., dementia or delirium) that are exhibited to express met or unmet needs. Labeling a person with a behavioural or psychological illness as “violent” can result in altered levels of care and stigmatization; for that reason, it is critical to understand the cause of violence in order to prevent and mitigate its occurrence.

## Topics Outside the Scope of this Best Practice Guideline

The following conditions and topics are not covered within the scope of this BPG:

- Workplace violence, bullying and/or harassment initiated by a health worker against a person receiving care.
- Violence, bullying and/or harassment outside of a health service organization or academic institution, or any such acts that do not pertain to health workers or students.
- Domestic and/or sexual violence perpetrated by a person not employed by the health service organization or academic institution who has a personal relationship to the health worker employed at the health service organization or academic institution (although some recommendations may be indirectly applicable to this issue).
- Terrorist events or mass incidents of violence that occur within a health setting.

## Recommendation Questions

Based on the scope defined above, the following priority recommendation questions and outcomes were developed by the RNAO expert panel. They informed the development of this BPG.

**Recommendation Question #1:** Should health workers be recommended to use risk assessment tools to detect behaviours indicative of workplace violence, harassment and/or bullying?

**Outcomes:** Reliability<sup>G</sup>, validity<sup>G</sup> and accessibility in practice (**surrogate outcomes**<sup>G</sup>: time and utility)

**Recommendation Question #2:** Should organizational policies and procedures to prevent and manage workplace violence, harassment and/or bullying among health workers be recommended to improve organizational and health worker outcomes?

**Outcomes:** Physical environment (surrogate outcomes: health worker injury, incident reporting, assault and threat towards health workers) and health worker well-being (surrogate outcomes: perceived **incivility**<sup>G</sup>, recognition of bullying, policy implementation)

**Recommendation Question #3:** Should education and training programs on preventing and managing workplace violence, harassment and/or bullying be recommended for health workers to improve outcomes for persons and health workers?

**Outcomes:** Patient injury, use of **restraints**<sup>G</sup>, perceived safety of health workers, attitudes and values of health workers, health worker injury, and staff health worker turnover

**Note:** These priority recommendation questions are condensed versions of the more comprehensive **PICO research questions**<sup>G</sup> (population, intervention, comparison, outcomes) developed by the RNAO expert panel to guide the **systematic reviews**<sup>G</sup> and development of this BPG. For the PICO research questions and the detailed process of how the RNAO expert panel determined these priority recommendation questions and outcomes, please see **Appendix C**.

## Recommendations

Recommendations are presented based on the recommendation question they answer.

The recommendations in this BPG provide guidance related to risk assessment, organizational policies and procedures, and education on approaches to prevent and manage workplace violence, harassment and bullying in practice and education.

## Registered Nurses' Association of Ontario Best Practice Guidelines and Resources that Align with this Best Practice Guideline

Other RNAO BPGs and evidence-based resources may support implementation of this BPG. See [Appendix B](#) for RNAO BPGs and other resources on the following related topics:

- cultural **sensitivity**<sup>G</sup>;
- implementation science, implementation frameworks and resources;
- interprofessional **health team**<sup>G</sup>;
- managing and mitigating conflict; and
- safe, effective staffing and workload practices.



# Interpretation of Evidence and Recommendation Statements

RNAO BPGs are developed using the **Grading of Recommendations Assessment, Development and Evaluation (GRADE)<sup>G</sup>** and **Confidence in the Evidence from Reviews of Qualitative Research (CERQual)<sup>G</sup>** methods. For more information about the guideline development process, including the use of GRADE and GRADE-CERQual methods, refer to **Appendix C**.

## Certainty of Evidence

The certainty of evidence (i.e., the level of confidence we have that an estimate of effect is true) for quantitative research is determined using GRADE methods (13). After synthesizing the evidence for each prioritized outcome, the certainty of evidence is assessed. The overall certainty of evidence is determined by considering the certainty of evidence across all prioritized outcomes per recommendation question. GRADE categorizes the overall certainty of evidence as *high*, *moderate*, *low* or *very low*. See **Table 1** for the definition of these categories.

**Table 1: Certainty of Evidence**

OVERALL CERTAINTY OF EVIDENCE	DEFINITION
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.
Very Low	We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect.

*Source:* Reprinted from The GRADE Working Group. Quality of evidence. In Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Table 5.1, Quality of evidence grades. Available from: <https://gdt.grade.org/app/handbook/handbook.html#h.svwngs6pm0f2>. Reprinted with permission.

## Confidence in Evidence

The confidence in evidence for **qualitative research<sup>G</sup>** (i.e., the extent to which the review finding is a reasonable representation of the phenomenon of interest) is determined using GRADE-CERQual methods (hereafter referred to as CERQual) (14). For qualitative evidence, an overall judgment of the confidence is made per finding in relation to each recommendation statement, as relevant. CERQual categorizes the confidence in evidence as *high*, *moderate*, *low* or *very low*. See **Table 2** for the definitions of these categories.

**Table 2: Confidence in Evidence**

CONFIDENCE IN EVIDENCE	DEFINITION
<b>High</b>	It is highly likely that the finding is a reasonable representation of the phenomenon of interest.
<b>Moderate</b>	It is likely that the finding is a reasonable representation of the phenomenon of interest.
<b>Low</b>	It is possible that the review finding is a reasonable representation of the phenomenon of interest.
<b>Very Low</b>	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Source: Reprinted from Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implement Sci.* 2018;13(Suppl 1):1-10. Table 3, Description of level of confidence in a review finding in the CERQual approach; p. 6. Reprinted with permission.

The assigned certainty and/or confidence of evidence can be found directly below each recommendation statement. For more information on the process of determining the certainty and/or confidence of the evidence – and the documented decisions made by RNAO guideline development methodologists – please see [Appendix C](#).

**Note:** To address workplace violence, harassment and bullying in health service organizations and academic institutions, multi-faceted initiatives are often implemented. Due to the complexity of these initiatives and the sensitive nature of the issue, it is difficult to conduct research studies that use control groups, adjust for confounding variables or blind participants to the outcomes. Therefore, the majority of research in this area is from **quasi-experimental**<sup>G</sup> or observational studies, as opposed to **randomized controlled trials**<sup>G</sup> (which by their nature eliminate contextual factors). For this reason, all of the recommendations have a certainty of evidence or confidence in the evidence that is either low or very low. Despite the generally low certainty of evidence, the expert panel determined that the benefits and health worker values and preferences for many of the interventions still clearly outweighed the potential harms noted in the research evidence or indicated from personal practice experience. As such, the strength of many of the recommendations is strong (see the explanation of strength of recommendations, also in [Appendix C](#)).

## Strength of Recommendations

Recommendations are formulated as *strong* or *conditional* by considering the certainty and/or confidence in evidence and the following key criteria (see [Discussion of Evidence](#), below, for definitions):

- balance of benefits and harms
- values and preferences
- potential impact on health equity.

## Strong Recommendation

A strong recommendation reflects the expert panel's confidence that "the desirable effects of an intervention outweigh its undesirable effects (strong recommendation for an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation against an intervention)" (13). A strong recommendation implies that the majority of persons will be best served by the recommended action (13).

## Conditional Recommendation

A conditional recommendation reflects the expert panel's confidence that while some uncertainty exists, the desirable effects probably outweigh the undesirable effects (i.e., a conditional recommendation *for* an intervention) or that the undesirable effects probably outweigh the desirable effects (i.e., a conditional recommendation *against* an intervention) (13). A conditional recommendation implies that not all persons will be best served by the recommended action: "there is a need for more careful consideration of personal circumstances, preferences and values" (13).

The strength of the recommendation statement is detailed directly below each recommendation statement and in the **Summary of Recommendations** table. For more information on the process used by the expert panel to determine the strength of each recommendation, please see **Appendix C**.

## Discussion of Evidence

The Discussion of Evidence that follows each recommendation includes the following main sections:

1. **Benefits and Harms:** identifies the potential desirable and undesirable outcomes reported in the literature when the recommended practice is used. Content in this section includes research from the systematic review.
2. **Values and Preferences:** denote the relative importance or worth placed on health outcomes from following a particular clinical action from a person-centered perspective. Content for this section may include research from the systematic reviews and, when applicable, observations and/or considerations from the RNAO expert panel.
3. **Health Equity:** identifies the potential impact that the recommended practice could have on health across different populations or settings and/or barriers to implementing the recommended practice in particular settings. This section may include research from the systematic reviews and, when applicable, observations and/or considerations from the RNAO expert panel.
4. **Expert Panel Justification of Recommendation:** provides a rationale for why the expert panel made the decision to rate a recommendation as strong or conditional.
5. **Practice Notes:** highlight pragmatic information for nurses and members of the interprofessional team. This section may include supporting evidence from the systematic review and/or other sources (e.g., other BPGs or the RNAO expert panel).
6. **Supporting Resources:** includes a list of relevant resources (e.g., websites, books and organizations) that support the recommendations. Content listed in this section was not part of the systematic review and was not quality appraised. As such, the list is not exhaustive, and the inclusion of a resource in one of these lists does not imply an endorsement from the RNAO.

# Summary of Recommendations

This BPG replaces the RNAO BPGs *Preventing and Managing Violence in the Workplace* (2009) (3) and *Workplace Health, Safety and Well-being of the Nurse* (2008) (2).

The following recommendations should be implemented as part of a multi-intervention, organizational strategy for prevention and management of workplace violence, harassment and bullying.

RECOMMENDATIONS		STRENGTH OF THE RECOMMENDATION
<p><b>Recommendation Question #1:</b></p> <p>Should health workers be recommended to use risk assessment tools to detect behaviours indicative of workplace violence, harassment and/or bullying?</p> <p><b>Outcomes:</b> Reliability, validity and accessibility in practice (surrogate outcomes: time and utility)</p>		
Recommendations addressing violent behaviour from persons	<p><b>Recommendation 1.1:</b></p> <p>The expert panel recommends that health service organizations establish an implementation plan for integrating a violence risk assessment tool for persons. This plan should include the following:</p> <ul style="list-style-type: none"> <li>■ selection of a risk assessment tool that is applicable to the clinical population and setting; and</li> <li>■ education and training on the chosen tool for all health workers who provide direct care.</li> </ul>	Strong
	<p><b>Recommendation 1.2:</b></p> <p>The expert panel recommends that health workers conduct a violence risk assessment on all persons using a validated tool.</p>	Strong
Recommendation addressing harassment and bullying from formal leaders, other health workers, or students	<p><b>Recommendation 1.3:</b></p> <p>The expert panel suggests that health service organizations and academic institutions support the use of validated risk assessment tools to measure and develop a quality improvement plan to address horizontal and/or vertical violence.</p>	Conditional

RECOMMENDATIONS	STRENGTH OF THE RECOMMENDATION	
<p><b>Recommendation Question #2:</b></p> <p>Should organizational policies and procedures to prevent and manage workplace violence, harassment and/or bullying among health workers be recommended to improve organizational and health worker outcomes?</p> <p><b>Outcomes:</b> Physical environment (surrogate outcomes: health worker injury, incident reporting, assault and threat towards health workers) and health worker well-being (surrogate outcomes: perceived incivility, recognition of bullying, policy implementation)</p>		
Recommendations addressing violent behaviour from persons	<p><b>Recommendation 2.1:</b></p> <p>The expert panel recommends that health service organizations provide education and training to health workers on addressing violent behaviours from persons (see <b>Recommendations 3.1 to 3.3</b> for specific education content).</p>	Strong
	<p><b>Recommendation 2.2:</b></p> <p>The expert panel recommends that health service organizations implement protective and security measures, such as the following:</p> <ul style="list-style-type: none"> <li>■ documentation and communication of a person’s previous incident(s) of violence;</li> <li>■ equipment to protect against violent behaviours, and a standardized approach for deciding what, when, and how to use these;</li> <li>■ environmental security measures, including locked doors, closed-circuit cameras and alarm systems; and</li> <li>■ formal reporting systems that are simple to use.</li> </ul>	Strong
	<p><b>Recommendation 2.3:</b></p> <p>The expert panel recommends that formal leaders within health service organizations support health workers in preventing and addressing workplace violence by doing the following:</p> <ul style="list-style-type: none"> <li>■ understanding and implementing policies against workplace violence; and</li> <li>■ reviewing and acting on reported workplace violence incidents.</li> </ul>	Strong
	<p><b>Recommendation 2.4:</b></p> <p>The expert panel recommends that health service organizations implement a process for formal incident reviews immediately following a violent event to discuss the details of what occurred, the approach that was used, and the strategies for violence prevention in the future.</p>	Strong

RECOMMENDATIONS		STRENGTH OF THE RECOMMENDATION
Recommendations addressing harassment and bullying from formal leaders, health workers or students	<p><b>Recommendation 2.5:</b></p> <p>The expert panel suggests that health service organizations and academic institutions provide education and training to health workers and students on addressing workplace harassment and bullying (see Recommendations 3.4 and 3.5 for specific education content).</p>	Conditional
	<p><b>Recommendation 2.6:</b></p> <p>The expert panel recommends that health service organizations and academic institutions implement appropriate policies and codes of conduct to address harassment and bullying in the workplace and learning environment.</p>	Strong
	<p><b>Recommendation 2.7:</b></p> <p>The expert panel recommends that formal leaders in health service organizations and academic institutions be actively involved in preventing and addressing harassment and bullying to support health workers and students by doing the following:</p> <ul style="list-style-type: none"> <li>■ understanding and reinforcing policies that address harassment and bullying; and</li> <li>■ providing mentorship and role modelling of professional behaviour.</li> </ul>	Strong

RECOMMENDATIONS		STRENGTH OF THE RECOMMENDATION
<p><b>Recommendation Question #3:</b></p> <p>Should education and training programs on preventing and managing workplace violence, harassment and/or bullying be recommended for health workers to improve outcomes for persons and health workers?</p> <p><b>Outcomes:</b> Patient injury, use of restraints, perceived safety of health workers, attitudes and values of health workers, health worker injury, and health worker turnover</p>		
Recommendations addressing violent behaviour from persons	<p><b>Recommendation 3.1:</b></p> <p>The expert panel recommends that health service organizations provide education to health workers on the risk factors and triggers for violent behaviours from persons.</p>	Strong
	<p><b>Recommendation 3.2:</b></p> <p>The expert panel recommends that health service organizations provide training to health workers on de-escalation techniques, including communication and re-direction strategies, to prevent and/or reduce violent incidents within their organizations.</p>	Strong
	<p><b>Recommendation 3.3:</b></p> <p>The expert panel recommends that health workers are provided training in breakaway techniques and when to safely use breakaway techniques in violent incidents.</p>	Strong
Recommendations addressing harassment and bullying from formal leaders, health workers or students	<p><b>Recommendation 3.4:</b></p> <p>The expert panel suggests that health service organizations provide education to health workers on how to identify harassment and bullying, understand the impact of harassment and bullying, and use effective communication strategies.</p>	Conditional
	<p><b>Recommendation 3.5:</b></p> <p>The expert panel recommends that, as part of an interactive learning approach, students learn to use guided communication responses to address harassment and bullying from multiple sources within an academic institution or clinical learning environment.</p>	Strong

## Best Practice Guideline Evaluation

As you implement the recommendations in this BPG, we ask you to consider how you will monitor and evaluate its implementation and impact.

The Donabedian model informs the development of indicators for evaluating quality health care, which includes three categories: structure, process, and outcome (15).

- Structure describes the required attributes of the health system, health service organization or academic institution to ensure quality care. It includes physical resources, human resources, and information and financial resources.
- Process examines the health activities being provided to, for, and with persons or populations as part of the provision of quality care.
- Outcome analyzes the effect of quality care on the health status of persons and populations, health workforce, health service organizations, academic institutions or health systems (15).

For additional information, please refer to the RNAO *Toolkit: Implementation of Best Practice Guidelines, Second Edition* (1).

**Tables 3, 4, and 5** provide potential structure, process and outcome measures to assess BPG success. It is important to evaluate evidence-based practice changes when implementing a BPG. Select the measures most relevant to the practice setting. There are few data repositories/indicator libraries available for violence, harassment and bullying in the workplace in Ontario and Canada. The following measures will support quality improvement and evaluation.

**Table 3** provides potential structure measures associated with all recommendation statements to assess attributes related to human resources.

**Table 3: Structure Measures for Overall BPG Success**

STRUCTURE MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
<p><b>HEALTH SERVICE ORGANIZATIONS:</b></p> <p>Percentage of health workers who received education and training on assessing and addressing violent behaviours from persons</p> <p><i>Numerator:</i> Number of health workers who received education and training on assessing and addressing violent behaviours from persons</p> <p><i>Denominator:</i> Total number of health workers</p> <p><b>ACADEMIC INSTITUTIONS:</b></p> <p>Percentage of students who received education and training on assessing and addressing violent behaviours from persons</p> <p><i>Numerator:</i> Number of students who received education and training on assessing and addressing violent behaviours from persons</p> <p><i>Denominator:</i> Total number of students</p>	New
<p>Percentage of health workers who provide direct care who received education and training on the selected violence risk assessment tool</p> <p><i>Numerator:</i> Number of health workers who provide direct care who received education and training on the selected violence risk assessment tool</p> <p><i>Denominator:</i> Total number of health workers who provide direct care</p>	New

**Table 4** supports evaluation of practice changes during implementation. The measures are directly associated with specific recommendation statements and support process improvement.

**Table 4: Process Measures for Overall BPG Success**

RECOMMENDATION	PROCESS MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
1.1 1.2	<p>Percentage of persons with a documented violence risk assessment using a validated tool</p> <p><i><b>Numerator:</b> Number of persons with a documented violence risk assessment using a validated tool</i></p> <p><i><b>Denominator:</b> Total number of persons</i></p>	New
2.4	<p>Percentage of documented incident reviews completed immediately following a violent event</p> <p><i><b>Numerator:</b> Number of documented incident reviews completed immediately following a violent event</i></p> <p><i><b>Denominator:</b> Total number of violent events</i></p>	New

**Table 5** provides potential outcome measures associated with all recommendation statements to assess overall BPG success.

**Table 5: Outcome Measures for Overall BPG Success**

OUTCOME MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
<p>Rate of workplace violence incidents (reported by health workers) per 100 full-time equivalents (FTE)</p> <p><i>Numerator: Number of workplace violence incidents (reported by health workers)</i></p> <p><i>Denominator: Total number of full-time equivalents</i></p>	<p><b>Partial Health Quality Ontario (HQO)</b></p>
<p>Percentage of workplace violence incidents (reported by health workers) resulting in time off work</p> <p><i>Numerator: Number of workplace violence incidents (reported by health workers) resulting in time off work</i></p> <p><i>Denominator: Total number of workplace violence incidents (reported by health workers)</i></p>	<p><b>Partial HQO</b></p>
<p>Percentage of workplace violence incidents (reported by health workers) resulting in a near miss<sup>1</sup></p> <p><i>Numerator: Number of workplace violence incidents (reported by health workers) resulting in a near miss</i></p> <p><i>Denominator: Total number of workplace violence incidents (reported by health workers)</i></p>	<p><b>Partial HQO</b></p>
<p>Percentage of workplace violence incidents (reported by health workers) resulting in physical injury</p> <p><i>Numerator: Number of workplace violence incidents (reported by health workers) resulting in physical injury</i></p> <p><i>Denominator: Total number of workplace violence incidents (reported by health workers)</i></p>	<p><b>Partial HQO</b></p>

<sup>1</sup> Near miss: An incident that occurred but did not result in physical and/or psychological injury or illness to the health worker

Other RNAO resources for the evaluation and monitoring of BPGs include the following:

- Nursing Quality Indicators for Reporting and Evaluation<sup>®</sup> (NQuIRE<sup>®</sup>), a unique nursing data system housed in the International Affairs and Best Practice Guideline Centre, allows BPSOs<sup>®</sup> to measure the impact of BPG implementation by BPSOs worldwide. The NQuIRE data system collects, compares and reports data on guideline-based, nursing-sensitive process and outcome indicators. NQuIRE indicator definitions are aligned with available administrative data and existing performance measures wherever possible, adhering to a “collect once, use many times” principle. By complementing other established and emerging performance measurement systems, NQuIRE strives to leverage reliable and valid measures, minimize reporting burden and align evaluation measures to enable comparative analyses. The international NQuIRE data system was launched in August 2012 to create and sustain evidence-based practice cultures, optimize patient safety, improve patient outcomes and engage staff in identifying relationships between practice and outcomes to advance quality and advocate for resources and policy that support best practice changes (16). Please visit [RNAO.ca/bpg/initiatives/nquire](http://RNAO.ca/bpg/initiatives/nquire) for more information.
- **BPG Order Sets**<sup>TM G</sup> embedded within electronic records provide a mechanism for electronic data capture of process measures. The ability to link structure and process indicators with specific client outcome indicators aids in determining the impact of BPG implementation on specific health outcomes. Please visit <http://RNAO.ca/ehealth/bpgordersets> for more information.

# Registered Nurses' Association of Ontario Best Practice Guideline Development and Research Team

**Giulia Zucal, RN, BScN, MA**

Guideline Development Methodologist (Lead, May 2018 – present)

Senior Manager, Guideline Development and Research  
International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

**Laura Ferreira-Legere, RN, MScN**

Guideline Development Methodologist (Lead, May 2017 – May 2018)

International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

**Megan R. Bamford, RN, MScN**

Associate Director, Guideline Development and  
Evaluation

International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

**Erica D'Souza, BSc, GC, DipHlthProm**

Guideline Development Project Coordinator

International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

**Althea Stewart-Pyne, RN, BN, MHSc**

Program Manager, Implementation Sciences

International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

**Oliwia Klej, BSc (Hons)**

Project Coordinator, Implementation Sciences

International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

**Danny Wang, RN, BScN**

Evaluation Analyst

International Affairs and Best Practice Guidelines Centre  
Registered Nurse' Association of Ontario  
Toronto, ON

**Dr. Shanoja Naik, PhD, MPhil, MSc, Bed, BSc**

Data Scientist/Statistician, Health Outcomes  
Research, NQuIRE

International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

**Doris Grinspun, RN, MSN, PhD, LLD (hon), Dr  
(hc), FAAN, O. ONT.**

Chief Executive Officer

Registered Nurses' Association of Ontario  
Toronto, ON

**Lucia Costantini, RN, PhD, CNeph(C)**

Former Associate Director, Guideline Development,  
Research and Evaluation

International Affairs and Best Practice Guidelines Centre  
Registered Nurses' Association of Ontario  
Toronto, ON

## Acknowledgments

Systematic search completed by:

### UHN HealthSearch

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## Registered Nurses' Association of Ontario Best Practice Guideline Expert Panel

**Gordon Gillespie, PhD, DNP, RN, CEN, CNE,  
CPEN, PHCNS-BC, FAEN, FAAN**

**Expert Panel Co-Chair**

Professor, Deputy Director, Graduate Occupational  
Health Nursing Program

University of Cincinnati College of Nursing  
Cincinnati, Ohio, USA

**Henrietta Van hulle, RN, BN, MHSM,  
COHN(C), CRSP, CDMP**

**Expert Panel Co-Chair**

Vice-President, Client Outreach

Public Services Health and Safety Association  
Toronto, ON

**Jamie Amaral, RN, BScN**

Inpatient Manager, WFSU & SOTU

Centre for Addiction and Mental Health  
Toronto, ON

**Irene Andress, RN, MSN**

Vice-President, Patient Experience, Health Professions  
and Chief Nursing Executive

Michael Garron Hospital  
Toronto, ON

**Andrew Aris**

Director, Security & Safety

Centre for Addiction and Mental Health  
Toronto, ON

**Nader Boutros, CHRL**

Manager, Labour and Employee Relations

Michael Garron Hospital  
Toronto, ON

**Kimberley Brophy, RN, MN**

Director of Quality, Safety and Patient Experience, Best  
Practice Spotlight Organization® Lead

Scarborough Health Network  
Scarborough, ON

**Laurie Brown, RN**

Vice President Health and Safety

Ontario Nurses Association  
Region 4

**Andréane Chenier, MSc, PhD**

National Representative, Health and Safety

Canadian Union of Public Employees  
Sudbury, ON

**Chris Clement, RN, BScN, MA**

Operations Director

Children's Hospital of Eastern Ontario  
Ottawa, ON

**Nicole A. Gibson, RN, BN, MN Student**

Alberta Health Services

McKesson Canada  
Lethbridge, AB

**Charis Kelly, RN(EC), MN, NP - Pediatrics**

Nurse Practitioner, Burns and Plastic Surgery

SickKids Hospital  
Toronto, ON

**Sarah Kipping, RN, MSN, CPMHN(C)**

Clinical Practice Leader, Professional Practice

Ontario Shores Centre for Mental Health Sciences  
Whitby, ON

**Metzie Lacroxi, RN, BHA, GNC(C)**

Director, Clinical Services  
Sienna Senior Living  
Markham, ON

**Burton Mohan, MD, MPH, BScN, BSc (hons),**

**Ethics Diploma, RN**

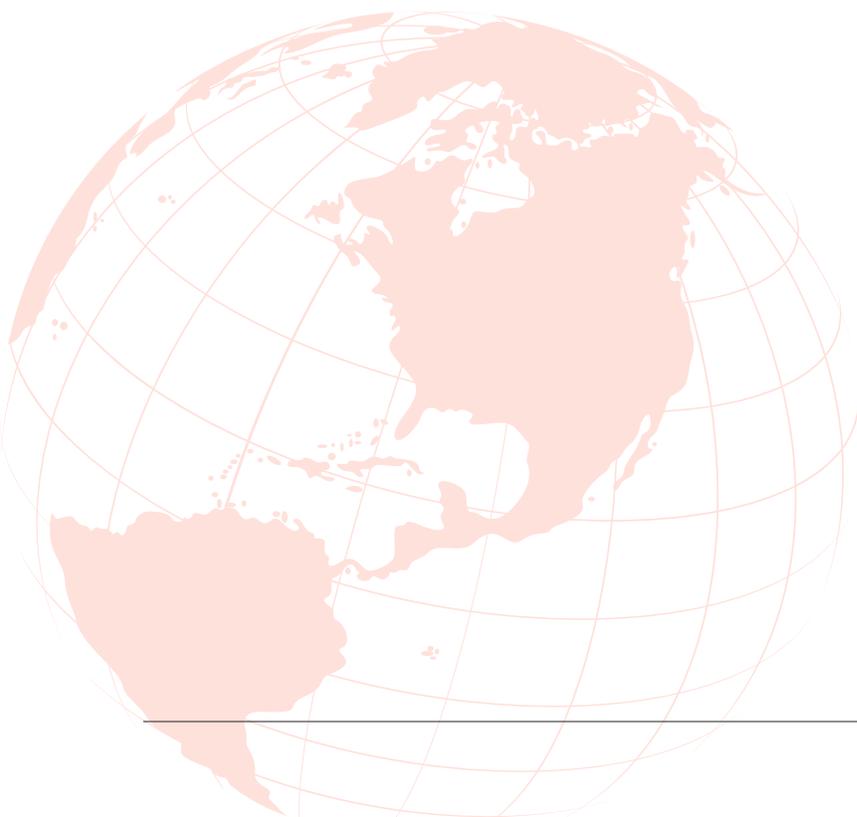
Toronto, ON

**Amanda Ottley, RN, BA, BScN, MN**

Occupational Health Nurse  
Toronto, ON

**Juanita Rickard, RN, BScN**

Vice-President  
Canadian Indigenous Nurses Association  
Ottawa, ON



## Stakeholder Acknowledgment

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**Michelle Acorn, DNP, NP, PHC Adult**  
Provincial Chief Nursing Officer  
Ministry of Health and Long Term Care  
Newronville, ON

**Sylvia Alloy-Kommusaar, RN**  
Retired  
Sault Ste. Marie, ON

**Sheila Blackstock, RN, MScN, COHN**  
Lecturer  
Thompson Rivers University  
Kamloops, BC

**Taliesin Magboo Cahill, BA, BSN, RN**  
Nursing Team Leader (Acting)  
Sandy Hill Community Health Center – Oasis Clinic  
Ottawa, ON

**Heather Charlesworth, MSc, M.Ad.Ed**  
Workplace Violence Prevention Programming Manager  
St. Michael's Hospital  
Toronto, ON

**Stephanie Crump, BSocSc, BScN, RN, MScN(c)**  
Registered Nurse  
University Health Network  
Toronto, ON

**Marisa Curran, RN, BScN**  
Public Health Nurse  
Pineridge District Health Unit  
Port Hope, ON

**Ashleigh Davis, RN, BScN**  
Registered Nurse  
Hamilton Health Sciences  
Hamilton, ON

**Juanita DeJong, Assoc. Sc. RN, GNC (C), BScN, MEd**  
Instructor  
Conestoga College  
Kitchener, ON

**Kathryn Ewers, RN, MSN, Med**  
Assistant Professor  
Nipissing University  
North Bay, ON

**Nataly Farshait, MN, CPN(C), CHE**  
Senior Director  
Humber River Hospital  
Toronto, ON

**George Fieber, RN**  
Nursing Practice Leader  
Thunder Bay Regional Health Sciences Centre  
Thunder Bay, ON

**Lela Fishkin, RN**  
Retired  
Toronto, ON

**Martin Green, CHPA**  
Manager, Security, Telecommunications & Emergency Preparedness  
Baycrest Health Sciences  
Toronto, ON

**Kathy Greig, RPN**  
Staff Nurse  
The Scarborough Rouge Hospital  
Toronto, ON

**Dan Hartley, EdD**

Epidemiologist  
National Institute for Occupational Safety and Health  
(NIOSH)  
West Virginia, USA

**Jennifer Hawkins, RN**

Director of Care  
Finlandia Nursing Home  
Sudbury, ON

**Laura Hendren, MN, RN(EC)**

Nurse Practitioner  
Atikokan Family Health Team  
Atikokan, ON

**Kelly Holt, RN, MScN, CPMHN(C)**

Clinical Nurse Specialist  
St. Joseph's Healthcare Hamilton  
Hamilton, ON

**Steven Hunt, RN, JD(c)**

Manager, Patient Care  
The Royal Ottawa Mental Health Center  
Brockville, ON

**Margaret Keatings, RN, MHSc**

Toronto, ON

**Sahana Kesavarajah**

Nursing student and Clinical extern  
University of Toronto and Hospital for Sick Children  
Toronto, ON

**Shannon Kift, BScN, RN**

Research Nurse  
Lakeridge Health  
Oshawa, ON

**Miran Kim, RN**

Mental Health Nurse  
Ministry of Community Safety and Correctional  
Services  
Toronto, ON

**Jill King, RN, BA(H), INTN ASA, COHN(C),  
COHN-S, ERGONOMIC DEGREE**

CEO  
King Health and Safety Inc.  
Newmarket, ON

**Kanika Kohli, BScN, MN, RN**

London, ON

**Lisa Lallion, RN, BScN, MN, CNS, CMSN(C)**

Clinical Nurse Specialist  
The Scarborough Stroke Clinic  
Toronto, ON

**Madeline Logan-Johnbaptiste, RN, BScN,  
MBA, ENC(C), CHE(C)**

Mackenzie Health  
Richmond Hill, ON

**Jessica Po Ying Lok, RN, BScN, MN**

Manager of Professional Practice  
VHA Home Health Care  
Toronto, ON

**Drew MacNeil, RN, BScN**

Clinical Practice Manager  
Hotel-Dieu Grace Healthcare  
Windsor, ON

**Jeny Mahendrakumar**

BScN Year 3 Student  
Red Deer College/University of Alberta  
Red Deer, Alberta

**Vanessa Maradiaga Rivas, RN, BScN**

Registered Nurse  
Hamilton Health Sciences and Revera Inc.  
Hannon, ON

**Margaret Millward, RN, MN**

Quality Improvement Specialist  
Health Quality Ontario  
Toronto, ON

**Noeman Mirza, RN, PhD**

Assistant Professor  
Thompson Rivers University  
Kamloops, BC

**Tasha Penney, RN, MN, CPMHN(C)**

Clinical Educator  
St. Michael's Hospital  
Toronto, ON

**Katie Poon, RN**

Registered Nurse  
St. Michael's Hospital  
Toronto, ON

**Madhumathi Rao, RN, BScN, MN**

Registered Nurse  
Humber River Hospital  
Toronto, ON

**Sabeena Santhirakumaran, RN, BScN, BSc**

Oncology Registered Nurse  
Princess Margaret Cancer Center – University Health  
Network  
Toronto, ON

**Nancy Smith, RN, BScN, MN**

Infant Nurse Specialist  
Children's Aid Society of Toronto  
Toronto, ON

**Olivia Soave, RN, BScN**

Nurse Educator  
Southlake Regional Health Centre  
Aurora, ON

**Grace Terry, RN, BScN**

Registered Nurse  
McMaster Children's Hospital  
Hamilton, ON

**Joyce Tsui, RN, BScN, MN**

Nursing Professor  
Centennial College  
Toronto, ON

**Natasa Vukojevic, RN**

Registered Nurse  
St. Joseph's Healthcare Hamilton  
Hamilton, ON

**Aaron Watamaniuk, RN, MN(c)**

Advanced Practice Nurse  
Sunnybrook Health Sciences Centre  
Toronto, ON

Stakeholder reviewers have given consent to the publication of their names and relevant information in this BPG.

# Organizing Framework for the System and Healthy Work Environments Best Practice Guidelines Project

Healthy work environments are practice settings that (a) maximize the health and well-being of nurses and other health workers and (b) improve organizational performance and patient, client, resident and societal outcomes. They comprise numerous components, including: physical, structural and policy components; professional and occupational components; and cognitive, psychological, sociological, and cultural components (142). These components, and the relationships among them, make them complex and multidimensional.

