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### Patient-To-Nurse Sexual Harassment

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PATIENT-TO-NURSE SEXUAL HARASSMENT

Submitted to the Faculty  
Yale University School of Nursing

In Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Nursing Practice

Erin Frances Micale

May 25, 2021

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## **Abstract**

Patient to nurse sexual harassment is an issue that can have significant effects on nurses physical and mental health, occupational function, and patient outcomes. It is an under-researched and often unaddressed issue, leaving many nurses unsure of what sexual harassment by a patient is and how to respond to it. This paper reviews the literature related to patient to nurse sexual harassment and the development and effectiveness of a webinar on recognizing, preventing, intervening, and coping with patient to nurse sexual harassment. The webinar is a two-hour educational program that covers topics related to what sexual harassment is, risk assessment and risk management, addressing sexual harassment by patients, bystander intervention, reporting, coping, and policy evaluation. Confidence on measures related to recognizing and responding to patient to nurse sexual harassment was evaluated as a pre and posttest. Further study of patient to nurse sexual harassment is needed.

*Keywords:* sexual harassment, patient to nurse sexual harassment, webinar training

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## **Dedications**

I dedicate this paper to my husband, Alex, my parents, my siblings, and my nephew. They have shared every excitement, every tear, every frustration, every joy, and every success that this program has brought. They have encouraged me and supported me in the littlest and biggest ways- whether letting me practice my webinar, offering kind and supportive words, or doing the laundry and dishes when I was feeling overwhelmed. My husband, in particular, has been my biggest fan and supporter- and with his confidence in all that I am capable of, I know I will make the impact on nursing and be the leader that I aspire to.

## Table of Contents

<b>Abstract</b> .....	iii
<b>Acknowledgements</b> .....	iv
<b>Dedications</b> .....	v
<b>Chapter I: Patient to Nurse Sexual Harassment</b> .....	1
Definition.....	1
History of Sexual Harassment in the Workplace.....	4
Current Status.....	6
<b>Chapter II: Review of the Literature</b> .....	7
Prevalence of Patient to Nurse Sexual Harassment.....	7
Effects of Patient to Nurse Sexual Harassment.....	11
Interventions.....	14
Conclusion of the Evidence.....	18
Organizational Analysis.....	18
Theoretical Frameworks.....	20
Knowledge to Action Framework (KTA).....	20
The Determinants of Target Responses to Sexual Harassment Framework.....	21
<b>Chapter III: Goals and Aims</b> .....	23
Aim 1.....	23
Aim 2.1.....	25
Aim 2.2.....	25

Aim 3.....	29
Aim 4.....	31
Implications.....	33
Statement about Human Subjects.....	34
Timeline.....	34
<b>Chapter IV: Results.....</b>	<b>35</b>
Aim 1.....	35
Aim 2.1.....	41
Aim 2.2.....	42
Aim 3.....	43
Aim 4.....	46
<b>Chapter V:Discussion.....</b>	<b>49</b>
Strengths and Limitations.....	52
Implications for Practice.....	53
Conclusion.....	54
<b>References.....</b>	<b>56</b>
Appendix A: Glossary of Terms.....	68
Appendix B: Frameworks.....	69
Appendix C: Tables.....	72
Appendix D: Sexual Harassment in the Workplace Timeline.....	73
Appendix E: Measurement Tools.....	77

Appendix F: Leadership Resource Packet.....	82
Appendix G: Results.....	89

## Chapter 1

### Patient-to-Nurse Sexual Harassment

Patient-to-nurse sexual harassment is a significant and growing concern in healthcare that can escalate into workplace violence with direct costs, including workers' compensation, sick days, and litigation (Papa & Venella, 2013). Patients are the most common perpetrators of sexual harassment and violence against nurses and may do so physically or verbally (Cogin & Fish, 2009; Grieco, 1987). The risk of harassment and violence varies based on the unit, setting, nurse experience, condition of the patient, and the type of harassment. Workers in the emergency department and psychiatric settings are at increased risk of being verbally, physically, or sexually assaulted or harassed by a patient when compared to other nursing settings. While there are no specific reports of the exact financial burden workplace violence and sexual harassment has in healthcare, we do know that healthcare workers are four times more likely to sustain injuries requiring treatment and time off work than other industries (OSHA, 2015).

Incidence of patient-to-nurse sexual harassment is less commonly measured compared to verbal and physical aggression, with variability in rates ranging from Spector, Zhou, and Che's (2014) estimate of 27.9% to Hibino, Hitomi, Kambayashi, and Nakamura's (2009) estimate of 56% of nurses being sexually harassed by a patient. The wide range and measurement issues are due to a lack of consistency in reporting, a lack of understanding of what constitutes sexual harassment, misinterpretation of patient intentions, lack of managerial or peer support, and nurses considering it part of the job.

#### Definition

Much research discusses the effects of sexual harassment and violence; however, few offer a concrete definition of sexual harassment and violence. The American Psychological

Association (APA), the World Health Organization (WHO), the Office of Human Resources (OHR), and the National Academies of Sciences, Engineering, and Medicine (NASEM) all use sexual harassment as the comprehensive term for inappropriate sexual behaviors and have similar, if not identical, definitions of sexual harassment. This is because they all define the term based on the definition used by the Equal Employment and Opportunity Commission (EEOC), which defined sexual harassment as:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive working environment (EEOC, 1997, para. 2).

This is further broken down into two kinds of sexual harassment: quid pro quo and hostile environment. Quid pro quo sexual harassment occurs when the harasser uses employment-related rewards or threats to try and coerce someone into sexual contact (EEOC, 1990). Hostile environment sexual harassment occurs when inappropriate or unwelcomed sexual behavior changes the working environment to be unfavorable, threatening, or hostile (EEOC, 1990).

While this definition helps clarify sexual harassment, it is geared toward occurrences in the workplace and can make it difficult to apply to everyday and non-work-related instances. McNamara (2012) further clarifies that examples of sexual harassment include: "inappropriately friendly behavior; sexually based verbal commands; vulgar, sexual language or inappropriate jokes or stories; unwelcome advances or requests for sexual favors; unwanted physical contact of a sexual nature; and sexual innuendo" (p. 536).

The National Sexual Violence Resource Center (NSVRC) (2010) uses sexual violence as the comprehensive term for sexually inappropriate behavior and defines it as “whenever a person is forced, coerced, and/or manipulated into any unwanted sexual activity, including when they are unable to consent, due to age, illness, disability, or the influence of alcohol or other drugs” (p. 1).

Similarly, the Centers for Disease Control and Prevention (CDC) (2019) also uses sexual violence as the comprehensive term for inappropriate behaviors that are sexual in nature, and defines it as a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. Workplace violence, including sexual violence, is categorized into different types. Type I is performed by someone outside of the workplace with criminal intent. Type 2 occurs from a customer, such as a patient (and is the focus of this paper). Type 3 occurs when an individual is sexually harassed by a coworker, and Type 4 is when the victim has a personal relationship with the harasser (Peek-Asa, Howard, Vargas, & Kraus, 1997).

Many studies use the terms sexual harassment, sexual violence, sexual misconduct, and sexual assault interchangeably when reporting the statistics and results of their studies. This is due to the variability in organizations’ use of sexual harassment or violence as a comprehensive term to encompass all other inappropriate sexual behaviors such as sexual assault, sexual abuse, sexual misconduct, and sexual harassment. For the sake of this paper, sexual harassment is used as the comprehensive term, as it is used by organizations in both the public sector and the work sector.

### **History of Sexual Harassment in the Workplace**

Sexual harassment in the workplace has been a significant issue for centuries, and is outlined in Appendix D. This is especially true for women and immigrant workers. Reports of sexual harassment by employers' date back to the 17<sup>th</sup> and 18<sup>th</sup> centuries when indentured servants and industrial workers reported sexual harassment by their masters and employers (Segrave, 1994). A century later, during the Crimean War, the first instances of sexual harassment against nurses were reported and addressed by Florence Nightingale. Nightingale encouraged her nurses to follow a dress code and act ladylike, as many of her nurses experienced sexual harassment by physicians, surgeons, and military officers (Bullough, 1990; Nightingale, 1860; Strauss, 2019).

Little was done to prevent sexual violence against women until the 1960s. Title VII of the Civil Rights Act (1964) prohibited discrimination based on sex. Some interpreted this act to make sexual harassment illegal. However, that wasn't officially the case until the Title VII modifications of 1991 identified sexual harassment as a compensatory and punitive offense (Civil Rights Act, 1991; Fitzgerald, 1993; Strauss, 2019). Despite this, sexual harassment both within and outside the workplace continued. In 1972, Title IX of the Education Amendments Act was passed and stated that "no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance" (p. 1). This act was initially passed to promote inclusivity in athletics but has since been interpreted to protect all students and employees at public schools, colleges, and universities. It does not necessarily protect hospital employees unless the hospital meets the criteria of providing an educational program or activity (Borkowski & Rushing, 2019).

During the 1980s, challenging sexual harassment in the workplace started to gain momentum. Pivotal court cases occurred annually and helped define the terms and consequences of sexual harassment and set the precedent for policy and processes to prevent and address sexual harassment in the workplace. In *Meritor Savings Bank v. Vinson* (1986), the court unanimously ruled that sexual harassment was considered sex discrimination under Title VII. In *Barrett v. Omaha National Bank* (1984), the court ruled that it is the employer's responsibility to address any reports of sexual harassment. In addition, the Bureau of National Affairs published guidelines in 1987 on what should be included in an organizational sexual harassment policy. These guidelines state that the policy must offer a definition, state that sexual harassment will not be tolerated, offer examples of sexual harassment, provide choices and direction on how to follow a complaint, information on how the organization will address the complaint, and lastly, offer a statement on corrective action. This Bureau also recommends that steps be taken to restore the victim's self-esteem, credibility, and privileges at work (Bureau of National Affairs, 1987).

Momentum continued into the 1990s when sexual harassment prevention for nurses was recommended by the American Nurses Association (ANA) during their 1992 national conference (Robinson, Franklin, & Fink, 1993). In 1994, The Violence Against Women Act was passed and provided for improved safety for women and allowed federal penalties for sex crimes, including repeat offenses.

While laws like the Violence Against Women Act, the EEOC, and Title IX provided legal protection for women against sexual misconduct in the workplace, sexual harassment continued both within and outside the workplace. Therefore, more recent decades have focused on increasing public awareness of sexual harassment. Movements, such as #MeToo and

#TimesUp, reinvigorated the momentum against sexual harassment as seen in the 1980s and 1990s. #EndNurseAbuse is a campaign set forth by the ANA to address instances of workplace violence, including sexual harassment in nursing. This campaign includes a panel of professionals to help develop policies and practices to improve reporting and safety of nurses in the workplace (ANA, 2019). Moving forward, nurses need to be more aware of what sexual harassment is and more prepared to report and address instances of sexual harassment by patients. Advocacy and education are key in this outcome.

### **Current Status**

There is evidence of patient-to-nurse sexual harassment and its effects, as well as inconsistent legal protection, guidelines, and resources on how nurses should act when sexually threatened or harassed by a patient, making it a growing issue.

Despite the existence of recommendations from the Joint Commission and other agencies to improve managerial support and reporting of incidents; further actions, such as improved policy and guidelines and leadership skills, need to be developed and implemented in the inpatient hospital setting to protect nurses from sexual harassment by patients (Cogin & Fish, 2009; Hibino, Ogino, & Inagaki, 2006; The Joint Commission, 2018). In addition, it is recommended that nurses and nursing students receive more education on sexual harassment, as well as assertiveness training, in order to improve the hospital culture and nurses' comfort and protection in handling sexual harassment from patients (Bronner, Peretz, & Ehrenfeld, 2002; Dan, Pinsof, & Riggs, 1995; Finnis, Robbins, & Bender, 1992). Therefore, this paper aims to describe and utilize current research on the prevalence, consequences, and interventions of patient-to-nurse sexual harassment in order to create a webinar that will successfully prepare nurses to recognize, prevent, address, report, and cope with such occurrences.

## **Chapter 2**

### **Review of the Literature**

Many scholarly sources were reviewed to gain a more extensive understanding of how patient-to-nurse sexual harassment affects nurses, patient safety, health outcomes, and system functions. A search was conducted using ProQuest Academic, Medline, PsychINFO, and CINAHL Complete databases, using the terms identified in Table 1 of Appendix C. The initial search yielded 12,492 articles. These sources were then narrowed to being available in English and published in an academic journal between 2010 and 2019. Review of these sources, as well as 14 additional sources recommended by other scholars, were examined for applicability. Following that, sources were examined to determine the primary research evidence. Relevant primary sources were included. In total, 45 sources were included in this review and consisted of mixed methods studies, qualitative studies, policy briefs, and organization statements.

### **Prevalence of Patient-to-Nurse Sexual Harassment**

The prevalence of patient-to-nurse sexual harassment varies for multiple reasons. One reason is that there is little consensus on the definition of sexual violence and sexual harassment, making it difficult to identify if a patient's behavior is sexual harassment. Organizations like the CDC, WHO, and the Joint Commission each define sexual violence. While the definitions vary, they include the same behaviors such as unwanted sexual attention, sexual coercion, and unwanted physical contact that can be interpreted as sexual in nature (Long, 2015). Some sources expand this further to include inappropriately friendly behavior, suggestive looks, sexual jokes and comments, unwelcomed advances, sexual innuendos, comments about gender, exposure of private anatomy, and asking personal questions (Dan et al., 1995; Grieco, 1987; Hibino et al., 2006; Lee, Song, & Kim, 2011; McNamara, 2012). Use of coercion and power is also noted to

play a role in those who initiate sexual harassment and inappropriate sexual behaviors (von Gruenigen & Karlan, 2018).

Other factors that affect reports of patient-to-nurse sexual harassment include the unit culture, setting, region, understanding, level of expertise, and condition of the patients. Park, Cho, and Hong (2014) found that 19.7% of nurses in South Korea reported being sexually harassed within 12 months prior to the study. Spector et al. (2014) estimated that number to be slightly higher at 27.9%. A review done by Cugin and Fish (2009) found that 60% of female nurses and 34% of male nurses reported being sexually harassed during the past two years. Grieco (1987) found that 76% of nurses reported being sexually harassed. Another study by Hibino, Hitomi, et al. (2009) reported 56% of nurses experienced sexual harassment by a patient. The highest reports of nurses experiencing sexual harassment in the workplace was 91% in a study done by Bronner et al., which included both nurses and nursing students (2003). Research by Spector et al. (2014) identified that nurses working in English-speaking countries are more likely to be sexually harassed by a patient than nurses working in other regions. This is attributed to the culture in western countries and the greater acceptability in talking about sexually related topics.

Reports of patient-to-nurse sexual harassment are also found to affect nursing students (Bronner et al., 2002; Cugin & Fish, 2009; Lee et al., 2011; Magnavita & Heponiemi, 2011). Despite varied incidence, most studies found that nurses and nursing students, especially those that are female, are more likely to be sexually harassed by a patient than any other individual, including visitors, coworkers, and physicians (Bronner et al., 2002; Dan et al., 1995; Finnis et al., 1992; Hibino et al., 2006). Male patients are more likely than female patients to sexually harass a nurse (Yang, Stone, Petrini, & Morris, 2018).

The number of reported instances of patient-to-nurse sexual harassment is often higher in psychiatric and geriatric settings, settings that care for patients with altered mental status or are under the influence of drugs/alcohol (Nielsen et al., 2017; Spector et al., 2014). In addition, the hierarchical hospital structure, units that are understaffed, have limited resources, more males in management positions than females, or are in a remote location also experience higher instances of reported sexual harassment (Cogin & Fish, 2009; Cipriano, 2018; Dan et al., 1995; NASEM, 2018). Furthermore, poor managerial support, lacking confidence to address issues of sexual harassment, lack of bystander intervention, and the intimate nature of nursing care contributes to unaddressed and unreported patient-to-nurse sexual harassment (Bronner et al., 2002; Cares et al., 2014; Cogin & Fish, 2009; Nielsen et al., 2017; Potter & Moynihan, 2011).

