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Concept of Self: Approach to Behaviors in Mental Health, The TAPOUT Program

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This is to certify that the doctoral study by

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2017

Abstract

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by

Tina Ann Goodrow

Post-Master's Psychiatric Nurse Practitioner Certification, Stony Brook University, 2013

MSN/Ed., University of Phoenix, 2009

BSN, University of Phoenix, 2007

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Violence in mental health care continues to be a problem. The incidence of violent episodes in healthcare settings with aggressive behavior of patients aimed at staff members or other patients is almost four times greater in healthcare than in other industries. Reducing violent episodes enhances the quality of care and improves safety for staff members and for patients. The project focused on development of a staff education program exploring the practice-focused question: Will this program effectively guide staff member approaches to mental health patients with challenging behaviors? The purpose of this project was to address the identified gap in practice in one mental health unit at a Florida correctional facility. A comprehensive literature review was completed using 30 sources from 2012-2017 and included peer-reviewed research and government resources to guide the development of this program, called TAPOUT. Sources of evidence emerged from a systematic review of the literature and an expert panel in mental health. Using the Delphi technique, all 5 panel members came to consensus after 2 rounds, agreeing to implement the TAPOUT program. The findings demonstrated the TAPOUT program may effectively guide staff member approaches to mental health patients with challenging behaviors and showed the benefits of using the TAPOUT program for reduction of violence. The DNP project has demonstrated TAPOUT can address the identified practice gap. The educational program's goal was to reduce violence and positively impact social change by providing staff members with tools to prevent and to deescalate emerging violent behaviors and episodes, preventing injury among staff members and patients alike.

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Dedication

I dedicate this project to my patients before, during, and following this educational milestone. You are my driving force to this social change project. May the result of this project reach many and change the lives of many more! Be the ripple of humanity, the force driving positive change, and role model of what is to be!

And to my husband, Vic; without your motivation, encouragement, patience, and support, my dream of attaining this goal would not be possible. You are my rock!

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My success and completion of this DNP project and program have only been possible because of the support, motivation, and encouragement by my husband, family, and special friends. Their love, guidance, and empowerment through many numerous difficult moments have driven me to accomplish this milestone.

A special thank you goes out to Dr. Barbara Niedz for her patience and countless hours of project mentoring to reach the finish line. Without your knowledge and expertise, this project would not have achieved completion.

Thank you, Dr. Tiffany Fuse and Cheryl Montpetit for your contributions, support, and guidance in the development of this project.

And one last BIG thank you to the Florida mental health team expert panel members for making this project possible!

Table of Contents

List of Tables

Section 1: Nature of the Project

Introduction

Violence in mental health care is a significant problem in the United States (Occupational Safety and Health Administration [OSHA], 2015). According to one study of 5,000 nurses in a U.S. urban community hospital system, 76% of the surveyed mental health care workers experienced violence by patients and visitors (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). Behavioral outbursts and physical assault have resulted in injuries requiring emergency care, hospitalizations, permanent disability, and even death (OSHA, 2015). Health care organizations are affected by increased costs associated with staffing shortages, overtime, worker compensation claims, and lawsuits from patient-to-worker violence. The nature of this Doctor of Nursing Practice (DNP) doctoral project was to create a unique, evidence-based staff training program that addresses violence in mental health care. I expect this project to bring positive social change by demonstrating the relevance of quality care and safety improvement outcomes in mental health organizations.

Problem Statement

Violence is a serious, widespread mental health care problem that needed to be addressed. The National Institute for Occupational Safety and Health (NIOSH, 1996) defined *workplace violence* as any physical assault, threatening behavior, or verbal abuse occurring in the workplace. Violence includes overt and covert behaviors ranging from verbal to physical aggression, including murder. The Joint Commission (TJC, 2012) identified hospital workers as having a rate of nonfatal assaults of 8.3 per 10,000

workers—far higher than the rate for private-sector industries of 2 per 10,000 workers. Furthermore, these attacks included various forms of violence including physical assaults, verbal aggression, and unwanted physical contact (TJC, 2012).

Correctional mental health care was the primary population focus for this DNP capstone project. My focus was to develop an evidence-based staff education program that addresses violence prevention and reduction strategies for mental health care professionals. The overall goal of this staff training program is to improve safety and quality of care outcomes in the Florida Department of Corrections (FDC).

Local Relevance

The National Commission on Correctional Health Care (NCCHC, 2013) recognizes violence as a serious public health problem and set long-term goals to combat violence in the correctional system. The NCCHC (2013) position statement addressed violence in the correctional system and identified the lack of dissemination and implementation of violence prevention strategies, techniques, and interventions. This NCCHC statement called for standards in all correctional institutes using health services as the basis for violence prevention, treatment, and education. In this DNP project, I sought to bridge the gap between the measures outlined in this statement and existing training programs and practices.

The FDC Assault Advisory (2017) identified 17 severe assaults on correctional officers from September 5th to September 25th, 2017 alone. This report did not account for all acts of violence as previously defined. According to FDC (2017), in the past 6 years, inmate-on-inmate assaults increased by 70%, and inmate-on-staff assaults

increased 46%. The number of staff with less than 2 years of experience increased by 43%, the amount of contraband introduced into correctional facilities increased by 407%, and overtime costs increased by 212% to $37.3 million (FDC, 2017). The training program developed within the context of this DNP project is called TAPOUT (tolerance, attitude, presentation, options, understanding, and timing) and may create a safer correctional environment for staff and inmates, and in turn the FDC might see a reduction in medical expenses, decreased overtime, and staff turnover rates.

The setting for this scholarly project was a correctional mental health care unit in a central Florida women's prison. According to the current mental health director, at the time of this project in October 2017, there were 25 mental health staff and 15 mental health professionals who served approximately 1,200 inmates with mental illness out of the 2,500 inmates housed at this facility. Common features of this population of inmates are borderline and antisocial tendencies, attention-seeking behavior, self-injury, disrespect, and noncompliance with treatment.

Significance

This doctoral project has the potential to improve the field of mental health nursing as it builds on existing training programs used to reduce violence and bridges gaps in those programs. The needs assessment I conducted to deliver a training of core quality components tailored to the organization's specific needs and postdelivery follow-up are essential to positive social change. This TAPOUT training program emphasizes staff as the primary tool to learn more about the therapeutic use of self in the prevention of violence. Staff learn how their approach and response can directly impact interactions

with patients. Staff will acquire knowledge on identifying the ways behaviors and early identification of individual triggers play a vital role in prevention. Staff will grasp how they can use these core skills to use themselves therapeutically as their primary tool to intervene according to their environments. The success of the intervention is through a proactive, self-aware approach. Staff will learn to employ the critical components successfully contained within this program. This training program holds significant potential to improve quality care and safety in the mental health setting. Its use is intended to augment existing training programs.

Purpose

The purpose of this project was to reduce the incidence of workplace violence by developing the multidimensional, evidence-based TAPOUT training program. Staff members can fail to recognize emerging violence to de-escalate at the earliest stages of violent behavior. Staff must grasp the critical concepts of prevention and utilize the skills in the existing training programs in the manner intended to prevent injury. This program will guide staff to better understand these critical skills for a safe intervention.

TJC (2010) has required annual training programs since 2004 on workplace violence for mental health institutions and inpatient acute care facilities alike. These trainings notwithstanding, organizations may continue to see an incidence of workplace violence, which is a call for enhanced training programs (Speroni, Fitch, Dawson, Durgan, & Atherton, 2014) to reduce incidents of violence. Though the trend of violence is decreasing (Madero, 2005), TJC supports the need for additional training programs to continue to address violence in mental health care. TAPOUT augments existing

programs by offering new perspectives and approaches in an easy-to-understand and recall format. This program was designed to help staff close the existing gaps in knowledge and skills with emphasis on the therapeutic use of self and a proactive approach.