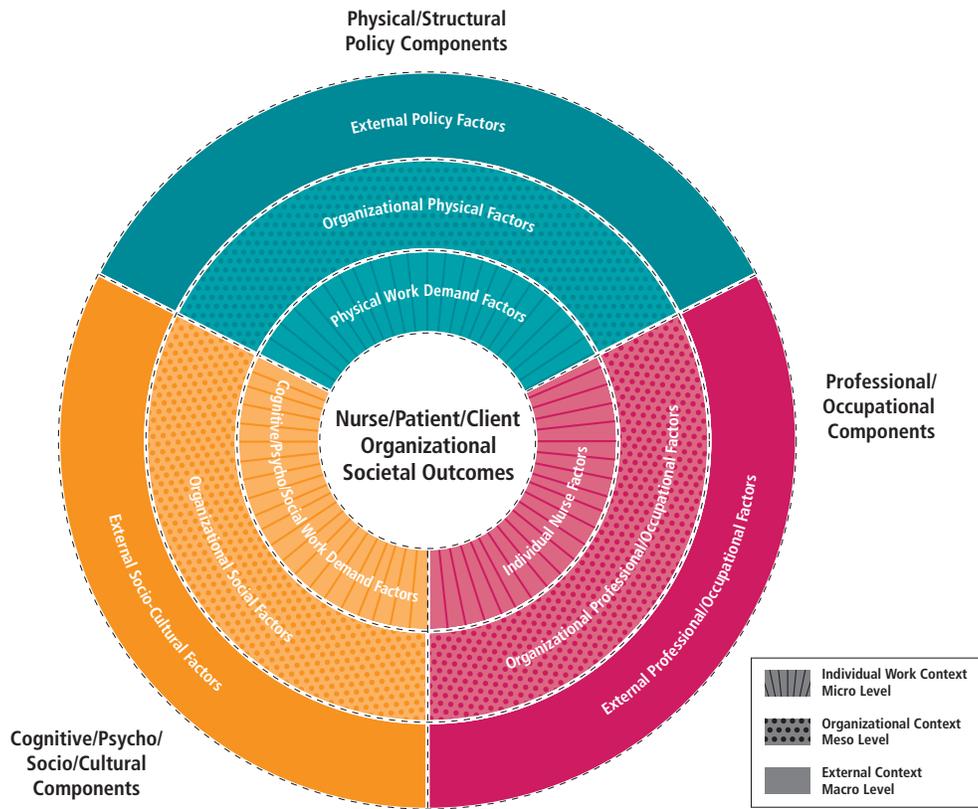
**Figure 1** represents a conceptual model for healthy work environments for nurses, including the components, factors and outcomes. Three concentric circles represent the three contexts or levels: the individual (micro), organizational (meso) and external (macro) contexts. The dotted lines within the model indicate the interdependence among the various components. At the center of the model are those who benefit from healthy work environments: nurses, persons, organizations, systems and society as a whole (17). The lines within the model are dotted, showing the synergistic interactions among all components of the model.

The following assumptions underlie the model:

- Healthy work environments are essential for high-quality, safe person care.
- Individual-level, organizational-level and system-level factors determine whether a work environment is healthy.
- Factors at all three levels (individually or in combination) affect the health and well-being of nurses, the quality of person outcomes, organization and system performance, and societal outcomes. At each level, there are policy components, cognitive/psycho/social/cultural components, and professional/occupational components.
- Professional and occupational factors are unique to each profession, while the remaining factors are generic and apply to all professions/occupations.

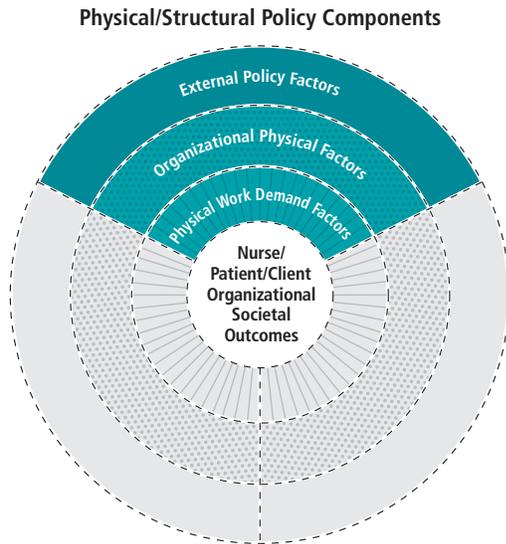
Because it is the combination of factors and components that determines the nature of the work environment and influences individual experience, interventions to promote healthy work environments must target multiple levels and components of the system – and, indeed, the system itself (18, 19)

Figure 1: Conceptual Model for Healthy Work Environments



Source: Banjok I, Stewart-Pyne A. Creating healthy workplaces: enabling clinical excellence. In: Grinspun D, Bajnok I, editors. Transforming nursing through knowledge. Indianapolis (IN): Sigma Theta Tau International; 2018. p. 69-92.

**Figure 2: Physical/Structural Policy Components**

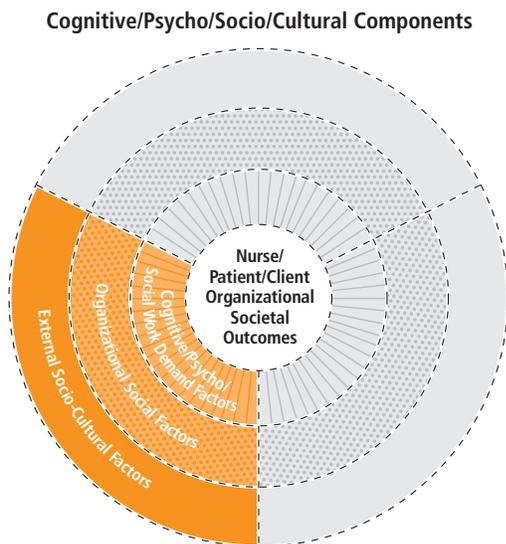


**Figure 2** depicts the physical/structural policy components at each level that influence a healthy work environment. For individuals (the inner circle), physical work demands include any requirement for physical capability and effort, such as workload, changing schedules and shifts, heavy lifting, exposure to hazardous or infectious substances, and threats to personal safety.

An organization’s physical environment (the middle circle) includes both built and natural characteristics, structures and processes surrounding the physical demands of the work. That includes staffing practices, flexible or self-scheduling, lifting equipment, occupational health and safety policies, and security personnel.

External policy factors (the outer circle) include everything from the local health delivery model to funding and the legislative, trade, economic and political frameworks that shape society.

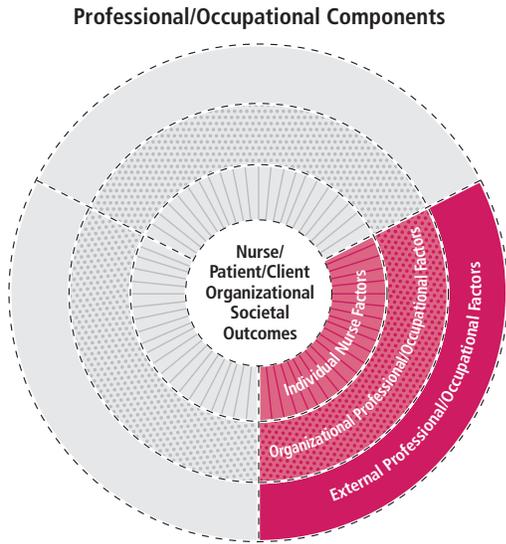
**Figure 3: Cognitive/Psycho/Socio/Cultural Factors**



**Figure 3** highlights the cognitive/psycho/socio/cultural components at each level that influence a healthy work environment. Individual cognitive and psycho/social work demand factors include clinical knowledge, coping and communication skills, clinical complexity, job security, team relationships, emotional demands, role clarity and role strain.

An organization’s social factors are related to its climate, culture and values. They include organizational stability, communication practices and structures, labour management relations, and a culture of continuous learning and support.

External socio-cultural factors influence how organizations and individuals operate. They include consumer trends, changing care preferences, changing roles in families, the diversity of the population and care providers, and changing demographics.



**Figure 4: Professional/Occupational Components**

Individual nurse factors include the personal attributes, knowledge and skills that determine how nurses respond to the physical, cognitive and psychosocial demands of work (20). Personal attributes include a nurse’s commitment to his or her patient, organization and profession, as well as his or her resilience, adaptability, self-confidence and ability to maintain a work–life balance. Knowledge and skills include the nurse’s values, ethics and reflective practice.

The organizational professional/occupational factors that shape a healthy work environment are derived from the nature and role of the profession/occupation. For nurses, these include their scope of practice, the level of autonomy over their practice, and the nature of their interprofessional relationships.

External professional/occupational factors include policies and regulations at the provincial, territorial, national and international levels that influence health and social policy and role socialization within and across disciplines and domains.

# Background Context

## Is Workplace Violence a Significant Issue?

Workplace violence is a global issue that is prevalent in all health service organizations and academic institutions, and affects all health workers and students. A 2017 report commissioned by the Ontario Council of Hospital Unions found that of the almost 2000 front-line health workers surveyed, 68 per cent had been physically assaulted in the previous 12 months, 86 per cent had experienced verbal violence and 42 per cent had been sexually assaulted or harassed (21). For nurses, a global review that included 150,000 nurses from 160 international samples reported that more than one third had been physically assaulted during their careers, two thirds had experienced non-physical assaults and 40 per cent had experienced bullying (22).

This BPG recognizes the dramatic increase in the prevalence and severity of workplace violence towards health workers and students in all health sectors. It is not surprising that the Association of Workers' Compensation Boards of Canada (AWCBC) found that the health and social services industry had the highest number of lost-time injuries: injuries in that industry represented 18 per cent of all lost-time injuries across all sectors (23). In fact, in 2015 the number of violence-related lost time injuries for frontline health workers was more than double that for police and correctional service officers combined - an increase of 66 per cent over 10 years (23). This increase from 2006 to 2015 has occurred at a rate that is three times greater than the rate of increase for police and correctional service officers combined (23).

## What is Considered to be Violence, Harassment and Bullying within a Health Service Organization?

Generally, violence is the use, or attempted use, of physical force against a person that causes, or could cause, physical injury. Sexual aggression, verbal statements, non-verbal behaviours or acts that are reasonably interpreted as a threat of physical force that can lead to physical harm are also considered violence (24). In health service organizations, the most prevalent type of workplace violence in health care is from the person receiving care or their family (25). Examples of this include verbal threats, threatening notes, shaking a fist in the worker's face, hitting/trying to hit a worker or throwing an object at a worker (24).

Other forms of negative behaviours in the workplace include horizontal or lateral violence and vertical violence. Horizontal or lateral violence are terms that are used interchangeably to denote violence, harassment and bullying directed at colleagues who are of equal level within an organization (8). This is in contrast to vertical violence, which is violence, harassment or bullying between colleagues who are at unequal levels within an organization.

Harassment refers to comments or behaviours towards a health worker that are unwelcome and persistent, including sexual harassment (6). For example, remarks, jokes or innuendos that demean, ridicule, intimidate or offend a health worker or student are considered to be workplace harassment. Bullying is a repeated and persistent behaviour that can include social isolation, creating or spreading rumours, excessive or unjustified criticism, intimidating a person, physically abusing or threatening abuse, and withholding job responsibilities (4). These two forms of violence differ from incivility, which is defined as a deterioration in relationships between peers in the workplace (9, 26), between students and health workers in the clinical learning environment (27), or between students and faculty in an academic institution (28). Incivility can include futile communication, disrespect, indifference, neglect, disregard, or impolite speech, and can result in stress and burnout (27). Although violence and harassment are prevalent issues in health care, the high rates of bullying and its effects on the well-being, productivity and retention of health workers has become an emergent issue (29).

## What are the Classifications of Violence, Harassment and Bullying in a Health Service Organization?

Violence can be classified according to its type and source. In 2001, occupational health researchers classified workplace violence into four main types:

- **Type 1 (criminal intent):** The perpetrator of violence has no legitimate relationship to the business or its employees. This violence typically includes acts such as robbery, pilfering and/or trespassing.
- **Type 2 (client or customer):** This is the most common source of violence in the health setting. The perpetrator is a person receiving care or a visitor who becomes violent and/or aggressive toward a health worker or another person or visitor.
- **Type 3 (worker to worker):** This type of violence is referred to as horizontal or vertical violence. It can include bullying. The perpetrator is a current or past employee (including supervisors, managers, physicians or other contract workers) and violence is directed towards another employee.
- **Type 4 (personal relationships):** The perpetrator has a relationship with an employee outside of the workplace but becomes violent and/or aggressive towards them or others in the workplace (30).

## What are the Personal and Economic Costs and Consequences of Workplace Violence?

The cost of workplace violence in Ontario hospitals alone is \$23.8 million annually, contributing to 10 per cent of hospital lost-time injuries (23). Workplace violence also leads to absenteeism, particularly among nurses: a Canadian national 2016 report found that the average rate of absenteeism for all occupations was 5.7 per cent, but that the rate for full-time public sector nurses was 9 per cent, resulting in an estimated cost of \$989 million annually (29).

In addition to the economic costs, health workers endure many physical and psychological consequences as a result of workplace violence:

- Physical consequences include physical injury (e.g., bruises, bites and lacerations), headaches, pain and life-threatening injuries (31).
- Commonly reported psychological consequences include post-traumatic stress disorder, hyper-vigilance, irritability, difficulties concentrating, sleep disturbances, depression, anxiety and burnout (31).
- Emotional consequences can include anger, sadness, fear and mistrust (31).
- Consequences of prolonged and persistent bullying include increased risk of mental and somatic health concerns, such as anxiety and depression (32), suicidal ideation (33), and headaches and sleep disturbances (34).

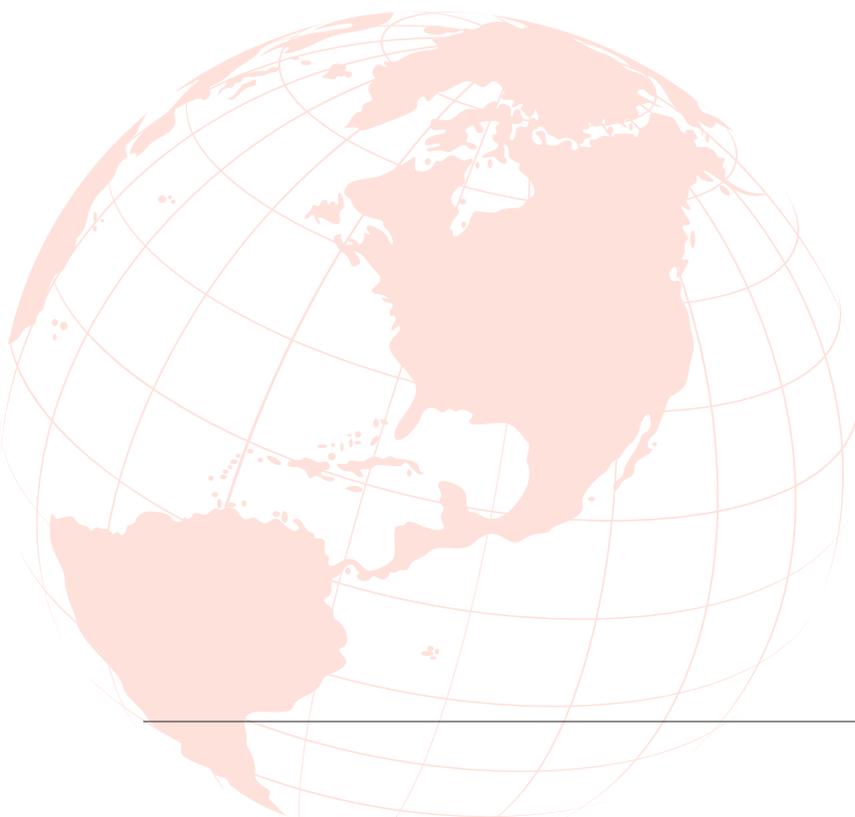
These consequences negatively impact recruitment and retention (35); for example, 66 per cent of nurses have thought of leaving their job to work for a different employer or change professions entirely (29). Other consequences of workplace violence may include increased sick leave (36), decreased productivity (37), fear of patients, lack of pleasure in working with patients, and spending less time with patients, thereby reducing the quality of care (31).

Although 61 per cent of nurses in Canada experienced some form of violence between 2016 and 2017, only one quarter sought help from a union and only 60 per cent actually reported the event (29). Given the fact that workplace violence is pervasive yet widely under-reported, the Ministry of Health and Long-Term Care recently mandated that workplace violence towards health workers (including physicians, subcontractors and students) be included in the quality improvement plans of hospitals, and that the overall number of workplace violent incidents be reported (38).

## What are Prevention and Management Initiatives from a System-level?

Although the creation of a safe work environment is the responsibility of everyone in a health service organization and academic institution, the employer must enforce prevention policies and strategies for workplace violence, harassment and bullying. Under the Ontario Occupational Health and Safety Amendment Act (Bill 168), employers must follow a set of key action items to prevent and manage violence in the workplace (20). A few of these actions include creating written workplace violence and harassment policies, and developing and maintaining a program to implement policies, training and precautions to protect employees from physical injury (39). These measures will not be effective unless meaningfully and consistently enforced (29).

Aside from legislation, prevention and management of workplace violence, harassment and bullying will require the concerted efforts of multiple key stakeholders, including federal and provincial governments, unions, health organizations, employees, persons, and the public. Owing to the detrimental effect that violence has on health workers and persons receiving care, this BPG provides evidence-based best practice recommendations to help organizations and health workers recognize, prevent and manage workplace violence, harassment and bullying.



# Recommendations

## RECOMMENDATION QUESTION #1:

Should health workers be recommended to use risk assessment tools to detect behaviours indicative of workplace violence, harassment and/or bullying?

Outcomes: Reliability, validity and accessibility in practice (surrogate outcomes: time and utility)

### Recommendations Addressing Violent Behaviour from Persons and Families

#### Recommendation 1.1:

The expert panel recommends that health service organizations establish an implementation plan for integrating a violence risk assessment tool for persons. This plan should include the following:

- selection of a risk assessment tool that is applicable to the clinical population and setting; and
- education and training on the chosen tool for all health workers who provide direct care.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Very low

## Discussion of Evidence:

### Benefits and Harms

Assessing the risk for violent behaviour is crucial for the safety of health workers. Two types of tools were identified in the literature: **actuarial instruments**<sup>G</sup> and **structured professional judgement (SPJ)**<sup>G</sup>. Actuarial tools use a formula or equation to combine known risk for violence with static (e.g., age) and dynamic (e.g., substance abuse and unemployment) factors to arrive at an expected probability that violence will occur (40). SPJ instruments also use static and dynamic risk factors, but they include clinical discretion to weigh the presence of risk factors and draw an overall conclusion about the probability of violence occurring (e.g., low, medium or high) (40).

Regardless of the tool used to assess the risk for violence, the literature highlights the importance of having an implementation plan in place. Instruments that had an implementation plan prior to their adoption in an organization had acceptable **predictive validity**<sup>G</sup> with respect to their ability to predict patient aggression (41-43) and good **inter-rater reliability**<sup>G</sup> between health workers (42). None of the included studies reported on the harms associated with having an implementation plan.

Components of an effective implementation plan identified in the literature included selection of a risk assessment tool applicable to the clinical population and setting, and education and training on the tool for all health workers who provide direct care.

#### *Selection of a Risk Assessment Tool that is Applicable to the Clinical Population and Setting*

Mental health professionals across 44 countries emphasized the importance of “goodness of fit” in risk assessment, such that instrument choice should depend on the applicability or “fit” between the population, setting and purpose of the instrument (40). Prior to implementing a tool in an organization, a careful analysis of costs, training requirements, and user and organizational preferences (i.e., preference for or against the use of SPJ and/or actuarial tools) needs to be considered (40). It should be noted that the validity and reliability of violence risk assessment tools have not been confirmed in all practice settings and among all populations, and generalizability in all health service organizations cannot be assumed (43, 44). Therefore, when selecting a tool to use in practice, consideration should be given to the applicability of the tool to the setting and population before the tools are broadly adopted.

#### *Education and Training on the Chosen Tool for Health Workers Providing Direct Care*

Specific SPJ assessment tools examined in the literature included the Aggressive Behavior Risk Assessment Tool (ABRAT) (45) and the Short-Term Assessment of Risk and Treatability (START) (41). The Dynamic Appraisal of Situational Aggression (DASA) was an actuarial assessment tool examined in the literature (42). Studies that assessed the **psychometric properties**<sup>G</sup> (reliability and validity) of these tools had a period of staff training as a component of the implementation plan. The staff education and training included theoretical information about the tools (40, 41, 43, 45), training on how to score the tool and interpret the results (41), practice with scoring the tools using pseudo-clinical cases (41, 47) and research evidence demonstrating the ability of the tool to predict patient aggression (45).

### Values and Preferences

Evidence suggests that health workers value receiving training prior to the organizational implementation of a new risk assessment tool (47, 48), and they appreciate the availability of ongoing support during and after the implementation process (42, 49). Health workers favour tools that are quick, easy and useful, because they empower staff to proactively minimize violent events (45).

### Health Equity

The expert panel suggests that establishing an implementation plan prior to a risk assessment tool being used in direct care could potentially improve health equity. Supporting the consistency in how health workers conduct violence risk assessments (through the use of a risk assessment tool) could potentially decrease practices that stigmatize or harm persons. More research is required to improve understanding of how an implementation plan can impact health equity.

### Expert Panel Justification of Recommendation

The expert panel attributed high value to having an implementation plan in place prior to the clinical or organizational use of a risk assessment tool. The expert panel valued appropriate tool selection and adequate staff education and training to enhance the utility, reliability and validity of the chosen tools within the clinical environment. Therefore, the expert panel determined the strength of the recommendation to be strong.

## Practice Notes

- The expert panel emphasized the importance of providing training not just on the tool itself, but also on the interventions that the health worker must take once risk has been identified. For more information on potential interventions following a violence risk assessment, please see **Recommendations 3.1 to 3.3**.
- Educational delivery methods found in the literature to be effective for supporting health worker knowledge and skills included the following:
  - Team discussions about the risk assessment tool, including how to understand the ratings, and the provision of feedback on pseudo-clinical cases (41).
  - The adoption of a “train-the-trainer” educational approach. For example, in a study that evaluated the effectiveness of the ABRAT to predict aggressive behaviour in recently admitted long-term care residents, key individuals in the long-term care facility were trained by investigators on how to use a violence risk tool. These key individuals then educated and trained staff in their respective long-term care facilities (45).
- There is no consistent agreement in the literature regarding the timing of risk assessments; thus, it is the responsibility of the organization to set a time frame for when risk assessments should be completed and to articulate clearly this decision to health workers as part of the implementation plan. However, risk assessments were generally completed once during hospitalization or weekly (48), within the first 24 hours of admission (45) and daily (41-42). One study found that the average amount of time until a violent incident arose was 4.4 days after admission (50).

## Supporting Resources

RESOURCE	DESCRIPTION
Public Services Health & Safety Association (PSHSA). PSHSA Violence, Aggression & Responsive Behaviour (VARB) Project [Internet]. Toronto (ON): PSHSA; c2018. Available from: <a href="https://www.pshsa.ca/article/marb-project/">https://www.pshsa.ca/article/marb-project/</a> .	<ul style="list-style-type: none"> <li>■ Model and toolkit to provide the workplace with a consistent and consensus-based approach to reduce the impact and incidence of aggression, violence and responsive behaviour.</li> <li>■ Includes access to a variety of workplace violence risk assessment tools and toolkits (designed for different types of settings and client populations), including the Flagging Handbook, Security Toolkit and the Personal Safety Response System Toolkit.</li> </ul>

**RECOMMENDATION 1.2:**

The expert panel recommends that health workers conduct a violence risk assessment on all persons using a validated tool.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Very low

**Discussion of Evidence:****Benefits and Harms**

Health workers who provide direct care to persons should conduct a violence risk assessment to identify persons who are at higher risk of violent behaviours, thereby potentially decreasing the incidence of violent events and injuries. A wide variety of violence risk assessment tools were identified in the literature, and their reliability, validity and utility in practice were assessed across different health service organizations. Violence risk assessment tools that demonstrated high reliability, validity and utility adopted either an SPJ or actuarial approach (see **Recommendation 1.1** for more on these instruments).

The validity of SPJ tools was found acceptable, specifically in their ability to predict violent incidents accurately (41, 43, 45, 48, 50-52). Two SPJ tools – the ABRAT (45) and the Workplace Assessment of Targeted Violence Risk (WAVR-21) (44) – had fair to good reliability (44, 45). One SPJ tool, the START (41), was also found to have high reliability between health workers, and users of the tool endorsed its utility, low degree of difficulty and ease of completion within practice (48). However, research suggests the ABRAT tool may not be sufficient to predict an individual's risk for violence if the user does not have specialized training or qualifications as a mental health provider (45), and agreement between subject matter experts using the START tool tends to be higher than ratings conducted by general mental health professionals (48). One study also reported that 44 per cent of health workers who used the START tool found it difficult to make finer distinctions between high, moderate or no evidence of violence risk (48).

The assessment of psychometric properties was found in the literature for one actuarial tool: the DASA (42). This tool was used and tested in mental health in-patient units, an adult acute care unit and a secure extended care unit. Evidence indicates that across these populations, the DASA has a high degree of accuracy in predicting violence, particularly in comparison to SPJ tools and unaided clinical judgments (42, 47, 49). However, the DASA tool can be time-consuming, which reduces the time nurses spend with patients, and the scoring system can be considered disrespectful or stigmatizing because assessments focus solely on an individual's negative characteristics (42).

**Values and Preferences**

Evidence suggests that health workers who used SPJ tools (particularly ABRAT and START) found them to be simple and reliable methods to triage potentially violent patients, and they enabled early focused interventions, helped staff identify impending violent situations (45) and were useful for identifying “signature risk signs” (48). Nurses who completed the DASA stated it was quick and easy-to-use, they could easily share information about patients, it was appropriate for inexperienced staff to complete, and it ultimately became incorporated into the patient's admission assessment (49). Some nurses, however, preferred their own clinical judgment over the tool, felt the time needed to complete the tool was inconvenient and were uncertain about interventions they could adopt once the assessment was made (49).

## Health Equity

Health equity may be impacted negatively as a result of using risk assessment tools: persons may inadvertently be stigmatized and labelled, which can impact care (49). The expert panel emphasized that identifying potentially violent persons can increase or decrease health equity depending on the setting, the type of alert system adopted and how the alert system is used to identify persons. Decisions on alerting must be made at the organizational level, and the balance between benefits and harms for health workers and persons need to be considered carefully.

Interestingly, the number of women involved in violent events is underestimated, and both male and female health professionals generally under-report violence from persons who are women (51). With respect to gender, the Violence Risk Screening-10 (V-RISK-10) tool was assessed for its ability to predict violence in men and women. Although the tool had good validity, there were higher rates of false positives for women than men, which indicates that risk factors specific to women may be missing from the tool (51). Using a tool that lacks validity for all patient characteristics (such as gender) could result in potential inconsistencies and inequities in care.

Gender can also negatively affect health equity, such that interventions chosen to prevent and/or mitigate aggression differ for men and women. Nurses completed the DASA for patients on three forensic acute units and documented subsequent interventions that were implemented (53). Results suggested that men were more likely to receive restrictive interventions (e.g., as needed (PRN) medications and observations), whereas more interpersonal approaches were provided to patients who were women (e.g., one-to-one nursing, limit setting and reassurance) (53).

### Expert Panel Justification of Recommendation

Despite very low certainty in the evidence and uncertainty about the impact that a violence risk assessment could have on health equity, the expert panel attributed higher value to conducting violence risk assessments for the safety of health workers and persons compared to the harm that could occur if risk assessments are not made. Therefore, the expert panel determined the strength of the recommendation to be strong.

### Practice Notes

- Although risk assessments provide a way to highlight imminent risk, and interventions can be implemented to potentially prevent violent behaviour from occurring or escalating, organizations need to ensure that proper resources are in place (such as adequate staffing and safety equipment) (53).
- Adequate time and necessary resources to complete a risk assessment tool are critically important for health workers.
- In Ontario, the *Occupational Health and Safety Amendment Act* states that employers need to assess for the risk of workplace violence as often as deemed necessary to ensure that their policies and programs on workplace violence protect workers (39). Thus, the use of risk assessment tools is highly recommended in settings where there is risk. Validation of some of these tools is currently in progress.
- Risk assessment tools should be appropriate for the scope of practice of the health worker and their role within the organization. See **Recommendation 1.1** for more on the selection of an appropriate risk assessment tool.
- Aside from the person receiving care and depending on the setting (e.g., pediatric setting with guardians, long-term care with substitute decision makers), violence risk assessments should be completed on the family and the environment in which the person is currently in.

- Organizations need to ensure that health workers are educated and trained such that the same quality of care (e.g., infection control precautions, violence precautions or fall risk precautions) is provided to all persons, regardless of their “alert” precautions.
- If the alert for violence risk was due to the acute clinical status of the person (e.g., delirium after surgery), the person’s risk for violence should be re-assessed once their clinical status returns to baseline. In collaboration with the person, the healthcare team can discuss and determine if the alert for violence risk should remain in the person’s clinical chart for future interactions they may have with health workers.
- The expert panel noted that after a person is identified as being at risk for violence, the development of an individualized care plan is required. Developing a plan of care will ensure that health workers understand and address the person’s triggers for violence, provide the appropriate level of care and ultimately make the environment safer for health workers and persons.
- A communication strategy to relay findings from the risk assessment needs to be identified. The expert panel emphasized that pertinent information that arises from the risk assessment should be shared in a clear and easy way: it should not be confined to the health record (electronic or paper-based), as that would make it ineffectual to those who are unable to access the document. This was also emphasized in a qualitative study, such that communication between occupational groups (e.g., dietary staff, personal support workers or housekeepers) was lacking because they were not included in nursing care huddles and did not have access to the patient’s medical charts (21).
- Health workers should consider both risk and protective factors for violence. Protective factors are based on an individual’s strengths, which can reduce the likelihood they become violent, and they can increase predictive ability (41). Evidence suggests that assessing a patient’s positive or protective traits also reduces negative biases towards that patient among health providers and improves therapeutic relationships (41).
- Evidence suggests that health workers need to be aware of the dispositional and situational factors that increase a person’s risk for violence. These traits or circumstances can include gender and a history of violence (51), multiple hospital admissions, involuntary admission and living in a group home (50). See **Appendix F** for a list of factors that may predict violent or aggressive behaviours.
- See **Appendix G** for the nine STAMPEDAR components that classify risk of violence and their corresponding cues to help health workers predict and prevent the incidents of violent or aggressive behaviours.
- See **Appendix H** for examples of actuarial and SJP tools used to support a violence risk assessment as identified in the systematic review.

## Supporting Resources

RESOURCE	DESCRIPTION
<p>Chaimowitz G, Mamak M. The Hamilton Anatomy of Risk Management HARM [Internet]. [publisher St Joseph's Healthcare Hamilton; c2018]. Available from: <a href="https://www.ais-harm.com/harm">https://www.ais-harm.com/harm</a></p>	<ul style="list-style-type: none"> <li>■ Structured clinical judgment tool to assist in the assessment of risk of violence by combining historical (static) and dynamic factors.</li> <li>■ Includes past, current and future assessments.</li> <li>■ Available for various populations, including in-patients in the forensic psychiatric unit, youth offenders in detention or treatment settings, adult in-patients in acute and chronic psychiatric settings, and vulnerable service users who are street-involved or in transitional housing.</li> </ul>
<p>Linaker, Bush Iversen, Almvik, et al. bvc: Brøset Violence Checklist [Internet]. Trondheim (Norway): [publisher unknown; date unknown]. Available from: <a href="http://www.riskassessment.no">http://www.riskassessment.no</a></p>	<ul style="list-style-type: none"> <li>■ Provides the Brøset Violence Checklist, an actuarial instrument that assists in the prediction of imminent violent behaviour.</li> </ul>
<p>Public Services Health &amp; Safety Association (PSHSA). Individual Client Risk Assessment [Internet]. Toronto (ON): PSHSA; c2018. Available from: <a href="https://workplace-violence.ca/tools/individual-client-risk-assessment/">https://workplace-violence.ca/tools/individual-client-risk-assessment/</a></p>	<ul style="list-style-type: none"> <li>■ Toolkit to identify client behaviours and triggers that can lead to violence in order for preventative measures to be implemented.</li> <li>■ Includes the Violence Assessment Tool, suggestions for control interventions and an example policy.</li> <li>■ Toolkit can be used in acute care, long-term care, community care and emergency services.</li> </ul>
<p>Public Services Health &amp; Safety Association (PSHSA). Use the Violence Assessment Tool (VAT) [Internet]. Toronto (ON): PSHSA; [date unknown]. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2017/05/VPRPSAEN0417-Individual-Client-Risk-Assessment-Tool-ICRA-Poster-V2.1-2017.04.25.pdf">https://www.pshsa.ca/wp-content/uploads/2017/05/VPRPSAEN0417-Individual-Client-Risk-Assessment-Tool-ICRA-Poster-V2.1-2017.04.25.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Provides a one-page summarized version of the VAT tool that assesses static and dynamic risk factors for violence.</li> <li>■ Provides link to the PSHSA website to download the full version of the tool.</li> </ul>

## Recommendation Addressing Harassment and Bullying from Formal Leaders, Health Workers or Students

### RECOMMENDATION 1.3:

The expert panel suggests that health service organizations and academic institutions support the use of validated risk assessment tools to measure and develop a quality improvement plan to address horizontal and/or vertical violence.

**Strength of the recommendation:** Conditional

**Certainty of the evidence of effects:** Very low

### Discussion of Evidence:

#### Benefits and Harms

Assessing for horizontal and vertical violence within health service organizations and academic institutions –and implementing quality improvement initiatives if horizontal and vertical violence exists – is important for the physical and mental well-being of health workers and persons. Risk assessment tools that predicted harassment and bullying in the workplace assessed horizontal violence from peers (26, 54), vertical violence from those in a position of power (55, 56), and both (57). Tools also were identified that detected incivility from staff nurses towards students in clinical placements (58, 59).

Tools that specifically examined horizontal violence (the Lateral Violence in Nursing Survey and the Horizontal Violence Scale) demonstrated adequate validity; however, the generalizability of the tools and the confidence in their predictive ability is questionable because they were used by charge nurses or nurse managers, and not staff nurses (26, 54). Adequate validity was also found for tools that assessed vertical violence (the Survey of Workplace Intimidation Instrument and the John Hopkins Disruptive Clinician Behavior Survey), although implementation was in an acute care setting and generalizability to other health settings is difficult (55, 56). One tool that assessed horizontal and vertical violence (the Hospital Aggressive Behavior Scale) demonstrated adequate psychometric properties and allowed for the examination of multiple sources of bullying within the environment (57). Two tools were found that examined violence from clinical nursing staff towards nursing students (the Uncivil Behavior in Clinical Nursing Education tool and the Nursing Student Perception of Civil and Uncivil Behaviors in the Clinical Learning Environment Survey), and both had good inter-rater reliability (58, 59).

There were no studies found that assessed the psychometric properties of tools that measured bullying between students.

#### Values and Preferences

In organizations that implemented valid tools to measure harassment and bullying, health workers generally preferred and placed greater value on tools that were brief and easy to administer (56, 58) and those that were easy to interpret (58).

## Health Equity

The impact on health equity of using a tool to identify harassment and bullying in the workplace or learning environment depends on the organization's willingness to address the issue adequately once it has been identified. The expert panel also emphasized that the tools currently lack the ability to measure the extent of bullying and harassment and the impact on the individual worker, which makes it difficult to ascertain how health equity is affected. More research is required to understand how tools that measure harassing and bullying behaviours can affect health equity in a health service organization or learning environment.