#### **Underreporting of incidence.**

Despite such varied data on the prevalence and contributing factors, most sources agree that more nurses are sexually harassed by patients than what is formally reported. A study done by MacCurtain, Murphy, O'Sullivan, MacMahon, and Turner (2017) noted that 54.6% of nurses don't feel comfortable reporting bullying. When considering patient-to-nurse sexual harassment, this also holds true and is a result of many factors. The most common reasons nurses don't report sexual harassment by a patient are because of uncertainty related to what sexual harassment is, misinterpretation of intention, and when they should speak up (Hall, Klein, Betts, & DeRanieri, 2018; Nielsen et al., 2017). Nurses may accept instances of sexual harassment in the workplace due to the intimate nature of the profession and their fear that addressing it may impact the patient's healing (Huebner, 2008). Examples of perceived intimate nursing interventions include bathing a patient, assessing them, and comforting them. In addition, much of the sexual harassment comes from patients who are under the influence of substances, developmentally

delayed, or have experienced other cognitive deficits and brain injuries that impair their judgment and understanding of appropriate versus inappropriate behaviors. In these situations, the nurses are often hesitant to report the incident as they may be unsure if the patient should be held accountable or responsible for their actions (Cipriano, 2018; Hibino et al., 2008; Nielsen et al., 2017).

Other factors include nurses (and nursing students) being fearful of how reporting will affect their career, lacking bystander and managerial support, and believing that reporting the incident will not result in any changes (Huebner, 2008; Lee et al., 2011; MacCurtain et al., 2017). Retaliatory behaviors against those that report instances of sexual harassment are common within nursing, the medical field, and other workplace settings. A study done by Wendt and Slonaker (2002) reviewed randomly selected sexual harassment claims submitted to the Ohio Civil Rights Commission. They found that 98% of the claims reviewed resulted in some form of retaliation against the claimant. Retaliatory behaviors identified in this study included termination, demotions, wage cuts, destruction of personal property, humiliation, threats of violence and assault, and other forms of aggression (Wendt & Slonaker, 2002). A study by Castner (2019) found that those in nursing academia often experienced “academic mobbing... a systematic attempt to wear down a colleague and encourage her to find employment elsewhere” as a form of retaliation when reporting instances of sexual and gender harassment (para 18). Lastly, a study by Bergman, Langhout, Palmieri, Cortina, & Fitzgerald (2002) measured the effects and prevalence of sexual harassment amongst women in the military and found that many victims did not report the instance to avoid lowered job satisfaction, psychological distress, and other negative consequences of reporting.

Currently, the literature recommends that intervention to improve reporting and policy occurs at the macrosystems level, the mesosystem, and the microsystem. From a macrosystem viewpoint (within a hospital or healthcare system), reporting programs can be standardized, improved to protect anonymity, and streamlined (The Joint Commission, 2018). Policies can be modified to offer more direct and easier-to-follow guidelines and procedures. This will decrease the amount of time that it takes the nurse to report and can eliminate fear of retaliation. From the mesosystem (unit-based) level, managers and those in leadership roles can be better equipped to encourage and support reporting. For example, they can report the incident as a bystander or start the reporting form until the individual is ready to complete documentation. Azar, Badar, Samaha, and Dee (2016) report that nurses are reluctant to reach out to those in leadership or management positions because they believe it may be useless and fear being blamed or losing their job. Because of this, managers and nurse leaders can be more proactive in lending emotional support to the individual and can assure them that they will not experience negative consequences or retaliation for reporting. From a microsystems level, nurses can be trained and encouraged to provide bystander support and assistance in reporting incidents of patient-to-nurse sexual harassment and creating a culture that discourages sexual misconduct (Hall et al., 2018).

### **Effects of Patient-to-Nurse Sexual Harassment**

As with other forms of harassment, patient-to-nurse sexual harassment can significantly affect the nurse's health and performance, patient safety, and occupational functioning.

#### **Effects on the nurse.**

Exposure to sexual harassment in the workplace may contribute to nurses experiencing a wide range of physical and emotional symptoms, mental illness, and decreased work performance and commitment (Draucker, 2019; Strauss, 2019). Sexual harassment can create a

hostile working environment, and it is reasonable to expect similar consequences, whether created from bullying or workplace violence. Common physical symptoms that develop from exposure to hostile working environments include physical injuries, insomnia, reproductive complications, weight gain and loss, stress, gastrointestinal dysfunction, cardiac arrhythmias, headaches, increased blood pressure, fatigue, chest pain, difficulties breathing, nausea, teeth grinding, and muscle stiffness (Dan et al., 1995; Mantzouranis, Fafliora, Bampalis, & Cristopoulou, 2014; McNamara, 2012; Yang et al., 2018).

In addition to physical symptoms, nurses who are sexually harassed also experience emotional and mental symptoms, such as decreased self-esteem and self-worth, isolation, fear, substance abuse, relational and communication difficulties, burnout, anger, humiliation, frustration, disgust, and shame (Bronner et al., 2002; Jacobwitz, 2013; McNamara, 2012; Nielsen et al., 2017; Yang et al., 2018).

If left untreated, these emotional symptoms can develop into more severe mental consequences, such as the development of clinical depression and anxiety, post traumatic stress disorder, and substance use (McNamara, 2012; Nielsen et al., 2017; Yang et al., 2018). The severity of the physical and emotional effects that correlate with instances of workplace violence, like sexual harassment, can be quite detrimental to the quality of life for the nurse and may cause increased use of sick leave and need for counseling (Yang et al., 2018). Lastly, a qualitative study by Nielsen et al. (2017) found that healthcare workers exposed to sexual harassment in the workplace had increased work absenteeism and decreased worker retention.

### **Effects on the patient.**

Although nurses are the primary victims of patient-to-nurse sexual harassment, it may also have a negative and indirect effect on patient safety and outcomes. While there isn't much

research on the effects sexual harassment towards nurses have on patients, there is evidence that other forms of workplace violence can negatively affect patient care. For example, patient-to-nurse physical violence can impact the nurse's performance and the unit environment and is correlated with a decrease in the quality of care and undesirable outcomes and consequences for the patient (Najafi, Fallahi-Khoshknab, Ahmadi, Dalvandi, & Rahgozar, 2017).

**Effects on the healthcare organization.**

In addition to poor patient outcomes and decreased staff performance and attendance, sexual harassment has also been linked to negative effects for the healthcare organization. Glomb, Richman, Hulin, Drasgow, & Schneider (1997) found that individuals who experienced sexual harassment in the workplace had lower job satisfaction, decreased ability to effectively complete job responsibilities, increased absenteeism, and leaving the position. Similarly, Fitzgerald, Drasgow, Hulin, Gelfand & Magley (1997) found that women who experienced sexual harassment in the workplace have higher levels of absenteeism and thoughts about leaving the job. More recent studies also identify absenteeism and increased job turnover in nurses that have experienced workplace violence, leading to increased hospital costs and recruitment problems (McNamara, 2012; Najafi et al., 2017; Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). In addition to these indirect costs to the hospital organization, there can also be many direct costs. For example, in other professions, legal fees for court cases and the cost of investigating complaints of sexual harassment have been extensive, in some instances costing up to two years back pay of salary and benefits in addition to the court and lawyer fees (Cogin & Fish, 2009; Fiedler & Hamby, 2000; McNamara, 2012; York & Brookhouse, 1988).

**Interventions**

As with many situations, interventions to address patient-to-nurse sexual harassment can be done at the individual level, environmental and organizational level, and the policy level.

**Individual factors.**

Nurses can take steps themselves to prevent patient-to-nurse sexual harassment. Literature supports increasing one's own awareness on issues related to sexual harassment. It is also suggested that nurses can increase their comfort and knowledge on how to prevent and address sexual harassment, examine the literature on sexual harassment protection and prevention, and take self-defense and assertiveness training classes (Dan et al., 1995; Long, 2015). Hellebrand (2018) reported that the best way to end workplace violence in healthcare is to recognize it, intervene, stop the spread of misinformation, and hold others accountable for addressing the toxic environment. The nurse can also improve their ability to recognize patients who are at risk for sexually harassing others through assessment scales (NSVRC, 2011). They can also seek support or mentorship from colleagues, switch patients, and educate patients on healthier and appropriate ways to express or accommodate their sexual needs, as many patients may not have the opportunity to satisfy their sexual needs in the hospital (Lux, Hutchenson, & Peden, 2014; Nielsen et al., 2017). Lastly, nurses can use their voice to advocate for their own safety and improved policy and legislation, as well as speak up when toxic situations, like patient-to-nurse sexual harassment, occur (McNamara, 2012; Long, 2015).

At the individual level, increased bystander intervention when the abused nurse is uncomfortable addressing the issue themselves can also be effective. According to MacCurtain et al. (2017), effective bystander intervention in bullying includes the following steps: notice the event, see it as something that can be addressed, feel responsibility to intervene, identify

necessary resources and skills needed to address the issue, and lastly, take action. Through increasing bystander intervention, nurses may feel more comfortable in voicing concerns, identifying harassment, and intervening in a timely and effective manner (MacCurtain et al., 2017)

While many of these interventions are recommended, few have been thoroughly studied to measure effectiveness in the nursing field. For example, Garcia, Lechner, Frerich, Lust, and Eisenberg (2011) studied university students' responses to sexual violence and found that they were more likely to report incidents and positively cope when exposed to it if those in leadership or management positions showed support and resources were readily available. Hall et al. (2018) and MacCurtain et al. (2018) concluded similar results, discussing that when nurses felt more supported by coworkers and management, they responded more positively to instances of incivility and were more likely to report the incidents. However, Drauker (2019) found that nurses preferred to find support in family and friends rather than in coworkers. Hoeve, Kunnen, Brouwer, and Roodbol (2018) studied experiences of novice nurses. While they didn't study the effects of training on sexual harassment, they did find that new nurses had experienced sexual harassment from patients and desired more continuing education. This presents the opportunity for continued education on sexual harassment prevention in new nurses. Jacobowitz (2013) suggested that training staff members to address workplace violence and having post-incident debriefings for nurses that were assaulted may be effective in reducing the effects of trauma. This approach may also be helpful when applied to nurses who experience sexual harassment or sexual trauma.

**Environmental and organizational factors.**

There are many interventions that management can implement to create a more supportive and positive environment that will encourage nurses to report sexual harassment and guide them through proper ways to address it (Dan et al., 1995; Hoeve et al., 2018; McNamara, 2012; Strauss, 2019). For example, Cugin and Fish (2009) found a correlation between nurses' perception of their managers' leadership skills and incidence of sexual harassment, suggesting if leaders can develop more positive leadership skills and relationships with nurses, it may help address sexual harassment in the workplace. Specific examples of interventions managers and nurse leaders can implement include: enforcing zero-tolerance policies, helping people report incidents, debriefing with afflicted staff, and openly offering support and positive affirmation for nurses who wish to report (Hall et al., 2018; Jacobwitz, 2013). Management also has a responsibility to listen to all instances in a nonjudgmental manner and check disruptive behaviors, and intervene when necessary (Dan et al., 1995; McNamara, 2012).

**Policy, guidelines, training, and jurisprudence.**

As previously discussed, laws like the Violence Against Women Act, the Equal Opportunity Act, Title VII, and Title IX may provide protection for nurses against sexual harassment in the workplace. Although these laws are helpful, they do not directly protect or guide nurses on how to address sexual harassment from patients. From a macrosystem level, there are many opportunities to improve policy, advocacy, training, and public education, and use of jurisprudence to protect nurses from patient-to-nurse sexual harassment. Examples include improved reporting systems, creating new policies and trainings, and assisting nurses in how to advocate for their safety (Cipriano, 2018; Nelson, 2018; Huebner, 2008; Speroni et al., 2014; Ward-Smith, 2018).

In accordance with the Bureau of National Affairs guidelines on what to include in a sexual harassment policy, many hospital policies consist of a statement that sexual harassment won't be tolerated, a definition of what is sexual harassment with examples, and information on how to file a complaint and how the organization will handle it (Bureau of National Affairs, 1987; Robinson et al., 1993). Some of these policies also define protected populations, such as ethnic minorities, women, individuals of a certain age, and those of military status, as being protected by the organization in instances of sexual harassment. While this is a start, the policies only provide guidance on how to file a complaint and do not offer guidance on how to address the sexual harassment, how to cope with it or prevent it, or what to do when the person who is engaging in sexual misconduct is the person to whom you would report.

Most of the literature also recognizes that nursing students and new nurses have limited to no education on workplace violence, incivility, and disruptive behaviors, including patient-to-nurse sexual harassment. Therefore, it is recommended that trainings be created and implemented to increase early awareness and comfort in using assertive and effective tactics to address and stop these situations (Finnis et al., 1992; Lux et al., 2014; McNamara, 2012). It is also recommended that the training include conflict management, communication strategies, and resilience training to improve health and outcomes when nurses experience disruptive behaviors, including sexual harassment from their patients (Lux et al., 2014). Proposed techniques for training nurses to address incivility or disruptive behaviors that may also be effective in response to sexual harassment include pre-rehearsed scenarios, cue cards, and in-person classes to improve nurses' practice with interventions (McNamara, 2012).

### **Conclusion of the Evidence**

Although there is ambiguity on the extent of patient-to-nurse sexual harassment, the literature agrees that it is a significant problem with significant effects on the nurse, the patient, and the organization. There are many factors that contribute to patient-to-nurse sexual harassment, including altered mental status, understaffing, poor managerial support, and limited policies and guidelines on how to prevent and address it. The literature supports improved managerial support, increased awareness and self-protection by the nurse, bystander interventions, and implementing trainings during nursing education and hospital orientation to improve nurses' confidence and skills in recognizing, addressing, preventing, and coping with sexual harassment in the workplace.

### **Organizational Analysis**

As noted in the literature review, the key to addressing patient-to-nurse sexual harassment in the hospital is to better train nurses on how to prevent, recognize, address, and cope with sexual harassment for themselves and as a bystander. While both the hospital and the university setting were evaluated for fit in implementing a pilot training for nurses in addressing patient-to-nurse sexual harassment, the hospital was chosen to better fit the Doctorate of Nursing Practice Essentials. Unfortunately, due to the COVID-19 pandemic and the restrictions many hospitals implemented, implementing training in the hospital was not a possibility.

Therefore, in order to best reach and educate nurses, this training was advertised as a webinar through the American Psychiatric Nurses Association (APNA) member discussion board. Continuing education credits were provided by Madonna University to those who attended the webinar. APNA was deemed an appropriate organization to advertise and recruit participants for a webinar on patient-to-nurse sexual harassment because of their value for

member participation, the large size of the organization, and easy access to a variety of nurses in different regions and settings. Psychiatric nurses are at higher risk of experiencing sexual harassment by a patient than those in other nursing settings (Nielsen et al., 2017; Spector et al., 2014).

Another benefit to this method of knowledge dissemination is it allows for easier access to nurses either in or pursuing management or leadership positions. As identified in the literature review, managerial support is desired and impactful in addressing patient-to-nurse sexual harassment. The effect that managers and leaders have on the working environment can be very influential to nurses' practices. In developing managers and leaders to be more knowledgeable and prepared to address matters of sexual harassment in the workplace, nurses can be more empowered to enforce zero-tolerance and cope with it more effectively.

The APNA is a national organization founded in 1986 to advance evidence-based practices and treatments for psychiatric-mental health nurses (APNA, 2020). The professional organization values practices that improve empowerment, inclusivity, integrity, collegiality, innovation, transparency, stewardship, and professional advancement. The organization excels in disseminating new research and best practices through its peer-reviewed journal, webinars, annual conference, and continuing education courses.

The organization is a national association within the United States and has over 13,500 members (APNA, 2020). Within the national organization, there are 40 state and local chapters, each with its own board of directors. Both the national and local boards are comprised of elected members who head different committees and task forces to make essential decisions for the organization. The national board has nine members, consisting of the president, president-elect, immediate past president, secretary, treasurer, executive director, and four board members-at-

large (APNA, 2020). Local boards consist of the following officer positions: a president, president-elect, immediate past president, secretary, treasurer, members-at-large, and board members (APNA, 2020).

Regular membership dues for the APNA are set at \$135 annually, with lower-cost options for students and retired nurses (APNA, 2020). This membership fee is slightly less than many other professional nursing organizations like the American Nurses Association (\$180 annually), the National League of Nursing (\$160 annually), and the American Association of Nurse Practitioners (\$150 annually) (ANA, 2020; NLN, 2020; AANP, 2020). The APNA values member participation and has been praised for its flexibility in providing members with the resources and opportunities they need. In order to maintain the quality and evidence-based focus for their continuing educational opportunities, those who present at conferences or conduct webinars are required to adhere strictly to organizational guidelines.

### **Theoretical Frameworks**

The Knowledge-to-Action Framework (KTA) was used to guide the implementation of this project and its sustainability. In addition, a framework developed to address sexual harassment was used to inform the educational interventions. No frameworks have been developed specifically for sexual misconduct by patients, so this project used the Determinants of Target Responses to Sexual Harassment Framework to help define the prevalence and significance of the problem, individuals' response to sexual misconduct, and the need for a variety of interventions.