I designed a multidimensional training program. In this instance, the best practice is the use of self as key in managing challenging behaviors in integrating concepts identified in this program. These concepts were designed within the TAPOUT program and included (a) tolerances, (b) attitudes, (c), presentations, (d) options, (e) understandings, (f) timing, and (g) tapout/timeout. The TAPOUT program uses the concept of self as a therapeutic tool. The evidenced-based practice problem identified in a PICOT design question was: Will this program effectively guide new staff member approaches to mental health patients with challenging behaviors requiring psychiatric care?

- Population = Those caring for the mentally ill.
- Intervention = TAPOUT program for violence reduction education.
- Comparison = Traditional workplace violence reduction education.
- Outcome = Reduced incidence of violence.
- Time = Six weeks following the training and ongoing thereafter annually.

This doctoral project's purpose was to address the gap in practice. Staff lack knowledge and skills in recognizing and de-escalating emerging violence. A program was created with an easy-to-recall method so that staff would be more likely to attempt to

employ the critical interventions needed to be proactive rather than reactive to emerging violence. This doctoral project is a multidimensional, specialized training program that addresses current organizational needs. It included a needs assessment for the organization. Through these findings, a customized TAPOUT training program was designed that specifically meets the needs of the correctional health facility that was the setting for this project. The needs assessment included a review of what the workplace violence has been like and what education and training programs have been used to address workplace violence. This study's goal was to bridge existing gaps identified through this process and to inform the development of the customized TAPOUT program that relies on the therapeutic use of self.

TAPOUT is a mnemonic for six words that assist a staff member to remember fundamental concepts. Through an integration of a familiar mnemonic, such as TAPOUT, the participant is more likely to recall key concepts that aid them in the intervention and de-escalation process. The use of a mnemonic strategy has been a solution to difficult educational problems in nursing education (Lander, 2002). Use of a mnemonic, such as TAPOUT, helps staff to remember how to apply the essential concepts needed to de-escalate violent behavior (VanSandt, 2005). Mnemonic strategies aid the learning process with ease of retention and recall of fundamental concepts through the use of familiar terms. The TAPOUT program is intended to bridge the gap in practice by emphasizing the quality components that were not captured in the original training programs offered.

Nature of the Doctoral Project

A group of five mental health leaders at one correctional health care facility served as an expert panel for this scholarly project. A qualitative approach using the Delphi technique with two rounds was used to reach a consensus that this project may be effective. The evidence from the literature demonstrated that this program can help to close the current gaps in existing training programs at this correctional facility and reduce violence. The overall goal of this project was to capture a consensus from this expert panel that this program has the potential to produce the desired positive social change of reducing mental health care violence.

Significance

Implications for Staff Members

Violence in mental health care is a problem. The American Association of Critical-Care Nurses (2004) published a position statement condemning acts of abuse perpetrated by or against any person, calling for a zero-tolerance stance. When patients are admitted to a behavioral health facility, they are provided this position statement and are required to "sign off," acknowledging that they have reviewed and understood the zero-tolerance policy. Inmates in a correctional health facility, though they are essentially incarcerated, have the same potential for violence to guards and health care professionals alike. Thus, the potential for harm to staff members, whether a behavioral health facility or a mental health correctional health facility, is ever present.

The American Nurses Association (ANA, 2006) posted a summary from the House of Delegates on Abuse and Harassment of Nurses in the Workplace. They also

developed a couple of brochures to prevent violence in the workplace, discussing three categories of risk factors: environmental, work practices, and characteristics of victims and perpetrators. Also, the brochures discussed risk factors that may lead to increased workplace violence and ways to prevent and respond. The ANA offers a website including additional information, tools, and courses for use to improve workplace safety (ANA, 2017).

There are many organizations focused on improving patient and worker safety through violence prevention programs. Violence can cause a significant financial fallout to the employer, staff, and patient. Examples of potential costs may include: loss of product and productivity, employee turnover, disability, worker compensation claims, and possible litigation due to acts of violence. As an example, Speroni et al. (2014) identified one hospital system with 30 nurses who required treatment for violent injuries in a year, at a total cost of $94,156 ($78,924 for treatment and $15,232 for lost wages).

Implications for Patients

Workplace violence at the extreme can result in patient death, which demonstrates the ultimate reason why the effective reduction of workplace violence is so necessary. Lieberman, Dodd, and De Lauro (1999) identified significant cases where staff engaged in a power struggle resulting in patient death by positional asphyxia that could have been prevented had they employed different skills learned in training.

Example of a power struggle: Case Study 1. An 11-year-old patient at a private psychiatric hospital weighed in at 96 pounds. He was eating breakfast one morning, talking and having fun with his friends. A staff member wanted him to move from his

breakfast table, probably because he was too loud, but he refused. A power struggle ensued because he did not want to move away from his friends. He ended up in restraint; with staff sitting on his back, he could not breathe, which resulted in death due to positional asphyxiation. He died because he would not move to another breakfast table (Lieberman, Dodd, & De Lauro, 1999)

Example of a power struggle: Case Study 2. A 15-year-old female patient residing at a youth center was on her way between activities. However, there was a rule that patients could not have something in their hands when they went between activities at this program. Staff asked her to hand over the item in her hand, and she refused. A power struggle ensued, and she ended up restrained face down and died from suffocation. The article in her hand was an unauthorized photograph of her family because she wanted to be close to her family (Lieberman, Dodd, & De Lauro, 1999).

These are just two published examples of power struggles resulting in a physical restraint that caused the patient to die. These cases continue to be used in training programs across the nation, raising awareness of the potential dangers of engaging in power struggles using restraint. Had the staff stopped and used alternative methods to prevent power struggles, these two individuals might still be alive today.

Implications for Social Change

The case scenarios that I shared ended in the dire consequence of death, and both were preventable. The TAPOUT program addresses critical areas, including the following:

- Staff *tolerances* were too personal, and staff operated at the personal level rather than the program or treatment level.
- *Attitudes* were too emotional, and staff responded out of frustration or anger rather than rational response.
- *Presentations* were too strong; staff were too excited, loud, and busy; and staff did not listen in silence.
- *Options* failed to be offered, and staff had an "if you do not comply… I will do this" attitude.
- *Understandings* were blurred, and staff failed to use humanity in their approach.
- *Timing* was too late, and staff failed to provide education at a neutral time when emotions were not elevated.

Understanding these concepts as critical elements in the prevention of violence in mental health care is important for positive social change in nursing practice. This project provided evidence to support the need for expanding the use of the staff education TAPOUT training program. This evidence was demonstrated through the literature review and through results of data shared from the expert panel responses. Social change is expected as staff gain a better understanding of how their actions influence the behavior of others, and by controlling themselves, they will improve intervention outcomes, ultimately improving practice standards (OSHA, 2015). No single universal strategy or program exists to prevent violence (TJC, 2012).

Summary

The Institute of Medicine (2011) presented a challenge to mental health care professionals to improve the quality of patient care by focusing on the enhancement of safety, effectiveness, efficiency, equitability, timeliness, and patient-centeredness approaches. This challenge allowed me to apply systems-level thinking to drive change and make a significant contribution to positive social change in the field of nursing. In this DNP scholarly project, I adopted a systems perspective by assuming the role of a transformational leader. Such leaders employ reasonable risks based on empirical data, commit to an action plan, reflect the core values of the plan, and overall strive for excellence in care (Zaccagnini & White, 2011).

