WORKPLACE VIOLENCE IN HEALTHCARE: “NOT JUST PART OF THE JOB”

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The Supervisory Committee certifies that this ***disquisition*** complies with North Dakota State University's regulations and meets the accepted standards for the degree of

DOCTOR OF NURSING PRACTICE

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ABSTRACT

Workplace violence in healthcare is a widespread issue that many healthcare providers accept as "just part of the job." According to Occupational and Safety Health Administration, in 2002 to 2013 incidents of serious workplace violence (those requiring days off for the injured worker to recuperate) were 4 times more likely in healthcare than in any other industry (Bureau of Labor Statistics, 2017). The aim of this study was to examine the experiences, beliefs, and knowledge among North Dakota nurse practitioners by administering a survey about workplace violence in their practice. Using the data obtained by this survey an educational opportunity about workplace violence was developed and offered to nurse practitioners and other healthcare professionals. The purpose of this practice improvement project was to improve healthcare professionals' knowledge and confidence in the recognition, prevention, and response to workplace violence in their healthcare practice.

Experiences of workplace violence can have lasting emotional, psychological, and physical effects on the victims. Increasing awareness and education among healthcare providers about workplace violence can help alleviate the negative effects felt by those who have these experiences. Healthcare professionals who feel safe and supported in their work environment can provide safer, higher quality care to their patients. Decreasing workplace violence in healthcare benefits everyone and violence is not something that should be considered "part of the job" (Fredrick, 2014).

ACKNOWLEDGMENTS

I would like to thank my family for their love and support during my education. Thank you for understanding when I couldn't be present and helping keep everything running at home. Thank you, Bob Jostad, Laura Lenca, Chaun Merkens and my wonderful nephew and niece, Zachary, and Brooke. I love you all very much!

Thank you to my chair, Dr. Tina Lundeen, for your assistance and patience in completing this project. I would also like to thank all the members of my committee for your assistance. Your guidance and expertise were very much appreciated.

DEDICATION

Dedicated to my mother, Cathryn Jostad. I know you would love to be here to see me complete my education. You are missed every day.

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LIST OF ABBREVIATIONS

HCW .....Health Care Worker

ND.....North Dakota

NP .....Nurse Practitioner

NDNPS .....North Dakota Nurse Practitioners

PA .....Physician Assistant

WPV.....Workplace Violence

CHAPTER 1. INTRODUCTION

Background and Significance

Workplace violence (WPV) is a serious problem within the healthcare community. Every healthcare provider is at risk for experiencing violence at work. Patients, their families, and even other healthcare workers (HCW) can perpetrate violence in the healthcare setting. The bulk of research about healthcare WPV focuses on interventions and strategies to prevent violence from occurring. While prevention is important, researchers must also examine how HCW process the aftereffects of violence at work.

Workplace violence often elicits unfavorable consequences for workers, including HCW. Per the U.S. Bureau of Labor Statistics (2020), the health care and social services industries are five times more likely to experience WPV than workers in other industries. HCW accounted for 73% of nonfatal workplace injuries in 2018 (U.S. Bureau of Labor Statistics, 2020). Lanctot and Guay's (2014) literature search of the short term and/or long-term consequences of WPV resulted in 7078 references, of which 68 studies met selection criteria. The authors separated the consequences of WPV by similarities, resulting in seven distinct categories of consequences 1) physical, 2) psychological, 3) emotional, 4) work functioning, 5) relationship with patients/quality of care, 6) social/general, and 7) financial. "Psychological (depression, posttraumatic stress) and emotional (anger, fear) consequences and impact on work functioning (sick leave, job satisfaction) were the most frequent and important effects of workplace violence" (Lanctot, 2014, p. 492).

Problem Statement

Healthcare workers endure a wide variety of mental, physical, personal, social, and economic consequences of WPV. Workers with psychological symptoms because of WPV

rarely seek psychological support. Healthcare workers tend to turn to colleagues for support and seldom request the help of a professional counselor or psychologist (Lanctot, 2014). Large gaps exist in the research related to understanding the consequences of WPV that North Dakota Nurse Practitioners (NDNPS) experience. The primary focus of the project was to explore NDNPS experiences related to WPV.

Purpose

Nurse practitioners (NPs) living in ND were asked to complete an education needs assessment survey with the intent of gathering information about NDNPS experiences related to WPV. The survey responses were collected, analyzed, and synthesized for the purpose of identifying NPs experience with WPV, including the NPs beliefs, and knowledge, as well as the organizational support received following the violence. Based upon the knowledge deficits or informational needs identified via the survey, a customized NP educational program on WPV was created and offered to NPs in ND and the region of the upper Midwest.

Objectives

1) Gathered information about NDNPS personal experience with WPV, including the type of violence experienced; the physical, emotional, and psychological consequences of the violence; perceptions of organizational support; and suggestions for perceived educational needs regarding WPV in healthcare.
2) After analysis of the survey results, a customized educational program was developed and presented to NDNPS free of charge via a Zoom platform. The educational presentation included the knowledge needs or deficits identified in the survey as well as approaches for preventing and diffusing WPV, and finally strategies and resources for coping with the consequences of violence at work.

3) Improved HCW confidence in dealing with WPV by providing education and evaluated provider confidence using the Confidence in Coping with Patient Aggression Instrument (CCPAI) (Thackrey, 1987).

CHAPTER 2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Workplace violence is a very real and commonplace occurrence in healthcare. A literature review on WPV was conducted with a focus on healthcare providers experiences with WPV, including the type and level of violence experienced, the consequences and effects of WPV, coping strategies, and prevention. The Social-Ecological Model was selected as the theoretical foundation of the project. Finally, the Iowa Logic Model was used as the framework for the project. The literature, theory, and project framework are further described and defined in Chapter 2.

Prevalence of Workplace Violence in Healthcare

From 2002 to 2013, incidents of serious WPV (those requiring days off for the injured worker to recuperate) were four times more common in healthcare than in private industry on average. In 2013, the broad "healthcare and social assistance" sector had 7.8 cases of serious WPV per 10,000 full-time employees (Occupational Health and Safety Administration, 2015). Other large sectors such as construction, manufacturing, and retail had fewer than two cases per 10,000 employees (Occupational Health and Safety Administration, 2015).

Maran et al. (2019) found that among Italian medical physicians, male physicians were more prone to report violent episodes than female physicians. Among non-physician HCW, females experience more verbal violence such as insults, while male HCW experienced more physical violence. Maran et al. (2019) also found that male HCW under the age of 30 were less likely to report incidents of WPV than male HCW with 6 to 15 years of experience. Liu et al. (2019) found in a synthesis of literature regarding WPV that the global prevalence of WPV is very high, particularly in Asian and North American countries. The settings of the emergency and psychiatric wards reported higher levels of non-physical and physical violence exposure,

respectively. Liu et al. (2019) identified that more experienced HCW, white populations, physicians, nurses, HCW in urban settings, and those that worked longer hours were more likely to experience non-physical violence. Also identified were that men, more experienced HCW, white populations, physicians, nurses, single/unmarried HCW, and those that worked longer hours were more likely to encounter physical violence (Liu et al., 2019)

Nevo et al. (2019) compared WPV experiences by physicians in the hospital versus community settings. Using a convenience sample of 63 hospital doctors and 82 community doctors, Nevo et al. (2019) stated that both groups experienced similar rates of physical and verbal WPV by patients. Hospital doctors (69.6%) experienced more incidents of verbal and physical abuse by family members than community doctors (43.1%).

In Nevo's study the most common reported causes of violence in both groups was long waiting time (23.9%) and dissatifaction with treatment (16.9%). One difference found between groups was that community doctors listed unjustified requests for medical prescriptions as a reason for WPV more frequently than hospital doctors. Seventy-three percent of the total study population felt that WPV was a significant problem, but a majority of doctors (73.9%) had not undergone any type of training to prevent or manage WPV.

The Joint Commission analyzed 33 homicides, 38 assaults, and 74 rapes in healthcare workplaces from 2013 to 2015 which resulted in death, permanent harm, or severe temporary harm. The most identified root causes of the events were from failures in communication, inadequate patient observation, lack of or noncompliance with policies addressing WPV prevention, and lack of or inadequate behavior health assessment to identify aggressive tendencies in patients (The Joint Commission, 2018).

The Joint Commission suggests the following actions to healthcare organizations to manage WPV.

1. Clearly define workplace violence and put systems in place across the organization that enable staff to report WPV instances, including verbal abuse.
2. Recognizing that information comes from several sources (hospitals, clinics, outpatient settings home care), capture, track, and trend all reports of WPV-including verbal abuse and attempted assaults when no harm occurred.
3. Provide proper follow-up and support to victims, witnesses and others affected by WPV, including psychological counseling and trauma-informed care if necessary.
4. Review each case of WPV to determine contributing factors. Analyze data related to WPV, and worksite conditions, to determine priority situations for intervention.
5. Develop quality improvement initiatives to reduce incidents of WPV (The Joint Commission, 2018, Sentinal Event Alert #59: Physical and verbal violence against health care workers. Workplace Violence Definition)

The Centers for Disease Control and Prevention (CDC) National Institute for Occupational Safety and Health (NIOSH) defines WPV as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty (Centers for Disease Control and Prevention. National Institue for Occupational Safety and Health (NIOSH), Occupational Violence). The U.S. Department of Labor defines WPV as an "action (verbal, written, or physical aggression) which intends to control or cause, or is capable of causing, death, or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority (HCW, police, managers, security personnel),

intimidating or harassing behavior, and threats" (U.S. Department of Labor. DOL Workplace Violence Program-Appendices, n.d.).

Types of Workplace Violence

The CDC classifies WPV as one of four types. The four types are:

Type 1: Criminal intent-the perpetrator has no legitimate relationship to the business or its employees and is usually committing a crime in conjunction with the violence (robbery, shoplifting, trespassing).

Type 2: Customer/Client on worker-the customer/client relationship includes patients, their family members, and visitors.

Type 3: Worker on Worker-also known as lateral or horizontal violence which often takes the form of bullying and includes verbal and emotional abuse.

Type 4: Personal Relationship-the perpetrator has a relationship to the victim outside of work that spills over to the work environment (Centers for Disease Control and Prevention, 2016).

Consumer/Client towards worker violence (Type 2) is the most prevalent violence in the healthcare settings. Type 2 violence is characterized by either verbal or physical assaults perpetrated by patients and visitors against providers. In a 2014 survey on hospital crime, Type 2 WPV accounted for 75% of aggravated assaults and 93% of all assaults against employees in healthcare settings (Phillips, 2016). Certain hospital settings are more prone to Type 2 WPV than other settings. The emergency department and psychiatric wards are the most violent and well-studied areas. Since rates of assault correlate with patient-contact time, nurses and nurse aids experience the highest rates of victimization (Phillips, 2016).

Cultural Acceptance of Workplace Violence in Healthcare

Among healthcare professionals, a cultural acceptance of WPV exists. Traditionally, healthcare professionals have accepted violent behavior as "part of the job" (Fredrick et al., 2014, p. 22). Workplace violence is grossly underreported by healthcare professionals for a multitude of reasons. Some of the most common cited reasons for underreporting violent events are a belief that violent events are part of the job, reporting of events is a cumbersome process and is unlikely to result in action from leadership, and fear of retaliation for reporting (Speroni et al., 2014).