#### **Knowledge-to-Action Framework (KTA)**

The KTA Framework, developed by Graham et al. (2006), is a framework that guides knowledge transfer to improve research utilization and improvement in quick adaption of

evidence-based practices. The framework was developed in response to the lack of evidence-based practice utilization in the healthcare setting, as up to 45% of patients in the United States still receive outdated care (Graham et al., 2006). This framework is divided into two parts: knowledge creation and action. Knowledge creation is done through a knowledge inquiry, synthesis, and evaluation of knowledge tools and products. The purpose of knowledge creation is to narrow information available on a topic to best identify and tailor knowledge to a specific problem, as symbolized by the funnel shape in the framework diagram. Once that is completed, a more selective review of the literature can be done to discern best practice on a topic (Graham et al., 2006).

The action cycle then follows with eight steps to guide application of the knowledge obtained in the first step starting with the focused problem and narrowed literature review. The knowledge obtained from the literature review is adapted to match the context and purpose of the review. Any barriers to applying the knowledge are identified, and a tailored implementation plan is created to disseminate the knowledge. Once the knowledge is disseminated, its use is monitored, as well as its outcomes. Lastly, measures are implemented to sustain continued use of the knowledge identified (Graham et al., 2006).

This framework is appropriate to implement a webinar on patient-to-nurse sexual harassment as it is a knowledge dissemination intervention aimed at improving the use of evidence-based practices to prevent, address, and cope with sexual harassment by patients.

### **The Determinants of Target Responses to Sexual Harassment Framework**

This conceptual framework developed by Knapp, Faley, Ekeberg, & Dubois (1997) outlines the factors that contribute to individuals' responses to sexual harassment. It was initially created as a response to growing costs of sexual harassment in the workplace and includes the

following factors to determine common outcomes of harassment: individual characteristics, power, legal/economic environment, workgroup characteristics, and organizational characteristics. This model also considers the reporting process, severity of sexual harassment, and level of distress in the individual as factors that influence the response and, therefore, outcome. A feedback loop is then used to indicate how one event's outcomes can influence the response to future events (Knapp et al., 1997). Lastly, this framework includes a model of responses that describes how the mode of response (self-response, supported response) and the focus of response (indicator focus, self-focus) determine the behavioral responses of an individual (avoidance/denial, confrontation/negotiation, social coping, and advocacy seeking) (Knapp et al., 1997). This framework is useful as it informs the project by providing guidance on identifying individual responses to sexual harassment and how to improve support for a more desirable outcome.

### **Chapter 3**

#### **Goals and Aims**

The overall goal of this project was to develop and implement a webinar on patient-to-nurse sexual harassment to improve nurses' ability to recognize, prevent, address, and cope with patient-to-nurse sexual harassment. In turn, this could improve job satisfaction, nurse retention, unit culture, and patient outcomes. It was intended that nurses who attended this webinar would show an improved understanding of patient-to-nurse sexual harassment and improved confidence in addressing it and supporting each other. Also, they would demonstrate improved reporting of patient-to-nurse sexual harassment so that understanding of the issue can improve. The aims, as well as the methods and evaluation of each aim, are described throughout this chapter. Lastly, this chapter discusses implications, special considerations, and the schedule for implementation of the project.

#### **Aim 1**

Review and synthesize best evidence on sexual harassment prevention, recognition, and coping in nursing to improve understanding of the issue and to provide evidence-based information that will be used in the training.

#### **Methods.**

Many organizations and universities have trainings for sexual harassment prevention. A literature search of these trainings was completed to ensure the best evidence was included in the webinar. The following terms were used for a literature search: sexual harassment training, sexual harassment prevention, sexual harassment workplace training, sexual harassment policies, and sexual harassment prevention guidelines. The databases used include CINAHL for the emphasis on nursing practice, MEDLINE for the medical perspective, PsychINFO on best

practices for sexual harassment, and Legal Source for information on guideline and policy writing. Current research conducted on these trainings is often generic and focuses on sexual harassment that occurs laterally and from coworker to coworker. While they do not address the complexity of patient-to-nurse sexual harassment, they were beneficial in the structuring of this training program.

To complete this aim, training programs from national and international organizations, such as the CDC, the NSVRC, OSHA, the WHO, and the International Labor Office, were reviewed to identify effective tools and techniques for sexual harassment prevention trainings. In addition, training programs from universities and healthcare organizations such as MacEwan University, Yale University, Madonna University, and Ascension Healthcare were evaluated. Lastly, position statements, guidelines, and policies set forth by the International Council of Nurses (ICN), NASEM, Dartmouth-Hitchcock, the University of Michigan, and other hospital systems were reviewed to determine current guidelines and practice recommendations to incorporate in the training. The selection of universities and healthcare systems was based on convenience and accessibility to information on their trainings and policies.

Elements of each training that best applied to effectively addressing patient-to-nurse sexual harassment were organized into a matrix. Such elements included effective prevention strategies, useful risk assessment tools, recognition skills, techniques for improved reporting, ways to improve coping and support, and a summary of resources for nurses on the topic of sexual harassment in the healthcare setting.

### **Evaluation.**

The matrix information was reviewed for applicability to patient-to-nurse sexual harassment, specifically, prevention strategies, recognition strategies, and coping and support

interventions. Information was then extracted into a summary that was used to guide development of the webinar. The quality of evidence-based information was identified and extracted, and the applicability the summary had to patient-to-nurse sexual harassment was evaluated.

### **Aim 2.1**

Develop a training program delivered through a webinar to educate nurses on how to recognize, prevent, address, and cope with patient-to-nurse sexual harassment.

### **Aim 2.2**

Develop policy resources for nurse managers to promote a sexual harassment-free environment, support nurses who experience sexual harassment, and generate content to include in sexual harassment prevention policies.

### **Methods.**

#### ***Aim 2.1.***

The purpose of this webinar was to inform and prepare nurses on how to recognize, prevent, address, and cope with patient-to-nurse sexual harassment so they can proficiently address such instances as RNs. Increasing nurses' proficiency in this area can have beneficial effects on nurses' performance and health, the health care setting environment, patient care and outcomes, nursing retention, and interdisciplinary collaboration.

Specifically, the objectives for this training program were:

1. The participant will be able to describe sexual harassment and identify behaviors and situations that exemplify sexual harassment.
2. The participant will be able to identify contributing factors to occurrences of patient-to-nurse sexual harassment and ways to address any modifiable risk factors.

3. The participant will be able to demonstrate effective strategies that prevent or address sexual harassment instances.
4. The participant will be able to demonstrate effective bystander intervention in situations where another individual is experiencing sexual harassment by a patient.
5. The participant will be able to identify coping strategies to implement following the occurrence of patient-to-nurse sexual harassment.

To meet the objectives of this webinar, the program was delivered through Zoom and incorporated the use of lecture and group discussion and activities. The webinar was two hours long and was advertised through the APNA Member Forum Board. Continuing education credits were provided upon completion of the webinar.

The training outline was as follows:

- Part 1 - Introduction (5 Minutes): During this time, the participants completed the knowledge assessment and Sexual Harassment Self-Efficacy Scale, which were created by researching elements of pretest-posttest questions used in sexual harassment prevention trainings, as well as by examining the objectives of this training and determining what information is essential to assess prior to attending. We reviewed the objectives and any disclaimers for the webinar and established rules for respectful, appropriate, and professional participation.
- Part 2 - Patient-to-Nurse Sexual Harassment (10 minutes): During this session, we discussed the unique factors related to patient-to-nurse sexual harassment. This included discussion on risk factors and accountability with varying degrees of mental status and judgment. It was also proposed that participants would have the

- opportunity to reflect and identify any instances they experienced or witnessed patient-to-nurse sexual harassment if time allowed.
- Part 3 - Prevention and Addressing Sexual Harassment (30-60 minutes): This session started with a brief discussion about victim response, managerial response, and coworker response to identify effective prevention strategies or interventions. The second part of this session involved a demonstration of appropriate responses to sexual harassment by patients and a case study for participants to practice techniques to address sexual harassment. During this time, we also discussed and exemplified bystander intervention responses. The demonstrations used were scripted, and measures were taken to prevent any emotional trauma or discomfort. Following this, a debriefing session was held to review the techniques and discuss effective coping strategies and resources. Each individual was encouraged to identify a coping strategy that would be most effective for themselves.
  - Part 4 - Reporting (10 minutes): We discussed barriers to reporting and how to overcome those barriers. The participants were educated on how to evaluate different guidelines, policies, and reporting systems, and we discussed ways that they can promote reporting of instances and advocate for the safety of nurses.
  - Part 5 - Conclusion (5 minutes). This final part of the webinar reiterated key concepts and information from the sessions. At this time, the nurses also completed their Sexual Harassment Self-Efficacy Scale and course evaluation based on the course objectives and recommendations on what to include in a posttest by other sexual harassment trainings.

*Aim 2.2.*

In addition to the actual webinar, attendees received a Leadership Resource Packet including information and guidance on writing or amending organizational sexual harassment policies; how to provide managerial support to victims of sexual harassment; how to promote sexual harassment-free working environments; and referral resources. This was done to help managers and nurse leaders further develop resources to better enforce guidelines and assist staff through preventative interventions, addressing instances of patient-to-nurse sexual harassment, documentation, and coping with the occurrence.

The steps to complete this aim included organizing and synthesizing resources and policy guidelines, as put forth by the Bureau of National Affairs and other recommendations found in the literature search. The resources on how to provide managerial support to victims were also obtained through the literature review and through resources put forth by other organizations on how to support victims and cope with sexual harassment. Resources for steps to promote sexual harassment-free working environments were also obtained through the literature review and through identifying strategies implemented by organizations that effectively address and prevent sexual harassment.

After that, the resources were organized and synthesized, and gaps were identified. Additional resources were added to fill the identified gaps in the Leadership Resource Packet. Once all the resources were collected and organized in a useful and logical way, a summary of the resources was developed to help guide nurse leaders.

**Evaluation.**

In order to consider this aim successfully met, each sessions' content, discussion prompts, and demonstrations needed to be developed in a way that was concise but allowed a thorough and effective understanding of the material and completion of training objectives. The Leadership Resource Packet and summary of resources for nurse leaders were evaluated. In addition, factors that would enhance the success of this webinar, as well as barriers to successful implementation, were identified, and a plan to accommodate such factors was created.

**Aim 3**

Create and utilize an expert panel to review the content of the webinar as it pertains to the recognition, prevention, intervention, and coping with patient-to-nurse sexual harassment.

**Methods.**

The following questions were presented to and answered by the expert panel:

- Is the webinar content relevant to the project objectives?
- Is the content important to the project objectives?

In order to effectively utilize an expert panel, and reach the desired rating of 0.78 (78% agreement), an appropriate panel size and inclusion criteria were determined. The goal for this expert panel was to have five to seven expert participants. The most appropriate experts to sit on the panel were determined through a review of the literature and sexual harassment prevention resources. In addition, the creators, evaluators, and presenters of current sexual harassment trainings were identified and considered. Lastly, it was essential to identify individuals that had done research on harassment and violence in healthcare, more specifically, sexual harassment prevention or advocacy, as they provided vital information and techniques to include in the training.

Identified experts included: Dr. Judith Strunk, a professor at Michigan State University and expert on sexual harassment prevention and victim response; Dr. Kevin McKenna, an expert in patient sexual harassment; Marilyn Ridenour, a Nurse epidemiologist for the CDC and expert in workplace violence prevention; Diane Burgermeister, a psychiatric nursing professor and board member for the APNA, and Amanda Barrett, the Senior Program Manager for the Michigan Coalition against Domestic and Sexual Violence.

After experts were identified, the individuals were contacted and invited to participate on the expert panel, and provided with the project objectives, expectations, and responsibilities of participating on the panel. After reviewing the information, the individuals had the opportunity to accept or reject participation on the expert panel and submit recommendations of further individuals that may be helpful to the project.

Participation on the panel involved the individuals reviewing the webinar content and completing a questionnaire that evaluated the factors listed above. In addition, they had the opportunity to provide supporting materials, suggestions, or recommended additions. The feedback was reviewed, and percent agreement was determined for each factor, based on the rating scale described above. Those falling below 78% agreement were further evaluated for removal from the webinar. Any additional recommended, relevant, and necessary changes to the training by the expert panel were reviewed and implemented. Any further communication that was necessary to clarify or seek additional feedback was completed, and the participants were thanked for their valuable contributions and assistance in furthering the understanding and training on sexual harassment prevention.

**Evaluation.**

The results from the panel were summarized, along with the frequency of agreement in relevance and importance of the questions outlined previously. The experts' feedback was also analyzed and used to revise and implement any necessary changes to the objectives, content, or pre and post webinar knowledge assessment and Sexual Harassment Self-Efficacy Scale.

Once the training was revised, the webinar objectives and outlines were further evaluated. A summary of the methods and resources needed for each webinar component was created, along with evaluation criteria of that session's appropriateness of content, time allocation, and effectiveness of dissemination strategies.

**Aim 4**

Implement a webinar for nurses on how to recognize, prevent, address, and cope with patient-to-nurse sexual harassment.

**Methods.**

The webinar was presented to participants recruited through the APNA Member Forum Board. Criteria for participation in the webinar included being a registered nurse or a nurse leader. It was offered via zoom, and participation was voluntary.

A proposal was sent to the board of APNA's Michigan branch and the national branch. The proposal included information on the training, a timeline of activity, the goals and objectives, expected benefits, and expected outcomes to ensure that the leadership was well informed on what they were approving. It was determined that approval was not needed if the webinar was advertised through the member discussion board. Financial considerations did not need to be discussed since it was a free webinar. An application to provide continuing education credits was completed as an incentive for attending the webinar.

The next step was to recruit participants and provide information on the training date, time, objectives, and expectations. It was desired to have between 15-25 participants.

Recruitment was discussed with the Michigan Board of APNA, and the project webinar was advertised to recruit nurses for the webinar. In addition, recruitment was also extended to nurses that had self-identified interest in attending the webinar.

The participants received a pre webinar knowledge assessment and a Sexual Harassment Self-Efficacy Scale to measure confidence in addressing sexual harassment (outlined in Appendix E) via Qualtrics prior to attending the webinar. This knowledge assessment was used to gauge the participants' understanding and experience with patient-to-nurse sexual harassment and to help tailor discussions and content to meet the participants' needs. The Sexual Harassment Self-Efficacy Scale was based on the work of Albert Bandura, who stated, "scales of perceived self-efficacy must be tailored to the particular domain of functioning that is the object of interest" (Bandura, 2006, p.307-308). Therefore, Bandura's recommended format was tailored to reflect confidence in addressing sexual harassment in the workplace. After the webinar, the participants were asked to retake the Sexual Harassment Self-Efficacy scale to measure growth of confidence and a course evaluation (also in Appendix E) via Qualtrics to measure the training's effectiveness in fulfilling the objectives and goals.

Once the webinar was completed, the Sexual Harassment Self-Efficacy Scale and course evaluations were evaluated. This included information on the participants' experiences, completion of objectives, and recommendations for continuation and sustainability of the training.

**Evaluation.**

This aim was met following the webinar's implementation through real-time feedback and the Sexual Harassment Self-Efficacy Scale and course evaluation. Quantitative and qualitative results from these reports were evaluated to measure an overall change in knowledge related to patient-to-nurse sexual harassment prevention, recognition, intervention, and reporting by the group of participants. Since the Sexual Harassment Self-Efficacy Scale was adapted from Albert Bandura's works and was not a validated tool, the evaluation used an item-to-item analysis. Processes were evaluated to identify any discrepancy between the implementation plan and the actual implementation, and included: evaluation of adherence to the scheduled time, whether it ran smoothly, and whether any barriers or unexpected circumstances occurred.

Another aspect of evaluation for this aim involved real-time evaluation during the webinar and included evaluation of the nurse's participation, understanding, and progression to help to determine if the implementation of the training was meeting objective goals or if the instructor needed to make quick modification to the education methods. In addition, any factors that improved the ease and effectiveness of the webinar or presented any barriers that could be addressed at that time were also evaluated during the training sessions, and changes were made when necessary.

**Implications**

This project was expected to improve knowledge and confidence in preventing and addressing patient-to-nurse sexual harassment. Patient-to-nurse sexual harassment is often a confusing occurrence and can create a hostile working environment that can have many negative effects on the patient, the nurse, the unit, and the hospital itself. Therefore, by better preparing and educating nurses on how to prevent it, this project aimed to ultimately create a safer and

healthier working environment. It could also help reduce medical errors, improve patient outcomes, foster well-being in the nurses, prevent physical and emotional injury, improve interdisciplinary communication and collaboration, and improve university reputation and recruitment. While these points are important, especially when responding to nurses who do not see the value or need of sexual harassment training, the most crucial point was that it would empower nurses to advocate for a healthier, sexual harassment-free working environment and to hold others accountable for doing the same.