TJC (2012) strives to continually improve mental health care for the public by offering opportunities for networking and collaborating and encouraging mental health care organizations to deliver the highest quality of care safely and effectively. The TAPOUT program aims to improve patient and worker safety through incorporating opportunities for synergy, collaboration, and innovation using a multidimensional approach that manages challenging behaviors in mental health. The problem of pervasive violence in mental health care needs to be addressed. The literature review provided limited evidence in demonstrating existing programs like TAPOUT that specifically address how to be proactive versus reactive and intervene in the early stages of behavior.

This section highlighted the importance of addressing violence in mental health care. The training can be helpful in assisting staff to better manage violence in the

clinical setting. The next section highlights concepts, evidence-based literature, and relevance to nursing practice.

Section 2: Background and Context

Introduction

Patient violence is a significant problem in mental health care settings. The goal of this DNP project was to pave the way for change in how staff members intervene with patients who demonstrate challenging behaviors through the use of the multidimensional TAPOUT program. Section 1 introduced the topic of violence in mental health care and explained the significance of the problem. This section includes a literature review of the following concepts, models, and theories: (a) workplace violence, (b) therapeutic use of self, (c) training programs that have been shown to reduce workplace violence, and (d) strategies that have been proven to reduce workplace violence. An explanation of how these models influenced the development of TAPOUT and what makes it unique while building on existing educational programs will be covered. The inclusion of how this program is relevant to the nursing profession will be discussed, followed by a concise summary of the local background and context that justified the relevance of this practice problem. Explanations of the roles of the DNP student and expert panel are included in this discussion.

Concepts, Models, and Theories

In this section, I produced research to support this doctoral project. The themes that were covered included workplace violence, therapeutic use of self, training programs that have worked, and strategies that have been proven to reduce workplace violence.

Workplace Violence

OSHA (2015) identified patients as the largest source of workplace violence in a health care setting, citing 80% of serious health care violence incidents reported in health care settings were caused by interactions with patients. Other events were caused by visitors, coworkers, or other people (Bureau of Labor Statistics [BLS], 2013). Workplace violence has been vastly underreported. An epidemiological study was conducted by the Minnesota Nurse Association to identify the magnitude and consequence of work-related violence (Gerberich et al., 2014). Using a sample of 4,738 Minnesota nurses, the researchers found that only 69% of physical assaults and 71% of nonphysical assaults were reported to a manager (Gerberich et al., 2014). OSHA identified the need for health care facilities to reduce workplace violence by following a comprehensive workplace violence prevention program including five components: (a) management commitment and worker participation, (b) worksite analysis and hazard identification, (c) hazard prevention and control, (d) safety and health training, and (e) recordkeeping and program evaluation.

The 2013 BLS data identified that out of 3,765 nurses, including student nurses, 21% reported being physically assaulted and over 50% were verbally abused in a 1-year review. Additionally, The Emergency Nurses Association (2011) stated that out of 7,169 emergency nurses, 12% experienced some form of physical violence and 59% experienced verbal abuse-during a 7-day period. Finally, out of 72,349 employees from 142 facilities in Veterans Health Administration (VHA) hospitals, only 13% reported being assaulted in a 1-year period in a completed Veterans survey in 2002 (Hodgson et

al., 2004). Underreporting of incidents has been common in the mental health care field as some nurses believe there is an elevated risk of censure or backlash, and therefore actual incidence may be higher than initially reported (OSHA, 2015). Common causes of workplace violence reported were identified as a breakdown in staff communication, psychiatric assessment, patient observation, team training, and policy compliance (TJC, 2016).

Speroni et al. (2014) conducted a study on the incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. Studying a U.S. urban/community hospital system of more than 5,000 nurses, they used a 34-item, validated survey in electronic format and retrospective database review. The sample size was 762, primarily white female registered nurses aged 26–64 years with greater than 10 years of work experience. Of these, 76.0% experienced violence; more specifically, they experienced verbal abuse (54.2% patients, 32.9% visitors), physical abuse (29.9% patients, 5% visitors), shouting or yelling (60.0% patient, 24.9% visitors), swearing or cursing (53.5% patients, 24.9% visitors), grabbing (37.8% patients, 1.1% by visitors), and scratching or kicking (27.4% patients, 0.8% by visitors). Emergency nurses experienced a statistically greater number of incidents ($P > .001$) at 12.1%, with more than 50 verbal (24.3%) and physical (7.3%) patient/visitor violence incidents over their careers. From a sample of 595 nurses, 78.1% of the original survey participants, the most serious career violence for 63.7% of the nurses was physical assault (60.8% by patients and 2.9% by visitors). Verbal aggression was noted in 25.4% of cases (18.3% of patients and 7.1% of visitors) and threatened physical assault in 10.9% (6.9% by patients and 4.0% of visitors).

Speroni et al.'s data analysis identified the commonalities among the aggressive patients, who were primarily white male patients, 26–35 years old, and who were confused or influenced by alcohol or drugs. Also, costs for workplace violence in 2.1% of nurses reporting injuries amounted to $94,156 (78,924 for treatment and $15,232 for indemnity). Speroni et al.'s study supported that workplace violence is all too common in the mental health care system and ranked higher risks for violence as nurses caring for those patients with dementia, Alzheimer's disease, drug-seeking behavior, or drug/alcohol influenced patients.

BLS (2013) identified that psychiatric aides experienced the highest rate of violent injuries that resulted in days away from work: approximately 590 injuries per 10,000 full-time employees. BLS also found that this rate is 10 times higher than nursing assistants at 55 injuries per 10,000 full-time employees. Registered nurses experienced about 14 violent injuries resulting in days away from work per 10,000 full-time employees, compared with a rate of 4.2 in U.S. private industry. BLS (2013) identified the top three high-risk areas as emergency departments, geriatrics, and behavioral health, with the common cause of violent injuries leading to lost time away from work including hitting, kicking, beating, and/or shoving.

Workplace violence has received national, federal, and state attention. This attention has driven organizational change as evidenced by the Centers for Disease Control and Prevention (CDC) research agency and NIOSH;s development of a brochure to increase worker and employer awareness of risk factors for violence in hospitals, offering strategies to reduce exposure to these elements. This section highlighted the

incidence and cost of violence as well as identified the potential perpetrator demographics and the violent acts committed. The following section addresses risk factors of violence in mental health care.

Violence: Risk Factors

OSHA (2015) identified several common risk factors for violence. Patient characteristics such as those who have a history of violence, may be delirious, or under the influence of drugs was one area of risk to consider. Work setting or related functions such as lifting, moving, and transporting patients or working alone were other risk factors. Environmental considerations posed significant risks as well and may include poor environmental design that may block vision or escape routes, poor lighting in hallways or exterior areas, long wait times, overcrowded waiting rooms, unrestricted public access, or lack of emergency communications. Human resource issues also posed risks such as lack of training, lack of policies for staff, understaffing in general and especially during meal times and visiting hours, high worker turnover, inadequate security staff, or presence of firearms. Other risk considerations included working in neighborhoods with high crime rates or the perception that violence was tolerated and reporting incidents would have no effect.

For this specific project, the focus was on staff interactions with patients and how staff members' actions directly influenced the outcome of given situations with the therapeutic use of self. This next section discusses the theoretical concept that guided the program development.