In an anonymous survey of hospital workers, 2,098 of 5,385 workers in hospital systems in Texas and North Caroline had experienced 1,180 physical assaults, 2,260 physical threats, and 5,576 incidents of verbal abuse by patients or family members. Fear for safety was common among HCW victims at 38%. However, only 19% of the incidents were formally reported and logged into official databanks. Most employees reported their experiences of WPV informally to coworkers/managers and said that physical assaults and threats were more likely to be reported in patient records than verbal abuse (Pompeii et al, 2015). Rees et al. (2018) conducted a survey of nurses and midwives in Queensland, Australia found that 53% of the 2,397 respondents had experienced some form of physical or verbal WPV in the previous three months. Furthermore, respondents that experienced violence reported significantly higher levels of burnout. The author conceptualized burnout as feelings of frustration, depressed mood, and exhaustion that arises a negative aspect of caring. Also, the respondents verbalized not reporting the incidents of WPV, having poor training regarding WPV, and working in rural areas. Reasons for not reporting incidents of WPV included insufficient time to process report, reporting process was

cumbersome, unsupportive leadership, and lack of leadership response to WPV incidents (Rees et al, 2018).

Workplace Violence Consequences

Experiences of WPV can have lasting mental and emotional effects for victims. Najafi, et al. (2017) discussed those nurses exposed to WPV showed reduced tolerance, negative attitudes toward the nursing profession, and had feelings of fear and insecurity in the workplace. The nurses also demonstrated poor communication with others due to wanting to avoid interacting with patients/coworkers and as a result patient care was compromised.

Researchers from the Northwestern Academy of Quality and Safety Initiatives conducted a survey of 802 HCW at Northwestern Memorial Hospital. Rosenthal et al. (2018) reported that 34.4% of the 802 respondents (435 clinical nurses, 160 physicians, 71 Advanced Practice Nurses/Physician Assistants, 57 direct daily care personnel, and 23 social workers) had experienced WPV in the preceding 12 months of which 13.5% were physical assaults. Respondents of the Rosenthal et al. study (9.4%) who experienced an incident of violence missed work, and 30.1% considered leaving their job or career because of the violence. More than half of respondents (60.2%) endorsed at least one posttraumatic stress symptom such as flashbacks, nightmares, or severe anxiety and 19.2% reported at least two posttraumatic symptoms. Whether the violence experienced by the HCW was physical or verbal did not change the reported psychological or physical effects for the HCW (Rosenthal et al., 2018).

Workplace violence can have significant financial consequences for individuals and healthcare organizations. Speroni et al. (2014) found that the cost of treatment for injuries sustained as a result of WPV for 30 HCW was $94,156 (range $89-$29,883), and indemnity charges averaged $15,232 (range $6,517-$8,716). The author also found that HCW missed an

average of 11 days of work and worked with restrictions an average of 55.3 days (Speroni, 2014).

The need for HCW is increasing and healthcare is facing a major shortage in the healthcare workforce. By retaining experienced workers there are staffing and financial benefits Rosenthal et al. (2018) reported that HCW who had experienced physical or verbal WPV, had increased incidents of missed work, and had considered leaving a job or career. According to Gilliland (2019) replacing one advanced practice provider would cost a facility $250,000 to $300,000. The cost includes the cost of orientation, decreased patient coverage, and disengagement by remaining team members. Disengagement by other team members results in an increased rate of turnover and patient safety events, as well as decreased patient satisfaction (Gilliland, 2019).

Burnout

Healthcare is a caring profession that requires immense physical, mental, and emotional commitment. Healthcare providers often sacrifice personal well-being to care for others. Burnout is a term referred to often in the literature used to describe the negative impact that stress can inflict on a person. However, burnout is not well-defined or is defined differently depending on setting or context.

Merriam-Webster.com dictionary (2021) defined burnout as: exhaustion of physical or emotional strength or motivation usually because of prolonged stress or frustration. American psychologist Herbert Freudenberger coined the phrase burnout in the 1970s to describe the consequences of severe stress and high ideals in helping professions (Freudenberger, 1974). Maslach and Leiter (2016) defined burnout as "a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job" (pg. 103). The authors

identified three key dimensions of burnout: an overwhelming exhaustion, feelings of cynicism, and detachment from the job, and a sense of ineffectiveness (Maslach, 2016).

While there is an absence of consensus on how to define or measure burnout, the Maslach Burnout Inventory (MBI) was developed solely for burnout research. The MBI incorporates three general scales: emotional exhaustion, depersonalization, and personal accomplishment. The emotional exhaustion scale measures feelings of emotional overextension and exhaustion related to work. The depersonalization scale measures unfeeling and impersonal response toward recipients of one's care or service. Finally, the personal accomplishment scale measures feelings of competence and success in one's work (Maslach, 1996).

While burnout shares characteristics with depression, burnout differs in that burnout primarily affects a person's relationship to one's work. Maslach (2016) found that six domains influence burnout in the workplace: workload, reward, community, fairness, and values. With work overload, the ability of people to meet the demands of the job is depleted because of the inability to rest and recover. Lack of control over the work environment such as violent incidents, decrease job engagement. Workplace violence negatively influences HCW feelings of fairness, feelings of reward from employment, and feelings of community support in the work environment. Health care workers values are compromised by WPV experience, which conflicts with ideals that drew them to the healthcare field in the first place.

Privitera (2016) found that WPV and burnout had several overlapping organizational contributions. Organizational contributions shared by WPV and burnout include resource allocation, cognitive overload, lack of social support, lack of control of environment, emotional work and distress, psychological contract violation, and administrative toxic. Privitera (2016) states that identifying and intervening with these overlapping contributions can help to reduce

both. As the frontline of the healthcare team, healthcare providers are exposed to the family and patient's stressors and the WPV incidents that result from tense interactions. Healthcare providers are at greater risk of burnout if they feel that the organization does not support a safe and ethical work environment. Burnout is linked to employee job dissatisfaction, turnover, and increased absenteeism, which has financial consequences for healthcare organizations (Poghosyan, 2018).

Burnout Characteristics

Emotional exhaustion is often described as feeling "empty, drained, and unable to cope." (Institute for Quality and Efficacy in Health Care, Informed Health Online, 2020 para 3). Emotionally exhausted individuals are unable to manage the stresses of daily life and work. The burned-out worker may experience persistent physical or somatic symptoms such as pain, fatigue, and/or gastrointestinal problems leading to increased absenteeism (Institute for Quality and Efficiency in Healthcare, 2020).

Feelings of depersonalization can result in people becoming cynical about their working conditions and colleagues. Workers view job responsibilities as increasingly stressful and frustrating. Burned-out workers may distance themselves emotionally from co-workers, become apathetic, and feel that the job is meaningless (Institute for Quality and Efficiency in Healthcare, 2020).

Burnout can result in a sense of low personal accomplishment that manifests in a negative outlook about tasks and a loss of motivation to perform those tasks. A lack of individual creativity and difficulty concentrating are burnout symptoms referred to as disengagement. A previously high-performing employee may underperform and disengage from co-workers and the work environment (Institute for Quality and Efficiency in Healthcare, 2020).

When healthcare providers perceive administrative support to be lacking or absent., they are more prone to burnout. According to Poghosyan (2018), providers in the hospital and outpatient setting care for increasingly complex patients and experience higher workloads with less resources, thus are more prone to experiencing burnout. Due to the factors identified by Poghosyan, healthcare professionals feel unable to act in a manner that consistent with their personal and professional values (Poghosyan, 2018).

Workplace Violence Prevention and Intervention

Healthcare workers in emergency and psychiatric departments are the riskiest areas for WPV (Phillips et al., 2016). Healthcare workers in the elevated risk settings have frequent interactions with patients and family members who have mental illness and/or substance misuse. Long-term care HCW are also at increased risk due to caring for patients with dementia or Alzheimer disease (Speroni et al., 2014). Recognizing the high-risk work environments and the predisposing factors for violence are essential to developing programs to prevent and respond to WPV.

In three studies, HCW felt that administrative support increased the likelihood that they would report incidents of violence (Najafi et al., 2018; Rees et al., 2018; Fredrick et al, 2014). Healthcare workers failed to report incidents of WPV because they felt the perpetrators were unable to control their actions due to mental illness or substance use. Workers viewed victimization as a failure on their part to effectively perform their duties or as just "part of the job" (Fredrick et al., 2014, p. 22).

Education is an important part of developing comprehensive strategies for dealing with WPV. Heckemann et al. (2016) found that aggression management training did not necessarily help nurses develop new strategies for managing aggression from patients or visitors but

activated existing knowledge. By participating in aggression management training these nurses become more confident in dealing with aggressive situations and developed strategies for emotional self-management. Halm (2017) when reviewing seven original research papers also found similar benefits from WPV education with an increase in nurses' knowledge, skills, and confidence in dealing with WPV situations. The Halm study also identified an increased incidence in reporting events of WPV and a decreased incidence and severity of WPV events (Halm, 2017).

Theoretical Framework: Social-Ecological Model

Gillespie et al. (2015) used the Social-Ecological Model to develop WPV prevention programs focused on individuals, relationships, communities, and society. Individuals can reduce the risk of violence by recognizing their own responses to negative actions of others, learning de-escalation techniques and violence prevention strategies. Individuals also need to have an awareness that violence is possible in their work environment. At a relationship level, support groups and mentoring programs can help employees learn social norms and team building. Effective communication is also essential among healthcare team members to alert others of potentially dangerous individuals. At the community level, management provides support for policies that outline consequences for violent behaviors. Organizations must develop a zero-tolerance policy for WPV. However, enforcement of a zero-tolerance stance may compete with the fact that patient satisfaction drives reimbursement. At the society level, continued efforts to address mental health and substance abuse issues are needed. Legislative efforts to increase penalties for WPV are imperative. Regional healthcare systems have integrated education programs such as Crisis Prevention and Intervention (CPI) and Management of Aggressive Behavior (MOAB) into their training for HCW. Commercial violence prevention