### **Statement about Human Subjects**

This project was not a research project but rather an educational program. While it does involve human subjects, it did not include any intervention, and it did not need to access identifiable or private information about the participants. Therefore, it did not require Institutional Review Board (IRB) review. Any data collection obtained during this project was through voluntary and confidential means and did not identify any personal information about the participants.

### **Timeline**

A timeline was prepared using a Gantt chart. This chart kept the project on task for completion by May of 2021 and included elements such as when the project was proposed, when the training took place, and when the results were disseminated.

## Chapter 4

### Results

The results from development, validation, and implementation of a webinar on patient-to-nurse sexual harassment will be reviewed. The first aim involved synthesizing the best evidence on sexual harassment prevention, recognition, intervention, and coping in nursing for use in the second aim. The second aim included developing policy materials and a training program delivered by webinar to educate nurses on how to recognize, prevent, address, and cope with patient-to-nurse sexual harassment and promote a sexual harassment-free environment. The final aims involved expert panel validation and implementation of the webinar. The following section details the results of completing each aim.

**Aim 1:** To review and synthesize the best evidence on sexual harassment prevention, recognition, intervention, and coping in nursing.

A literature search on sexual harassment prevention training programs and policies was conducted with results synthesized to guide further development of the webinar curriculum on best practices and recommendations for the recognition, prevention, intervention, and coping with patient-to-nurse sexual harassment. This literature search supplemented the literature review from Chapter 2 to validate the proposed content covered in the webinar outline and address any gaps in the outline. In addition, it was intended to identify content delivery methods that support evidence-based practices and standards for sexual harassment prevention programs.

A search of the terms sexual harassment trainings, sexual harassment prevention, addressing sexual harassment, workplace violence training, sexual harassment intervention, and sexual harassment policy were entered into CINHALL, MEDLINE, PsychINFO, and Legal Source databases. Evidence from results was extracted to a matrix organizing the summary of

information on best practices, recommendations, and policy evaluation. The summary was used to guide curriculum development and the Leadership Resource Packet (see Appendix F) on how to review a sexual harassment policy, how to support victims of sexual harassment, and how to create a healthier, sexual harassment-free working environment.

### **Sexual harassment training.**

A search was conducted to compare and analyze information in current sexual harassment training programs. From the database search of sexual harassment training terms, eight articles were selected for the review based on the relevance and importance of information to this aim. The information was extracted to a matrix using the categories: effective prevention strategies, useful risk assessment tools, recognition skills, techniques for improved reporting, ways to improve coping and support, other information, and training techniques.

The trainings identified through secondary literature and expert recommendation included those put forth by the CDC, NSVRC, OSHA, WHO, International Council of Nurses (ICN), MacEwan University, Yale University, Madonna University, and Ascension Healthcare. The information and focus of the sexual harassment trainings varied significantly. The training from MacEwan University mainly focused on sexual violence risk assessment, while the trainings from the CDC, WHO, ICN, and OSHA focused on sexual violence prevention, and the NSVRC focused on sexual violence outside of the healthcare field with a focus on child abuse and intimate partner violence. Only the training from Yale University contained information related to responding to sexual harassment. Almost all of the trainings included information on resources available to support victims of sexual harassment and abuse.

At MacEwan University, the sexual harassment in healthcare training focused on risk assessment through unstructured clinical judgment, actuarial approaches, and structured clinical

(or professional) judgment. Structured clinical judgment (SCJ) is the recommended approach because it combines both actuarial scales with clinical judgment and intuition while also considering individual factors about the person being assessed (Hart, Douglas, & Guy, 2016).

Trainings by the WHO, CDC, ICN, etc., contained information on the nature of sexual violence, risk factors for offending, and how to modify the environment to create a stronger zero-tolerance for sexual harassment. Recommendations included: better security, improved use of risk assessment and risk management, how to train staff, improve reporting techniques, improve managerial support, and how to provide better resources and emergency response to victims of sexual violence.

The National Sexual Violence Resource Center (NSVRC) focused on how to screen patients who may be a victim of sexual violence, but also contained techniques on how to create safer and better environments in which to address sexual harassment. The NSVRC also addressed how to structure sexual harassment trainings to include information related to root causes of violence, how to identify those at risk for violence, and how to implement both primary and secondary interventions.

Lastly, the training by Yale University included information on ways to promote a sexual harassment-free environment through role modeling, treating others with respect, taking disrespect and instances seriously, and improving communication. The training also discussed bystander intervention; a concept proposed to effectively reduce the incidence and impact of sexual harassment and create a safer environment (Hall et al., 2018).

In addition to studying actual trainings, reviews of sexual harassment trainings and their effectiveness were also analyzed. Most of the training reviews focused on what should be included in sexual harassment trainings and what were effective strategies to relay the

information. According to Pilgrim & Keyon (2009), trainings should include activities and information that improve individuals' recognition skills of sexual harassment through non-verbal cues and behavior identification. Both Wiskow (2003) and Edroso (2018) recommended improved reporting techniques, with Edroso emphasizing the impact that time and ease of filing the report has on improving compliance.

The reviews also identified that synchronous trainings were more effective but were rarely used. Most trainings used reading materials and a pre-recorded informational lecture. In-person interactions showed better outcomes than trainings that did not have interactive activities. This guided the methods of content delivery for the patient-to-nurse sexual harassment webinar and the balancing of interactive activities versus didactic content.

Recommendations on improving support and coping and content to include in the trainings were consistent with those discussed earlier in the literature review, emphasizing critical incident debriefing and crisis counseling, improved managerial response, bystander support and intervention, promotion of gender equality, provision of internal and external resources, changing the nurse's patient assignment, improved risk assessment, improved policy, and improved use of coping skills. (Edroso, 2018; Hart et al., 2016; ILO, ICN, WHO, PSI, 2003; NSVRS, 2004; NSVRC, 2014; Wiskow, 2003; Yale University, n.d.).

### **Policy summary.**

An initial search for policies in the CINHALL, MEDLINE, PsychINFO, and Legal Source databases did not result in identification of any policies. To include information on policy, policies were obtained by searching organizations directly. Many organizations did not have sexual harassment policies available for public use, limiting the number of policies included in this synthesis. The policies that were used were selected based on convenience, accessibility, and

expert recommendation. Policies were sought out until adding new policies did not result in the addition of new information. In total, nine policies were reviewed from seven organizations, including seven focusing on inpatient hospital or healthcare settings: Ascension Healthcare, Craig Hospital, Dartmouth-Hitchcock, Moffitt Cancer Center, and Union Hospital, and two relevant to academic settings, from the National Academies of Science, Engineering, and Medicine (NASEM) and the University of Michigan.

The U.S. Equal Employment Opportunity Commission (EEOC) has identified the following required information to include in a sexual harassment policy: a statement that harassment is illegal and intolerable, definitions and examples of sexual harassment, steps for reporting an incident of sexual harassment (with options), assurance of confidentiality, prohibition of retaliation, a description of HR responsibilities in responding to reports, information on the process of the investigation (with a time frame), a statement about corrective and preventative action, consequences for violating policy, and whether or not the individual who filed the complaint will be notified on the status of the investigation (and if so, how?) (EEOC, n.d.). In addition, it is recommended that policies include resources for coping and recovery following exposure to sexual harassment.

Of the nine policies reviewed, only two fully met the suggested criteria to include in a sexual harassment policy set forth by the EEOC: Moffitt Cancer Center and the University of Michigan. The University of Michigan policy also included the recommended criteria of providing options for recovering and restoring self-esteem following exposure to sexual harassment.

Examples of sexual harassment provided in the policies varied, and included behaviors like unconsented viewing of sexually explicit images, verbal comments, non-verbal gestures, and

physical contact. Two of the nine policies did not include examples of sexual harassment. The criteria most often missing in the policies were the zero-tolerance for sexual harassment statement, examples of sexual harassment, and a statement on corrective action. Most policies minimally explained the process for reporting and what actions will be taken to address a report. Some organizations, such as Ascension Healthcare and Dartmouth-Hitchcock, only prohibit sexual harassment based on a protected class, such as being of veteran status, minority ethnicity, disability, female gender, or advanced age.

Notable information included in some policies that expanded beyond the requirements by the EEOC was a confidentiality statement (five policies) and prohibition of retaliatory behaviors with information on what retaliation is and how it will be handled (two policies). One policy required all investigations start within three business days of a complaint. Moffitt Cancer Center included providing counseling and training for the harasser. The University of Michigan also provides information on frequently educating and training both staff and students on what sexual harassment is, how to prevent it, and how to report it with a firm stance that it will not be tolerated.

### **Evaluation.**

The proposed methods were closely followed in completing this aim. Initially, proposed methods for the literature search yielded minimal information on policies and trainings. As a result, information was obtained through expert-recommended materials and policies and trainings that were accessible. This potentially limits the reliability of the information found. In order to overcome that barrier and to ensure that the information used was reliable, only accredited and nationally recognized organizations and institutions were included. Ultimately,

this review did result in information that was applicable to synthesizing evidence on prevention, recognition, coping, and support strategies.

**Aim 2.1:** Develop a training program delivered through a webinar to educate nurses on how to recognize, prevent, address, and cope with patient-to-nurse sexual harassment.

Prior to the webinar, participants received a pre webinar knowledge assessment tool related to sexual harassment and a Sexual Harassment Self-Efficacy Scale to determine confidence in recognizing and addressing sexual harassment. The Sexual Harassment Self-Efficacy Scale was developed based on the work of Albert Bandura (2006) and adapted to fit the webinar focus and objectives (see Appendix E).

The webinar content was organized into sections, including what sexual harassment is, patient-to-nurse sexual harassment, how to recognize and respond, and the importance of reporting sexual harassment. During the introduction, use of the webinar platform (Zoom), key terms related to sexual harassment, actions in the case of distress, and disclosures were shared. The second part of the webinar was on patient-to-nurse sexual harassment specifically and covered statistics, risk factors, and effects that patient-to-nurse sexual harassment has on nurses, patients, and the healthcare setting. There was also opportunity for discussion and reflection on the pre webinar knowledge assessment. Part three of the webinar discussed common reactions to sexual harassment and evidence-based techniques to prevent and address such instances. This included discussion on risk assessment tools, bystander intervention, boundary setting, and appropriate responses. Both a case study discussion and demonstration on responses were completed during this time to reiterate and practice the concepts discussed. The section on reporting patient-to-nurse sexual harassment was discussed, identifying what should be included in a sexual harassment policy and policy evaluation and how to advocate for nurses. This

discussed statistics on reporting, barriers to reporting, the importance of proper reporting, and techniques to overcome barriers. The webinar concluded with a reiteration of key concepts and a discussion of the Leadership Resource Packet that was developed and provided to all participants. Any questions on the webinar content were discussed. To conclude the webinar, the participants were asked to complete the Sexual Harassment Self-Efficacy Scale again to measure any improvements in confidence in recognizing and addressing sexual harassment by patients. The participants were also provided with information on the CE credits from an accredited provider.

### **Evaluation.**

The webinar content was successfully developed to provide information in a concise and effective manner. It allowed for a thorough understanding of patient-to-nurse sexual harassment and how to prevent, address, and cope with it. The content also met the objectives identified. The webinar development was based on evidence-based research and recommendations and closely followed the webinar outline developed from the initial literature review, with additions made to enhance learning and content delivery based on the literature.

### **Aim 2.2**

Develop policy resources for nurse leaders to promote a sexual harassment-free environment, support nurses who experience sexual harassment, and content to include in sexual harassment prevention policies.

The Leadership Resource Packet (see Appendix F) was developed based on recommendations and evidence obtained through the literature reviews. This resource includes three parts. The first part contains information on sexual harassment policy and an evaluation tool that was developed based on the recommendations of the EEOC. This section also includes

information on the benefit of and how to advocate for strong sexual harassment policies. The second section contains information on how to support victims of sexual harassment and incorporates general interventions, interventions following an event, resources for sexual harassment prevention, and referral resources for victims. Lastly, the section on how to prevent sexual harassment in the workplace contains recommendations for improving the environment, reporting process, and safety within the hospital.

### **Evaluation.**

The Leadership Resource Packet was created using evidence-based recommendations and resources. All three parts of the packet followed what was originally proposed for the development of Aim 2.2. No additional content was identified as necessary to include beyond that planned with this aim.

### **Aim 3**

Create and utilize an expert panel to review the content of the webinar as it pertains to the recognition, prevention, intervention, and coping with patient-to-nurse sexual harassment.

An evaluation tool was developed for expert panel participants. This tool (Appendix E) identified each part of the webinar with topical content information and asked experts to answer ‘Yes’ or ‘No’ to “Is this content relevant to include?” and “Is this content important to include?”. The tool also provided space for comments or suggestions. Part 1 included an introduction to the webinar and what sexual harassment is. Part 2 focused on patient-to-nurse sexual harassment specifically, including risk factors and consequences. Part 3 included information about sexual harassment prevention and response, including both didactic content and application activities. Part 4 focused content on reporting sexual harassment. Lastly, Part 5 included content that concluded and summarized information covered in the webinar. The Leadership Resource Packet

was included and identified: policy criteria and evaluation, resources to create a zero-tolerance for sexual harassment, resources on how to support staff, and referral resources.

To assemble the expert panel, ten individuals with expertise in sexual harassment prevention, knowledge of patient-to-nurse violence, and experience in webinar trainings were identified and invited to participate. Identification of expertise and experience was based on the individual's scholarship or publications, work responsibilities, and leadership experience. Of the original ten, one declined (lack of time), four did not respond, and five agreed to participate. Those contacted identified other individuals with expertise and experience related to patient-to-nurse sexual harassment and workplace violence to include, resulting in an additional seven individuals being asked to participate. Of the seven, one declined, one did not respond, and five agreed to participate, providing a total of ten expert panel participants with experience working as lawyers, nurses, therapists, and sexual harassment researchers.

The evaluation tool was shared with the participants with a request to complete and return the evaluation tool within two weeks. All members were reminded to complete the form, and anyone not returning the evaluation form was recontacted. All experts agreeing to participate submitted a response.

The feedback was then evaluated with a goal of obtaining 78% agreement on the relevance and importance (n=8 or more participants). Experts found all of the content (33 items) relevant to patient-to-nurse sexual harassment prevention, recognition, intervention, and coping. Five topics, however, did not meet the 78% agreement desired for importance to include in the webinar. These topics were: review of the self-awareness questions (70%), discussion of personal experiences (60%), explanation of risk factors (70%), the policy evaluation activity (50%), and current statistics on reporting (70%). The reasons given for it not being important to

include these topics were largely due to time constraints and the experts' belief that other content was more important. For discussion of personal experiences, some experts also felt that it might be too personal or that it might detract focus from the webinar content and activities.

Additional comments and suggestions included six of the ten participants feeling that the time allocation was not enough to effectively cover the proposed topics. It was recommended that the webinar be extended to a series or a part to full day training. Others felt that dialogue on zero-tolerance policies had conflicting evidence on efficacy and that it should be removed. Lastly, it was recommended that webinar participants be provided with pre webinar documents covering key terms and the basics of Zoom.

The topics with less than 78% agreement were reevaluated and modified or removed. Comments and suggestions by the panel members were also reviewed, and changes were made as appropriate.

### **Evaluation.**

Ten of the 17 experts invited to participate agreed and completed the evaluation tool. This exceeded the goal of five to seven participants. As previously mentioned, all topics met 78% agreement of relevance to patient-to-nurse sexual harassment prevention, recognition, intervention, and coping. Five topics did not meet 78% agreement on importance to include. Three of those topics were removed from the webinar: review of self-awareness questions, discussion of personal experiences related to patient-to-nurse sexual harassment, and the policy evaluation activity. This decision was due to time constraints and to reduce the risk of retraumatization of those who have been affected by sexual harassment.

The explanation of risk factors and current statistics on reporting were both kept in the webinar, despite not having 78% agreement on importance to include. This decision was made

because the explanation of risk factors is important to understanding how to recognize and address patient-to-nurse sexual harassment. In addition, the current statistics on reporting are important to discuss because it was important to inform discussion on the barriers to reporting and the importance of reporting.

Changes made after reviewing the comments and suggestions by the panel included increasing the webinar from 60-90 minutes to 120 minutes. Recommendations for creating an environment with zero tolerance for sexual harassment were removed. Instead, recommendations on creating supportive environments and mitigating risk of sexual harassment were provided. Lastly, a Zoom instruction guide and a guide on key terms were created and provided to participants pre webinar.