Therapeutic Use of Self

Peterson and Nisenholz (1999) characterized framing of self as an instrument and maintained staff should have acuity in observation, note verbal and nonverbal cues of the client, be multiculturally competent, and be able to adapt to differing cultures. Staff should have the energy to be subjective and ready to enter the world of the patient to help achieve therapeutic rapport. The TAPOUT training program embraces *self* as the primary tool in the prevention of violence. The program demonstrates staff actions and reactions have a direct impact on patients' responses to behavioral interventions. This training helps staff recognize their actions and reactions, identifies subtle changes in behaviors, and offers different approaches that were proven effective in the de-escalation of anger.

TAPOUT

This program challenges participants to look at concepts through a critical lens to capture potential variations of insight that may have been lacking in their understanding. The TAPOUT program challenges staff to define the components of what they knew before and are challenged to provide insights on different perspectives following the program. TAPOUT engages the audience in developing the components that need to be covered in their settings. This approach offered staff a way to integrate case scenarios, role-playing opportunities, and post-delivery follow-up to guide learners to acquire new insights gained from this training and immediately apply to their clinical practice. The emphasis of this training is to teach staff how to place their attitudes, thoughts, and beliefs aside, in order to alter their approach to gain a better outcome.

TAPOUT is a mnemonic for tolerance, attitude, presentation, options, understanding, and timing. Each letter represents an association that aids the memory of the critical components needed to reduce violence. The following section provides evidence to support these vital elements in the development of this staff education program.

Tolerance. Vasiljevic and Crisp (2013) conducted a series of experiments linking the concepts of tolerance, conflict, counterstereotypical thinking on individual thought processes that influence behavior. The sixth experiment demonstrated that individuals can learn strategies that affect their level of tolerance and increase their ability to tolerate. This study also showed a person's ability to foster tolerance and decrease prejudices against stereotypical expectations.

Araya and Ekehammar (2009) investigated tolerance and its effects on social judgments using three separate studies to determine the factor structure of this concept. Data were combined from three studies (n = 17) to achieve a reliable index, with a principal factor analysis providing a 53% variance with a correlation matrix. The most significant positive and first factor was identified as being sympathetic, interesting, kind, considerate, reliable, and intelligent. Intolerance was the second factor which included being deceitful, boring, and dishonest, and the third factor was the negative element identified as deceitful, boring, and dishonest as well. The Cronbach alpha reliabilities were 0.83, 0.80 and 0.72 for the positive, intolerance, and negative scales respectively. This study demonstrated that though the intention of an intervention is meant to be positive, a different outcome may emerge from the intention. The TAPOUT educational

program translates tolerance research into practice and guides staff to understand tolerance with a different perspective.

Attitude. Barsade (2002) studied emotional contagion and its influence on group behavior with a random sample of 94 business school undergraduates. Group size ranged from two to four participants, and each group participated in a videotaped, leaderless group discussion simulating a managerial exercise. Using a 2 X 2 between-subject design, Barsade assigned subjects to random conditional factors with bipolar levels. Each participant was assigned a role in the management forum simulation. Participants with a positive and higher energy level presentation demonstrated a positive outcome, with statistical significance of $p < .001$ on both findings. This study concluded a ripple effect in behavioral responses does occur and affects group dynamics. This finding supported the need for staff to maintain a positive presence in the workplace. The TAPOUT program teaches staff more about this ripple effect and its influence on behavioral outcomes.

Presentation. Stensrud, Gulbrandsen, Mjaaland, Skretting, and Finset (2013) developed an evidenced-based training program and conducted a test–retest study with 21 general practitioners. They aimed to test a communication skills training program based on six skills proven to be helpful. These six strategies facilitate the communication process and included exploring emotions, responding empathically, exploring the patient's perspective, providing insight, exploring resources, and promoting coping. Using a 21-item scale, the test–retest result demonstrated a significant increase of 74% improvement comparing before and after training. Stensrud et al.'s study supported the

premise that staff communication behavior may have influenced patient outcomes. What this study failed to address was the nonverbal communication role in the staff–patient interaction. Sending and receiving messages and ensuring patients are capturing what staff are trying to convey and vice versa is imperative to the communication process. Nonverbal communication plays a significant role in the communication process, and failure to address it in such a study results in significant limitations. The TAPOUT program bridges this gap and ensures participants understand the role nonverbal communication plays in the communication process.

Hills (2012) revealed approximately 60–93% of communication is nonverbal. These numbers are significant and must be recognized when discussing the communication process. Hills further identified 25 recent findings of workplace body language. Learning to differentiate the meanings of the nonverbal communicative methods is integral in using a proactive approach in diffusing potential volatile behavior. The TAPOUT program provides education on how to recognize subtle changes and emphasizes the need to be more aware of these changes in patients' usual behavior.

Options. Gaynes et al. (2017) completed a systematic review of the evidence on strategies to de-escalate aggressive behaviors among mental health patients. They identified 17 eligible studies, 13 of which were randomized trials, which provided data for this review with more than 3,628 participants. Sample size ranged from 20–973 participants. Gaynes et al. aimed to fill gaps in existing literature about the various strategies that reduce aggressive behaviors. Their findings suggested a risk assessment is a reasonable strategy for decreasing violence, and so is integration of a multimodal

approach based on the six core strategies to reduce violence. They concluded further research is needed to guide staff on how to de-escalate aggressive behaviors best. TAPOUT focuses on the importance of early engagement and use of intervention strategies in the earliest stages of anger for staff to become more proactive in violence reduction.

Understanding. Farrelly and Lester (2013) completed a critical interpretive synthesis exploring the relationship between staff and patients with psychotic disorders. A literature search between 1990 and 2011 identified 13 papers to be included in this synthesis. Mutual trust, respect, and shared decision-making were repeating themes that emerged. Their analysis demonstrated the importance of adequately describing and understanding the components of a therapeutic relationship in the mental health setting. The information from Farrelly and Lester's study on therapeutic relationships was explored further in the TAPOUT program.

Timing. Hewitt, Keeling, and Pearce (2015) completed a case study on training a family in physical interventions as a part of a positive behavioral support intervention for challenging behavior. They identified best practices in managing challenging behavior to combine a person-centered approach, functional analysis, proactive and reactive strategies, and teaching alternatives. These procedures were also employed in the TAPOUT program with an emphasis on a person-centered proactive plan. For behavioral change to occur, the educational approach was tailored to the level of an end user and at a neutral time for the best outcome to occur.

TAPOUT/Timeout. Lambrechts and Maes (2012) explored staff members' emotional reactions and experiences to challenging behaviors through an interview study. The sample included 12 staff members working in 10 different services for patients with intellectual disabilities. Staff were confronted and video recorded to capture their own behavior in the challenging setting. They were then interviewed to discuss their emotional experiences. This study demonstrated to staff the need to consider their own emotions, emotional experiences, and the influence emotions have on their reactions. These findings supported the need to maintain neutrality when engaging patients with challenging behaviors. In the clinical setting, if staff are getting emotionally charged, it would be appropriate to excuse them from the interaction to maintain a therapeutic interaction. Staff members have a professional responsibility and obligation to respond rationally rather than emotionally to challenging behaviors. TAPOUT/Timeout provides staff with the reminder to keep it professional and to excuse themselves if they find it difficult to work while remaining neutral.

Therapeutic Use of Self and TAPOUT

Priami, Plati, and Mantas (1998) supported the idea that nurses' attitudes have the most significant impact on mental health ward atmosphere. They also found high levels of engagement to be influential in a positive culture of care. The theoretical concept of use of self, though initially designed for the psychologist in practice, has found its way into workplace violence training programs.

