2019

Preventing Patient on Nurse Violence Through Education

Sandra Risoldi
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Sandra Risoldi

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Cassandra Taylor, Committee Chairperson, Nursing Faculty
Dr. Mary Martin, Committee Member, Nursing Faculty
Dr. Jonas Nguh, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

Preventing Patient on Nurse Violence Through Education

by

Sandra L. Risoldi

MSN Ed., Walden University, 2017

BSN, South University, 2014

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

June 2019

Abstract

Many nurses are physically and verbally abused by the patients under their care, with those providing care to patients dealing with mental illness or addition being at particular risk. Leadership of the project site, an urban mental health treatment center, identified a need to provide additional education to improve their nursing staff's ability to work with combative patients and prevent escalation of violent behaviors. Albert Bandura's social cognitive theory and adaptation to the environment guided the development of this project to answer the question if an education program for nurses working with potentially combative patients will increase their knowledge of strategies to prevent escalation of violent behavior. The education program was developed using results from an extensive literature review and input from a team of local subject experts, who provided evaluation regarding their satisfaction with the planning process through the completion of an anonymous, 10 questions, Likert-type survey. All team members scored each question with a (5) strongly agree or (4) agree. Project deliverables handed over to the facility included the developed education program, an associated handout, a plan for later implementation, and plans for outcome evaluation through evaluation of learning. This project has the potential to achieve positive social change through less violent encounters between nurses and patients, contributing to an increased culture of safety.

Preventing Patient on Nurse Violence Through Education

by

Sandra L. Risoldi

MSN Ed., Walden University, 2017

BSN, South University, 2014

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

June 2019

Dedication

This project is dedicated to my children, without you, I wouldn't be where I am today. My Grandmother, I know you are smiling from heaven, and thank you for being there for me, I miss you every day. Finally, but not least, my nursing family. Nursing is a caring profession that welcomed me into its arms 29 years ago as a nurse's aide-assistant. This project is a symbol of my love for what we do and dedicate my life to help us stay safe and promote healthy coping mechanisms. Together we can do this!

Acknowledgments

I would like to acknowledge my project committee chair Dr. Cassandra Taylor, committee member, Dr. Mary Martin, and university research reviewer, Dr. Jonas Nguh. Thank you for all your time, hard work, and dedication throughout my DNP project. I would also like to thank with great gratitude, my preceptors Dr. Leslie Rainaldi, and Dr. Selman Manual. Thank you for the guidance, encouragement, laughs, and support with achieving my doctorate, this has been a dream come true!

Table of Contents

Section 1: Nature of the Project

Introduction

Verbal and physical violence against nurses is growing at an epidemic rate. The American Nurses Association (ANA, 2018) #EndNurseAbuse survey revealed out of 14,000 nurses who responded, 62% stated they had suffered both physical and verbal abuse from patients. The most recent report reflects that interactions with patients caused 80% of nurse injuries, and 17,000 violence-related injuries occurred in a combination of hospital and long-term care facilities (Esposito, 2017, Occupational Safety and Health Administration [OSHA], 2015). Among hospital departments, emergency departments contain multiple risk factors for patient-on-nurse violence. Over the last 10 years in the United States, the number of patients visiting the emergency department has grown from 90.3 million to 119.2 million, with psychiatric visits increasing to 2.89 million per year (Florida Council for Community Mental Health, 2011). Among those admitted to the emergency department, there has been an increase number of patients with acute mental illness and substance abuse; who are brought in by law enforcement officers for medical clearance, admission, and observation (Gacki-Smith et al., 2009).

While the emergency department staff often receives training for de-escalation of potentially violent patients, few nurses on the general and intensive hospital units have been formally trained with an escalation behavior management program. When a patient is admitted to an observation bed, it could be on a medical-surgical, orthopedics, telemetry, or a stand-alone observation unit where the nurse may or may not have had specific escalation behavior management training. The project site is a specialty unit,

providing care during recovery from acute mental illness, drugs and alcohol. Staff in this setting have a greater understanding of working with this population but felt the need to improve their knowledge with a focus on prevention of violent behavior escalation. The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The projected positive social change of this doctoral project is to prevent behavior escalation, thereby reducing patient-on-nurse violence and subsequent physical and mental injury.

Problem Statement

The ANA (2018) #EndNurseAbuse survey revealed that out of 14,000 nurses who responded, 62% stated they had suffered both physical and verbal abuse from patients. Violence is affecting nurses in various ways. Nurses may suffer from burn-out or posttraumatic stress disorder, which leads to the reduction of productivity, an increase in call-offs, and high turnover rates (Gates, Gillespie, & Succop, 2011). The morale of the nursing population is being negatively affected by the growing number of violent episodes against nurses.

The local problem is that the selected urban hospital's leadership has recognized the need to provide additional education for staff to improve their nursing staff's ability to work with combative patients and prevent escalation. Currently, there is no formal continuing education in place at this facility. Pre-licensure education for the practical and professional nursing program, provide approximately 25 hours of mental illness and addiction training. The combination of minimal formal nursing education requirements and little to no continuing education in the healthcare setting means that experienced

nurses and new graduates are not prepared to work with behavior escalation (Zhao et al., 2015).

Purpose

The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The gap in practice is that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients. Provision of continuing education may address this practice gap by providing nurses with information on strategies to prevent escalation. The guiding question for this project was: Will an education program for nurses working with potentially combative patients increase their knowledge of strategies to prevent escalation of violent behavior?

Nature of the Doctoral Project

In order to develop a staff education program for staff nurses, it was essential to conduct a literature search for several key terms referencing workplace violence while utilizing the team of local experts. Incorporating evidence from the literature, along with valuable input from the team, I developed an education program tailored to the organization's need. The interdisciplinary team consisted of a physician, a family nurse practitioner (FNP), and a staff nurse, all experts within their profession. The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The gap in practice is that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients.

Significance

The stakeholders identified are the nurse managers, staff nurses, therapists, ancillary staff, and patients. Staff nurses, ancillary staff and therapists would be affected since they work directly with the patient population and at a higher risk for being injured. When working with potentially combative patients, education is key to reducing injury by increasing skills to manage the risk. Other stakeholders are the patients on the healthcare unit, who are witness to escalation during the day or at night, are at a higher risk for sleep disturbance, affecting the patient's healing process (Stiver et al., 2017). Nursing managers and administrators are stakeholders, since this education could assist in the creation and maintenance of a culture of safety.

The potential impact on nursing practice will be a decrease in violent acts against nurses, an increase in morale, improved working conditions, increased self-efficacy, and decreasing turnover rates. This project has transferability to any workplace where nurses care for patients who are at risk for violent behaviors, which essentially is any area where nurses work. This project has the potential to influence positive social change by decreasing violence in health care environments and protecting both nurses and their patients.

Summary

The ANA (2018) #EndNurseAbuse survey revealed out of 14,000 nurses who responded, 62% stated they had suffered both physical and verbal abuse from patients. The gap in practice is that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients. The purpose of this

project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The guiding question for this project was: Will an education program for nurses working with potentially combative patients increase their knowledge of strategies to prevent escalation of violent behavior? The goal is to prevent escalation of violent encounters with combative patients.

Section 2: Background and Context

Introduction

The ANA (2018) #EndNurseAbuse survey revealed out of 14,000 nurses who responded, 62% stated they had suffered both physical and/or verbal abuse from patients. The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The guiding question for this project was: Will an education program for nurses working with potentially combative patients increase their knowledge of strategies to prevent escalation of violent behavior? The goal is to prevent escalation of violent encounters with combative patients. Utilizing established concepts such as the social cognitive theory, along with the subcomponent's resilience and adaptation, the staff education program was created for the facility by the interprofessional team of experts.