#### **Aim 4**

Implement the webinar for nurses on how to recognize, prevent, address, and cope with patient-to-nurse sexual harassment.

The Patient-to-Nurse Sexual Harassment webinar was implemented in February 2021 via the Zoom platform. Once the date for the webinar was decided upon, a flier was created to advertise the webinar, and 23 nurse participants were recruited through the APNA Member Discussion Board. Ten nurses attended the webinar. The webinar was 120 minutes long, with 105 minutes being designated for content, discussions, and activities and 15 minutes reserved for questions and completion of the post webinar Sexual Harassment Self-Efficacy Scale.

The webinar contained five parts and closely followed the outline discussed in Aim 2. Timing differed from the original plan (a total of 105 minutes plus 15 minutes for questions at the end), Part 1 required only 10 of 10 to 20 minutes planned, Part 2 used 20 of the 10 to 30 minutes, Part 3 used 65 minutes (5 minutes longer than the 30 to 60 minutes planned), and Part 4

used 5 of the 10 minutes allocated. The webinar concluded with a five-minute reiteration of key concepts covered and a review of the Leadership Resource Packet contents. Following the webinar, participants were provided with a link to the post webinar Sexual Harassment Self-Efficacy Scale and information on the process to obtain continuing education credit. The remaining 15 minutes were used to answer questions and discuss feedback by the participants.

### **Evaluation.**

The pre webinar knowledge assessment contained four multiple-choice and three true or false questions. Six participants completed the assessment, with four questions being answered correctly by all participants and 33%-83% of participants correctly answering the remaining questions (see Appendix G). Most pretest errors were made on responses defining what constitutes sexual harassment and the role of policy and law in regulating sexual harassment.

The pre webinar assessments also included the Sexual Harassment Self-Efficacy Scale (Appendix E), which measured the participant's perceived self-efficacy in identifying, addressing, and coping with patient-to-nurse sexual harassment. The mean rating for self-efficacy was measured both pre and post webinar by asking participants to rate how confident they were in their ability to perform each of the 15 items on the scale. All 15 items showed an increase in mean confidence, with an average increase of 8.8 points, between the pre and post webinar ratings (see Appendix G). The improvement ranged from 1.8 to 15.2 points on the 0 to 100-point scale. The greatest improvement in mean efficacy was 'understanding what sexual harassment is' with a 15.2% increase, followed by 'recognizing what behaviors are considered sexual harassment' with a 14.5% increase. Other increases in mean greater than 10% included: respond effectively when a patient engages in appropriate behavior (13.1%), recognize risk factors of patient-to-nurse sexual harassment (12.1%), implementing measures to prevent

patient-to-nurse sexual harassment (11.8%), identifying coping strategies following sexual harassment (11.6%), implement effective coping (10.2%), and set boundaries when a patient is at risk for patient-to-nurse sexual harassment (10.1%). All other items had less than a 10% increase in mean efficacy but had higher ratings on the post webinar scale than the pre webinar Sexual Harassment Self-Efficacy Scale results.

Participants received a survey to evaluate the webinar, and the feedback included the participants finding the webinar to be informative, interesting, and necessary. All participants expressed their belief that this is an important topic, and it is good to have a webinar covering it. Two participants provided feedback that the webinar would be beneficial to nursing students and new nurses. Two of the participants also reported that the case study was helpful but was more applicable to nurses working in a medical-surgical setting rather than a psychiatric setting.

Logistically, the webinar followed the time schedule as planned, with only one instance of interruption related to technical issues. Overall, about half of the participants participated throughout the webinar. It was originally intended that the participants would be placed in break-out rooms for discussions; however, given the small number of participants, break-out rooms were not utilized. All participants showed understanding of the concepts covered throughout the webinar, with questions related to how concepts covered would apply to a child-adolescent psychiatric unit and the different state laws and processes between geographical locations.

## **Chapter 5**

### **Discussion**

The project goal of developing and implementing a webinar on patient-to-nurse sexual harassment with the intent of improving nurses' ability to recognize, prevent, address, and cope with patient-to-nurse sexual harassment was met. The webinar developed was effective in improving knowledge related to the identification and management of patient-to-nurse sexual harassment. The results of project implementation, including strengths and limitations, and implications for nursing research, practice, and policy will be evaluated and identified.

A literature search was completed, however the literature is limited on sexual harassment training, especially when focused on patient-to-nurse sexual harassment. An expert panel review of the webinar content validated the information included; however, the lack of evidence on the topic remains a limitation of this work. Ultimately, the search validated the content of the webinar and contributed to the development of the live webinar format and the combination of didactic instruction, discussion, and interactive activity.

Multiple (publicly available) sexual harassment policies were reviewed and compared to the requirements the EEOC set forth for sexual harassment policies. There was much variability in policies used by organizations. Policy guidance on reporting sexual harassment was often unclear or confusing, and few included information on examples of sexual harassment, statements on corrective action, and that sexual harassment will not be tolerated. This has the potential to cause confusion and a lack of guidance and support for nurses that experience sexual harassment in the workplace.

Upon completion of the webinar, the webinar content was evaluated to determine any necessary or recommended changes. To strengthen the webinar, content and activities could be

adapted to apply more specifically to the different nursing settings and roles of attendees. For example, the unfolding case study related to patient-to-nurse sexual harassment can be changed to better address the audience's experiences, knowledge, and needs.

Results of the webinar indicated that all webinar objectives were met. However, webinar attendance was low, with less than half of those registered attending. Contributing factors to low attendance may be unexpected work conflicts and differing time zones of participants. Ten participants attended the webinar, and only six completed the pre and post webinar knowledge assessment and Sexual Harassment Self-Efficacy Scales, limiting evaluation of the results.

Participants who completed the pre and post webinar knowledge assessments and Self-Efficacy Scale showed a fairly good understanding of concepts related to sexual harassment prior to the webinar, as evidenced by the pre webinar knowledge assessment (Appendix E). This allowed for greater focus on the three topics that participants answered incorrectly in the pre webinar knowledge assessment. The first of the three topics was Question 1, with participants answering that "asking a coworker on a date" is considered sexual harassment. This is not sexual harassment but has the potential to be if the date is declined and the individual continues to persistently propose a date. Second, there were diverse responses on whether or not a person without insight and judgment to understand what behaviors are inappropriate can engage in sexual harassment or be held accountable. Regardless of insight and judgment, it is still considered to be sexual harassment if the behavior makes the recipient of the behavior uncomfortable and if they perceive it as harassment. The pre webinar Sexual Harassment Self-Efficacy Scale confirmed a lack of confidence in understanding and identifying sexual harassment, with a mean efficacy of 84% confidence. These two factors had the greatest improvement in mean efficacy following completion of the webinar (14-15%).

This lack of understanding of what sexual harassment is could be correlated to the lack of sexual harassment trainings in nursing and limited definition and examples included in organizational policies. In addition, sexual harassment is often considered “part of the job” in nursing and is a common occurrence in society and the workplace, making it confusing for individuals to identify sexual harassment. Both of these questions and the initial responses on the Sexual Harassment Self-Efficacy Scale show a need for further education and improved understanding of what sexual harassment is.

The last pre webinar knowledge assessment question that resulted in inconsistencies was related to the legality of sexual harassment. Whether or not sexual harassment is against policy, the law, or both varies based on state laws. The webinar attendants were from at least five different states, contributing to the inconsistency. This indicates a need for standardization and improved policies and legislation against patient-to-nurse violence and sexual harassment.

Additionally, the pre webinar Sexual Harassment Self-Efficacy Scale indicated that nurses not only lacked an understanding of what sexual harassment by patients is but also lacked confidence in addressing sexual harassment. This is consistent with the literature, which suggests that nurses lack confidence in addressing or reporting patient-to-nurse sexual harassment because they are worried nothing will change, they will experience retaliatory behaviors, or they won't be supported in intervening (Huebner, 2008; Lee et al., 2011; MacCurtain et al., 2017).

Participants did express more confidence in using effective bystander techniques and seeking support from and providing support to others prior to the webinar. This is also consistent with the literature and an important factor to emphasize in sexual harassment trainings, as the literature identifies it as an effective intervention strategy that helps to decrease the incidence of

sexual harassment, the effects of sexual harassment, and foster a sexual harassment-free environment (Hall et al. 2018; MacCurtain et al., 2017).

Lastly, the participants' mean confidence in coping with patient-to-nurse sexual harassment pre webinar (based on the Sexual Harassment Self-Efficacy Scale) was 85.8% with an increase in mean confidence to 97.4% post webinar. This increase was surprising, as many programs and organizations devote time, money, and energy to improving mental wellness and coping in staff, so it was assumed that participants would have had practice and exposure with using coping skills in a variety of different settings. It is proposed that participants may be unfamiliar with using coping in regard to patient-to-nurse sexual harassment because of the ambiguity on what is considered sexual harassment and limited access to resources and support following sexual harassment by a patient.

### **Strengths and Limitations**

As previously discussed, limited research on the topic of patient-to-nurse sexual harassment is the main limitation of this project of developing an educational program on the topic. Patient-to-nurse sexual harassment is rarely identified and addressed, yet commonly experienced in nursing. This problem requires more research and increased attention by staff members, leadership, and employers. While there is limited research on patient-to-nurse sexual harassment, there is more research on sexual harassment in general, in the workplace, and at universities. This project was able to use information and evidence-based recommendations from these settings and apply it specifically to nursing roles in healthcare settings. A strength of this project is that the webinar is an innovative approach to addressing the issue of patient-to-nurse sexual harassment and provides needed information and strategies that are useful in training

nurses and building confidence to recognize, prevent, address, and cope with sexual harassment by patients.

Another limitation to this project was the small number of webinar participants. While there were nine attendees, only six participants completed the pre and posttest. However, the webinar piloted the content and met the learning objectives identified.

Another strength of the project was the Leadership Resource Packet, and in particular, the policy evaluation tool developed for the packet. This tool incorporates evidence-based recommendations and legal requirements that are important in a sexual harassment policy. While the tool is not validated, it is easy to use and guides nurses and their managers on identifying and advocating for strong policies and protection against sexual harassment in the workplace.

The expert panel was also a strength of this project. The participants exhibited diversity geographically, occupationally, culturally, and in experiences. This allowed for diverse feedback and perspectives. The participants all demonstrated expertise in sexual harassment prevention and included: lawyers, nurses, educators, therapists, and researchers. This diversity in experience and perspectives offered feedback and validation of the webinar content, as well as suggested important changes.

### **Implications for Practice**

This project has many implications for nursing practice and recommendations to better support nurses that experience sexual harassment from their patients. There is limited information available on patient-to-nurse sexual harassment, and more research is needed on the rates of patient-to-nurse sexual harassment, as well as the effects it has on the nurses and effective responses to reduce these events.

In regard to nursing practice, recommendations are to improve education and training for nurses on patient-to-nurse sexual harassment. This may be especially helpful when implemented early and is recommended for nursing students and new nurses in orientation to have this education. Additionally, hospital reporting systems can be streamlined and easier to use to improve reporting of patient-to-nurse sexual harassment. In turn, this can improve understanding, resources, and support for nurses and victims of sexual harassment.

From a policy perspective, this webinar and Leadership Resource Packet have the potential to encourage others to evaluate and advocate for stronger policies. With stronger sexual harassment policies, victims of sexual harassment will have better resources and support to help cope with the incident, potentially reducing the emotional, physical, and occupational consequences. It is recommended that organizational policies be evaluated and strengthened to meet recommendations set forth by the EEOC and that organizations provide a list of support resources in their sexual harassment policies.

### **Conclusion**

Patient-to-nurse sexual harassment is a common problem in nursing; however, specific prevalence is unknown. Despite being an important issue with multiple physical, emotional, and functional effects on the nurse, patients, and organizations, this problem is under-researched and often unaddressed. This two-hour long, live webinar was created using evidence-based research, content expert recommendation, and Zoom technology to educate and train nurses on how to recognize, prevent, respond to, and cope with patient-to-nurse sexual harassment. Content included what sexual harassment is, risk identification and management, prevention of sexual harassment, effective responses and bystander intervention to sexual harassment, sexual harassment policy, reporting instances, and coping strategies.

After attending the webinar, participants found an increase in mean confidence for all measurements related to recognizing, preventing, addressing, and coping with patient-to-nurse sexual harassment. Recommendations for future practice are that the webinar be modified and focused on specific nursing settings and positions. In addition, it is recommended that research on patient-to-nurse sexual harassment continues and that nurses continue to advocate for stronger policies and laws to protect them from sexual harassment by patients.

### References

- American Association of Nurse Practitioners (AANP). (2020). Membership: Be a part of the voice of the nurse practitioner. Retrieved from: <https://www.aanp.org/membership>
- American Nurses Association (ANA). (2018). ANA addresses sexual harassment as part of #EndNurseAbuse initiative. *American Nurse Today* 13(3), 42.
- American Nurses Association (ANA). (2019). Protect yourselves, protect your patients. Retrieved from: <http://www.nursingworld.org/practice-policy/work-environment/end-nurse-abuse/>
- American Psychological Association (APA). (2019). What you can do. *Sexual Abuse*. Retrieved from: <https://www.apa.org/topics/sexual-abuse/>
- American Nurses Association (ANA). (2020). Membership. Retrieved from: <https://www.nursingworld.org/membership/joinanapilot/>
- American Psychiatric Nurses Association (APNA). (2020). About the American Psychiatric Nurses Association: An introduction. Retrieved from: <https://www.apna.org/i4a/pages/index.cfm?pageid=3277>
- American Psychiatric Nurses Association (APNA). (2020). APNA leadership: Board of directors. *Get Involved*. Retrieved from: <https://www.apna.org/i4a/pages/index.cfm?pageid=3299>
- American Psychiatric Nurses Association (APNA). (2020). Membership types & dues. Retrieved from: <https://www.apna.org/m/pages.cfm?pageID=3295>
- American Psychiatric Nurses Association (APNA). (2020). Officers. *Michigan*. Retrieved from: <https://www.apna.org/i4a/pages/index.cfm?pageid=4424>

- Azar, M., Badar, L., Samaha, H., & Dee, V. (2016). Does administrative support negate the consequences of nurse abuse? *Journal of Nursing Management*, *24*, e32-e43.  
doi: 10.1111/jonm.12286
- Bainbridge, H., Perry, E., & Kulik, C. (2018). Sexual harassment training: explaining differences in Australian and U.S. approaches. *Asia Pacific Journal of Human Resources*, *56*, 124-147. doi: 10.1111/1744-7941.12169
- Bandura, A. (2006). Guide for constructing self-efficacy scales. In F.P. Editor and T.U. Editor., *Self-Efficacy Beliefs of Adolescents* (pp 307-337). Information Age of Publishing.
- Barrett v. Omaha National Bank, 726, (8<sup>th</sup> Cir. 1984).
- Bergman, M., Langhout, R., Palmieri, P., Cortina, L., & Fitzgerald, L. (2002). (Un)reasonableness of reporting: Antecedents and consequences of reporting sexual harassment. *Journal of Applied Psychology*, *87*(2), 230-242.  
doi: 10.1037//0021-9010.87.2.230
- Borkowski, J. & Rushing, A. (2019). Do the detailed federal requirements for addressing sex discrimination apply to your hospital? *Husch Blackwell*. Retrieved from:  
<https://www.healthcarelawinsights.com/2019/02/do-the-detailed-federal-requirements-for-addressing-sex-discrimination-apply-to-your-hospital/>
- Boyd, M. (2017). *Essentials of psychiatric nursing*. (1<sup>st</sup> edition). Philadelphia: Wolters Kluwer.
- Bronner, G., Peretz, C., & Ehrenfeld, M. (2003). Sexual harassment of nurses and nursing students. *Journal of Advanced Nursing* *42*(6), 637-644.