In 2004, TJC mandated that psychiatric organizations implement annual workplace violence prevention programs. The TAPOUT program builds on and

augments publicly available workplace violence prevention programs with the incorporation of the therapeutic use of self and the six key concepts represented by the TAPOUT mnemonic.

Relevance to Nursing Practice

One of the key features of this project is to engage in and provide leadership for evidence-based practice in a mental health correctional setting. This goal requires theoretical, empirical, and experiential application of knowledge, including translation of research to practice, evaluation and improvement of mental health care practice outcomes, and participation in collaborative scholarship (DePalma & McGuire, 2005, pp. 257–300).

Over the past 10 years, there has been a significant push from legislatures and national accrediting bodies to establish training programs to help reduce violence in mental health care. Recently the Florida Department of Health (2014) and Florida Hospital Association devised training programs to address violence in the workplace. Additionally, the FDC (2017) published an executive summary listing as the number one goal to improve the safety of staff and inmates in the correctional setting.

Cashmore, Indig, Hampton, Hegney, and Jalaudin (2016) conducted a quantitative survey, inviting 710 correctional health professionals exploring their experiences of workplace violence in the preceding 3 months. There was a 42% response rate with five emerging themes: workplace policies and procedures, professionalism in the delivery of health care, professionalism in the provision of correctional security, horizontal violence and its management, and the physical environment. Participants felt the risk of violence

increased with low staffing, high caseloads, lack of performance, and inadequate control of violence. These views support the need to improve efforts to prevent and manage violence in the correctional setting.

Training programs guiding staff are available at the national and local levels, but there continues to be a gap that prevents staff from fully grasping the concepts that enhance a safe and therapeutic work environment and the need to make a proactive response. The program evaluation indicated potential improvement in skill acquisition and use in the clinical setting to attain favorable responses.

The TAPOUT program is different from existing applications because it offers a needs assessment, engages the audience with live role-playing, case reviews, clinical discussions, and problem-solving skills, as well as offered a postdelivery follow-up. This type of program delivery was not in existence in this correctional facility. The program evaluation proved that there is potential benefit to reduce violence in this correctional facility.

Local Background and Context

The aggregate population for this scholarly project was correctional mental health care staff in one central Florida women's prison. According to the current mental health director, as of October 5, 2017, there are currently 25 mental health staff members and 15 mental health professionals who serve approximately 1,200 inmates with mental illness out of the 2,500 inmates housed at this facility. Typical features of this patient population were generalized as inmates with borderline and antisocial tendencies, attention-seeking behavior, self-injury, disrespect, and noncompliance with treatment.

Role of the DNP Student

I, as the DNP student, served as project leader, completed the literature review, conducted a needs assessment, and developed the TAPOUT program as a package suitable (with customization) for any inpatient psychiatric organization, including correctional health settings. To evaluate the potential effectiveness of the project, a panel of five expert members of this inpatient site evaluated the program and provided feedback to me as the DNP project leader.

Summary

A thorough review of this literature demonstrated the problem of violence in mental health care and the need for strategies to further reduce the incidence through training programs focused on a proactive approach (TJC, 2016). Furthermore, evidence showed that there were multiple systems at the national, state, and organizational levels trying to reduce incidences of violence (OSHA, 2015). Through the literature review, I found that health care organizations are continually seeking to improve practice approaches to manage challenging behaviors, that there is no one single tool, and flexibility is important to promoting safety and improving quality outcomes in violence reduction plans (TJC, 2016). This DNP scholarly project was intended to aid in retention of critical elements using a multidimensional approach and a mnemonic for immediate recall and use of set skills that have been proven to reduce episodes of violence (El Hussein & Jakubec, 2015).

White and Brown (2012) noted the key to making significant contributions to nursing today lies in the ability to understand the need to develop and sustain evidence-

based practices. Translation of current evidence into current practice was fundamental in ensuring the quality of my program design. This review of the literature supported the need for the development of an educational program that improves recall and retention of critical elements in acute situations to reduce the incidence of violence. The use of a mnemonic for recall is useful for retention of important information and bridges the gap from classroom to practice where critical elements are not always being implemented. This TAPOUT program is essential for recalling key concepts that directly influence interactions/interventions and outcomes. The next section highlights collection and analysis of evidence that supported the benefits of implementing this program into existing programs where staff may be exposed to challenging behaviors.

Section 3: Collection and Analysis of Evidence

Introduction

The goal of this DNP project was to pave the way for change by bridging the clinical gap in how staff members intervene with those who demonstrate challenging behaviors, with the multidimensional TAPOUT program. Section 1 introduced the topic of violence in mental health care and shared the significance of the problem. Section 2 included a systematic literature review of concepts, models, and theories: (a) workplace violence, (b), therapeutic use of self, (c) TAPOUT program components, (d) training programs that have been shown to reduce workplace violence, and (e) strategies that have been proven to reduce workplace violence.

This section describes the system used for recording, tracking, organizing, and analyzing the evidence to support this scholarly project. Analysis procedures used in this DNP project to address the practice-focused question are discussed.

Practice-Focused Questions

This project was designed to use a multidimensional model of care approach. The model of care in this context defines the way health services have been delivered, providing for best practices (Agency for Clinical Innovation, 2013). In this instance, the best practice was identified as the use of self as primary in managing challenging behaviors by integrating quality concepts identified in this program. These quality concepts are designed within the TAPOUT program and include (a) tolerances, (b) attitudes, (c), presentations, (d) options, (e) understandings, (f) timing, and (g) tapout/timeout. The TAPOUT program uses the concept of self as a therapeutic tool.

The evidenced-based practice problem identified in a PICOT design question was: Would this program effectively guide new staff member approaches to mental health patients with challenging behaviors requiring psychiatric care?

- Population = Those caring for the mentally ill
- Intervention = TAPOUT program for violence reduction education
- Comparison = Traditional workplace violence reduction education
- Outcome = Reduced incidence of violence
- Time = Six weeks following the training and ongoing thereafter annually

Sources of Evidence

Sources of evidence for this project derived from a systematic review of the literature and an expert panel. A systematic review is a structured synthesis of research literature used to determine the best evidence available to answer the practice focus question. In addition to the systematic review of the literature, a panel of experts was used to evaluate the potential effectiveness of this program using the Delphi technique.

Published Evidence

A systematic review of the literature was conducted using the Walden Library and other appropriate databases to guide the development of this project. Resources included in this section were derived from electronic databases, professional organizations, experts in the field, books, handbooks, and manuals. Initially, articles for this literature review were excluded if they were published before 2012 to obtain the most up to date findings. The initial search phrase used was a *multidimensional approach to managing challenging*

behaviors and de-escalation strategies. The initial search yielded very limited results. The search was expanded to include the following terms: *concept analysis*, *restraint reduction strategies*, *feeling safe*, *nurse–patient relationship*, *nursing theory*, *patient perspective*, *patient safety*, *therapeutic relationship*, *effects of borderline personality (staff perceptions and causal attributions)*, *challenging behaviors*, *recovery*, *intimidation*, *harassment*, *lateral violence*, *horizontal violence*, *psychological abuse*, *empowerment*, *consumer participation*, *mental health*, *role stress*, *milieu toxicity*, *burnout*, *hardiness*, *theory of planned behavior*, *theory of reasoned action*, *holistic nursing*, *cultural competence of the mentally ill*, *humanism*, *tolerances*, *attitude*, *self-presentation/presentation*, *nonverbal communication*, *behavioral interventions*, *acting out*, *changing behaviors*, *FDC*, *violence in corrections*, *risk factors for violence in corrections*, *FDC goals*, *correctional violence reduction strategies*, *assault advisory and response*, *mental health problems in prison*, and *correctional officer response to mental illness*. Inclusion criteria were: peer-reviewed, evidence-based, theoretical concepts, theoretical frameworks, educational sources, and governmental sources. Exclusion criteria included Wikipedia, non-evidence-based and nonconfirmed sources. Boolean search strings included: *nursing staff and patient reactions*, *staff response or staff actions to patient behaviors*, and *influences of behavior on staff responses and patient's actions*. The article titles and abstracts were appraised to reduce further search results, and articles were excluded if they were not pertinent to this project. The remaining items were used in the literature to support the development of this DNP project.