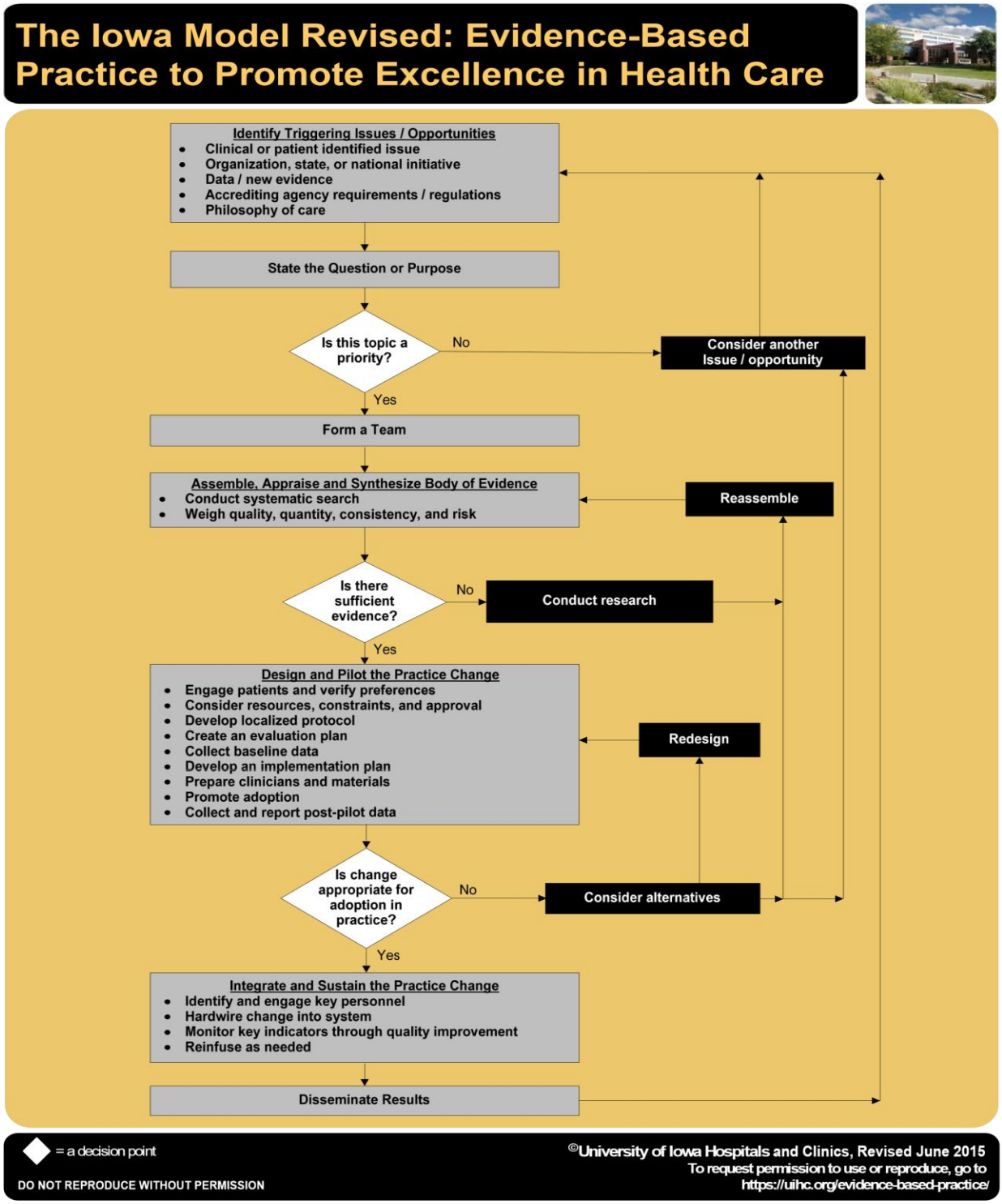
programs such as CPI and MOAB emphasize de-escalation techniques and identifying ways to avoid physical confrontation (Gillespie et al., 2015).

Project Framework: The Iowa Model

The Iowa Model is a widely utilized framework used to guide evidence-based practice in nursing (Figure 1.). Nurses at the University of Iowa Hospitals and Clinics in the 1990s developed the guide for clinicians to evaluate and use research findings to improve patient care. The Iowa Model was revised in 2015 and remains an application-oriented guide for point of care clinicians to use evidence-based process to promote excellence in health care (University of Iowa Hospitals and Clinics, 2017).

Figure 1

The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Healthcare



Permission for use granted. Refer to Appendix G.

Conclusion

Workplace violence is a major public health concern and HCW experience higher rates of violence than workers in other workplace settings. Healthcare workers are at higher risk for WPV due to an intimate contact with patients that is integral to their work and have too long accepted violence as "part of the job." A cultural shift needs to occur among healthcare professionals, including developing a belief that violence is not acceptable in any situation. Administrators and HCW themselves must support a stance of an intolerance to WPV and prioritize developing violence prevention strategies. Every HCW deserves a safe work environment.

CHAPTER 3. PROJECT DESIGN AND EVALUATION

Project Framework: Iowa Model

The Iowa Model is a stepped approach to evidence-based problem solving, project implementation, outcome analysis, and dissemination of information to improve or change practice. The Iowa model has been widely used in healthcare as a problem-solving framework. The steps used by the Iowa model include identification of a clinical problem, team formation, review and synthesis of the literature, translation of the research into practice, critical review of the outcomes, and dissemination of the results. (University of Iowa Hospitals and Clinics, 2017).

Step 1: Identify Triggering Issue

Workplace violence in healthcare is a widespread problem accepted by HCW as "just part of the job." In healthcare, nurses and other providers are more likely to be a victim of WPV than any other profession (Bureau of Labor Statistics, 2017). Research into WPV causes and effects is important to mitigate the impact WPV has on HCW.

Step 2: Statement of Purpose

As identified in the literature review, HCW experience negative effects from exposure to WPV. This practice improvement project was designed to increase ND NP knowledge and confidence in dealing with WPV in healthcare.

Step 3: Assemble a Team

A survey to assess the perceived educational needs regarding WPV by NDNPS was developed with input from dissertation committee members. Additionally, a psychologist from Sanford Health participated in the development of an educational presentation for healthcare professionals.

Step 4: Assemble, Appraise, and Synthesize Body of Evidence

The results of the survey were analyzed and synthesized with evidence gathered via literature review. The education focused on knowledge gaps and areas of interest identified in the survey of NDNPS, specifically, NPs experience, beliefs, and knowledge about WPV, as well as perceived organizational support following the violence. The bulk of the research on WPV focused on nurses or physicians. Nurse practitioners have been rarely addressed in research.

Step 5: Design and Pilot the Practice Change

North Dakota Nurse Practitioners completed a survey regarding WPV experiences, beliefs, and knowledge.

- A survey of current NDNPS and North Dakota State University (NDSU) NP students about experiences and if applicable, response to WPV. Participation was voluntary and participants were able to withdraw participation at any time.
- Potential NP respondents were contacted with the help of the North Dakota Nurse Practitioner Association (NDNPA) who granted access to the member listserv and the association's social media platform.
- A target number of NP and NP student respondents was 50.
- Collected demographic information including age, number of years of practice, specialty, and place of practice.
- Collected information on NP experiences with WPV and perceived educational needs regarding WPV.
- Administered survey via Qualtrics after IRB approval in Spring of 2021.
- Data management: Data was stored in a secure location in the coinvestigator's residence. Identifying information was not connected to participant responses as participants names

were not attached to data. Participants were identified as numbers. Data was collected using Qualtrics to assist in organizing responses. A NDSU statistician assisted in analysis of collected data.

- Presented an educational session for NPs and NP students. The two-hour educational session was done via online delivery to maintain current social distancing requirements.

Step 6: Integrate and Sustain the Practice Change

- Evaluation of project objectives through data obtained by needs assessment survey and development of education session.
- Evaluated attendee knowledge, intent to change practice, need for added education, and confidence regarding WPV using Confidence in Coping with Patient Aggression Instrument (CCPAI) (Thackrey, 1987). Pre and post educational intervention measurements was obtained to determine if objective was met. The CCPAI is a 10-item tool that uses an 11-point Likert -type scale. The measure has a range from 1 (low confidence) to 11 (high confidence). This measurement instrument uses a ten-item unidimensional construct with strong internal consistency (Cronbach's alpha 0.92) and precision (standard error 1.5) (Thackrey, 1987).

Step 7: Disseminate Results

Project results shared during NDSU poster presentation Spring 2021.

Setting

The educational survey was administered online using Qualtrics software. Due to social distancing requirements, the educational session was delivered via NDSU Zoom platform during a live two-hour presentation on May 4, 2021.

Sample/Sample Size/Recruitment

The survey sample consisted of members of the NDNPA and NDSU DNP students. NDNPS were recruited via the NDNPA listserv and social media platform. The NDNPA has a membership of 400-500 NPs from ND and the region. The survey was open for two weeks. A total of 43 responses were received, 29 from NDNPS and 14 from NDSU DNP students.

Implementation

A project proposal meeting was held December 17, 2020, and the dissertation committee approved the project. Approval was obtained from NDSU IRB prior to project implementation. Additionally, the NDNPA Board of Directors granted approval to use association listserv to recruit survey participants. The NDNPA secretary sent a prepared invitation and link to the Qualtrics survey to NDNPA members via the association listserv. The survey was available to NDNPA for two weeks. An identical invitation was sent by the NDSU School of Nursing administrative assistant to NDSU DNP of the second- and third-year cohorts of students via the school's listserv. A total 34 NDSU DNP students were invited to participate with a response received from 14 students. The survey was also available to DNP students for two weeks.

A local psychologist with expertise in WPV and provider education delivered the two hours Zoom presentation on May 4, 2021. Education via online delivery free of charge for attendees. Education presentation was offered to members of NDNPA and NDSU NP students and advertised via listservs from NDNPA association and NDSU DNP students. As an added incentive for attendance two hours of continuing educations credits were offered free of charge to attendees. Continuing education credits were approved and received from the ND Board of Nursing.

Resources and Costs

Zoom through NDSU was free to use for up to 300 attendees. Due to online delivery of survey and educational session there was nominal cost to the project. The expert speaker, a psychologist from Sanford Health, volunteered her time for the presentation. The cost continuing education credit from North Dakota Board of Nursing was $120. There was no cost from NDNPA to advertise education via social media site.

Evaluation Plan

Objective One

The survey data was collected electronically using Qualtrics. Qualtrics is a web-based survey tool that will aid in organizing the data obtained and allows participants to respond anonymously. To protect the identity of subjects' data was coded and the results were stored on an external device locked in the coinvestigator's home. No one had access to information except primary investigator, coinvestigator, and a statistician.

Data analysis: This project identified the prevalence of violence for NDNPS and provided descriptive data regarding this prevalence. While there are many forms of WPV in healthcare, this study only addressed physical and verbal violence. Participants were also asked to identify perceived education needs regarding WPV. The data analysis provided frequencies for variables collected. Data was analyzed using SAS software by NDSU statistician.

Objective Two

Work with psychologist from Sanford Health to develop educational presentation for healthcare professionals. Provide educational opportunity to NDNPS to address identified education needs.

Objective Three

Improve HCW confidence in dealing with WPV by providing education and evaluate provider confidence using CCPAI. Healthcare workers taking part in the education session were administered both a pre and post survey regarding their confidence level in managing WPV. Confidence levels were measured using CCPAI to compare pre and post intervention levels of personal confidence for participating healthcare professionals.

IRB Approval

Application and approval for exempt status was obtained from the North Dakota State University Institutional Review Board (IRB) per university policy. Participation in the survey and education was entirely voluntary and could be suspended by the participant at any time without penalty. Participants implied consent by completion of the survey and attendance at the education session. All participants were adults, NPs, with a MS or doctoral degree and capable of providing informed consent. The data collected was void of personal identifiers and anonymously collected via Qualtrics. Only the primary investigator, Co-investigator and NDSU statistician had access to the survey data and results Participation in the study had minimal risk to participants. The only foreseen potential risks were loss of confidentiality due to the collection of demographic data and potential emotional distress due to a participant being asked to recall a traumatic event.