- Brown, D. (2018). How Recy Taylor's brutal rape has become a symbol of #MeToo and #TimesUp. *The Washington Post*. Retrieved from:  
<http://www.washingtonpost.com/news/retropolis/wp/2017/11/27/the-gang-rape-was-horrific-the-naacp-sent-rosa-parks-to-investigate-it/>
- Bullough, V. (1990). Nightingale, nursing, and harassment. *Journal of Nursing Scholarship*, 22(9). Retrieved from:  
<https://sigmapubs.onlinelibrary.wiley.com/doi/epdf/10.1111/j.1547-5069.1990.tb00160.x>
- Bureau of National Affairs. (1987). *Sexual harassment: Employer policies and problems*. Washington, D.C.
- Cares, A., Banyard, V., Moynihan, M., Williams, L., Potter, S., & Stapleton, G. (2015). Changing attitudes about being a bystander to violence: Translating an in-person sexual violence prevention program to a new campus. *Violence Against Women*, 21(2), 165-187. doi: 10.1177/1077801314564681
- Castner, J. (2019). Healthy environments for women in academic nursing: Addressing sexual harassment and gender discrimination. *Online Journal of Issues in Nursing*, 24. Retrieved from:<https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-24-2019/No1-Jan-2019/Healthy-Environments-for-Women.html?css=print>
- Centers for Disease Control and Prevention (CDC). (2018). Sexual violence: Definitions. Retrieved from: <https://www.cdc.gov/violenceprevention/sexualviolence/definitions.html>
- Center for Disease Control and Prevention (CDC). (2019). Violence Prevention: Sexual Violence. Retrieved from:  
<https://www.cdc.gov/violenceprevention/sexualviolence/index.html>

Cipriano, P. (2018). Stopping sexual harassment and violence against nurses. *American nurse Today*, 12(7), 28.

Civil Rights Act of 1964 § 7, 42 U.S.C. § 2000e et seq (1964).

Civil Rights Act of 1991 § 109, 42 U.S.C. § 2000e et seq (1991).

Cogin, J. & Fish, A. (2009). Sexual harassment- A touchy subject for nurses. *Journal of Health, Organization, and Management*, 23(4). 442-462. doi: 10.1108/14777260979326

Dan, A., Pinsof, D., & Riggs, L. (1995). Sexual harassment as an occupational hazard in nursing. *Basic and Applied Social Psychology*, 17(4). 563-580.

doi: 10.1207/s15324834basp1704\_8

Darjee, R., Russel, K., Forrest, L., Milton, E., Savoie, V., Baron, E., Kirkland, J., & Stobie, S. (2016). *Risk for sexual violence protocol (RSVP): A real world study of the reliability, validity and utility of a structured professional judgement instrument in the assessment and management of sexual offenders in South East Scotland*. Retrieved from:

[https://www.rma.scot/wp-content/uploads/2018/04/Risk\\_for\\_Sexual\\_Violence\\_Protocol\\_-\\_RSVP.pdf](https://www.rma.scot/wp-content/uploads/2018/04/Risk_for_Sexual_Violence_Protocol_-_RSVP.pdf)

Draucker, C. (2019). Responses of nurses and other healthcare workers to sexual harassment in the workplace. *The Online Journal of Issues in Nursing*, 24(1).

doi: 10.3912/OJIN.Vol24No01Man03

Edroso, R. (2018). In #MeToo era, tighten up sexual harassment training and policies to avoid big settlements. *Post-Acute Advisor*. Retrieved from:

<https://postacuteadvisor.blr.com/2018/09/01/in-metoo-era-tighten-up-sexual-harassment-training-and-policies-to-avoid-big-settlements/>

Education Amendments Act of 1972 § 9, 20 U.S.C. § 1681-1688 et seq (1972).

EEOC. (1990). Policy guidance on employer liability under title VII for sexual favoritism.

Retrieved from: <https://www.eeoc.gov/laws/guidance/policy-guidance-employer-liability-under-title-vii-sexual-favoritism>

EEOC. (1997). Facts about sexual harassment. *Publications*.

Retrieved from: <https://www.eeoc.gov/publications/facts-about-sexual-harassment>

Fiedler, A., & Hamby, E. (2000). Sexual harassment in the workplace: nurses' perceptions.

*Journal of Nursing Administration, 10*, 497-503.

Finnis, S., Robbins, I., & Bender, M. (1993). A pilot study of the prevalence and psychological sequelae of sexual harassment of nursing staff. *Journal of Clinical Nursing, 2*, 23-27.

Fitzgerald, L. (1993). Sexual harassment violence against women in the workplace. *American Psychologist, 48*(10), 1070-1076.

Fitzgerald, L., Drasgow, F., Hulin, C., Gelfand, M., & Magley, V. (1997). Antecedents and consequences of sexual harassment in organizations: A test of integrated model. *Journal of Applied Psychology, 82*, 578-589.

Garcia, C., Lechner, K., Frerich, E., Lust, K., & Eisenberg, M. (2012). Preventing sexual violence instead of just responding to it: Students' perceptions of sexual violence resources on campus. *Journal of Forensic Nursing 8*, 61-71.

doi: 10.1111/j.1939-3938.2011.01130.x

- Glomb, T., Richman, W., Hulin, C., Drasgow, F., & Schneider, K. (1997). Ambient sexual harassment: An integrated model of antecedents and consequences. *Organizational Behavior and Human Decision Processes*, 71(3), 309-328. Retrieved from: [https://www.researchgate.net/profile/Fritz\\_Drasgow/publication/4819556\\_Ambient\\_Sexual\\_Harassment\\_An\\_Integrated\\_Model\\_of\\_Antecedents\\_and\\_Consequences/links/545bb1310cf249070a7a7b30.pdf](https://www.researchgate.net/profile/Fritz_Drasgow/publication/4819556_Ambient_Sexual_Harassment_An_Integrated_Model_of_Antecedents_and_Consequences/links/545bb1310cf249070a7a7b30.pdf)
- Graham, I., Logan, J., Harrison, M., Straus, S., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *The Journal of Continuing Education in the Health Professions*, 26(1), 13-24. Doi: 10.1002/chp.47
- Grieco, A. (1987). Scope and nature of sexual harassment in nursing. *The Journal of Sex Research*, 2, 261-266. doi: 10.1080/00224498709551362
- Hall, N., Klein, V., Betts, K., & DeRanieri, J. (2018). Speaking up: fostering “silence breaking” through leadership. *Nurse Management*, 51-53. doi: 10.1097/01.NJMA.000053377422167.12
- Hart, D., Douglas, K., & Guy, L. (2016). *The structured professional judgment approach to violence risk assessment: Origins, nature, and advances*. Retrieved from: [https://www.researchgate.net/profile/Stephen-Hart-3/publication/318437145\\_The\\_structured\\_professional\\_judgment\\_approach\\_to\\_violence\\_risk\\_assessment\\_Origins\\_nature\\_and\\_advances/links/59de56c5aca27247d79431f3/The-structured-professional-judgment-approach-to-violence-risk-assessment-Origins-nature-and-advances.pdf](https://www.researchgate.net/profile/Stephen-Hart-3/publication/318437145_The_structured_professional_judgment_approach_to_violence_risk_assessment_Origins_nature_and_advances/links/59de56c5aca27247d79431f3/The-structured-professional-judgment-approach-to-violence-risk-assessment-Origins-nature-and-advances.pdf)
- Hellebrand, A. (2018). No fear: Be productive to end workplace violence and bullying. *Nephrology Nursing Journal*, 15(1), 11,85.

- Hibino, Y., Hitomi, Y., Kambayashi, Y., & Nakamura, H. (2009). Exploring factors associated with the incidence of sexual harassment of hospital nurses by patients. *Journal of Nursing Scholarship, 41*, 124-131. doi: 10.1111/j.1546-5069.2009.01244.x
- Hibino, Y., Ogino, K., Inagaki, M. (2006). Sexual harassment of female nurses by patients in Japan. *Journal of Nursing Scholarship, 38*(4). 400-405.
- Hoeve, Y., Kunnen, S., Brouwer, J., & Roodbol, P. (2018). The voice of nurses: Novice nurses' first experiences in a clinical setting. A longitudinal diary study. *Journal of Clinical Nursing, 27*, e1612-e1626. doi: 10.1111/jocn.14307
- Huebner, L. (2008). It is part of the job: Waitresses and nurses define sexual harassment. *Sociological Viewpoints, 24*, 75-90.
- ILO, ICN, WHO, PSI (2003). Workplace violence in the health sector country case studies research instruments. *World Health Organization*. Retrieved from: <https://www.who.int/publications/m/item/workplace-violence-in-the-health-sector---country-case-study-research-instruments---survey-questionnaire>
- Jacobwitz, W. (2013). PTSD in psychiatric nurses and other mental health providers: A review of the literature. *Issues in Mental Health Nursing, 34*(11), 787-795.  
doi: 10.3109/0162840.2013.824053
- The Joint Commission. (2018, April 16). Sentinel Event Alert 59: Physical and verbal violence against health care workers. Retrieved from: [https://www.jointcommission.org/sea\\_issue\\_59/](https://www.jointcommission.org/sea_issue_59/)
- Knapp, D., Faley, R., Ekeberg, S., Dubois, C. (1997). Determinants of target responses to sexual harassment: A conceptual framework. *The Academy of Management Review, 22*(3), 687-729.

- Lee, S., Song, J., & Kim, S. (2011). Experience and perception of sexual harassment during the clinical practice of Korean nursing students. *Asian Nursing Research*, 5, 170-176.  
doi: 10.1016/j.anr.2011.09.003
- Long, D. (2015). Addressing sexual violence through preventative nursing practice. *Nursing for Women's Health*, 18(6), 477-484.
- Lux, K., Hutchenson, J., & Peden, A. (2014). Ending disruptive behavior: Staff nurse recommendations to nurse educators. *Nurse Education in Practice*, 14, 37-42.  
doi: 10.1016/j.nepr.2013.06.014
- MacCurtain, S., Murphy, C., O'Sullivan, M., MacMahon, J., & Turner, T. (2017). To stand back or step in? Exploring the responses of employees who observe workplace bullying. *Nursing Inquiry*, 25, 1-10. doi: 10.1111/nin.12207
- Magnavita, N., & Heponiemi, T. (2011). Workplace violence against nursing students and nurses: An Italian experience. *The Journal of Nursing Scholarship*, 43(2), 203-210.  
doi: 10.1111/j.1547-5069.2011.01392.x
- Mantzouranis, G., Fafliora, E., Bampalis, V., & Cristopoulou, I. (2014). Assessment and analysis of workplace violence in a Greek tertiary hospital. *Archives of Environmental & Occupational Health*, 70(5), 256-264. doi: 10.1080/19338244.2013.879564
- McNamara, S. (2012). Incivility in nursing: unsafe nurse, unsafe patients. *AORN*, 95(4), 535-540. doi:10.1016/j.aorn.2012.01.020
- Meritor Savings Bank v. Vinson, 477 U.S. 57, 106 S.Ct. 2399, (1986).
- Me Too. (2019). *You are not alone*. Retrieved from: <http://www.metoomvmt.org>

- Najafi, F., Fallahi-Khoshknab, M., Ahmadi, F., Dalvandi, A., & Rahgozar, M. (2017). Antecedents and consequences of workplace violence against nurses: A qualitative study. *Journal of Clinical Nursing, 27*, 116-128. doi:10.1111/jocn.13884
- National Academies of Sciences, Engineering, and Medicine (NASEM). (2018). *Sexual harassment of women: Climate, culture, and consequences in academic sciences, engineering, and medicine*. Washington D.C.: National Academies Press
- National League of Nursing (NLN). (2020). Individual. *Membership*. Retrieved from: <http://www.nln.org/membership/categories-and-benefits/individual>
- Nelson, R. (2018). Sexual harassment in nursing: A long standing, but rarely studied problem. *American Journal of Nursing, 118*(5), 19-20.
- Nielsen, M., Kjaer, S., Aldrich, P., Madsen, I., Friberg, M., Rugulles, R., & Folker, A. (2017). Sexual harassment in care work- Dilemmas and consequences: A qualitative investigation. *International Journal of Nursing Studies, 70*, 122-130. doi: 10.1016/ijnurstu.2017.02.018
- Nightingale, F. (1860). *Notes on nursing: What is it, and what it is not*. London: Harrison.
- NSVRC. (2004). Global perspectives on sexual violence: Findings from the world report on violence and health. *National Sexual Violence Resource Center*. Retrieved from: [https://www.nsvrc.org/sites/default/files/Publications\\_NSVRC\\_Booklets\\_Global-perspectives-on-sexual-violence.pdf](https://www.nsvrc.org/sites/default/files/Publications_NSVRC_Booklets_Global-perspectives-on-sexual-violence.pdf)
- NSVRC. (2010). The impact of sexual violence: Fact sheet. *National Sexual Violence Resource Center*. Retrieved from: [https://www.nsvrc.org/sites/default/files/2012-03/Publications\\_NSVRC\\_Factsheet\\_Impact-of-sexual-violence\\_0.pdf](https://www.nsvrc.org/sites/default/files/2012-03/Publications_NSVRC_Factsheet_Impact-of-sexual-violence_0.pdf)

NSVRC. (2011). Assessing patients for sexual violence: A guide for health care providers.

*National Sexual Violence Resource Center*. Retrieved from:

<https://www.nsvrc.org/publications/assessing-patients-sexual-violence-guide-health-care-providers>

NSVRC. (2014). Prevention tips for medical professionals. *National Sexual Violence Resource*

*Center*. Retrieved from: [https://www.nsvrc.org/sites/default/files/saam\\_2014\\_prevention-tips-for-medical-professionals\\_0.pdf](https://www.nsvrc.org/sites/default/files/saam_2014_prevention-tips-for-medical-professionals_0.pdf)

OSHA. (2015). Understanding the challenge. *Workplace Violence in Healthcare*. Retrieved

from: <https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:3da2cb5d-2d9d-47af-a782-c9ccb944ee52#pageNum=1>

Papa, A., & Venella, J. (2013). Workplace violence in healthcare: Strategies for

advocacy. *The Online Journal of Issues in Nursing*, 18(1), 1.

doi:10.3912/OJIN.Vol18No01Man05

Park, M., Cho, S., & Hong, H. (2014). Prevalence and perpetrators of workplace violence by

nursing unit and the relationship between violence and the perceived work environment.

*Journal of Nursing Scholarship*, 47(1), 87-95. doi: 10.1111/jnu.1212

Peek-Asa, C., Howard, J., Vargas, L., Kraus, J. (1997). Incidence of non-fatal workplace assault

injuries determined from employer's reports in California. *Journal of Occupational &*

*Environmental Medicine*, 39(1), 44-50. doi: 10.1097/00043764-199701000-00009

Pilgrim, M., & Keyon, J. (2009). Evaluation of sexual harassment training instructional

strategies. *NASPA Journal About Women in Higher Education*, 2(1), 224-242. doi:

10.2202/1940-7890.1032

- Potter, S., & Moynihan, M. (2011). Bringing in the bystander in-person prevention program to a U.S. military installation: Results from a pilot study. *Military Medicine*, 176, 870-875.
- Robinson, R., Franklin, M., & Fink, R. (1993). Sexual harassment at work: Issues and answers for healthcare administrators. *Hospital & Health Services Administration*, 38(2), 167-180.
- Roehling, M., & Huang, J. (2017). Sexual harassment training effectiveness: An interdisciplinary review and call for research. *Journal of Organizational Behavior*, 39, 134-150.  
doi: 10.1002/job.2257
- Segrave, K. (1994). *Sexual harassment of women in the workplace, 1600 to 1993*. Jefferson: McFarland & Company, Inc.
- Spector, P., Zhou, Z., & Che, X. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, 51, 72-84. doi:10.1016/ijnurstu.2013.01.010
- Speroni, K., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. (2014). Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *Journal of Emergency Nursing*, 40(3), 218-228. Retrieved from:  
<https://www.clinicalkey.com/nursing/#!/content/playContent/1-s2.0-S009917671300216X?returnurl=null&referrer=null>
- Strauss, S. (2019). Overview and summary: Sexual harassment in healthcare. *Online Journal of Issues in Nursing*, 24(1), 1-7. doi: 10.3912/OJIN.Vol24No01ManOS
- Times Up. (2019). *Safe, fair, and dignified work for women of all kinds*. About. Retrieved from:  
<http://www.timesupnow.org/about/>
- Violence Against Women Act of 1994 § 42 U.S.C. § 13701 et seq (1994).