Primary literature that supported the development of this project included strategies identified by TJC, CDC, Substance Abuse and Mental Health Services Administration, and OSHA (TJC, 2012). Guidelines from these organizations also guided the development of this project. Literature from the existing facility training programs was also used to support the development of this project.

Evidence Generated for the Doctoral Project

According to Grove, Burns, and Gray (2013), the best research evidence summarizes the highest quality, current empirical knowledge in the field and develops from a synthesis of study findings in this area. Previously I explored the literature of primary research supporting each of the components of TAPOUT, and here I formulated an expert panel to review the staff education manual. The literature review and the expert panel feedback supported the potential benefit of addressing violence in correctional mental health care with the TAPOUT program. This program has the potential to make a significant contribution toward social change with strategies to reduce violence in health care, and specifically for this project, correctional mental health care.

Participants. Choosing the appropriate subjects was the most crucial step in the entire Delphi process because it directly related to the quality of the results generated (Jacobs, 1996; Judd, 1972; Taylor & Judd, 1989). Subjects who served as the expert panel were competent in the specialized field related to the practice problem. This expert panel was used to answer the practice-focused question. The expert panel included five key mental health leaders in one central Florida prison. Expert panel members held a

minimum of a master's degree with a preference for a doctoral degree in the mental health field such as medicine, nursing, psychology, or social work.

In order of decision making authority, the expert panel members included;

1. Senior psychologist, doctorate in psychology with 5 years of experience,
2. Mental health professional, doctorate in psychology with 21 years of experience,
3. Psychology resident, doctor of psychology, 6 years of experience,
4. Mental health professional, education specialist, 30+ years of experience, and
5. Mental health professional, master of science, 33+ years of experience.

Procedures. After approval from Walden University's Institutional Review Board (IRB; Approval # 11-03-17-0289041), this project was presented to the expert panel members in an electronic format using a PowerPoint presentation with a discussion of how this program may be utilized (see Appendix A). An examination of how a needs assessment would be collected and used was included to customize the TAPOUT training program to current needs of the hospital or organization. The needs assessment included the review of what the workplace violence has been and what education and training programs have been used to address workplace violence. The program was finalized with the goal to bridge existing gaps identified through the process that informed the development of the customized TAPOUT program package that relies on the therapeutic use of self. A debriefing process in this training program is offered as a means for follow up on skills acquisition and ongoing education to staff members. The debriefing also

includes a chance for participants to provide feedback on the implementation of components learned in the program. A description of the debriefing process was included in the PowerPoint presentation for panel members to gain a sense of how this three-part program is delivered.

Through the PowerPoint presentation, the expert panel recognized how the needs assessment was conducted, reviewed the core TAPOUT program components, and learned about how the debriefing process occurs. The in-scope activities for this multidimensional project included a detailed review of the literature providing evidence supporting this project. An organizational needs assessment was developed and implemented to tailor a TAPOUT program customized to organizational needs.

The out-of-scope activities that were not be completed in this project but are pertinent are the actual implementation of this TAPOUT program and the needs assessment. As a result, there was not an observed reduction in workplace violence in this correctional mental health setting. There was a review of the needs assessment, with a customized TAPOUT program design. A discussion of the debriefing process and ongoing supervision was held with the potential vision of reduced workplace violence.

The expert panel was then asked to complete a summative evaluation using a semistructured survey through the Delphi process. These findings were summarized, and *yes or no* questions were asked of the panel to achieve consensus (found in Appendix B). All five members of the expert panel needed to agree to achieve consensus on the outcome of the project.

Protections. Potential risks and burdens were explained to the expert panel members, and informed consents were obtained. The participants had the right to withdraw from this panel at any time. The project was reviewed by the committee chair and committee, reviewed by the university research reviewer and IRB before data collection at the correctional health setting. Site approval documentation for this staff education doctoral project was filed with the IRB and permissions granted by the institution as well as the university. A consent form for questionnaires was offered to all expert panel participants. All data associated with the project were summarized anonymously and held in strict confidence. The project followed the guidance included in the educational manual.

Walden University's doctoral project step plan was followed addressing measures to ensure the ethical protection of participants. These measures included data retention, consents, and safeguarding of privacy for 7 years. During introductions, participants were made aware that they may withdraw their participation at any time and provided consent to participate.

Summary

This section outlined the practice-focused question. The evidence derived was two-fold. First, adequate research evidence of high quality was compiled in support of TAPOUT as a strategy to reduce workplace violence. Secondly, a Delphi technique was used to gather evidence from an expert panel to create an evidence-based program unique to organizational needs addressing workplace violence.

Section 4: Findings and Recommendations

Introduction

This DNP project has potential to address the gap-in-practice through the TAPOUT program. Since 2004, TJC (2010) has required annual training programs on workplace violence for mental health institutions and inpatient, acute-care facilities alike. This requirement notwithstanding, organizations may comply with this annual training but continue to see an incidence of workplace violence calling for enhanced training programs (Speroni et al., 2014) to reduce incidents of violence. Though the trend of violence is decreasing (Madero, 2005), TJC advocated the need for additional training programs to continue to address violence in mental health care. TAPOUT adds to existing programs by offering new perspectives and approaches in an easy-to-understand and recall format. This program was designed to help staff close the existing gaps in knowledge and skills with emphasis on the therapeutic use of self and using a proactive approach. Staff lack knowledge and skills in recognizing and de-escalating emerging violence. Staff members fail to recognize emerging violence and de-escalate at the earliest stages of behavior. It is imperative that staff grasp these critical concepts and use the skills in the existing training programs, in the manner intended, to prevent injury. By creating a program with an easy-to-recall method, they are more likely to attempt to employ the critical interventions needed to be proactive rather than reactive to emerging violence.

The evidence-based practice problem identified in a PICOT design question was: Will this program effectively guide new staff member approaches to mental health patients with challenging behaviors requiring psychiatric care?

- Population = Those caring for the mentally ill.
- Intervention = TAPOUT program for violence reduction education.
- Comparison = Traditional workplace violence reduction education.
- Outcome = Reduced incidence of violence.
- Time = Six weeks following the training and ongoing thereafter annually.

This project's purpose is to reduce the incidence of workplace violence by developing a multidimensional, evidence-based TAPOUT training program. This program guides staff to better understand critical skills for safe intervention and to ensure quality and safety are maintained.

Findings and Implications

Evidence for this DNP project was collected using a classic Delphi technique. This technique was identified as an acceptable method for achieving a consensus in specific topic areas by a panel of experts. This method allows the experts to express their opinions and provide feedback in an asynchronous manner, without meeting together. One of the primary advantages of this technique is anonymity and confidentiality, which can reduce the effects of dominant individuals (Dalkey, 1972). This technique minimizes the potential for manipulation or coercion that is more likely with group dynamics in other group feedback models. The process of data gathering included two rounds for the

feedback process, which allowed the expert panel to reassess their initial judgments about the information provided in previous iterations by other panel members.