## Expert Panel Justification of Recommendation

The expert panel could not attribute high value to the use of tools that measure harassing and bullying behaviours from formal leaders or colleagues due to variability in the outcomes. The expert panel emphasized that the methods used by organizations to interpret and use the results from the validated tools could potentially influence the risk of harm to workers and students. For example, if results indicate that a high degree of harassing and bullying behaviours exist in a health setting, negativity could escalate, especially if the setting does not take the necessary steps to change the culture and remedy the issue. An organization that is unwilling to enact positive change could cause harm to employees and/or students who complete the tool; thus, the expert panel determined the strength of the recommendation to be conditional.

## Practice Notes

- Use a tool that is validated for the particular health service organization or academic institution where the data will be gathered.
- The risk assessment tool can be an avenue for health workers to comment anonymously on the culture of their health service organization or academic institution. The results can then be used to stimulate discussion and formulate a plan of action to address the issue of harassment and bullying.

## Supporting Resources

RESOURCE	DESCRIPTION
National Research Centre for the Working Environment. Copenhagen Psychosocial Questionnaire – COPSOQ II [Internet]. Copenhagen: National Research Centre for the Working Environment; [date unknown]. Available from: <a href="http://nfa.dk/da/Vaerktoejer/Sporgeskemaer/Copenhagen-Psychosocial-Questionnaire-COPSOQ-II/Engelsk-udgave">http://nfa.dk/da/Vaerktoejer/Sporgeskemaer/Copenhagen-Psychosocial-Questionnaire-COPSOQ-II/Engelsk-udgave</a>	<ul style="list-style-type: none"> <li>■ Developed in Denmark with the aim of assessing and improving the psychosocial work environment.</li> <li>■ Provides three questionnaires that are tailored for different target groups.</li> </ul>

**RECOMMENDATION QUESTION #2:**

Should organizational policies and procedures to prevent and manage workplace violence, harassment and/or bullying among health workers be recommended to improve organizational and health worker outcomes?

**Outcomes:** Physical environment (surrogate outcomes: health worker injury, incident reporting, assault and threat towards health workers) and health worker well-being (surrogate outcomes: perceived incivility, recognition of bullying, policy implementation).

The recommendations that emerged from this recommendation question are based on literature that examined the implementation of organizational multi-component strategies for the prevention and management of workplace violence, harassment and bullying from all sources (e.g., persons, health workers and students) (60-63). Recommendations are based on components of the multi-component interventions identified in the literature. The following recommendations should be implemented as part of a multi-intervention organizational initiative for the prevention and management of workplace violence, harassment and bullying, in alignment with findings from the systematic review.

**Recommendations Addressing Violent Behaviour from Persons****RECOMMENDATION 2.1:**

The expert panel recommends that health service organizations provide education and training to health workers on addressing violent behaviours from persons (see Recommendations 3.1 to 3.3 for specific education content).

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

**Discussion of Evidence:****Benefits and Harms**

Education and training programs are commonly implemented by organizations to prevent – or prevent and manage – aggression and violence experienced in health service organizations (57-59). Evidence suggests that multi-component organizational initiatives that include education and training for health workers decreased staff injuries (60-62) and reduced rates of assault and threat against health workers (60, 62). Due to the diversity of approaches utilized, it is unclear which components of education are most effective.

It is also important to note that there is potential for decreased formal violence incident reporting following an organizational initiative that includes an educational component (61). This may be due to perceptions among health workers that only incidents perceived as serious and causing physical harm should be reported, that no action would be taken, that violence is part of the job, that reporting takes too much time, or not wanting to involve managers (61).

## Values and Preferences

Generally, health workers who participated in an organizational initiative that had an educational component found it was beneficial in reducing workplace violence. However, some health workers reported that education offered on the Internet was time-consuming and led to technical problems (64).

## Health Equity

Health equity may vary based on the access to educators with expertise in violence, the educational approaches provided across different organizations, and the consistency and timing of educational refreshers. The cost associated with education and training can also affect health equity. For example, one study emphasized the extensive amount of staff, human and material resources and funds required for education programs, particularly when incorporating simulation scenarios with standardized patients and/or health workers (65). More research is required to improve understanding of the impact of education and training on workplace violence and health equity.

## Expert Panel Justification of Recommendation

Despite the low certainty in the evidence and the uncertain impact that education and training will have on health equity, the expert panel emphasized the importance of educational approaches that increase knowledge and skill. The expert panel attributed more value to organizational initiatives that include education and training to reduce workplace violence and determined the strength of the recommendation to be strong.

## Practice Notes

The following are considerations for the design and delivery of educational and training content on addressing violent behaviours to increase knowledge and skills:

- Education and training should include refreshers, drills and on-the-job training.
- Education should include an active learning component (such as a demonstration, return demonstration or simulation training) to provide health workers with different strategies for learning and skill acquisition. For example, to educate health workers on how to respond to violence in an emergency department, one study had registered nurses, physicians, social workers and security guards attend lectures that provided information about how to identify and approach workplace violence. Subsequent to the lectures, health workers participated in three separate realistic simulations using standardized patients to elicit authentic feelings and responses. Debriefing after the simulation allowed health workers to reflect on their observations and strategize appropriate responses to manage workplace violence. Results suggested an increase in health worker self-reported self-efficacy in responding to workplace violence (65).
- Education also should be tailored to the scope of practice of the health worker and their role within the organization.
- See **Recommendations 3.1 to 3.3** for information on specific educational content that should be addressed. See **Appendix I** for additional information on approaches and strategies for delivering education on workplace violence.
- See **Appendix J** for the Safewards Model and 10 principles to make environments safer for health workers, persons and families.

## Supporting Resources

RESOURCE	DESCRIPTION
<p>Advanced Gerontological Education (AGE). Gentle Persuasive Approaches (GPA) [Internet]. Hamilton (ON): AGE; c2017. Available from: <a href="https://ageinc.ca/about-gpa-2/">https://ageinc.ca/about-gpa-2/</a></p>	<ul style="list-style-type: none"> <li>■ Offers information about the evidence-based Gentle Persuasive Approach (GPA) that educates care providers how to respond to responsive behaviours effectively.</li> <li>■ Provides information about the GPA education curriculum and how you can register for it.</li> <li>■ Provides resources, such as a blog and videos that demonstrate GPA.</li> </ul>
<p>Crisis Prevention Institute (CPI). Training and events [Internet]. [place unknown]: CPI; c2018. Available from: <a href="https://www.crisisprevention.com/en-CA/Training-and-Events">https://www.crisisprevention.com/en-CA/Training-and-Events</a></p>	<ul style="list-style-type: none"> <li>■ Provides training and consulting to manage and prevent challenging behaviour in a safe manner.</li> <li>■ Courses are available in both Canada and the United States in non-violent crisis intervention and dementia care specialties.</li> </ul>
<p>International Association for Healthcare Security &amp; Safety (IAHSS). Certifications [Internet]. [place unknown: publisher unknown]; c2018. Available from: <a href="http://www.iahss.org/?page=certifications">http://www.iahss.org/?page=certifications</a></p>	<ul style="list-style-type: none"> <li>■ Provides Basic, Advanced and Supervisor-level training for health security and safety officers.</li> <li>■ Topics at the Basic level include fundamental security skills, the role of security in health organizations and health care emergency management security.</li> <li>■ Topics at the Advanced level include communicating effectively throughout the organization and defining security's role within the organization.</li> <li>■ In the Supervisor-level training program, health security professionals with some supervisory responsibilities will cover topics such as selecting and managing employees, mitigating risks, managing security events and making informed decisions.</li> </ul>
<p>Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers [Internet]. [place unknown]: U.S. Department of Labor, Occupational Safety and Health Administration; 2016. Available from: <a href="https://www.osha.gov/Publications/osh3148.pdf">https://www.osha.gov/Publications/osh3148.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Provides an overview of approaches to be included in workplace violence prevention programs and education.</li> <li>■ Applicable to multiple diverse settings and health and social service workers.</li> </ul>

RESOURCE	DESCRIPTION
<p>Ontario Ministry of Labour. Health and safety guidelines. Workplace violence and harassment: understanding the law [Internet]. Toronto (ON): Queen’s Printer for Ontario; 2016. Available from: <a href="https://www.ontario.ca/page/understand-law-workplace-violence-and-harassment">https://www.ontario.ca/page/understand-law-workplace-violence-and-harassment</a></p>	<ul style="list-style-type: none"> <li>■ Provides an explanation for workers, supervisors, employers, and constructors of the workplace about the workplace violence and harassment requirements in the Occupational Health and Safety Act.</li> <li>■ Provides samples of workplace violence policies, workplace violence programs and workplace harassment policies and programs.</li> </ul>
<p>Safewards. Resources for Safewards implementation [Internet]. [place unknown]: Safewards; c2018. Available from: <a href="http://www.safewards.net">http://www.safewards.net</a></p>	<ul style="list-style-type: none"> <li>■ The Safewards model is a set of 10 principles aimed at making health organizations safer for both patients and workers.</li> <li>■ Provides an overview of the model itself, resources on how to use the interventions, and methods to plan, implement and evaluate the potential training of health workers in this approach.</li> </ul>
<p>International Labour Office; International Council of Nurses; World Health Organization; et al. Framework guidelines for addressing workplace violence in the health sector [Internet]. Geneva: International Labour Organization; 2002. Jointly published by the International Council of Nurses; World Health Organization; and Public Services International. Available from: <a href="http://www.who.int/violence_injury_prevention/violence/activities/workplace/en/">http://www.who.int/violence_injury_prevention/violence/activities/workplace/en/</a></p>	<ul style="list-style-type: none"> <li>■ Intended to support all those responsible for safety in the workplace.</li> <li>■ Provides considerations when developing workplace violence prevention programs and education.</li> </ul>

**RECOMMENDATION 2.2:**

The expert panel recommends that health service organizations implement protective and security measures, such as the following:

- documentation and communication of a person’s previous incident(s) of violence;
- equipment to protect against violent behaviours, and a standardized approach for deciding what, when and how to use these;
- environmental security measures, including locked doors, closed-circuit cameras and alarm systems; and
- formal reporting systems that are simple to use.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

**Confidence in the evidence:** Moderate

**Discussion of Evidence:****Benefits and Harms**

The research evidence explores the use of various protective and security measures to support health workers within an organization. Due to the diversity of approaches utilized, it is unclear which protective and security measures are most effective in reducing health worker injuries and assaults (60, 66-68). However, those identified in the literature list the following components.

*Documentation and Communication of a Person’s Previous Incident(s) of Violence*

A quality improvement initiative in one psychiatric unit for patients with high-risk behaviours was implemented to protect health workers from patient aggression. The initiative included various documentation and **communication strategies**<sup>G</sup> about a person’s previous incidents of violence. For example, unit staff completed an initial assessment interview with a person’s caregivers about their behaviour in the previous six months. This provided health workers with pertinent information about the person’s violence history prior to engaging and interacting with them (63). Other communication strategies included the following:

- huddles between shifts to discuss aggressive patient behaviours and how to manage them;
- bedside safety handoffs where oncoming and outgoing staff discuss patient-related information (e.g., patient’s recent behavior and the individualized behavioural protocol) in the presence of the patient;
- easily accessible patient information binders that hold information about the patient; and
- a patient identification board, updated every shift, that displays all of the patients on the unit and whether they are at high risk for violence (63).

One year after the implementation of these strategies (and others), a 65 per cent decrease in staff injuries was recorded; the number of days between recordable staff injuries also improved, increasing from 26.5 to 124 (63).

*Equipment to Protect Against Violent Behaviours and a Standardized Approach for Deciding What, When and How to Use Them*

In conjunction with documentation and communication strategies, the previously mentioned organization also had safety equipment available for health workers to protect against aggressive patient behaviour. An accompanying decision key indicated what type of equipment to use and when. Based on information from the initial assessment interview about a person's challenging behaviours, the health worker followed the decision key to arrive at what type of equipment should be worn or easily accessible when engaging with the person (63). Equipment available included **Kevlar sleeves<sup>g</sup>** and gloves, forearm pads, face shields and hair covers.

*Environmental Security Measures, including Locked Doors, Closed-circuit Cameras and Alarm Systems*

Multi-component organizational initiatives to prevent and manage workplace violence also include environmental changes, such as the installation of safety systems (e.g., panic buttons, locked doors and closed-circuit cameras) (64). After changes to the environment were implemented in one hospital, significant decreases in both the rate of assaults (23.5 per cent decrease) and threats (24.5 per cent decrease) were recorded; however, when the site was compared to other sites that did not implement the changes, there was no significant decrease in the rate of assaults and threats (60). A common theme identified among three qualitative studies suggested the need for appropriate equipment and security precautions to prevent violence and injury and increase feelings of safety in an effective way (66, 67, 69). For instance, the use of a patient alert system that identified patients who were at risk of being violent enabled staff to take the necessary steps to prevent violence and/or injury from occurring (67). However, with respect to personal alarm devices, participants in two qualitative studies reported that alarms alone did not increase the sense of safety among health workers; instead, it was the responsiveness of personnel and security who responded to and monitored the alarms and surveillance systems that increased their perception of safety (66, 69).

*Formal Reporting Systems that are Simple to Use*

Nurses who participated in a qualitative study were more likely to report workplace violence through medical records and patient alert systems, as opposed to formal reporting systems that they felt were difficult to use and time-consuming (67).

## Values and Preferences

Evidence suggests that when initiatives – such as personal safety devices, security personnel and incident reporting procedures – are not consistently incorporated and adhered to, health workers feel that violence and aggression is tolerated by the organization and its prevention is not a priority (70).

## Health Equity

Health equity may vary based on whether health workers have access to security equipment and safety procedures to prevent and/or manage violent situations. More research is required to increase understanding of the impact of security equipment, protective measures and safety procedures on health equity.

### Expert Panel Justification of Recommendation

Despite the low certainty in the evidence and the variable impact that security equipment and safety procedures have on health equity, the expert panel attributed high value to organizational initiatives that implement security and protective measures in relation to the harm that can result when these measures are not in place. Therefore, the expert panel determined the strength of the recommendation to be strong.

### Practice Notes

When incorporating security equipment and safety procedures, it is important to consider the following:

- Organizations should conduct a gap analysis based on their resources, and implement the necessary tools, measures and procedures outlined in the recommendation.
- Organizations should document the implementation of protective and security measures within a policy. The policy should identify the stakeholders responsible for implementing, maintaining and following up on the protective and security measures that are implemented.
- The organization should convene a team of relevant stakeholders who will be responsible for implementing, maintaining and following up on these measures (as required). Stakeholders should include individuals from various departments (e.g., human resources, occupational health and safety or clinical units) who will advocate for the safety and well-being of both the person and the health worker.
- In addition to the communication strategies outlined in the Benefits and Harms section, electronic or paper-based health records can be used to alert or notify health workers that a potentially violent patient has been admitted.
- Primary prevention strategies as outlined in **Recommendations 3.1 to 3.3** need to be considered and implemented in addition to security equipment and safety procedures.
- Security and safety strategies should align with health and safety laws within the region in which the recommendation is being implemented.
- Security personnel should be included in the implementation of the initiative (64, 66). A good working relationship between health workers and security personnel is important.
- Implemented strategies, including incident reporting systems, should be efficient, easy-to-use and not consume a lot of time or resources (63, 67). If health workers feel a system is too burdensome and time consuming, reporting will not occur, particularly for incidents that do not lead to physical injury (71).
- Clear guidance on what the health worker needs to do regarding the security and safety strategy or approach is crucial (63, 67). This includes education and training on the documentation of violent incidents, including what information is pertinent to report.

## Supporting Resources

RESOURCE	DESCRIPTION
<p>Canadian Standards Association (CSA); Bureau de normalisation du Québec. Psychological health and safety in the workplace – prevention, promotion, and guidance to staged implementation [Internet]. [place unknown]: Bureau de normalisation; 2013. Jointly published by the CSA. Available from: <a href="https://www.csagroup.org/documents/codes-and-standards/publications/CAN_CSA-Z1003-13_BNQ_9700-803_2013_EN.pdf">https://www.csagroup.org/documents/codes-and-standards/publications/CAN_CSA-Z1003-13_BNQ_9700-803_2013_EN.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Although not specific to health service organizations, this document specifies requirements for a documented and systematic approach to develop and sustain a psychologically healthy and safe workplace.</li> <li>■ Provides specific guidance on some key preventive and protective measures in the workplace.</li> </ul>
<p>International Association for Healthcare Security &amp; Safety (IAHSS). Certifications [Internet]. [place unknown: publisher unknown]; c2018. Available from: <a href="http://www.iahss.org/?page=certifications">http://www.iahss.org/?page=certifications</a></p>	<ul style="list-style-type: none"> <li>■ IAHSS has a list of certifications for security personnel, managers and directors in health organizations to improve the health and safety of the workplace.</li> <li>■ Provides both industry and design guidelines to assist health-care administrators (regardless of the type, size or geographic location of their health-care facility) to provide safe and secure environments. The Guidelines are in congruence with regulatory, accreditation and health-care professional association requirements.</li> </ul>
<p>Ontario Health Care Health and Safety Committee Under Section 21 of the Occupational Health and Safety Act. Guidance note for workplace parties #8: workplace violence [Internet]. [place unknown]: Ontario Health Care Health and Safety Committee; 2014. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2014/12/Workplace-Violence-Health-Care-Section-21-Committee-December-2014.pdf">https://www.pshsa.ca/wp-content/uploads/2014/12/Workplace-Violence-Health-Care-Section-21-Committee-December-2014.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Offers guidance on safety procedures that would be considered good practices to reduce the risks of workplace violence in health care.</li> <li>■ Assists organizations and health workers to understand their legislative responsibilities when developing and maintaining a workplace violence policy and program.</li> </ul>
<p>Public Services Health &amp; Safety Association (PSHSA). Security toolkit: resource manual [Internet]. Toronto (ON): PSHSA; 2017. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2017/04/VPRMNKEN0317-Security-Toolkit-v1.1-2017.04.21.pdf">https://www.pshsa.ca/wp-content/uploads/2017/04/VPRMNKEN0317-Security-Toolkit-v1.1-2017.04.21.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Designed to help community and health service organizations establish an effective security program.</li> <li>■ Provides sample tools to identify security program gaps and develop a comprehensive and customized action plan.</li> </ul>

RESOURCE	DESCRIPTION
<p>Public Services Health &amp; Safety Association (PSHSA). Communicating the Risk of Violence: A Flagging Program Handbook for Maximizing Preventative Care [Internet]. Toronto (ON): PSHSA; [date unknown]. Available from: <a href="https://workplace-violence.ca/tools/flagging/">https://workplace-violence.ca/tools/flagging/</a></p>	<ul style="list-style-type: none"> <li>■ Tools and information that organizations can use when implementing a flagging-alert program to advise health workers of violence-related risks.</li> </ul>
<p>Public Services Health &amp; Safety Association (PSHSA). Personal Safety Response System [Internet]. Toronto (ON): PSHSA; [date unknown]. Available from: <a href="https://workplace-violence.ca/tools/personal-safety-response-system/">https://workplace-violence.ca/tools/personal-safety-response-system/</a></p>	<ul style="list-style-type: none"> <li>■ For community and health organizations, a toolkit containing resources when implementing a system to summon immediate assistance when a workplace violence episode is imminent or in progress.</li> </ul>
<p>Public Services Health &amp; Safety Association (PSHSA). Appendix D: overview of PSRS device options and features tools. Toronto (ON): PSHSA; [date unknown]. Available from: <a href="https://workplace-violence.ca/wp-content/uploads/2017/06/VWVTLHEN1117-Appendix-D-Overview-of-PSRS-Device-Options-and-Features-Tool.pdf">https://workplace-violence.ca/wp-content/uploads/2017/06/VWVTLHEN1117-Appendix-D-Overview-of-PSRS-Device-Options-and-Features-Tool.pdf</a></p>	<ul style="list-style-type: none"> <li>■ A component of the personal safety response system toolkit listed above, this appendix provides an overview of the various tools and devices, their features and the setting (e.g., community, acute or long-term care) where they are most applicable.</li> <li>■ Some devices include a cellular phone with working alone app, pagers, two-way radios, physical alarms and more.</li> </ul>
<p>Sentinel Alert Event [Internet]. [place unknown]: The Joint Commission; c2018. Available from: <a href="https://www.jointcommission.org/sentinel_event.aspx">https://www.jointcommission.org/sentinel_event.aspx</a></p>	<ul style="list-style-type: none"> <li>■ The Sentinel Event Alert describes the essential role of leadership in developing a safety culture within an organization, and it recommends steps to reduce and prevent adverse events from occurring.</li> </ul>

**RECOMMENDATION 2.3:**

The expert panel recommends that formal leaders within health service organizations support health workers in preventing and addressing workplace violence by doing the following:

- understanding and implementing policies against workplace violence; and
- reviewing and acting on reported workplace violence incidents.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

**Confidence in the evidence:** Low

**Discussion of Evidence:****Benefits and Harms**

The literature demonstrates that when formal leaders have an understanding of workplace violence prevention policies and are supportive of their implementation, rates of staff injury decrease. For instance, a 65 per cent decrease in documented staff injuries was found after implementation of a multi-component workplace violence initiative that included leadership rounds to ensure thorough understanding and adoption of policies and interventions to prevent and manage workplace violence (62, 63).

A decrease in staff injury is also noted when formal leaders encourage and review workplace violence incidents. For example, when incidents of patient aggression towards health workers were consistently reviewed by leadership – including in-depth assessments of the successes and challenges of the events – a 48 per cent decrease in staff injuries was reported (62). However, one study found that after management encouraged health workers to report any aggressive and violent events that arose in an emergency department, only reporting of actual physical aggression committed by patients towards health workers increased. In contrast, reporting of overall incidents of workplace aggression and threats of patient aggression decreased (61).

Two qualitative studies identified the important role that managers and supervisors have in contributing to feelings of safety and support among health workers during and after violent incidents (68, 69). For instance, lack of routine follow-up and managerial support after a violent patient event created feelings of disappointment and solitude in health workers, and it led to a decrease in the reporting of future incidents (69).

**Values and Preferences**

In one study, participants stated they did not report incidents of violence and/or aggression because they did not feel supported when they reported an incident in the past, especially if the same clinical manager was working (71).

## Health Equity

Although managerial and leadership involvement in preventing and managing workplace violence has an uncertain impact on health equity, it is reasonable to assume that health equity increases when formal leaders create safe working conditions. Health workers who feel protected and supported at work are able to deliver quality care to patients and clients effectively. More research is required to increase understanding of the impact that leadership involvement has on health equity.

## Expert Panel Justification of Recommendation

The expert panel attributed more value to having formal leaders use strategies and skills to assist health workers to prevent and/or manage violent incidents. This promotes a culture of safety and instils a sense of satisfaction and competence in health workers, which can potentially increase health equity. For that reason, despite the low certainty in the evidence, the expert panel determined the strength of the recommendation to be strong.

## Practice Notes

- To ensure that formal leaders have the capacity and capability to support health workers effectively, organizations are required to invest in support, education and training in the area of workplace violence.
- Managers and other formal leaders need to be actively involved in supporting health workers, reviewing violent incidents, understanding and embracing change and promoting a culture that advocates against violence (61, 62).
- One qualitative study found that health workers were reluctant to complete incident reports because they were afraid of the potential for negative repercussions from management and their employer or professional body (21). Staff should be supported and encouraged to report workplace violence incidents and participate in post-incident reviews, free from judgment.
- Strategies such as purposeful dialogue with staff and patients enable nurse managers to participate actively in the safety of health workers and patients (68). Thus, formal leaders should involve health workers in the process of understanding and implementing policies against workplace violence, and in the review of violent incidents.
- Aside from reviewing the reported workplace violence incidents, formal leaders need to follow-up with all parties involved in the incident and indicate what steps have been taken to mitigate its damage and prevent the incident from occurring again.

## Supporting Resources

RESOURCE	DESCRIPTION
Health Quality Ontario (HQO). Quality improvement plan guidance: workplace violence prevention [Internet]. Toronto (ON): HQO; 2017. Available from: <a href="http://www.hqontario.ca/Portals/0/documents/qi/qip/guidance-workplace-violence-en.pdf">http://www.hqontario.ca/Portals/0/documents/qi/qip/guidance-workplace-violence-en.pdf</a>	<ul style="list-style-type: none"> <li>■ Supports hospitals in meeting the expectations of the mandatory workplace violence indicator in Ontario for the 2018/2019 quality improvement plans.</li> <li>■ Includes guidance for improving reporting culture on workplace violence.</li> </ul>
Public Services Health & Safety Association (PSHSA). Fast facts: how to investigate an incident [Internet]. Toronto (ON): PSHSA; 2013. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2013/02/How_To_Investigate.pdf">https://www.pshsa.ca/wp-content/uploads/2013/02/How_To_Investigate.pdf</a>	<ul style="list-style-type: none"> <li>■ A guide that outlines the steps involved when conducting an investigation into a reported incident.</li> <li>■ The reported incident is one that did not result in any harm to the worker or cause damage to property, but it is an undesired event.</li> <li>■ The intention of the investigation is to stimulate discussion between formal leaders and health workers.</li> <li>■ A toolkit on how to investigate violent incidents is currently being created by PSHSA.</li> </ul>
PTSD Association of Canada. Welcome to the PTSD Association of Canada [Internet]. London (ON): PTSD Association of Canada; c2006-2018. Available at: <a href="http://www.ptsdassociation.com/">http://www.ptsdassociation.com/</a>	<ul style="list-style-type: none"> <li>■ Provides information about PTSD, including articles, research and coping strategies.</li> <li>■ The information is for persons experiencing PTSD, persons at risk of experiencing PTSD, and caregivers and families who care for persons experiencing PTSD.</li> </ul>
U.S Department of Veterans Affairs. PTSD: National Center for PTSD. Washington (DC): U.S. Department of Veterans Affairs; c2018. Available from: <a href="https://www.ptsd.va.gov">https://www.ptsd.va.gov</a>	<ul style="list-style-type: none"> <li>■ Provides manuals, modules and resources for individuals suffering from PTSD or families of individuals with PTSD.</li> <li>■ Although the resources were developed for the immediate aftermath of disaster and terrorism, it also can be used by primary and health care providers.</li> </ul>

RESOURCE	DESCRIPTION
<p>Workplace Violence Prevention in Healthcare Leadership Table. A framework for making hospitals a safer workplace free from workplace violence [Internet]. [place, publisher, date unknown]. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2017/03/P1_VPRTLYEN0217-Accountability-Framework-2.pdf">https://www.pshsa.ca/wp-content/uploads/2017/03/P1_VPRTLYEN0217-Accountability-Framework-2.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Health workers have the right to do their jobs in a safe environment, free from violence.</li> <li>■ Hospitals that are safer workplaces benefit everyone, because a safe environment enables health workers to meet the evolving needs of all patients more effectively.</li> </ul>
<p>Workplace Violence Prevention in Healthcare Leadership Table. Training matrix [Internet]. [place, publisher, date unknown]. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2017/03/P9_VPRTLAEN0317-Training-Matrix.pdf">https://www.pshsa.ca/wp-content/uploads/2017/03/P9_VPRTLAEN0317-Training-Matrix.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Provides direction on assessing supervisory competency and associated violence risk training for a specific setting.</li> <li>■ It is recommended that the tool be completed by a multi-stakeholder assessment team, including senior management and others.</li> </ul>

**RECOMMENDATION 2.4:**

The expert panel recommends that health service organizations implement a process for formal incident reviews immediately following a violent event to discuss the details of what occurred, the approach that was used and the strategies for violence prevention in the future.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

**Confidence in the evidence:** Moderate

**Discussion of Evidence:****Benefits and Harms**

A **formal incident review**<sup>G</sup> is a method to discuss and analyze the events leading up to an accident, injury or near miss. Incident reviews can occur verbally during a huddle (62) or in an online or paper format (63). As part of a larger organizational initiative, debriefing huddles with staff were held immediately following an aggressive patient event (62). Huddles provided an opportunity to review and reflect on the incident, including a discussion on the challenges and successes of the techniques used, and to create recommendations for improvement and prevention (62). Five years after implementation, a 48 per cent decrease in staff injuries was reported (62).

In a quality improvement initiative, a 17-item questionnaire completed by staff was introduced to review violent incidents, specifically the factors that led to the event (63). A 65 per cent decrease in staff injuries was found nine months after the initiative commenced (63). Participation in post-incident reviews was also found to increase understanding of workplace violence and contribute to the continued development of organizational initiatives to prevent and manage violent incidents (63).

In one qualitative study, the attitude of the manager was found to be a critical factor in how the violent event is resolved, such that if the event is taken seriously by managers it is more likely to be appropriately handled (e.g., police are contacted and staff are provided with helpful information on managing the incident (69).

**Values and Preferences**

The expert panel emphasized that before engaging in a post-incident review, the health worker involved in the incident should feel supported by co-workers and formal leaders, and that their physical and mental well-being should be addressed and given priority. This is elucidated in a qualitative meta-synthesis, where staff felt isolated and abandoned when support from management was lacking after a difficult or dangerous event (70).

**Health Equity**

The expert panel suggests that health equity may increase if health workers involved in a violent incident are provided with physical and emotional support, and if the post-incident review is conducted in a manner that encourages open dialogue and is free from blame. More research is required to improve understanding of the impact that post-incident reviews after violent events have on health equity.

### Expert Panel Justification of Recommendation

Despite the low certainty in the evidence and the uncertain impact that a formal incident review will have on health equity, the expert panel attributed high value to post-incident reviews where both health workers and leaders actively participate in purposeful and supportive discussions. Therefore, the expert panel determined the strength of the recommendation to be strong.

### Practice Notes

It is important to consider the following when conducting post-incident reviews:

- Promoting the recovery of health workers from the aftermath of the violent incident should occur.
- Although the formal incident review should be conducted immediately following the event, the time frame may vary depending on the situation. At minimum, an immediate informal review of the event is required for protective measures to be established to prevent further harm or injury.
- Organizations should document the implementation of formal incident reviews within a policy. The policy should identify the stakeholders responsible for implementing, maintaining and following up on the formal incident reviews.
- The organization should convene a team of relevant stakeholders who will be responsible for implementing, maintaining and following up on the formal incident review. Stakeholders should include individuals from various departments (e.g., human resources, occupational health and safety or clinical units) who will advocate for the safety and well-being of both the patient and the health worker.
- Discussion of the incident needs to be conducted in a sensitive manner that does not place blame on the health worker.
- Post-incident support is more likely when the overall occupational health and safety environment is positive, such as when the organization has policies and training in place for the prevention and management of violence, occupational health and safety is made a priority, supervisors support a safe environment for their staff, and there are high levels of psychological safety among colleagues (72).
- In Ontario, Bill 168 (the Occupational Health and Safety Amendment Act, 2009) requires employers to have measures and procedures that employees can use to report incidents of workplace violence and/or harassment; they also must have a procedure to investigate and manage incidents or complaints of workplace violence and/or harassment (24).

## Supporting Resources

RESOURCE	DESCRIPTION
Bill 168. Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace). Toronto (ON): Legislative Assembly of Ontario; 2009.	<ul style="list-style-type: none"> <li>■ Bill 168 outlines requirements that workplace organizations must follow to protect employees from workplace violence and harassment.</li> </ul>
Canadian Patient Safety Institute; Institute for Safe Medication Practices Canada; Saskatchewan Health; et al. Canadian incident analysis framework [Internet]. Edmonton (AB): Canadian Patient Safety Institute; 2012. Available from: <a href="http://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF">http://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF</a>	<ul style="list-style-type: none"> <li>■ Provides a framework and information for conducting a critical incident analysis related to patient care in health settings.</li> <li>■ Describes how an incident can be analyzed, recommendations can be created, and improvements can be made in order to reduce future risk.</li> </ul>
Public Services Health & Safety Association (PSHSA). Fast facts: how to investigate an incident [Internet]. Toronto (ON): PSHSA; 2013. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2013/02/How_To_Investigate.pdf">https://www.pshsa.ca/wp-content/uploads/2013/02/How_To_Investigate.pdf</a>	<ul style="list-style-type: none"> <li>■ A guide that outlines the steps involved when conducting an investigation into a reported incident.</li> <li>■ The reported incident is one that did not result in any harm to the worker, or cause damage to property, but an undesired event did occur.</li> <li>■ The intention of the investigation is to stimulate discussion between formal leaders and health workers.</li> <li>■ A toolkit on how to investigate violent incidents is currently being created by PSHSA.</li> </ul>
Workplace Safety and Insurance Board. Employer’s responsibilities in the return to work process [Internet]. Available from: <a href="http://goo.gl/RT2M2W">goo.gl/RT2M2W</a>	<ul style="list-style-type: none"> <li>■ Provides employers of injured workers with insight on what is required after a workplace incident and what is involved in the process of returning to work.</li> </ul>

## Recommendations Addressing Harassment and Bullying from Formal Leaders, Health Workers or Students

### RECOMMENDATION 2.5:

The expert panel suggests that health service organizations and academic institutions provide education and training to health workers and students on addressing workplace harassment and bullying (see Recommendations 3.4 and 3.5 for specific education content).

**Strength of the recommendation:** Conditional

**Certainty of the evidence of effects:** Low

### Discussion of Evidence:

#### Benefits and Harms

Providing health workers and students with education to address harassment and bullying in health service organizations and academic institutions is important for identifying and addressing issues of harassment and bullying. A **meta-analysis**<sup>G</sup> measured the effectiveness of the **Civility, Respect, and Engagement in the Workforce (CREW)**<sup>G</sup> intervention on harassment and bullying. CREW is a tailored organizational intervention that includes training facilitators and hospital leaders on methods to discuss and improve working relationships in the workplace (73). The results of the meta-analysis indicated an increase in perceived civility scores, and one study demonstrated a decrease in perceived supervisor incivility (8).

To enhance professional opportunities for nursing students attending a college designated by the U.S. Department of Education as a Hispanic-serving and minority-serving institution, an educational workshop was incorporated into the teaching methodology of the undergraduate nursing program (35). The aim of these two-hour workshops was for nursing students to recognize bullying, become empowered by learning communication and behavioural strategies, and learn how to manage the political landscape in which they are situated (35). A 10 to 33 per cent increase in the ability of students to recognize bullying was found after the workshops were implemented. Students also became more dedicated to ending bullying, and they served as advocates for creating bully-free work zones (35). The success of the program led other health departments within the school – as well as for-profit and non-profit agencies within the community – to request the inclusion of the workshops for their own multicultural staff (35).

#### Values and Preferences

There was no literature identified that reported on the values and preferences of health workers or students with respect to education and training on workplace harassment and bullying.