Concepts, Models, and Theories

Albert Bandura was the sole creator of the social cognitive theory, which evolved originally from the social learning theory in the 1960s and separated in 1986 where the learning involves the return of the same behavior from the person within the environment (LaMorte, 2018). The social cognitive theory is best explained when personal experiences, life events, behavioral patterns, mixed with environmental factors interact with another, influencing each other (Bandura, 2001). Belief systems can play a role in how the patient or nurse is perceived during care by anticipating behavior that could arise during a hospital stay (Bandura, 1989). Through social cognitive therapy, it is suggested that the behavior exhibited from nurses and patients may model one's behavior or actions

(Sidhu & Park, 2018). Ultimately resulting in the patient perception of the nurse's reactions as a reason to escalate or become combative.

The use of the adaptation theory, a component of the social cognitive theory, enables the nurse to take control of their actions and thoughts, through finding the meaning behind the violent event (Benight & Bandura, 2003; Chapman, Styles, Perry, & Combs, 2010). When a nurse experiences a traumatic event, they start to adapt to the behavior by searching for another meaning, attempting to understand the situation and adjust their behavior to better themselves (Taylor, 1983). If the nurse does not recognize the need for an outlet to cope with the on-going stressful events of the healthcare environment, it can lead to compassion fatigue, burn-out, and post-traumatic stress disorder, reducing the ability to adapt (Schmidt & Haglund, 2017). The connection between the adaptation theory and this education program, is the nurse will adapt to the environment by remaining free from verbal and physical abuse and gain knowledge to effectively work with combative patients.

Relevance to Nursing Practice

Recent statistics revealed that a large number of nurse respondents have suffered and reported verbal and physical abuse, resulting in the need for training and subsequent educational training opportunities (ANA, 2018; Bolvin, 2018; Florida Department of Education [FLDOE], 2018). Studies have revealed a relationship between substance abuse and patient aggression in the healthcare setting (American College of Emergency Physicians [ACEP], 2009; Kleissl-Muir, Raymond, & Rahman, 2018). The nursing school curriculum in Florida, for both practical and professional nurse programs, have

minimal requirements for addressing mental health and substance abuse. One full section addresses communication and interprofessional skills, and three subheadings address care planning for a psychiatric patient, defense mechanisms, and adverse effects of substance abuse (FLDOE, 2018). When creating a course curriculum, the nursing instructor is given the autonomy to address the depth and amount of education on a determined subject, within the approved guidelines. The amount of education for each section is not standardized; as a result, if the instructor that creates the course curriculum is not proficient in the area, then the area may not have extensive detail. Insufficient mental health and substance abuse training in both the practical and professional nursing curriculum may contribute to the epidemic of patient violence against nurses (FLDOE, 2018).

The recent statistical data released from the ANA (2018) #EndNurseAbuse survey revealed out of 14,000 nurses who responded, 62% stated they had suffered both physical and verbal abuse from patients. Bolvin (2018) released further statistics that one in five nurses reported a physical assault, where 42 percent made a written report, and nearly half of those who did report were not satisfied with the outcome of the incident. The incidence of underreporting workplace violence can be contributed to the beliefs of nurses that nothing will get done, violence is a part of the job, nobody was hurt, and the violence may be unintentional due to the patient's condition (Sofield & Salmond, 2003; Chojnacka, 2005; Snyder, Chen, & Vacha-Haase, 2007; Gates et al., 2011; Sato, Wakabayashi, Kiyoshi-Teo, & Fukahori, 2012; Arnetz et al., 2015; Hogarth, Beattie, & Morphet, 2015; Copeland & Henry, 2017; The Joint Commission, 2018; American

Nurses Association [ANA], 2018; Bolvin, 2018). From an administrative standpoint, reported data are the only way that an issue can be identified (The Joint Commission, 2018). Gates (2011) has also further suggested that organizations do not favor reporting as it may directly affect the patient satisfaction scores. If no statistical data can be retrieved in the system, then there will be no evidence of a problem.

A recent study was conducted on the effects of patient-inflicted violence towards nurses, resulting in burnout and nursing turnover (Laeeque, Bilal, Babar, Khan, & Rahman, 2017). The research was conducted between four hospitals, 350 questionnaires were sent to the human resources department where they were distributed among the participants and the ability to remain anonymous over the study's three-month period (Laeeque et al., 2017). The result of the research concluded that patient on nurse violence increased occupational stress, leading to burn-out, directly and indirectly resulting in staff turnover (Laeeque et al., 2017). Recommendations from the research suggested the benefit of building social groups for nurses to vent their concerns, giving advice, blogging, and attending online communities are one way to help nurses cope with the stressors they face on healthcare units (Laeeque et al., 2017).

The Agency for Healthcare Research and Quality (AHRQ) performed a systematic literature review of strategies geared towards the de-escalation of aggressive behavior that could potentially eliminate the need for seclusion or restraints through prevention measures (2016). The AHRQ (2016) suggested several avenues in the study to help reduce or enhance the milieu on the unit, including; the increase of staffing ratios, decrease the noise or chaotic environments, and utilize risk assessments on patients to

prevent triggers and prevent behavior escalation. In addition to the unit modification suggestions, the use of cognitive behavior techniques, non-verbal support, and treatment of the underlying psychiatric or medical condition, could play a major part in preventing escalation (AHRQ, 2016). The presented study in the systematic literature review consisted of data captured from both men and women psychiatric patients from 38 to 40 years of age, with any ethnic background (AHRQ, 2016). The conclusive results pointed to the use of a risk assessment tool as the most effective with the reduction of seclusion and restraints in the acute care hospital. It was shown that increasing staff training and interpersonal communication skills fostered the relationship between patient and nurse, ultimately reducing the need for de-escalation procedures and prevented occurrences (AHRQ, 2016).

The next article reviewed demonstrated that staff education training decreased the use of seclusion and restraints throughout 12 months. The goals of the training program were to 1) increase awareness of what could increase behavior; 2) promote knowledge and use less restrictive measures to reduce behavior; 3) increase knowledge and training to staff to know how to react to the behavior. The training also included the hands-on simulation of being in a 5-point restraining system to provide a real example of how it must feel for the patient, also reminding learners of patient rights to reduce the more aggressive approach. By using a preventative approach with verbal interventions, self-defense training, and role-play, the annual rate of restraint use went down an overall 13.8 percent and staff injuries reduced by 18.8 percent in two-years (Forster, Cavness, & Phelps, 1999).

Another article focused on the surveillance of three hospitals and fourteen acute mental health wards, with a total of 5,384 admissions, over a three-year time frame (Bowers et al., 2006). Psychiatric staff reported feelings of guilt, self-blame, anger, anxiety, post-traumatic stress disorder, and feelings of shame following an increase of attacks from patients. The organization developed a prevention program that aimed to manage violence and aggression through education regarding how to break away from a patient attack or hold, legalities of restraining individuals, and how to manually restrain until treatment was rendered. The training program originated as a five-day course within the prison system and was modified to meet the needs of the healthcare providers working with those that have addiction and acute mental illness (Bowers et al., 2006).