Project Timeline

- Literature Review Completed
- Proposal document completed November 2020
- Schedule proposal meeting-November 2020
- Proposal meeting-December 2020

- IRB Application and Approval December 2020/January 2021
- Conduct Survey-February 2021
- Analyze and synthesize survey responses-February 2021
- Develop educational presentation-March/April 2021
- Deliver education-May 4, 2021
- Evaluate education and provider confidence-May 2021
- Complete project and dissertation document-July 2021.
- Defend dissertation-July 27, 2021
- Submitted final documentation to Graduate School-December 2021

CHAPTER 4. RESULTS

A link to access the Qualtrics survey was distributed to members of NDNPA and NDSU NP students via email. Forty-three responses were recorded: including 29 practicing NPs and 14 NDSU NP students. Demographic information of participants is summarized in Table 1.

Table 1

Demographics

Sex	Frequency	
	NP *N* = 29	DNP-S *N* = 14
Male	0	2
Female	29	12
Age		
	NP *N* = 29	DNP-S *N* = 14
20-29 years	2	9
30-39 years	14	4
40-49 years	6	1
50-59 years	4	0
60 years and older	3	0
Years in Practice	NP *N* = 29	
Less than 1 year	1	
1-4 years	8	
5-10 years	11	
11-15 years	4	
More than 15 years	5	
Primary geographic location of practice	NP *N* = 29	
Rural Area (10,000 population or less)	10	
Community or Suburban (10,000-50,0000 people)	8	
Urban (Greater than 50,000 people)	1	
Setting of Practice	NP *N* = 29	
Inpatient hospital	2	
Medical center outpatient clinic	18	
Private outpatient clinic	4	
Urgent Care	2	
Other	3	
Area of NP certification	NP *N* = 29	
FNP	27	
ANP/GNP	1	
Other (Women's Health)	1	

Objective One

The first project objective: Gather information about NDNPS personal experience with WPV, including the type of violence experienced; the physical, emotional, and psychological consequences of the violence; perceptions of organizational support, and suggestions for perceived educational needs regarding WPV in healthcare. Tables and bar graphs were used to summarize data from questions to evaluate participant responses. Results are summarized in Tables 2-10. While 43 respondents participated in the survey, some questions were not answered by all respondents. Even if respondent did not answer all questions in the survey, all responses were included to increase amount of data collected by the survey. The coinvestigator had planned to investigate if a significant relationship existed between variables such as demographic variables (age, gender, experience, practice location, and type of practice) and respondent's response to WPV experiences. However, the small sample size precluded evaluation with Chi-square or t-test. Nonparametric statistical tests were also not considered due to small sample size.

Table 2

Experiences of WPV

Have you experienced workplace violence in your career as a RN, LPN, or CNA?	NP *N* = 29	DNP-S *N* = 14
Yes	18	12
No	7	2
Unsure	4	0
Have you experienced workplace violence in your career as a NP?	NP *N* = 29	
Yes	12	NA
No	16	NA
Unsure	1	NA

Table 3

Type of Workplace Violence Experienced

Type of WPV Experienced	NP *N* = 13	DNP-S *N* = 5
Verbal Only	1	-
Physical & Verbal	-	1
Verbal & Emotional	5	0
Physical, Verbal & Emotional	7	4

Table 4

Perpetrator of WPV Violence

Who Perpetrated Violence?	NP *N* = 13	DNP-S *N* = 5
Patient	3	0
Patient/Family	1	0
Patient/Coworker	5	0
Patient/Family/Visitor	-	4
Patient/Family/Coworker	3	1
Patient/Family/Visitor/Coworker	1	-

Table 5

Employee Action after Experiencing WPV

After experiencing WPV, what did you do? *Able to check multiple responses*	NP *N* = 12	DNP-S *N* = 5
I did not report the incident.	3	2
I filed a written incident report as per my organization's policy.	6	2
I verbally informed my supervisor.	9	3
I discussed the incident with coworkers.	9	5
I reported to the incident to law enforcement.	4	1
Other	-	1

Table 6

Employer Response

If applicable, did you feel your employer supported you after the WPV incident?	NP *N* = 12	DNP-S *N* = 5
Yes	5	2
No	3	1
Unsure	3	1
Comment about employer support.	1	1
"*As a nurse I was supported as long as the incident was caused by a patient. However, verbal abuse by a doctor was usually never dealt with. As an NP I have had verbal abuse by doctors, patients, and family members. These incidents are not common, but do happen. I am not afraid to confront individuals myself about these types of things any longer."*		

Table 7

Professional Counseling

Were you offered professional counseling after the violent incident?	NP *N* = 12	DNP-S *N* = 5
Yes	1	0
No	11	5

Table 8

Employer Offered Training and Requirement

Does your employer offer training on preventing WPV?	NP ***N*** = 29	DNP-S ***N*** = 14
Yes	18	11
No	6	0
Unsure	5	3
Does your employer offer training on de-escalation of a potential volatile person or situation?	**NP *N* = 29**	**DNP-S *N* = 14**
Yes	17	12
No	6	1
Unsure	6	1
If your employer offers WPV training, is it:	**NP *N* = 29**	**DNP-S *N* = 14**
Mandatory	15	12
Optional	2	1
Unsure	11	1
What type of WPV training does your employer provide? (Check all that apply)	**NP *N* = 23**	**DNP-S *N* = 14**
1. Online	14	2
2. In-person	1	2
3. Outside organization training	1	3
4. Other see Q 38	4	0
1 & 2	1	1
1, 2, & 3	1	3
1 & 3	1	3
Comments *"**De-escalation training at all staff meeting, so about 20 minutes' worth**"* *"**No training**"*		

Table 9

Feel Safe at Work

Do you feel safe at your workplace?	NP *N* = 13	DNP-S *N* = 5
Yes	8	0
No	3	5
Unsure	2	0

Table 10

WPV "Part of the Job"

Do you feel WPV is "part of the job" for individuals working in healthcare?	NP *N* = 13	DNP-S *N* = 5
Yes	5	1
No	6	1
Unsure	2	-
Comments	-	3
"It shouldn't be but feel that is often considered part of the job.;" "Sometimes if it's a patient who doesn't know what they're doing.;" "I feel we encounter it all the time; the expectation is that it is part of the job and we need to know how to deal with it professionally."		

Objective Two

The second project objective: Develop a customized educational program to present to NDNPS. The customized educational presentation took place on May 4, 2021, via Zoom. Over half (54.7%) of the 42 respondents expressed interest in WPV education (Table 11). Respondents' expressed interest in all of topics listed as choices on the survey (Figure 2). The co-investigator and speaker devoted a separate section of the presentation to four of the five topic areas. Survey respondents were able to choose all topics of interest. Of the 38 respondents (26 NPs and 12 DNP students) 82.5% were interested in de-escalation techniques, 45% in coping strategies, 37% in risk factors, and 34% in prevention of WPV. Although 66% of respondents expressed interest in self-defense education, the presentation did not include specific self-defense

education. Employee-pursued self-defense training was touched on as an employee-level prevention strategy. The educational presentation occurred via a live Zoom format, though respondents preferred *(n* = 18, 43%) an online module format. The Zoom presentation, scheduled for May 4, 2021, from 2 PM to 4 PM, transpired as scheduled, lasting the total time of presentation was 2 hours. Respondents overwhelmingly (*n* = 40, 93%) preferred one-hour of education however, the volume of content and the number CE credits granted by the ND Board of Nursing, necessitated a 2-hour presentation. Most respondents (*n* = 26, 60%) preferred continuing education credits for attendance.

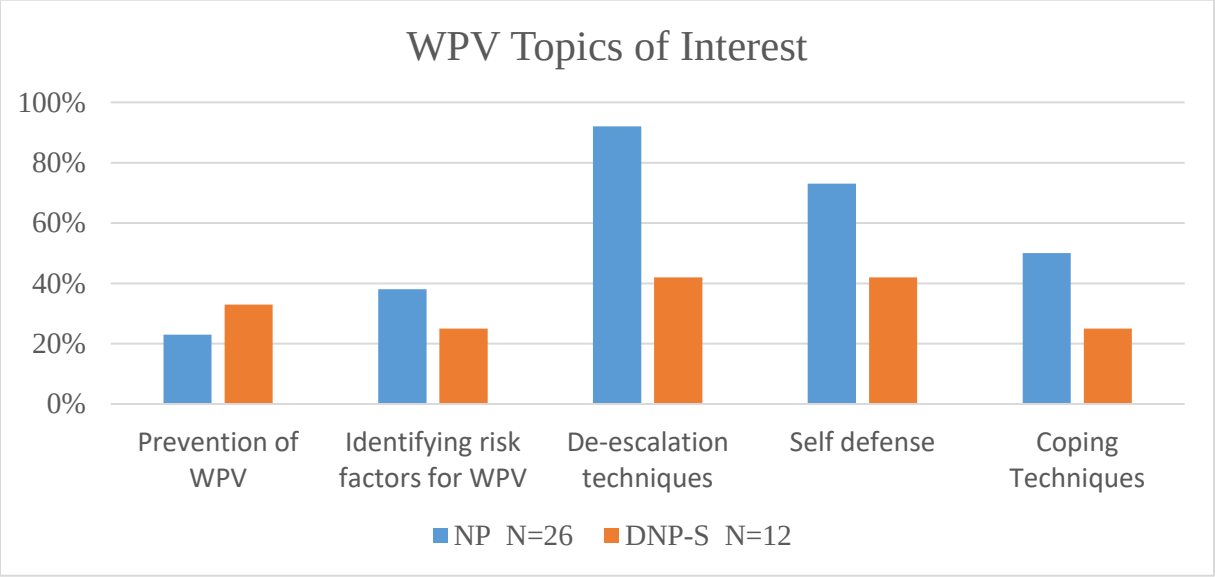
Table 11

Interest in WPV Education

Would you be interested in additional education on WPV?	NP *N* = 29	DNP-S *N* = 13
Yes	15	8
No	14	5

Figure 2

What Topics Related to Workplace Violence Interest you?



Note: Respondents were able to choose multiple responses.

Table 12

Format of Education

What format for education would you prefer?	Frequency *N* = 43	Percent
On-line module	18	42.9%
Zoom presentation-live	8	19.1%
Zoom presentation-recorded	15	35.7%
Written materials	1	2.4%

Table 13

Interest in WPV Education

What length of training do you prefer?	Frequency *N* = 43	Percent
1 hour	40	93.1%
2 hours	3	6.9%

Table 14

Importance of CEUs

Is it important to you to earn Continuing Education Units for this training?	Frequency *N = 43*	Percent
Yes	26	60.5%
No	17	39.5%

Objective Three

The third project objective: Improve HCW confidence in dealing with WPV by providing education and evaluate provider confidence using CCPAI. The presentation attendees completed the Confidence in Coping with Patient Aggression Instrument (CCPAI) which was intended to measure attendees' perceived confidence in preventing, recognizing, and coping with WPV. Three current NPs, two NDSU NP students, and three Registered Nurses attended the

educational session. Two DNP student participants completed the CCPAI. See Table 15 for responses. The small sample size prohibited statistical analysis of the data.