#### Health Equity

Health workers and students with multiple intersections of identity may disproportionately be affected by harassing and bullying behaviours that increase health inequity (35). Harassment and bullying, particularly directed at populations who are oppressed, can also reduce leadership and professional opportunities. Implementing educational programs that address harassment and bullying can bring the issue to the forefront, empower health workers and students, improve the quality of work life and ultimately increase quality care.

### Expert Panel Justification of Recommendation

The expert panel could not attribute high value to providing education about harassment and bullying for health workers and students due to low certainty in the evidence and the possibility that education may be delivered inappropriately. According to the expert panel, education can be potentially harmful if it is not delivered effectively and does not include resources to support health workers and students. The expert panel also cautions that education cannot be a stand-alone approach; instead, a larger cultural shift towards an environment free from harassment and bullying needs to occur. Therefore, the expert panel determined the strength of the recommendation to be conditional.

### Practice Notes

It is important to consider the following before implementing education and training on workplace harassment and bullying:

- Legislation in Ontario, Canada states that employers need to provide their employees with information and instruction about the contents of the workplace violence and workplace harassment policies and programs (Bill 168). Moreover, employers need to let their employees know if there is a risk of workplace violence from a person with a history of violent behaviour who an employee may encounter in the workplace (24).
- Health service organizations and academic institutions have a responsibility to review the necessary legislation in their region and deliver education as mandated.
- Harassment and bullying should be addressed continuously, with discussion of the topic occurring during team meetings, huddles, in-services, and more. This will help to increase awareness and resolve conflicts.
- For additional information on approaches and potential strategies to deliver education on workplace harassment and bullying, refer to [Appendix I](#).

## Supporting Resources

RESOURCE	DESCRIPTION
<p>Bill 132. Sexual Violence and Harassment Action Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment). Toronto (ON): Legislative Assembly of Ontario; 2016. Available from: <a href="https://www.ola.org/en/legislative-business/bills/parliament-41/session-1/bill-132">https://www.ola.org/en/legislative-business/bills/parliament-41/session-1/bill-132</a></p>	<ul style="list-style-type: none"> <li>■ Outlines the legislation in Ontario, Canada, to advance the action plan of the provincial government to stop sexual violence and harassment across schools, workplaces and rental units.</li> </ul>
<p>Bill 168. Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace). Toronto (ON): Legislative Assembly of Ontario; 2009.</p>	<ul style="list-style-type: none"> <li>■ Bill 168 outlines requirements that workplace organizations must follow to protect employees from workplace violence and harassment.</li> </ul>
<p>Excellent Care for All Act. Toronto (ON): Ministry of Health and Long-Term Care; 2010. Available from: <a href="http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx">http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx</a></p>	<ul style="list-style-type: none"> <li>■ Legislation that sets out requirements for health care providers employed in Ontario hospitals.</li> <li>■ Requirements for hospitals are listed, such as the establishment of an interprofessional quality committee that includes the hospital's chief nursing executive.</li> </ul>
<p>Public Services Health &amp; Safety Association (PSHSA). Fast facts. Workplace violence: complying with the Occupational Health and Safety Act [Internet]. Toronto (ON): PSHSA; 2010. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2013/01/FFWorkplaceViolence.pdf">https://www.pshsa.ca/wp-content/uploads/2013/01/FFWorkplaceViolence.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Provides organizations with guidance on complying with the Ontario Occupational Health and Safety Amendment Act on employer responsibilities for addressing violence, harassment and domestic violence in the workplace.</li> </ul>

**RECOMMENDATION 2.6:**

The expert panel recommends that health service organizations and academic institutions implement appropriate policies and codes of conduct to address harassment and bullying in the workplace and learning environment.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

**Discussion of Evidence:****Benefits and Harms**

A literature review was conducted to assess how policies that address lateral violence in hospitals are effectively implemented (8). Results suggested that successful adoption of these policies is contingent on having policies that are guided by best practices and implemented by a designated council that legislates and standardizes practice change across the organization (8). In a nursing undergraduate program, a code of conduct to address bullying was implemented. The code of conduct included ground rules for behaviour, misconduct and issues such as removal from classes and clinical settings; it also outlined the consequences if those rules were not followed (74). Both faculty and students reported a decrease in perceived uncivil behaviour in the classroom (58 per cent and 25 per cent, respectively) four months after the code of conduct was implemented (8).

**Values and Preferences**

There was no literature identified that reported on the values and preferences of health workers and students with respect to the implementation of policies and codes of conduct to address harassment and bullying in the workplace and academic learning environment.

**Health Equity**

Health equity may vary based on how the policies and/or codes of conduct are implemented across an organization or academic setting, particularly if they are well-understood and consistently endorsed and supported. More research is required to increase understanding of the impact of anti-harassment and anti-bullying policies on health equity.

**Expert Panel Justification of Recommendation**

Despite the low certainty in the evidence and the variable impact that policies and/or codes of conduct have on health equity, the expert panel attributed more value to the implementation of policies and codes of conduct that address harassment and bullying due to the harm that could potentially occur to health workers and students if such policies and codes of conduct are not in place. The expert panel emphasized that when policies and codes of conduct are consistently understood, implemented and endorsed, health workers and students feel safe and supported. Therefore, the expert panel determined the strength of the recommendation to be strong.

**Practice Notes**

It is important to consider the following when implementing policies and codes of conduct that address harassment and bullying in the workplace and academic institutions:

- Under Bill 168, employers in Ontario, Canada are required to write policies on workplace violence and harassment. These policies must be reviewed at least annually to ensure their effectiveness (24).
- The expert panel emphasized that health service organizations and academic institutions must have the resources and culture in place in order for policies that address harassment and bullying to affect health workers or students in a positive manner.
- Zero tolerance policies and passive dissemination strategies do not promote anti-bullying practices (8). Instead, for successful implementation of policies to occur, formal leaders need to consistently understand, support and endorse anti-harassment and anti-bullying policies. Refer to **Recommendation 2.7** for more details.
- Administrators need to actively participate in daily activities in a workplace for lateral violence policies to be effective (8). In order to participate actively in daily activities, administrators need to understand workflows, pressures and potential and/or actual sources of conflict.
- Health workers should be consulted and involved when developing and implementing policies and codes of conduct in a health service organization and academic institution.

### Supporting Resources

RESOURCE	DESCRIPTION
Alberta Health Services. Workplace violence: prevention and response [Internet]. [place unknown]: Alberta Health Services; 2014. Available from: <a href="https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-workplace-violence-prevention-response.pdf">https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-workplace-violence-prevention-response.pdf</a>	<ul style="list-style-type: none"> <li>■ Provides a policy developed by Alberta Health Services to describe strategies for the prevention of (and response to) workplace violence.</li> </ul>
Bill 168. Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace). Toronto (ON): Legislative Assembly of Ontario; 2009.	<ul style="list-style-type: none"> <li>■ Bill 168 outlines requirements that workplace organizations must follow to protect employees from workplace violence and harassment.</li> </ul>
Binney E. Experts Recommend Workplace Bullying Policies [Internet]. 2012 Oct 2. [place unknown]: Society for Human Resource Management; c2018. Available from: <a href="https://www.shrm.org/resourcesandtools/hr-topics/employee-relations/pages/experts-recommend-workplace-bullying-policies.aspx">https://www.shrm.org/resourcesandtools/hr-topics/employee-relations/pages/experts-recommend-workplace-bullying-policies.aspx</a>	<ul style="list-style-type: none"> <li>■ Provides policy resources for developing anti-harassment and anti-bullying policies. Includes links to sample policies and training resources.</li> <li>■ Although not specific to health service organizations, these resources could still be applicable when an organization is creating or modifying existing policies.</li> </ul>

RESOURCE	DESCRIPTION
<p>Michael Garron Hospital. Harassment and discrimination prevention policy. [place unknown]: Michael Garron Hospital; 2018. Available from: <a href="https://rnao.ca/bpg/guidelines/workplaceviolence">https://rnao.ca/bpg/guidelines/workplaceviolence</a></p>	<ul style="list-style-type: none"> <li>■ Policy document created to increase awareness of harassment and discrimination among members of the hospital committee, to provide education about the standards of conduct, and to provide a complaint and resolution process that is impartial and efficient in order to address issues that arise.</li> </ul>
<p>Ontario Ministry of Labour. Code of practice to address: workplace harassment under Ontario’s Occupational Health and Safety Act [Internet]. [Toronto (ON)]: Queen’s Printer for Ontario; 2016. Available from: <a href="https://files.ontario.ca/workplace_harassment_en.pdf">https://files.ontario.ca/workplace_harassment_en.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Describes a code of practice to address workplace harassment in Ontario.</li> <li>■ Employers can follow these practices to help meet their workplace harassment legal responsibilities under the Occupational Health and Safety Amendment Act.</li> </ul>

**RECOMMENDATION 2.7:**

The expert panel recommends that formal leaders in health service organizations and academic institutions be actively involved in preventing and addressing harassment and bullying to support health workers and students by doing the following:

- understanding and reinforcing policies that address harassment and bullying; and
- providing mentorship and role modelling of professional behaviour.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

**Confidence in the evidence:** Moderate

**Discussion of Evidence:****Benefits and Harms**

Both quantitative and qualitative research highlights the importance of having managerial and leadership involvement to prevent and/or address bullying and harassment in health service organizations and academic institutions.

*Understanding and Reinforcing Policies that Address Harassment and Bullying*

A common theme identified among three qualitative studies was that for the successful and consistent implementation of policies to occur, managers and supervisors were required to show support, understanding and endorsement of anti-bullying policies and actions (37, 66, 75). For instance, one study that interviewed nurse managers from various units across 15 hospitals identified several challenges when trying to understand and reinforce anti-harassment and anti-bullying policies. Policies were difficult to implement consistently and effectively when they were unclear, did not explicitly outline the manager's role in acknowledging or reprimanding harassing or bullying behaviours, and were not shared with the entire organization (75).

*Providing Mentorship and Role Modelling of Professional Behaviour*

An organizational initiative to prevent lateral violence used the concept of “managers as champions” to create a safe and respectful work environment where everyone was expected to behave with courtesy (8). The initiative was successfully implemented, as evidenced by the uptake and endorsement of all lateral violence policies (8). An anti-bullying workshop and mentoring of nursing students by faculty led to increased awareness of the bullying phenomenon among students, as well as their recognition of self-involvement in bullying behaviours and increased commitment to ending bullying (35).

## Values and Preferences

Health workers value leaders who actively participate in the daily operations of the organization, because it sends the message that they are committed to achieving and maintaining anti-harassment and anti-bullying standards (8). In contrast, leaders who do not have a presence on the unit, are not supportive of staff, overlook unprofessional behaviour and do not enforce “no tolerance” policies are perceived by health workers as aggravating lateral violence (76).

## Health Equity

Health equity may vary, depending on the effectiveness of formal leaders in preventing and addressing harassment and bullying. Formal leaders who have the ability and skills to understand and reinforce anti-harassment and anti-bullying policies – and who model professional behaviour – promote positive working environments. This can increase the sense of safety and support perceived by health workers and students when issues of bullying and/or harassment arise and need to be reported.

## Expert Panel Justification of Recommendation

Despite low certainty in the body of quantitative evidence, moderate confidence in the body of qualitative evidence, and the variable impact on health equity, the expert panel attributed high value to the active involvement of formal leaders in addressing harassment and bullying in order to foster a safe and supportive workplace culture. Therefore, the expert panel determined the strength of the recommendation to be strong.

## Practice Notes

The following are strategies that can effectively increase the ability of formal leaders to be involved in actively preventing and addressing harassment and bullying:

- Managers and leaders must demonstrate commitment to improving the quality of the workplace environment, which will in turn elicit positive responses from health workers (8).
- Managers need to be approachable, supportive and purposeful in actions to prevent violence; this helps staff feel safer at work (66). For example, formal leaders can regularly interview health workers and/or ask health workers to complete a validated risk assessment to assess the extent of harassment and/or bullying on the unit or within the organization (see **Recommendation 1.3**). With this information, formal leaders will be able to intervene appropriately. Moreover, it is important that formal leaders be aware that not hearing or witnessing harassing and/or bullying behaviours does not indicate that these behaviours do not exist.
- Ineffective leadership was experienced by nursing students who felt disrespected and neglected by nurses, preceptors, and physicians during their clinical placements. The nursing students experienced a range of situations such as a lack of guidance from their preceptors, receiving excessive demands for chores, and being blamed by their preceptors for errors in a patient’s vital signs. This perpetuated acts of incivility within the clinical learning environment (27).
- The expert panel emphasized that health workers often are concerned with being alienated by their peers if they involve superiors in conflict management. This was also identified in the literature: health workers fear bullying will worsen if incidents of bullying are reported or discussed with formal leaders (37). In contrast, nurses report that peer support after an incident of horizontal violence is a protective factor that can mitigate the effects of the violence (76). The expert panel determined that one way to encourage reporting is for formal leaders to share personal stories and/or experiences about how they handled similar situations, including the successes and lessons learned. Formal leaders can also hold frequent coaching sessions to increase the competence and confidence of health workers in managing these difficult situations.

- The expert panel stressed the importance of providing formal leaders with the necessary education to address concerns about harassment and bullying successfully. Education should include information about what is considered violence, harassment and bullying, along with the classifications of violence (i.e., Type I through IV).
- The expert panel emphasized that formal leaders require adequate support, skills and resources to resolve issues of harassment and bullying within health service organizations and academic institutions.

## Supporting Resources

RESOURCE	DESCRIPTION
College of Nurses of Ontario (CNO). Practice guideline: conflict prevention and management [Internet]. Toronto (ON): CNO; 2017. Available from: <a href="https://www.cno.org/globalassets/docs/prac/47004_conflict_prev.pdf">https://www.cno.org/globalassets/docs/prac/47004_conflict_prev.pdf</a>	<ul style="list-style-type: none"> <li>■ Highlights the role of nurses in formal leadership positions in the prevention and management of conflict between nurses, clients and colleagues in the workplace.</li> <li>■ Provides additional resources and further suggested reading.</li> </ul>
Emergency Nurses Association (ENA). ENA toolkit: workplace violence [Internet]. Des Plaines (IL): ENA; 2010. Available from: <a href="https://www.ena.org/docs/default-source/resource-library/practice-resources/toolkits/workplaceviolencetoolkit.pdf?sfvrsn=6785bc04_28">https://www.ena.org/docs/default-source/resource-library/practice-resources/toolkits/workplaceviolencetoolkit.pdf?sfvrsn=6785bc04_28</a>	<ul style="list-style-type: none"> <li>■ Designed for an emergency department manager or team leader as a resource for developing and implementing a comprehensive plan to address and manage workplace violence and protect staff.</li> <li>■ Provides practical solutions and reporting templates.</li> </ul>
Guarding Minds @ Work: A Workplace Guide to Psychological Health and Safety. Documents and Resources [Internet]. [place unknown]: Centre for Applied Research in Mental Health and Addiction (CARMHA); c2018. Available from: <a href="https://www.guardingmindsatwork.ca/resources">https://www.guardingmindsatwork.ca/resources</a>	<ul style="list-style-type: none"> <li>■ Provides a list of available resources to download on assessment, action and evaluation of psychological health safety in the workplace.</li> <li>■ Additional resources also are available on possible threats to psychological safety and on distinguishing between mental injury, mental distress and mental illness.</li> </ul>

## RECOMMENDATION QUESTION #3:

Should education and training programs on preventing and managing workplace violence, harassment and/or bullying be recommended for health workers to improve outcomes for persons and health workers?

**Outcomes:** Patient injury, use of restraints, perceived safety of health workers, attitudes and values of health workers, health worker injury, and health worker turnover

### Recommendations Addressing Violent Behaviour from Persons

#### RECOMMENDATION 3.1:

The expert panel recommends that health service organizations provide education to health workers on the risk factors and triggers for violent behaviours from persons.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

### Discussion of Evidence:

#### Benefits and Harms

Education for health workers on how to identify risk factors and triggers for violence is beneficial, because it provides health workers with the necessary knowledge and tools to mitigate and/or prevent patient and family aggression (8, 77-80). Overall, evidence suggests improvements in the attitude of health workers towards patient violence and aggression that can be sustained for several months after education is completed (8, 77-80).

#### Values and Preferences

Evidence suggests that educational programs that provided health workers with information about the cues and triggers that may indicate a person will become violent were positively received by health staff (79).

#### Health Equity

Providing education to health workers on identifying risk factors has an uncertain impact on health equity, because it depends on how the education is used to communicate risk. The expert panel suggests that health equity may increase if information about an individual being identified as “high risk” for violence is communicated to health workers in a manner that avoids stigma. For example, hanging a sign on the door or placing a wrist ban on the “at risk” patient may be stigmatizing unless this protocol is commonplace on the unit and implemented across an organization. More research is needed to improve understanding of the impact of education regarding risk factor identification on health equity.

#### Expert Panel Justification of Recommendation

The expert panel attributed high value to providing health workers with education on risk factors and triggers for violence, because it could support improvements in the attitudes and perceptions that health workers have towards persons who display violent behaviours. The expert panel emphasized that education should include cues that health workers can observe in persons that indicate a violent incident is imminent. Therefore, despite low certainty in the evidence and an uncertain impact on health equity, the expert panel determined the strength of the recommendation to be strong.

## Practice Notes

- Risk factors and triggers should be identified to help prevent violent events from occurring. Training provided to health workers about the warning signs of violent behaviour from patients, communication skills to prevent or diffuse the violent situation, and strategies to maintain personal safety may increase self-reported confidence in coping with patients who engage in aggressive behavior (81).
- Triggers should be integrated into the person-centered care planning process.
- It is important to note that while the risk factors and triggers may be tailored to the person receiving care, they also can be applied to families and visitors.
- Education should focus on supporting persons at risk rather than stigmatizing them.
- It is important to recognize that in some situations there is no warning that a violent event is imminent or that a risk factor has not been identified. In these situations, it is crucial for a culture of support (and not blame) to be adopted.
- See **Appendix F** for a list of risk factors or triggers that may predict violent or aggressive behaviours in persons.

## Supporting Resources

RESOURCE	DESCRIPTION
Registered Nurses' Association of Ontario (RNAO). Delirium, dementia, and depression in older adults: assessment and care, second edition [Internet]. Toronto (ON): RNAO; 2016. Available from: <a href="http://RNAO.ca/bpg/guidelines/assessment-and-care-older-adults-delirium-dementia-and-depression">http://RNAO.ca/bpg/guidelines/assessment-and-care-older-adults-delirium-dementia-and-depression</a>	<ul style="list-style-type: none"> <li>■ Provides guidance on exploring the underlying causes of behavioural and psychological symptoms of dementia that could illicit aggressive behaviours.</li> <li>■ Describes assessment and care recommendations specifically for older adults with dementia, delirium and depression.</li> </ul>
The National Institute for Occupational Safety and Health (NIOSH). Occupational Violence: Workplace Violence Prevention for Nurses. [Internet]. [place unknown]: Centers for Disease Control; 2018. Available from: <a href="https://www.cdc.gov/niosh/topics/violence/training_nurses.html">https://www.cdc.gov/niosh/topics/violence/training_nurses.html</a>	<ul style="list-style-type: none"> <li>■ A free online course to help health workers understand the scope and nature of workplace violence.</li> <li>■ Topics include definitions and types of violence, the consequences of violence, risk factors for violence and prevention strategies for both organizations and nurses.</li> </ul>
United States Department of Labour Occupational Safety and Health Administration. Workplace Violence [Internet]. Available from: <a href="https://www.osha.gov/dte/library/">https://www.osha.gov/dte/library/</a>	<ul style="list-style-type: none"> <li>■ Contains links to training and resource materials about workplace violence and workplace violence prevention for nurses.</li> <li>■ Includes resources about risk factors, prevention programs, training and enforcement.</li> </ul>
Workplace Violence Prevention in Health Care Leadership Table. Triggers and care planning in workplace violence prevention [Internet]. [place, publisher, date unknown]. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2017/03/P7_VPRTLCE0317-Triggers-and-Care-Planning.pdf">https://www.pshsa.ca/wp-content/uploads/2017/03/P7_VPRTLCE0317-Triggers-and-Care-Planning.pdf</a>	<ul style="list-style-type: none"> <li>■ Provides an overview of triggers and predisposing factors (risk factors) for violence.</li> <li>■ Although specific to care planning, the list of risk factors and triggers can be applicable to a variety of health workers in various settings.</li> </ul>

**RECOMMENDATION 3.2:**

The expert panel recommends that health service organizations provide training to health workers on de-escalation techniques, including communication and re-direction strategies, to prevent and/or reduce violent incidents within their organizations.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Very low

**Discussion of Evidence:****Benefits and Harms**

**De-escalation<sup>G</sup>** is a strategy to prevent and/or reduce escalation of aggressive and violent incidents, and to decrease the need for mechanical and chemical restraints. A systematic review of four studies that investigated the effect of de-escalation training on restraint use demonstrated a reduction in physical restraint use (82). As part of a multi-component organizational initiative, health worker education about de-escalation strategies has been associated with a 6–75 per cent decrease in the rate of restraint use (62, 83, 84).

A component of de-escalation training is education on communication strategies. A systematic review investigated the effectiveness of aggression management training for nurses and nursing students. Common among the included studies was training content on de-escalation techniques (including verbal and non-verbal communication strategies); these generally led to improvements in the attitudes that participants had about patients who behaved aggressively (82). Likewise, a two-day aggression management course for psychiatric nurses that included theory and education on aggression – and training on communication strategies – found improvements in the perceptions that participants had about why patients act aggressively (77).

Education and training in de-escalation techniques and effective communication skills, including lectures and simulations, led to significant improvements in the attitudes that participants had about the factors that can cause patient aggressive behaviours (85). They also increased awareness about the quality of staff–patient communication (79). Furthermore, an Internet intervention that included videos and narration to train staff on re-direction strategies and de-escalation skills found a non-significant decrease in the number of aggressive incidents per day eight weeks after the training, and a significant decrease after 16 weeks (86). Staff attitudes also improved, and this was maintained when assessed two months after the intervention (87).

Finally, two studies reported a 49 and 63 per cent decrease in staff injuries over a five-year period following the implementation of education on communication strategies within a larger workplace violence prevention program (62, 88).

De-escalation training can also be harmful. After training on the technique, the duration of time that patients were restrained was found to increase by 52 per cent (83), and the odds of new incidents of restraint use increased by 43 per cent (89).

A limitation with all of the aforementioned studies is that the follow-up periods ranged from six months to two years, which makes it challenging to determine the sustainability of education on de-escalation techniques.

### Values and Preferences

Generally, education on communication and re-direction strategies was well received by health workers (79), had a high degree of user acceptance (86) and was rated high for usefulness and satisfaction (87). Nurses, patient care assistants and security staff who participated in interprofessional simulation training about verbal de-escalation were highly satisfied with the learning gained through simulation, and appreciated the discussion that occurred after the simulation session (90). Participants in a mixed-method quasi-experimental study that was conducted across various units in two teaching hospitals reported that de-escalation training taught them active listening and empathy skills, increasing their confidence and competence when communicating with aggressive patients. These health providers also believed that their attitude towards persons who behaved aggressively improved (91). This was in contrast to health providers in the control group, who reported a lack of confidence when dealing with aggressive patients (91). Moreover, it was important for health workers that de-escalation training be conducted in short sessions (as opposed to lengthy workshops) and that refreshers be held periodically (91).

One education program was actually initially rejected by health workers as being more unsafe, even though its aim was to change unsafe practice through communication and re-direction (88). This may indicate the importance of adequate training and understanding of how the strategies should be used in practice to improve safety for workers.

### Health Equity

Many of the included studies were conducted in psychiatric in-patient settings (62, 83, 84, 89). Individuals with mental illness who reside in these environments may have intersecting identities and unique histories that can disproportionately affect their experiences with health equity. Education surrounding optimal de-escalation techniques can increase health worker competence when addressing violent patient behaviour in a non-restrictive, safe and respectful manner. However, as highlighted in one study, education can also negatively affect health equity depending on the resources required (92). The study used a simulation-based approach to train health workers on communication and re-direction techniques, and it reported the extensive time and number of staff needed to ensure that everyone within their department received the education (92). More research is required to improve understanding of the impact of de-escalation techniques on health equity.

### Expert Panel Justification of Recommendation

Despite the very low certainty in the evidence – and an uncertain impact on health equity – the expert panel attributed more value to reducing the incidents of violence and aggression by using de-escalation methods compared to the potential harm that could result from the adoption of such techniques. The expert panel emphasized that numerous quality improvement reports and personal experiences indicate that de-escalation training reduces the use of physical force in health service organizations, and that it increases patient and staff safety. Therefore, the expert panel determined the strength of the recommendation to be strong.

## Practice Notes

It is important to consider the following when providing education on de-escalation techniques:

- When educating health workers about de-escalation techniques, the importance of staff safety needs to be emphasized, as does the continued need for compassionate and person-centered care.
- In order to positively impact person and health worker safety, health workers require adequate and effective education about de-escalation techniques.
- Education should be tailored to the scope of practice of the health worker and their role within the organization. Moreover, mandatory and ongoing refreshers, re-training and simulation are critical to ensure competency.
- When education includes both lectures (e.g., about potential risk factors and how to recognize them, and appropriate verbal and nonverbal communication strategies to de-escalate the situation) and simulated scenarios, health workers increase their knowledge on how to recognize the factors that may lead to violence and how to de-escalate actual or potential aggressive behaviour (93). Moreover, an increase in self-reported skills, ability, confidence and preparedness has been reported (90).
- When possible, simulation should include a variety of direct care team members in order to promote effective interprofessional communication and teamwork (65, 90).
- Workshops that focus on communication techniques, group dynamics and managing discomfort, and dealing with difficult situations may also be a valuable intervention to decrease aggression towards health workers, and also improve health workers' psychological well-being, distress level, and communication competence (94).
- The expert panel stated that education needs to focus on the safe execution of the techniques, and that it should include ongoing support and reinforcement of the learned strategies.
- The expert panel stated that violent behaviour can occur from persons, families and visitors, regardless of time or place. For that reason, targeted communication training for all health workers in all health service organizations is needed.
- Health workers require adequate resources to engage effectively in de-escalation strategies. For example, health providers reported using more restrictive behaviours (e.g., PRN medication or physical restraints) when patients were aggressive because these strategies were more efficient when time and staffing was problematic (95).
- Patients emphasize that de-escalation is a process where health providers do the following:
  - Tolerate the patient's escalating behaviour, and give them time and space.
  - Ask patients why they are behaving aggressively as opposed to imposing their own assumptions.
  - Involve patients in the de-escalation process by listening to the patient, asking them what they want to do to fix the situation, and suggesting (not enforcing) alternative strategies if necessary.
  - Facilitate patient coping strategies.
  - Foster a sense of equality between the provider and patient.
  - Act authentically and truthfully (95).
- See **Appendix J** for the Safewards Model. This internationally recognized model includes 10 interventions that can be used to de-escalate tense situations by engaging both staff and patients.
- See **Appendix L** for the Institute for Work & Health (IWH) scale to measure worker vulnerability to injury before and after a violence prevention education program, and to measure the effectiveness of a communication training program.

## Supporting Resources

ONLINE MODULES ON DE-ESCALATION	DESCRIPTION
<p>Health Employers Association of British Columbia (HEABC). Violence prevention. Respond to the risk: part 1 – perform de-escalation – communication [Internet]. [place, publisher, date unknown]. Available from: <a href="http://www.heabc.bc.ca/VPM/RespondRisk1_Communication/story_html5.html">http://www.heabc.bc.ca/VPM/RespondRisk1_Communication/story_html5.html</a></p>	<ul style="list-style-type: none"> <li>■ Describes how respectful communication can be used to prevent escalation or defuse an emotional crisis before it becomes a behavioural emergency.</li> <li>■ Non-verbal, vocal and verbal communication is presented.</li> </ul>
<p>Health Employers Association of British Columbia (HEABC). Violence prevention. Respond to the risk: part 2 – perform de-escalation – communication [Internet]. [place, publisher, date unknown]. Available from: <a href="http://www.heabc.bc.ca/VPM/RespondRisk2_Strategies/story_html5.html">http://www.heabc.bc.ca/VPM/RespondRisk2_Strategies/story_html5.html</a></p>	<ul style="list-style-type: none"> <li>■ Describes additional strategies that workers can use to respond to an emotional crisis to prevent it from becoming a behavioural emergency.</li> <li>■ Explains when and how to use various de-escalation strategies.</li> </ul>
<p>Health Employers Association of British Columbia (HEABC). E-learning Modules [Internet]. Available from: <a href="http://www.heabc.bc.ca/Page4272.aspx#.Ws4LhljwZPZ">http://www.heabc.bc.ca/Page4272.aspx#.Ws4LhljwZPZ</a></p>	<ul style="list-style-type: none"> <li>■ Provides a full list of eight e-learning modules on violence prevention and links to access the modules.</li> </ul>

LINKS TO SPECIFIC TRAINING PROGRAMS AND COURSES	DESCRIPTION
<p>Advanced Gerontological Education (AGE). Gentle Persuasive Approaches (GPA) [Internet]. Hamilton (ON): AGE; c2017. Available from: <a href="https://ageinc.ca/about-gpa-2/">https://ageinc.ca/about-gpa-2/</a></p>	<ul style="list-style-type: none"> <li>■ Offers information about the evidence-based Gentle Persuasive Approach (GPA) that educates care providers how to respond to responsive behaviours effectively.</li> <li>■ Provides information about the GPA education curriculum and how you can register for it.</li> <li>■ Provides resources, such as a blog and videos that demonstrate GPA.</li> </ul>
<p>Behavioural Supports Ontario Education and Training Consortium Committee. Behavioural education and training supports inventory: section A – introduction and overview [Internet]. [place unknown: publisher unknown]; 2012. Available from: <a href="http://brainxchange.ca/Public/Files/BSO/BETSI-Full-Version-Updated-191212.aspx">http://brainxchange.ca/Public/Files/BSO/BETSI-Full-Version-Updated-191212.aspx</a></p>	<ul style="list-style-type: none"> <li>■ Provides an education and decision-making tool for providers interested in providing safe, quality patient-centred care for older adults with responsive behaviours.</li> <li>■ Provides guidance on choosing the most appropriate education programs and supporting the application of new knowledge into practice for older adults.</li> </ul>
<p>Crisis Prevention Institute (CPI). Training and events [Internet]. [place unknown]: CPI; c2018. Available from: <a href="https://www.crisisprevention.com/en-CA/Training-and-Events">https://www.crisisprevention.com/en-CA/Training-and-Events</a></p>	<ul style="list-style-type: none"> <li>■ Provides training and consulting to manage and prevent challenging behaviour in a safe manner.</li> <li>■ Courses are available in both Canada and the United States in non-violent crisis intervention and dementia care specialities.</li> </ul>
<p>Safe Management Group. Training programs [Internet]. [Oakville (ON)]: Safe Management Group Inc.; [date unknown]. Available from: <a href="http://safemanagement.org/training-programs">http://safemanagement.org/training-programs</a></p>	<ul style="list-style-type: none"> <li>■ Safe management group is a training provider based in Oakville, Ontario, that provides training programs related to safety in a variety of workplaces and contexts.</li> <li>■ The crisis intervention training program is recognized by the Ontario Ministry of Community and Social Services.</li> </ul>
<p>Understanding and Managing Aggressive Behaviour (UMAB) Canada. Understanding and managing aggressive behaviour [Internet]. [place unknown: publisher unknown]; c2011. Available from: <a href="http://www.umabcanada.com/">http://www.umabcanada.com/</a></p>	<ul style="list-style-type: none"> <li>■ Describes the UMAB program, which was developed to address the safety needs of both the service provider and people receiving care.</li> <li>■ Provides resources and tools for health workers and caregivers who work directly with people who experience difficulty and may express it in an unsafe manner.</li> </ul>

RESOURCE	DESCRIPTION
<p>College of Nurses of Ontario (CNO). Therapeutic nurse-client relationship, revised 2006 [Internet]. Toronto (ON): CNO; 2018. Available from: <a href="http://www.cno.org/globalassets/docs/prac/41033_therapeutic.pdf">http://www.cno.org/globalassets/docs/prac/41033_therapeutic.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Describes the expectations for all nurses in establishing, maintaining and terminating a therapeutic relationship.</li> <li>■ Provides guidance on using therapeutic communication.</li> </ul>
<p>Registered Nurses' Association of Ontario (RNAO). Crisis intervention for adults using a trauma-informed approach: initial four weeks of management. 3rd ed. [Internet]. Toronto (ON): RNAO; 2017. Available from: <a href="http://RNAO.ca/bpg/guidelines/crisis-intervention">http://RNAO.ca/bpg/guidelines/crisis-intervention</a></p>	<ul style="list-style-type: none"> <li>■ Provides evidence-based recommendations for crisis intervention using a trauma-informed lens.</li> <li>■ Lists additional resources to enhance crisis care.</li> </ul>
<p>Registered Nurses' Association of Ontario (RNAO). Establishing therapeutic relationships [Internet]. Toronto (ON): RNAO; 2006. Available from: <a href="https://RNAO.ca/bpg/guidelines/establishing-therapeutic-relationships">https://RNAO.ca/bpg/guidelines/establishing-therapeutic-relationships</a></p>	<ul style="list-style-type: none"> <li>■ Provides resources and support for integrating evidence-based nursing practice in the area of establishing therapeutic relationships.</li> </ul>
<p>Registered Nurses' Association of Ontario (RNAO). Person- and family-centered care. Toronto (ON): RNAO; 2015. Available from: <a href="http://RNAO.ca/bpg/guidelines/person-and-family-centred-care">http://RNAO.ca/bpg/guidelines/person-and-family-centred-care</a></p>	<ul style="list-style-type: none"> <li>■ Provides resources and support to enhance the quality of the partnerships nurses and the interprofessional team have with individuals accessing care.</li> </ul>

**RECOMMENDATION 3.3:**

The expert panel recommends that health workers are provided training in breakaway techniques and when to safely use breakaway techniques in violent incidents.

**Strength of the recommendation:** Strong

**Certainty of the evidence of effects:** Low

**Discussion of Evidence:****Benefits and Harms**

**Breakaway techniques<sup>G</sup>** are strategies used to remove oneself safely from various holds, grabs and pulls, while at the same time not physically compromising the aggressor (96). Breakaway techniques do not address the issue of workplace violence; instead, the training can complement education that focuses on the prevention of aggression and violence (96). Research examining the effectiveness of breakaway technique training found that nurses reported a 46 per cent increase in perceived safety. Loss of skills acquired was evident, suggesting that routine refreshers are important to ensure competency (96).

