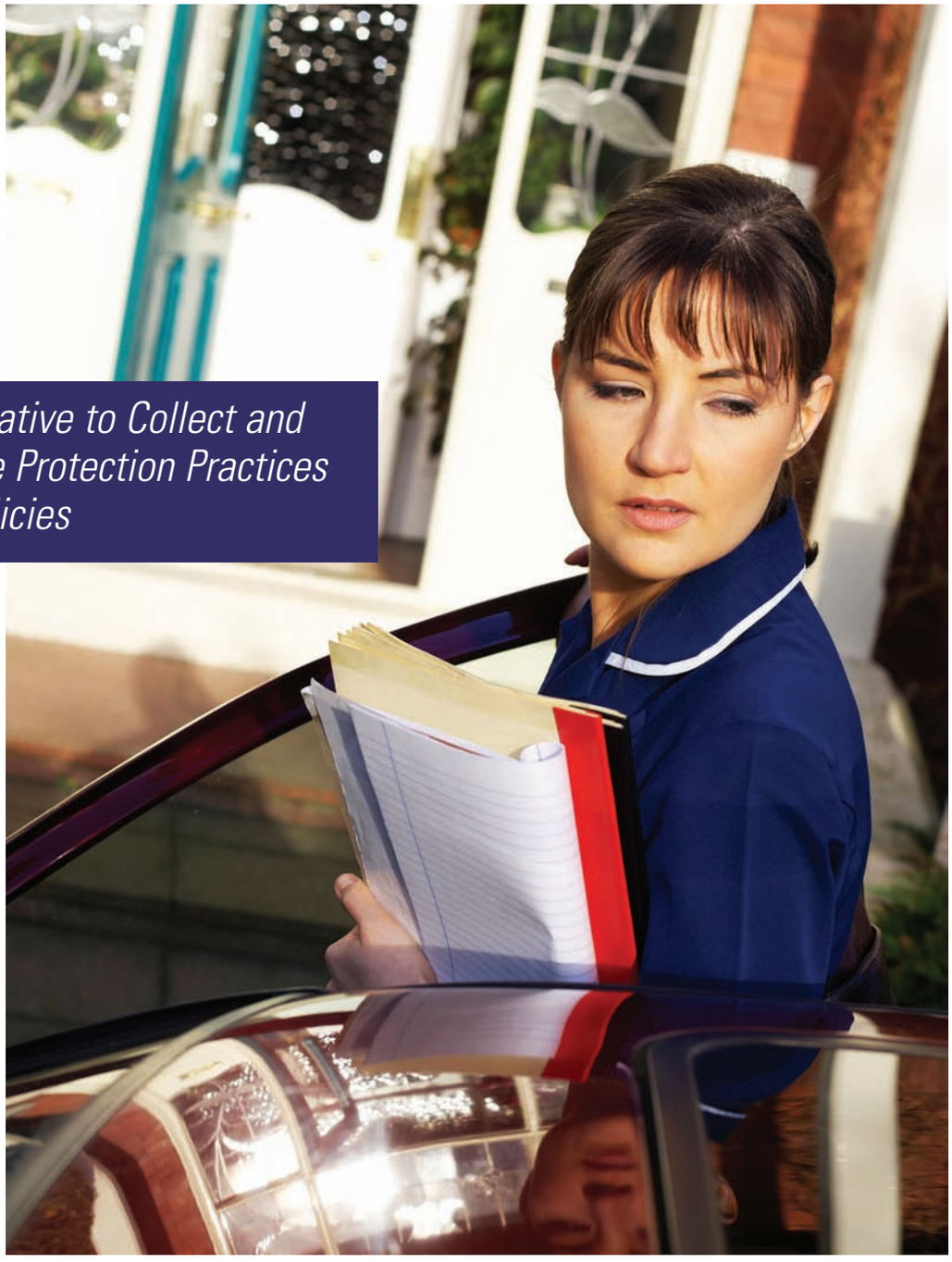
CE



An Initiative to Collect and Analyze Protection Practices and Policies

Opening the Door to Improve Visiting Nurse Safety

The number of home healthcare clinicians who have been harmed by workplace violence as the direct result of patient care is not known. An initiative in the form of a 36-question survey was sent to the nurse administrators of 156 visiting nurse organizations in the United States. The purpose was to describe workplace violence policies and practices and explore what agencies are doing to protect visiting nurses.