The use of the six core strategies, formulated by the National Association of State Mental Health Program Directors, was beneficial in the creation of this education project (National Association of State Mental Health Program Directors [NASMHPD], 2006). Strategy steps within this article are used to reduce the need for restraints and seclusion through cooperation of patients and the prevention of behavior escalation. The areas of focus are on organizational leadership, data collection of possible deficiencies, education development, restraint/seclusion prevention tools, consumer involvement in care, and debriefing techniques (NASMHPD, 2006). One proponent that is echoed throughout this article, would be the education strategies, and how it is necessary to gather input from an interdisciplinary team and the need for a proactive leadership. Data were gathered from reported incidents advancement of the education piece through modifications and updates. The involvement of the senior level staff would prove beneficial and create a

culture of reporting and promotion of safety (NASMHPD, 2006). To tie in the benefits and disadvantages of using the six core strategies, it is necessary to evaluate the effectiveness of the steps, to ensure all possible interventions were utilized during the debriefing which is held approximately 24 to 48 hours concluding the seclusion and restraint event (NASMHPD, 2006).

The Substance Abuse and Mental Health Services Administration aims to reduce the number of restraints and seclusion. Aligning insights with NASMHPD, SAMHSA has a comprehensive training program that includes the six core strategies and links inadequate staffing as a contributor to injuries, abuses, and even deaths as the result of using seclusion and restraints (Substance Abuse and Mental Health Services Administrations [SAMHSA], 2005). Through using restraints and seclusion techniques, staff could suffer secondary traumatization, which can mimic post-traumatic stress disorder when either being involved in an episode or witnessing the traumatic event (SAMHSA, 2005). Staff trained to decrease the use of restraints and seclusion did not expect the techniques to be effective, but combative behavior and injuries decreased after the training (O'Hagan, Divis, & Long, 2008; SAMHSA, 2005). The method of preventing combative behavior can begin with gathering information about triggers and what works to prevent escalation, or help the patient to feel safe (SAMHSA, 2005). Steps provided throughout the training program, are designed to strengthen the organization with guidance, explore coping mechanisms, decrease mental health stigma, increase education about seclusion or the use of restraints, prevention methods and personal behavior modification or techniques (SAMHSA, 2005).

The benefit of using the education and literature on seclusion and restraints for this education project, is that it offers support and addresses the need for preventing escalation and how to decrease incidences of violence. The next article discusses best practices to eliminate restraints and seclusion; with a spotlight on workforce development, staff education, promote patient autonomy, escalation prevention with early intervention tools, and debriefing (O'Hagan, Divis, & Long, 2008). Highlighting the prevention and debriefing sections from this article as planning and re-evaluation of the methods or approach is vital to improve the outcome for the patient. Several plans and assessments can be employed to predict the rise of behavior escalation with knowledge specific to the patient, to ensure escalation is prevented with a blueprint of what works for the patient. The debriefing is used as a tool for staff to reconfigure what should be done better and offered as a learning opportunity. Additional benefits of the debriefing help staff to share how they feel about the experience and areas where they feel improvements should be made (O'Hagan, Divis, & Long, 2008).

Local Background and Context

When the mental health units are filled in the hospital, the emergency room will stabilize the patient and refer them to a local mental health and recovery center. The setting for this doctoral project is located Orlando, Florida, in a small private mental health and recovery center; that accepts insured patients who are suffering from mental illness and substance abuse. In this setting, there will be approximately 25 staff members that would be a target for this education program. On a monthly average, the facility admits "85 patients with 30 that are or have volatile tendencies, with most having a

criminal history" (K. Alexander, personal communication, January 22, 2019). Currently, the facility does not have an education program to help prevent violence escalation. At this present time, the federal government does not have workplace violence protections in place; and the Occupational Safety and Health Administration (OSHA) only have recommendations for healthcare agencies to report violent episodes (Trinkoff et al., n.d.). Despite the recovery center reporting "eight verbal and one physical escalation last month, there has been a steady increase of volatile admissions over the last few months" (K. Alexander, personal communication, January 22, 2019). The facility management expressed a need for an education program, as there has been an increase of verbal escalation leading to a recent physical attack on a nurse.

Role of the Doctor of Nursing Practice Student

Currently, I am a nursing professor at an area school of nursing, teaching didactic, lab, and clinical for a registered nursing (RN) program in the Orlando area. My affiliation with the recovery center is clinical and project-based for this project. Potential personal bias with this project is that nurses may not consider the impact of not reporting violent situations, and how it can directly affect nursing safety. My role with this doctoral project is to create an education program geared toward preventing behavior escalation and decreasing violent incidents in the healthcare unit. Once the education was created with the facility experts, my role then was to create an education presentation with coordinating hand-outs for future use of this education program.

Role of the Project Team

When determining the success of this doctoral project, it was vital to consider the roles of those chosen. The interdisciplinary team consisted of a physician, FNP, and a staff nurse, all of whom are experts in their field. The nurses have been in the field for a combined 50 years. The physician has been in the profession for approximately 25 years and has valuable expertise with mental health, mental illness, and addiction. The collective experience of the project team involves knowledge of addiction therapy, behavior modification, acute and chronic mental illness. Each expert involved in the creation of this project brought their observations of past or current situations of verbal or physical escalation. My role was to determine the gap in practice and lead the team by performing the review of literature and developing the education program.

When I concluded the project with the interdisciplinary team of experts, they received the created staff education materials, hand-outs to assist in the teaching program, and the education evaluation form. During the final stages of transferring the project to the facility, the team was consulted with the creation of a plan to implement the completed project. Within 3-months of the completion of this project, the Director of Nursing will hand the materials over to the education specialist for evaluation. In 6-months, the training program will be administered to all nursing staff. The goal is to prevent escalation of violent encounters with combative patients.

Summary

The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The

gap in practice is that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients. Concepts utilized for this staff education project stem from the social cognitive theory, and adaptation theory, which were applied to create evidence-based education regarding strategies to prevent escalation of violence. Once the project was completed, the materials were handed over to the facility to implement into their long-term education program.

Section 3: Collection and Analysis of Evidence

Introduction

The ANA (2018) #EndNurseAbuse survey revealed out of 14,000 nurses who responded, 62% stated they had suffered both physical and verbal abuse from patients. Violence is affecting nurses in various ways, from burn-out to post-traumatic stress disorder, resulting in low morale, productivity, an increase of call-offs and turnover (Gates, Gillespie, & Succop, 2011). The project site is a recovery center inpatient facility with outpatient programs that focus on those who are seeking help for substance abuse and mental illness. The team of experts within the facility agreed with the project focus on an education program regarding violence escalation in combative patients for nursing staff.

The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The next section will review the practice-focus question, sources of evidence, and an analysis and synthesis of pertinent information relating to this project. Nurses play a large, intricate role in the process of care of all patients, in every capacity and situation. Not having the information needed through either a formal education setting or continuing facility education to help nurses understand how to holistically care for combative and combative patients; could leave both experienced and new nurses open for mental or physical injury. The goal is to prevent escalation of violent encounters with combative patients.

Practice-Focus Question

The local problem is that the selected urban hospital's leadership has recognized the need to provide additional education for staff to improve their nursing staff's ability to work with combative patients and prevent escalation of violence. The gap in practice is that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients. The guiding question for this project was: Will an education program for nurses working with potentially combative patients increase their knowledge of strategies to prevent escalation of violent behavior? When nurses do not have the knowledge or resources to assist them with learning how to work with patients who exhibit combative behavior, they have a high incidence of becoming a victim of abuse (Taylor, 1983). The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients.

Sources of Evidence

The project education program was developed based on published literature in combination with valuable input from the project team, consisting of a physician, FNP, and a staff nurse. The team of experts employed for this project were well-rounded, established within their fields, have valuable insight, and working knowledge of common deficiencies when caring for a potentially volatile patient. The team of experts have a combined experience of over 50 years and agreed that an education program would be beneficial to their facility.