**Values and Preferences**

One quasi-experimental study had nursing staff from four wards (emergency, neuroscience, aged care and community services) participate in a workshop to develop a violence risk assessment and management plan, and learn de-escalation and breakaway techniques that can be used to respond to aggressive or violent persons. Participants found the training on breakaway techniques to be particularly useful, as it increased their confidence to manage different types of patient aggression. Although nurses felt that actively participating in the workshop was effective for learning, some had concerns about the use of breakaway techniques in real-life circumstances (97).

**Health Equity**

Health workers who feel unsafe may be more likely to implement coercive or restrictive practices that can harm patients (96). Organization-wide training on breakaway techniques may increase the confidence and competence of health workers in prevention methods to address violent situations, avoid injuries and increase safety, potentially improving the quality of care. More research is required to better understand the impact of breakaway techniques on health equity.

**Expert Panel Justification of Recommendation**

Despite the low certainty in the evidence and an uncertain impact on health equity, the expert panel attributed more value to health worker safety. When adequately trained, the use of breakaway techniques provides health workers with a strategy to extract themselves from a violent incident, and it potentially decreases exposure to harm and severe injury. Therefore, the expert panel determined the strength of the recommendation to be strong.

**Practice Notes**

It is important to consider the following when employing breakaway techniques:

- Education on breakaway techniques is provided as a complement to education that focuses on the prevention of aggression and violence (96).

- Other techniques, such as communication and de-escalation (see **Recommendation 3.2**), should always be used first. Should those approaches prove to be ineffective, then breakaway techniques may be required to extract oneself from a harmful or dangerous situation.
- Training on breakaway techniques should be modified as required based on the health organization, unit environment and the persons receiving care.
- Mandatory ongoing refreshers, re-training and simulation are crucial (i.e., opportunities to practice using the technique); this will help to ensure competency and reduce the potential for sustaining injury from using the technique. This was also reported by participants in one study who felt that skill maintenance, refreshers and ongoing competency training was required (92).
- If a worker uses the technique incorrectly during a violent incident, a culture of support (and not blame) for the worker should be adopted, regardless of the unit or practice setting.

### Supporting Resources (also see supporting resources in **Recommendation 3.2**)

RESOURCE	DESCRIPTION
<p>Crisis Prevention Institute (CPI). Training and events [Internet]. [place unknown]: CPI; c2018. Available from: <a href="https://www.crisisprevention.com/en-CA/Training-and-Events">https://www.crisisprevention.com/en-CA/Training-and-Events</a></p>	<ul style="list-style-type: none"> <li>■ Provides training and consulting to manage and prevent challenging behaviour in a safe manner.</li> <li>■ Courses are available in both Canada and the United States in non-violent crisis intervention and dementia care specialities.</li> </ul>
<p>Workplace Violence Prevention in Health Care Leadership Table. Engaging patients and families in workplace violence prevention: a handbook for organizational leaders in healthcare [Internet]. [place, publisher, date unknown]. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2017/03/P8_VPRTLBN0317-Engaging-Patients-and-Families-in-Workplace-Violence-Prevention-and-sample-brochure.pdf">https://www.pshsa.ca/wp-content/uploads/2017/03/P8_VPRTLBN0317-Engaging-Patients-and-Families-in-Workplace-Violence-Prevention-and-sample-brochure.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Provides important information on primary prevention of violence as a first-line defence before using breakaway techniques.</li> <li>■ Provides a supplement to other prevention approaches, because it describes how hospitals can partner with patients and families to help prevent violence in the workplace.</li> </ul>

## Recommendations Addressing Harassment and Bullying from Formal Leaders, Health Workers or Students

### RECOMMENDATION 3.4:

The expert panel suggests that health service organizations provide education to health workers on how to identify harassment and bullying, understand the impact of harassment and bullying, and use effective communication strategies.

**Strength of the recommendation:** Conditional

**Certainty of the evidence of effects:** Low

**Confidence in the evidence:** Low

### Discussion of Evidence:

#### Benefits and Harms

Several studies explored the effectiveness of educational programs to increase awareness about bullying in the health service organization and the perceived safety of health workers (specifically on measures of incivility). An intervention to combat nurse-to-nurse lateral violence included theory and history about the issue, resources on how to deal with conflict, cue cards with effective verbal responses and an outline of expected professional behaviours. Results suggested a non-significant increase in the nurse's awareness of lateral violence (98).

Education and simulation activities about the issue of incivility led to decreases in perceived acts of incivility reported by nurses (99, 100). Education and discussion about the impact of incivility resulted in a 6 per cent increase in awareness of incivility among nurses (101). Moreover, when nurses are trained in assertive communication skills, decreases were found in reported **mobbing**<sup>G</sup> (102), verbal abuse at work (103), vacancy rates (from 8.9 per cent to 3.0 per cent over three years), and turnover rates (from 8.9 per cent to 6.0 per cent over three years) (103).

#### Values and Preferences

There was no literature identified that reported on the values and preferences of health workers with respect to education for health workers on harassment and bullying in health service organizations.

#### Health Equity

The expert panel suggests that the impact of this recommendation on health equity would be dependent on the culture of the organization and the overall presence of bullying and harassment. In environments described as “non-toxic,” there is a tendency for health workers to be more engaged and productive, which translates to better patient care and outcomes (101). Alternatively, organizational staff turnover related to problems with bullying and harassment can significantly impact the quality and continuity of care that patients receive (101).

#### Expert Panel Justification of Recommendation

The expert panel could not attribute more value to educating health workers about harassment and bullying – including identification of the issue and communication strategies to manage it effectively – because there is a potential for harm. The expert panel emphasized that bullying behaviours could worsen or become amplified

when harassment and bullying are identified as significant problems on a unit or within an organization. A power differential also could ensue or be exacerbated depending on the perpetrator and how the problem is managed. Therefore, the expert panel determined the strength of the recommendation to be conditional.

### Practice Notes

The following are educational approaches to assist health workers understand and address harassment and bullying:

- The expert panel emphasized that tools and strategies need to be provided to health workers to encourage effective dialogue about harassment and bullying, and that a process should be adopted within health service organizations and academic institutions to handle harassing and bullying situations.
- Employee involvement in the development of an educational program may facilitate adoption of strategies to address lateral and vertical violence. For example, in one quality improvement project a team of 100 interprofessional staff were convened to develop strategies to target negative behaviours, communicate the strategies across the organization, and ensure that staff remained accountable to follow the strategies. Survey results collected two years after implementation suggested a decrease in lateral and vertical aggression by employees (104).
- Training strategies to increase assertiveness can include confidently expressing thoughts and feelings, taking criticism well, coping with stress and protecting rights without conflict (102).
- Education to increase awareness of incivility among health workers can include Power Point presentations or didactic teaching (101, 105).
- Interactive role-play and simulations should be implemented to practice strategies to manage incivility, and to open discussions of personal experiences with incivility (92, 105).
- Strategies to address harassment and bullying for students in academic institutions and the clinical learning environment can be found in **Recommendation 3.5**.

### Supporting Resources

RESOURCE	DESCRIPTION
Institute for Healthcare Improvement. SBAR Tool: Situation-Background-Assessment-Recommendation [Internet]. [place unknown]: Institute for Healthcare Improvement; c2018. Available from: <a href="http://www.ihl.org/resources/pages/tools/sbartoolkit.aspx">http://www.ihl.org/resources/pages/tools/sbartoolkit.aspx</a>	<ul style="list-style-type: none"> <li>■ A tool for clinicians, leaders and educators that structures communication between members of the interprofessional team.</li> </ul>
Fehr FC, Seibel LM. Cognitive rehearsal training for upskilling undergraduate nursing students against bullying: a qualitative pilot study. <i>Quality Advancement in Nursing Education</i> . 2016;2(1):1-17.	<ul style="list-style-type: none"> <li>■ Identifies effective ways for educators to teach and model constructive ways to address and manage workplace bullying.</li> <li>■ Provides students with tools to address bullying, and provides curriculum developers and leaders with information and data.</li> </ul>
Public Services Health & Safety Association (PSHSA). <i>Bullying in the workplace: a handbook for the workplace</i> [Internet]. 1st ed. Toronto (ON): PSHSA; 2010. Available from: <a href="https://www.pshsa.ca/wp-content/uploads/2013/02/BullyWkplace.pdf">https://www.pshsa.ca/wp-content/uploads/2013/02/BullyWkplace.pdf</a>	<ul style="list-style-type: none"> <li>■ A handbook for employers, supervisors, co-workers and victims of bullying to learn about the prevalence and effects of bullying, and to obtain information about how to prevent and/or manage it.</li> </ul>

**RECOMMENDATION 3.5:**

The expert panel recommends that, as part of an interactive learning approach, students learn to use guided communication responses to address harassment and bullying from multiple sources within an academic institution or a clinical learning environment.

**Strength of the recommendation:** Strong

**Confidence in the evidence:** Low

**Discussion of Evidence:****Benefits and Harms**

Two qualitative research studies explored the use of interactive educational programs for students in an academic environment to address the issue of harassment and bullying. The educational programs included cognitive rehearsal training (99) and role-play simulations (99, 100). Both curricula enabled students to explore their perceptions of harassment and bullying, and allowed them to practice effective actions and strategies they could adopt to prevent and address harassment and bullying (99, 100). With the cognitive rehearsal training, students also reported an increase in their perception of confidence to handle future situations (99).

Neither study reported any harms as a result of the educational interventions; however, both discussed the importance of safeguarding students from potentially recreating upsetting scenarios. To mitigate this potential harm, please see the **Practice Notes** below.

**Values and Preferences**

Feedback from the participants in the included studies was positive: the interactive programs were well received, the lanyard cards that outlined communication responses were valued, and the training and role-play simulations were reported to be beneficial learning experiences (99). Participants in another study felt the cognitive rehearsal activity taught them how to effectively communicate in stressful situations and advocate for the safety of their patients (106). Interactive learning modules for undergraduate nursing and midwifery students that included videos of bullying scenarios in clinical settings, links to literature, reflective activities and in-class role-play simulations of how to respond to bullying were also deemed valuable. Students reported that the ability to supplement the online videos with readings and class discussion helped them to recognize bullying behaviours and engage in coping strategies (107).

**Health Equity**

The expert panel suggests that the impact of this recommendation would increase health equity. Students who participate in role-play simulations and learn effective communication responses may be more confident and capable to intervene when confronted with harassment and bullying in academic institutions and/or clinical learning environments. More research is required to improve understanding of the impact of interactive learning approaches and guided communication techniques on health equity.

### Expert Panel Justification of Recommendation

Despite low confidence in the body of qualitative evidence, the expert panel attributed more value to interactive learning approaches for improving knowledge and skill in addressing harassment and bullying than to any potential harms that could result. The expert panel agreed that students need guided communication responses that will assist them if and when confronted with challenging situations from colleagues or faculty in clinical or academic settings. Therefore, the expert panel determined the strength of the recommendation to be strong.

### Practice Notes

It is important to consider the following when implementing an interactive learning approach to address harassment and bullying:

- An integrative literature review found that the most effective teaching methods are active ones that educate students on techniques to address bullying and offer them the ability to practice newly learned strategies (e.g., cognitive rehearsal) (108).
- Using a variety of modalities (e.g., videos, readings and in-class discussion) facilitates and enhances student engagement and learning (107).
- E-learning modules (such as slides or video scenarios) about incivility and how to intervene (28) and cognitive rehearsal training about disruptive behaviours and how to respond (109) can provide effective avenues to increase the ability and self-efficacy of nursing students to identify and respond appropriately to both incivility in the academic environment (100) and disruptive behaviours in the health service organization (99).
- Allowing students to withdraw from an exercise at any point if they find the role-play upsetting – and providing information in advance about the content of the simulation activity – are important strategies to consider when implementing education on this issue (99, 100).
- After cognitive rehearsal simulations, debriefing sessions should be held in a safe environment so that participants can reflect on their thoughts and feelings with respect to the simulated activity, identify aspects that went well or need improvement, and explore strategies that can be implemented when confronted with incidents in the future (106).
- For more information on the communication responses outlined in the study conducted by Fehr & Seibel (2016), please see the lanyard card in **Appendix K**.

## Supporting Resources

RESOURCE	DESCRIPTION
<p>Great-West Life Centre for Mental Health in the Workplace. Communicating effectively. Exercise: using appreciative inquiry [Internet]. [place unknown]: Great-West Life Centre; [date unknown]. Available from: <a href="https://www.strategiesdesantementale.com/mmhm/exercises/2_UsingAppreciativeInquiryJun122011JFMAB.pdf">https://www.strategiesdesantementale.com/mmhm/exercises/2_UsingAppreciativeInquiryJun122011JFMAB.pdf</a></p>	<ul style="list-style-type: none"> <li>■ Provides guidance to employers on using appreciative inquiry and open-ended, strengths-oriented questions to determine how to manage a distressed worker.</li> <li>■ Although specific to the workplace, the questions could be used by faculty to ask students before, during and after interactive bullying education to determine program effectiveness.</li> </ul>
<p>Registered Nurses' Association of Ontario (RNAO). Practice education in nursing [Internet]. Toronto (ON): RNAO; 2016. Available from: <a href="http://RNAO.ca/bpg/guidelines/practice-education-nursing">http://RNAO.ca/bpg/guidelines/practice-education-nursing</a></p>	<ul style="list-style-type: none"> <li>■ This BPG provides recommendations that help nurse educators, preceptors and staff nurses understand how to foster and support effective teaching and learning strategies for nursing students in a variety of practice settings.</li> </ul>

RECOMMENDATIONS



## Research Gaps and Future Implications

In reviewing the evidence for this BPG, the RNAO Best Practice Guideline Development and Research Team and the expert panel identified the priority areas for research set out in **Table 6**. Studies conducted in these areas would provide further evidence to support prevention and management of workplace violence, harassment and bullying in health service organizations and academic institutions. The list is not exhaustive; other areas of research may be required.

**Table 6: Priority Research Areas for Each Recommendation Question**

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
<p><b>RECOMMENDATION QUESTION #1:</b></p> <p><b>Should health workers be recommended to use risk assessment tools to detect behaviours indicative of workplace violence, harassment and/or bullying?</b></p> <p><b>Outcomes:</b> Reliability, validity and accessibility in practice (surrogate outcomes: time and utility)</p>	<ul style="list-style-type: none"> <li>■ Studies on the reliability and validity of instruments in different settings and with different populations in order to increase their generalizability.</li> <li>■ Studies that assess the costs associated with implementing risk assessment tools, and the training and education of health workers.</li> <li>■ Identification of individual characteristics that are strong predictors of violence.</li> <li>■ Validation of risk assessment tools that measure bullying and harassment.</li> <li>■ Impact of using risk assessment tools that measure bullying and harassing behaviours.</li> </ul>
<p><b>RECOMMENDATION QUESTION #2:</b></p> <p><b>Should organizational policies and procedures to prevent and manage workplace violence, harassment and/or bullying among health workers be recommended to improve organizational and health worker outcomes?</b></p> <p><b>Outcomes:</b> Physical environment (surrogate outcomes: health worker injury, incident reporting, assault and threat towards health workers) and health worker well-being (surrogate outcomes: perceived incivility, recognition of bullying, policy implementation)</p>	<ul style="list-style-type: none"> <li>■ Comparing the effectiveness of two or more components of an organizational initiative or program.</li> <li>■ Development of valid and reliable instruments or measures that capture indicators related to workplace violence, harassment and/or bullying in order to decrease heterogeneity of outcomes across studies.</li> <li>■ Longitudinal studies on the sustainability of organizational interventions to prevent and manage workplace violence, harassment and/or bullying.</li> <li>■ Longitudinal studies on the dose and frequency of education programs.</li> <li>■ Comparison studies on the effectiveness of two or more policies implemented to reduce workplace violence, harassment and/or bullying and to increase staff safety.</li> <li>■ Identifying interventions or approaches implemented by organizations to address violence from persons and/or families.</li> </ul>

RECOMMENDATION QUESTION	PRIORITY RESEARCH AREA
<p><b>RECOMMENDATION QUESTION #3:</b></p> <p><b>Should education and training programs on preventing and managing workplace violence, harassment and/or bullying be recommended for health workers to improve outcomes for persons and health workers?</b></p> <p><b>Outcomes:</b> Patient injury, use of restraints, perceived safety of health workers, attitudes and values of health workers, health worker injury, and health worker turnover</p>	<ul style="list-style-type: none"> <li>■ Effectiveness of health worker education and training on reducing and/or preventing injury to the person.</li> <li>■ Effectiveness of de-escalation training on health worker outcomes.</li> <li>■ Longitudinal studies on the sustainability of health worker education and/or training on workplace violence, harassment and/or bullying.</li> <li>■ If randomized control trials are not feasible, then quasi-experimental studies that adopt more sophisticated statistical analyses to decrease risk of bias.</li> <li>■ Comparison studies on the effectiveness of the following:                         <ul style="list-style-type: none"> <li>□ individual components of an educational intervention and/or methods of training; and</li> <li>□ methods of delivery or facilitator attributes.</li> </ul> </li> <li>■ Effectiveness of bullying education in an undergraduate curriculum.</li> <li>■ Effectiveness of educating undergraduate students in communication strategies.</li> <li>■ Identification of the number of students who are injured in clinical placements.</li> </ul>

## Implementation Strategies

Implementing BPGs at the point of care is multi-faceted and challenging. It takes more than awareness and distribution of BPGs for practice to change: BPGs must be adapted for each practice setting in a systematic and participatory way to ensure that recommendations fit the local context. The 2012 RNAO *Toolkit: Implementation of Best Practice Guidelines, Second Edition* provides an evidence-informed process for doing this (1). It can be downloaded at [www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition](http://www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition).

The *Toolkit* is based on emerging evidence that successful uptake of best practices in health care is more likely when the following occur:

- leaders at all levels are committed to supporting BPG implementation;
- BPGs are selected for implementation through a systematic, participatory process;
- stakeholders for whom the BPGs are relevant are identified and engaged in the implementation;
- environmental readiness for implementing BPGs is assessed;
- the BPG is tailored to the local context;
- barriers and facilitators to using the BPG are assessed and addressed;
- interventions to promote use of the BPG are selected;
- use of the BPG is systematically monitored and sustained;
- evaluation of the BPG's impact is embedded in the process; and
- there are adequate resources to complete all aspects of the implementation.

The *Toolkit* uses the “Knowledge-to-Action” framework to demonstrate the process steps required for knowledge inquiry and synthesis (110) (see **Figure 5**). It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools (such as BPGs) to identify gaps and to begin the process of tailoring the new knowledge to local settings.

RNAO is committed to widespread deployment and implementation of our BPGs. We use a coordinated approach to dissemination, incorporating a variety of strategies, including the following:

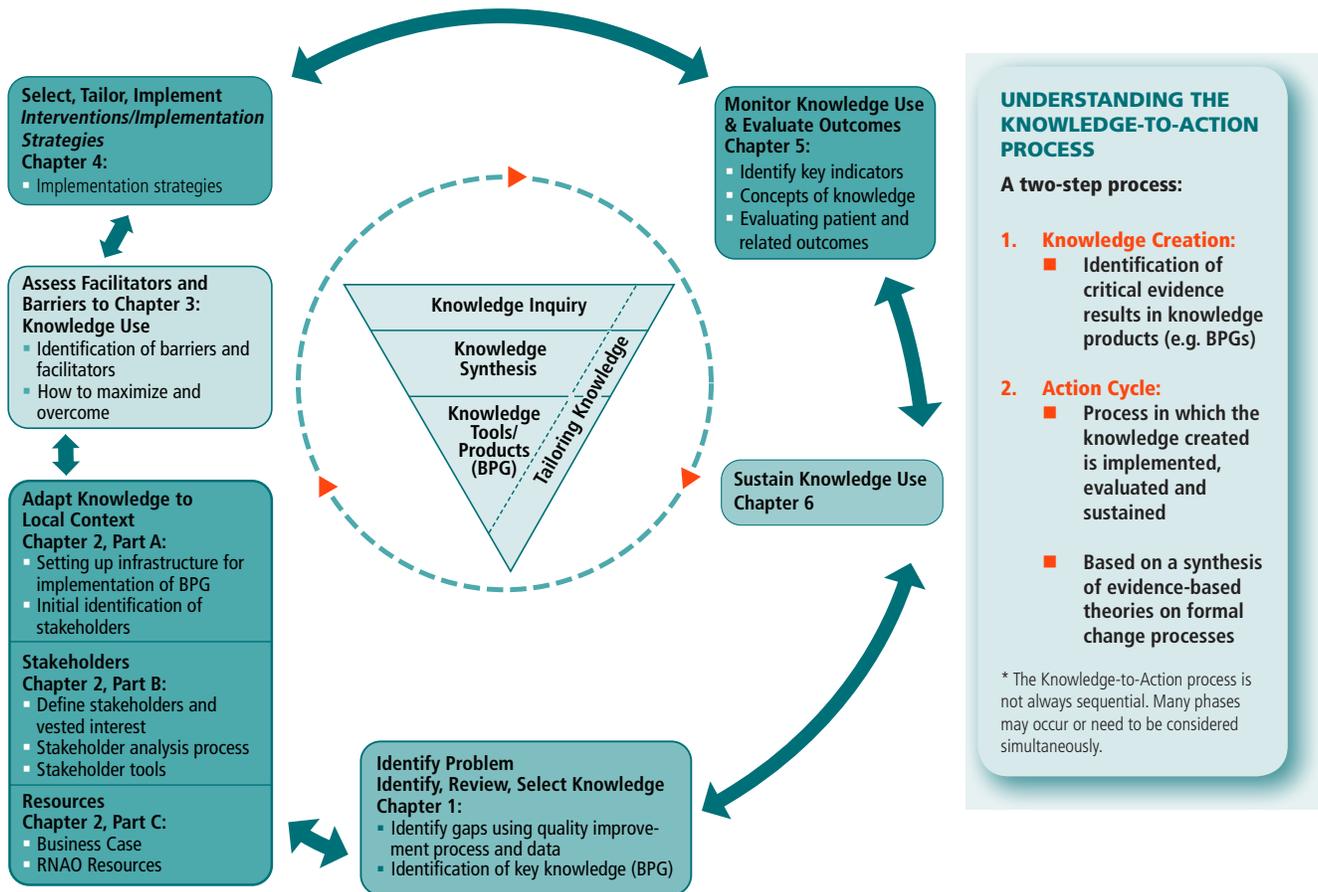
1. The Nursing Best Practice Champion Network<sup>®</sup>, which develops the capacity of individual nurses to foster awareness, engagement and adoption of BPGs.
2. The BPG Order Set<sup>™</sup> provides clear, concise and actionable intervention statements derived from practice recommendations. BPG Order Sets can be readily embedded within electronic records, but they may also be used in paper-based or hybrid environments.
3. BPSO<sup>®</sup> designation, which supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on specific BPGs and their implementation. Information about our implementation strategies can be found at the following locations:

- RNAO Best Practice Champions Network® : [www.rnao.ca/bpg/get-involved/champions](http://www.rnao.ca/bpg/get-involved/champions)
- RNAO BPG Order Sets™ : <http://rnao.ca/ehealth/bpgordersets>
- RNAO BPSOs® : <https://rnao.ca/bpg/bpso>
- RNAO capacity-building learning institutes and other professional development opportunities: [https:// rnao.ca/ events](https://rnao.ca/events)

Figure 5: Knowledge-to-Action Framework

### REVISED KNOWLEDGE-TO-ACTION FRAMEWORK



Source: Adapted by the RNAO expert panel from Straus S, Tetroe J, Graham ID, editors. Knowledge translation in health care. Oxford (UK): Wiley-Blackwell; 2009. p. 151-159. Adapted with permission.

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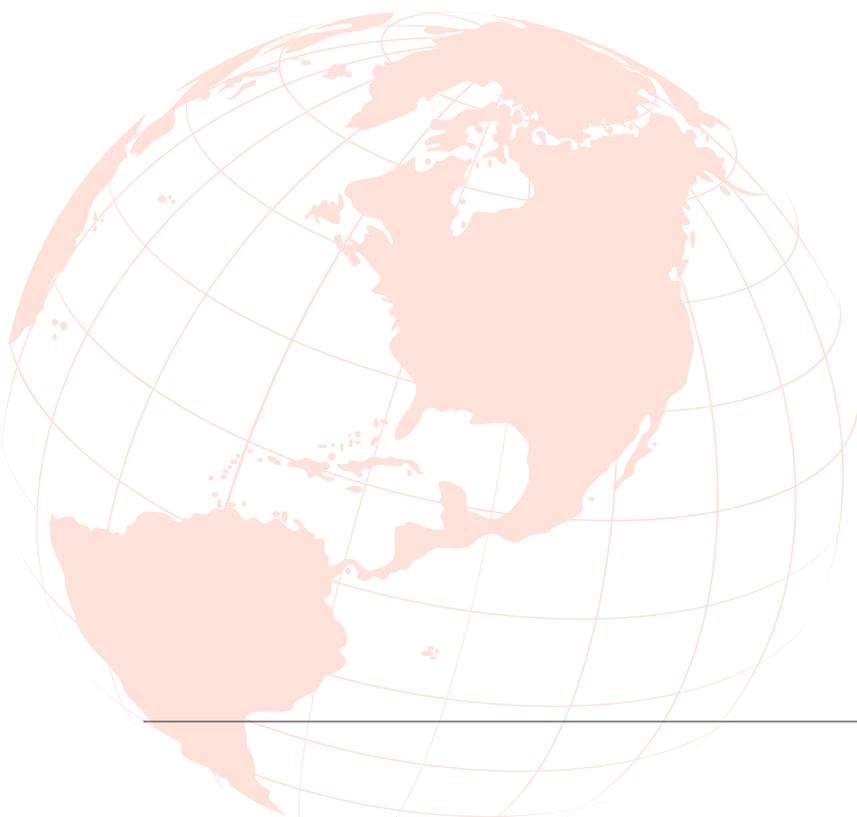
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## Appendix A: Glossary of Terms

**Actuarial instruments:** Actuarial risk assessment instruments use a formula or equation to combine known risk and other factors (both static and dynamic) for violence in order to arrive at an expected probability of violence occurring (40). They are used to create a formal risk assessment that is typically conducted by a health worker providing direct care.

**Best practice guideline (BPG):** BPGs are systematically developed, evidence-based documents that include recommendations for nurses, members of the interprofessional team, educators, leaders, policy-makers and persons and their families on specific clinical, system and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies and health education, ultimately leading to optimal health outcomes for people, communities and the health system (112).

**BPG Order Set™:** Provides clear, concise and actionable intervention statements derived from a practice recommendation. BPG Order Sets™ can be readily embedded within electronic records, but they also may be used in paper-based or hybrid environments.

**Breakaway techniques:** Methods for the “safe removal of yourself from various holds, grabs and pulls, whilst not physically compromising the aggressor or confused perpetrator” (96). These techniques should only be used when all other efforts have failed.

**Bullying:** Repeated and persistent behaviours that can include social isolation, creating or spreading rumours, engaging in excessive or unjustified criticism, intimidating a person, physically abusing or threatening abuse, and withholding job responsibilities (4). In a health service organization or academic institution, harassment can occur: (a) towards health workers from persons; (b) between colleagues; (c) between students and health workers; and (d) between formal leaders and health workers.

**CERQual criteria:** When using CERQual, four components contribute to the assessment of confidence in the evidence for each individual finding:

1. Methodological limitations, which look at issues in the design of the primary study or problems in the way it was conducted.
2. Relevance, whereby each primary study that supports a finding are assessed together and a decision is made regarding the applicability of the findings to the population, phenomenon and setting outlined in the research question.
3. Coherence, whereby an assessment is made of whether the primary studies provide sufficient data and a convincing explanation for the review findings.
4. Adequacy of data, whereby an overall assessment is made about the richness and quantity of data that supports the review finding and phenomenon of interest (113).

**Civility, Respect, and Engagement in the Workforce (CREW):** CREW is a flexible and tailored organizational intervention that includes a training component for facilitators and hospital leaders to discuss methods for improving working relationships (114).

**Communication strategies:** A variety of verbal and non-verbal techniques that can be adopted to reduce and/or prevent the experience of violence and/or aggression (115). Examples of communication strategies include verbal and non-verbal cues, body language, mirroring, group dynamics, open and closed questions, empathy, the expression of positive and negative feelings, and the reception of opinions (102).

**Confidence in the Evidence from Reviews of Qualitative Research (CERQual):** The Confidence in the Evidence from Reviews of Qualitative Research (CERQual) is a methodological approach for assessing the amount of confidence that can be placed in findings from a body of qualitative evidence about an outcome of interest. The assessment provides a transparent means to decide if the review finding reasonably represents the phenomenon under study, which can help expert panels make health recommendations (113).

**Consensus:** A process used to reach agreement among a group or expert panel during a Delphi or modified Delphi technique (116). A consensus of 70 per cent agreement from all expert panel members was required to determine the direction and strength of the recommendations within this BPG.

**Cultural sensitivity:** Awareness, understanding and attitude towards a culture, which requires self-awareness and insight (117).

**De-escalation:** An approach using a set of interventions and techniques that have been adopted to reduce or eliminate violence and aggression during a period of escalation. Interventions can include the following:

1. Engaging individuals who are displaying aggression by establishing a bond with them and maintaining a rapport and connection.
2. Decision-making about the optimal time to intervene based on knowledge of the aggressor, the meaning and danger of the aggressive behaviour, and the resources available in the setting.
3. Assessing safety of the area and the situation.
4. Using verbal and non-verbal skills (e.g., using a calm and gentle tone of voice, body language, posture, eye contact and active listening) to de-escalate the aggressor (118).

**Downgrade:** When limitations in the individual studies potentially bias the results in GRADE and GRADE-CERQual, the quality of evidence will decrease (119). For example, a body of quantitative evidence for one priority outcome may begin with high certainty, but due to serious limitations in one or more of the five GRADE criteria, it will be rated down by one or two levels (13).

**Education:** Obtaining theoretical knowledge and cultivating the ability to use critical thinking and decision-making skills. Education includes three continuous and fluid levels: awareness, training for specific needs and competency-based skills, and specialization (5). Education should be tailored to the scope of practice of the health worker and their role within the organization.

**Evidence-based nursing practice:** The integration of the methodologically strongest research evidence with clinical expertise and patient values. Unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (120).

**Evidence-to-Decision (EtD) framework:** A table that facilitates expert panels to make decisions when moving from evidence to recommendations. The purpose of the framework is to summarize the research evidence, outline important factors that can determine the recommendation, inform expert panel members about the benefits and harms of each intervention considered, and increase transparency about the decision-making process in the development of recommendations (13).

**Family:** “A term used to refer to individuals who are related (biologically, emotionally or legally) to and/or have close bonds (friendships, commitments, shared households and child-rearing responsibilities, and romantic attachments) with the person receiving health care. A person’s family may include all those whom the person identifies as significant in his or her life. ... The person receiving care determines the importance and level of involvement of any of these individuals in their care based on his or her capacity” (12).

**Formal incident review:** A method to discuss and analyze the events leading up to an accident, injury or near miss. Reviews can occur verbally during a huddle (62) or in an online or paper format (63).

**Formal leader:** Refers to a person in a formal leadership position, including managers, supervisors, clinical educators, faculty and administrators.

**Grading of Recommendations Assessment, Development and Evaluation (GRADE):** The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) is a methodological approach for assessing the quality of a body of evidence in a consistent and transparent way, and for developing recommendations in a systematic manner. The body of evidence for an important and/or critical outcome is evaluated based on risk of bias, consistency of results, relevance of the studies, precision of the estimates and publication bias (13).

**GRADE criteria for randomized controlled trials:** When using GRADE to assess the body of evidence for randomized controlled trial, five components contribute to the assessment of confidence in the evidence for each outcome:

1. Risk of bias, which focuses on the flaws in the design of a study or problems in its execution.
2. Inconsistency, which looks at a body of evidence and assesses whether the results from each research study point in the same direction or are different.
3. Imprecision, which refers to the accuracy of results based on the number of participants and/or events included, as well as the width of the confidence intervals across a body of evidence.
4. Indirectness, whereby each primary study that supports an outcome is assessed and a decision is made regarding the applicability of the findings to the population, intervention and outcome outlined in the research question.
5. Publication bias, where a decision is made about whether the body of published literature for an outcome potentially includes only positive or statistically significant results (13).

**GRADE criteria for quasi-experimental studies:** When using GRADE to assess the body of evidence for quasi-experimental studies, in addition to the five criteria mentioned above in “GRADE Criteria for Randomized Controlled Trials” three criteria assessed are:

1. Magnitude of effect, where magnitude of effect of an intervention on the outcome is assessed.
2. Dose-response gradient, where consideration is made regarding the effect of the intervention on the outcome.
3. Effect of plausible confounding, where consideration is made regarding residual confounders that cause an underestimation of treatment effect.

**Harassment:** Comments or behaviours that that are unwelcome and persistent, including sexual harassment (6). Remarks, jokes or innuendos that demean, ridicule, intimidate or offend a health worker or student are considered examples of workplace harassment. In a health service organization or academic institution, harassment can occur: (a) towards health workers from persons; (b) between colleagues; (c) between students and health workers; and (d) between formal leaders and health workers.

**Health worker:** Defined as “all people engaged in actions whose primary intent is to enhance health” (7). This includes regulated health professionals (e.g., registered nurses, registered practical nurses, physicians, social workers and physiotherapists), unregulated health workers (e.g., personal support workers, physician assistants and outreach workers) and additional support staff who come into contact with persons receiving care and their families. Students enrolled in a health worker program also are included in this definition when they enter a clinical placement.

**Health service organization:** Within this BPG, this term can represent any health setting or workplace in which a health worker provides care to persons and/or families and practices within their scope. Violence, harassment and bullying can occur in any health service organization, and the applicability of the recommendations are not limited to acute care unless otherwise stated.

**Horizontal violence:** Violence, harassment or bullying directed at colleagues who are at equal level within an organization. Depending on the literature, horizontal violence can also be referred to as “lateral violence” (8). The most common example of horizontal violence is harassment, including verbal abuse, threats, intimidation, criticism, humiliation and exclusion (9).

**Incivility:** A deterioration in relationships between peers in the workplace (9, 26), between students and health workers in the clinical learning environment (27), or between students and faculty in an academic institution (28). Incivility can include futile communication, disrespect, indifference, neglect, disregard, or impolite speech, and can result in stress and burnout (27). It also includes bullying, harassment, horizontal violence, hostility and conflict (105).

**Interprofessional health team:** “A team comprised of multiple health-care providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health care and services to people within, between and across health-care settings” (12).

**Inter-rater reliability:** A measure to assess the level of agreement in scores or collected data between two or more observers (raters) (121).

**Kevlar sleeves:** Made of a strong, synthetic fibre, these sleeves are a type of personal protective equipment that can protect from cuts, abrasions and heat (122).