Ann Mathiews, RN, DNP, CHPN, and Susan Salmond, RN, EdD, ANEF, FAAN

Introduction

Visiting nurses are usually alone in changing environments with potentially high-risk situations. The United States' National Institute for Occupational Safety and Health stated that all workplace violence is preventable and defined workplace violence as "violent acts, including physical assaults and threats of assaults, directed at persons at work or on duty" (National Institute for Occupational Safety and Health, 1999, p. 7). Home healthcare agencies (HHAs) should be concerned about improving safety practice because exposure to risky situations and episodes of workplace violence in 2009 has made being a visiting nurse the most dangerous occupation in the United States, second only to law enforcement (United States Crime Statistics, 2010). According to the U.S. Department of Justice, nearly 500,000 nurses each year become victims of violent crimes in the workplace (Hilton, 2010). The number of home healthcare clinicians who have been harmed by workplace violence as the direct result of patient care is not known.

Background

Workplace violence, defined as nonfatal assaults and threats, experienced by visiting nurses are likely underestimated due to underreporting at a rate reported as high as 95% (Fazzone et al., 2000; McPhaul & Lipscomb, 2004; Sanford, 2000). Contributing to this underreporting is the underlying perception among healthcare workers that violence is part of the job (normalized) and that violence cannot be prevented (Gacki-Smith et al., 2009). Ethically, nurses must balance their accountability to the institution to report episodes of workplace violence against their loyalty and duty to the patient (Little, 2002). This moral dilemma can raise the stakes of employee reporting to the level of whistle-blowing that can have grave consequences for the nurse's career. Nurses rarely report episodes of violence or verbal abuse to the police (Hilton, 2010). Peer and administrative pressure, in all care settings, causes nurses to tolerate verbal abuse and violence (Gellner et al., 1994; Hegney et al., 2010; Morris et al., 2004; Sellers et al., 2009; Trenoweth, 2003). Persistent organizational inaction and chronic clinician underreporting lead to increased fears related to job performance, hostile work environment, repeat offenses, and escalation of violent offenses. Flanagan (2009) suggests the underreporting problem may be more "hidden" in homecare than in the hospital workforce.

Purpose

The purpose of this initiative was to identify and analyze the protection practices and policies in use by sampled visiting nurse organizations to answer the following questions:

- Does the HHA know their state assault laws related to HHA staff?
- What is the HHA's perception of staff safety in the community?
- Did the HHA have a workplace violence policy?
- Did the HHA have a dedicated group within the agency to address safety issues and concerns?
- What impact did violence in the workplace have on the HHA?
- What practices were in use to assure protection for the clinician from workplace violence?
- Were the roles of administrator, manager, and clinician clearly defined in policy and practice?

Proposed Model

The Protection Matrix Model (Figure 1) demonstrates the elements needed to build an effective protection culture. Protection theory was first used as a basis to delineate the role of protector, a parent teaching birth control to their child, and specifically clarified that the protector must guide the education and practices to raise awareness to the threat (unwanted pregnancy, sexually transmitted disease) for the child to be protected (Schuster et al., 1985). In keeping with this theory, the literature review demonstrated that administrators and managers must first say the words "workplace violence" before nurses will report episodes experienced (Hegney et al., 2010). A comprehensive workplace protection strategy should include multiple activities before, during, and after the home care visit. Before the first visit, activities should encompass a prevention risk assessment, violence identification, and development of a risk management plan as deemed appropriate. Once the first visit begins, the clinician should use interventions to eliminate or mitigate harm as required. If harm should occur, reconciliation activities should be instituted to restore the clinician. By using the

Persistent organizational inaction and chronic clinician underreporting lead to increased fears related to job performance, hostile work environment, repeat offenses, and escalation of violent offenses. Flanagan suggests the underreporting problem may be more "hidden" in homecare than in the hospital workforce.

protection matrix to develop a culture of protection, communication will be enhanced through all levels of the organization resulting in safe home visiting for clinicians. This in turn may promote an "open door" communication environment among the administrator, manager, and clinician.

Study Design and Methods

A comprehensive review of the literature was conducted with 42 articles identified as relevant to home care visiting nurses (see Supplemental Digital Content 1, http://links.lww.com/HHN/A24). An instrument to collect data on safety issues specific to home visiting was not identified through the literature review. The Visiting Nurse Protection Questionnaire (VNPQ) (Table 1) was developed and procedures to establish validity and reliability were followed. Additionally, participating organizations were asked to provide a copy of their workplace violence policies that were scrutinized for delineation of roles and work practices. The decision was made to specifically target the questionnaire to the nursing administrator or director of nursing, as they would be the individual likely to have the most comprehensive information about the organization's knowledge of violence and they should be functioning in the role of protector. Approval was obtained from the Institutional Review Board at University of Medicine and Dentistry of New Jersey. The tool was piloted with four agencies in the northeast region of the United States and two of the four sample agency administrators responded. Both indicated the questions were clear and recommended no substantial changes. The questionnaire was sent out on December 6, 2011, and received back on January 30, 2012.