- von Gruenigen, V., & Karlan, B. (2018). Sexual harassment in the workplace: Its impact on gynecologic oncology and women's health. *Gynecologic Oncology*, *149*(2), 227-229. doi: 10.1016/j.ygyno.2018.02.018
- Ward-Smith, P. (2018). The impact of 'Me Too' on nurses. *Urological Nursing*, *38*(3), 111, 128. doi: 10.7257/1053-816X.2018.38.3.111
- Wendt, A., & Slonaker, W. (2002). Sexual harassment and retaliation: A double-edged sword. *S.A.M. Advanced Management Journal*, *67*(4), 49-57. Retrieved from: <https://search.proquest.com/docview/231236998/abstract/3434AADD012A44EDPQ/1?accountid=27927>
- Wiskow, C. (2003). Guidelines on workplace violence in the health sector. *World Health Organization*. Retrieved from: [https://www.who.int/violence\\_injury\\_prevention/violence/interpersonal/en/WV\\_ComparisonGuidelines.pdf](https://www.who.int/violence_injury_prevention/violence/interpersonal/en/WV_ComparisonGuidelines.pdf)
- Yale University. (n.d.). *Yale Sexual Misconduct Training* [virtual training]. Retrieved from: <https://smr-training.yale.edu/>
- Yang, B., Stone, T., Petrini, M., & Morris, D. (2018). Incidence, type, and related factors, and effect of workplace violence in mental health nurses: A cross-sectional survey. *Archives of Psychiatric Nursing*, *32*, 31-38. doi:10.1016/j.apnu.2017.09.013
- York, K., & Brookhouse, K. (1988). The legal history of work-related sexual harassment and implications for employers. *Employee Responsibilities and Rights Journal*, *1*(3), 227-237.

### **Appendix A: Glossary of Terms**

**Physical Violence:** direct physical contact with another individual in attempts to cause physical harm, fear, or emotional distress; and includes actions such as: hitting, slapping, kicking, pinching, pushing, burning, strangling, punching, stabbing, or shooting.

**Sexual Harassment:** as defined by the Centers for Disease Control and Prevention (CDC), is “any completed or attempted forced or unwanted penetration...unwanted sexual contact, or noncontact, unwanted sexual experiences” (CDC, 2018). Examples of this include touching of the groin, buttocks, breast, arm, back, or thigh; unwanted exposure to pornography; or any unwanted sexual comments or remarks about one’s appearance.

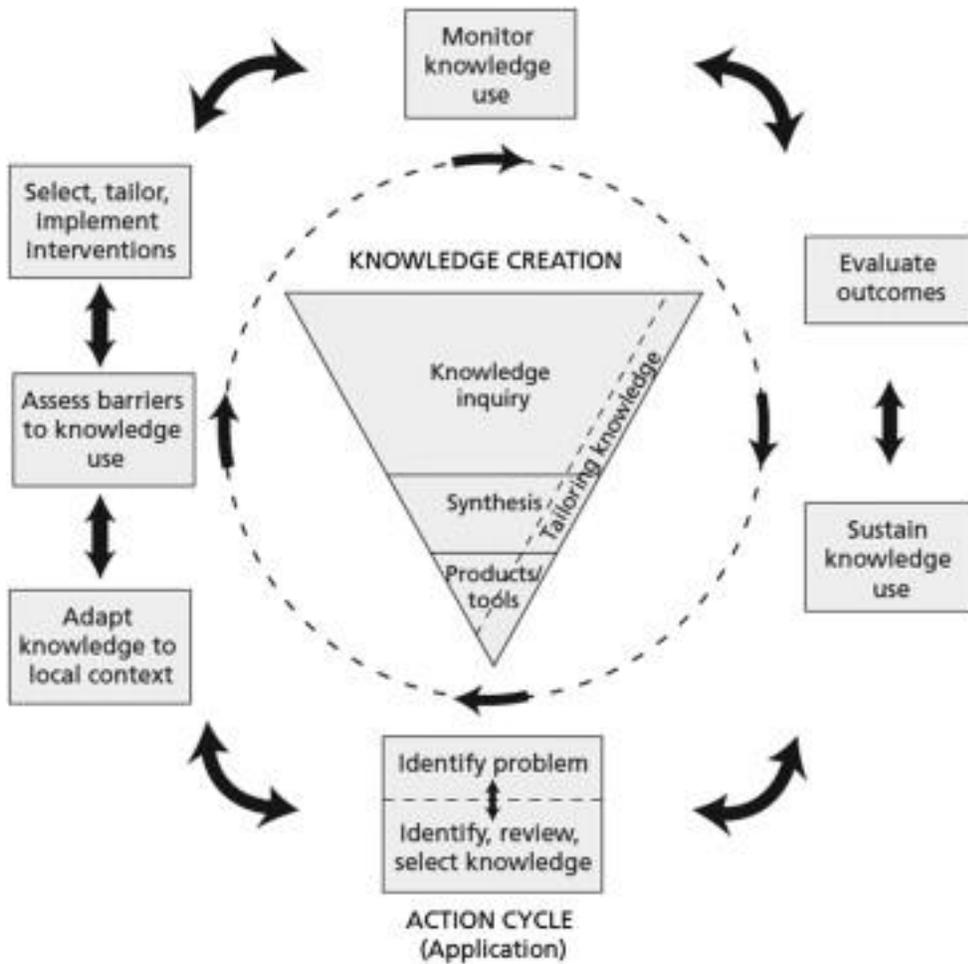
**Sexual Assault:** any form of nonconsenting sexual activity. This may include inappropriate touching, use of objects, or rape (Boyd, 2017).

**Verbal Assault:** often occurs out of anger or fear and is when an individual uses words to criticize, insult, degrade, or defame another person in attempt to humiliate or threaten them.

**Violence:** The World Health Organization (WHO) defines violence as “the intentional use of physical force or power, threatened or actual...that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (2018).

Appendix B: Frameworks

Figure I: Knowledge-to-Action Framework



(Graham et al., 2006)

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**Figure II:**  
 Determinants of Target Responses to Sexual Harassment Figures

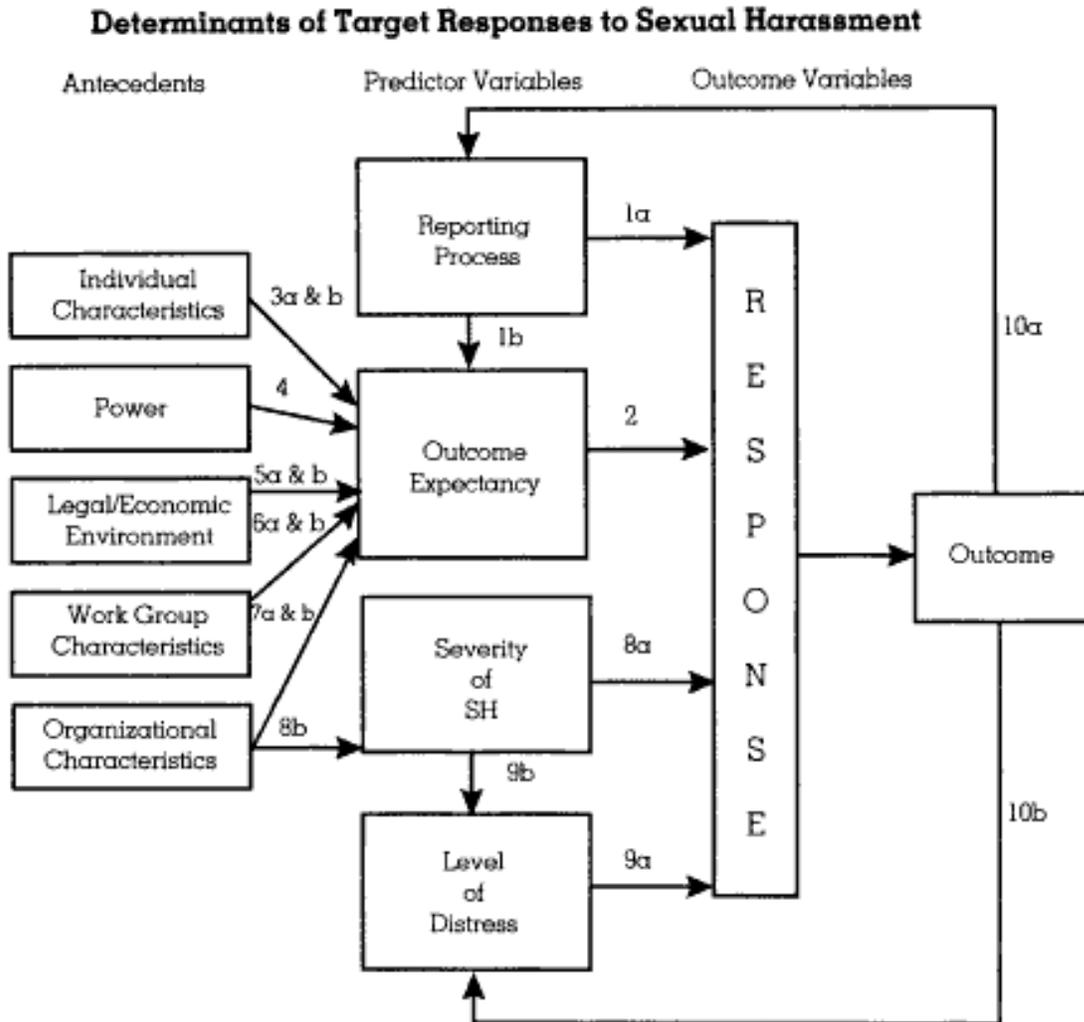
**Typology of Target Responses to Sexual Harassment**

		Mode of Response	
		Self-Response	Supported Response
Focus of Response	Self-Focus	Avoidance/Denial	Social Coping
	Initiator Focus	Confrontation/ Negotiation	Advocacy Seeking

(Knapp et al., 1997)

**\*Permission granted for use and reprinting of figure by the Academy of Management**

Figure III:



(Knapp et al., 1997)

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**Appendix C: Tables**

**Table 1: Literature Search Terms**

Concept 1	Concept 2	Concept 3	Concept 4
Nurse	Guidelines	Patient	Sexual Harassment
RN	Law	Client	Sexual Violence
Registered Nurse	Policy	Inpatient	Sexual Offense
Healthcare Worker	Training	Psychiatric Patient	Sexual Abuse
Healthcare Staff	Protocol	Case	Sexual Misconduct
Healthcare Provider	Jurisprudence		
Healthcare Personal	Clinical Policy		

**Table 2: Literature Search Inclusion Criteria**

Identification 	Initial literature search using literature search terms in Table 1: n= 7197			Initial literature search using “Patient-to-nurse sexual harassment”: N= 5,295	
	Total sources identified: n= 12, 492				
Screening 	Removal of duplicate articles: n= 7,937			Additional recommended sources through review of citations and by referral: n= 14	
	Total sources after screening: n= 7,951				
Eligibility 	Limited to full text n= 7,038	Limited to academic journal publications n= 5, 827	Limited to written in English n= 5,771	Limit to published between 2010-2019 n= 3,195	Limit to articles relevant to project objectives n=46
	Total articles eligible: n= 46				
Sources Included	Final number of studies included in literature review: n= 45				

**Appendix D: Sexual Harassment in the Workplace Timeline**

<b>Year</b>	<b>Event</b>	<b>Description/ Significance</b>
1734	Workers Protest	Female house servants protest to ask for rights against being beaten by Master of the house that they are employed by.
1760-1840	Industrial Revolution	Immigrant factory workers are often sexually harassed by the floorman and managers.
1853-1856	Crimean War	Women working as nurses were harassed by physicians, surgeons, and drunken military noncommissioned officers.
1946	Committee for Equal Justice for Recy Taylor is formed	Created by Rosa Parks and Recy Taylor to increase awareness of sexual harassment following the kidnapping and rape of Recy Taylor while leaving church.
1960s	Formation of Rape Centers	Centers that do postsexual assault assessment and provides support and treatment.
	Formation of Bay Area Women Against Rape	Advocacy group in California to increase awareness of rape.
1964	Title VII of Civil Rights Act of 1964 Passed	Defined sexual harassment and made sexual harassment actionable, and therefore illegal.
1972	Equal Employment Opportunity Act Passed	Made discrimination in the workplace based on race, color, religion, gender, or national origin a federal offense.
	Title IX Passed	Prohibited discrimination against an individual based on gender or race for academic activities and sports in institutional facilities receiving federal funding
1976	Williams v. Saxbe	Recognized quid pro quo sexual harassment as a form of gender-based discrimination.
1979	Kyriazi v. Western Electric Co.	Western Electric was found guilty of denying women employment opportunities, promotions, benefits, pay raises, and trainings based on their gender; as well as allowing sexual harassment against women and firing (Kyriazi) when it was reported.
1980	Alexander v. Yale	First case that used Title IX to support female students who reported sex discrimination by Yale University. While the women did not win the suit, it did result in Yale University creating a grievance procedure and guidelines on reporting sexual harassment and discrimination.
1981	Rogers v. L'enfant Plaza Hotel	Rogers sued employer for \$500,000 in compensatory and punitive damages for intentional infliction of emotional distress related to sexual harassment in the workplace.

1983	Cummings v. Walsh Construction Co.	Mary Cummings filed a complaint against Walsh Construction Co. for sexual harassment and wrongful termination based on the EEOC.
	Phillips v. Smalley Maintenance Services, Inc.	Phillips sued Smalley Maintenance Services, Inc. based on Title VII of the Civil Rights Act of 1964 after wrongful termination related to her refusal to engage in sexual activities with Smalley.
1984	Barrett v. Omaha National Bank	Ruled that when sexual harassment has occurred, organization automatically incurs legal obligation to investigate the situation. Investigation must be unbiased and documented.
	Lucas v. Brown and Root, Inc.	Beverly Lucas won a case against Brown and Root, Inc. after unlawful termination based on her refusal to have sex with her foreman. This decision was upheld by Title VII of the Civil Rights Act of 1964.
	Meritor Savings Bank v. Vinson	Ruled sexual harassment as violation of Title VII of the Civil Rights Act of 1964 and redefined the standards for analyzing sexual harassment in the workplace. This is the first court case that made sexual harassment illegal discrimination.
1987	Bureau of National Affairs releases guidelines on what to include in sexual harassment policy	Guidelines for what should be included in a sexual harassment policy are as follows <ol style="list-style-type: none"> <li>1. statement that it will not be tolerated</li> <li>2. definition of sexual harassment</li> <li>3. examples of sexual harassment</li> <li>4. choice for how to file complaint</li> <li>5. information on how organization will handle it</li> <li>6. statement on corrective action</li> </ol> Also, discusses how steps should be taken to restore victim's self-esteem, credibility, and privileges at work.
1991	Robinson v. Jacksonville Shipyard	Jacksonville Shipyard was sued for allowing the display of pornographic pictures in the workplace.
	Ellison v. Brady	Defined the Reasonable Worker Standard which stated that sexual harassment is more than flirtation and fun, and that victims of sexual harassment are not being overly sensitive or histrionic in nature, and therefore have a right to report instances of sexual harassment.
	Civil Rights Act of 1991	Allowed the right to sue for compensatory and punitive damages such related to sexual harassment. Compensation may be anywhere from \$50,000 to \$300,000.
1992	U.S. v. Lanier	The U.S. judge was convicted for sexually harassing 5 women during job interviews.
	Franklin v. Gwinnett	Ruled that students who are subject to sexual harassment in the school can receive monetary compensation for damages

	Country School District	based on Title IX after a high school student sued the school for sexual harassment by her teacher and coach.
	EEOC releases guidelines based on Discrimination because of gender	Provided further guidance on how Title VII can be applied in instances of gender discrimination in the workplace.
	Recrimination of Oregon Senator Bob Packwood	Women came forward reporting Senator Bob Packwood for sexual harassment. He had formerly been accused of such in the 1970s; however, this was written off as a political attack from his opponents and therefore not true. However, when the women came forward in the 1990s, it shed further light on the sexual misconduct by Senator Packwood and discussion of sexual harassment in politics.
	Navy Tailhook Trial	100 Navy and Marine Corps officers sexually assaulted over 80 men and women. They also sent misogynistic messages and wore t-shirts that identified women as property. This led to the dismissal of many military officers and called for a culture change in the military that respected and protected women.
	ANA National Conference	The American Nurses Association releases a resolution to denounce sexual harassment in the workplace and recommends health care institutions implement policies and guidelines to prohibit and decrease sexual harassment.
1994	Violence Against Women Act	Provides funding for women who have experienced violence and provides resources to end domestic and dating violence, as well as sexual assault and stalking, especially against minority women. In addition, it allows women to press federal charges against perpetrators of violence.
1996	Johnson v. Community Nursing Services	Community Nursing Services were sued for violating Title VII of Civil Rights Act of 1964 related to same gender sexual harassment in the workplace.
1998	Steele v. Superior Home Health Care of Chattanooga	A psychiatric nurse was rewarded \$850,000 from Superior Home Health Care of Chattanooga for instances of sexual harassment in the workplace.
2017	#MeToo founded	Movement to increase advocacy on sexual harassment prevention and provide resources for victims of sexual violence.
	#EndNurseAbuse founded	Movement to improve protection of nurses from violence by patients.