**Meta-analysis:** A systematic review of randomized controlled trials that uses statistical methods to analyze and summarize the results of the included studies (123).

See *systematic review*

**Mobbing:** Persistent and escalating antagonistic and harassing behaviours directed by one or more people towards a single individual (99).

**Nurse:** “Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses in Ontario), registered psychiatric nurses and nurses in advanced practice roles such as nurse practitioners and clinical nurse specialists” (12).

**Outcomes:** A dependent variable, or the clinical and/or functional status of a patient or population, that is used to assess if an intervention is successful. In GRADE, outcomes are prioritized based on if they are critical for decision-making, important but not critical for decision-making, or not important. In so doing, the literature search and systematic reviews are more focused (13).

**Person:** An individual with whom a health worker has established a therapeutic relationship for the purpose of partnering for health. Replaces the terms “patient,” “client,” and “resident,” which are used across health service organizations. The term “person” will not only include an individual in the health system, but also their family (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities and populations) (11, 12).

**PICO research question:** A framework to outline a focused question. It specifies four components:

1. The patient or population that is being studied.
2. The intervention to be investigated.
3. The alternative or comparison intervention.
4. The outcome that is of interest (13).

**Predictive validity:** The ability to assess accurately the likelihood that an event (such as violence) will occur (124).

**Psychometric properties:** The measurement properties of questionnaires or instruments used in research, clinical practice and health assessment. These properties indicate the quality of the questionnaire or instrument so that individuals seeking to use a tool can choose the best one. The most common measurement properties include reliability and validity (125).

See *reliability and validity*

**Qualitative research:** An approach to research that seeks to convey how human behaviour and experiences can be explained within the contexts of social structures, using an interactive and subjective approach to investigate and describe phenomena (126).

**Quasi-experimental study:** A study that estimates causal effects by observing the exposure of interest, but in which the experiments are not directly controlled by the researcher and lack randomization (e.g., before-and-after designs) (127).

**Randomized controlled trial (RCT):** An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (placebo or no intervention) (123).

**Recommendation:** A course of suggested action(s) that directly answers a recommendation question. A recommendation is based on a systematic review of the literature and is made in consideration of its potential benefits and harms, values and preferences from a person-centered perspective, and impact on health equity. All recommendations are given a strength - either strong or conditional - through expert panel consensus. It is important to note that recommendations should not be viewed as prescriptive, as recommendations cannot take into account all of the unique features of individual, organizational and clinical circumstances (13).

A **strong recommendation** reflects the expert panel’s confidence that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation for an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation against an intervention)” (13). A strong recommendation implies that the majority of persons will be best serviced by the recommended action (13).

A **conditional recommendation** reflects the expert panel’s confidence that while some uncertainty exists, the desirable effects probably outweigh the undesirable effects (i.e., conditional recommendation for an intervention) or that the undesirable effects probably outweigh the desirable effects (i.e., a conditional recommendation against an intervention) (13). A conditional recommendation implies that not all persons will be best served by the recommended action, and that there is a need for more careful consideration of personal circumstances, preferences and values (13).

**Reliability (reliable):** The degree to which results from a measurement procedure can be reproduced with minimal measurement error (123). For example, two users could use a tool at different times but reach the same result.

See *psychometric properties*

**Restraint:** “Physical, chemical or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body” (128).

**Scoping review:** A scoping review is a means to map existing literature or evidence in order to identify research gaps, summarize research findings and/or inform systematic reviews (129).

**Stakeholder:** An individual, group or organization that has a vested interest in the decisions and actions of organizations and may attempt to influence decisions and actions (130). Stakeholders include all of the individuals and groups who will be directly or indirectly affected by the change or solution to the problem.

**Structured professional judgement (SPJ):** Structured professional judgment (SPJ) instruments use specified risk factors (static and dynamic) and clinical discretion to weigh the presence of risk factors and draw an overall conclusion about the probability of violence occurring (e.g., low, medium or high) (40). They are a formal risk assessment that is typically conducted by a health worker providing direct care.

**Surrogate outcome:** A surrogate outcome is a substitute measure to the one originally selected. Surrogate outcomes are considered when evidence about the desired outcomes is lacking or unexplored (13).

**Systematic review:** A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (123).

See *meta-analysis*

**Validity (valid):** The degree to which a measurement is likely to be true and free of bias (123). For example, a tool would be considered valid if it accurately measures the construct that it aims to measure.

See *psychometric properties*

**Vertical violence:** Violence, harassment or bullying that occurs between colleagues who are at unequal levels within an organization (9).

**Violence:** The use, or attempted use, of physical force against a person that causes, or could cause, physical injury. Sexual aggression, verbal statements, non-verbal behaviours, or acts that are reasonably interpreted as a threat of physical force that can lead to physical harm are also considered violence (24). In health service organizations, the most prevalent type of workplace violence is from the person receiving care or their family (25). Examples of workplace violence include: verbal threats, threatening notes, shaking a fist in the worker's face, hitting/trying to hit a worker or throwing an object at a worker (24).

It is important to note that aggressive behaviours from a person receiving care can be the result of behavioural and psychological symptoms of an illness (e.g., dementia or delirium) that are exhibited to express met or unmet needs. Labeling a person as “violent” can result in altered levels of care and stigmatization; for that reason, it is critical to understand the cause of violence in order to prevent and mitigate its occurrence.

See *horizontal violence* and *vertical violence*

## Appendix B: Registered Nurses' Association of Ontario Best Practice Guidelines and Resources that Align with this Best Practice Guideline

The following are topics and some suggested RNAO BPGs and resources from other organizations that align with this BPG.

TOPIC	RESOURCE(S)
<b>Cultural sensitivity</b>	Registered Nurses' Association of Ontario (RNAO). Embracing cultural diversity in health care: developing cultural competence. Toronto (ON): RNAO; 2007. Available from: <a href="https://RNAO.ca/sites/rnao-ca/files/Embracing_Cultural_Diversity_in_Health_Care_-_Developing_Cultural_Competence.pdf">https://RNAO.ca/sites/rnao-ca/files/Embracing_Cultural_Diversity_in_Health_Care_-_Developing_Cultural_Competence.pdf</a>
<b>Implementation science, implementation frameworks, and resources</b>	<p>Registered Nurses' Association of Ontario (RNAO). Toolkit: implementation of best practice guidelines, second edition. Toronto (ON): RNAO; 2012. Available from: <a href="https://RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition">https://RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition</a></p> <p>The National Implementation Research Network's Active Implementation Hub. Get Started [Internet]. Chapel Hill (NC): State Implementation and Scaling-up of Evidence-based Practices Center (SISEP); c2013-2018. Co-published by National Implementation Research Network. Available from: <a href="https://implementation.fpg.unc.edu/">https://implementation.fpg.unc.edu/</a></p> <p>Safer Healthcare Now! Improvement frameworks: getting started kit [Internet]. [place unknown]: Safer Healthcare Now!; 2015. Available from: <a href="http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Documents/Improvement%20Frameworks%20GSK%20EN.PDF">http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Documents/Improvement%20Frameworks%20GSK%20EN.PDF</a></p> <p>Dissemination &amp; Implementation Models in Health Research &amp; Practice. Seminal Publications [Internet]. [place, publisher, date unknown]. Available from: <a href="http://dissemination-implementation.org/content/resources.aspx">http://dissemination-implementation.org/content/resources.aspx</a></p>
<b>Interprofessional health team</b>	Registered Nurses' Association of Ontario (RNAO). Developing and sustaining interprofessional health care: optimizing patients/clients, organizational, and system outcomes. Toronto (ON): RNAO; 2013. Available from: <a href="https://RNAO.ca/sites/rnao-ca/files/DevelopingAndSustainingBPG.pdf">https://RNAO.ca/sites/rnao-ca/files/DevelopingAndSustainingBPG.pdf</a>
<b>Managing and mitigating conflicts</b>	Registered Nurses' Association of Ontario (RNAO). Managing and mitigating conflict in health-care teams. Toronto (ON): RNAO; 2012. Available from: <a href="https://RNAO.ca/sites/rnao-ca/files/Managing-conflict-healthcare-teams_hwe_bpg.pdf">https://RNAO.ca/sites/rnao-ca/files/Managing-conflict-healthcare-teams_hwe_bpg.pdf</a>

TOPIC	RESOURCE(S)
<b>Restraints</b>	Registered Nurses' Association of Ontario (RNAO). Promoting safety: alternative approaches to the use of restraints. Toronto (ON): RNAO; 2012. Available from: <a href="https://RNAO.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints">https://RNAO.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints</a>
<b>Safe and effective staffing and workload practices</b>	Registered Nurses' Association of Ontario (RNAO). Developing and sustaining safe, effective staffing and workload practices, second edition. Toronto (ON): RNAO; 2017. Available from: <a href="https://RNAO.ca/sites/rnao-ca/files/bpg/Staffing_and_Workload_Practices_2017.pdf">https://RNAO.ca/sites/rnao-ca/files/bpg/Staffing_and_Workload_Practices_2017.pdf</a>



# Appendix C: Best Practice Guideline Development Methods

This Appendix presents an overview of the RNAO guideline development process and methods. RNAO is unwavering in its commitment that every BPG be based on the best available evidence. The GRADE and CERQual methods have been implemented to provide a rigorous framework and meet international standards for guideline development.

## Scoping the Guideline

The scope sets out what an RNAO BPG will and will not cover (see **Purpose and Scope**, p. 6). To determine the scope of this BPG, the RNAO Best Practice Guideline Development and Research Team conducted the following steps:

1. A review of previous BPGs. The RNAO BPGs *Preventing and Managing Violence in the Workplace* (2009) (3) and *Workplace Health, Safety and Well-being of the Nurse* (2008) (2) were reviewed to inform the purpose and scope of this BPG.
2. A guideline search and gap analysis. The RNAO Best Practice Guideline Development and Research Team searched an established list of websites for guidelines and other relevant content published between January 2011 and January 2017. The purpose of the guideline search and gap analysis was to gain an understanding of existing guidelines regarding violence, harassment and bullying in health service organizations, and to identify opportunities to develop the purpose and scope of this BPG. A list of 20 reputable resources and guides was compiled from international sources. The RNAO expert panel members were also asked to suggest additional guidelines. The resources and guides were reviewed for content, scope of practice related to nurses and interprofessional team members, accessibility and quality. None of the screened guidelines were based on a systematic review, and they were not considered to be true guidelines that could be appraised using the Appraisal of Guidelines for Research and Evaluation Instrument II (AGREE II) (143) (see **Figure 6** in **Appendix D**). Detailed information about the search strategy for existing guidelines, including the list of websites searched and the inclusion criteria used, is available at <https://RNAO.ca>.
3. Two scoping reviews of the literature were conducted. In 2013 and 2015, two scoping reviews of the literature were undertaken to develop a better understanding of the existing literature on bullying between health providers in health service organizations.

## Assembly of the Expert Panel

In alignment with the Statement on Diversity and Inclusivity that appears in its Mission and Values, RNAO aims for diversity in the membership of the expert panel (you can find a copy of the RNAO Mission and Values at <https://RNAO.ca/about/mission>.) RNAO also aims for persons impacted by BPG recommendations, especially persons with lived experiences and caregivers, to be included as expert panel members.

There are numerous ways that RNAO finds and selects members of an expert panel, including searching the literature for researchers in the topic area; recommendations from key informant interviews; drawing from established professional networks, such as RNAO interest groups, Champions Network<sup>®</sup> and BPSOs<sup>®</sup>; other nursing and health provider associations; topic-relevant technical associations or organizations; and advocacy bodies. When relevant, a call for an expression of interest from expert panel members who have previously served on prior editions of the BPG is completed.

For this BPG, the RNAO Best Practice Guideline Development and Research Team assembled a panel of experts from nursing practice, administration, research, education and policy, as well as other members of the interprofessional team representing a range of sectors and practice areas, and persons with lived experience (see the RNAO Expert Panel, p. 24).

The expert panel engaged in the following activities:

- approved the scope of the BPG;
- determined the recommendation questions and outcomes to be addressed in the BPG;
- participated in a **consensus**<sup>G</sup> development process to finalize recommendation statements;
- provided feedback on the draft of the BPG;
- participated in the development of evaluation indicators; and
- identified appropriate stakeholders to review the draft prior to publication.

The expert panel co-chairs led the following activities:

- monthly co-chair meetings with the guideline development methodologists and guideline development project coordinator;
- facilitated expert panel meetings;
- provided in-depth guidance on clinical and/or research issues; and
- moderated and acted as tiebreakers in voting processes.

### Conflict of Interest

In the context of RNAO best practice guideline development, the term ‘conflict of interest’ (COI) refers to situations in which an expert panel member’s financial, professional, intellectual, personal, organizational or other relationship may compromise their ability to independently conduct panel work. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the RNAO expert panel prior to their participation in guideline development work using a standard form (<https://rnao.ca/bpg/guidelines/workplaceviolence>). Expert panel members also updated their COI at the beginning of each guideline meeting. Any COI declared by an expert panel member was reviewed by the RNAO Best Practice Guideline Development and Research Team and expert panel co-chairs. No limiting conflicts were identified. See “**Declarations of Conflicts of Interest Summary**” at <https://rnao.ca/bpg/guidelines/workplaceviolence>.

### Identifying Priority Recommendation Questions and Outcomes

In May 2017, the RNAO Best Practice Guideline Development and Research Team and expert panel convened in-person to determine the purpose, scope and recommendation questions for this BPG. In July 2017, the recommendation questions were further modified to include priority outcomes. A comprehensive list of outcomes that this BPG could potentially address was developed, informed by the guideline gap analysis, the scoping review of the literature and discussion with the expert panel co-chairs.

This comprehensive list of potential outcomes was presented to the expert panel for a vote. Each expert panel member reviewed the recommendation questions and participated in a confidential online vote using a seven-point Likert scale that ranged from “strongly agree” to “strongly disagree” to determine the top 11 outcomes across

recommendation questions. An outcome with agreement of 91.6 per cent or above was considered critical; an outcome with agreement of 83.3 per cent to 91.5 per cent was considered important; and an outcome with agreement of 75 per cent to 83.2 per cent was considered less important. Outcomes were excluded if the level of agreement was less than 75 per cent. Expert panel co-chairs did not participate in the vote because they functioned as tiebreakers.

Each recommendation question informed a PICO research question which guided the systematic reviews. The three recommendation questions and their respective PICO research questions are presented below:

**Recommendation Question 1:** Should health workers be recommended to use risk assessment tools to detect behaviours indicative of workplace violence, harassment and/or bullying?

**PICO Research Question:**

**Population:** Health workers.

**Intervention:** Person or co-worker risk assessment tools.

**Comparison:** No risk assessment tools.

**Outcomes:** Reliability (less important), validity (important), accessibility in practice (less important) (*surrogate outcomes: utility and time*).

**Recommendation Question 2:** Should organizational policies and procedures to prevent and manage workplace violence, harassment and/or bullying among health workers be recommended to improve organizational and health worker outcomes?

**PICO Research Question:**

**Population:** Health workers.

**Intervention:** Organizational policies and procedures for workplace violence, harassment and/or bullying.

**Comparison:** No organizational policies and procedures for workplace violence, harassment and/or bullying.

**Outcomes:** Physical environment (important) (*surrogate outcomes: health worker injury, incident reporting, assault and threat towards health workers*), and health worker well-being (critical) (*surrogate outcomes: perceived incivility, recognition of bullying, policy implementation*).

**Recommendation Question 3:** Should education and training programs on preventing and managing workplace violence, harassment and/or bullying be recommended for health workers to improve person and health worker outcomes?

**PICO Research Question:**

**Population:** Health workers.

**Intervention:** Education and training programs on preventing and managing workplace violence, harassment and/or bullying.

**Comparison:** No education and training programs on preventing and managing workplace violence, harassment and/or bullying.

**Outcomes:** Patient injury (important), use of restraints (critical), perceived safety of health workers, attitudes and values of health workers (critical), health worker injury (important), and health worker turnover (less important).

## Systematic Retrieval of the Evidence

RNAO BPGs are based on a comprehensive and systematic review of the literature.

For this BPG, a search strategy was developed by RNAO's Best Practice Guideline Development and Research Team and a health sciences librarian for each of the PICO research questions. A search for relevant research studies published in English between January 2012 and September 2017 was applied to the following databases: Cochrane Central Register of Controlled Trials, Cochrane Library (Cochrane Database of Systematic Reviews), Cumulative Index to Nursing and Allied Health (CINAHL), Education Resources Information Center (ERIC) (for Research Question #3 only), Embase, MEDLINE, MEDLINE In-Process and PsycINFO. All study designs were included. Expert panel members were asked to review their personal libraries for key studies not found through the search strategies. Detailed information on the search strategy for the systematic reviews, including the inclusion and exclusion criteria and search terms, is available at <https://RNAO.ca>.

Studies were independently assessed for relevance and eligibility by two guideline development methodologists based on the inclusion and exclusion criteria. Any disagreements were resolved through consensus.

All included articles were independently assessed for risk of bias by study design using validated and reliable tools. The Cochrane Risk of Bias Tool 2.0 (132) was used for randomized controlled trials, the Risk of Bias in Non-randomized Studies of Interventions (ROBINS-1) tool (133) was used for quasi-experimental studies, an adapted version of the Critical Appraisal Skills Programme Tool for Qualitative Research (CASP) (134) was used for qualitative studies, and the Assessing the Methodological Quality of Systematic Reviews (AMSTAR-2) (130) was used for systematic reviews. Two reviewers reached consensus on all scores through discussion.

Data extraction was performed simultaneously, and completed by both reviewers for all included studies. In total, 56 studies were included across all three systematic reviews (see **Figures 7, 8 and 9** in **Appendix D**).

In August 2018 and March 2019 two literature searches were completed with a health sciences librarian to search for updated literature to inform the content within the values and preferences, health equity and practice notes sections of the Discussion of Evidence for each recommendation statement. Three databases were searched (CINAHL, Medline and PsychINFO) for literature and guidelines published in English between January 2018 and March 2019.

## Determining Certainty and Confidence of Evidence

### Certainty of Evidence

The certainty of quantitative evidence (i.e., the extent to which one can be confident that an estimate of the effect is correct) is determined using GRADE methods (13). First, the certainty of the evidence is rated for each prioritized outcome across studies (i.e., for a body of evidence) per recommendation question (13). This process begins with the study design and then requires an examination of five criteria – risk of bias, inconsistency, imprecision, indirectness and publication bias – for the potential **downgrade**<sup>G</sup> of the certainty of evidence for each outcome. See **Table 7** for a definition of each of these certainty criteria.

**Table 7: GRADE Certainty Criteria**

CERTAINTY CRITERIA	DEFINITION
<b>Risk of bias</b>	Limitations in the study design and execution that may bias study results. Valid and reliable quality appraisal tools are used to assess the risk of bias. First, risk of bias is examined for each individual study and then examined across all studies per defined outcome.
<b>Inconsistency</b>	Unexplained differences (heterogeneity) of results across studies. Inconsistency is assessed by exploring the magnitude of difference and possible explanations in the direction and size of effects reported across studies for a defined outcome.
<b>Indirectness</b>	Variability between the research and review question and the context within which the recommendations would be applied (applicability). There are four sources of indirectness that are assessed: <ol style="list-style-type: none"> <li>1. Differences in population</li> <li>2. Differences in interventions</li> <li>3. Differences in outcomes measured</li> <li>4. Differences in comparators.</li> </ol>
<b>Imprecision</b>	The degree of uncertainty around the estimate of effect. This is usually related to sample size and number of events. Studies are examined for sample size, number of events and confidence intervals.
<b>Publication bias</b>	Selective publication of studies based on study results. If publication bias is strongly suspected, downgrading is considered.

Source: Reprinted from: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.svwngs6pm0f2>

After considering the five criteria outlined in **Table 7**, three factors are assessed that can potentially enable rating up the certainty of evidence for observational studies:

1. **Large magnitude of effect:** If the body of evidence has not been rated down for any of the five criteria and a large estimate of the magnitude of intervention effect is present, there is consideration for rating up.
2. **Dose-response gradient:** If the body of evidence has not been rated down for any of the five criteria and a dose-response gradient is present, there is consideration for rating up.
3. **Effect of plausible confounding:** If the body of evidence has not been rated down for any of the five criteria and all residual confounders would result in an underestimation of treatment effect, there is consideration for rating up (13).

The overall certainty of evidence is the combined rating of the certainty of evidence across all prioritized outcomes per recommendation question. GRADE categorizes the overall certainty of evidence as high, moderate, low or very low. See **Table 8** for the definitions of these categories.

For this BPG, the five GRADE certainty criteria for potentially downgrading quantitative evidence and the three GRADE certainty criteria for potentially rating up quantitative evidence were independently assessed by two guideline development methodologists. Any discrepancies were resolved through consensus. An overall certainty of evidence per recommendation question was assigned based on these assessments. Recommendations that were derived from the recommendation questions were assigned this certainty of evidence, accordingly.

**Table 8: Certainty of Evidence**

OVERALL CERTAINTY OF EVIDENCE	DEFINITION
<b>High</b>	We are very confident that the true effect lies close to that of the estimate of the effect.
<b>Moderate</b>	We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
<b>Low</b>	Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect.
<b>Very Low</b>	We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted from: Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.svwngs6pm0f2>. Reprinted with permission.

### Confidence in Evidence

Similar to GRADE, CERQual has four criteria to assess the confidence in qualitative findings related to a phenomenon of interest:

1. Methodological limitations
2. Relevance
3. Coherence
4. Adequacy.

See **Table 9** for a definition of each of these criteria.

**Table 9: CERQual Confidence Criteria**

CERTAINTY CRITERIA	DEFINITION
<b>Methodological limitations</b>	The extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding.
<b>Relevance</b>	The extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest or setting) specified in the review question.
<b>Coherence</b>	An assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesizes the data. Cogent refers to being well-supported or compelling.
<b>Adequacy of data</b>	An overall determination of the degree of richness and quantity of data supporting a review finding.

Source: Reprinted from Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implement Sci.* 2018;13(Suppl 1): 1-10. Table 2, Definitions of the components of the CERQual approach; p. 5. Reprinted with permission.

Qualitative findings related to each of the prioritized outcomes were independently assessed by the guideline development methodologists using the four criteria. Discrepancies were resolved through consensus.

Recommendations that included qualitative evidence were assigned an overall confidence in evidence based on the corresponding review finding. See **Table 10** for the definitions of these categories.

**Table 10: Confidence in Evidence**

OVERALL CONFIDENCE OF EVIDENCE	DEFINITION
<b>High</b>	It is highly likely that the finding is a reasonable representation of the phenomenon of interest.
<b>Moderate</b>	It is likely that the finding is a reasonable representation of the phenomenon of interest.
<b>Low</b>	It is possible that the review finding is a reasonable representation of the phenomenon of interest.
<b>Very Low</b>	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Source: Reprinted from Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implement Sci.* 2018;13(Suppl 1): 1-10. Table 3, Description of level of confidence in a review finding in the CERQual approach; p. 6. Reprinted with permission.

## Summarizing the Evidence

GRADE and CERQual evidence profiles are used to present decisions on the certainty and confidence of evidence, as well as general information about the body of research evidence, including key statistical or narrative results (135). Evidence profiles summarize the body of evidence for each systematic review per outcome and are developed by the guideline development methodologists.

Evidence profiles for the body of quantitative studies present the decisions made by the two reviewers on the five key GRADE certainty criteria for downgrading and three GRADE certainty criteria for rating up. The evidence profiles also present general information about the body of evidence, including the population, the countries where the studies were conducted, a description of the intervention, key results and transparent judgments about the certainty underlying the evidence for each outcome (13). For this BPG, **meta-analyses<sup>G</sup>** was not performed; therefore, results were synthesized using narrative format.

CERQual evidence profiles were created for the body of qualitative evidence for each systematic review per outcome. Similar to the GRADE evidence profiles used for quantitative research, the CERQual evidence profiles presented the body of evidence supporting each theme as related to each outcome per recommendation question. These evidence profiles presented the decisions made by the two reviewers on the four key **CERQual criteria<sup>G</sup>** and transparent judgements about the confidence underlying the evidence for each theme.

For the GRADE and CERQual evidence profiles for each systematic review per outcome, please contact us at <https://RNAO.ca/contact>.

## Formulating Recommendations

### Evidence-to-Decision Frameworks

**Evidence-to-Decision (EtD) frameworks<sup>G</sup>** outline proposed recommendations and summarize all necessary factors and considerations based on available evidence and expert panel judgement for formulating the recommendation statements. EtD frameworks are used to help ensure that all important factors required to develop recommendation statements are considered by an expert panel (13). The guideline development methodologists draft the frameworks with both quantitative and qualitative evidence from the systematic reviews.

For this BPG, the EtD frameworks included the following areas of consideration for each drafted recommendation statement (see **Table 11**):

- Background information on the magnitude of the problem:
  - includes the PICO research question and general context related to the research question.
- The balance of benefits and harms of an intervention.
- Certainty and/or confidence of the evidence.
- Values and preferences.
- Health equity.

### Decision-making: Determining the Direction and Strength of Recommendations

Expert panel members are provided with the EtD frameworks to review prior to a scheduled two-day in-person meeting to determine the direction (i.e., a recommendation for or against an intervention) and strength (i.e., strong or conditional) of the BPG's recommendations. Expert panel members were also given access to the complete evidence profiles and full-text articles.

Using the EtD frameworks as a guiding document, the expert panel members participated in an online vote from February 26, 2018 to March 13, 2018. The following questions were posed to all expert panel members for each draft recommendation:

- Is the problem a priority?
- Is there important uncertainty about or variability in how much people value the main outcomes?
- Does the balance between desirable and undesirable effects favour the intervention or the comparison?
- What would be the impact on health equity?

The Likert scales created by the GRADEpro software were used to vote on each factor (136). There was also the opportunity for expert panel members to provide written comments related to each of the judgement criteria.

The results of the online vote were calculated and presented to the expert panel at the two-day in-person meeting held on March 21<sup>st</sup> and 22<sup>nd</sup>, 2018. The online vote results were used to help guide discussion to determine the required direction and strength of each recommendation. The expert panel co-chairs and guideline development methodologists facilitated the meeting to allow for adequate discussion for each proposed recommendation.

The decision on direction and strength of each recommendation statement was determined by discussion and a consensus vote of 70 per cent. The voting process was moderated by the expert panel co-chairs and guideline development methodologists. In determining the strength of a recommendation statement, the expert panel was asked to consider the following:

- the balance of benefits and harms;
- certainty and confidence of the evidence;
- values and preferences; and
- potential impact on health equity.

See **Table 11** for more on these considerations.

In cases where 70 per cent consensus could not be reached after one vote, the expert panel co-chairs acted as tiebreakers by weighing the expert panel's feedback with the scientific evidence to determine the final decision. Following the in-person meeting, the final decisions made on all recommendations were summarized and sent electronically to the full expert panel.

**Table 11: Key Considerations for Determining the Strength of Recommendations**

FACTOR	DEFINITION	SOURCES
<b>Benefits and harms</b>	<p>Potential desirable and undesirable outcomes reported in the literature when the recommended practice or intervention is used.</p> <p>“The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a conditional recommendation is warranted” (137).</p>	Includes research exclusively from the systematic review.
<b>Certainty and confidence of evidence</b>	<p>The extent of confidence that the estimates of an effect are adequate to support a recommendation. The extent of confidence that a review finding is a reasonable representation of the phenomenon of interest (111).</p> <p>Recommendations are made with different levels of certainty or confidence; the higher the certainty or confidence, the higher the likelihood that a strong recommendation is warranted (137).</p>	Includes research exclusively from the systematic review.
<b>Values and preferences</b>	<p>The relative importance or worth of the health outcomes of following a particular clinical action from a person-centered perspective (137).</p> <p>“The more values and preferences vary or the greater the uncertainty in values and preferences, the higher the likelihood that a conditional recommendation is warranted” (137).</p>	Includes evidence from the systematic review (when available) and other sources (e.g., insights from the expert panel).
<b>Health equity</b>	<p>Represents the potential impact of the recommended practice or intervention on health outcomes or health quality across different populations (138).</p> <p>The greater the potential for increasing health inequity, the higher the likelihood that a conditional recommendation is warranted.</p>	Includes evidence from the systematic review (when available) and other sources (e.g., insights from the expert panel).

Source: Adapted by the RNAO expert panel from Schunemann H, Brozek J, Guyatt G, et al., editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013. Available from: <https://gdt.gradeapro.org/app/handbook/handbook.html#h.svwngs6pm0f2>

## Drafting the Best Practice Guideline

The guideline development methodologists wrote the draft of this BPG. The expert panel reviewed the draft and provided written feedback. The BPG then proceeded to external stakeholder review.

### Stakeholder review

RNAO is committed to obtaining feedback from (a) nurses and other health providers from a wide range of practice settings and roles, (b) knowledgeable administrators and funders of health services, and (c) stakeholder associations as part of the guideline development process.

Stakeholder reviewers for RNAO BPGs are identified in two ways. First, stakeholders are recruited through a public call issued on the RNAO website (<https://RNAO.ca/bpg/get-involved/stakeholder>). Second, individuals and organizations with expertise in the BPG topic area are identified by the RNAO Best Practice Guideline Development and Research Team and the expert panel, and they are directly invited to participate in the review.

Stakeholder reviewers are individuals with subject matter expertise in the BPG topic or those who may be affected by its implementation. Reviewers may be nurses, members of the interprofessional team, nurse executives, administrators, research experts, educators, nursing students or persons with lived experience and their family members.

Reviewers are asked to read a full draft of the BPG and participate in the review prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire. The stakeholders are asked the following questions:

- Is the guideline title appropriate?
- Is the guideline development process description clear?

In addition, the stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Is the discussion of evidence thorough and does the evidence support the recommendation?

The survey also provides an opportunity to include comments and feedback for each section of the BPG, including the evaluation indicators. Survey submissions are compiled and feedback is summarized by the RNAO Best Practice Guideline Development and Research Team. A teleconference with the expert panel was held on November 28, 2018 to review both expert panel and stakeholder feedback and if necessary, BPG content and recommendations were modified prior to publication to reflect the feedback received.

For this BPG, the stakeholder review process was completed from November 8<sup>th</sup> to November 23<sup>rd</sup>, 2018 and diverse perspectives provided feedback (see **Stakeholder Acknowledgement**, p. 26).

### Procedure for Updating the Best Practice Guideline

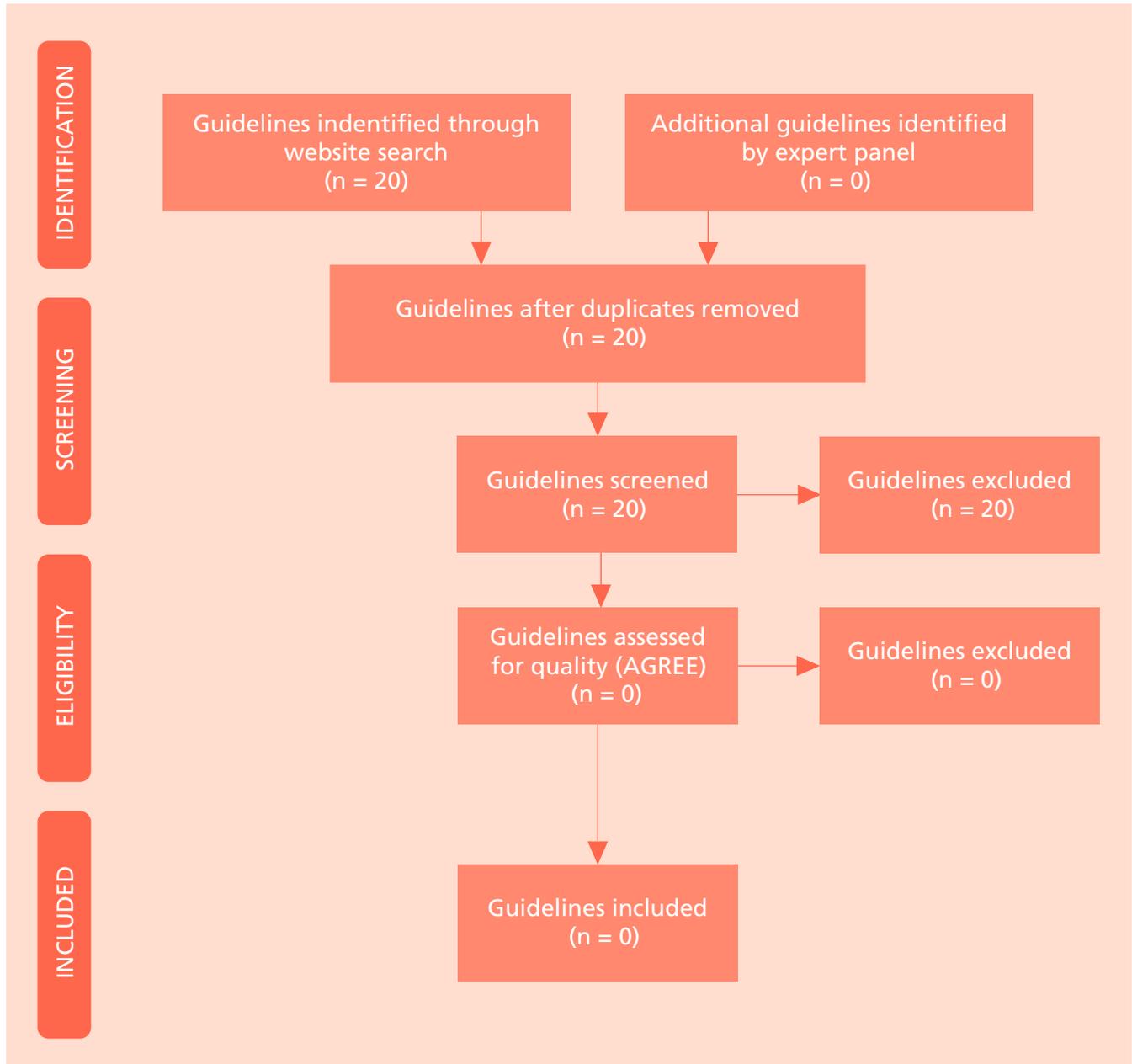
The RNAO commits to updating all BPGs, as follows:

1. Each BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.
2. RNAO International Affairs and Best Practice Guideline Centre staff regularly monitor for new systematic reviews, randomized controlled trials and other relevant literature in the field.
3. Based on that monitoring, staff may recommend an earlier revision period for a particular BPG. Appropriate consultation with members of the original expert panel, other specialists and experts in the field will help inform the decision to review and revise the BPG earlier than planned.
4. Three months prior to the review milestone, the staff commences planning of the review as follows:
  - a) Compiling feedback received and questions encountered during the implementation, including comments and experiences of BPSOs<sup>®</sup> and other implementation sites regarding their experiences.
  - b) Compiling a list of new clinical practice guidelines in the field and refining the purpose and scope.
  - c) Developing a detailed work plan with target dates and deliverables for developing a new edition of the BPG.
  - d) Identifying the potential BPG expert panel co-chairs with RNAO's CEO.
  - e) Compile a list of specialists and experts in the field for potential participation on the expert panel. The expert panel will be comprised of members from the original expert panel and new ones.
5. New editions of BPGs will be disseminated based on established structures and processes.