Sample

A purposive, convenience sample was drawn from active member organizations of the Visiting Nurse Associations of America representing nonprofit community-based visiting nurse agencies in the United States. The organizational membership was queried and 156 home care agencies became the target sample. These sample visiting nurse organizations vary in size from 3 to over 120,000 staff members, and were geographically distributed across the United States in 39 different states. A return rate of 45% was the desired response for the questionnaire.

Data Collection

The Tailored Design Method was used to maximize return rates on the mailed questionnaire (Dillman, 2000). The first contact to the sample HHAs was a letter introducing the questionnaire and encouraging participation, with notice the questionnaire would follow by mail in 1 week. One week after the letter of introduction was sent, the 156 administrators received a mailed packet consisting of a booklet containing a consent letter, a VNPQ questionnaire (Supplemental Digital Content 2, http://links.lww.com/HHN/A25), a prepaid postage return envelope, and a reminder to send a copy of their agency's protection policy. Two weeks later, any agency that had not responded received a reminder postcard to return the survey and policy.

Analysis of the Returned Questionnaires

Data were coded by zip code to target potential for high-risk urban areas with known gang activity. Data were then inputted into SPSS (SPSS, Inc., Chicago, IL) 18.0. Each question was analyzed individually. Descriptive statistics and frequencies were reported for demographics, violence prevalence, and work practices. All returned organizational safety policies were analyzed using the JoAnna Briggs Institute software, NOTARI (Joanna Briggs Institute, Adelaide, South Australia, Australia), allowing examination of content for practices. The data were cleaned for duplication and relevance. Content analysis from

the safety policies was used to build a thematic map to delineate the roles of administrator, manager, and clinician within the protection model.

Findings From the Questionnaires

Thirty-five of the questionnaires were returned out of the 156 mailed. Although the VNPQ survey followed the Dillman method to increase response rates, only 25% were returned, so caution must be used in interpreting results. The following is a report of the survey findings; questions reported are not inclusive of the entire questionnaire (see Supplemental Digital Content 2).

Demographic Data

- The first five questions were purely demographic data: the sample 35 responding organizations reported a range of 2,100 to 110,000 visits per year generating a total of 884,731 visits per year for the sample. The respondent reported that average number of visits per day for each nurse ranged from 3 to 8 with an average of 4.99 visits per day per nurse.

Feelings and Perceptions About Workplace Violence and Safety

- Only 3 of the responding 35 administrators correctly knew the state laws concerning staff safety in the community.
- Twelve percent (n = 4) of organizations felt workplace violence was a routine part of the job in healthcare. All of the administrators reported visiting nurses felt safe working in homes in their communities in Question 2; however, in Question 3, some administrators (44%) responded that some nurses felt unsafe (10% or fewer).
- Looking at the impact of workplace violence on the agencies, the majority 23 (66%) reported that this did not apply to the visiting nurse. "Impact" was defined as fear levels (6, or 17%), turnover (3, or 9%), morale (3, or 9%), productivity (2, or 6%), and recruitment (1, or 3%).

Workgroup for the Protection Culture

- Forty-nine percent of agencies had a workgroup (i.e., in-house committees addressing nurse safety). Most often, the workgroup participants were administrators (14, or 82%), managers (15, or 88%), and staff nurses (12, or 72%), and met monthly (9, or 53%) or quarterly (4, or 23%).

Workplace Violence Policy: Development and Review

- Thirty-one agencies (88%) had a workplace violence policy; 24 (74%) revised their policies annually; 27 (77%) reviewed or revised the policies after each reported occurrence; 29 (83%) used personal reports of violence to effect the development of policies related to workplace violence.

Risk Assessment Tools

Findings related to risk assessment tools to communicate violence risk from referral source to the home healthcare team and hand-off reports of violence risk between providers during transfers included:

- Most agencies did not have an established tool for risk assessment of violence (27, or 77%). The consensus was to refrain from inquiring or requiring the violence history of the patient or family prior to admission to service (31, or 88.5%). Seven (20%) agencies had a risk assessment tool. A debriefing violence risk review was given after the admission visit to (8, or 23%) managers and at hand-off to coworker by (7, or 20%). Transfers and hand-off report to a facility did not mandate communication of the violence risk by any of the agencies.

Education and Training Related to Violence Provided to Managers and Visiting Nurses

- Most education related to violence was delivered informally (22, or 63%) or by lecture (20, or 57%). Managers and clinicians did not receive the same training; generally, clinicians received broader training (see Table 1).
- The majority of educational topics were provided to nurses at orientation (28–83%) and annually (17–91%). Education in topics mandated through laws and regulations was the most frequently delivered formal training. Education in protecting vulnerable patients was the next most frequently delivered training (Table 2).