The project evaluation was completed using a panel composed of five mental health professionals and members of the correctional health facility's leadership team identified as experts for this Delphi process. Delphi-structured questions were developed with a two-round response from panel members to gain consensus. Expert panel member provided feedback in an anonymous manner consistent with Walden University guidelines. Final approval of this staff education program was granted by expert panel members and will be forwarded to the regional director for review and possible implementation statewide. The Delphi questionnaire forms can be found in Appendix B for Rounds 1 and 2.

Delphi Round 1

In the first round, panel members were provided an open-ended questionnaire. Custer, Scarcella, and Stewart (1999) identified this type of questionnaire as being the foundation of acquiring specific information regarding the content area of this study. The first round consisted of a discussion and presentation of the evidence collected by the literature review, the drafted TAPOUT program in a PowerPoint presentation (see Appendix A), and the Delphi questionnaire (see Appendix B). Results of the Delphi technique can be found in Table 1.

Table 1

Themes Emerging From Delphi Technique Round 1

	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5
TAPOUT can reduce workplace violence	Yes	Yes	Yes	Yes	Yes
TAPOUT Advantages	Communicate / De-escalate	Helpful Works on strengths of self	Recognize personal triggers & aware of enviornment	Staff will feel support, enriched, cohesive, and under-stood	Encourage Pro-active Vs. Reactive Interactive exercises
TAPOUT Disadvantages	Resistance	Institution obstacles	Ensure Non-MH aware not meant for assess MI	Department of Corrections may not welcome an outsider to present content	None
Concerns	None	None	None	None	None
Recommendations	Proceed	Proceed	Proceed	Proceed	Proceed

Delphi Round 2

The second round was completed by the five expert panel members. The panel reviewed comments from Round 1 and responded with their insights. The Round 2 survey is included in Appendix B and formatted as a questionnaire incorporating quality components from Round 1 to achieve and confirm consensus.

The expert panel member with the highest authority took the floor and went to the front board and led the discussion. Using their Round 1 questionnaire responses, the expert panel conducted a professional discussion and achieved consensus. This expert panel group leader shared a summary of the evaluation of the TAPOUT program:

- It appears to be an innovative and results-oriented tool.
- It may initially be better for closed environments.
- It seems as if it will be most effective when used with interdepartmental training.
- It is contingent upon consistency.
- It may require a new culture with mandatory employee training.
- It may result in sensitization of the department of corrections system.

All five expert panel members agreed with this summary and expressed their consensus that this correctional facility could benefit from the TAPOUT program. They also agreed about the need to move forward with implementing the TAPOUT program as part of the formal training for this correctional health setting. In addition to this correctional facility, the expert panel expressed the idea that this program may be beneficial to other programs such as Alzheimer's programs, long-term hospitalization, medical facilities, confinement, inpatient units, mental health units, and close management. There may also be the potential for incorporating the TAPOUT program into various state-run programs. There were no unanticipated limitations implicit in the project, and the outcomes that arose at the conclusion of the project (full consensus to proceed with TAPOUT) were expected.

Implications

The expert panel suggested the TAPOUT program design has potential to make a positive impact to improve safety, increase quality care provided, and reduce costs by enhancing a therapeutic clinical milieu using strategies presented in this TAPOUT training program.

At the individual level, staff participating in this educational program may be better equipped with strategies to interact and intervene in a proactive manner. Staff should be able to make rational decisions with the least restrictive approach when implementing strategies within this program. And most importantly, they should understand that their positive use of self is integral for a favorable outcome.

At the community level, there may be improved family member satisfaction and reassurance that their relative is receiving safe and effective care, with a humanistic and empathetic approach. Reduced financial burden would be expected with the reduction in workplace violence due to increased staff competence.

At the institutional level, there may be reduced injury rates and associated costs such as absences, overtime, worker compensation, and lawsuits. Improved staff retention rates and less job turnover are expected as staff members' confidence in their ability to manage behaviors increases. This confidence also leads to less burnout or compassion fatigue.

At the system level, positive social change emerges as organizations collectively implement best practices for reduction of violence, not only in mental health care but for all professions. These areas may include but are not limited to mental health facilities,

hospitals, prisons, jail, police, schools, families, and friends. The concept of self is useful and effective in violence reduction efforts. Understanding the TAPOUT critical elements in combination with a therapeutic use of self is the key to reducing workplace violence and thus influence positive social change.

Recommendations

The evidence from the literature and Delphi process demonstrates the TAPOUT program's potential role in effectively reducing violence in the workplace. The proposed solution for ongoing violence reduction efforts is to implement the TAPOUT training program in the correctional health setting and ultimately in the entire correctional system. This training program would be offered to all staff through initial new employee training, including at correctional academies and annually thereafter.

Strengths and Limitations of the Project

The expert panel achieved consensus agreeing that this program does have the potential to help staff gain a better understanding of the quality components that guide the management of behaviors. The expert panel expressed the idea that this program would be helpful and have recommended that this program be implemented as soon as possible. Staff members in managerial positions who were present at the TAPOUT overview shared that they liked the activities to help them better identify the feelings of the inmates, which allows staff members to be sensitive to patients' needs.

There have been many strengths identified through this project development. The main strength identified is the potential to reduce workplace violence. By offering different modalities to approach behaviors and tools to manage self, there is a suggested

improved outcome. This will improve safety, enhance quality of care, and reduce costs associated from violence. With less violence, there will be less patient and staff injury and fewer costs associated with violence in the workplace.

The strengths identified by this expert panel include:

- TAPOUT encourages proactiveness versus reactiveness.
- As leadership offers the TAPOUT program to staff members, there is the potential that staff members may express the idea that they feel supported, understood, and enriched.
- Staff cohesiveness may increase as a result of TAPOUT.
- The program may be indicated as a good addition to officer training and allow mental health clinicians to recognize personal triggers to aggressive patients.
- It is a good reminder/refresher for those with experience.
- It works off people's individual strengths.
- It provides staff members who do not have experience in mental health with information on how to effectively communicate with difficult populations and de-escalate dangerous situations.

The potential concerns raised by the expert panel on implementing TAPOUT include:

- There are sometimes people from other fields who are unwilling to try mental-health-related interventions. It may be beneficial to explicitly state how it can positively impact their job.

- There may be institutional obstacles unanticipated by the leadership expert panel.
- It is important to ensure that those who are not mental health professionals be aware that this program does not mean they can assess mental illness.
- Departments may not welcome outsiders to present/enhance/benefit.and

Through observation and postprogram delivery debriefing, people using this program will be able to identify ongoing areas of concern. Future projects focusing on the development of additional training approaches to reach the audience in diverse ways to capture their attention and aid in retention of the critical elements would add to this program. Using a needs assessment, exploring the current literature, devising a training program, and using a panel for review before delivery is key to providing a good evidence-based training program in the clinical setting.

Summary

The evidence presented shows the TAPOUT program may effectively guide new staff member approaches to mental health patients with challenging behaviors requiring psychiatric care. Evidence has shown the potential benefits of using this program in this correctional setting on the reduction of violence. The next section will share my dissemination plan and my analysis of self through the completion of this doctoral capstone project.

Section 5: Dissemination Plan

The dissemination plan for this institution is to extend this training program to all staff members for the initial training of this TAPOUT program, first starting with the close management and self-harm observation dorm staff then moving to the rest of the compound. The recommended training plan would be scheduled by administrative staff, and all staff will be required to attend. I would work with the institution to establish set dates and times. Once a full round and all current staff are trained, I would monitor progress through tracking trends of incidents. The program may be modified and retraining offered on an as-needed basis for this approach. This program is also recommended to be included in the new employee orientation program for all new hires.