The guiding question for this project was: Will an education program for nurses working with potentially combative patients increase their knowledge of strategies to prevent escalation of violent behavior? The education development was guided by social cognitive theory, created by Albert Bandura, which describes how personal experiences, behavioral patterns, life events, and environmental factors influence the outcome of an event (Bandura, 2001). Nurses may or may not understand the concept of how modeling behavior could benefit their outcome with the nurse-patient relationship (Sidhu & Park, 2018). If the nurse does not recognize the need for an outlet to cope with the on-going stressful events of the healthcare environment, it can lead to compassion fatigue, burn-out, and post-traumatic stress disorder, reducing the ability to adapt (Schmidt & Haglund, 2017). As a result, the behavior escalation prevention education program can assist in the reduction of workplace injuries, enabling the nurse to enhance their well-being and gain mastery with working in potentially volatile patient scenarios (Chapman et al., 2010).

Program Development

As a part of the ethical protection of the project team of experts, each individual voluntarily participated in the development of the education program and was allowed to withdraw at any time. This educational project was required to be submitted through the Walden University Institutional Review Board (IRB) for ethics approval, and to comply with the site facility IRB policies and procedures. To locate relevant literature to synthesize information for the educational program, I used the CINAHL, MEDLINE, and the Joanna Briggs Institute databases. Keywords used for the search included violence against nurses, patient on nurse violence, de-escalation, education programs, burn-out,

posttraumatic stress disorder, workplace violence, mental illness, mental health, social cognitive theory, adaptation theory, behavior prevention education programs, physical violence, verbal abuse, reporting workplace violence, strategies for de-escalation, addiction, and anxiety. Articles over 15 years were discarded, though sources about psychology theories/theorists range up to 35 years.

Analysis and Synthesis

The content obtained through a literature search was instrumental in the creation of the escalation behavior prevention program. The initial draft of the education program was developed from the gathered literature. To ensure the project remains on track, it was vital for my role as the project manager to present the details to the team for discussion. It was the project manager's responsibility to incorporate the team's feedback regarding the initial draft into a revision of the education and present the revision to the team for review. At the conclusion of the project, all deliverables were handed over to the facility for later implementation. Deliverables were defined as education materials, associated handouts, a plan for education delivery and evaluation of learning. Once the project was complete, the team of experts provided project evaluation through a survey regarding their satisfaction with the planning process and the leadership provided by myself. See Appendix A for the questionnaire that was used for the project evaluation.

Summary

The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. After a review of the literature, an education program was developed for nurses that are

working in a mental health and recovery center. The goal is to prevent escalation of violent encounters with combative patients. This program included educational materials and hand-outs to help nurses remember the reviewed material. An evaluation form was developed and was included for subsequent use to evaluate the participants learning. The planning team of experts provided project evaluation through a survey regarding their satisfaction with the planning process.

Section 4: Findings and Recommendations

Introduction

Verbal and physical violence against nurses is growing at an epidemic rate. The American Nurses Association (ANA,2018) #EndNurseAbuse survey revealed that that out of 14,000 nurses who responded, 62% stated they had suffered both physical and verbal abuse from patients. The most recent report reflects that interactions with patients caused 80% of nurse injuries, and 17,000 violence-related injuries occurred in a combination of hospital and long-term care facilities (Esposito, 2017, Occupational Safety and Health Administration [OSHA], 2015). The gap in practice is that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients. The guiding question for this project was: Will an education program for nurses working with potentially combative patients increase their knowledge of strategies to prevent escalation of violent behavior? The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The sources of evidence involved with this project were information on verbal and physical violence against nurses obtained through scholarly searches in combination with valuable input from the project team of experts' knowledge of deficiencies in the care of patients in their facility. Information gathered was used to create the education and handouts, utilizing both social cognitive and adaptation theories.

Findings and Implications

Findings from the literature review that were included in this project are; awareness, recognizing the beginning symptoms of behavior escalation, implementing conflict resolution with increased communication, and the benefits of debriefing (Forster et al., 1999; Johansen, 2012; NASMHPD, 2006; SAMHSA, 2005). Other areas covered in this program include the creation of a safe environment for the nurse to express feelings, report violent events, and increase both interprofessional and interprofessional communication. A draft of the educational program was created and distributed to the project team of experts for review and further input. The team of experts included a physician, a FNP, and a staff nurse who currently work on a mental health and recovery unit. The team of experts was given a timeline at the beginning of the project, and quarterly to reveal progress. During the first meeting, the team discussed the educational objectives. The objectives identified for the escalation behavior prevention program synthesized from the gathered literature were:

1. Review situations that could potentially increase patient stress levels.
2. Recognize the beginning symptoms of behavior escalation.
3. Review conflict resolution and the need for communication.
4. Recognize the importance of self-care and reporting events.

Team meetings were guided by the objectives and organized into short, simple steps with rationales for simple knowledge assimilation. Team discussions focused on a three-step approach to escalation prevention. The first step is awareness, which consists of reviewing the patient's situation, support system, and employment, while observing

their actions and reactions. Awareness must also include understanding of the patient's commitment status (voluntary or involuntarily), their use of substances, and decisions regarding further assessment criteria. The second step is prevention, through reflection on the patient's behavior and possible explanations such as flashbacks undiagnosed or untreated. The third and final step is conflict resolution, in which the nurse helps the patient through a difficult moment with increased therapeutic communication. The team discussed these specific behavior techniques:

1. Recognize stress behaviors.
2. Address the issue before the loss of control.
3. Actively listen, using non-verbal and verbal communication methods.
4. Be aware of one's breathing and slow it down.
5. Identify the problem and find a solution.

The last area that ties the three steps together is debriefing and reporting the event. Without reporting the verbal or physical incident, the facility is unaware of the trauma created for the staff member. Mandatory debriefing measures are suggested to help prevent staffing issues by increasing the milieu and remaining cognizant of the noise stimulation on the unit.

A draft education presentation was discussed in the second team meeting. During the final meeting, the team critiqued and revised educational handouts, to ensure their coordination with the information on the presentation and effectiveness to promote recall of the escalation behavior prevention program, and subsequent training. The team of experts remained in sync with one another and were successful in planning assistance by

sharing input, insight, and experiences needed to create the escalation prevention program.

The project site received a visit from their accreditation organization during the same approximate time that team meetings for planning the project education program had been scheduled. The accreditation visit created unexpected fluctuations in the team's schedules, which was resolved through virtual and in-person meetings to ensure deadlines met the demands of this project. When the accreditation review was completed with remediations resolved, in-person meetings resumed as scheduled.

At the conclusion of the staff education project, the team of three experts completed an evaluation questionnaire located in Appendix A. All members answered agree or strongly agree that the problem was clear, and the literature was analyzed and synthesized to reflect the need for staff education to prevent violence escalation in the workplace. One of the evaluators mentioned in their evaluation that staff nurses expressed that they would feel more confident and ready to work with patients to prevent combative behavior if there was a program in place. The team of experts all agreed that the project objective to develop and create an education program that will focus on strategies to prevent escalation of violent behavior for nurses has been met. Every member in the team of experts agreed that I had exhibited leadership throughout the project; the flow was organized, and scheduled meetings were on-time and efficient. The team of experts were happy about the staff education program, as it gives valuable information to fill in gaps of knowledge that the nurse will need to keep themselves and others safe in the workplace.