Table 15

Responses to CCPAI

CCPAI	**Respondent 1**		**Respondent 2**	
	Before Education	*After Education*	*Before Education*	*After Education*
1. How comfortable are you in working with an aggressive patient? Very uncomfortable 1 2 3 4 5 6 7 8 9 10 Very comfortable 11	11	11	6	6
2. How good is your present level of training for managing psychological aggression? Very poor 1 2 3 4 5 6 7 8 9 10 Very good 11	11	9	8	8
3. How able are you to intervene physically with an aggressive patient? Very unable 1 2 3 4 5 6 7 8 9 10 Very able 11	1	1	4	4
4. How self-assured do you feel in the presence of an aggressive patient? Not very self- assured 1 2 3 4 5 6 7 8 9 10 Very self-assured 11	11	11	6	7
5. How able are you to intervene psychologically with an aggressive patient? Very able 1 2 3 4 5 6 7 8 9 10 Very unable 11	1	1	6	4
6. How good is your present level of training for handling physical aggression? Very poor 1 2 3 4 5 6 7 8 9 10 Very good 11	11	11	5	8
7. How safe do you feel around an aggressive patient? Very unsafe 1 2 3 4 5 6 7 8 9 10 Very safe 11	11	11	1	1
8. How effective are the techniques that you know for dealing with aggression? Very ineffective 1 2 3 4 5 6 7 8 9 10 very effective 11	11	11	8	8
9. How able are you to meet the needs of an aggressive patient? Very unable 1 2 3 4 5 6 7 8 9 10 Very able 11	11	11	5	7
10. How able are you to protect yourself physically from an aggressive patient? Very unable 1 2 3 4 5 6 7 8 9 10 Very able 11	11	11	8	8

CHAPTER 5. DISCUSSION AND RECOMMENDATIONS

Discussion

WPV is a substantial public health problem that not only affects healthcare professionals, but also the safety of the patients in their care. Workplace violence is a complex issue that is not understood fully due to the vast underreporting by healthcare professionals who often consider WPV an expected part of their work. The issue of WPV experiences, beliefs, and educational needs has not been researched in NDNPS providing a need for further exploration of this topic.

Objective One

Objective One examined WPV experienced by NDNPS including prevalence, the type and perpetrator of violence, reporting of incident, employer response to reporting, and WPV educational needs. This investigator learned that 62% of NDNPS and 86% of NDSU DNP students had experienced WPV during their career as RNs as compared to the 41% experiencing WPV while working as a NP. The length of career as a RN and NP was not considered in comparing the experiences of WPV during each career. The amount of time in each role may have an influence on frequency of experiences of WPV. This finding is in line with other studies (Liu et al., 2019; Maran, 2019) that found that nurses and other direct care staff are more frequently exposed to incidents of WPV than physicians and NP/PAs due to the increased amount of time spent directly with patients, families, and visitors.

According to the US Bureau of Labor Statistics, HCW accounted for 73% of all nonfatal workplace injuries and illnesses due to violence in 2018. There has been a 67% increase in the incidence of violence related HCW injuries from 2011 to 2018. Healthcare workers were 5 times more likely to experience WPV than all workers (US Bureau of Labor Statistics, 2020). The current Covid-19 pandemic has only increased incidents of WPV in healthcare. A survey by

National Nurses United in 2020 reported that 20% of nurses reported experiencing increased WPV during the Covid-19 pandemic as compared to pre Covid-19. The respondents attributed decreased staffing levels, changes in the patient population, and visitor restrictions as factors contributing to increased incidents of WPV (National Nurses United, 2020).

North Dakota NP and NP student respondents in this project conveyed experiencing physical, verbal, and emotional incidents of WPV. Twenty-six percent of respondents reported suffering from physical violence such as hitting, kicking, biting, and pushing. Thirty-nine percent of respondents faced verbal violence such as insults, yelling, naming calling, and inappropriate comments. Thirty-five percent of respondents reported enduring emotional violence such as bullying, intimidation, and threat. Respondents believed that a majority of WPV was perpetrated by patients (42%). Twenty-three percent of respondents experienced WPV perpetrated by a patient's family member and an additional 23% responded that WPV was perpetrated by a coworker. WPV perpetrated by a visitor was reported at 12%.

Survey results are similar to earlier research (Kumari et al., 2020; Liu et al., 2019; Maran, 2019) on perpetrators of WPV and types of WPV experienced by HCW. Verbal violence was the most frequently experienced type of WPV (Kumari et al., 2020; Antao et al., 2020). According to Kumar et al. (2019) HCW felt that poor communication was a significant cause of WPV. Healthcare workers in Kumar's study felt that conflict management should be a regular part of education and conflict management teams should be formed to guide prevention and response to WPV (Kumar, 2019).

Underreporting of WPV incidents and unfamiliarity with how to report WPV in organizations is a common theme in the literature (Antao et al., 2020; Kumar et al., 2019; Kumari et al., 2020). During the current project, only 17.8% of the NDNPS and DNP student

respondents had filed a formal incident report with their organization and 11.1% of respondents had filed a police report. Eleven percent of respondents did not report the incident and 31% discussed the WPV incident with their coworkers (see Table 5). The results of the current project are similar to current literature in that formal reporting of WPV incidents is low and most HCW informally process the incident with coworkers.

Fifty percent of respondents stated "no" or "unsure" when asked if they felt supported by their employer after a WPV incident (see Table 6). One respondent commented "*As a nurse I was supported as long as the incident was caused by a patient. However, verbal abuse by a doctor was usually never dealt with. As an NP I have had verbal abuse by doctors, patients, and family members. These incidents are not common but do happen. I am not afraid to confront individuals myself about these types of things any longer."*

Most NDNPS and DNP students (67%) work for an employer with a formal procedure for reporting WPV and 67% of respondents receive training by employers on WPV prevention. Nearly 63% of respondents' employers mandate WPV education. Fifty-two percent of respondents stated that WPV training was provided as an online module. Forty-four percent of NP respondents reported feeling safe at their workplace and all 5 DNP student respondents stated that they did not feel safe in their current RN positions (see Table 9). However, 33% of respondents responded "yes" when asked if they felt WPV was "part of the job" for HCW and 16% made comments about feeling that WPV is an accepted part of their job: *"It shouldn't be but feel that is often considered part of the job".; "Sometimes if it's a patient who doesn't know what they're doing.;" "I feel we encounter it all the time; the expectation is that it is part of the job and we need to know how to deal with it professionally."*

Objective Two

Objective two aimed to develop an educational presentation based on the responses from the survey examining NDNPS perceived educational needs regarding WPV. Fifty-five percent of respondents answered "yes" when asked if they would be interested in additional education on WPV. Respondents listed the following topics of areas of interest for education: de-escalation techniques (82.5%); self-defense (66%); coping strategies (45%); identifying risk factors for WPV (37%); and preventing WPV (34%). Respondents preferred an on-line module (43%) followed by a recorded Zoom presentation (36%). The presentation was done via Zoom live due to the preferred interactive nature of the presenter. In past presentations, the presenter had participants engage in interactive scenarios of de-escalation techniques. Unfortunately, practicing de-escalation scenarios was not feasible due to Covid social distancing restrictions. A live Zoom session was the closest approximation to an in-person training. Respondents preferred a 1-hour (93%) presentation however 2 hours were needed to cover the bulk of the topics of interest to respondents. Sixty percent of respondents were interested in receiving continuing education credit for attendance which was provided through the ND Board of Nursing.

Sixty-six percent of respondents expressed interest in learning self-defense techniques, regrettably in-person training was not possible attributable to social distancing restrictions and the Zoom platform. The two largest healthcare organizations in the local area offer commercial WPV education program that address self-defense techniques as well as de-escalation and prevention. The programs offered are *Crisis Prevention Institute* and *Management of Aggressive Behavior*. Techniques of how to avoid or deflect hits/kicks, how to remove self from a bite or hair pull, and how to safely restrain a patient are included in this education (Crisis Prevention Institute, 2021; MOAB Training Internationa, Inc., 2021) Usually, the aforementioned courses

are offered to employees working in high-risk areas such as the Emergency Department and Psychiatric unit. WPV occurs throughout healthcare environment and this training would benefit all HCW.

Kumar et al. (2019) found that 76% of the study RN respondents felt that communication played a significant role in preventing WPV. Lack of professional training played a factor in victimization of less experienced HCW (Kumar et al., 2019). Provost et al. (2019) recommended WPV education include training on effective communication and de-escalation techniques. Communication and de-escalation skills help HCW to be more aware of their own emotional responses and improve their approach to potentially violent patients. Role modeling of WPV skills improves employee's confidence in dealing with violent situations. Support from management and a "no blame culture" can be effective in increasing reporting of incidents and decrease the severity and frequency of WPV incidents (Provost et al., 2021).

The healthcare system is a unique environment in terms of WPV. Healthcare workers are more tolerant of WPV from patients and families due to patients' mental and physical health issues as an excuse for the behavior. However, violent communication or behavior is not acceptable in any environment. Many HCW find that WPV is not taken seriously by hospital administrators, government agencies, and even law enforcement. Gerard Brogan, director of nursing practice at National Nurses United, a union and professional organization for 170,000 nurses, states "*Hospitals don't want to deal with it. They don't want their hospitals to get a reputation as being a difficult place to work. Nor do they want a public image as a violent hospital."* He goes on to say "*This sounds incredible, but true. Nurses tend to get blamed if they're victims of workplace violence. The usual situation is a nurse will be counseled and asked what she or he could have done to prevent that workplace violence, as though it was some action*

or words on their part that had instigated the violence. Nurses are dissuaded from pressing charges. That is a PR issue for the hospital." (WebMD, 2021)

Objective Three

Objective three was to improve HCW confidence in dealing with WPV by providing education and evaluate provider confidence using CCPAI. Unfortunately, a low attendance rate of 8 participants (3 current NPs, 2 NDSU NP students, and 3 RNs) and completion of the CCAPI by 2 participants precluded evaluation of meaningful data. Pre and post scoring of the CCAPI by the 2 participants did not show a marked increase in confidence in dealing with WPV by the participants (see Table 15). A probable reason for low participation could have been due to timing of presentation. The presentation was re-scheduled from April 28 to May 4 from 2 PM to 4 PM, which is during clinic hours for most working NPs. To improve attendance, the educational presentation should have been offered outside of usual work hours, on several times and dates, and recorded for later viewing. Likewise, if the Zoom presentation had been recorded, the education would have been accessible to a larger audience.

Extending the event advertisement to include frequent event reminders and additional sources of advertising may have improved recruitment. The event invitation was sent out via link on NDNPA's Facebook site, NDNPA email listserv, and via NDSU DNP student list serve and repeated one time over a two-week period. One page color flyers were placed at three local healthcare facilities in employee lounges and emailed to the NPs in one local clinic.

Part of relicensing requirements for RNs and NPs in ND is 12 hours of continuing education every 2 years. Nurse practitioners that prescribe must also have 15 hours of pharmacology continuing education (North Dakota Board of Nursing, 2021). Two hours of free continuing education credits were offered as an incentive for attendance.

Theoretical Framework and Model

The Social-Ecological Model provides an appropriate theoretical framework to examine prevention of WPV. Gillespie et al. (2015) used the Social-Ecological Model to develop WPV prevention programs focused on individuals, relationships, communities, and society. Changes made on the individual level can make immediate changes to healthcare providers safety, but it is necessary to make changes on the community and societal levels to truly eliminate WPV in healthcare.

Providing healthcare providers education regarding WPV prevention is one intervention at the individual level that has been effective in decreasing incidences of WPV. Halm (2017) discussed those benefits of education included "improvement in knowledge, skills, and confidence related to aggression management, as well as increased reporting and some reduction in the incidence and severity of WPV" (Halm, 2017, pg 506). Education may also result in increased reporting of incidents of WPV to help researchers in determining the true prevalence of the problem of WPV.