This project was developed by me as a DNP-prepared scholar/practitioner with future intentions of being a behavioral consultant to organizations, institutions, groups, and families who could benefit from a reduction in violence, particularly those dealing with mental health concerns. This program has the potential to assist many audiences who deal with difficult and challenging behaviors. This program gives different perspectives and insights with tools for recall that help facilitate and transition self to manage these behaviors in a more effective manner.

Analysis of Self

Through this educational program, I have found myself developing my role as a practitioner, scholar, and project manager through this DNP capstone project. While working as a psychiatric-mental health practitioner, I have observed many interactions with inmates/patients that elicit a negative behavioral response. I have been approached

by my supervisors at various times asking how I could gain compliance and reduce crises. The conceptual knowledge and empirical experience helped me understand what my successes were. From this experience, I learned there was a need to help others understand what helps reduce violence. I needed to explore the existing programs to address this need. Through this scholarly process, I learned that there are programs in existence, but gaps in solutions still exist. This understanding led to my transitional role in the DNP program as scholar/practitioner. This DNP project was the result of this epiphany. As a practitioner, I kept in mind what worked and what did not. As a scholar, I explored the existing evidence to see what was available to support my ideas and found that there was an extensive call for help in managing violence. I developed this program from my professional experience and current evidence. As project manager, I worked with institutions and staff to devise a training plan with a three-step process: assess, deliver, and follow-up.

With the de-institutionalization of mental health facilities, correctional facilities are experiencing growth of the mentally ill in the jail/prison population. There are potential opportunities to extend this program to guide correctional officers on ways to therapeutically manage the mentally ill in this setting. In fact, one upstate New York correctional facility leader has already voiced interest in integrating this program into the training academy. I can see this program growing nationally, and I want to be the scholar/practitioner guiding the growth of this program to meet the needs of the nation in violence reduction strategies. At first, I will be hands on and building the portfolio of this program design, and as it grows, the plan will be to develop a train-the-trainer program

and extend training opportunities to other organizations paving the path for growth and opportunity with this program. The possibilities are endless, and my dissemination plan is to keep this program moving and be the scholar/practitioner who is recognized for a significant contribution to social change for those caring for the mentally ill in any setting there is potential for violence.

Additional ideas for showcasing this project include poster presentations, podium presentations, and publications in psychiatric nursing journals. I have plans to network with national organizations' committees and conferences to target social change at a national level to introduce this TAPOUT program and its purpose.

The completion of this project provided an opportunity for integration of new knowledge and discovery of new practices. There were many challenges along this path. I learned how to explore problems at the system level and develop new strategies to address those systems problems. I learned how to dig deep into the existing research to capture methodologies that address current needs. I learned how to accept constructive feedback and integrate new-found knowledge. I learned how to develop educational programs to cover the gaps in practice. I learned how to become a scholar/practitioner writing in a scholarly voice, and I learned how to network and develop strategies to disseminate this project.

Summary

The problem identified was violence in health care. The purpose of this project was to develop a staff training program to address the gaps identified in existing training programs for violence in health care. Current research supported the evidence to develop

this TAPOUT training program, and an expert panel provided consensus that this program has potential to address violence in health care. The Delphi process was used to achieve this consensus and added validity to my TAPOUT training program. This DNP project has demonstrated TAPOUT can address the identified practice gap. The overall goal of this manual is to reduce incidence of violence using the evidence-based strategies presented in my TAPOUT program and is my social change project.

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Appendix A: PowerPoint Describing TAPOUT for Expert Panel

Concept of Self: As Therapeutic Tool

Using a Multidimensional Approach to Manage Challenging Behaviors in Mental Health

THE

TAPOUT

(Tolerances, Attitudes, Presentations, Options, Understandings, Timings)

Approach

PROGRAM OVERVIEW

- Needs assessment
- Program Delivery
- Post delivery/debriefing

- Multidimensional
- Therapeutic use of self

- Case Studies
- Role Playing
- Sensitivity exercises
- Dialogues
- Peer discussions
- Follow-ups

Learning Objectives

- Demonstrate an increase awareness of conditions which could elicit a staff emotional response
- Identify individual triggers and ways to Q-Tip (*Quit taking it personally*); Building and maintaining a therapeutic relationship
- Recognize and avoid power struggles
- Apply a continuum of interventions to assist in maintaining professional response
- Strengthen team approach

ISSUES

- a). **Tolerances-** staff were not working on the same level of tolerances (e.g., Personal, program or treatment).
- b). **Attitudes-** staff were taking things personally, bringing their personal issues into the workplace, negative ripple effect
- c). **Presentations**- staff were showing their emotions on the floor. Engaging in power struggles
- d). **Options-** staff were not being observant, they were not able to catch clients in the early stages of anger
- e). **Understandings-** communications, actions and intentions, perceptions were misread
- f). **Timing**- Staff were trying to correct too early or too late and when the client was already emotionally charged, not at a neutral time

SOLUTIONS

- a). **Tolerances-** Being self-aware of your own triggers and being able to set them aside to work within the confines of the program and treatment tolerances is a skill that is acquired and requires practice to perfect. Don't allow yourself to get involved in a power struggle.
- b). **Attitudes-** Check them at the door! Don't allow the negative energy to flow into the building. Keeping a positive attitude is half the battle. Think Q-TIP (Quit- Taking It Personally).
- c). **Presentations**- What you say, how you say it and the actual words of what was said influence behavior. Make sure your not sending the wrong signal.
- d). **Options-** What is available at what stage (early, middle, late) of the interaction. Early detection and early intervention is the best approach. Actively assessing the situation will allow you to intervene early and may prevent a situation from escalating into a crisis.
- e). **Understandings-** Successful Treatment = balance of warmth, caring, compassion, proper amount of firmness, realistic tolerances and competent teaching.
- f). **Timing-** "Timing is everything." All proactive education must occur at a neutral time. A neutral time for both the resident and yourself. Neither party can provide or accept effective teaching when there is emotional involvement. Find the recipient's "Carrot" that will 'want' them to change.

Action Steps

- Seek facility management team approval to work, as part of a multidisciplinary team to gather current needs for improvement from:
  - Facility Management
  - Quality Management
  - Education and Training
  - Departmental Supervisors
- Work with Education and Training to finalize current draft, implement a train-the-trainer program and deliver the training to all direct care staff on the TAPOUT program.
- Evaluate program effectiveness and adjust needs
- Ongoing training

Program Delivery

- Work with supervisors to schedule training sessions on all shifts and all buildings (Beginning with Confinement) Resources needed:
  - Paper (training packets)
  - Pen
  - Copier
  - Time
    - Initial training 4 hours
    - Annual training 2 hours
    - May consider longer/shorter pending needs
  - Time with supervisors to collect current training needs from incidents

The End…

References

Available in proposal

Appendix B: Delphi Technique Evaluation Questions

Expert panel session 1 questionnaire

1. What is your initial reaction to this TAPOUT program?
2. What do you see as significant advantages to this program?
3. What do you see as significant disadvantages to this program?
4. What do you perceive the impact of this program on reduction of workplace violence would be?
5. What additional final thoughts/insights can you offer about this TAPOUT program design?
6. What other institutions and organizations you believe may benefit from this training program?

Expert panel session 2 questionnaire

The expert committee round 2 questions included:

1. Do you agree with this summarization?
2. Do you agree that this correctional facility would benefit from TAPOUT?
3. Do you agree we need to move forward with the TAPOUT program?
4. Should this program be implemented into formal training for this setting?
5. When should we schedule implementation?
6. What units should we start with, over what timeframe?