Education on preventing violence escalation is essential for nurses that work with patients that potentially may be volatile. The concept of escalation prevention decreases the need for de-escalation techniques; through being more aware, recognizing increased stress, conflict resolution with increased communication, and the benefits of debriefing. When a patient reaches the point of escalation, their voice becomes elevated, verbally abusive and at times resulting in physical attacks. The concept behind de-escalation is to subdue and control a patient that has reached a level of behavior escalation that is combative and puts the patient, other patients, and nursing staff at risk for injury. Whereas, an escalation prevention program gives the nurse tools to recognize signs of increased stress, to help the patient calm down which ultimately will prevent further escalation. Eventually, the nurse will become proficient in escalation prevention skills and become resilient in protecting their mental and physical health (Chapman et al., 2010; Taylor, 1983).

There are many implications that can arise from having an escalation prevention program in place. Staff nurses who receive this prevention training will have new and updated information to help them understand how to care for someone who is in mental health or addiction crisis and develop better understanding of self-care and coping mechanisms to protect themselves from absorbing the behaviors on the unit. For individuals in the community, nurses who are utilizing the escalation behavior prevention program will ultimately assist the patient in having a more holistic approach to their care, reducing the incidence of increasing trauma to the patient and nurse. The recovery center may benefit from an escalation prevention program through improved staff satisfaction,

reduced nurse turnover and workforce shortages. Financial benefit to the facility is possible if patient satisfaction measures increase, which then trigger improved reimbursement from insurance carriers. When the initial draft was presented, all members responded with positive feedback and stated that the information created was relevant to the current trends in healthcare and promoted social change.

Recommendations

The gap in practice is that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients. The staff education program covers the topics of preventing behavior escalation by covering the gap in practice through increasing knowledge, awareness, symptom recognition, conflict resolution with communication, and debriefing of the event. Added benefits of the education project will give the nurse tools for success to prevent injuries and mental trauma from the event. The completed project includes the educational program in an electronic presentation, one handout, and a questionnaire that will evaluate the understanding of the learned material.

The electronic presentation (Appendix B) will contain 13 slides that will cover the steps of the escalation behavior prevention program in detail. It was important to align the steps of the education program in the handout, keep it simple, and easy to read as a summary of the strategies for the nurse on-the-go. (see Appendix C). The escalation prevention education will be delivered in-person by a trained expert, with attendance mandatory for all RNs working on the mental health and recovery units. New employees will receive the education during orientation as preparation for working with potentially

volatile patients. Subsequently, RNs will independently review the electronic presentation during their annual training and complete the comprehensive questionnaire as evaluation of learning.

Appendix D contains the comprehension questionnaire, to be completed before and after the education. Six multiple choice questions are designed to evaluate learning. The comprehension questionnaire also contains space for the participants to offer suggestions if they choose, which can assist the organization with future updates of the educational material. When the project concluded, the team of experts had all the education materials to begin their escalation prevention education program for the nurses. Implementation of the escalation prevention education program could help decrease violent encounters with combative patients and result in less escalation of violence when encounters do occur.

Contributions of the Doctoral Project Team

The team of experts used for this doctoral project consisted of a medical physician, nurse practitioner, and a staff nurse who work in the mental health and recovery units. I selected these leaders to assist with the creation of the educational program due to their experience working with volatile patients, and their ability to ensure all nurses utilize the training for the safety of patients and staff. The team of experts were supportive and forthcoming with providing information that would lead to the discovery of the gap in practice and feedback on the education that was created. Although not a psychiatrist, the physician has spent over 25 years working patients' mental health and addiction problems, experiencing how certain patients may get triggered in a healthcare

setting if the nurse is not adequately prepared through education or training. The FNP was instrumental in guiding the facility-specific details and how the education could be specifically applied in the project facility. Finally, I observed nurse-patient interactions while shadowing the staff nurse, who also assisted with the project by soliciting nurses' views about the current events of potentially volatile situations. Over some time, the use of the program evaluations and comments/suggestions area will help the team of experts with updating the escalation prevention education. When working in a facility that does not have continuing education on managing combative patient encounters, the escalation prevention education program can be the missing link to build strong education to help nurses keep patients and staff members safe.

Strengths and Limitations of the Project

The local problem is that the selected urban hospital's leadership has recognized the need to provide additional education for staff to improve their nursing staff's ability to work with combative patients and prevent escalation. There are many strengths to this education project. When conducting a literature review, many articles supported the need for an escalation prevention education program for nurses. The main strength of this program is the welcome and participation from the facility to develop an education program that will be utilized in their facility to enhance safety on the units. Some nurses have preconceived barriers about working with patients that are potentially volatile, which is a limitation of the education developed during this project. It is important to eliminate preconceived ideas of mental health and addiction, also known as stigma, as it can lead to patient behavior escalation if the nurse is not adequately trained.

Section 5: Dissemination Plan

Dissemination Plan

The purpose of this project was to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The goal for dissemination in the small mental health and recovery center will be simple as it is a stand-alone facility and the planning team of experts received the education and will distribute it to the Director of Nursing for decision regarding delivery to nursing staff. There are other means of dissemination for this education project, and this is to promote the use and benefits through social media, share project findings in professional conferences for nurses and healthcare leadership, publication in a journal, and write a book. There are various organizations that I would like to disseminate this valuable information to would include American Nurse Today, Journal of Forensic Nursing, Journal of Psychiatric and Mental Health Nursing, Journal of Nursing Education, and Nursing Standard. Some of these journals are linked to professional organizations that hold yearly conferences and may have the opportunity to submit my project for publication. There also may be an opportunity to speak and discuss the need for a program to prevent violent behavior and decrease violence in the workplace.

Analysis of Self

Throughout my DNP program, I was allowed to improve the care of both patients and nurses through various roles as a scholar, practitioner, and project manager. As a scholar, I have excelled within my field of developing an education program aimed to decrease and prevent violence escalation. Working as a practitioner within the nursing

field, I can relate to the material, and bring my knowledge to create a viable education program. Using the AACN (2016) DNP essential VI: Interprofessional collaboration for improving patient and population outcomes, it aligns with the role of a project manager. Working with the team of experts, through interprofessional communication, we were able to locate the gap in practice and complete this project seamlessly. The increased communication and professionalism were a determining factor for the success of this project.

The completion of the project was both a challenging and rewarding experience. As a nurse leader, it is essential to slow down and observe all aspects of issues leading to a greater problem. The challenge was determining from the nursing quality indicators a possible issue. Instead, I found the connection between staffing, nursing turnover, job satisfaction, and psychiatric physical abuse (Montalvo, 2007). Through the brainstorming and development of the project, it has expanded my knowledge and expertise within my profession. I have grown into a nurse leader, pausing to reflect, listening to feedback, and incorporating valuable ideas into my practice. Long-term professional goals include but not limited to public speaking, training seminars, build more programs to help nurses, and continue to expand my knowledge.

Summary

The purpose of this project is to develop an education program for nursing staff regarding strategies to prevent escalation of violent behavior in combative patients. The gap in practice was discovered that nurses are not prepared to prevent violence escalation, due to the lack of knowledge of how to work with combative patients. Collaborating with

the interprofessional team of experts, we were able to develop an education program aimed to increase knowledge regarding strategies to prevent escalation of violence when working with combative patients. Upon the completion of the educational project, the mental health and recovery center received the complete escalation prevention education program, consisting of an electronic presentation, handout, and a comprehension questionnaire for evaluation of learning. The knowledge gained through this education program will help prepare nurses recognize the beginning stages of stress and use strategies to prevent escalation behavior, with the goal to decrease escalation of violence when working with combative patients. The improved culture of safety that results will bring a potential for positive social change for both nurses and the patients under their care.