At the relationship level, support from coworkers can be an effective WPV prevention strategy. Mentorship programs and support groups can help employees learn organization policies and work culture. Positive working relationships can help prevent WPV by providing support in the workplace (Gillespie et al., 2015).

At a community/organizational level root cause analysis of violent incidents can help develop preventions strategies (Gillespie et al., 2015). Identifying environmental factor, policies, and processes that influence WPV trends are necessary to make the changes to decrease WPV in an organization. Some prevention strategies include organizations having a Zero-tolerance

policy regarding WPV that is supported at the management and enterprise levels (Gillespie et al., 2015).

At a societal level, it is important to educate the public about WPV in healthcare. On April 16, 2021, Bill H.R. 1195 was passed by the House. Bill H.R. 1195 Workplace Violence Prevention for Health Care and Social Service Workers Act would mandate that all states have comprehensive workplace violence prevention programs in place and would protect workers from retaliation from employers for reporting incidents of workplace violence to their employers or government authorities (GovTrack.us, 2021). On 4/19/2021 the Senate received, read, and referred the bill to the Senate Committee on Health, Education, Labor and Pensions.

Recommendations

The current project examines the experiences of NDNPS with WPV. Nurse practitioners in ND and in fact throughout the existing literature are an unrepresented group in WPV research. Further study of WPV in this demographic would be helpful to research the prevalence and effects of education on preventing WPV for NDNPS. Recommendations for improving access to WPV education and prevention include:

1. Collaboration with healthcare organizations within the region or state to develop a comprehensive program that would include site specific education and policies. The education should be customized to the organization. Provost et al. (2021) recommends that WPV education be clinical area specific with trainers who are familiar with the clinical area. Advice and training from outside resources is appropriate, but using relevant clinical examples helped with building teams in clinical areas. Provost's study also recommends having adequate staffing to ensure team members have sufficient physical and mental energy to deal with WPV. Clear WPV policies that management

supports are necessary to provide for a safe working environment, along with a culture free from judgement or blame. Follow up after an incident of WPV is important to systemically monitor organizational violent events and develop preventative measures (Provost et al., 2021).

2. Include WPV education at new provider orientation. Niedermier and Kasik (2018) discussed the development of a WPV education program focusing on psychiatric medical residents. This program was facilitated by experienced physicians who were able to incorporate their personal experiences into discussions and provide an interactive experience with the participants. Many participants commented that they had not been aware of the problem of WPV and now had skills and knowledge to better approach these situations. Niedermier and Kasik (2018) recommended that this curriculum be made available to all medical professionals, as this is a common education need throughout health care (Niedermier & Kasik, 2018).
3. Employer response and investigation of WPV to support employees and develop prevention strategies is an important and often overlooked part of WPV education and prevention. Employers must recognize the impact incidents of WPV on HCW overall well-being. Vincent-Hoper et al. (2020) studied how physical and verbal aggression were related to three dimensions of burnout (emotional exhaustion, depersonalization, and personal accomplishment). Findings in this study indicated that WPV was a factor in employee burnout and that providing follow-counseling helped to minimize all dimensions of burnout including experiencing physical violence and the dimension of depersonalization of experiencing verbal violence. Organizational support can play a key

role in improving HCW mental wellbeing and mitigating the effects of WPV on employee burnout (Vincent-Hoper et al., 2020).

Dissemination

This project was presented as a virtual poster at the 2020 North Dakota Nurse Practitioner Association pharmacological conference. Poster presentations were also done at NDSU in Fall of 2020 and Spring of 2021. During poster presentations at NDSU, undergraduate students were allowed to photograph poster to use information for future use.

Strengths and Limitations

Strengths of this project include a large amount of literature available describing the issue of WPV, in terms of prevalence and in suggestions for prevention from such sources as the CDC and OSHA. Despite the existence of a large amount of literature about WPV little has been studied about the experiences of NPs. Most of the literature focuses on nursing staff and to a lesser extent physician staff. The problem of WPV has only been exacerbated by the Covid pandemic and the increased stress on HCW and patients. Workplace violence in NDNPS has not been studied and this study, while small in nature, adds to the body of research available on the topic.

Limitations include the limited number of NPs responding to this project's survey. Response to survey could have been fostered by providing more reminders via email or social media to encourage participation. A more robust recruitment of participants would add to the validity of the study. Partnering with a healthcare facility could be beneficial in recruiting participants and developing clinical specific interventions.

A second limitation is the poor attendance at the presentation. Attendance could have been bolstered by offering the education at a time that did not coincide with typical NP work

hours, offering the education on multiple times and dates, and recording the presentation for later viewing. The presenter's availability and time preference were the number one limiting factor for the presentation. Additionally, Covid restrictions limited the interactive aspects of this presentation by necessitating the presentation be done via virtual platform.

Conclusion

WPV will continue to be a pervasive issue in healthcare and continued research is needed to better manage this problem. As a DNP, it is important to provide leadership in dealing with critical issues that affect patient and HCW safety. By providing evidence-based research and training, this information will focus attention on this often-ignored issue. NPs are a growing part of the healthcare workforce and it is necessary to expand the body of research regarding their experiences in the workplace. WPV can be a large contributor to NPs feeling burnout and job dissatisfaction which leads to decreased NP retention in the workforce. WPV training is one measure that can make an impact on the problem of WPV for NPs.

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APPENDIX A. IRB APPROVAL

From: no-reply@erac.ndsu.edu <no-reply@erac.ndsu.edu>
Sent: Monday, February 1, 2021 10:37 AM
To: Lundeen, Tina <tina.lundeen@ndsu.edu>
Cc: Jostad, Lisa <lisa.jostad@ndsu.edu>
Subject: Re: IRB Determination of Exempt Human Subjects Research: IRB0003427

NDSU NORTH DAKOTA STATE UNIVERSITY

The above referenced human subjects research project has been determined exempt (category 1,2) in accordance with federal regulations (Code of Federal Regulations, Title 45, Part 46, *Protection of Human Subjects*).

Thank you for your cooperation with NDSU IRB procedures. Best wishes for a successful study.

Sincerely,

Kristy Shirley, CIP
Administrator / Institutional Review Board
NORTH DAKOTA STATE UNIVERSITY

phone: 701.231.8995
fax: 701.231.8098
kristy.shirley@ndsu.edu
ndsu.irb@ndsu.edu

For more information regarding IRB Office submissions and guidelines, please consult https://www.ndsu.edu/research/for_researchers/research_integrity_and_compliance/institutional_review_board_irb/. This Institution has an approved FederalWide Assurance with the Department of Health and Human Services: FWA00002439.

APPENDIX B. EXECUTIVE SUMMARY

Executive Summary

Workplace Violence in Healthcare Workers in North Dakota: "Not just part of the job"

Purpose

Healthcare workers in North Dakota are experiencing violence in their workplaces. This violence is instigated by patients, families, and other healthcare employees. This has somehow become accepted as "just part of the job," but NO ONE should experience violence while doing their job.

Project Design and Results

An education needs assessment survey was done with ND nurse practitioner and nurse practitioner students. In the survey participants answered that as a CNA, LPN, or RN: 71% had experienced WPV • As a NP: 33% had experienced WPV • Type of WPV experienced: Physical 26%, Verbal 39% and Emotional 35% • Perpetrator of WPV: Patient 42%, Patient family member 23%, Visitor 12%, and Coworker 23% • Areas of interest identified: De-escalation techniques 31%, Self-defense 25%, Coping strategies 17%, Identifying risk factors 14%, and Prevention 13%

An education regarding WPV was presented by an experienced psychologist to educate participants on prevalence of WPV, risk factors, and de-escalation techniques.

Conclusion and Recommendations

Healthcare workers need support by employers, the community, and fellow healthcare workers to develop ways to feel safe at work.

Healthcare workers need training and support through to help decrease violence in the workplace.

Healthcare workers who feel safe and supported in their work environment are able to provide higher quality of care to their patients. Decreasing violence in the healthcare setting benefits everyone.

APPENDIX C. FLYER FOR EDUCATION

Title: Workplace Violence in Healthcare: Risk Factors and Prevention Strategies

Presenter: Mariah Laver Juanto, PhD

Behavior Objectives:

1. Describe workplace violence in healthcare settings
2. Identify at least 3 risk factors for workplace violence in healthcare settings
3. Identify at least 3 ways to prevent workplace violence in healthcare settings
4. Describe two reasons for using verbal de-escalation strategies with agitated individuals
5. Describe the 10 key elements of effective verbal de-escalation

May 4, 2021 1400-1600
Due to Covid 19 safety concerns will be presented via Zoom virtual platform
Lisa Jostad is inviting you to a scheduled Zoom meeting.

Topic: Workplace Violence in Healthcare
Time: May 4, 2021, 02:00 PM Central Time (US and Canada)

Join Zoom Meeting
https://ndsu.zoom.us/j/98875534583?pwd=NGtxRVlCc1pqSWZiODdZWlBBeVFudz09

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Passcode: 311585
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98875534583@zoomcrc.com

Join by H.323
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162.255.36.11 (US East)
213.19.144.110 (Amsterdam Netherlands)
213.244.140.110 (Germany)
69.174.57.160 (Canada Toronto)
65.39.152.160 (Canada Vancouver)
207.226.132.110 (Japan Tokyo)
149.137.24.110 (Japan Osaka)
Meeting ID: 988 7553 4583
Passcode: 311585

PRESENTATION AS PART OF COMPLETION OF DNP DISSERTATION PROJECT-LISA JOSTAD RN, DNP-STUDENT

North Dakota State University
| lisa.jostad@ndsu.edu |

Approved for 2 Hours CEUs through ND Board of Nursing

APPENDIX D. QUALTRICS SURVEY

Workplace Violence Needs Assessment

Start of Block: Block 3

Q40 Hello, my name is Lisa Jostad, a graduate student in the Doctor of Nursing Practice program at North Dakota State University. I am conducting a survey to assess North Dakota nurse practitioners experience with workplace violence and to inquire about the need for additional education on de-escalation and violence prevention. Nurse practitioners are an unrepresented population in research concerning workplace violence. Participation in the study involves completing a short electronic survey. The survey should take 10 minutes or less to complete. Participation is entirely voluntary. If at any time you feel uncomfortable have the right to decline answering question(s) or to stop taking the survey at any time without consequence. The responses you give in the survey will not influence your current or future employment. There are no costs or reimbursement for survey completion. Survey responses are anonymous. The survey responses are confidential and individual responses are not identifiable in the survey results. The survey results will be part of the researcher's Doctor of Nursing Practice dissertation at NDSU and may be published in a professional journal. Participant's individual survey results will not be identifiable in the researcher's published work. Although, identification of all risk is not possible, there are no anticipated risks associated with the survey. If you have any questions or concerns about completing the survey or about being in this study, you may contact me at (218) 261-0454 or at lisa.jostad@ndsu.edu or contact my advisor Dr. Tina Lundeen at (701) 231-7747 or tina.lundeen@ndsu.edu. You have rights as a research participant. If you have questions about your rights or complaints about this research, you may talk to the researcher or contact the NDSU Human Research Protection Program at 701.231.8995, toll-free at 1-855-800-6717, by email at ndsu.irb@ndsu.edu, or by mail at NDSU HRPP Office, NDSU Dept. 4000, and P.O. Box 6050, Fargo, ND 58108-6050. Completing the survey below indicates that I have read the description of the study and I agree to participate in the study.