2018	#TimesUp founded	Movement formed in response to Harvey Weinstein allegations that advocates for sexual harassment-free working environments.
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### Appendix E: Measurement Tools

#### Tool 1:

#### Knowledge Assessment (pre webinar)

1. Which of the following actions demonstrate sexual harassment? (select all that apply)
  - a. Asking a coworker out on a date
  - b. Posting posters or pictures in the office that are sexual or pornographic
  - c. Calling a coworker “honey,” “dear,” or other terms of endearment
  - d. Repeated and unwanted comments about a person’s appearance, gender, or that are sexual in nature
  
2. Sexual harassment can occur to: (select all that apply)
  - a. A male by a male
  - b. A male by a female
  - c. A female by a male
  - d. A female by a female
  
3. Which of the following is true about patient-to-nurse sexual harassment?
  - a. If the patient has altered mental status or is unaware of their actions, it isn’t considered sexual harassment.
  - b. If the person engaging in sexual behaviors didn’t mean to be offensive, but the victim still perceives it as sexual harassment, it is considered sexual harassment.
  - c. The impact of patient-to-nurse sexual harassment via verbal comments is very minimal since no physical contact was involved.
  - d. There is no way to prevent or avoid patient-to-nurse sexual harassment.

#### True/False

- |  |   |   |
|--|---|---|
| 4. If the person consented, it can’t be sexual harassment. | T | F |
| 5. Sexual harassment only occurs when there is attraction. | T | F |
| 6. Sexual harassment is against policy but not the law.    | T | F |
| 7. Sexual harassment complaints are generally unjustified. | T | F |



**Tool 3: Expert Panel Survey**

Content	Relevance - Is the category relevant to include?		Importance - Is the category important to include?		Suggestions
	Yes	No	High	Low	
<b>Part 1: Introduction</b>					
Introduction of myself, and possibly others (depending on # of attendees)					
Disclaimer on the sensitivity of the topic					
Establishing Rules for the webinar <ul style="list-style-type: none"> <li>- Respect</li> <li>- How to use Zoom</li> <li>- Breakout Sessions</li> </ul>					
Review of Self-Awareness questions (participants will receive this and will complete prior to attending the webinar)					
Definition of sexual harassment <ul style="list-style-type: none"> <li>- EEOC definition                             <ul style="list-style-type: none"> <li>o Quid Pro Quo</li> <li>o Hostile Environment</li> </ul> </li> <li>- Layman’s/Public Definitions</li> </ul>					
Examples of sexual harassment					
Key terms for discussing sexual harassment					
<b>Part 2: Patient-to-Nurse Sexual Harassment</b>					
<i>Discussion:</i> Experiences participants have had related to patient-to-nurse sexual harassment (if comfortable sharing)					
Explanation of Risk Factors to Patient-to-Nurse Sexual Harassment <ul style="list-style-type: none"> <li>- Patient-Related</li> <li>- Nurse-Related</li> <li>- Organization-Related</li> <li>- Management/Leadership-Related</li> <li>- Geographical/Culturally Related</li> </ul>					
<i>Discussion:</i> What is the degree of accountability/responsibility for patients with altered mental status or impaired insight/judgment					
Explanation of common effects of patient-to- nurse sexual harassment <ul style="list-style-type: none"> <li>- Patient-related effects</li> <li>- Nurse-related effects</li> <li>- Healthcare organization-related effects</li> </ul>					
<b>Part 3: Prevention and Addressing Sexual Harassment</b>					

<p>Explanation of common responses to sexual harassment</p> <ul style="list-style-type: none"> <li>- By the nurse</li> <li>- By management/leadership</li> <li>- By bystanders</li> </ul>					
<p><i>Explanation/Discussion:</i> Appropriate responses and interventions to patient-to-nurse sexual harassment as recommended by evidence-based practices</p> <ul style="list-style-type: none"> <li>- By the nurse</li> <li>- By a coworker/peer</li> <li>- By management/leadership</li> <li>- By the organization</li> <li>- Miscellaneous interventions                             <ul style="list-style-type: none"> <li>o Policy</li> <li>o Security</li> <li>o Environment</li> </ul> </li> </ul>					
<p><i>Activity:</i> Discerning sexually inappropriate behaviors (This activity will involve showing a series of images/videos of interactions in different settings to help participants discern if body language, verbal communication, and interactions are sexually inappropriate or nonthreatening compliments.)</p>					
<p><i>Activity:</i> Unfolding case study (This interactive case study will run through the day of a nurse who is caring for a sexually inappropriate patient, starting with the patient being overly friendly and then escalating their sexually inappropriate behaviors. The case study will go through patient education, nurse response, bystander intervention, and managerial response.)</p>					
<p><i>Demonstration/Roleplay:</i> Appropriate Responses to Patient-to-Nurse Sexual Harassment</p> <ul style="list-style-type: none"> <li>- Scenarios for the nurse</li> <li>- Scenarios for the coworker/peers</li> <li>- Scenarios for the manager/nursing leadership</li> </ul>					
<p><i>Activity:</i> Policy evaluation (Staff can bring in their organizations’ sexual harassment policy. Other policies will also be provided. They will be broken into groups to evaluate the policy and determine if it meets the recommended criteria for what to include in a sexual harassment policy. They will also discuss</p>					

if and what changes should be made to make the policy more effective.)					
<i>Debrief</i> (During this time, we will debrief on Part 3 of the webinar as a group. This will include discussing participants’ comfort with different interventions, as well as identifying coping skills and discussing the importance of support, self-care, and resilience.)					
<b>Part 4: Reporting Patient-to-Nurse Sexual Harassment</b>					
Share current statistics on reporting patient-to-nurse sexual harassment					
Share/Discuss barriers to reporting					
Share techniques to improve reporting - Macrosystem-level interventions - Mesosystem-level interventions - Microsystem-level interventions					
<i>Discuss:</i> Why reporting patient-to-nurse sexual harassment is important					
<b>Part 5: Conclusion and Summary</b>					
<i>Review:</i> What sexual harassment is					
<i>Review:</i> Why sexual harassment should not be tolerated					
<i>Review:</i> Summary of appropriate responses and considerations of patient-to-nurse sexual harassment					
<i>Review:</i> Barriers to responding					
<i>Review:</i> Barriers to reporting					
<i>Review:</i> Self-care strategies to reduce effects of patient-to-nurse sexual harassment					
Time for participants to ask questions and/or share feedback/comments					
<b>Resource Packet</b>					
Resources on policy criteria and evaluation resources					
Resources on how to create an environment with zero-tolerance for sexual harassment					
Resources on how to best support staff and help them cope					
Referral resources for staff members exposed to sexual harassment by a patient					

**Appendix F: Leadership Resource Packet**

# Leadership Resource Packet:

How Leadership can Prevent and  
Address Sexual Harassment

## Part 1: Sexual Harassment Policy

Having a strong sexual harassment policy is very important. It provides clarification, guidance, and support to anyone experiencing sexual harassment and to leaders that support others. Sexual harassment policies can be used as an educational tool for patients engaging in inappropriate sexual behaviors and can help a manager or nurse leader support their staff, set boundaries, and encourage appropriate conduct by the patient. Without a strong sexual harassment policy, the manager or leader has limited support in guiding their staff and discouraging harmful behaviors by the patient.

According to the U.S. Equal Employment Opportunity Commission (n.d.), a sexual harassment policy should contain the following information:

- A statement that harassment is illegal and intolerable
- Definitions and examples of sexual harassment
- Steps for reporting the harassment. It should also include options for reporting harassment outside of the reporter's chain of command if someone in that chain is involved in the incident
- Ensure confidentiality
- Prohibit retaliation
- A description of the responsibilities of leadership and Human Resources (HR) in responding to the report
- Information on the process of investigation, possibly including a timeframe
- State that proper and effective corrective or preventative actions will be enforced if necessary
- Consequences of violating the policy
- Whether or not the individual who filed the complaint will be notified of the status of their case, and if so, how they will be notified

As a manager or leader, it is important to evaluate your institution's sexual harassment policy to ensure that it contains all the recommended information. This will help to protect the manager, staff, and organization against any legal consequences of sexual harassment in the workplace. It is also recommended that if a manager or leader does not feel that their sexual harassment policy meets recommended criteria or is inclusive enough, that they take action to amend the policy. This is usually done by reaching out to the HR department or the author of the policy and recommending the needed changes or inquiring on the amendment process.

The next page has a checklist to aid in evaluating your organization's sexual harassment policy.

*Reference:* EEOC. (n.d.) Harassment policy tips. *In U.S. Equal Employment Opportunity Commission Small Business Resource Center.* Retrieved December 28, 2020 from <https://www.eeoc.gov/employers/small-business/harassment-policy-tips>

**Sexual Harassment Policy Evaluation Checklist**

<b>Requirement</b>	<b>Is it in the policy?</b>	<b>Is it written in a way that is clear and easy to understand?</b>	<b>Additional thoughts or recommendations on how to strengthen this requirement?</b>
Statement that sexual harassment is illegal and not tolerated			
Definition of sexual harassment with examples			
Steps for reporting the harassment			
Is there more than one option listed for reporting?			
Statement ensuring confidentiality			
Statement prohibiting retaliation			
Responsibilities of HR and/or the leader/manager			
Process of the investigation			
Timeframe of the investigation			
Statement about corrective or preventative action			
Consequence for violating the policy			
Notification process for updates to the case			

Is there any additional information to add to this policy that is beneficial to preventing and addressing patient-to-nurse sexual harassment?

What information can be added to strengthen your organizations' sexual harassment policy?

# Part 2: How to Support Victims of Sexual Harassment

Everyone responds to sexual harassment differently and can be affected in many different ways and with varying severity. As a manager, it is important to recognize the emotional, physical, cognitive, or social effects that exposure to sexual harassment by a patient may have on your staff. Not only can these effects impact the health and well-being of the nurse or staff member, but they can also impact the health and safety of the working environment, patient care, and the organizations reputation. According to research\*, environments that have supportive leadership tend to have fewer instances and effects of sexual harassment and have staff that feel more comfortable in reporting and coping with exposure to sexual harassment.

The next page has a list of suggestions and referrals to guide you in providing the support your staff members need to cope with exposure to sexual harassment by patients effectively

\*References:

- Cogin, J. & Fish, A. (2009). Sexual harassment- A touchy subject for nurses. *Journal of Health, Organization, and Management*, 23(4). 442-462.  
doi: 10.1108/14777260979326
- Hall, N., Klein, V., Betts, K., & DeRanieri, J. (2018). Speaking up: fostering "silence breaking" through leadership. *Nurse Management*, 51-53.  
doi: 10.1097/01.NJMA.000053377422167.12
- MacCurtain, S., Murphy, C., O'Sullivan, M., MacMahon, J., & Turner, T. (2017). To stand back or step in? Exploring the responses of employees who observe workplace bullying

### **Things you can do as a Manager or Leader**

#### **General Interventions**

- Educate staff on what sexual harassment is and ways to prevent, address, and cope with any exposure to it
- Train staff on the use of sexual violence risk assessment tools
- Advocate for resources and legislation to improve workplace safety and a sexual harassment-free working environment

#### **Interventions Following an Event**

- Take all reports and instances of patient-to-nurse sexual harassment seriously
- Ensure that no negative consequences will occur to the staff member reporting the event
- Check on your staff member one hour after the event, one day after the event, one week after the event, and at regular intervals for as long as seems necessary
- Start reporting the incident as a bystander or assist the employee in reporting the event if they are too busy to file a report or if they have been affected in a way that reporting the event may cause retraumatization
- Modify the staffing assignment so that the staff member does not have to work with a patient that has sexually harassed them
- Educate the patient on the organization's sexual harassment policy and express the need for behavior change, offering examples of what was not acceptable and what behaviors are acceptable
- Prevent and correct the spread of gossip or misinformation following the event and ensure the employee's confidentiality
- Have a post incident debriefing session if appropriate (and will not retraumatize any affected staff members)

#### **Organizations with Additional Resources and Trainings on Sexual Harassment/Violence Prevention**

- The World Health Organization (WHO)
- The Centers for Disease Control and Prevention (CDC)
- The Rape, Abuse & Incest National Network (RAINN)
- The National Alliance to End Sexual Violence (NAESV)
- The National Sexual Violence Resource Center (NSVRC)

#### **Referral Resources for Victims of Sexual Harassment**

- Employee Assistance Program
- Many organizations have a list of local counseling services
- National Sexual Assault Hotline: (800) 656-HOPE or <https://ohl.rainn.org/online/>
- Department of Defense Safe Helpline for Sexual Assault: (877) 995-5247

## Part 3: How to Prevent Sexual Harassment in your Workplace

There are many contributing factors to patient-to-nurse sexual harassment. While some factors (example: patient-based factors) cannot be changed, there are things that can be done to decrease the risk of sexual harassment occurring and resulting in negative consequences. As a manager, it is important to create a healthy working environment that includes support, effective communication and teamwork, and overall safety. In doing so, you can also reduce the risk of sexual harassment in your unit. The following page includes ways that you can improve the working environment to prevent sexual harassment and to support staff that are affected by it.

## **Environmental Changes to Reduce Sexual Harassment in the Workplace**

- Evaluate and revise organizational sexual harassment policies to be more effective
- Improve reporting systems to be easy to use, streamlined, and consistent to encourage reporting
- Post information on behavioral expectations for patients and visitors while in the hospital. This may include a list of acceptable or unacceptable behaviors and the possible actions or consequences for unacceptable behavior. Patients can receive this information as a brochure in their welcome packet, or it can be posted on the hospital's website, in the common areas, or on the hospital's television channel.
- Ensure adequate staffing and improved support for staff working in isolated environments
- Ensure proper security, CCTV, and violence prevention training in high-risk settings, such as the ER, Psychiatry, ICU, and Geriatric settings
- Create a space for staff that encourages positive coping. This may be a room with aromatherapy, calming colors, journals, and other resources that will allow the staff member to process and heal from the effects of patient-to-nurse sexual harassment.

**Appendix G: Results**

**Results Table 1: Pre and Post Webinar Sexual Harassment Self-Efficacy Scale Results**

Question	Pre Webinar						Post Webinar						Change in Mean
	Min	Max	Mean	STD	Variance	n	Min	Max	Mean	STD	Variance	n	
<b>1</b>	50	100	<b>84</b>	16.33	266.67	6	98	100	<b>99.2</b>	0.98	0.96	5	<b>15.2</b>
<b>2</b>	51	100	<b>84.3</b>	16.09	258.89	6	97	100	<b>98.8</b>	1.17	1.36	5	<b>14.5</b>
<b>3</b>	52	100	<b>86.5</b>	16.93	286.58	6	97	100	<b>98.6</b>	1.2	1.44	5	<b>12.1</b>
<b>4</b>	52	100	<b>87</b>	16.53	273.33	6	96	100	<b>98.8</b>	1.6	2.56	5	<b>11.8</b>
<b>5</b>	52	100	<b>88.3</b>	17.22	296.56	6	95	100	<b>98.4</b>	2.06	4.24	5	<b>10.1</b>
<b>6</b>	51	100	<b>84.5</b>	17.2	295.92	6	92	100	<b>97.6</b>	3.2	10.24	5	<b>13.1</b>
<b>7</b>	52	100	<b>85.8</b>	17.5	306.14	6	90	100	<b>97.4</b>	3.77	14.24	5	<b>11.6</b>
<b>8</b>	70	100	<b>94.2</b>	10.96	120.14	6	98	100	<b>99.6</b>	0.8	0.64	5	<b>5.5</b>
<b>9</b>	70	100	<b>88.2</b>	10.17	103.47	6	95	100	<b>97.4</b>	2.24	5.04	5	<b>9.2</b>
<b>10</b>	70	100	<b>87.2</b>	9.72	94.7	6	93	100	<b>97.6</b>	2.24	5.04	5	<b>10.2</b>
<b>11</b>	70	100	<b>93.7</b>	10.98	120.56	6	87	100	<b>97.4</b>	5.2	27.04	5	<b>3.7</b>
<b>12</b>	70	100	<b>92.8</b>	11.26	126.81	6	100	100	<b>100</b>	0	0	5	<b>7.2</b>
<b>13</b>	90	100	<b>96.3</b>	4.07	16.56	6	99	100	<b>99.8</b>	0.4	0.16	5	<b>3.5</b>
<b>14</b>	90	100	<b>97</b>	4.28	18.33	6	95	100	<b>98.8</b>	1.94	3.76	5	<b>1.8</b>
<b>15</b>	90	100	<b>97.7</b>	3.73	13.89	6	100	100	<b>100</b>	0	0	5	<b>2.3</b>
<b>Average</b>			<b>89.8</b>						<b>98.6</b>				<b>8.8</b>