# Appendix D: Process for Best Practice Guideline and Systematic Review

**Figure 6: Guideline Review Process Flow Diagram**

\* No formal guidelines addressing workplace violence, harassment or bullying were identified \*



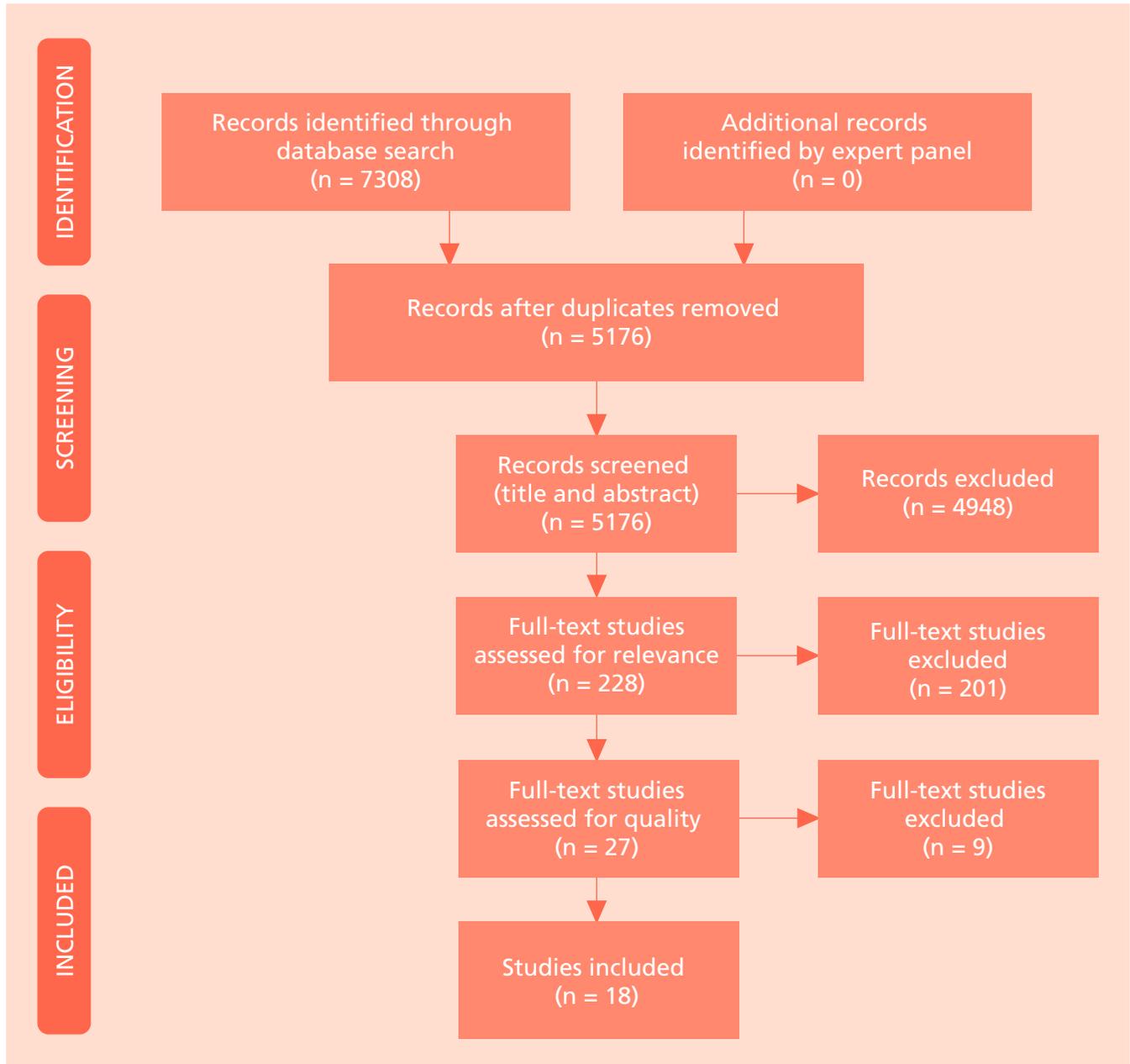
Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

## RECOMMENDATION QUESTION #1:

Should person or co-worker risk assessment tools to detect behaviours indicative of workplace violence, harassment and/or bullying be recommended?

**Outcomes:** Reliability, validity and accessibility in practice (surrogate outcomes: time and utility)

Figure 7: Recommendation Question #1 Article Review Process Flow Diagram



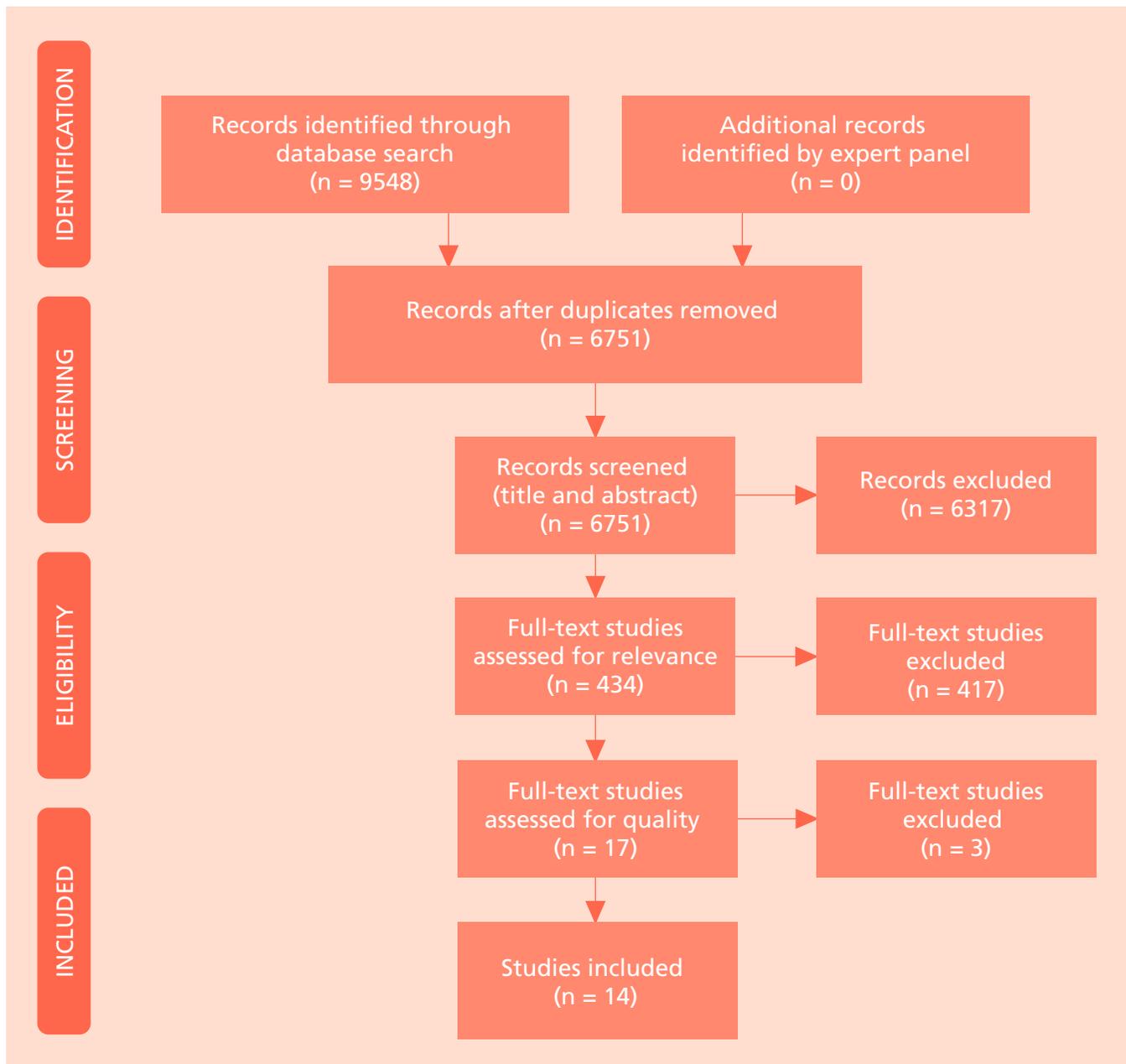
Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

**RECOMMENDATION QUESTION #2:**

Should organizational policies and procedures to prevent and manage workplace violence, harassment and/or bullying among health workers be recommended to improve organizational and health worker outcomes?

**Outcomes:** Physical environment (surrogate outcomes: health worker injury, incident reporting, assault and threat towards health workers) and health worker well-being (surrogate outcomes: perceived incivility, recognition of bullying, policy implementation)

**Figure 8: Recommendation Question #2 Article Review Process Flow Diagram**



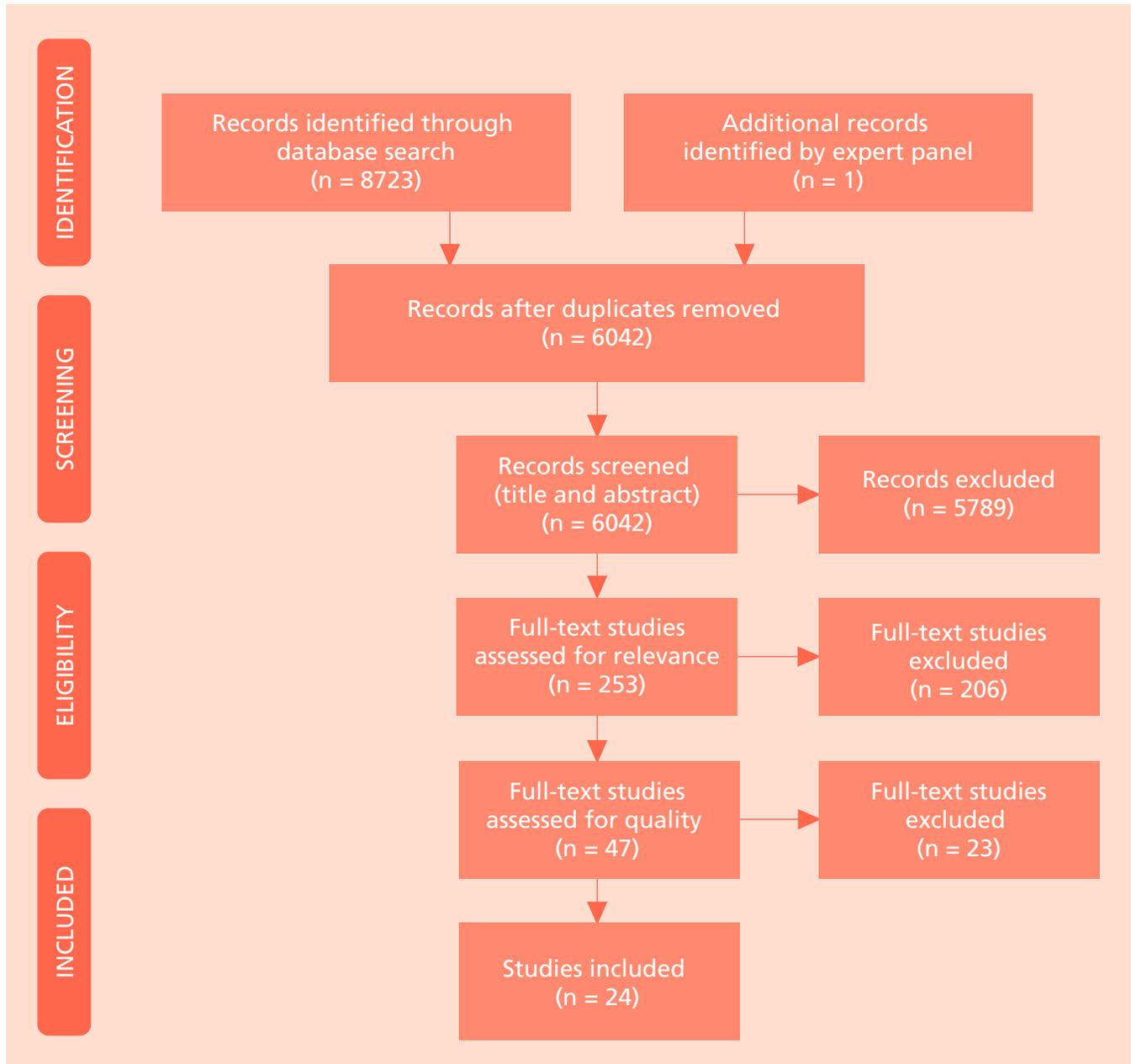
Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

### RECOMMENDATION QUESTION #3:

Should education and training programs on preventing and managing workplace violence, harassment and/or bullying be recommended for health workers to improve person and health worker outcomes?

**Outcomes:** Patient injury, use of restraints, perceived safety of health workers, attitudes and values of health workers, health worker injury, and health worker turnover

**Figure 9: Recommendation Question #3 Article Review Process Flow Diagram**



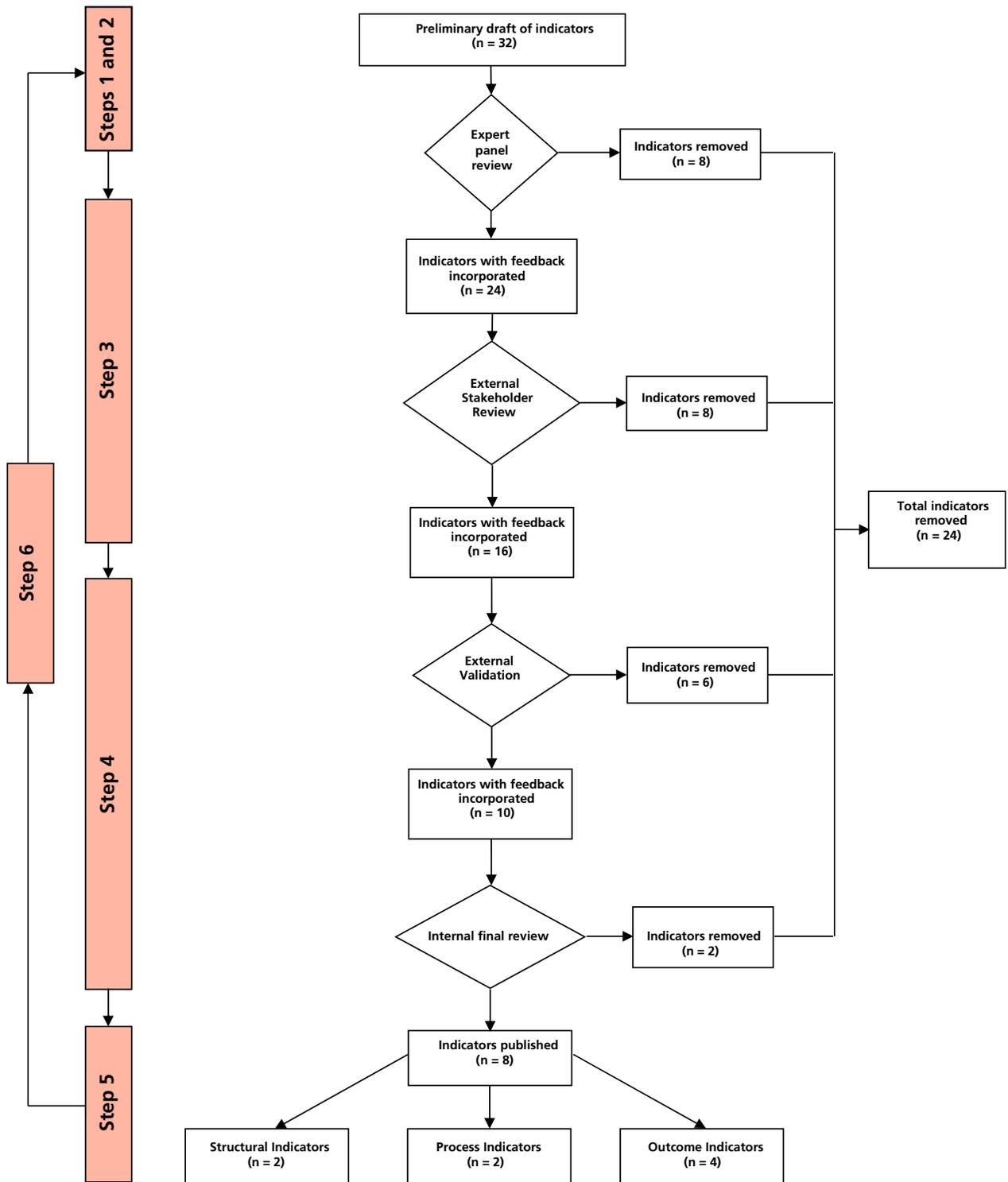
Source: Adapted by the RNAO expert panel from Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

## Appendix E: Indicator Development Process

The RNAO indicator development process steps are summarized below (**Figure 10**).

1. **BPG selection.** Indicators are developed for BPGs focused on health system priorities, with an emphasis on filling gaps in measurement while reducing the reporting burden.
2. **Extraction of recommendations.** Practice recommendations, overall BPG outcomes and BPG Order Sets™ (if applicable) are reviewed to extract potential measures for indicator development.
3. **Indicator selection and development.** Indicators are selected and developed through established methodology, including alignment with external data repositories, health information data libraries and expert consultation.
4. **Practice test and validation.** Proposed indicators are internally validated through face and content validity, and externally validated by national and international organization representatives.
5. **Implementation.** Indicators are published in the Evaluation and Monitoring chart, and data dictionaries are published on the NQuIRE® website.
6. **Data quality assessment and evaluation.** Data quality assessment and evaluation, as well as ongoing feedback from BPSOs®, ensure purposeful evolution of NQuIRE indicators.

Figure 10: Indicator Development Flow Diagram



## Appendix F: Risk Factors

The following is not an exhaustive list of risk factors; rather, it is a selection of those identified within the systematic literature review. Inclusion in this list does not constitute an endorsement by RNAO.

**Table 12: List of Factors That May Predict Violent or Aggressive Behaviours**

VIOLENCE RISK FACTOR GROUP	RISK FACTORS	SUPPORTING REFERENCES
1. Behavioural or psychological	<ul style="list-style-type: none"> <li>■ abusive language (e.g., name calling or swearing)</li> <li>■ aggressive statements</li> <li>■ agitation</li> <li>■ anxiety</li> <li>■ auditory/visual hallucinations</li> <li>■ cognitive impairment (e.g., confusion, disorientation or memory impairment)</li> <li>■ delirium</li> <li>■ diagnosis (psychogeriatric, mental illness, psychopathy)</li> <li>■ drug/alcohol intoxication</li> <li>■ drug withdrawal</li> <li>■ history of poly-substance use</li> <li>■ history of use of illicit substances</li> <li>■ history of violence/positive attitudes toward violence</li> <li>■ mumbling</li> <li>■ prolonged or intense glaring</li> <li>■ regular use of psychoactive drugs</li> <li>■ resistance to health-care practices or staff</li> <li>■ restlessness or pacing</li> <li>■ thought disturbance (delusions or states of minds, such as hostility, suspiciousness and irritability)</li> <li>■ threatening to leave</li> <li>■ yelling</li> </ul>	<p>Burk RS, Grap MJ, Munro CL, et al. Predictors of agitation in critically ill adults. <i>Am J Crit Care</i>. 2014; 23 (5): 414-23.</p> <p>Considine J, Berry D, Johnson R, et al. Vital signs as predictors for aggression in hospital patients (VAPA). <i>J Clin Nurs</i>. 2017; 26(17/18): 2593-2604.</p> <p>Jackson D, Wilkes L, Luck L. Cues that predict violence in the hospital setting: findings from an observational study. <i>Collegian</i>. 2014; 21(1): 65-79.</p> <p>Kim SC, Young L, Berry B. Aggressive Behaviour Risk Assessment tool for newly admitted residents of long-term care homes. <i>J Adv Nurs</i>. 2017; 73(7): 1747-56.</p> <p>Podubinski T, Lee S, Hollander Y, et al. Patient characteristics associated with aggression in mental health units. <i>Psychiatry Res</i>. 2017; 250: 141-5.</p> <p>Sands N, Elsom S, Gerdtz M, et al. Mental health-related risk factors for violence: using the evidence to guide mental health triage decision making. <i>J Psychiatr Ment Health Nurs</i>. 2012; 19(8): 690-701.</p>

VIOLENCE RISK FACTOR GROUP	RISK FACTORS	SUPPORTING REFERENCES
<b>2. Biological</b>	<ul style="list-style-type: none"> <li>■ abnormal respiratory and heart rate</li> <li>■ age younger than 35 years</li> <li>■ decreased oxygenation</li> <li>■ increasing severity of illness, such as deteriorating neurological condition</li> <li>■ low levels of cholesterol (TC)</li> <li>■ low levels of high-density lipoprotein cholesterol (HDL) associated with violence for men and women during their hospital stay. Low levels of HDL are associated with violence only in men in the first three months after discharge.</li> <li>■ low pH</li> </ul>	<p>Burk RS, Grap MJ, Munro CL, et al. Predictors of agitation in critically ill adults. <i>Am J Crit Care</i>. 2014; 23 (5): 414-23.</p> <p>Considine J, Berry D, Johnson R, et al. Vital signs as predictors for aggression in hospital patients (VAPA). <i>J Clin Nurs</i>. 2017; 26(17/18): 2593-2604.</p> <p>Eriksen BMS, Bjørkly S, Lockertsen Ø, et al. Low cholesterol level as a risk marker of inpatient and post-discharge violence in acute psychiatry – a prospective study with a focus on gender differences. <i>Psychiatry Res</i>. 2017; 255: 1-7.</p>
<b>3. Environmental or situational</b>	<ul style="list-style-type: none"> <li>■ admission to new, unfamiliar environment</li> <li>■ being in isolation room</li> <li>■ high levels of stress or triggers of stress</li> <li>■ lack of space/privacy</li> <li>■ physical environment</li> <li>■ quality of treatment/care received</li> <li>■ use of catheters</li> <li>■ use of restraints</li> </ul>	<p>Burk RS, Grap MJ, Munro CL, et al. Predictors of agitation in critically ill adults. <i>Am J Crit Care</i>. 2014; 23 (5): 414-23.</p> <p>Kim SC, Young L, Berry B. Aggressive Behaviour Risk Assessment tool for newly admitted residents of long-term care homes. <i>J Adv Nurs</i>. 2017; 73(7): 1747-56.</p> <p>Tölli S, Partanen P, Kontio R, et al. A quantitative systematic review of the effects of training interventions on engaging the competence of nursing staff in managing challenging patient behaviour. <i>J Adv Nurs</i>. 2017; 73(12): 2817-31.</p>
<b>4. Socio-economic</b>	<ul style="list-style-type: none"> <li>■ homelessness</li> <li>■ poor self-care and functioning (such as poor hygiene or lack of orderliness)</li> <li>■ poor social functioning and limited life skills (e.g., lack of employment)</li> <li>■ social isolation</li> </ul>	<p>Sands N, Elsom S, Gerdtz M, et al. Mental health-related risk factors for violence: using the evidence to guide mental health triage decision making. <i>J Psychiatr Ment Health Nurs</i>. 2012; 19(8): 690-701.</p>

## Appendix G: STAMPEDAR Framework

The following appendix is an overview of the STAMPEDAR framework. The framework covers nine components that classify risk of violence and their corresponding cues. Being alert and aware of these potential behaviours and triggers may help health workers predict and prevent the incidents of violent or aggressive behaviours.

**Table 13: STAMPEDAR Components and Cues**

COMPONENT	CUES
<b>Staring</b>	<ul style="list-style-type: none"> <li>■ staring</li> <li>■ not breaking eye contact/no eye contact</li> </ul>
<b>Tone</b>	<ul style="list-style-type: none"> <li>■ tone and volume of voice</li> <li>■ calling out in a loud voice</li> <li>■ aggressive tone</li> <li>■ demanding</li> <li>■ name calling</li> <li>■ swearing</li> </ul>
<b>Anxiety</b>	<ul style="list-style-type: none"> <li>■ anxiety</li> <li>■ agitated</li> <li>■ requiring reassurance</li> </ul>
<b>Mumbling</b>	<ul style="list-style-type: none"> <li>■ muttering</li> </ul>
<b>Pacing</b>	<ul style="list-style-type: none"> <li>■ refusing to stay in room</li> <li>■ refusing to stay in bed</li> </ul>
<b>Emotions</b>	<ul style="list-style-type: none"> <li>■ unhappy</li> <li>■ frightened</li> <li>■ frustrated</li> <li>■ dissatisfied with care</li> </ul>
<b>Disease process</b>	<ul style="list-style-type: none"> <li>■ confusion</li> <li>■ intoxication (drugs or alcohol)</li> <li>■ organic disorders</li> <li>■ regular attendee at the agency</li> </ul>

COMPONENT	CUES
<b>Assertive/non-assertive</b>	<ul style="list-style-type: none"> <li>■ disrespectful</li> <li>■ confrontational</li> <li>■ not assertive</li> <li>■ over-assertive</li> </ul>
<b>Resources</b>	<ul style="list-style-type: none"> <li>■ long wait times</li> <li>■ staff inexperience</li> <li>■ staff knowledge and skill level</li> <li>■ inappropriate communication styles</li> </ul>

Source: Reprinted from Chapman R, Perry L, Styles I, et al. Predicting patient aggression against nurses in all hospital areas. Br J Nurs. 2009;18(8):476-83. Reprinted with permission.

# Appendix H: Validated Risk Assessment Tools

The following is not an exhaustive list of risk assessment tools; rather, it is a selection of those identified within the systematic literature review. Inclusion in this list does not constitute an endorsement by RNAO.

**Table 14: Validated Tools to Assess for the Risk of Violence**

NAME OF TOOL	SETTING OR POPULATION	DESCRIPTION OF TOOL/APPROACH	REFERENCES
<b>STRUCTURED PROFESSIONAL JUDGMENT TOOLS</b>			
<b>Short-Term Assessment of Risk and Treatability (START)</b>	<p><b>Population:</b> Adults with mental, personality, and substance-related disorders; forensic patients.</p> <p><b>Setting:</b> Has relevance to clients in correctional, civil or forensic community and institutional settings.</p>	<ul style="list-style-type: none"> <li>■ Identifies recent, historical and dynamic factors to assess the risk for violence and treatability in the short-term future (weeks to months).</li> <li>■ A person’s strengths, needs and case-specific risk factors are all considered.</li> </ul>	<p><a href="http://criminal-justice.iresearchnet.com/forensic-psychology/short-term-assessment-of-risk-and-treatability-start/">http://criminal-justice.iresearchnet.com/forensic-psychology/short-term-assessment-of-risk-and-treatability-start/</a></p> <p><a href="http://www.bcmhsus.ca/health-professionals/clinical-resources/start">http://www.bcmhsus.ca/health-professionals/clinical-resources/start</a></p>

NAME OF TOOL	SETTING OR POPULATION	DESCRIPTION OF TOOL/APPROACH	REFERENCES
<b>ACTUARIAL TOOLS</b>			
<b>Aggressive Behavior Risk Assessment Tool (ABRAT)</b>	<b>Setting:</b> Medical-surgical units and long-term care homes.	<ul style="list-style-type: none"> <li>■ Predicts potentially aggressive in-patients by assessing the following using a yes/no checklist:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> agitation</li> <li><input type="checkbox"/> anxiety</li> <li><input type="checkbox"/> confusion/cognitive impairment</li> <li><input type="checkbox"/> history of mania</li> <li><input type="checkbox"/> history of physical aggression</li> <li><input type="checkbox"/> mumbling</li> <li><input type="checkbox"/> physically threatening</li> <li><input type="checkbox"/> shouting</li> <li><input type="checkbox"/> staring</li> <li><input type="checkbox"/> threatening to leave.</li> </ul> </li> </ul>	Berry B, Young L, Kim SC. Utility of the aggressive behavior risk assessment tool in long-term care homes. <i>Geriatr Nurs.</i> 2017;38:417-22.
<b>Workplace Assessment of Violence Risk (WAVR-21)</b>	<p><b>Population:</b> Adults and students 18 years of age or older.</p> <p><b>Setting:</b> A workplace or campus setting.</p>	<ul style="list-style-type: none"> <li>■ Twenty-one items that look at psychological, behavioural, historical and situational factors associated with violence.                             <ul style="list-style-type: none"> <li>■ The primary use is the assessment of homicidal targeted workplace and campus violence.</li> <li>■ The secondary use is the identification of other forms of problematic aggression (e.g., stalking, anger or bullying).</li> </ul> </li> </ul>	<a href="https://www.wavr21.com/the-wavr-explained/">https://www.wavr21.com/the-wavr-explained/</a>

NAME OF TOOL	SETTING OR POPULATION	DESCRIPTION OF TOOL/APPROACH	REFERENCES
<b>ACTUARIAL TOOLS</b>			
<b>Historical, Clinical, Risk Management-20 (HCR-20)</b>	<p><b>Population:</b> Adults 18 years of age or older who have the potential to be violent in the future.</p> <p><b>Setting:</b> Correctional, forensic, general or civil psychiatric institutions; the community.</p>	<ul style="list-style-type: none"> <li>■ Comprehensive set of professional guidelines to assess and manage risk for violence.</li> <li>■ Used to identify treatment and management plans for potentially violent individuals or those who have a mental disorder.</li> <li>■ Includes 20 probing questions, with three main focus areas: history, clinical and risk management.</li> </ul>	<p><a href="http://hcr-20.com/">http://hcr-20.com/</a>  <a href="http://www.minddisorders.com/Flu-Inv/Historical-Clinical-Risk-Management-20.html">http://www.minddisorders.com/Flu-Inv/Historical-Clinical-Risk-Management-20.html</a></p>
<b>Violence Risk Screening-10 (V-RISK-10)</b>	<p><b>Population:</b> Persons in general and acute psychiatry.</p> <p><b>Setting:</b> Acute and general psychiatry.</p>	<ul style="list-style-type: none"> <li>■ A screen or checklist to identify individuals who may need more thorough risk assessments.</li> <li>■ Used to identify risk for violence during a hospital stay upon admission, and at discharge for predicting violence in the community during the first year.</li> <li>■ Can have higher rates of false positives for women than men (34).</li> </ul>	<p><a href="http://www.forensic-psychiatry.no/violence_risk/index.html">http://www.forensic-psychiatry.no/violence_risk/index.html</a>  <a href="http://www.forensic-psychiatry.no/violence_risk/v_risk_10_english.pdf">http://www.forensic-psychiatry.no/violence_risk/v_risk_10_english.pdf</a></p>

NAME OF TOOL	SETTING OR POPULATION	DESCRIPTION OF TOOL/APPROACH	REFERENCES
<b>ACTUARIAL TOOLS</b>			
<b>Dynamic Appraisal of Situational Aggression (DASA)</b>	<p><b>Population:</b> Persons on an in-patient mental health unit.</p> <p><b>Setting:</b> Psychiatric in-patient environment or forensic facility.</p>	<ul style="list-style-type: none"> <li>■ Identifies likelihood that a person will become violent or aggressive in the short-term (24 hours).</li> <li>■ Scored on a daily basis, it consists of seven items that measure irritability, impulsivity, unwillingness to follow instructions, sensitivity to perceived provocation, ease of anger when requests are denied, negative attitudes and verbal threats.</li> </ul>	<p><a href="https://www.centreforperfectcare.com/media/1097/dasa.pdf">https://www.centreforperfectcare.com/media/1097/dasa.pdf</a></p>
<b>Brøset Violence Checklist (BVC)</b>	<p><b>Population:</b> Developed based on data from forensic in-patients.</p> <p><b>Setting:</b> Tested in acute wards, nursing homes and geriatric wards.</p>	<ul style="list-style-type: none"> <li>■ Assists in prediction of imminent violent behaviour (i.e., risk for violence in the next 24 hours).</li> <li>■ To be completed per shift or per day (depending on organizational policy).</li> <li>■ Checklist that includes six variables/behaviours: confused, irritable, boisterous, physically threatening, verbally threatening and attacking objects.</li> </ul>	<p><a href="http://www.riskassessment.no/">http://www.riskassessment.no/</a></p>
<b>Violence Risk Appraisal Guide (VRAG)</b>	<p><b>Population:</b> Mentally disordered offenders and individuals with lower IQs.</p>	<ul style="list-style-type: none"> <li>■ Used to predict statistically whether a convicted criminal will reoffend, eliminating bias that can occur with unstructured judgements.</li> <li>■ The tool is comprised of 12 items that assess the likelihood of re-offending. However, assessors first complete an eight-item worksheet that assesses for psychopathy before the age of 16, including symptoms of conduct disorder.</li> </ul>	<p><a href="http://www.psyconsult.it/public/Protocollo_VRAG_SORAG.pdf">http://www.psyconsult.it/public/Protocollo_VRAG_SORAG.pdf</a></p> <p><a href="http://dustinkmacdonald.com/using-violence-risk-appraisal-guide-vrag/">http://dustinkmacdonald.com/using-violence-risk-appraisal-guide-vrag/</a></p>

NAME OF TOOL	SETTING OR POPULATION	DESCRIPTION OF TOOL/APPROACH	REFERENCES
<p><b>ACTUARIAL TOOLS</b></p> <p><b>Hare Psychopathy Checklist-Revised (PCL-R)</b></p>	<p><b>Population:</b> Developed for adult males in prisons, criminal psychiatric hospitals and those awaiting psychiatric evaluations or on trial in correctional and detention centers. However, may also be used to diagnose sex offenders or female and adolescent offenders.</p>	<ul style="list-style-type: none"> <li>■ The original purpose of the tool was to assess persons accused or convicted of crimes.</li> <li>■ Used to diagnose psychopathy and antisocial tendencies.</li> <li>■ Consists of two parts:                             <ol style="list-style-type: none"> <li>1. Twenty items where an examiner compares a person’s degree of psychopathy to that of a “typical” psychopath.</li> <li>2. An interview to evaluate the person’s background.</li> </ol> </li> </ul>	<p><a href="https://www.mhs.com/MHS-PublicSafety?prodname=pcc-sv">https://www.mhs.com/MHS-PublicSafety?prodname=pcc-sv</a></p> <p><a href="https://www.researchgate.net/publication/312447998_Psychopathy-Checklist_Screening_Version_PCLSV">https://www.researchgate.net/publication/312447998_Psychopathy-Checklist_Screening_Version_PCLSV</a></p>

NAME OF TOOL	SETTING OR POPULATION	DESCRIPTION OF TOOL/APPROACH	REFERENCES
<b>ACTUARIAL TOOLS</b>			
<p><b>Hare Psychopathy Checklist: Screening Version (PCL: SV)</b></p>	<p><b>Population:</b> Adults 18 years of age or older in the general population, or persons in the forensic and psychiatric population.</p> <p><b>Setting:</b> Workplace organizations to screen candidates before offering them employment, or in psychiatric and forensic environments.</p>	<ul style="list-style-type: none"> <li>■ Abbreviated version of the PCL-R, used to screen for Psychopathic Personality Disorder.</li> <li>■ Includes both a semi-structured interview and a 12-item scale to assess core personality traits of psychopathy and socially deviant or antisocial behaviours of psychopathy.</li> </ul>	<p><a href="https://www.researchgate.net/publication/312447998_Psychopathy_Checklist_Screening_Version_PCLSV">https://www.researchgate.net/publication/312447998_Psychopathy_Checklist_Screening_Version_PCLSV</a></p>

NAME OF TOOL	SETTING OR POPULATION	DESCRIPTION OF TOOL/APPROACH	REFERENCES
<b>ACTUARIAL TOOLS</b>			
<b>Violence Risk Scale (VRS)</b>	<p><b>Population:</b> Incarcerated criminal offenders, criminal offenders released into the community, criminal offenders hospitalized in forensic institutions, and persons who have a mental disorder and are hospitalized in a forensic institution.</p>	<ul style="list-style-type: none"> <li>■ The main objective is to assess future violence risk in persons who may be released from a forensic institution into the community.</li> <li>■ Can also be used to identify changes in risk after treatment, or to make decisions about treatment.</li> <li>■ Assesses both static (e.g., offense history) and dynamic (e.g., interpersonal aggression) factors.</li> </ul>	<p><a href="http://www.psynergy.ca/uploads/Psynergy_Website_VRS_brief_intro.pdf">http://www.psynergy.ca/uploads/Psynergy_Website_VRS_brief_intro.pdf</a></p>
<b>Classification of Violence Risk (COVR)</b>	<p><b>Population:</b> Persons between the ages of 18 and 60 years in acute care psychiatric facilities and forensic facilities.</p>	<ul style="list-style-type: none"> <li>■ An interactive software program used to assess the risk that an individual in an acute psychiatric facility will become violent towards others after being discharged from hospital.</li> <li>■ The assessment includes:                             <ol style="list-style-type: none"> <li>1. a brief chart review; and</li> <li>2. an individualized 10-minute interview with the person, whereby the questions the examiner asks are determined by the person's previous responses.</li> </ol> </li> </ul>	<p><a href="https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.62.4.pss6204_0430">https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.62.4.pss6204_0430</a></p>

## Appendix I: Approaches to Education Delivery

The following is not an exhaustive list of potential approaches to education delivery; rather, it is a selection of those identified within the systematic review literature. Inclusion in this list does not constitute an endorsement by RNAO.