End of Block: Block 3

Start of Block: Demographics

Q1 Do you identify as:

- ○ Male (1)
- ○ Female (2)
- ○ Other (3)
- ○ Prefer not to say (4)

Q41 Specify gender identified:

_____

Q2 What is your age:

- ○ 20-29 years (1)
- ○ 30-39 years (2)
- ○ 40-49 years (3)
- ○ 50-59 years (4)
- ○ 60 years and older (5)

Q3 How many years have you practiced as an NP?

- ○ Current NP student (1)
- ○ Less than 1 year (2)
- ○ 1-4 years (3)
- ○ 5-10 years (4)
- ○ 11-15 years (5)
- ○ More than 15 years (6)

Q4 What is your primary geographic location of practice?

- ○ Rural area (10,000 population or less) (1)
- ○ Community or Suburban (Population of 10,000 to 50,000 people) (2)
- ○ Urban (Population greater than 50,000 people) (3)

Q5 What is the setting of your practice?

- ○ Inpatient hospital (1)
- ○ Long term care (2)
- ○ Medical Center outpatient clinic (3)
- ○ Private outpatient clinic (4)
- ○ Urgent care (5)
- ○ Emergency center (6)
- ○ Other (7)

Q30 Specify other setting:

_____

Q6 Area of NP certification

- ○ FNP (1)
- ○ PNP (2)
- ○ ANP/GNP (3)
- ○ ACNP (4)
- ○ NNP (5)
- ○ Other (6)

Q31 Specify other area of NP certification:

_____

End of Block: Demographics

Start of Block: Workplace Violence Experience

Q8 The U.S. Department of Labor defines Workplace Violence as an action (verbal, written, or physical aggression) intended to control or cause, or is capable of causing, death, or serious bodily injury to oneself or others, or damage to property.

Q20 Have you experienced workplace violence in your career as a RN, LPN, or CNA?

- Yes (1)
- No (2)
- Unsure (3)

Q21 Have you experienced workplace violence in your career as a NP?

- Yes (1)
- No (2)
- Unsure (3)

Skip To: End of Block If Have you experienced workplace violence in your career as a NP? = No

Q22 What type of workplace violence have you experienced? (Check all that apply)

- ☐ Physical (hitting, kicking, biting, pushing, etc.) (1)
- ☐ Verbal (insults, yelling, name calling, inappropriate comments, etc.) (2)
- ☐ Emotional (bullying, intimidation, threats, etc.) (3)

Q23 Who perpetrated the violence? (Check all that apply)

- ☐ Patient (1)
- ☐ Family member (2)
- ☐ Visitor (3)
- ☐ Coworker (4)

Q24 After experiencing workplace violence, what did you do? (Check all that apply)

- [ ] I did not report the incident. (1)
- [ ] I filed a written incident report as per my organization's policy. (2)
- [ ] I verbally informed my supervisor. (3)
- [ ] I discussed the incident with coworkers. (4)
- [ ] I reported the incident to law enforcement. (5)
- [ ] Other (6)

Q32 Specify what other action you took after workplace violence incident:

_____

Q25 If applicable did you feel your employer supported you after the workplace violence incident?

- ○ Yes (1)
- ○ No (2)
- ○ Unsure (3)
- ○ Comments about employer support: (4)

Q33 Comments about employer support:

_____

Q26 Were you offered professional counseling after the violent incident?

- Yes (1)
- No (2)
- Comment (3)

Q34 Comments about previous question:

_____

Q27 Did you receive professional counseling after the incident?

- Yes (1)
- No (2)
- Comments (3)

Q35 Comments about previous question:

_____

Q28 Do you feel safe at your workplace?

- ○ Yes (1)
- ○ No (2)
- ○ Unsure (3)
- ○ Comments (4)

Q36 Comments about previous question:

_____

Q29 Do you feel that workplace violence is "part of the job" for individuals working in healthcare?

- ○ Yes (1)
- ○ No (2)
- ○ Unsure (3)
- ○ Comments (4)

Q37 Comments about previous question:

_____

End of Block: Workplace Violence Experience

Start of Block: Workplace Violence Training

Q9 Does your employer have a formal procedure for reporting workplace violence?

- ○ Yes (1)
- ○ No (2)
- ○ I am unsure. (3)

Q10 Does your employer offer training on preventing workplace violence?

- ○ Yes (1)
- ○ No (2)
- ○ I am unsure. (3)

Q11 Does your employer offer training on de-escalation of a potential volatile person or situation?

- ○ Yes (1)
- ○ No (2)
- ○ I am unsure. (3)

Q12 If your employer offers workplace violence training is it:

- ○ Mandatory to complete training (1)
- ○ Optional to complete training (2)
- ○ Not sure (3)

Q13 What type of workplace violence training does your employer provide? (Check all that apply)

- ☐ On-line module (1)
- ☐ In person class (2)
- ☐ Training done by company outside of organization; (MOAB: Management of Aggressive Behavior, CPI: Crisis Prevention and Intervention, other commercial program) (3)
- ☐ Other (4)

Q14 Would you be interested in additional education on workplace violence?

- ○ Yes (1)
- ○ No (2)

Q15 What topics related to workplace violence interests you? (Check all that apply)

- [ ] Preventing workplace violence (1)
- [ ] Naming risk factors for workplace violence (2)
- [ ] De-escalation techniques (physical and/or verbal) (3)
- [ ] Self-defense (4)
- [ ] Coping strategies (5)
- [ ] Other (6)

Q39 Other topics that interest you regarding workplace violence:

_____

Q16 What format for education would you prefer?

- ○ Online module (1)
- ○ Zoom presentation-live (2)
- ○ Zoom presentation-recorded (3)
- ○ Written materials (4)

Q17 What length of training do you prefer?

- ○ 1 hour (1)
- ○ 2 hour (2)
- ○ Other (3)

Q40 Length of training suggested:

_____

Q18 Is it important to you to earn Continuing Education Units (CEUs) for this training?

- ○ Yes (1)
- ○ No (2)

Q40 If you are interested in participating in a free educational session about workplace violence, please provide your email here.

_____

End of Block: Workplace Violence Training

APPENDIX E. CCPAI

Workplace Violence Confidence Survey Confidence in Coping with Patient Aggression

Instrument

Instructions: This questionnaire is a series of questions about your personal levels of confidence with incidents of aggression and use of de-escalation techniques within the past month. Please be truthful about your answers for what your confidence really is, not what you would like for it to be. There are no wrong answers. All answers are anonymous.

1. How comfortable are you in working with an aggressive patient?

    Very uncomfortable 1 2 3 4 5 6 7 8 9 10 Very comfortable 11

2. How good is your present level of training for managing psychological aggression?

    Very poor 1 2 3 4 5 6 7 8 9 10 Very good 11

3. How able are you to intervene physically with an aggressive patient?

    Very unable 1 2 3 4 5 6 7 8 9 10 Very able 11

4. How self-assured do you feel in the presence of an aggressive patient?

    Not very self- assured 1 2 3 4 5 6 7 8 9 10 Very self-assured 11

5. How able are you to intervene psychologically with an aggressive patient?

    Very able 1 2 3 4 5 6 7 8 9 10 Very unable 11

6. How good is your present level of training for handling physical aggression?

    Very poor 1 2 3 4 5 6 7 8 9 10 Very good 11

7. How safe do you feel around an aggressive patient?

    Very unsafe 1 2 3 4 5 6 7 8 9 10 Very safe 11

8. How effective are the techniques that you know for dealing with aggression?

    Very ineffective 1 2 3 4 5 6 7 8 9 10 very effective 11

9. How able are you to meet the needs of an aggressive patient?

    Very unable 1 2 3 4 5 6 7 8 9 10 Very able 11

10. How able are you to protect yourself physically from an aggressive patient?

Very unable 1 2 3 4 5 6 7 8 9 10 Very able 11

APPENDIX F. PERMISSION TO USE CCPAI

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Expected presentation date	Jan 2021
Portions	Confidence in Coping with Patient Aggression Instrument

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APPENDIX H. EDUCATION PRESENTATION SLIDES

Workplace Violence in Healthcare: Risk Factors and Prevention Strategies

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Sanford Health

May 4, 2021

Verbal Disclosure of Conflicts of Interest

- Dr. Laver Juanto indicate that this presentation will not include discussion of commercial products or services, off-label or investigational uses of products, or services or trade names.

Learning Objectives

- Describe workplace violence in healthcare settings
- Identify at least 3 risk factors for workplace violence in healthcare settings
- Identify at least 3 ways to prevent workplace violence in healthcare settings
- Describe two reasons for using verbal de-escalation strategies with agitated individuals
- Describe the 10 key elements of effective verbal de-escalation

Workplace Violence in Healthcare Settings

Definitions and Background Information

Definition of Workplace Violence (WPV)

According to the CDC's National Institute of Occupational Safety & Health (NIOSH):

"violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty"

(NIOSH, 1996)

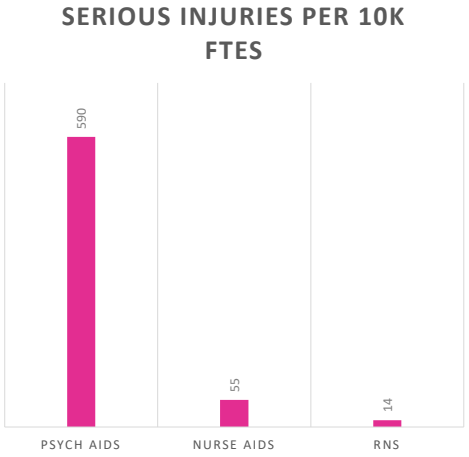
WPV includes **verbal, sexual, and physical assaults/threats, stalking, intimate partner violence, and harassment** (Wyatt, Anderson-Drevs, & Van Male, 2016)

Workplace Violence in Healthcare Settings – The Quick Stats

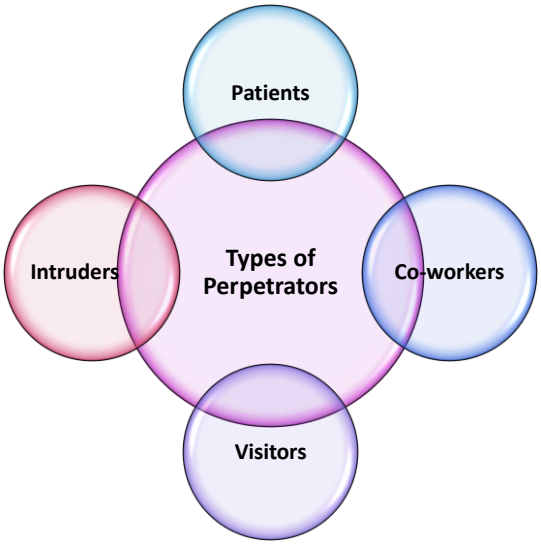
- Significantly more likely to experience WPV than all other worker groups
  - 2018 data suggests 5 times more likely as compared to all workers overall (US Bureau of Labor Statistics, 2020)
- Between 2013 & 2015 – 33 homicides, 38 assaults, and 74 rapes occurred in healthcare workplaces (The Joint Commission (TJC), 2016)
- Most data on WPV in healthcare is on inpatient settings, emergency departments, and long-term care facilities
- Little is known about non-hospital settings/clinics
  - 2nd leading cause of workplace death for home health workers is homicide (Phillips, 2016)