Outcome and Assessment Information Set Data Sets Related to Violence Risk

- Two questions focused on specific Outcome and Assessment Information Set (OASIS) codes that are "at-risk" codes for potential violence. OASIS data sets M1740 (cognitive,

Table 1. Responses to "Are Managers (Clinicians) Formally Instructed in These Responsibilities?"

Choice	Manager	Clinician
Training for recognition of risk	20 (57%)	25 (71%)
Communicating risk to clinician (or manager)	23 (65%)	30 (86%)
Conduct if situation unsafe	24 (68%)	28 (80%)
Incident reporting of threats by phone	18 (51%)	20 (57%)
Incident reporting of threats or physical attack	—	27 (77%)
Injury reporting	—	28 (80%)
How to debrief clinicians (or manager)	11 (31%)	7 (20%)
None of the above	7 (20%)	3 (8%)

Source: Collected Visiting Nurse Protection Questionnaire data.

Table 2. Responses to "How Is Education and Training Related to Violence Provided to Nurses?"

Choice	Results
Informal: staff to staff, face to face, one to one	22 (63%)
Lecture, presentation, or classroom	20 (57%)
Formal: manager to clinician	16 (46%)
Video	9 (25%)
Computer self-paced module	8 (23%)
Memo or e-mail	6 (17%)
Brochure or newsletter	4 (11%)
Not taught specifically	4 (11%)
Poster or sign	2 (6%)
Mandatory lecture	1 (3%)
Policy provided	1 (3%)

Source: Collected Visiting Nurse Protection Questionnaire data.

behavioral, and psychiatric symptoms that are demonstrated at least once a week) and M1745 (disruptive behavior physical, verbal, disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety) *did not* trigger a risk review by the organization in more than (29, or 80%) respondents.

Reportable as Workplace Violence

- Assaultive behaviors were identified by more agencies as violence than verbal episodes. None of the 32 listed behaviors was identified by 100% of the agencies as reportable workplace violence, including being shot with a gun. VNPQ prevalence statistics showed that verbal threats were more common than physical assault by a ratio of 5:1. All agencies reported that nurses did not carry medications.
- Four agencies reported assaults; the frequency of assault varied from daily to yearly. Two of the agencies had a workgroup and a workplace violence policy, and held formal education for staff. The two agencies without a workgroup had no policy or formal education related to workplace violence.
- In addition to type of event, information was collected on occurrence of actual events. Agencies were asked to focus on the past year to ascertain estimates of actual events. Twenty (57%) agencies reported events of verbal abuse, and four (11%) reported an actual violent event. Based on 884,731 visits per year, the VNPQ threat of violence/no physical assault to visiting nurse was 0.02/1,000 and the VNPQ number of assaults to visiting nurse was 0.005/1,000.
- Based on the past year, the most common assaults were by the patient (10, or 28%), followed by family (7, or 20%), friend (3, or 9%), and stranger (2, or 6%).
- Assaults that were theft-related (6, or 17%) did not involve a weapon (5, or 14%). One agency reported an assault with a gun (3%), and two agencies (6%) reported a dog attack.
- When asked directly if nurses had experienced theft at work, the majority replied no (22, or 63%); however, 13 (37%) did report an event. After the computer (8, or 23%), the most frequently stolen objects included the nurse's bag (4, or 11%), personal objects (3, or 9%), cars (3, or 9%), medical supplies from the car trunk (3, or 9%), and cell phones/personal

data assistants (2, or 6%). The episodes of theft based on total visits per year = 884,731, a rate of 0.006/1,000 visits.

Environmental Designations as a Risk Management Tool

- Agencies used the following designations: "everywhere is high risk" (5, or 14%), "high risk: no visit" (6, or 17%), "high-moderate risk: escort required" (6, or 17%), and "moderate risk: escort optional" (6, or 17%). Self-guarding by the nurse was used and differentiated as raised awareness in the home (6, or 17%) and raised awareness in the neighborhood (7, or 20%).
- Although all the methods listed to monitor crime were used by at least one agency, no agency used all the techniques. Proposed crime monitoring methods included gang task force reports, Community Crime Map (computer), the National Sexual Offender Web site, local police department sends agency an e-mail of crimes in area, local police department sends agency a fax of crimes in area, agency monitors local newspaper for information and posts to bulletin board, police liaison calls reports when an event occurs in area, and police liaison calls to report daily whether there is an event or not.