**Table 15: Approaches to Delivery of Educational Content on Workplace Violence**

EDUCATION DELIVERY APPROACH	DESCRIPTION OF THE APPROACHES USED WITHIN THE LITERATURE	RESULTS OF USING THE APPROACH
<p><b>1. Online education</b></p>	<p>Online education can involve various adult-learning strategies on the Internet, either through modules, videos and discussion boards, or through a series of courses with written assignments. The advantage of using an online approach is that the content can include various learning methods (e.g., audio or visual approaches, and written discussions) and it can be tailored to each learner's objectives (84, 86). Learners can still acquire many fundamental skills and techniques by using online interactive assessments and detailed explanations as a means to deepen content understanding and enhance learning. In addition, eLearning is cost-effective because it reduces instructor training time, travel, labour costs and institutional infrastructure (84).</p>	<p>A randomized controlled trial found positive results in knowledge, attitudes, self-efficacy and empathy after online education, and the effects were sustained for two months (86). This suggests that online programs can elicit meaningful impacts on learners and enhance learning outcomes (86). In another randomized controlled study, the authors found that staff in the intervention (online) group reduced the length of restraint use significantly – from 36 hours to 4 hours – following online education (84).</p>

EDUCATION DELIVERY APPROACH	DESCRIPTION OF THE APPROACHES USED WITHIN THE LITERATURE	RESULTS OF USING THE APPROACH
<p><b>2. Simulation-based, interactive strategies</b></p>	<p>Role simulation is a realistic but safe forum for learners to address clinical practice issues such as violence and aggression (92, 100). Simulation-based strategies and role-play activity involve imitating real clinical situations in a controlled learning environment, and they can evoke authentic affective responses from participants. The responses and perceived impact of role simulations are similar to those exhibited in real-life situations (100).</p> <p>In addition, simulation-based learning can influence the attitudes of learners, and it encourages interprofessional teamwork and shared dialogue (92). Learners can experience stressful situations in a safe learning environment, which allows them to practice different ways of reacting and learning how to best prevent violence and aggression (100). An interprofessional, team-based approach to the design of simulation-based education can stress the importance of staff attitudes toward violent and aggressive behaviours and improve safety in practice (92).</p>	<p>Gillespie, Farra, and Gates (2014) found a significant increase in knowledge among emergency department employees six months following a simulation activity (139).</p> <p>In an observational study, staff attitudes about the management of violence and aggression did not change significantly after simulation-enhanced education. However, the simulation-enhanced education prompted the implementation of multiple quality improvement initiatives and the review of protocols and policies to support the prevention of violence and aggression (92).</p>

EDUCATION DELIVERY APPROACH	DESCRIPTION OF THE APPROACHES USED WITHIN THE LITERATURE	RESULTS OF USING THE APPROACH
<p><b>3. Cognitive rehearsal education</b></p>	<p>Cognitive rehearsal education is an approach to negotiating emotional or stressful situations that is based on the principles of cognitive behavioural therapy. It includes the consideration of knowledge and best practices, recognizing personal perceptions and behaviour, managing personal reactions, rehearsing responses in a safe and collaborative environment, and increasing skill and confidence (99). Cognitive rehearsal education enables nurses to have an increased awareness of inappropriate behaviours that can occur, specifically as a result of workplace violence (98).</p>	<p>After the implementation of one cognitive rehearsal education program for nurses, many participants reported increased feelings of personal empowerment. They reported relying less on external judgement and felt more empowered to speak up against lateral violence in the workplace (98).</p> <p>Fehr and Seibel (2016) also found that cognitive rehearsal education was an effective tool for addressing bullying, and that it contributed to the development of positive attitudes, habits and competencies in student participants (99).</p>
<p><b>4. Train-the-trainer approaches</b></p>	<p>A train-the-trainer approach is based on the concept of modelling and promoting empowerment to learners. Trainers provide the education content to health workers so that they can in turn train others within their workplace, thus creating a sustainable learning environment, enhancing self-efficacy and facilitating unlearning of undesired behaviours/attitudes (79, 103, 105).</p> <p>An example of a train-the-trainer approach is the training course developed by a multi-disciplinary team on the prevention of aggression in acute care settings. The course was followed by a facilitated discussion of the various local approaches that were used and suggestions for practice improvements. Trainers were clinical educators or experienced registered nurses with specialized expertise (79).</p>	<p>Ceravolo, Schwartz, Foltz-Ramos, et al. (2012) found that following the implementation of a train-the-trainer approach to education, the assertive communication skills of nurses were enhanced because they had the opportunity to practice communication and leadership skills in a constructive and tangible way (103).</p>

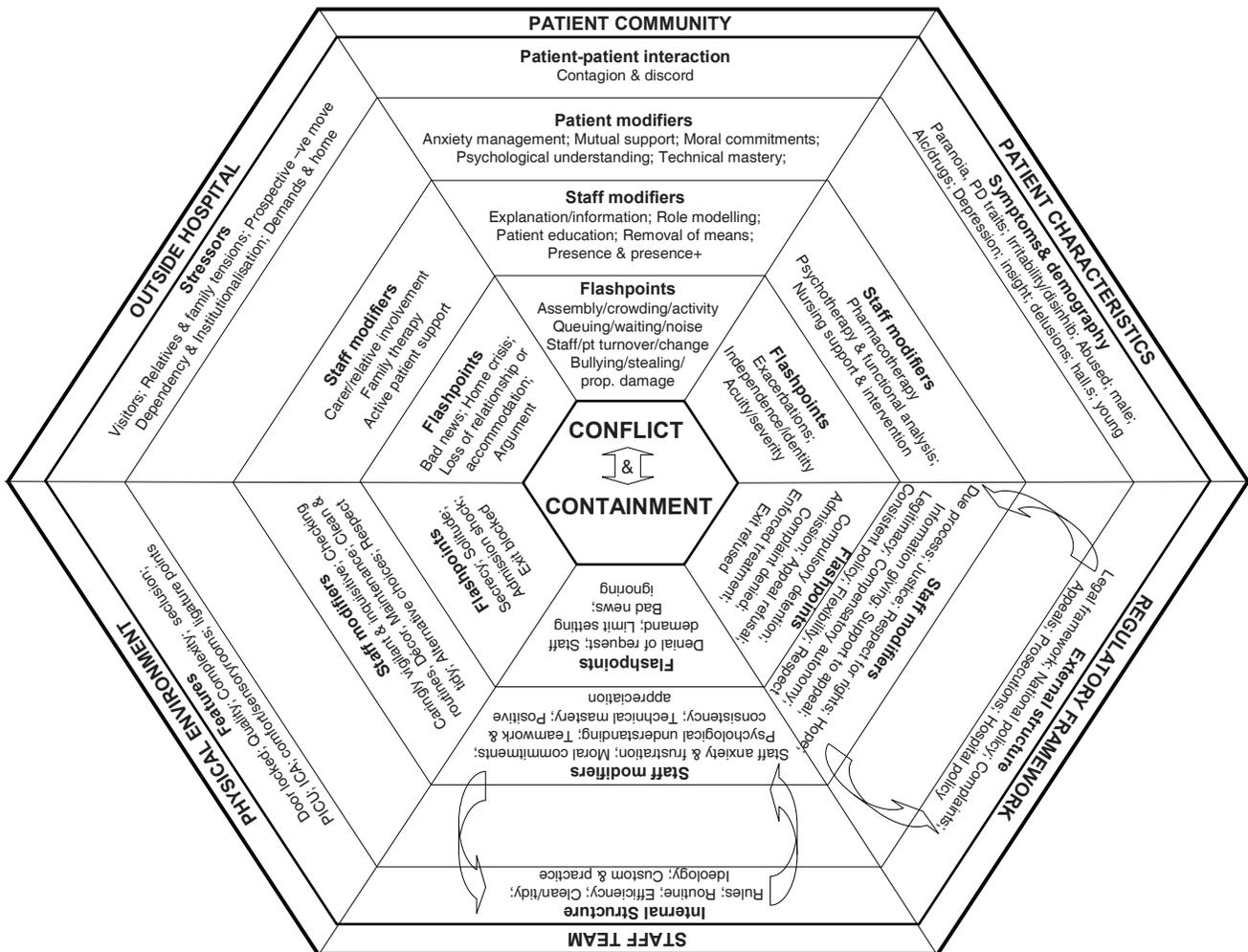
EDUCATION DELIVERY APPROACH	DESCRIPTION OF THE APPROACHES USED WITHIN THE LITERATURE	RESULTS OF USING THE APPROACH
<p><b>5. Ongoing approaches to re-education and refresher training</b></p>	<p>Consistent reinforcement and support for re-education are needed in order to integrate learned techniques and strategies into clinical practice (62). There often are no agreed upon criteria for when refreshers to learning should take place; however, yearly mandatory re-education is required within some organizations.</p> <p>Leadership and organizational support are keys to successful organizational culture changes, specifically in regards to implementing ongoing re-education (88).</p>	<p>A common theme across the literature is that continuous education and training are essential to workplace violence prevention (62, 79, 84, 88, 96, 101, 140).</p> <p>Regardless of the content or focus of the education, health workers need to receive training regularly to ensure they are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Refreshers on knowledge, attitudes and skills learned through initial educational sessions can be integrated into practice only through ongoing re-education and reinforcement (62, 79, 84, 88, 96, 101, 140).</p>

# Appendix J: Safewards Model

This appendix provides an overview of the Safewards Model and a table describing the 10 principle interventions aimed at making environments safer for both persons and families.

The Safewards model (Figure 11) identifies six domains of originating factors that may influence conflict and containment in the health workplace. The table that follows the model (Table 16) provides 10 principles aimed at making health workplaces safer environments for both health workers and persons.

Figure 11: Safewards Model



Source: Reprinted with permission from Bowers L. Safewards: a new model of conflict and containment on psychiatric wards. Safewards; 2008. Available from <http://www.safewards.net/images/pdf/Safewards%20model.pdf>. Reprinted with permission.

**Table 16: Ten Safewards Intervention Principles**

INTERVENTION	DESCRIPTION
<b>Clear mutual expectations</b>	Health workers and patients should determine a list of expectations for the unit or health setting. At first, these expectations should be decided on independently by the two groups; after that, they should be mutually agreed upon. This list should be visible for all to see on the unit or within the health setting, and it should be referred to consistently.
<b>Soft words</b>	Health workers and patients should work collaboratively to avoid escalating frustrations and miscommunication. Health settings should create and regularly update posters displaying tips for using “soft words” and distribute postcards to workers with reminders on how to frame communication in a positive way.
<b>Talk down</b>	Health workers should understand basic-to-advanced de-escalation techniques, and the information should be presented by a “Talk Down Champion” within the organization. Posters and handouts should be available to all workers in order promote utilization of talk down techniques.
<b>Positive words</b>	Change of shift reports given to oncoming staff often focus on a patient’s difficult behaviours or the risks they pose to others. This can create a negative perception of that individual. Alternatively, health workers should focus on something positive about each patient while giving report and provide a possible psychological understanding of any difficult or disruptive behaviour.
<b>Bad news mitigation</b>	Health workers should be cognizant of the bad news that is given (or about to be given) to patients and the angry or upset reactions that could result. When health workers can anticipate bad news, they can support and facilitate discussion, express empathy, acknowledge frustration and be receptive to concerns to avoid conflict.
<b>Know each other</b>	In a collaborative effort to build therapeutic relationships, both health workers and patients should create one-page profiles of information they are willing to share. The profiles can include things such as likes and dislikes, and they can be laminated and shared at the bedside for patients and in a public area of the health setting for workers.

INTERVENTION	DESCRIPTION
<b>Mutual help meeting</b>	A voluntary meeting of all patients and health workers on duty should be held regularly to create a culture of helping and understanding (the more regularly the meetings occur, the shorter they can be). The meeting can be structured and discuss how everyone can help each other during the day.
<b>Calm down methods</b>	Health settings should have a box containing items for patients that can promote comfort and a calming effect when needed. The tools should be used (under supervision) by a patient who is increasingly agitated. The box may contain items such as stress balls, blankets or coloring pages.
<b>Reassurance</b>	Following an incident that could be potentially anxiety-invoking for patients in a health setting, everyone should be spoken to in order to assess their understanding and provide an explanation. Patients should be supported to feel safe and secure, and health workers should understand the effect that the incident has had on each individual.
<b>Discharge messages</b>	Upon discharge, health workers should ask if the patient would like to write a message to be displayed in the unit or health setting. The message should include their name, what they liked about the unit, positive advice for new patients and what went on in the unit during their stay. New patients should be shown these messages for reassurance during their admittance.

Source: Adapted by the RNAO expert panel from Safewards: Resources for Safewards Implementation; 2018. Available from: <http://www.safewards.net/>.

## Appendix K: Communication Responses Lanyard Card

This appendix provides a tool to guide students on communication responses to address harassment and bullying in practice settings. In a study by Fehr and Seibel (2016), students used this as a lanyard card to assist them in responding to bullying behaviour as it occurs.

**Figure 12: Communication responses to address harassment and bullying**



**STOP, REFLECT AND RESPOND  
WHAT TO SAY**

Verbal affront (covert or overt snide remarks)  
***What do you mean by that comment?***

Non-verbal innuendo (raising of eyebrows, making faces)  
***I see from your facial expression that you might be confused. What else do you need to know?***

Withholding information (related to one's practice or a patient)  
I feel that you aren't telling me everything I need to know.

Sabotage (any underhand interference in production, work)  
***I feel this should not have happened. We need to talk about this privately.***

Undermining activities (to weaken, injure, destroy by secret or insidious means)  
I feel that you don't trust me. Will you tell me why?

Infighting (bickering with peers)  
***We need to stop this behaviour and learn to work together.***

Backstabbing (betraying a friend or an associate)  
I don't feel comfortable talking about (person's name) when they are not present.

Broken confidences  
***This is information that should remain confidential.***

Scapegoating (assigning the blame to one person for the shortcomings of others)  
We can't blame one person for everything that goes wrong.

Gossiping (idle talk, groundless rumor)  
***This is inappropriate conversation that should not be taking place.***

Developed by M. Griffen (2004), modified by N. Fleming & L. Sutherland (2011).  
Used with permission.

Source: Reprinted with permission from Fehr FC, Seibel LM. Cognitive rehearsal training for upskilling undergraduate nursing students against bullying: a qualitative pilot study. *Quality Advancement in Nursing Education*. 2016; 2(1), Article 5 DOI: <https://doi.org/10.17483/2368-6669.1058>.

## Appendix L: Workplace Health and Safety Survey Vulnerability Scale

The following appendix is the Occupational Health and Safety (OHS) vulnerability measure. It was developed at the Institute for Work & Health (IWH) to assess risk for injury and illness at work. The scale assesses vulnerability in four areas:

1. Hazard exposure
2. Workplace policies and procedures
3. Worker awareness of hazards and OHS rights and responsibilities
4. Worker empowerment to participate in injury and illness prevention.

The measure can be used both before and after a violence prevention program initiative to evaluate effectiveness within an organization.



Figure 13: Measure to assess risk for injury and illness at work

## Workplace health and safety survey

You are invited to share your opinions about your work and how it affects your health and safety by taking this survey.

Please answer the questions below on the hazards you face on the job and the occupational health and safety (OHS) policies and procedures in place to protect you. Please note that the survey is anonymous (i.e. we are not asking for your name). Your answers will help pinpoint areas that may need improvement to better protect the health and safety of workers.

Answer each question carefully. There are no right or wrong answers. For each question, please indicate the response option you feel best answers the question. (DK/NA stands for Don't Know /Not Applicable)

**Part 1: Workplace hazards**

This section asks about the kinds of health and safety hazards you might be exposed to in your job. For each item below, please put an X under the heading that best describes how often you do the stated task or are exposed to the stated condition.

In your job, how often do you ...?	Never	Once a year	Every 6 months	Every 3 months	Every month	Every week	Every day	DK/NA
1. Manually lift, carry or push items heavier than 20 kg at least 10 times during the day								
2. Do repetitive movements with your hands or wrists (packing, sorting, assembling, cleaning, pulling, pushing, typing) for at least 3 hours during the day								
3. Perform work tasks, or use work methods, that you are not familiar with								
4. Interact with hazardous substances such as chemicals, flammable liquids and gases								
5. Work in a bent, twisted or awkward work posture								
6. Work at a height that is 2 metres or more above the ground or floor								
7. Work in noise levels that are so high that you have to raise your voice when talking to people less than one metre away								
8. Experience being bullied or harassed at work								
9. Stand for more than 2 hours in a row								

**Part 2: Workplace policies and procedures**

This section asks about the kinds of policies and systems in place to make the workplace safe. For each item below, please put an X under the heading that best describes how much you agree or disagree with the statement.

At my workplace ....	Strongly agree	Agree	Disagree	Strongly disagree	DK/NA
10. Everyone receives the necessary workplace health and safety training when starting a job, changing jobs or using new techniques					
11. There is regular communication between employees and management about safety issues					
12. Systems are in place to identify, prevent and deal with hazards at work					
13. Workplace health and safety is considered to be at least as important as production and quality					
14. There is an active and effective health and safety committee and/or worker health and safety rep					
15. Incidents and accidents are investigated quickly in order to improve workplace health and safety					
16. Communication about workplace health and safety procedures is done in a way that I can understand					

**Part 3: Occupational health and safety awareness**

This section explores your awareness of occupational health and safety (e.g. hazards, the rights and responsibilities of both employees and employers). For each item below, please put an X under the heading that best describes how much you agree or disagree with the statement.

At my workplace ....	Strongly agree	Agree	Disagree	Strongly disagree	DK/NA
17. I am clear about my rights and responsibilities in relation to workplace health and safety					
18. I am clear about my employers' rights and responsibilities in relation to workplace health and safety					
19. I know how to perform my job in a safe manner					
20. If I became aware of a health or safety hazard at my workplace, I know who (at my workplace) I would report it to					
21. I have the knowledge to assist in responding to any health and safety concerns at my workplace					
22. I know what the necessary precautions are that I should take while doing my job					

**Part 4: Participation in occupational health and safety**

This section explores your ability to ask questions about, and participate in, health and safety at work. Your ability to participate in making a safer workplace for yourself depends on both your actions and abilities and your employer's actions and practices. For each item below, please put an X under the heading that best describes how much you agree or disagree with the statement.

At my workplace ....	Strongly agree	Agree	Disagree	Strongly disagree	DK/NA
23. I feel free to voice concerns or make suggestions about workplace health and safety at my job					
24. If I notice a workplace hazard, I would point it out to management					
25. I know that I can stop work if I think something is unsafe and management will not give me a hard time					
26. If my work environment was unsafe I would not say anything, and hope that the situation eventually improves (reverse scored)					
27. I have enough time to complete my work tasks safely					

Thank you for your participation.



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<http://creativecommons.org/licenses/by-nc-nd/4.0/>. That means this survey can be used and shared as long as IWH is credited as the source, the tool is not modified, and the tool is used for non-commercial purposes. If you wish to modify and/or use the tool for commercial purposes, please contact ip@iwh.on.ca.

This survey is part of the OHS Vulnerability Measure developed by the Institute for Work & Health (IWH), a not-for-profit organization based in Toronto, Canada, that aims to promote, protect and improve the safety and

health of working people by conducting actionable research that is valued by employers, workers and policy-makers. The full tool is also available online at: [www.iwh.on.ca/ohs-vulnerability-measure](http://www.iwh.on.ca/ohs-vulnerability-measure)

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For more information, please contact: [info@iwh.on.ca](mailto:info@iwh.on.ca)

Institute for Work & Health  
481 University Ave., Suite 800  
Toronto, ON Canada M5G 2E9



[www.iwh.on.ca](http://www.iwh.on.ca)

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## Appendix M: Resources

**Table 17**, which was compiled by the RNAO Best Practice Guideline Development and Research Team and members of the expert panel – with input from external stakeholder reviewers – lists some of the main organizations that provide information or resources on workplace violence, harassment and bullying. Other resources may be available at the local level. Clinicians also are encouraged to research local supports to which they can refer people.

Links to websites are provided for information purposes only; RNAO is not responsible for the quality, accuracy, reliability or currency of the information provided through these sources. Furthermore, RNAO has not determined the extent to which these resources have been evaluated. Questions regarding these resources should be directed to the source.

**Table 17: Organizations That Provide Information or Resources on Workplace Violence, Harassment, and Bullying**

ORGANIZATION, PROGRAM OR RESOURCE	DESCRIPTION	LINK
<b>Arete Safety Training and Protection, Inc.</b>	Provides workshops on workplace violence and conflict. Workshops are customizable to meet the needs of the workplace.	<a href="http://www.arete.ca/programs/service-to-safety-workplace-violence-prevention-training/">http://www.arete.ca/programs/service-to-safety-workplace-violence-prevention-training/</a>
<b>Canadian Centre for Occupational Health and Safety (CCOHS)</b>	The CCOHS serves Canadians and the world with credible and relevant tools and resources to improve workplace health and safety programs.	<a href="https://www.ccohs.ca">https://www.ccohs.ca</a>
<b>Canadian Federation of Nurses Unions (CFNU)</b>	The CFNU advocates for unionized nurses and nursing students across Canada, promotes the nursing profession on a national level, and aims to protect the quality of health care for patients. The website provides multiple tools and resources related to various topics, including psychological violence, workplace violence, and bullying.	<a href="https://nursesunions.ca/">https://nursesunions.ca/</a> <a href="https://nursesunions.ca/?s=workplace+violence">https://nursesunions.ca/?s=workplace+violence</a>

ORGANIZATION, PROGRAM OR RESOURCE	DESCRIPTION	LINK
<b>Canadian Nurses Association</b>	Represents Canadian registered nurses nationally and internationally with the goal of influencing healthy public policy, and advocating for the role of registered nurses in the health environment. Also provides a code of ethics for registered nurses.	<a href="https://www.cna-aiic.ca">https://www.cna-aiic.ca</a> <a href="https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive">https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive</a>
<b>Canadian Patient Safety Institute</b>	Provides tools and resources for patients, health care providers and leaders to ensure safe health care, with particular emphasis on patient safety and quality.	<a href="http://www.patientsafetyinstitute.ca">www.patientsafetyinstitute.ca</a>
<b>Health Quality Ontario (HQO)</b>	“HQO is the provincial lead on the quality of health care. They help nurses, doctors and other health-care professionals working on the front lines be more effective in what they do by providing objective advice and data, and by supporting them and government in improving health care for the people of Ontario” (141).	<a href="http://www.hqontario.ca">www.hqontario.ca</a>
<b>International Association on Workplace Bullying and Harassment (IAWBH)</b>	IAWBH is a group of scholars and practitioners who specialize in the field of workplace bullying and harassment. The aim of the association is to “stimulate, generate, integrate and disseminate research and evidence-based practice in the field of workplace bullying and harassment.”	<a href="https://www.iawbh.org/">https://www.iawbh.org/</a>
<b>National Alliance for Safety and Health in Healthcare (NASHH)</b>	The NASHH was established to reduce and eliminate workplace injuries on the front line of health and seniors care in Canada. They are comprised of seven provincial senior care safety associations.	<a href="http://nashh.ca">http://nashh.ca</a>

ORGANIZATION, PROGRAM OR RESOURCE	DESCRIPTION	LINK
<b>Ontario Ministry of Labour – Workplace Violence and Workplace Harassment</b>	Provides information about the Occupational Health and Safety Act, including education, tools and resources on the development and implementation of policies and programs on workplace violence and harassment.	<a href="https://www.labour.gov.on.ca/english/hs/topics/workplaceviolence.php">https://www.labour.gov.on.ca/english/hs/topics/workplaceviolence.php</a>
<b>Ontario Nurses' Association (ONA)</b>	ONA is the union that represents registered nurses, health professionals, and student affiliates in Ontario. The website provides guidance and resources about workplace violence and harassment.	<a href="https://www.ona.org/about-ona/our-vision-mission-and-history/">https://www.ona.org/about-ona/our-vision-mission-and-history/</a> <a href="https://www.ona.org/member-services/health-safety/violence-harassment/">https://www.ona.org/member-services/health-safety/violence-harassment/</a>
<b>Public Services Health and Safety Association (PSHSA)</b>	PSHSA works with public sector employees to provide occupational health and safety training and resources. Specifically, their website focuses on workplace violence and provides resources, supporting documents and recommendations on workplace violence in health care.	<a href="https://www.pshsa.ca/workplace-violence/">https://www.pshsa.ca/workplace-violence/</a>
<b>Safety First Training</b>	Safety First Training is a provider of workplace health and safety services. These services include online and onsite training courses on workplace harassment and violence prevention. This training provides individuals with (a) the knowledge required to identify potentially violent situations and (b) the skills and strategies to prevent or manage them.	<a href="https://www.safetyfirsttraining.ca/course/onsite-training/workplace-violence-harassment-training/">https://www.safetyfirsttraining.ca/course/onsite-training/workplace-violence-harassment-training/</a>

ORGANIZATION, PROGRAM OR RESOURCE	DESCRIPTION	LINK
<b>Sigma Theta Tau International (STTI)</b>	STTI is a non-profit organization whose aim is to advance global health and to celebrate excellence in nursing scholarship, leadership and service. STTI offers numerous online continuing nursing education learning activities that are peer-reviewed and interactive, including a “Bullying in the Workplace” online course.	<a href="https://www.sigmanursing.org/sigma_branded_homepageupdate">https://www.sigmanursing.org/sigma_branded_homepageupdate</a> <a href="https://www.sigmamarketplace.org/bullying-in-the-workplace-solutions-for-nursing-practice-online-course.html">https://www.sigmamarketplace.org/bullying-in-the-workplace-solutions-for-nursing-practice-online-course.html</a>
<b>Workplace Safety &amp; Prevention Services (WSPS)</b>	WSPS provides tools and resources about violence and harassment in the workplace, including a toolkit on developing violence and harassment policies and programs. They also provide online courses about identifying violence and establishing a prevention program for your organization.	<a href="http://www.wspcs.ca/Information-Resources/Topics/Violence-Harassment.aspx">http://www.wspcs.ca/Information-Resources/Topics/Violence-Harassment.aspx</a>

## Appendix N: Description of the Toolkit

BPGs can only be successfully implemented if planning, resources and organizational and administrative supports are adequate, and if there is appropriate facilitation. To encourage successful implementation, an RNAO expert panel of nurses, researchers and administrators has developed the *Toolkit: Implementation of Best Practice Guidelines* (1). The Toolkit is based on available evidence, theoretical perspectives and consensus. We recommend the *Toolkit* for guiding the implementation of any clinical or healthy work environment BPG in a health organization.

The *Toolkit* provides step-by-step directions for the individuals and groups involved in planning, coordinating and facilitating the BPG implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase, preparation for the next phases and reflection on the previous phases is essential. Specifically, the *Toolkit* addresses the following key steps, as illustrated in the Knowledge-to-Action framework (110):

1. Identify the problem: identify, review and select knowledge (e.g., BPG).
2. Adapt knowledge to the local context:
  - assess barriers and facilitators to knowledge use; and
  - identify resources.
3. Select, tailor and implement interventions.
4. Monitor knowledge use.
5. Evaluate outcomes.
6. Sustain knowledge use.

Implementing BPGs to effect successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process. It can be downloaded at [www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition](http://www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition)

## Endorsements



### Ontario Nurses' Association

85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2  
TEL: (416) 964-8833 FAX: (416) 964-8864

December 11, 2018

Dr. Doris Grinspun, CEO  
Registered Nurses' Association of Ontario (RNAO)  
158 Pearl St.  
Toronto, ON  
M5H 1L3

Dear Doris,

The Ontario Nurses' Association (ONA) is pleased to offer our support for and endorsement of the RNAO's Best Practice Guideline-Violence, Harassment and Bullying: Prevention and Management in the Health-Care Workplace, Second Edition.

Health-care workers are at greater risk of workplace violence compared to workers in other businesses and sectors. This Best Practice Guideline is a helpful resource for nurses and members of the inter-professional team, including formal leaders, to help them identify, prevent and manage violence, harassment and bullying in the workplace.

There are a number of useful tools and strategies to support workplaces in creating safe workplaces.

Congratulations on this important work.

Sincerely,

#### ONTARIO NURSES' ASSOCIATION

Vicki McKenna, RN  
President

- C. Erica D'Souza, Project Lead, Implementation Science, RNAO  
Cathryn Hoy, First Vice-President  
Laurie Brown, Vice-President, Health and Safety  
Beverly Mathers, Interim Chief Executive Officer  
Carol Anderson, Senior Director, Nursing Practice and Advocacy

Provincial Office: Toronto  
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Safe Environments.  
Healthy Workers.

December 11, 2018

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT  
Chief Executive Officer  
Registered Nurses' Association of Ontario (RNAO)  
158 Pearl Street, Toronto, Ontario M5H 1L3

Dear Dr. Grinspun,

As the safety association in Ontario that supports the healthcare and education sectors, the Public Services Health & Safety Association (PSHSA) is pleased to offer our support for and endorsement of the RNAO's Best Practice Guideline- Violence, harassment, and bullying: Prevention and management in the health-care workplace, Second edition.

PSHSA's mission is to create safer workplaces through collaboration, innovation and knowledge transfer. The rigorous process using the GRADE methodology and the stakeholder engagement that went into the development of this guideline ensures it will be an invaluable resource for leaders, nurses, students and all members of the interprofessional team.

PSHSA has long supported the need for cohesive guidance and support to address this complex issue. This RNAO Best Practice Guideline provides a succinct and multi faceted approach to assist healthcare workplaces and education facilities to mitigate the pervasive issue of workplace violence, harassment and bullying.

Thank you for your dedication to workplace violence prevention and assisting PSHSA to enable a healthier and safer tomorrow for Ontario's healthcare workers and patients.

Sincerely,

Glenn Cullen  
CEO and COO  
Public Services Health & Safety Association

4950 Yonge Street  
18th floor, Suite 1800  
Toronto, ON Canada M2N 6K1  
Phone: 416.250.2131  
Toll free: 1.877.250.7444

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**PSHSA.ca**



28 January 2019

Doris Grinspun, RN, MSN, PhD, LLD (hon), O.ONT  
Chief Executive Officer  
Registered Nurses' Association of Ontario  
158 Pearl Street, Toronto, Ontario M5H 1L3

Dear Doris,

On behalf of the Sigma Theta Tau International (Sigma) Honor Society of Nursing, we are pleased to endorse the Registered Nurses' Association of Ontario's (RNAO) best practice guideline— *Preventing Violence, Harassment and Bullying in Health Workplaces*. We commend RNAO on this very important work to promote safer work environments for nurses and all health care workers. Notably, we appreciate the inclusion of promoting a safe work environment in the academic setting as the academic setting is not often included in this work.

As you know, Sigma is dedicated to advancing world health and celebrating nursing excellence in scholarship, leadership, and service. With more than 135,000 active members from over 90 countries, we promote programs and services that focus on education, leadership, career development, evidence-based nursing, research, and scholarship.

We are confident that RNAO's BPG *Preventing Violence, Harassment and Bullying in Health Workplaces* will enable nurses at all levels to deliver evidence-based, person-centred care in safe work environments internationally.

Thank you for your leadership in developing this impressive work.

Sincerely,

A handwritten signature in black ink that reads "Beth Baldwin Tigges". The signature is written in a cursive, flowing style.

Beth Baldwin Tigges, PhD, RN, PNP, BC  
2017-2019 President

[SigmaNursing.org](http://SigmaNursing.org)

550 W. North Street, Indianapolis, IN 46202







**ia** BPG

INTERNATIONAL  
AFFAIRS & BEST PRACTICE  
GUIDELINES

TRANSFORMING  
NURSING THROUGH  
KNOWLEDGE

## Best Practice Guideline

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L'Association des infirmières et infirmiers  
autorisés de l'Ontario



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