Healthcare Violence

- Rates may not be accurate because not everyone reports, especially if there was not a serious injury
- Rates of violence depend on both the job and the setting
  - More incidents in hospital settings vs. non-hospital settings
  - More incidents in high-crime areas than low-crime areas



Healthcare Injuries



- Patients account for 80% of healthcare worker injuries that resulted in days away from work
- Of the other 20%:
  - 12% were due to other clients or customers
  - 3% due to students
  - 3% due to coworkers
  - 1% due unspecified individuals
  - 1% due to assailant/suspect/inmate

(OSHA, 2015)

Risk Factors

Perpetrator, Worker, Environmental & Organizational Factors

Perpetrator Risk Factors

- Gender & age
  - Men – ages 35-65 = verbal assaults
  - Men – ages 66 & older = physical assaults
- History of trauma
- Victim of violence (especially if involved firearms)
- Currently in significant pain
- Having an acute stress reaction
  - Receiving a devastating prognosis, traumatic circumstances related to admission
- Being under the influence of mood- and mind-altering substances, medications, etc.
  - Detoxification from alcohol and/or drugs
- Mental health disorders/problems (e.g., dementia, psychosis, delirium, suicidal ideation)

(Beattie, Griffiths, Innes, & Morphet, 2019; OSHA, 2015; Gillespie, Gates, Miller, & Howard, 2010)

Worker-Related Risk Factors

- Contradictory research on gender – so it is not clear if it matters
- Being under the age of 40
- Less years of work experience
- Working full-time
- Being unmarried
- Having training in violence prevention
  - More likely to report, more likely to intervene in potentially violent situations, work in higher risk settings
- Working in higher risk settings where exposed to more patients with:
  - Histories of violence, alcohol/drug users, gang members, relatives of patients
- Jobs involving transporting patients
- Working alone in a facility and/or in patients' homes

(OSHA, 2015; Gillespie et al., 2010)

Environmental Risks

- Poorly designed facilities, poorly lit corridors/rooms/parking lots
- Time of day (noon & midnight; 4pm – 8pm)
- Overcrowded, uncomfortable waiting rooms and/or long wait times
- High prevalence of patients and visitors who carry firearms/weapons
- Settings (inpatient, acute psychiatric care, geriatric long-term care, emergency departments)

(Phillips, 2016; OSHA, 2015; Gillespie et al., 2010)

Organizational Risks

- Inadequate security and lack of appropriate mental health personnel on site
- Lack of policies & staff training for recognizing and/or managing escalating, hostile, & assaultive behaviors
- Perception that WPV is "part of the job"
- Understaffed, especially during busier times of the day; high worker turnover
- Lack of emergency communication

(Phillips, 2016; OSHA, 2015; Gillespie et al., 2010)

Prevention Strategies

Organizational & Employee-Level Strategies

Organizational Prevention Strategies – OSHA Guidelines (2015)

1. Management needs to commit and employees need to participate in workplace violence prevention strategies
2. Worksites need to be analyzed and hazards need to be identified
3. Processes, procedures, and programs seek to eliminate or control the risks
4. Employees should have education/training on hazard recognition and control, as well as what to do in an emergency (e.g., de-escalation training, self-defense training)
5. Evaluate the programs, policies, procedures, etc., and keep solid records

Employee-Level Prevention Strategies

- REPORT all incidents of WPV
- Seek training for yourself (e.g., self-defense, de-escalation)
- Know what your workplace policies/procedures are & how to use the reporting system
- Know how to utilize emergency services at your workplace (e.g., alarm badges, employer phones)
- Use assertive communication & boundary setting – consistently!
- Support your coworkers and seek support from them – be a team!
- Create a plan for if you are working alone, understaffed, or entering patients' homes
- Have your cell phone handy when walking alone through the facility/parking lot

(OSHA, 2015; Gillespie et al., 2010)

Verbal De-escalation

Definitions and Pros/Cons

Verbal De-escalation Defined

"a collective term for a range of interwoven staff-delivered components comprising communication, self-regulation, assessment, actions, and safety maintenance, which aims to reduce patient aggression/agitation irrespective of its cause, and improve staff-patient relationships while eliminating or minimizing coercion or restriction"

(Hallett & Dickens, 2017, p. 16)

- "Verbal" de-escalation does involve non-verbal components (e.g., facial expressions, posture, hand gestures)
- Primary goal is SAFETY through working with the patient to defuse the situation

Why Use Verbal De-escalation?

Pros

- Emphasizes collaboration between patient and staff
- Encourages patient to feel a sense of control in the situation
- Role-models using problem-solving rather than aggression
- Builds & maintains therapeutic relationships
- Reduces use of restraint/seclusion
- Reduces likelihood of physical injury to staff & patients

Cons

- May take more of staff's time
- May not be effective
- Requires training and practice
  - Some are naturally better than others

(Knox & Holloman, 2012; Richmond et al., 2012)

The 10 Key Elements of Verbal De-escalation

Richmond et al. (2012), Fishkind (2002), Mavandadi, Bieling, & Madsen (2016)

1: Respect Personal Space

- Maintain at least 2 arms' lengths of distance between yourself & the person
- Can have more distance
- Mind your exits
  - Both you and the person should be able to exit the room without feeling that the other is blocking the way

2: Don't Provoke

- Body language is KEY
- Demonstrate through body language that you **will not harm** the person, that you **want to listen**, and that you want to **keep everyone safe**
  - Hands should be visible – do NOT clinch; NO pockets
  - Knees bent, stand at an angle
  - Calm demeanor & facial expression are important
  - Be nurturing
- DO NOT:
  - Cross arms, stare intently, turn your back
  - Act like the authority

2.1: Self-Awareness

- Need to be aware of your own emotions and triggers
- Noticing your reactions allows you to manage them
- **You have to be the calm person**
- Your body is likely not feeling calm -- must actively work at being calm

- **Techniques for staying calm:**
  - Adhering to posture guidelines
  - Slow your breathing – EXHALE practice
  - Speak more slowly than normal
  - Talk at a lower volume than normal
  - Take your time with verbal responses

3: Establish Verbal Contact

- ONE person interacts with the person at a time
  - Only jump in if:
    - you are asked to do so
    - you can see your coworker is struggling
- **Introduce yourself** – and how you want to help
- **Ask person their preferred name** *(if not known)*
- Provide orientation and reassurance *(when needed)*

4: Be Concise

- **Individuals in distress do NOT comprehend** information well
- Use concise language – **short, simple sentences**
- Allow person **time to process** information
  - **Do NOT rush!**
- **Repetition is ESSENTIAL**
  - Repeat any requests, limits, or offered choices/alternatives
  - Use a firm, but nurturing tone

5: Use Active Listening

- Convey that you are paying attention
- Should be able to repeat back to the person what has been said and what the person is feeling
- "Tell me if I have this right…" – or – "So, it sounds like…"
- **"To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of." – *Miller's Law***
  - The goal is understanding the patient
  - Leads to less judgmental thinking on your part
  - Improve patient-staff relationship
- **Examples: Pain issues; Delusional thinking**

6: Identify Wants, Needs, & Feelings

- **Feelings are related to wants/needs**
  - Want something, didn't get it, still want it → angry
  - Want something, didn't get it, never will → sad
  - Want to *avoid* something bad happening → fear
- **Express what you think the patient is feeling:**
  - "It sounds like you got scared."
  - "It seems to me that you're frustrated."
- **Ask the patient for more information when it is not easy to identify:**
  - *"What would be helpful for you right now?"*
  - *"Help me understand it from your perspective."*
  - *"I can't make any promises, but I would like to know what you want so that we can work on it together."*

7: Agree or Agree to Disagree

- **Agree with anything that is the truth**
  - "Yes, this is the 4th time you've had a blood draw, and it's still really important for us to do it."
- **Agree with the principle**
  - *Patient complaining about being disrespected* - "I agree with you in that everyone deserves respect."
- **Agree with the odds**
  - "Other people get upset about that, too."
  - "I would probably be upset about that if I were in your shoes."
- **Agree to disagree**
  - "I'm not sure about that, so maybe we can agree to disagree."
  - "I've never experienced that, but I believe that's how you're feeling."

8: Set Clear Limits

- Indicate that you want to work with the patient, AND identify if you feel disrespected, frightened, or uncomfortable.
- In a matter-of-fact voice – share what the rules/limits are
  - "Hurting yourself or anyone else is not acceptable on this unit"
  - Do not say things as a "threat" – but think of it as conveying information
- **"I agree that everyone deserves respect, and we can talk about that more if you lower your voice."**
- **"I really would like you to sit down – when you pace, I can't pay attention to what you're saying because I'm distracted."**
- **"I could understand you better if you can use a calm voice."**

9: Offer Choices & Optimism

- Patients who feel their only choice is violence need to be offered alternatives
- While offering choices, include things that will be perceived as **acts of kindness**
  - Only offer **REALISTIC** choices
- Make sure to include a limit when necessary
  - "If you can talk calmly with me for 2 minutes, we can make that phone call to your mom."
  - "If you sit here with me, we will get you some Gatorade."
- **DELEGATE! –** If you have established rapport, do NOT leave the person to get items – have another team member get them whenever possible
- Medications – offer the choice of shot or oral (when available)
- Be optimistic & GENUINELY hopeful – let patient know things are going to improve
- **DO NOT MAKE PROMISES!**

10: Debrief Patient & Staff

- **If there was any involuntary intervention used** – then debriefing allows for restoration of the therapeutic relationship

With the Patient:

- Explain why the intervention was necessary
  - Let the patient explain events from his/her perspective
- Explore alternatives for managing aggression if the patient were to become agitated again
- Teach the patient how to request a "time out" and how to appropriately express anger
  - "What works when you are very upset as you were today? What can we/you do in the future to help you stay in control?"

With Staff

- Suggestions of what went well and what did not; make recommendations → **SUPPORT EACH OTHER**
- **Take a BREAK –** drink a cold beverage, sit and quietly breathe, create/utilize a "Safe Space"

Reducing the Negative Impacts of WPV

Suggestions, Recommendations, and Other Ideas on Coping

Coping After an Incident

- Use resources through your workplace (e.g., EAP, other employee-support programs)
- Engage with your social supports & in your leisure activities
- Do whatever recharges you – but avoid excessive use of alcohol
- TALK about what happened with people who are supportive and caring
- LISTEN to others about their experiences and offer support and concern
- **Seek professional behavioral health care** if you continue to struggle – the sooner you tackle the problem, the better

Coping After an Incident

- Monitor for burnout – know the signs!
- Re-focus on the positives of your job – even if they seem small!
- Practice mindfulness during your work day – even if it is only for 5 minutes
- Engage in healthy outlets, such as exercise and using a healthy diet
- Have fun at work – connect with your colleagues during the day
  - Humor can be used in a healthy way
- Change out of work clothes when you get home – take off your work "hat"!
- Practice healthy sleep hygiene

Questions/Comments

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