References

Agency for Healthcare Research and Quality. (2016). Strategies to de-escalate aggressive behavior in psychiatric patients, (180). Retrieved from https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/aggression_executive.pdf

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from ACCN Nursing website: http://www.aacnnursing.org/Education-Resources/AACN-Essentials

American College of Emergency Physicians. (2009). Emergency department violence. Retrieved from http://newsroom.acep.org/2009-01-04-emergency-department-violence-fact-sheet

American Nurses Association. (2018, April 18). ANA responds to the Joint Commission sentinel event alert on physical and verbal violence against healthcare workers. *Nursing World*. Retrieved from https://www.nursingworld.org/news/news-releases/2018/ana-responds-to-the-joint-commission-sentinel-event-alert-on-physical-and-verbal-violence-against-health-care-workers/

Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. (2015, May). Underreporting of workplace violence. *Workplace Health & Safety*, 200-210. https://doi.org/10.1177/2165079915574684

Bandura, A. (1989, September). Human agency in social cognitive theory. *American Psychologist*, *44*, 1175-1184. https://doi.org/10.1037//0003-066x.44.9.1175

Bandura, A. (2001). Social cognitive theory: An agentic perspective. *Annual Review Psychology*, *52*, 1-26. https://doi.org/10.1146/annurev.psych.52.1.1 Benight, C. C., & Bandura, A. (2003, August 8). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behaviour Research and Therapy*, *42*, 1129-1148. https://doi.org/10.1016/j.brat.2003.08.008

Bolvin, J. M. (2018, November). 2018 nursing trends and salary results. *American Nurse Today*, *13*(11). Retrieved from https://www.americannursetoday.com/wp-content/uploads/2018/11/ant11-SALARY-Trends-2018-1024.pdf

Bowers, L., Nijman, H., Allan, T., Simpson, A., Warren, J., & Turner, L. (2006, June). Prevention and management of aggression training and violent incidents on U.K. acute psychiatric wards. *Psychiatric Services*, *57*, 1022-1026. https://doi.org/10.1176/appi.ps.57.7.1022

Chapman, R., Styles, I., Perry, L., & Combs, S. (2010). Nurses' experience of adjusting to workplace violence: A theory of adaptation. *International Journal of Mental Health Nursing*, *19*, 186-194. http://dx.doi.org/10.1111/j.1447-0349.2009.00663.x

Chen, W., Huang, C., Hwang, J., & Chen, C. (2010, June 10). The relationship of health-related quality of life to workplace physical violence against nurses by psychiatric patients. *Quality of Life Research*, *19*, 1155-1161. https://doi.org/10.1007/s11136-010-9679-4

Chojnacka, F. T. (2005, February 3). Reporting incidents of violence and aggression towards NHS staff. *Nursing Standard*, *19*, 51-56.

Copeland, D., & Henry, M. (2017, April). Workplace violence and perceptions of safety among emergency department staff members: Experiences, expectations, tolerance, reporting, and recommendations. *Journal of Trauma Nursing*, *24*, 65-77, E1-E2.

Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general* [Report]. Retrieved from https://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf

Esposito, L. (2017). Nurses face more violence from hospital patients. Retrieved from https://health.usnews.com/wellness/articles/2017-01-18/nurses-face-more-violence-from-hospital-patients

Florida Council for Community Mental Health. (2011, January). Mentally ill individuals use of emergency departments: Fact sheet. *Florida Council for Community Mental Health*. Retrieved from http://www.fccmh.org/resources/docs/Emergency_Departments.pdf

Florida Department of Education. (2018). *PSAV Programs; Practical Nursing H170607* [Educational Standards]. Retrieved from http://www.fldoe.org/academics/career-adult-edu/career-tech-edu/curriculum-frameworks/2018-19-frameworks/health-science.stml

Forster, P. L., Cavness, C., & Phelps, M. (1999, October). Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. *Archives of Psychiatric Nursing*, *13*, 269-271. https://doi.org/10.1016/s0883-9417(99)80037-5

Gacki-Smith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2009, July/August). Violence Against Nurses Working in US Emergency Departments. *Journal of Nursing Administration*, *39*, 340-349. https://doi.org/10.1097/nna.0b013e3181ae97db

Gates, D. M., Gillespie, G. L., & Succop, P. (2011, March/April). Violence against nurses and its impact on stress and productivity. *Nursing Economics*, *29*, 59-66.

Hogarth, K. M., Beattie, J., & Morphet, J. (2015, March 26). Nurses' attitudes towards the reporting of violence in the emergency department. *Australasian Emergency Nursing Journal*, *19*, 75-81. https://doi.org/10.1016/j.aenj.2015.03.006

Jang, H., Song, Y., & Kang, H. (2017, September). Nurses' perception of patient safety culture and safety control in patient safety management activities. *Journal of Korean Academy of Nursing Administration*, *23*, 450-459. https://doi.org/10.11111/jkana.2017.23.4.450

Joint Commission. (2018). Physical and verbal violence against health care workers. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf

Kleissl-Muir, S., Raymond, A., & Rahman, M. A. (2018, October 15). Incidence and factors associated with substance abuse and patient-related violence in the emergency department: A literature review. *Australasian Emergency Care*, *21*, 159-170. https://doi.org/10.1016/j.auec.2018.10.004

Kvas, A., & Seljak, J. (2014, October 14). Sources of workplace violence against nurses. *Work*, *52*, 177-184.

Laeeque, S. H., Bilal, A., Babar, S., Khan, Z., & Rahman, S. U. (2017, November 11). How patient-perpetrated workplace violence leads to turnover intention among nurses: The mediating mechanism of occupational stress and burnout. *Journal of Aggression, Maltreatment & Trauma*, *27*, 96-118. https://doi.org/10.1080/10926771.2017.1410751

LaMorte, W. W. (2018). The social cognitive theory. Retrieved from http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories5.html

Montalvo, I. (2007, September 30). The National Database of Nursing Quality Indicators (NDNQI). *The Online Journal of Issues in Nursing*, *12*. https://doi.org/10.3912/OJIN.Vol12

National Association of State Mental Health Program Directors. (2006). *Six core strategies for reducing seclusion and restraint use* [Report]. Alexandria, VA: National Association of State Mental Health Program Directors.

Netsmart. (2018). EHR for medication-assisted addiction treatment. Retrieved from https://www.ntst.com/Communities-We-Serve/behavioral-health/medication-assisted-treatment/

Netsmart. (2018). The netsmart story. Retrieved from https://www.ntst.com/The-Netsmart-Story/

Occupational Safety and Health Administration. (2015). Workplace violence in healthcare: Understanding the challenge. Retrieved from https://www.osha.gov/Publications/OSHA3826.pdf

O'Hagan, M., Divis, M., & Long, J. (2008). *Best Practice in the reduction and elimination of seclusion and restraint - Seclusion: Time for change* [Educational standards]. Retrieved from https://www.mentalhealth.org.nz/assets/ResourceFinder/FINAL-SECLUSION-REDUCTION-BEST-PRACTICE-Research-Report.pdf

Paterson, B., Miller, G., Bowie, V., & Ledbetter, D. (2008, May). Zero tolerance and violence in services for people with mental health needs. *Mental Health Practice*, *11*, 26-31. https://doi.org/10.7748/mhp2008.05.11.8.26.c7707

Relias. (2018). Workplace violence. Retrieved from https://www.relias.com/resource/workplace-violence

Rodriguez-Acosta, R. L., Myers, D. J., Richardson, D. B., Lipscomb, H. J., Chen, J. C., & Dement, J. M. (2008, September 6). Physical assault among nursing staff employed in acute care. *Work*, *35*, 191-200. https://doi.org/10.3233/WOR-2010-0971