Guarding by Others as a Risk Management Tool

- No agency ever had an event/nonfatal assault while an escort was present. When guarding was used, the majority of the responding agencies (19, or 54%) used chaperones to protect the visiting nurses, followed by use of police (6, or 17%), trained armed escorts (3, or 9%), and trained unarmed escorts (7, or 20%) hired by agencies. Ten used a cell phone engaged with the agency during the visit (28%).

Self-Guarding Mechanisms as a Risk Management Tool

- Most agencies reported self-protective activities as cell phones (26, or 74%), raised awareness in the home (22, or 63%), and environmental surveillance before getting out of the car (18, or 51%). Call in/call out was used (5, or 14%). Behaviors used less than 5% included sign in/sign out, alarm or air horn, whistle, martial arts training, bug spray or mace, pepper spray, or Taser. No agency used a gun or service animal: guard dog.

Healthcare Team: Specific Role Definitions

- Only one action was used by all agencies: *evaluate referral, make the decision safe or not safe* (an administrative prevention activity). Most pre-event or prevention behaviors were completed by the nurse manager or administrator, who assumed more responsibility for policy decisions. Clinician behaviors included recognition of risk during their introductory call so that they can plan risk management with their manager and awareness of risk in the home so that violence could be evaded. Managers were most frequently identified with operational actions; administrators were predominantly responsible for program decisions or directions.

Limitations

The sample size was small, which limits the scope of these findings. This initiative relied on the perceptions of the nurse administrators from multiple agencies. Self-reported data are subject to limitations: (a) selective memory (remembering or not remembering events that occurred at some point in the past); (b) attribution (the act of attributing positive events to one's own agency but attributing negative events to external forces); (c) telescoping (recalling events as if they occurred at another time); (d) exaggeration (the act of embellishing events as more significant than is actually suggested from data) (Polit & Beck, 2008). Collection and analysis of the policies were added to the initiative to compare beliefs about practice to what policies require in actual practice. Only one agency had a policy that comprehensively addressed all elements seen in the Protection Culture Model (see Figure 1). Although laws, standards, regulations, and rules direct practice and diminish violence to a certain degree, modifications to protection policies can only be generated at the administrative level (Gabe & Elston, 2008). Policy interpretation and evaluation needs to be internal, regular, and ongoing to provide protection effectively (Denney, 2010). The authors suggest that if administrators are not attuned to the episodes of workplace violence, the agency may not act to protect visiting nurses. The assumption

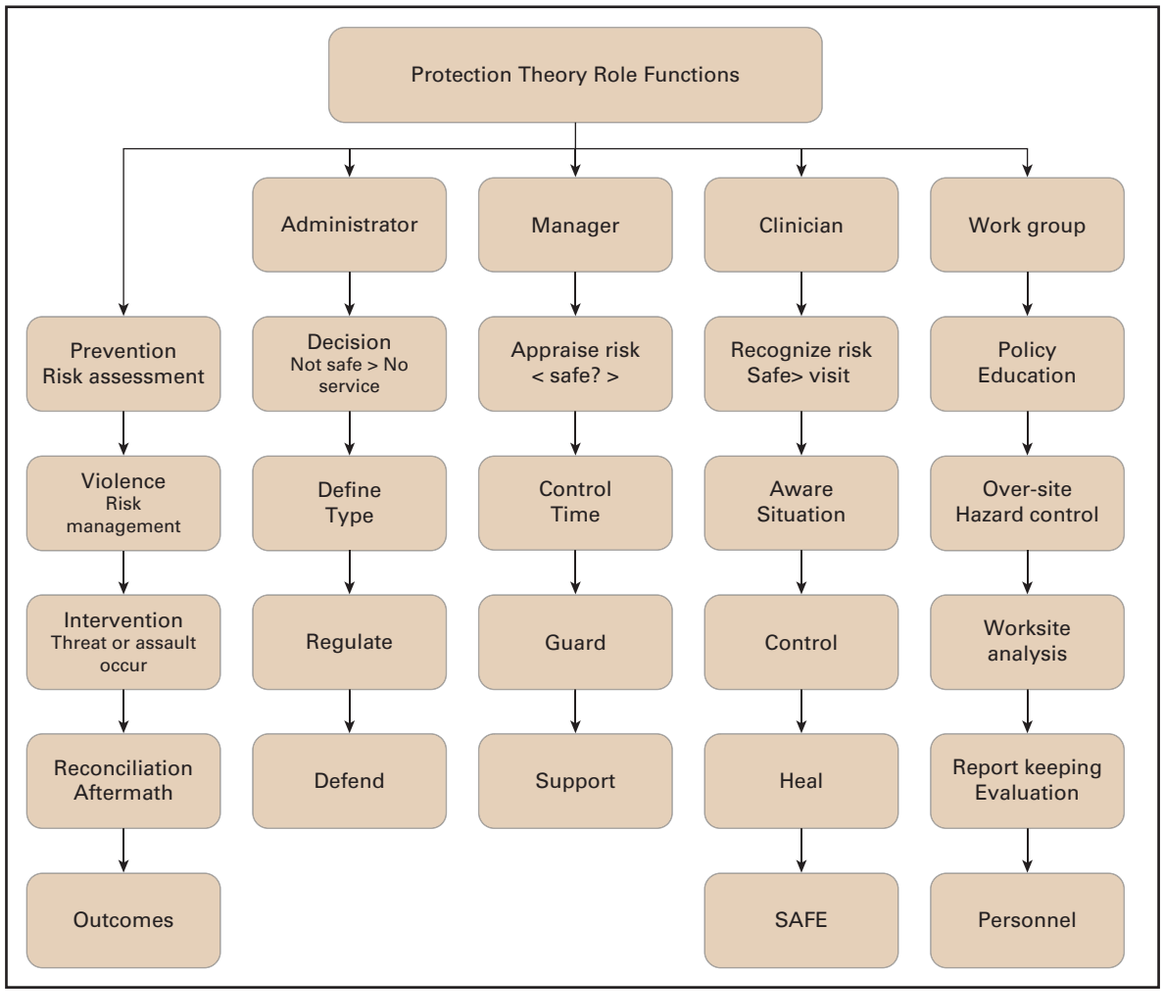


Figure 1. The Protection Culture model.
Source: Authors.

that urban areas were more risky than rural areas was not supported by the findings from these data. Although the literature recognized that cultural diversity and disparity can be foundational to misunderstandings that lead to violence, causation was not explored and this area could be explored in future research.

Discussion

A key finding was information about the general safety of the home care environment. The actual event occurrence of the VNPQ was 0.02/1,000 per patient visits, which was lower than the rate 2.5/1,000 per patient visits calculated for organizational nurses (U.S. Crime Statistics, 2010). It is important to note that the U.S. Crime Statistics data were collected in 2009 and were based on inpatient data, which is also a limitation. Although further research is needed to validate the accuracy of these findings, it makes sense that people may be calmer in their own homes than in strange environments (e.g., in their home rather than an inpatient setting such as a hospital).

The reporting administrators' belief that the home environment is safe is congruent with the low actual event of violence reported in the VNPQ. Overall, the administrators who answered the survey appeared to view being a visiting nurse as a safe occupation. However, when asked about the percentage of nurses who feel unsafe at work, 12 agencies (44%) identified some degree of being unsafe. A possible explanation is that safety is achieved because of the nurses' ability to (or attempt to) manage an unsafe situation;

Protection Matrix Risk Assessment and Management Tool					
Name:		**DOB:**	**Person completing tool:** _____ **Intake Nurse** ____ **Manager** _____ **Visiting Nurse**		
Does the patient have a history of threats, harassment, or violence?	○ **Yes**	○ **No**	Is the community considered unsafe?	○ **Yes**	○ **No**
Does the family have a history of threats, harassment, or violence?	○ **Yes**	○ **No**	Is the home considered unsafe?	○ **Yes**	○ **No**
Are there animals on the property and are they dangerous?	○ **Yes**	○ **No**	○ **Safe, visit with precautions** ○ **Unsafe, no visit**		

Assess risk using the five questions and check if yes. All risk designations must have an intervention planned.

	Red Zone: High Risk	Yellow Zone: Moderate Risk	Green Zone: Low Risk
Type	____Community has active street gangs or recent crime events. Patient vulnerable. _____Is there a history of weapon-related incidents or visible guns in home?	____Is there a history of drug or alcohol abuse in the home? ____Is there discussion of weapons in home but no weapons seen?	____Are there dangerous animals on the property? ____Is the home in an area physically isolated from other homes? ____Are there any factors affecting access to the home (e.g., lighting, broken steps, parking)?
Time	____The home located in an area considered dangerous during the day and night?	____Community safe with daytime visits only.	____Community safe only on Monday–Friday but not during weekends and holidays. ____Community considered safe.
Situation	____Does patient has past history on service of violence/ aggression with service providers? _____Are family or friends known to be unsafe and patient is vulnerable? _____Is there a potential for violence or aggression in the home—domestic violence, sexual abuse?	____Had verbal abuse, false accusations or threats to service providers by patient or family? ____Is there excessive inappropriate language by patient? ____Is there excessive inappropriate language by family? ____Are there challenging behaviors?	____Are there a large number of people in home during visit? ____Are there any illnesses/conditions that affect the client's behavior (e.g., dementia, psychosis, brain trauma)? ____Are there any illnesses/conditions that affect the family's behavior (e.g., dementia, psychosis, brain trauma)? ____Delays in service causing family frustration? ____Have there been socio cultural misunderstandings?
INTERVENTION		**INTERVENTION**	**INTERVENTION**
____Police as escort to accompany nursing/clinician		____Consult manager for safety plan	____Duress phrase with manager (lime) call police to home
____Escort required ____Manager to assign		____Cell phone call in/call out before and after visit with manager	____Self guarding: Define acceptable behavior>perpetrator ____Home safety: Protection assessment
____Escort optional ____Schedule all visits between 7 a.m.–11 a.m. ____All after hours visits to go to hospital emergency room		____Chaperone/buddy recommended ____Duress phrase: a word that lets the buddy know there is a problem; to raise awareness (oranges) or to leave (lemons)	____Consider family to assist with care efforts ____Request that animal is restrained or contained. ____If don't know, carry cell phone; is the cell phone service adequate?
____ Speak to manager regarding risks ____Consider Protective Service referral		____Consider patient's family escort from car to home	____Raised awareness at all times, if situation changes, leave, notify manager to change risk level.

Note: DOB = date of birth.

Figure 2. Protection Matrix Risk Assessment and Management Tool for visiting nurse agencies.
Source: Authors.

According to the U.S. Department of Justice, nearly 500,000 nurses each year become victims of violent crimes in the workplace. The number of home healthcare clinicians who have been harmed by workplace violence as the direct result of patient care is not known.

however, the disparity more likely may indicate an inaccurate or an underreporting of events. Low occurrence rates of violence should not be interpreted to mean that nurses are protected. Safety cannot be achieved without accurate, timely reports from clinicians, and a protection culture promotes open dialog between administrators, managers, and clinicians to elicit those reports.

Implications for Practice

The results of this initiative and questionnaire show a clear need for establishing a comprehensive, explicit framework for protection. The findings from the questionnaire emphasize that providing *a safe environment that is free of known hazards* requires assessment for unknown hazards and the obligation to screen referrals, perhaps with a risk assessment.

Risk assessment needs to be a preventive activity and could be guided by a consistent tool or framework. Once the administrator has determined the visit to be "safe," the manager assigns the appropriate level of guarding and acts as a mentor for staff facing challenging behaviors found in the community. When the clinician makes the visit, risk can be reassessed and the level of guarding changed if necessary.

Prompt reporting of risk exposure is necessary from staff to the manager for the program to be effective and accurate reports of episodes of violence and threat of violence need to be collected for performance improvement to occur. A risk assessment and management tool (see Figure 2) could become a part of the patient's medical record so that transitions are facilitated; but it could also be kept by the manager to prompt appropriate assignments. A visiting nurse occurrence report could standardize collection of episode data (see Supplemental Digital Content 3, http://links.lww.com/HHN/A26). These documents could be provided to the organization's protection workgroup so that analysis of ongoing risk is facilitated and definitions of when to use other guarding or environmental risk designations are refined.

More than half of the agencies reported that they did not have specific workgroups, policies, or written standards for workplace violence management. The lack of a policy actually increases the distress for clinicians and managers as the case-by-case process essentially forces participants to identify and/or create for guidelines when violence episodes occur. Guidelines can be empowering for staff. Guidelines give structure to the process of determining safe or unsafe visits that enhances staff's perceived respect and work effectiveness; prevents emotional exhaustion; and relieves work pressures (Ray, 2007; Spence-Laschinger, 2004). Kantian philosophy illustrates the nurse–patient nexus, which argued that people react rationally to their situation when empowered and that empowerment is potentiated when visible jobs have access to the information, resources, education, and support needed to do the job (Spence-Lassinger et al., 2001; Tomey & Alligood, 2002). The Protection Culture Model may provide structure to the organizational mission to help protect their clinicians.

Threats, harassment, and violence cannot be ignored behind closed doors. The "open door" ideal is essential to the transparency of the visit; where professionals help protect each other using tools, assessments, and communication. Comparing the VNPQ results to U.S. Crime Statistics (2010) data illustrated that the episodes of violence in home care are less frequent than at hospitals and nursing homes. Anticipatory risk assessment and risk management planning is an effective strategy to create a protection culture within the organization. Clearly defined practices will support the nurse when confronted by workplace violence and threats of violence. This model creates a framework for organizations to improve protection practices for the visiting nurse. The findings from this initiative are a call to action to improve agency communication so that all visits are safer. ⌂

Ann Mathiews, RN, DNP, CHPN, *is the Hospice Manager at Princeton Hospice, Princeton, New Jersey, and is a Clinical Coordinator and Educator for the Interim Home Health Aide Certification Program. She is the author of* Angels Don't Lie*, a novel, and* There Are No Baby Butterflies*, a children's bereavement coloring book.*

Susan Salmond, RN, EdD, ANEF, FAAN, *is the Dean of Nursing, a Professor, and the Codirector of the New Jersey Center for Evidence-Based Practice, University of Medicine and Dentistry of New Jersey, Newark, New Jersey. Among her many publications is* Comprehensive Systematic Review for Advanced Nursing Practice*, a textbook by Springer Publishing.*

The authors and planners have disclosed that they have no financial relationships related to this article.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (http://journals.lww.com/homehealthcarenurseonline).