Sato, K., Wakabayashi, T., Kiyoshi-Teo, H., & Fukahori, H. (2012, December 16). Factors associated with nurses' reporting of patients' aggressive behavior: A cross-sectional survey. *International Journal of Nursing Studies*, *50*, 1368-1376. https://doi.org/10.1016/j.ijnurstu.2012.12.011

Schmidt, M., & Haglund, K. (2017, September/October). Debrief in emergency departments to improve compassion fatigue and promote resiliency. *Journal of Trauma Nursing*, *24*, 317-322. https://doi.org/10.1097/JTN.0000000000000315

Sidhu, S., & Park, T. (2018, March 8). Nursing curriculum and bullying: An integrative literature review. *Nurse Education Today*, *65*, 169-176. https://doi.org/10.1016/j.nedt.2018.03.005

Snyder, L. A., Chen, P. Y., & Vacha-Haase, T. (2007). The underreporting gap in aggressive incidents from geriatric patients against certified nursing assistants. *Violence and Victims*, *22*, 367-379. https://doi.org/10.1891/088667007780842784

Sofield, L., & Salmond, S. W. (2003, July/August). Workplace violence: A focus on verbal abuse and intent to leave the organization. *Orthopaedic Nursing*, *22*, 274-283.

Stiver, K., Sharma, N., Geller, K., Smith, L., Stephens, J., Daoud, E., . . . Mazzaferri, E. (2017). "Quiet at night": Reduced overnight vital sign monitoring linked to both safety and improvements in patients' perception of hospital sleep quality. *Patient Experience Journal*, *4*, 90-96. Retrieved from https://pxjournal.org/cgi/viewcontent.cgi?article=1185&context=journal

Substance Abuse and Mental Health Services Administrations. (2005). *Roadmap to seclusion and restraint free mental health services* [Educational standards]. Retrieved from Connecting Learners with Knowledge: https://www.clwk.ca/wp-content/uploads/buddyshared/SAMHSA-Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services.pdf

Taylor, S. E. (1983, November). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist, 38*(11), 1161-1173. https://doi.org/10.1037//0003-066x.38.11.1161

Trinkoff, A. M., Geiger-Brown, J. M., Caruso, C. C., Lipscomb, J. A., Johantgen, M., Nelson, A. L., . . . Selby, V. L. (n.d.). Personal safety for nurses. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, 1-36. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2661/

Zhao, S., Liu, H., Ma, H., Jiao, M., Li, Y., Hao, Y., . . . Qiao, H. (2015, November 13). Coping with workplace violence in healthcare settings: Social support strategies. *International Journal of Environmental Research and Public Health*, *12*, 14429-14444. https://doi.org/10.3390/ijerph21114429

Appendix A: Evaluation Questionnaire for Team of Experts

Stakeholder/Team Member Evaluation of DNP Project

Problem:

Purpose:

Goal:

Objective:

Scale: SD=Strongly Disagree D=Disagree U=Uncertain A=Agree SA=Strongly Agree

	1=SD	2=D	3=UC	4=A	SA=5
Q1 Was the problem made clear to you in the beginning?	___	___	___	___	___
Q2 Did the DNP student analyze and synthesize the evidence-based literature for the team?	___	___	___	___	___
Q3 Was the stated program goal appropriate?	___	___	___	___	___
Q4 Was the stated project objective met?	___	___	___	___	___
Q5 How would you rate the DNP student's leadership throughout the process?	___	___	___	___	___
Q6 Were meeting agendas sent out in a timely manner?	___	___	___	___	___
Q7 Were meeting minutes submitted in a timely manner?	___	___	___	___	___
Q8 Were meetings held to the allotted time frame?	___	___	___	___	___
Q9 Would you consider the meetings productive?	___	___	___	___	___
Q10 Do you feel that you had input into the process?	___	___	___	___	___

Q11 Please comment on areas where you feel the DNP student excelled or might learn from your advice/suggestions:

Appendix B: Behavior Prevention Educational Program

Behavior Prevention Program: Staff Education

Objectives:

This presentation on violence prevention will educate nurses to stay safe while working with potentially volatile patients in our mental health and recovery areas.

This presentation will:

- Review situations that could potentially increase patient stress levels.
- Recognize beginning symptoms of behavior escalation.
- Review conflict resolution and the need for communication.
- Recognize the importance of self-care and reporting events.

1st Step to Prevention:
Awareness

- The 1st step to preventing escalation is being Aware of patient's situation.
  - *When obtaining a history, it is vital to find out where the patient is living, if they have any family or support system.*
  - *Do they have a job?*
  - *Are they using substances? What kind? The last time used?*
  - *Are they using medication to control their impulses and mood?*
  - *How is the patient acting?*
  - *Another area to explore is the decrease of behavior triggers and risk for violence (NASMHPD, 2006).*

1st Step to Prevention:
Awareness & Understanding the Patient

- Upon admission: Situational Anxiety – Fear of the unknown.
- Patients may have an undiagnosed or diagnosed mental illness.
- Patient may be medicated or unmedicated.
- Baker Acted – BA52 Involuntary 72-hour hold, pending a Psych Evaluation.
- Addiction, possible withdrawals
- Homeless

1st Step to Prevention:
Awareness

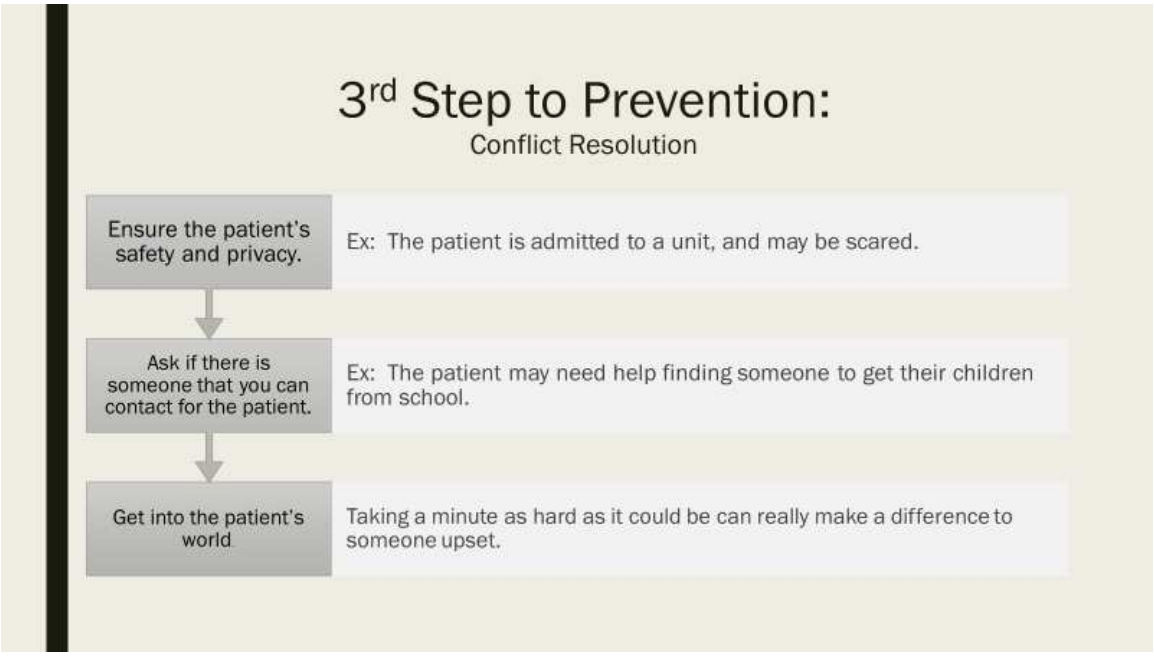
- While assessing and obtaining information from the patient, the social cognitive theory (SCT) addresses personal life experiences, life events, behavioral patterns, mixed with environmental factors interact with another, influencing each other (Bandura, 2001).
- Beliefs play a role in how a patient is perceived during the assessment and the behavior that may arise throughout their stay (Bandura, 1989).
- It has been suggested that behavior that is exhibited from nurses or patients may model one's behavior or actions (Sidhu & Park, 2018).