Address for correspondence: Ann Mathiews, RN, DNP, CHPN, 505 New Durham Rd., Piscataway, NJ 08854 (joymakerrn@optonline.net).

DOI:10.1097/NHH.0b013e318293634f

REFERENCES

Denney, D. (2010). Violence and social care staff: Positive and negative approaches to risk. *British Journal of Social Work, 40*(4), 1297-1313. doi:10.1093/bjsw/bcq025

Dillman, D. (2000). *Mail and internet surveys: The tailored design method* (2nd ed.). New York, NY: Wiley.

Fazzone, P. A., Barloon, L. F., McConnell, S. J., & Chitty, J. A. (2000). Personal safety, violence, and home health. *Public Health Nursing, 17*(1), 43-52.

Flanagan, A. (2009). *Violence in the healthcare workplace ACEP: CME resource*. Retrieved from http://www.netce.com/coursecontent.php?courseid=572

Gabe, J., & Elston, M. A. (2008). We don't have to take this: Zero tolerance of violence against health care workers in a time of insecurity. *Social Policy and Administration, 42*(6), 691-709.

Gacki-Smith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2009). Violence against nurses working in US emergency departments. *Journal of Nursing Administration, 39*(7-8), 340-349.

Gellner, P., Landers, S., O'Rourke, D., & Schlegel, M. (1994). Community health nursing in the 1990s–Risky business. *Holistic Nursing Practice, 8*(2), 15-21.

Hegney, D., Tuckett, A., Parker, D., & Eley, R. M. (2010). Workplace violence: Differences in perceptions of nursing work between those exposed and those not exposed: A cross-sector analysis. *International Journal of Nursing Practice, 16*(2), 188-202. doi:10.1111/j.1440-172X.2010.01829.x

Hilton, L. (2010, November). Provider Protection Felony. *Nursing Spectrum*, 20-21.

Little, M. (2002). Advocating safely. *AWHONN Lifelines, 6*(1), 18-20. doi: 10.1111/j.1552-6356.2002.tb00013.x

McPhaul, K. M., & Lipscomb, J. A. (2004). Workplace violence in health care: Recognized but not regulated. *Online Journal of Issue in Nursing, 9*(3), 7.

Morris, R., Krueger, C., & Yaross, D. (2004). Better safe than sorry: One agency's successful safety and security strategies. *Home Healthcare Nurse, 22*(6), 417-422.

National Institute for Occupational Safety and Health. (1999). *Nonfatal assaults in workplace violence 1993 - 1999*. Washington, DC: MMWR.

Polit, D., & Beck, C. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (Vol. 8). Philadelphia, PA: Wolters Kluwer.

Ray, M. M. (2007). The dark side of the job: Violence in the emergency department. *Journal of Emergency Nursing, 33*(3), 257-261. doi:10.1016/j.jen.2007.01.015

Sanford, R. C. (2000). Caring through relation and dialogue: A nursing perspective for patient education. *ANS: Advances in Nursing Science, 22*(3), 1-15.

Schuster, E. A., Kruger, S. F., & Hebenstreit, J. J. (1985). A theory of protection: Parents as sex educators. *ANS: Advances in Nursing Science, 7*(3), 70-77.

Sellers, K., Millenbach, L., Kovach, N., & Yingling, J. K. (2009). The prevalence of horizontal violence in New York State registered nurses. *Journal of the New York State Nurses' Association, 40*(2), 20-25.

Spence-Laschinger, H. K. (2004). Hospital nurses' perceptions of respect and organizational justice. *Journal of Nursing Administration, 34*(7-8), 354-364.

Spence-Lassinger, H. K., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *Journal of Advanced Nursing, 31*(5), 260-272.

Tomey, A., & Alligood, M. (2002). *Nursing theorists and their work* (5 ed.). St. Louis, MO: Mosby.

Trenoweth, S. (2003). Perceiving risk in dangerous situations: Risks of violence among mental health inpatients. *Journal of Advanced Nursing, 42*(3), 278-287.

U.S. Crime Statistics. (2010). *U.S. Crime Statistics*. from http://www.disastercenter.com/crime/uscrime.htm