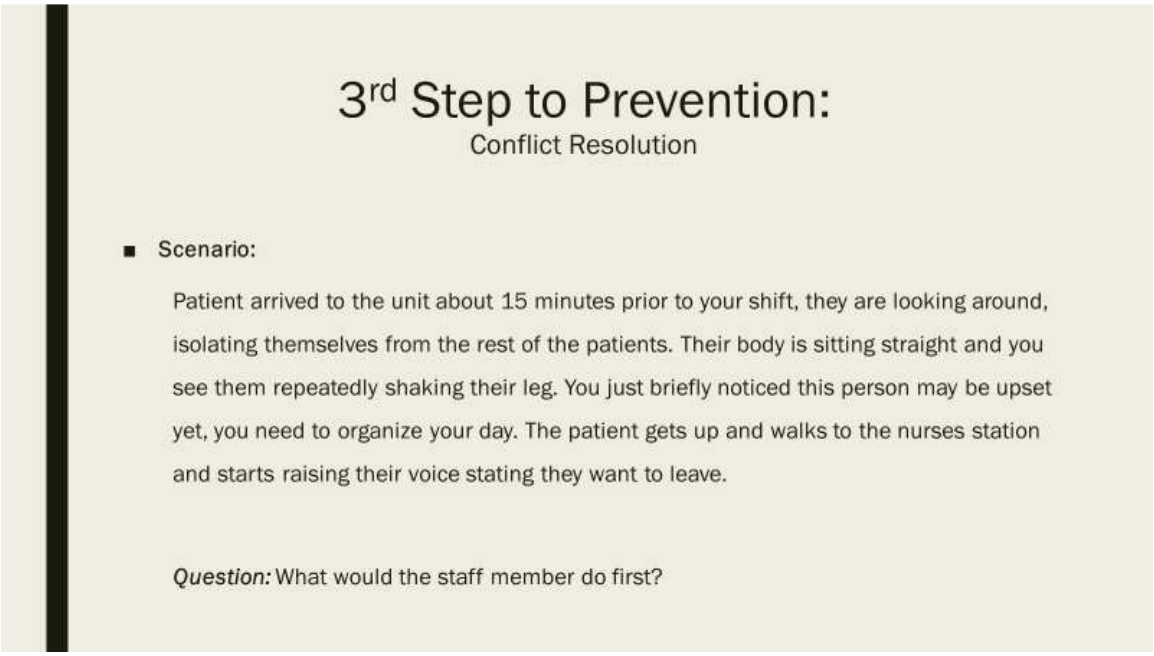
2nd Step to Prevention:
Recognizing Escalation

The patient may show anxiety or increased stress level by pacing, short abrupt answers, looking around, no eye contact, rubbing hands together, and talking louder then before.

Verbal escalation may start at this point.

- **Several things may be happening to the patient:**
  - Has a psychiatric condition either diagnosed or undiagnosed
  - Addiction issues, possible withdrawals
  - No support system
  - Childcare issues
  - Money worries
  - Afraid


3rd Step to Prevention:
Conflict Resolution
Ensure the patient's safety and privacy.
Ex: The patient is admitted to a unit, and may be scared.
Ask if there is someone that you can contact for the patient.
Ex: The patient may need help finding someone to get their children from school.
Get into the patient's world
Taking a minute as hard as it could be can really make a difference to someone upset.


3rd Step to Prevention:
Conflict Resolution
Scenario:
Patient arrived to the unit about 15 minutes prior to your shift, they are looking around, isolating themselves from the rest of the patients. Their body is sitting straight and you see them repeatedly shaking their leg. You just briefly noticed this person may be upset yet, you need to organize your day. The patient gets up and walks to the nurses station and starts raising their voice stating they want to leave.
Question: What would the staff member do first?

3rd Step to Prevention:
Conflict Resolution & Increase Communication

Answer: Stop what you are doing! Take a few minutes to talk with the patient and see how you can help them.

Something to consider, if the patient is homeless, off of their medication and showing physical signs of stress, then the first thing that should be done is bring them to a quiet place, then offer something to eat or drink.

3rd Step to Prevention:
Conflict Resolution & Self-Preservation

The Combined Steps to Prevent Injury:

- Be aware and recognize increased stress behaviors.
- Address the issue before the patient has lost control.
- Actively listen, exercising verbal and non-verbal communication methods.
- Watch your breathing, slow it down.
- Identify the problem and find a solution (Johansen, 2012).

Debriefing

Debriefing

- Everyone involved in a hostile situation will need to debrief.
  - *To identify anything that created the patient to start escalating.*
    - Revise their plan of care.
    - Increase the milieu of the unit.
    - Staffing issues
    - Noise, increased environmental stimuli (NASMHPD, 2006).

Debriefing

- To ensure those involved feel supported.
  - *Identify coping mechanisms for Nursing Staff*
    - Exercise
    - Laughing
    - Traveling
  - *Were holistic methods of coping taught to the patient?*
    - Guided Imagery
    - Meditation
    - Voluntary time out (SAMHSA, 2005).

Appendix C: Education Handout

Behavior Prevention Education Handout

1st Step of Prevention: Awareness

Consider what the patient is going through. Questions to ask yourself:

1) Are they homeless?

2) Do they have a history of a violent past?

3) How is the patient acting?

4) Have they been involuntarily committed?

5) Does the patient use drugs or alcohol?

6) History of psychiatric illness? Treated? Untreated?

2nd Step of Prevention: Recognizing Escalation

Signs to look for:

1) Does the patient appear to be isolating themselves?

2) Pacing

3) Fidgeting

4) Looking around, appearing to look unsure or nervous.

5) Poor eye contact

6) Short abrupt answers, voice is getting louder.

3rd Step of Prevention: Conflict Resolution

1) Be aware and recognize increased stress behaviors.

2) Address the issue before the patient has lost control.

3) Actively listen, verbally and non-verbally

4) Watch your breathing, slow it down.

5) Solve the problem.

Debriefing

Immediately Hold a Debriefing After the Event

Notify the Supervisor if they have not been notified already.

Top Organization, Supervisors, and Support Staff meet within 24-48 hours following the Event.

Remember Self-Care! When you can, exercise, meditate, laugh, take a fun trip, take breaks & Eat!

Appendix D: Educational Program Comprehension Questionnaire

Behavior Prevention Education Program: Comprehension Questionnaire

Name:_____

Supervisor:_____

1) The behavior prevention education program is designed to help prevent the patient from getting upset or angry. True or False

2) It is important for the nurse to review or ask questions about work, living situations, and family support. Why?
    a. To see if you are related.
    b. To alert a social worker to help patient to feel more at ease.
    c. The patient may want assistance and is either too afraid to ask or they do not know they exist.

3) Can you interchange the steps of prevention?
    a. Yes. One can happen before the other.
    b. No. They are stuck and have to be in sequence.

4) Social cognitive theory is the way we perceive our environment and how one interacts with another. True or False

5) What are signs of elevated stress?
    a. No eye contact
    b. Rubbing hands together
    c. Raised voice level
    d. All of the Above

6) Can nurses absorb the behavior from the environment? True or False

Comments or Suggestions: