AGGRESSION MANAGEMENT CURRICULUM FOR ACUTE, NON-PSYCHIATRIC MEDICAL UNITS WITHIN A GENERAL HOSPITAL

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Abstract

ABSTRACT

CURRICULUM - AGGRESSION MANAGEMENT WITHIN ACUTE MEDICAL HOSPITAL UNITS

Patty Inacker LCSW, MBA

Dissertation Chair: Katherine C. Ledwith, DSW, LCSW

Workplace violence in acute hospitals is a significant issue for organizations and for the personal well-being of employees in high risk settings. Evidence clearly identifies the potential threats, but there is limited understanding of the management of aggression on acute medical units. Nursing staff, physicians, social work and ancillary staff are ill equipped to de-escalate a patient and/or effectively protect themselves and others from harm. Hospitals must develop and incorporate effective educational strategies that prepare employees to manage this increasing epidemic of violence. With a focus on prevention, this paper introduces a comprehensive curriculum that can meet the needs of these employees. The CAMPS (Cognitions, Actions, Medical, Psychological, and Stressors) Aggression Management tool is established within an overall didactic program. The curriculum and the CAMPS tool development were informed by the following: a thorough review of aggression management literature, principles of Transformational Learning Theory, exploration of interactive effects of personal and environmental determinates of behaviors, integration of organizational leverage points and intermediaries for health promotion within organizations, and the author’s career experience in healthcare. This module-based program, designed for multidisciplinary teams, uses evidence-based, trauma informed skill development with goals of building confidence, team cohesion and increased effectiveness. The curriculum will equip hospital staff with strategies to realize, recognize, respond, and safely diffuse aggressive behavior. It answers the call for training to address agitated patients and inform safety for staff and patients across all hospital settings.

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Aggression Management Curriculum for Acute, Non-psychiatric Medical Units

within a General Hospital

Patty Inacker

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

In

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Degree of Doctor of Social Work

2018

_________________________________________________________________

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Perceptions of efficacy will be examined and integrated as part of transformational learning.

ABSTRACT

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Workplace violence in acute hospitals is a significant issue for organizations and for the personal well-being of employees in high risk settings. Evidence clearly identifies the potential threats, but there is limited understanding of the management of aggression on acute medical units. Nursing staff, physicians, social work and ancillary staff are ill equipped to de-escalate a patient and/or effectively protect themselves and others from harm. Hospitals must develop and incorporate effective educational strategies that prepare employees to manage this increasing epidemic of violence. With a focus on prevention, this paper introduces a comprehensive curriculum that can meet the needs of these employees. The CAMPS (Cognitions, Actions, Medical, Psychological, and Stressors) Aggression Management tool is established within an overall didactic program. The curriculum and the CAMPS tool development were informed by the following: a thorough review of aggression management literature, principles of Transformational Learning Theory, exploration of interactive effects of personal and environmental determinates of behaviors, integration of organizational leverage points and intermediaries for health promotion within organizations, and the author’s career experience in healthcare. This module-based program, designed for multidisciplinary teams, uses evidence-based, trauma informed skill development with goals of building confidence, team cohesion and increased effectiveness. The curriculum will equip hospital staff with strategies to realize, recognize, respond, and safely diffuse aggressive behavior. It answers the call for training to address agitated patients and inform safety for staff and patients across all hospital settings.
Chapter 1: Introduction and Background

Introduction to Curriculum Development

Healthcare providers are expected to maintain lifelong learning in ever-changing environments such as hospitals and other clinical settings. One significant issue that impacts healthcare workers in these environments is violence in the workplace. Development of standardized strategies that enhance the professional advancement and safety of healthcare workers is paramount, and subsequently, this curriculum design is a timely addition to an emerging issue of frontline healthcare worker assault prevention.
Statement of the Problem

The extent of violence in healthcare settings has been escalating over time. Aggression in emergency settings is a major concern for workers and policy makers, with a staggering 1.7 million episodes occurring annually in the United States alone (Holloman & Zeller, 2011). The Occupational Safety and Health Administration (OSHA) estimates that each year more than 1.5M service workers are injured nationally. The majority of these injuries affect healthcare workers who are injured by patients, family members, and co-workers (Sorensen & Wilder, 2001). Another large survey representing 1,377 nurses, conducted by Hader (2008) on nursing and workplace violence, reported that an overwhelming majority of respondents (80%) from various regions, including the United States, Afghanistan, Taiwan, and Saudi Arabia, experienced some form of violence in the workplace (Hadar, 2008).

Although one might assume aggression and violence are reserved for behavioral health areas, it has become more prevalent on acute care units in medical hospitals. One study indicated that out of 26,979 nurses surveyed, 49.6% experienced at least one episode of violence in the past year with the highest prevalence in emergency departments and intensive care units, followed by general medical wards, operating rooms, and delivery rooms (Wei et al., 2016). Patient aggression is a common behavioral emergency associated with a high risk of injury to patients and healthcare professionals (Zeller & Rhodes, 2010). Aggressive behaviors can be unsafe and potentially disruptive, and are part of the most complex and dangerous occupational hazards in the healthcare environment (McPhaul et al., 2013). Up to this point little research attention has been focused on how to best prepare frontline healthcare staff to proactively address patient aggression in the non-psychiatric, acute medical unit, which is why it is being addressed in this curriculum.
In the acute care setting, aggressive and violent patient and family behavior that is directed toward healthcare personnel namely, type II workplace violence, is a significant problem worldwide (Arnetz JE et al., 2015), that includes verbal abuse (e.g., yelling, name calling, swearing, etc.), and physical threats or physical assault (e.g., hitting/punching, grabbing/pulling, pushing, kicking, scratching, biting). A recent study of US hospitals reported a 12-month overall prevalence rate of 39% for type II violence against hospital workers, with mental health/behavioral issues as contributing factors in nearly two thirds of cases (Pompeii LA, et al., 2015). The World Health Organization (WHO) reported that nearly a quarter of workplace violence occurred in healthcare settings, and health professionals were 16 times more likely to be attacked than workers in other industries (Elliot, 1997). Workers in healthcare and social assistance settings are five times more likely than the average worker in all other occupations to be victims of nonfatal assaults or violent acts (Sorensen & Wilder, 2001). Nurses and nursing assistants are at high risk of verbal and physical violence (Kynoch K. et al., 2010), suffering from twice as many workplace violence injuries as other healthcare personnel (Gomaa AE, et al., 2015).

In part, the issue of workplace violence in medical settings is exacerbated because many patients, who may or may not have psychiatric diagnoses, can become aggressive while being treated for medical issues. Numerous medical conditions without a psychiatric diagnosis can cause aggressive behaviors, and some of these medical conditions can be life threatening. Aggression is a serious medical problem in a number of neurologic and psychiatric patient groups. It can be a sign of an underlying non-psychiatric medical disorder, or a symptom of a psychiatric or substance use problem. When faced with a patient that has aggressive behavior the most important actions include ensuring safety of the patient and staff, followed closely by
evaluating the etiology of the aggression. In acute aggression, physical restraints may be needed for a short period until the physical examination and clinical assessment have been made (Lane, 2011). It is critically important to differentiate between medical and behavioral health causes of aggression so that patients can receive appropriate and timely treatment (Holloman & Zeller, 2011). In addition, hospitals have a responsibility to educate and train their staff to effectively manage patient aggression and best address the safety and health needs of patients, families, and staff.

Considering the high incidence rate of aggression toward healthcare professionals, many of these professionals are not adequately trained, or do not feel confident, to manage challenging and erratic behaviors. Agitation, which leads to patient aggression, is a leading cause of hospital staff injuries and can cause untold physical and psychological suffering for staff as well as those who witness these incidents (Gates et al., 2006). Nursing staff, ancillary departments, and physicians are often ill-equipped to de-escalate a patient’s behavior or effectively protect themselves or patients and others from harm. This creates an unsafe environment in which both staff and patients feel at risk for emotional or physical injury.

**Purpose of Curriculum Design**

The primary focus of this curriculum is to deliver an operational resource for healthcare providers to effectively identify and respond appropriately to aggressive patient behaviors in the acute medical area of the hospital setting. This resource includes the development of a training curriculum for healthcare staff that will be standardized across institutions. This curriculum development is housed under the social work construct for two reasons. First, social workers are trained to take a holistic approach to patient health and wellness. This person in environment framework is a core concept in the curriculum. Second, social workers play a significant role on
the healthcare team. They are trained to respond and communicate in ways that can bring teams together to optimize care coordination. Subsequently, the curriculum will provide staff with a safety protocol that includes a systematic response for addressing patient aggression. Although the importance of training in reducing healthcare workplace violence is generally acknowledged in the healthcare field, little is known about the effectiveness of such programs (Kruijver, Kerkstra, Francke, Bensing, & Van de Wiel, 2000).

This curriculum design is based on the adult learning *Theory of Transformational Learning*. It includes the introduction of skills that develop insights and essential critical reflections on the management of aggression of individuals when under the care of healthcare providers. Creating conditions for healthcare providers with effective reasoning and critical reflection will enhance and empower staff working within adverse situations in the workplace. This curriculum also addresses current gaps in adult education for healthcare providers in the management of aggression on acute medical units in the hospital setting. Based on the post-evaluation of confidence data obtained anonymously from staff at Pennsylvania Hospital, this curriculum addresses the needed efficacy of healthcare employees and workplace violence.

**Significance**

As a leader in a hospital psychiatry department, I have personally witnessed multiple scenarios of patient aggression in a hospital setting. I have seen a nurse who, while providing care to a patient in a medical-surgical care unit, was physically attacked by that patient who was in an agitated state. I also was informed of a nutritionist being verbally abused while assessing a patient during intake in the hospital. Other incidents include an aggressive patient who assaulted an environmental services worker while she tried to clean the patients’ room, and a physician who was cornered and nearly attacked while interviewing a patient before help arrived. I was
made aware of these scenarios with requests for specialized behavioral health management training and strategies. Sadly, these examples of aggressive behavior are all too common in healthcare settings.

Workplace violence is internationally recognized as a major occupational hazard for many organizations and employees. Workplace violence is especially pronounced within the healthcare field (Beech & Leather, 2006; Ryan & Maguire, 2006). The expansive nature of violence in the healthcare setting has ignited a call for effective interventions, and on a small scale, has resulted in the development, implementation, and evaluation of inconsistent and diverse training programs for healthcare workers. Despite this, little is known about the effectiveness of such programs because published examples of systematically performed training evaluations are relatively scarce (Farrelle & Cubit, 2005).

Workplace violence has been established as a significant problem in healthcare and there are identifiable factors which increase the risk of aggression in the workplace. Research has indicated that 77% of patients being treated in healthcare facilities are the most common perpetrators of physical violence, while 50% of non-physical violence is perpetrated by employees on one another (Findorff, et al., 2007). Although each violent or aggressive event is independent with its own set of variables, a comprehensive review of incidents is warranted. The curriculum will identify those features which increase the risk of violence and aggression, and may lead to tackling the problem and ultimately decreasing the incidence rate.

For many institutions, workplace violence also represents an important financial drawback because of increased absenteeism, early retirement, and reduced quality of care (Arnetz & Arnetz, 2011; Hoel, Sparks, & Cooper, 2000). Workplace violence can cause
considerable psychological damage on healthcare workers. Examples of this are posttraumatic stress (Morrison & Love, 2003) and decreased job motivation (Arnetz & Arnetz, 2011).

Managing sensitive situations in a healthcare setting can be challenging, confusing and concerning, and dealing with sensitive patient-provider situations can be extremely unsettling, especially while care is needed and being provided. Nearly two-thirds of all nonfatal victims of violence are healthcare workers, which places them at a risk five times greater than the entire work force in the United States (NIOSH, 2013a). There is also evidence of the adverse effects of violence in the workplace and its impact personally, professionally, and organizationally (Findorff, McGovern, & Sinclair, 2005). Some healthcare providers are acutely aware of the risks associated with caring for aggressive patients, but are often ill-equipped in their response to managing these situations. The evidence clearly identifies that exposure to violence in healthcare is commonplace, with half of all workers reporting exposure (Findorff, McGovern, Wall, & Gerberich, 2005; Winstanley & Whittington, 2004). There is some evidence suggesting that a lack of training and education for healthcare staff may contribute to this crisis.

The practice of, and subsequent data related to aggression management training in healthcare research has shown varying results. Research found that physicians were not required to attend training in 75% of California hospitals and 55% of New Jersey hospitals (Peek-Asa et al., 2009). Many professionals lack the education and training to assess levels of agitation, perform basic triage of aggressive behaviors, use de-escalation techniques, and recognize signs and symptoms, to determine whether a medical etiology is likely. It seems that mandatory training is necessary for these basic skills, especially considering the high incidence rate.

Another significant issue is that training curricula, when provided, are inconsistent across institutions. Some organizations focus on the identification of aggressive factors, verbal de-
escalation, and physical methods to diffuse aggression (Peek-Asa et al., 2009). Other institutions focus on identification of characteristics of aggressive patients, and factors that predict aggression (Peek-Asa, et al., 2009). Although the risk may be identified, the programs do not include management techniques such as adding resources or personnel. It is virtually impossible to examine the effectiveness of aggression management programs in healthcare as there is currently no standardized curriculum or intervention that has proven effective across institutions (Peek-Asa et al., 2009). This lack of consistency across institutions supports the need to standardize procedures and evaluate outcomes.

Mental health professionals have recently been incorporated into managing aggression on acute units in medical hospitals, at times creating undue burden on these professionals. Some institutions have established teams that consist of psychiatrictally-trained personnel to meet the needs of people with or without mental illness to receive appropriate therapeutic care in a non-psychiatric setting (Loucks, Rutledge, Hatch & Morrison, 2010). Targeted issues for behavioral health response teams include potentially disruptive or threatening behaviors, or other actions of individuals that compromise the safety and well-being of others. Although behavioral response teams have shown efficacy in management, this can create an additional burden on mental health professionals (Loucks, Rutledge, Hatch & Morrison, 2010). A more effective solution would be to systematically educate and train healthcare staff to appropriately and consistently manage aggressive patients in the acute medical unit to decrease the overuse of psychiatric consults (Conrad, 2007).

Although the phenomenon of aggression within acute medical units has been studied, there is little understanding of how these behaviors are managed across healthcare settings. In order to create an informed curriculum, a detailed exploration of the current literature regarding
the impact, etiology and risk factors of aggression will be examined. This review of literature will be the basis of the curriculum development.

Chapter 2: Literature Review

Violence in America has spilled over into the workplace, putting the personal safety, productivity, and mental and physical health of American workers at risk (Sorensen & Wilder, 2001). Aggression toward healthcare providers is indisputable, evidenced by The U.S. Department of Labor, through the Occupational Safety and Health Administration’s (OSHA) introduction of OSHA 3148, “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.” This standard was designed to assist healthcare organizations to prepare and execute plans to identify and decrease violent acts toward healthcare providers. There are five key components to the OSHA Workplace Violence Standard: (1) Management Commitment and Employee Involvement; (2) Worksite Analysis/Risk Assessment; (3) Development of Hazard Prevention and Controls; (4) Training, and (5) Recordkeeping.

Each of these key components is significant in addressing and reducing workplace violence/aggression. Although each of these components is critical, the focus of this dissertation is on the development of a curriculum with training as an essential element. In order to develop the curriculum, I will do a systematic review of the existing guidelines and policies regarding patient aggression. Further, I will more deeply explore the literature regarding the prevalence of patient aggression, key healthcare personnel, psycho-education regarding aggression, clinical assessment strategies, and de-escalation techniques.

Current State of Aggression in Hospital Settings
Literature on aggressive behavior and violence in the healthcare setting is quite extensive and published across a number of different disciplines (e.g., medicine, nursing, psychology/psychiatry, and healthcare safety and security). However, literature specifically focused on non-pharmacological strategies for managing aggressive/violent patient behavior directed toward healthcare workers is much more limited. Healthcare worker training in aggression/violence-prevention and management should be considered a required activity, with training on an annual basis as the most commonly recommended timeframe (Trustees of the University of Pennsylvania, 2017).

Evidence shows that younger/less experienced nurses, night shift, and weekend staff are more at risk of violence/workplace aggression, and that male nurses are more likely to experience physical aggression than female nurses (Trustees of the University of Pennsylvania, 2017). Evidence also shows that nurses’ knowledge and confidence increases after participation in aggression management training programs. The majority of aggression management programs for healthcare personnel include information on risk assessment, communication strategies, and physical protective techniques.

By raising awareness of violence on individual medical units through quality improvement, the framework initially reduced the rate of violence, but this was not sustained in the longer term (Trustees of the University of Pennsylvania, 2017). Additionally, implementation of rapid response/behavioral emergency response teams is associated with decreases in the number of reports of hospital violence (Trustees of the University of Pennsylvania, 2017). This systematic review shows evidence to support that the timing of intervention is key in decreasing violence.
Healthcare providers do not always recognize signs of impending aggression or violence, and sometimes healthcare providers can be very reactive, therefore contributing to the aggression. A comprehensive assessment of all patients can assist providers in proactively determining patients’ health needs. Another proactive approach is to train all staff to recognize early signs or cues, to use non-offensive techniques, to de-escalate a situation and to participate in frequent drills (Napolitano, 2017).

Underreporting of work-related violence may be due in part to recognition and training. The definitions of what constitutes violence have varied and continue to vary among institutions. The lack of institutional definition of what constitutes verbal abuse is related to aggression reporting (Makoto, et al., 2006). Reporting of violence has historically been through self-reporting or observational reporting. Research (Nijman, et al., 2005) has indicated that incident-based observation of aggression and self-reporting of violence is inconsistent. One study examined verbal abuse in nursing and identified that within the institutions where the research was conducted, there were no methods of reporting verbal abuse and no procedures related to the management of verbal abuse (Oztung, 2006).

The prevalence of violence in the workplace is said to be underreported by nurses. If staff members incur an injury, they are more likely to report. Conversely, when there is an aggressive act without employee injury, it tends to go unreported (Trustees of the University of Pennsylvania, 2017). One study noted that 43% of physical violence and 61% of non-physical violence went unreported (Findorff, M.J., McGovern, P.M., Sinclair, E., 2005). Frequency and severity of aggression is supposed to be reported, unless nurses consider aggression and violence as “part of the job” (Findorff, M. J., et al., 2004). In the same study, 86 percent of the reports of violence were completely verbal rather than in writing (Findorff, M. J., et al., 2004).
There is acknowledged research to suggest that certain employee/staff member profiles are at increased risk of assault by patients. Characteristics such as young age, mostly less than thirty years old, and being male, place an employee at increased risk for violence in healthcare settings (Estryn-Behar, M. et al, 2008; Soares, J.J., Lawoko, S., Nolan, P., 2000). The likelihood that experience and training has some impact on decreasing violence is implied (Johnson, M.E., 2004). Another identified risk factor, which pertains to nursing, is increased contact with patients. Given the nature of their job responsibilities, nurses are more exposed to violence which places them at higher risk as opposed to psychiatrists working in the in-patient hospital setting (Lawoko, S., Soares, J.J., Nolan, P., 2004). There is also evidence to suggest, that a nurses’ interpersonal communication and attitude when working with this population is a potential risk factor. A hostile provocative staff member or one who is fearful has been associated with an increased risk or violence (Quintal, S.A., 2002). Individual risk factors are often combined with environmental factors, which outline the deficiencies in this work-related hazard.

The lack of institutional definition of what is considered verbal abuse is another factor which is relational to aggression reporting (Makoto, et al, 2006). In July, 2008, the Joint Commission on Accreditation of Hospitals initiated the requirement for non-disciplinary reporting of disruptive physicians, which includes those physicians who demonstrate foul language, rude, loud or offensive comments, and/or intimidation of staff (Retrieved 9/1/17 from http://www.jcrinc.com/Audio-Conferences/Disruptive-Physician-Behavior/824/). This lack of interpersonal skills lends itself to deeper rooted problems such as substance abuse or depression and is relational to what is considered horizontal violence in the workplace (Retrieved 9/1/17 from the www.massmedboard.org/regs/pdf/01-01_disruptive_physicians.pdf).
The evidence regarding the prevalence of workplace violence has shown variable results for several potential reasons. The first reason may be the evidence itself. Currently, there is no uniform reporting system for workplace violence (Trustees of the University of Pennsylvania, 2017). The research conducted on workplace violence tends to have self-selected samples, often across institutions or within small regions or systems, utilizing cross-sectional survey design methods, with lack of randomization and generalizability across the nursing population. In addition, the literature notes that there is clearly a lack of reporting by nurses (Trustees of the University of Pennsylvania, 2017).

Rew and Ferns (2004) proposed a balanced approach in dealing with and reporting violence and aggression at work. The United Kingdom has established guidelines rooted in The Health and Safety at Work Act of 1974 (UK) which states that “employers have a legal duty under the Act to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees”. On the other hand, “employees also have a responsibility to ensure that any concerns about aggression and violence are brought to the attention of the management and that action is taken” (Diamond, 2002). The “NHS Zero Tolerance Zone Campaign” was developed in 1999 to raise awareness among staff and the general public that violent behavior will not be tolerated. The authors also introduced alternative approaches and philosophies to conflict management. Such strategies include developing successful communication styles, as well as strengthening confidence and self-esteem by practicing the philosophies embedded in eastern martial arts (Aikido). These philosophies include acknowledging the conflict, accepting the involvement, and appreciating the feelings and viewpoints of all parties to the problem (Rew, 2004). Providing ongoing training focused on better understanding of the trigger factors,
teaching better communication skills and applying alternative approaches and principles may improve outcomes for successfully tackling violence and aggression at work.

Underreporting of work-related violence may be reflective of institutional policy. A survey conducted by the Massachusetts Nursing Association indicated that in the majority of incidents that were reported to management, nothing was done, and that 6% of those who reported said that management intimidated or discouraged the nurses from reporting to police while 4% said that management harassed or blamed them for the incident (Retrieved from the web 8/1/17 from http://www.massnurses.org/files/file/Health-and-Safety/Workplace%20Violence/Workplace_Violence_booklet.pdf). The perception from nurses about the aftermath of violence included blame and punishment, fear, poor morale, vigilance, and distrust within the organization (Kindy, D., Peterson, S., Parkhurst, D., August 2005). This representation must be factored into an employee’s motivation to report this type of adverse event.

Violence and aggression against healthcare workers cannot be disputed. The prevalence and incidence, although varied, identifies a significant issue for healthcare providers. It may be implied that the nurses as a “class of individuals within a social organization” represent the elements of social injustice as described through social theory. Social injustice exists when there is known exploitation or oppression, which continues through a hierarchy, in this case organizational or institutional structure. The existence of violence can only be diminished through identification of factors correlated to the problem. The examination of the scope of violence in healthcare can further be addressed by examining the impact of violence and the risk factors of patient aggression so that social change can occur.

**Consequences of Patient Aggression**
The effect of workplace violence has an impact on individuals. Symptoms associated with PTSD after assault in psychiatric settings have been reported in several studies. A study which examined psychiatric nurses post-assault in the workplace found that 17% met criteria for Post-Traumatic Stress Disorder (PTSD) immediately after the assault and after 6 months, 10% met the criteria for a diagnosis of PTSD (Richter & Berger, 2006). Other studies have reported PTSD symptoms at approximately 11% in post-assault psychiatric personnel, but the variation in numbers can be accounted for by the cross-sectional design of the studies (Lauvrud, C., Nonstad, K., Palmstierna, and T., 2009). Seventy-eight percent of workers exposed to work-related violence experienced at least one adverse symptom (Findorff, M.J., McGovern, P.M., Sinclair, S., 2005).

Although PTSD is associated with workplace assault as reviewed above, other consequences must be noted. Those who were physically assaulted (20%) and those who were non-physically assaulted (25%) also experienced symptoms of PTSD including; anger, irritation, sadness, depression (Findorff, M.J., McGovern, P.M., Sinclair, S. 2005). Other frequently reported symptoms that nurses experience after assault are anger and anxiety. O’Connell et al. (2000) found that the most frequent emotional responses to violence in the workplace include frustration, anger, fear and emotional hurt. Verbal aggression also has a negative impact on nurses. Nurses exposed to verbal abuse reported anger, frustration and anxiety (Ozge, U., 2003). This emotional response also effects workplace functioning including low morale, decreased productivity, and increased errors (Ozge, U., 2003). This can lead to a compromise in job-related duties.
When individual employees are affected and job-related duties are compromised, this impacts the organizational operations within healthcare settings. One study identified reactions to aggression in the workplace, including staff sick leave (20%) and employee use of alcohol or drugs (20%) after an incident (O’Connell, B. et al., 2000). In light of the consequences, research has indicated that most employees exposed to violence did not receive employer provided resources such as Employee Assistance Programs (EAP) (Caldwell, M.F., 1992).

Exploring the organizational impact of workplace violence in healthcare requires review of institutional cost. The cost of interpersonal violence accounts for absenteeism, related medical care and productivity losses, and cost to employers. The International Labor Organizations reported that the cost of violence and stress in the workplace represent 1.0-3.5% of GDP over a range of countries (Waters, H.R., et al., 2005). In a presentation by Colonel John S. Murray, President of the Federal Nurses Association, the cost of violence in the workplace was estimated at $4.3 million annually, or approximately $250,000 per incident, excluding hidden expenses experienced by victim and families (Murray, 2008). The well-being of employees, including their mental and physical health, job satisfaction, and morale is closely tied to an organization’s productivity and overall cost (Hatch-Maillette, M.A. & Scalora, M.J., 2002). As important as it is to understand the impact of violence, it is especially important to understand the causes and risk factors. These factors will contribute to the development of the curriculum, and are explored below.

**Risk Factors**
Workplace violence has been established as a significant problem in health care and evidence has demonstrated there are identifiable factors which increase the risk of aggression in the workplace. Research has indicated that 77% of patients are the most common perpetrators of physical violence, while 50% of non-physical violence is perpetrated by employees (Findorff, et al., 2007). Another study by O’Connell et al. (2000) identified that patients were the most frequent source of physical and verbal aggression reported by staff. A large portion of staff reported that they had experienced incidents involving patient’s relatives who were also verbally aggressive. Intimidation from medical staff was reported by 42.8% of nurses. Intimidation by peers and the nursing hierarchy was reported by 32.7% and 30.1% retrospectively. Holden (1985) also supports that patients are the main aggressors, followed by relatives, nursing peers, and physicians. Although each violent or aggressive event is independent with its own set of variables, evaluation of prevalence is warranted. Identifying those features which increase the risk of violence and aggression may ultimately lead to tackling the problem and decreasing the incidence.

Patients can become aggressive for several reasons. Often the aggressive behavior displayed in an acute medical unit is secondary to an underlying medical, physical, or emotional issue. Some forms of aggression can be a reaction to the loss of control/autonomy that results from hospitalization. Anxiety, fear, and loneliness, and can result in a patient, family member, or visitor becoming aggressive. Reactions to medications or withdrawal from drugs and/or alcohol can result in aggressive behaviors as well. Patients and/or family members may become aggressive when they receive a new diagnosis, or misinterpret or question the course of treatment (Heckemann, 2015). Regardless of the reasons for the aggressive expression, healthcare providers must continue to fulfill their ethical, legal, and moral responsibility to provide quality
care to patients. Additionally, healthcare workers must protect patients and themselves from harm.

Causes of aggression can be neurological, behavioral, nutritional, environmental, and/or medical in nature. It is important to understand these causes to inform best practices of managing patient aggression. The need to examine the perception of the “aggressor” is critical if we are to understand the causes of aggression and the methodology to effectively deal with it. Understanding the etiology will inform the development of the strategies, but it is important to highlight that not all staff are responsible for diagnosing these issues. Medical staff are primarily responsible for assessment and management of aggression. The etiology of aggression towards healthcare workers can be characterized by three distinct variables: internal, external, and situational/interactional (Duxbury and Whittington, 2005). We will explore the internal, external, and situational factors that lead to aggression which will inform the development of the curriculum to assess and respond to patient aggression.

**Internal**

This model asserts that factors leading to aggression are those directly linked to patient age, gender, pain, and pathology (Duxbury and Whittington, 2005). A recent study found 80% of violent patients at admission to an acute psychiatric hospital can be classified under the following eight risk factors: diagnosis of a psychotic or bipolar disorder, younger than 35 years of age, male, below average estimated intelligence, psychiatric history, no history of employment, homelessness, and aggressive/agitated behavior (Newtown et al., 2012).

The literature presents a picture of concerning results on the prevalence and distribution of workplace violence. There are several forms of violence reported in the literature. Physical aggression has been documented as the experience of being hit, grabbed, punched, pushed,
pinched, kicked, scratched, spat at or bitten. Verbal abuse is considered intimidation, extreme criticism, bullying behavior and harassment, threatening behavior, cursing, demeaning, and shouting, screaming and using vulgarity directed at others. Horizontal violence included in this typology is aggression perpetrated by peers. The majority of research on the prevalence of aggression groups violent behaviors as one category (Australian Nursing Journal, 2008).

Jaber et al. (2005) conducted a prospective study in evaluating the incidence, risk factors, and outcomes of agitation in a medical-surgical ICU. Agitation in this study is defined as “frequent movement of head, arms, or legs, and/or bucking ventilator that persisted despite attempts of staff to calm the patient” (Jaber et al, 2005. P-2750). It is reported that agitation (differing from delirium) developed in 95 of 182 patients (52%) that enrolled in the study and it typically started 4.4 days after admission to ICU, and lasted 3.9 days. Seven independent risk factors for agitation in the ICU were identified including: psychoactive drug use at the time of the ICU admission, history of alcohol abuse, hyper/hypo-anemia, fever, use of sedatives in the ICU, and sepsis. Agitation, as opposed to increased mortality, in the ICU is associated with increased morbidity due to prolonged ICU stay, infections, unplanned removal of ventilator, and central venous catheter. Increased knowledge on the topic will facilitate identification of patients at risk and decrease the adverse outcomes.

Data from both human and non-human studies find that subcortical brain regions, particularly the limbic system and specifically the amygdala, are associated with the processing of emotionally salient events, including aggression (Lane, 2011). Furthermore, there is considerable evidence that the limbic-dorsolateral prefrontal – and orbital frontal networks facilitate the activation and inhibition of aggressive behavior (Lane, 2011). Research has also shown that aggression can be associated with Central Nervous System diseases (e.g. Dementia),
medical conditions (e.g. Thyrotoxicosis), and substance abuse (e.g. alcohol, cocaine) (Zeller S.L. & Rhoades R.W., 2010). In addition to the internal factors that may increase the risk for violence, there are also external factors. We will review these factors as they are salient in understanding the ways staff can respond to effectively mitigate patient aggression.

**External**

This model asserts that environmental factors contribute to the incidence of aggression (Duxbury and Whittington, 2005). Tishler et al. (2013) conducted a systemic review focusing on mental health professionals who have encountered violent and aggressive patients in emergency departments (ED). Current statistics suggest that each year approximately 1.7 million medical ED contacts involve agitated patients (Allen & Currier, 2004). Factors that potentially increase the risk of violence in the ED include the lack of a robust therapeutic alliance to defray escalating violence; unhelpful partners that accompany patients; the long wait in a loud and chaotic area; the overcrowded and small space for assessment and treatment, and toxic alcohol and drug reactions.

In addition, clinicians should be aware of common social antecedents that may trigger violence including: romantic obsession, divorce, death of a loved one, financial problems, recent incarceration, police arrest, elopement from mental health facility, involuntary transport to the hospital, or some cumulative life stressors such as contentious child custody battles (Serper et al., 2005). Since the clinician’s ability to predict violence appears to be only slightly higher than 50% (Lamberg, 2007), it is essential for clinicians to maintain a working knowledge of common risk factors associated with patient violence. This highlights the need for clinicians and staff to have interpersonal skills such as good listening and empathy to be able to build rapport with patients.
Aggression is not limited to the Emergency Department. Two articles are focused on difficult behavioral situations and agitation in intensive care unit (ICU). Maunder (1997) discussed the principles and practice of managing difficult behavioral situations (mainly aggression and manipulation) demonstrated by patients’ relatives, and that nurses working in ICUs may be vulnerable to such situations. The author believes within a clinical area, the causes of aggression may be from patient/relative, staff or the environment. It is indicated that the quality of communication is critical in avoiding or managing difficult behaviors. Communication style of “adult–adult type transaction” that focuses on tone of voices, gestures and postures, and words is the most productive. The principles of de-escalating aggression are: assistance (send/call for help); move other people away (discretely); acknowledge fear (the relative may be afraid); calm (establish inner calm before communicating); voice (low, clear); what to say (listen carefully); body language, and timing (try to slow things down). Manipulation is behavior that is intended to influence or impose a limitation on the freedom or action of another. Limit setting, whether it is explicit (verbal) or implicit (non-verbal), is a useful technique in establishing boundaries of acceptable/unacceptable behavior. On the one hand, it is important to recognize the many internal and external factors affecting ICU visitors such as uncertainty and receiving bad news; on the other hand, it is also important to view their aggressive or manipulative behaviors in responding to these stressors as atypical, thus to avoid labeling these relatives as being “aggressive or difficult”, which may result in a self-fulfilling prophesy (Maunder, 1997). Inpatient hospitalization is structured to provide a supportive environment for treatment but the milieu itself is a risk factor. Precipitants of violence have been associated with enforcement of unit rules, denial of privileges and commitment to treatment (Flannery, R. B., 2005; Johnson,
M.E., 2004). Effective management of difficult behaviors can help to reduce stress in an already stressful environment and help staff, relatives, and visitors maintain healthy boundaries.

Working conditions and organizational structure are included in the evidence for increased violence in psychiatric mental health nursing. Working full-time, as opposed to part-time, and working shift work has been associated with an increased risk for violence (Estryn-Behar, M., et al., 2008). This may be due in part to increased exposure to the patient population. The physical environment has also been implicated. Poor lighting, ventilation, and overcrowding, which are environmental stressors for both patients and staff, are cited as potential risks (Lawoko, S., Soares, J.J., Nolan, P., 2004). Working conditions and the strain under which nurses function are considered high risk factors. The nature of nursing duties, including lifting or holding patients, may be a threat. Inadequate staffing and increased patient workload has also been implicated in violence in the workplace (Lawoko, S., Soares, J.J., Nolan, P., 2000; Oztung, G., 2006; Soares, J.J., Lawoko, S., Nolan, P., 2004). Lastly, organizational structure such as staff supervision, satisfaction with salary, organizational enhancements, and adequate numbers of staff to accomplish job duties has consistently been noted throughout the literature as contributory to work-related violence toward psychiatric mental health nurses (Johnson, M.E., 2004; Lawoko, S., Soares, J.J., Nolan, P., 2000; Oztung, G., 2006; Soares, J.J., Lawoko, S., Nolan, P., 2004). Now that we have explored the risk factors for patient aggression, it is important to understand how one can assess patient aggression and understand the context for the aggression.

Assessing Aggression: Current Practice

The current practice of assessing aggression in the healthcare setting is imperative to the health and safety of patients and staff. Zeller and Rhoades (2010) carried out two systemic
reviews, one focused on identifying measures to assess the severity of agitation and to predict aggression/violence and/or the need for medication, and the other on finding clinical trials of pharmacological agents for agitation. Among 13 scales identified for the assessment of agitation/aggression across multiple treatment settings, three were found to be applicable in predicting aggression/violence in patients with agitation (Brosset Violence Checklist, Violence Risk Assessment Scheme, and McNeil-Binder Violence Screening Checklist). Only one was found to be useful in assessing the need for medication. The 31 clinical trials that were included investigated oral, intramuscular, and intravenous therapies with specifications for immunotherapy and combination therapy for both oral and intramuscular agents.

Calow et al. (2016) reviewed the current use of standardized violence risk assessment tools regarding workplace violence (WPV) in the ED setting, with the aim of reducing future risk of violence toward staff in ED. Among three risk assessment tools implemented in the ED setting, the STAMP (Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling and Pacing) violence assessment framework was shown to be an effective tool for early identification of violent behavior, while BVC (6 items to assess confusion, irritability, boisterousness, physical threat, verbal threat, and attack on objects) was the most prevalent violence risk assessment tool with the best validity and reliability in the in-patient setting (psychiatric and medical-surgical units). The evidence from this study supports the use of a standardized violence risk assessment for early identification of aggressive behavior, coupled with early de-escalation intervention and/or seclusion, and could potentially reduce the risk of injury to healthcare workers.

**Current Interventions – Literature Review**

The current interventions will be examined to explore their efficacy in decreasing patient
aggression. The use of psychopharmacology, restraints, and education and training will be reviewed. A strong understanding of the evidence base of what works in certain populations will inform the development the training curriculum. Below, benefits and risks of each intervention are also explored.

**Psychopharmacology /Chemical Restraints**

Kynoch et al.’s (2011) review included six studies (five conducted in the United States and one in Australia) that examined the effectiveness of pharmacological agents in managing aggressive behaviors in acute hospital settings. The results from these studies suggested Droperidol and Midazolam have a more rapid and stronger sedation effect compared to Lorazepam and Haloperidol, however Midazolam necessitates greater need for active airway management (Battaglia et al., 1997; Knott et al., 2006; Nobay et al., 2004; Richards et al., 1998; Thomas et al. 1992).

The results indicate that oral administration of Haloperidol, Olanzapine, Risperidone, Aripiprazole, and Quetiapine; intramuscular administration of Haloperidol, Droperidol, Olanzapine, Aripiprazole, and Ziprasidone, and Midazolam; intravenous administration of Droperidol and Lorazepam in any route of administration were effective for the treatment of agitation (Zeller & Rhoades, 2010). However, it is also reported that more rapid onset of action is through intramuscular route compared with oral route for medication such as Olanzapine. The authors concluded that developing an easy-to-administer instrument that can predict the risk of aggression/violence in agitated patients, selecting pharmacological agents that are well accepted by healthcare professionals, and training staff who could facilitate the management of agitated patients in the emergency setting are the most effective actions healthcare professionals can take to reduce violence.
Alam (2007) discussed managing behavioral disturbances in general hospital settings in the United Kingdom by highlighting the importance of accurate identification of specific problems such as comorbid medical or mental illnesses. Delirium accounts for the majority of patients with behavioral disturbances in general hospitals. Management of aggression should be focused on primary prevention and non-pharmacological approaches to modify contributing factors, followed by medication with Haloperidol as the first line of treatment. Detecting patients with alcohol problems in the medically ill patients is extremely important as alcohol withdrawal accounts for a significant number of patients presenting with challenging behaviors, and delirium tremors (a severe complication of alcohol withdrawal). A successful strategy in managing this population for a hospital include a screening tool for early detection, brief intervention for co-incidental hazardous drinkers, widely available protocols for pharmacological detoxification, and good links to specialized services (Alam, 2007).

In addition, patients admitted to a general hospital due to deliberate self-harm who meet the requirement for capacity to consent to, or refuse, medical treatment may also present potential behavioral disturbances. Pharmacological agents (Lorazepam and Haloperidol) could be used to manage behavioral difficulties, particularly aggression, in a general hospital setting depending on the patient’s history, assessment, medical condition, drug interactions, side effects, and safety (Trustees of the University of Pennsylvania, 2017).

Holloman and Zeller (2012) led efforts to develop best practice in evaluation and treatment of agitation, known as “Project BETA,” to address the major concern of aggression in emergency settings. Five workgroups that followed a patient through an intervention, were established to address 5 specific topics: (1) Medical evaluation and triage of the agitated patient; (2) Psychiatric evaluation of the agitated patient; (3) Verbal de-escalation of the agitated patient;
(4) Psychopharmacological approaches to agitation; (5) Use and avoidance of seclusion and restraint. The algorithms included in each topic provide guidance for non-coercive evaluation and management of the agitated patient. The goal is to assist clinicians in recognizing that agitated patients do not necessarily need to go straight into restraints, but rather that more benign collaborative treatments could be applied to reduce injury, establish therapeutic alliance, and improve long-term outcomes.

**Restraints**

Unfortunately, restraints have been overused in our society as a means to control aggression. One prospective which was an observational study conducted in the United States over a 1-year period examined the effects of mechanical restraints on consecutive patients who presented to an inner-city emergency department in a United States hospital. The reasons warranting restraints included agitation, violence, disruptive behavior, confusion, dementia, and alcohol/drug intoxication. (Zun, 2003). The authors concluded there is limited evidence to support the use of chemical and mechanical restraints in managing patient aggression in acute care settings. However, more high-quality training in this area would improve patient outcomes and possibly decrease incidents of aggression. The development of an aggression management curriculum supports the findings mentioned above. In my view, evaluation, and management of aggression within a healthcare setting must include elements of Cognitive Neoassociation and Social Learning Theories. Cognitive Neoassociation theory suggests that negative feelings and experiences are the main cause of anger and angry agitation. Education and training is a critical component of aggression management.

**Current Training/Education Practices**
It is important not only to recognize the signs and symptoms of patient aggression, but also to be educated about potential causes of the aggression. One responds differently depending on the cause and the context of the aggression. This section explores some of the evidence to support the value of education and training for healthcare staff.

Kynoch et al. (2011) performed a systematic review of interventions for preventing and managing aggressive patients admitted to acute hospitals. The authors analyzed quantitative research studies from 1990 to 2007 that included adult patients over the age of 18 admitted to the hospital who exhibited aggressive behaviors consisting of verbal abuse, nonverbal abuse, physical violence, threatening behaviors, and assaults. They found three studies (two conducted in Australia and one in Sweden) that investigated the use of staff training programs to reduce the incidence of aggressive behaviors in acute care settings (geriatric wards and emergency departments). The overall results from these studies indicate that staff can be prepared to manage patients’ aggressive behaviors through increasing knowledge, skills, attitudes, and confidence (Arnetz & Arnetz, 2000; Deans, 2003; Grenyer et al., 2004).

Loucks et al. (2011) published an article on the development of Behavioral Emergency Response Teams (BERT) to assist hospital staff in de-escalating situations on non-psychiatric units, in a general hospital serving patients with psychiatric illness. The tools for BERT include the BERT algorithm, educational cue cards for staff, and an aspect of performance improvement in the form of a survey. This was first trialed in a medical pulmonary unit and then expanded to the entire hospital over a 2-year period. The BERT algorithm consists of BERT members engaging in methods (1) to identify patients for BERTS, (2) to activate BERT, (3) to communicate, (4) to incorporate BERT into the care process and (5) to measure the effectiveness. BERT has allowed nurses on non-psychiatric units to access specially trained
behavioral health staff to assist in potentially dangerous situations as an alternative to consultation-liaison services. To date, patient and cost outcomes are still lacking.

Quite a few studies have a primary focus on the importance of training programs in helping general hospital staff deal with patient aggression. Beaulier et al. (2008) evaluated the effectiveness of an interdisciplinary behavior management training program on the use of restraints and the delivery of PRN (as needed) medication on an acute 20-bed inpatient brain injury unit. The specific training utilized was the NCI Certified Instructor Training Program (Crisis Prevention Institute, Inc. 2007) with a goal of training the staff on how to identify the level of escalation and how to intervene appropriately for each level. The results showed that the use of physical restraints initially declined and then increased after the training. Similarly, the delivery of PRN selected medication also increased across the duration of the study. The authors believe that interdisciplinary training to improve behavioral management is a complex issue that needs to incorporate environmental and milieu variables in addition to patient and staff variables to determine its effectiveness. The results of this study challenge healthcare professionals to design a training program that is more appropriate to their own environment, which could ultimately lead to decreased use of physical and chemical restraints.

Swain and Gale (2014) studied a multimedia communication skills training program for healthcare workers designed to reduce the experience of aggression in community healthcare workers in New Zealand. The interactive, multimedia communication skills training package included workbooks, didactic teaching, interaction, and scenarios of good and bad communication that could be paused and commented upon. The training was delivered at two community care organizations over several months. Outcome measures were the perceived aggression and wellbeing of 46 participating community healthcare workers before the program
and one month after, two months after, and at the end of the workshops. Statistically significant reduction was achieved in perceived aggression for one and two months after baseline measures; so was the reduction in distress, as well as increase in general mental wellbeing. In addition, the majority of the participants rated the training program as excellent or good. The study has enriched the growing body of research on the effectiveness and the different types of delivery of the intervention information, and calls for a randomized controlled trial with longer term follow up in the future.

An escalation of any imminent signs of violence (warning signs) should alert clinicians to the need for immediate intervention. These signs include loud talking, inappropriate language (profane, intimidating, overly sexual), the demand for unnecessary care, accusations of clinicians of conspiring against patient, aggression toward (i.e. throwing or punching) inanimate objects, agitated behavior (pacing, darting eye movements, invading personal space, clenched or gripping hands, clenched jaw) and inability to comply with directions and/or reasonable limit setting. Research indicates that many clinicians do not feel confident in their training or skills to manage aggressive/violent patients effectively and safely (Trustees of the University of Pennsylvania, 2017).

Providing further training for clinicians will help staff build a “toolbox” of interventions with verbal, physical/environmental, and restraint (physical and pharmacological) strategies that would allow for flexibility in responding to specific situations and provide alternative actions should one intervention fail. Different pharmacological agents including antipsychotics, benzodiazepines, and anticholinergics are discussed in detail in the literature and may be justified, given that the benefits of use clearly outweigh the risks. Additional investigation of the best practices and training in violence risk assessment and intervention for acute medical units
within a general hospital will be imperative, and such training should occur early in the careers of hospital personnel.

Heckemann et al. (2015) systemically reviewed current research evidence on the effects of aggression management training programs for nursing staff and students working in some acute hospital settings. The results of the review include (1) Effect of training on attitudes (2) Effect of training on confidence (3) Knowledge and skills about risk factors (4) Effect of incidence rates of patient or visitor aggression (PVA). Among nine studies, the author found that only one had strong study design. Two had weak designs and the rest had moderate designs. All studies reported improved attitude, knowledge, and skills, as well as increased confidence, but no significant long-term reduction in incidence of PVA. The study calls for “inner shifts”, i.e. changes in culture across all hierarchical levels within an organization to be part of an overall strategy in reducing PVA. A curriculum administered to many levels of staff hierarchy could lead to an “inner shift.”

Baydin and Erenler (2014) studied workplace violence (WPV) in the ED, focusing on the effects of violence on ED staff. The definition of WPV is “incidents in which an employee is abused, sexually harassed, or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health” (Norwegian Labour Inspection Authority, 2009). Characteristics of WPV are similar in different parts of the world (England, U.S., Canada, Australia, Italy, Pakistan, Norway, and many more) despite a wide range of sociocultural and economic conditions, and the untoward effects on mental and physical health of staff are serious. The most common psychological effects of WPV are fear and reduced job satisfaction. Attributable factors behind WPV include lack of preventative policies, inadequate education, unwillingness to report assaults due to staff’s viewing violence as routine or “a part of
the job” and unmet expectations of patients and their families. The authors call for universal guidelines to prevent WPV and to prevent staff from assaults and to encourage ED staff to report every incident regardless of its magnitude.

Temple (1994) discussed managing physical assault in a healthcare rehabilitation center, where nurses are at a high risk of physical assault. It is reported that healthcare workers who have had appropriate self-defense training are attacked less often, and they incur less serious injuries when they are attacked (Infatino & Musingo, 1985). Nurses in the United States have the legal right to defend themselves and others from unlawful attack, even in a psychiatric setting (Creighton, 1986). The management of aggression is focused on four stages: prevention (by changing the environment), escalation (by remaining calm, distracting the patient, taking the patient to a quiet area, etc.), violence (by staying calm, calling for help, and preparing for self-defense), aftermath (taking deep breaths to regain control, receiving and giving first aid, and completing incident reports). In conclusion, healthcare workers are at increased risk for being attacked at work, thus they must equip themselves with self-defense techniques that will enable them to prevent and/or defuse potentially lethal situations. Additionally, it is the responsibility of the employer to ensure employees are equipped to protect themselves in the event of a violent episode.

The literature suggests there is not an effective multi-disciplinary framework for addressing violence and aggression in the workplace. Although several variables exist, there is no algorithm for management of workplace violence that frontline healthcare staff can readily utilize to diffuse potentially threatening events. Ideally, healthcare workers should know their institution’s policy on the use of defensive techniques as well as their legal rights to protect themselves from being attacked at work. There are significant barriers to training all staff in self-
defense, and therefore a training curriculum based on identifying the cues that lead to aggressive behaviors is indicated and is the basis of this suggested curriculum.

**Chapter 3: Theoretical Framework**

Patient aggression is conceptualized in this project by using the Model of Ecological Development, Social Ecological Model (SEM), and the Transformational Learning Theory (TLT). A holistic dynamic model of development that integrates social-learning and individual processes of development is the Model of Ecological Systems, by Urie Bronfenbrenner. His model focused on a scientific approach that emphasizes the interrelationships of individual development and contextual variations (Darling, 2007).

The core of Bronfenbrenner’s (1994) model is the individual person. The person is the center of the developmental process and is examined in the context of gender, biological differences and genetic expression (Darling, 2007). Bronfenbrenner contends that these characteristics evoke differential responses from the environment and the individual’s reaction to it (Darling, 2007). Bronfenbrenner scientifically tested his theory through studying children and their families in real life situations, including the social context within which development occurs. Included in Bronfenbrenner’s theory is the depiction of an affective element of motivation.

The dynamic theory of Bronfenbrenner advances the theory of relationships and environments. Bronfenbrenner explores conceptual terms of environment to produce systemic models that elicit growth if certain environmental conditions apply. Bronfenbrenner further explores the concepts of environment to include family, community, culture and the remote experiences of identified individuals within an individual’s environment. Bronfenbrenner has
taken into account the social historical context into human growth and development (Bronfenbrenner, 1994).

There are two general underlying propositions that define Bronfenbrenner's model. The first proposition is that human development takes place through progressive more complex reciprocal interactions between an evolving human organism and the persons, objects and symbols in their immediate environment (Bronfenbrenner, 1994). Time is a related factor as interactions must occur regularly over extended periods of time and form what Bronfenbrenner calls proximal process (Bronfenbrenner, 1994).

The second proposition further defines these proximal processes. The form, power, content and direction of the proximal processes that effect development vary according to the environment, both immediate and remote, and the nature of the outcomes (Bronfenbrenner, 1994). This dynamic process indicates the extent of proximal processes in development. Bronfenbrenner’s view is that individual biological variants such as gender and genetics impact development due to the evoked responses from the environment related to these biological components. Also, Bronfenbrenner's model notes that proximal processes operate to produce and sustain development, but do not elucidate this process (Bronfenbrenner, 1994).

Professional development is an essential component for employers to offer and encourage for all staff. To further elucidate the ecology approach of human development, Bronfenbrenner (1994) conceptualized the perspective of environment on human development. Bronfenbrenner described the ecological environment nested in structures from the innermost to outermost levels in psychological fields. This concept is the key element to his theory. The first structure in the environment is the micro-system. The micro-system, according to Bronfenbrenner, includes patterns of activity, social roles and interrelationships constructed by the developing person that
consist of the physical, social and symbolic features that permit, inhibit, or sustain development and progress to more complex interactions. It is within this environment that proximal processes operate and depend on the content and structure of this micro-system. Examples of these micro-systems include family, schools, peer groups, and the workplace (Bronfenbrenner, 1994).

The second structure composes a linkage to the processes between two or more settings known as the meso-system (Bronfenbrenner, 1994). This system examines the relationships between and beyond two party relations expanding the circles to include the community in which the individual develops (Bronfenbrenner, 1994). This system provides more expansive inter-relations.

The third system described by Bronfenbrenner is the exo-system (Bronfenbrenner, 1994). The exo-system consists of linkages between two or more systems. It does not contain the developing individual, but indirectly influences processes in the setting in which the developing person lives (Bronfenbrenner, 1994). This is explained as the “nest” where individuals live and is considered a system that is psychological in nature not physical (Swick & Williams, 2006). Exo-systems are vicarious experiences that have a direct impact on the individual (Swick & Williams, 2006). Swick & Williams (2006) describe this concept as a parent at work physically, but psychologically with their children or a child’s experience of stress from a parent’s workplace. The linkage of development includes social networks that are broad in context.

Bronfenbrenner’s fourth system is called the macro-system. Macro-systems are overarching patterns of micro-, meso-, and exo-systems and are characteristic of a given culture, with references to the belief systems, customs, lifestyles, material resources, and life course that are embedded into broader systems (Bronfenbrenner, 1994). The social aspect of culture and class impact psychological development and ultimately affect the processes that occur for the
individual (Bronfenbrenner, 1994). The concept of macro-systems reflects social growth as the individual is depicted as a member of society in a systemic manner.

The last system related concept presented by Bronfenbrenner is the chrono-system (Bronfenbrenner, 1994). This concept extends to the passage of time, not in respect maturational growth, but in life’s course or history in time (Bronfenbrenner, 1994). Dimensions of historical context are significant because world events influence the macro-system and may affect relational dynamics (Swick & Williams, 2006). Urie Bronfenbrenner’s theory of ecological development is a model of human socialization through linkage. The underlying meanings of interactions with others are the premise of development. Bronfenbrenner’s theory helps us understand the system within which aggression occurs and therefore informs curriculum development on the matter.

Social Ecological Model (SEM) is a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations. There are five nested, hierarchical levels of the SEM: individual, interpersonal, community, organizational, and policy (UNICEF, 2017). To fully understand the comprehensive nature aggression, we need to critically examine the dynamics at play at each level and how they are interrelated.

The individual level of SEM takes a patient’s biological makeup, medical condition, personality, and coping style into account. It reviews their individual beliefs, values, culture, and history. All of these factors play into how an individual behaves and responds in his or her own environment. The interpersonal level refers to what social supports are available to a patient. Social supports are shown to decrease stress anxiety. The amount of support available, as well as
how individuals utilize their resources and support system can contribute to levels of patient aggression. The community level of the SEM is defined as relationships among organizations, and informal networks within defined boundaries, including the built environment (UNICEF, 2017).

Aggression is a complex issue which might simply reflect a wide range of societal attitudes and norms. Therefore, proactively managing aggression in a healthcare facility becomes a major public health dilemma. The community where one resides, especially access to care, can contribute to patient aggression. Nevertheless, understanding the theories behind aggression will help us take a more considered approach in dealing with aggression in the clinical area. The fourth level on the SEM is the organizational level. The organization is responsible for training and providing the necessary support for staff to effectively manage aggression (UNICEF, 2017).

As prevalent and pervasive as the impact of violence is on individual workers, organizations, and those being served, there are few interventions to support professionals in their work with victims of violence. Organizations need to take more responsibility for this issue in making sure that employees have the appropriate knowledge and training to address this issue. The proposed curriculum development can help organizations move toward this responsibility.

The final level of the SEM is the policy level which is defined by local, state, national and global laws and policies, including policies regarding the allocation of resources (UNICEF, 2017). The policy level directly affects medical care in our society. These laws and policies have a great impact on the healthcare industry, quality of hospitals, training of staff, and funding and resources available. All of these factors can indirectly impact a patient’s experience, level of frustration, and availability of resources.

**Theoretical Framework for Training Curriculum for Workplace Violence**
To successfully and adequately address workplace violence in the healthcare industry, a dynamic model that encompasses change through education is required. The framework for the training curriculum must focus on the task of adult education which helps a learner realize their capabilities by developing skills and insights essential for their practice (Mezirow, 2010). As presented in the review of literature, there are multiple variables that need to be considered in relation to workplace violence and its management in the healthcare setting. The approach must be holistic in order for change to occur. Transformational learning theory (TLT) is a conceptual framework for understanding how adults learn (Dirkx, 1998). This framework will be particularly important in developing a training curriculum aimed at changing the behavioral responses of adult learners.

Because the effect of workplace violence on healthcare staff is egregious, adult professionals in a healthcare setting require an educational approach that meets the needs of individuals in addition to an inherent transformational learning theory. Transformational learning is a metacognitive approach to adult education. The model transforms problematic frames of reference with a set of fixed assumptions and expectations to create a more inclusive discriminating open and emotionally open venue for change (Mezirow, 2010). The task of adult education is to help the learner realize capabilities by developing skills and insights essential for practice (Mezirow, 2010). The educator, therefore, will need to assist the learner with acquisition of skills, sensitivities, and understandings that are essential for becoming more reflective on assumptions and to participate more fully in critical dialectical discourse (Mezirow, 2010). This skeptical stance assists in changing one’s world view regarding the patients they care for. This is the essence of adult education.
It is essential to incorporate all levels of the problem (individual, family, environment, and staff) into the curriculum development. In doing so, this system of operations will allow for greater transparency, stronger teamwork, increased cohesion, and will decrease the tendency to blame at every level of the system. Inclusion at all levels of the system will promote transparency and a commitment to interventions that address internal, external, and situational factors that are often at the core of aggressive behavior. By incorporating theoretical concepts from Bronfenbrenner’s theory, from SEM, and from TLT, this curriculum seeks to address this inclusion to inform good outcomes.

**Definitions of Terms for Curriculum**

The concepts used in this curriculum design are informed by the definitions from literature. It is notable that definitions may vary across healthcare settings and the curriculum could be amended to reflect organizational language. Below is a review of the definitions.

**Aggression**

Aggression is defined as hostile or violent behaviors or attitudes toward another; readiness to attack or confront (Merriam-Webster’s, 2017). Aggression encompasses both verbal abuse (yelling, name calling, swearing), as well as physical assaults (hit, punch, grab, kick, bite, scratch). Aggression is a common healthcare emergency, and if not immediately intervened, poses a great risk to patients, healthcare professionals, and others in the treatment area. Aggression, though not the core feature of agitation, is frequently associated with psychiatric
conditions, and can also be associated with ACNS disease (e.g.; dementia), medical conditions (e.g.; thyrotoxicosis), and substance abuse (Zeller SL & Rhoades R.W., 2010).

**Workplace Violence**

Workplace violence refers to incidents in which staff are abused, threatened, or assaulted in circumstances related to work, involving an explicit or implicit challenge to their safety, well-being, or health (Wynne, Clarkin, Cox, & Griffiths, 1997).

**Acute Medical Setting**

Acute Medical Units serve adults 18 years and older that are being cared for in the acute care hospital setting. Acute care units provide treatment for patients who need short-term treatment for a severe injury, episodes of illness, or recovery from surgery (Trustees of the University of Pennsylvania, 2017).

**Healthcare Providers**

Healthcare providers are individuals who provide healthcare services in a structured setting such as hospitals, clinics, and community nursing facilities. Under federal regulations, a "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law (UC Regents, 2017). Social workers are an integral part of the curriculum development and implementation. Social workers are often the first to respond to patient’s psychosocial presentations and are an excellent resource to coordinate care. For this curriculum design, healthcare providers are those individuals providing direct care or ancillary services to patients in an acute care medical unit within a general hospital. This curriculum will
address staff who have the most face-to-face patient contact. It is important to note that there is an inherent hierarchy within.

**Key Providers within acute units**

*Physician:* a person skilled in the art of healing; specifically: one educated, clinically experienced, and licensed to practice medicine as usually distinguished from surgery (Merriam-Webster’s, 2017).

*Nurse:* a person who cares for the sick or infirm; specifically: a licensed health-care professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining health (Merriam-Webster’s, 2017).

*Environmental Services Worker:* a person who cleans services and keeps in an aseptic and orderly state, assigned hospital areas, including patient rooms, office areas, treatment and utility areas, nurses’ stations, conference rooms, waiting rooms, public and private bathrooms, hallways, stairways, corridors, etc. (Pennsylvania Hospital, 2017).

*Food & Nutrition Worker:* a person who performs all tasks associated with providing food service in-patients and retail areas. Is responsible in carry out all assigned duties listed on production sheets, procedure policies, tally sheets and other written and oral instructions. Responsible for utilization of consumable products, maintaining tight schedules and in general meeting the overall daily volume requirement of the in-patient and retail areas of the department (Pennsylvania Hospital, 2017).
Methodology

The purpose of this project is to develop a curriculum that is a training program for healthcare staff to effectively identify and address potential multiple antecedents of patient aggression on acute medical units. A thorough review of the literature on the current interventions and their efficacy will guide the development of this curriculum. The goal of the curriculum is to standardize the response by all hospital staff to patient aggression, and secondly educate staff regarding underlying causes of aggression.

The identification and management of aggression is a complex multifactorial event requiring integrated theory application in curriculum development. Although evidence has suggested that a multimedia approach has shown some effect (Swan & Gale, 2014), the sample size was small and not implemented in a strictly medical surgical hospital setting. To promote the needed change in an organizational culture, the targeted audience would need to be multidisciplinary workers across the healthcare organization. This has not yet been applied, across the healthcare environment. It is Brofennberenner’s theory that has identified reciprocal interactions between the human organism and the environment as proximal processes that can promote development and organizational change. According to Brofennberenner, the macro-systems are the characteristics of a given system, these systems will be embedded within the curriculum to promote cultural organization change.

The application of environment for this curriculum is the healthcare setting with the identified patient at the center to re-enforce positive proximal processes. The tenants of the curriculum for the integrated event of aggression will be based on the ecological model. The ecological model identifies individual biological makeup, medical condition, personality, and
coping style. The curriculum will address evidence on management of aggression through the lens of this ecological model.

The focus on the learner will be illuminated by the application of the Transformational Learning Theory. The adult learner will gain essential insights from an ecological framework utilizing reflective assumptions on positive outcomes of aggression and effective management. The educational delivery will include small interdisciplinary groups, shared experiences, case studies, and interactive learning through roleplaying. The evidence has demonstrated that a better understanding of aggression and the factors underlying it are essential for learning how to manage and prevent the negative impact of violence.

Curriculum development will include two phases, the “Planning Phase” and the “Curriculum Development Phase”. The planning phase will primarily be based off of the literature review. The current research on the prevalence of workplace violence and strategies to decrease incidents of aggression demonstrate the need for a curriculum steeped in the research. The selection of the theoretical constructs, such as the Social Ecological Model and the Ecological Systems Model address the systemic factors associated with hospital aggression. The Transformational Learning Theory addresses the learning style of the proposed participants (adult learners) and how to best present the information to increase learning. Additionally, the operational definitions are included in the review.

The second phase is the Curriculum Development Phase. The curriculum will have 3 modules: Module 1: Realize - Understanding aggression in the workplace; Module 2: Recognize – Identify signs and symptoms of aggression; Module 3: Respond – Learn skills and strategies on how to address aggression appropriately and improve relationships between patients and providers. For each module, there will be a reflective process to enhance and optimize the
learning capacity for participants. All elements of the instruction will be informed by the literature reviewed. In addition to the content of the curriculum, I will include implementation guidelines for best practice.

Chapter 4: The curriculum

Introduction

Workplace violence in acute hospitals is a significant issue for organizations and for the personal well-being of employees in high risk settings. One example is nurse who, while providing care to a patient in a medical-surgical care unit, was physically attacked by that patient who was in an agitated state. Another time, a nutritionist was verbally abused while assessing a patient during intake in the hospital. Other incidents include an aggressive patient who assaulted an environmental services worker while she tried to clean the patient’s room, and a physician who was cornered and nearly attacked while interviewing a patient before help arrived. Sadly, these examples of aggressive behavior are all too common in healthcare settings. I was made aware of these scenarios with requests for specialized behavioral health management training and strategies. The curriculum below answers the call for training to address agitated patients and inform safety for staff and patients across hospital settings.

Evidence clearly identifies the potential threats, but there is limited understanding of the management of aggression in acute medical units. Nursing staff, physicians, social work, and ancillary staff are ill equipped to de-escalate a patient and/or effectively protect themselves and others from harm. Hospital organizations need to incorporate effective educational strategies that prepare employees to meet the increasing epidemic of violence in the workplace. A comprehensive curriculum can meet the need of employees practicing in these settings. With a focus on prevention, this curriculum will equip hospital staff with strategies to identify, manage,
and safely diffuse aggressive behavior. The management of aggression in the workplace requires a dynamic approach incorporating developmental models that encompass ecological development, social ecology and transformational learning. The interconnectedness and collaboration of these models will provide a holistic approach to a dynamic curriculum that can address the management of aggression from a diverse work force. This chapter includes an overview of the aforementioned curriculum. Detailed slide decks, including definitions, module flow, and reflective prompts are attached in Appendix A.

**Curriculum Development Planning Phase:**

**Identified Learners**

There is documented evidence of the effects of workplace violence on the individual. In accordance with the Theory of Transformational Learning, the process of making meaning from ones’ experience impacts the individual adult learner. Transformational learning is a process that recognizes to a greater degree the significant influence of context, the varying nature of the catalyst of the process, the minimization of the role of reflection and an increased role in knowing the relationships. Overall, this provides a broadening of the defined outcome to formulate a perspective of transformation (Taylor, 1998). The initial cohort of adult learners for this curriculum will be hospital staff that has experienced an episode of violence in the hospital setting in their current institution. Participants will be hospital employees within a multidisciplinary team including physicians, nurses, environmental services workers, food and nutrition workers, and social workers. These learners will be self-selected. The most significant learning occurs when the communicative domain includes identifying problematic areas, values, beliefs and feelings, and critically examining assumptions upon which they are based, testing justification through rational discourse and making decisions predicting upon the resulting
consensus based on the learners selected (Mezirow, 1995). These tenets are infused throughout the curriculum to ensure that the new knowledge can be incorporated into each individual’s values and beliefs, so that there is a greater chance of learning and implementing the new strategies. The curriculum includes reflection, group discussions, and problem-solving strategies grounded in Transformational Learning Theory which helps to integrate new knowledge into one’s current beliefs and values.

The first cohort will be a limited group. Transformational learning takes place in intensive group settings (Taylor, 1998). Conditions that are essential to transformational learning include those that arise from a social context by involved participants with the intention not to replicate power structures, ideological stances and other aspects of the institutional status quo. Therefore, all learners will be from one identified selected medical unit from the same institution (Taylor, 1998). The self-selected cohort will meet the most informative conditions to promote transformational learning. These conditions include dialogic context, identify and voice, ownership and agency, dissonance and conflict and mediational events and demonstrations, reflection, action and generation, self-assessment and evaluation and reflective practice and recreating teaching (Taylor, 1998).

The curriculum design is consistent with Transformational Learning Theory. The common theme of transformational learning includes centrality of the experience, critical reflection, and rational discourse in the process of meaning structure transformation (Taylor, 1998). As a starting point, the adult learners experience will be initiated upon introduction, to provide a common base through group discussion facilitated by the instructor. Critical reflection will occur as participants’ beliefs regarding workplace violence are challenged and modified through three learning modules. The learning modules will provide a new world view
from which the participants can change their established points of reference. Critical reflection of assumptions is most essential for transforming the meaning of structures and perspectives in transformation (Taylor, 1998). It is important for each participant to recognize the impact of aggression and how it manifests differently in each of the participants. There will be a set time for reflection after each module. Intentional reflection will allow each of the participants to identify the impact aggression has on them and the importance of managing it effectively and responsibly.

**Identified Setting**

To best integrate the experience into the cultural context of a multi-disciplinary workforce, the learning environment must be conducive. Bronfenbrenner’s ecological theory will be used as a systematic framework to better assist the adult learners. Based on Bronfenbrenner’s theory, learning is a function of social interaction, with embedded sub-structures (Sub-environments) where learning can be interdependent based on microsystems, mesosystems, exosystems, macrosystems and chronosystems (Lau & Ng, 2014).

Microsystems are patterns of activities, roles and interpersonal relationships experienced by the developing person in a given setting (Bronfenbrenner, 1979). Each person participating in this training, has his or her own unique microsystem. These microsystems are affected by their individual roles, their relationships and social supports. Each member’s experiences will be used as part of the curriculum to include diverse perspectives and group discussions. This also provides lived experiences for the learner that correspond with other members of the inter-disciplinary team. The experience provided will emphasize the relevant features of the environment to not only include objective properties, but also a way the person in the environment perceives the properties as explored by Lau and Ng (2014).
The mesosystem is the interrelations between two or more settings in which the developing person becomes an active participant (Bronfenbrenner, 1979). For the purpose of the learner, it is imperative that the interrelations of the workplace setting are understood and defined as the mesosystem of the hospital workplace. This will provide a linkage that takes place across setting boundaries and inter professional practice. The curriculum includes elements of each of Bronfenbrenner’s systems to make sure that learning is an individual and holistic process.

Bronfenbrenner also describes the importance of the exosystem in social development. The exosystem is noted by Bronfenbrenner as one or more settings that involve the developing person as an active participant, but in which events occur that are affected by what happens in this setting (Bronfenbrenner, 1979). The application of the exosystem in this case, the hospital-based medical unit, can indirectly impact the individual learner participant. A bi-directional relationship between the individual and the hospital system, that includes but is not limited to support of peers, environment and resources, and policies and procedures will significantly impact the learners’ self-efficacy in the management of aggression.

The last integration of the ecological framework in the learning environment for adult learners include the macrosystem. The macrosystem looks at the overall culture of the given environment. The macrosystem is defined as the consistency observed within a given culture that includes the microsystem, mesosystem, and ecosystem as well as any underlying belief systems or ideological inconsistencies (Lau & Ng, 2014). The macrosystem includes the unique differences of the individuals and for this curriculum this is the multidisciplinary learners and the perspectives that they have within the care model. These unique perspectives are addressed in the curriculum by identifying the current stereotypes, beliefs, and values regarding aggression. From a macrosystem perspective, members of a culture find support for their behaviors and values.
from each other; therefore, their behaviors and values are manifested by each other and work in a cylindrical pattern (Lau & Ng, 2014). For this reason, it is important to challenge some of the stereotypes that may exist regarding patients, aggression, and potentially regarding illness as well. Historically, our society has oppressed “sick” patients, and had often stripped away their power. The curriculum includes a discussion of some of these historical practices as a way to increase empathy for patients. In addition, there is a review of patients’ rights.

Utilizing the Bronfenbrenner’s ecological model within this curriculum can inform the overall individual and organizational goal of a reduction of workplace violence. The ecological model provides an overall perspective on the organization, including the individual participant learners. In addition, the Transformational Learning Model provides the structure for the adult learner experience. Learner development and the learning environment has been established, the process and content for the curriculum is further detailed below.

The curriculum was developed using tenets from The Substance Abuse and Mental Health Services Administration (SAMHA’s) Trauma-Informed Care Model. According to SAMHSA, “a trauma-informed system: Realizes the widespread impact of trauma, recognizes the signs and symptoms in clients, families, and staff, and responds by integrating this knowledge into policy and practice” (SAMHSA, 2018). The curriculum is broken into 3 modules. Module 1 focuses on the ‘realization’ of the prevalence and impact of trauma and violence on patients, staff, and the organization. There is great emphasis on defining aggression and its impact. We define secondary traumatic stress, and allow staff to reflect on how their connection to patient’s trauma can affect them emotionally, cognitively, behaviorally, and physically. Module 2 focuses on the ‘recognition’ of patient aggression in which the facilitator teaches staff about the signs and symptoms of aggression, as well as, the underlying medical and
psychosocial conditions that can exacerbate aggression in patients. Module 3 incorporates elements from the trauma-informed care model and demonstrates how to effectively identify and respond to patient aggression using this approach.

**Learning Objectives:**

At the conclusion of this curriculum, participants will demonstrate:

1. The ability to REALIZE the impact of trauma and violence on patients, staff, and the organization.
2. The ability to RECOGNIZE the signs, symptoms, and causes of patient aggression.
3. The ability to appropriately RESPOND to patient aggression by using best practices.

**Confidence Scale**

A pre/post Confidence in Coping with Patient Aggression Instrument is used to measure individual’s learning of the material presented. The construct of the Confidence in Coping with Patient Aggression Instrument is a psychometrically sound instrument for assessing clinician confidence in coping with patient aggression (Thackrey, 1987). Utilization of the instrument will assist in evaluating the immediate and long-term effects of the training program. Participants will complete the instrument at the beginning of Module 1 and then one month after the completion of Module 3. Please refer to Appendix C for Confidence Instrument.

**Course Timeline**

Sessions will be held on a weekly basis for three consecutive weeks. The sessions will be scheduled at times that ensure the least amount of work-related conflicts for the participants. Each session will be 120 minutes.

**Participants**

Participants will self-select to participate in this curriculum. Participants must have direct contact with patients. Participants must commit to three consecutive sessions. The instructor will
coordinate coverage with management for the participants, this will support and demonstrate organizational buy-in for participation. Recruitment for the group will be from each of the following disciplines: physician, nursing, social work, food & nutrition, and environmental services, all from the same acute medical unit within the hospital.

**Meeting location**

The meetings will take place in a conference room on hospital property.

**Table 1: Objectives and Goals of Curriculum**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Goals:</th>
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| Realize- Understand Aggression in the workplace | 1. To define different types of aggression  
2. To understand who is at risk  
3. To increase trust and safety among healthcare workers |
| Recognize- Identify signs and symptoms of aggression | 1. To increase early identification of signs and symptoms of patient aggression |
| Respond- Learn skills and strategies on how to address aggression appropriate and improve relationships between patients and providers | 1. To reduce risks associated with aggression  
2. To increase awareness and confidence in managing aggression  
3. To learn protective approaches to managing aggression  
4. To improve relationships between patients and providers  
5. To build unity and cohesion among interdisciplinary teams |

**Module 1**

**Content - Realize:** Understanding aggression and violence in the workplace – emphasis is on understanding different types of aggression and who is at risk:
• Review goals of the curriculum – interactive discussion with participants. Obtain participant background information regarding experience with aggression in the workplace
• Define aggression and its impact
• Identify different types of aggression – physical, psychological, and verbal
• Define secondary traumatic stress and understand the impact of staff
• Understand risk factors

Module 1 content includes the definition of aggression, and different types of aggression (verbal, psychological, physical). These forms of aggression can alter the workplace environment and often have a negative impact on the provider, patient, and/or visitor. There is a strong emphasis on identifying who is at risk and the different types of risks that are associated with patient aggression. Next, there is discussion around the risks; including safety, impact on patient care, secondary traumatic stress and turnover. Please refer to Appendix A for Module 1 slide deck.

Process

Participants will begin by introducing themselves, including their role in the organization. A Confidence in Coping with Patient Aggression Instrument will be distributed and completed. The instructor will provide relevant background information on the purpose, goals, and expectations of the curriculum. Next, the instructor facilitates a discussion on patient aggression and different meaning of that term. Patient aggression will be defined as well as the different types of aggression (verbal, psychological, physical). A review of data will be presented including who is at the most risk for patient aggression, and in what settings aggression is most likely to occur.

Next, the facilitator reviews the risk associated with patient aggression and goes into further detail regarding the impact on staff and patients, including; safety, patient care, secondary
traumatic stress and turnover. Towards the end of the session, participants will each describe a work related incident involving an aggressive patient. The instructor gathers themes as each participant recounts their experiences. Using some of the patients’ own experiences, the instructor explicates the risks associated with patient aggression. The use of personal reflection will enhance staff’s understanding and applicability of aggression.

**Relevance**

The initial contact is pivotal between the instructor and the learner. The learners’ experience is the starting point for transformational learning (Mezirow, 1995). This introductory period provides the basis for transformational learning as the learners openly discuss their personal experiences with workplace violence in the hospital setting. Consistent with transformational learning, the initial learner contact will include critical reflection regarding workplace aggression and understanding their own experience. Critical to promoting learning in adulthood is communicative learning. Communicative learning involves identifying ideas, values, beliefs and feelings, critically examining assumptions based upon which they are based, testing justification through rational discourse and making decisions predicted upon the resulting consensus (Mezirow, 1995, p. 58). This essential form of learning is identified and developed throughout Module 1.

The instructor provides an alternative perspective to the participant’s experience in the group setting. The instructor may consciously attempt to disrupt the learner’s world view and stimulate uncertainty, ambiguity, and doubt about previously taken-for-granted interpretations of the experience, in order to deepen the participant’s understanding of their experience and increase their capacity to be open to other techniques and strategies as described by Taylor (1998). Critical reflection is crucial to the learning process as the adult learners becomes aware
of their assumptions and beliefs based on their experience. “Reflection is the appreciative process by which we change our minds, literally and figuratively. It is the process of turning our attention to justification for what we know, feel, believe and act upon” (Mezirow, 1995, p 46). This activity in the curriculum is a powerful tool to help challenge participants preconceived notions, and possible unhealthy practices in addressing patient aggression.

Due to the interdisciplinary nature of the participants, the Social Ecological Model comes into play. It is important to understand each member’s unique experience, and how each participant is part of larger systems that impacts cognitive processes and behavior. Bronfenbrenner (1979) described the microsystem as a pattern of activities, roles and interpersonal relationships experienced by the developing person in a given setting and its important emphasis on the powerful aspects of the environment that gives meaning to the experience. Module 1 encompasses the social ecological development of healthcare employees who have had the lived experience of workplace violence in the hospital setting. As Bronfenbrenner (1979) has described the mesosystem of interrelationships and the connections between them, so too does Module 1 illuminate this concept in the health care system. Giving participants an opportunity to reflect on their own unique experiences and the larger systems at play, ensures that we are able to incorporate systemic or organizational components that may overlap with individual changes.

Module 2

**Content: Recognize** - Identify signs and symptoms – emphasis on early identification; identifying medical disorders with high incidence of aggression; identifying patient and provider stressors:

- Identify early warning signs of aggression
- Assess risk and resources available
• Understand medical/psychosocial conditions with high incidence of aggression
• Understand patient/provider stressors
• Increase empathy for patients
• Encourage self-care strategies to reduce provider stress

Healthcare providers need to adequately assess for the risk of aggression, as well as monitor, and safely manage aggression within the acute medical units. Most often staff is focused on treatment for the individual’s medical condition and not paying enough attention to the early signs of aggression. Module 2 is geared towards identifying these signs and symptoms. Participants are encouraged to pay attention to patients’ verbal and non-verbal cues, medical conditions, family circumstances, and environmental stressors to assess risk. Early signs of aggression include but are not limited to: substance use withdrawal, pain, fear, loss of control, environmental conditions, poor communication, mental illness, language barriers, and the relationship between provider and patient.

It is critical for providers to differentiate medical symptoms from withdrawal symptoms and psychological behaviors. Prior knowledge of substance use issues will better prepare providers for meeting the needs of patients and for avoiding potential situations from becoming aggressive or out of control. Similarly, healthcare providers must have the skills and support to manage patients who exhibit aggressive behaviors due to pain, fear, and loss of control. Patients often display aggressive behaviors such as, yelling, physical violence, name calling, punching, and various forms of intimidation. For example, the environmental conditions as well as poor communication within the acute medical unit may contribute to aggressive behaviors. Healthcare workers are often the frontline recipients of these forms of aggression.

Identifying, instilling, and facilitating positive interpersonal and communication skills could prevent and/or diffuse aggressive situations between providers and patients. Positive patient-
centered communication between provider and patient is an essential element in preventing and/or decreasing adverse situations. Patients within an acute medical setting are compromised, confused, and vulnerable. The relationship between provider and patient is critical on many levels. Patients need to be seen, feel heard, and taken care of. Lack of clear communication can cause confusion, and/or frustration, and may result in aggressive behavior. Recognizing the early signs of aggression is critical to circumventing a potentially dangerous situation.

It is recognized that aggressive incidents occur across all healthcare settings, and that staff need to have a comprehensive awareness of the issues and be able to draw on a wide variety of response options (Farrell, 2005). It is essential for healthcare workers to readily identify the various forms of aggression that occur in the healthcare setting.

**Process**

First, the facilitator presents a brief review of Module 1. Next, the facilitator introduces the CAMPS Aggression Management Tool (see table/ appendix?). The CAMPS (Cognitions, Actions, Medical, Psychological, and Stressors) tool is presented by the facilitator in this section. This tool will be used to have participants learn to pause and practice with a questioning attitude. They will use this tool to assess a patient’s cognitions, actions, medical conditions, psychological presentation, and internal and external stressors. The facilitator asks participant to identify any factors or causes of aggression in each of these domains. This will help participants recognize the cognitive, behavioral, medical, and psychological signs and symptoms of aggression. There will be great emphasis on understanding both patient stressors and staff stressors and how these elements can create an unstable and potentially dangerous environment. This tool can help providers tune in to the source of aggression, and identify red flags earlier. This information is essential in identifying potential pre-aggression indicators to avert increased escalation. Once
identified, support from the healthcare team is imperative and solutions can be implemented expeditiously and effectively.

Next, the facilitator shows a video to illustrate patient/provider interactions that can provide safety for patients or contribute to agitation that can lead to aggression. After the video, participants discuss their reactions. Towards the end of the session, participants are asked to reflect on the work-related incident involving an aggressive patient that they discussed in Module 1. The facilitator asks questions about their experiences in identifying early signs and symptoms in patients. Facilitator ends the session with a check-in to make sure participants feel comfortable with the material and are not having their own reactions.

**Relevance**

Module 2 is critical in the process of transformational learning. The goal of adult learning is to help the individual become a more autonomous thinker by learning to negotiate his or her own values, meanings, and purpose, rather than uncritically acting on those of others (Mezirow, 1997). Module 2 provides the structure and content for the adult learning to view aggression from and alternate dimension. Ultimately this invites the employee to view aggression in a new lens.

It is important to convey that the way an individual views themselves in an environment and the perceptions of the individual living the experience is paramount in development. Module 2 presents an ecological view with new formed perceptions related to the interactions healthcare workers have with patients experiencing aggressive symptomatology. Application of Bronfenbrenner’s theory describes this relationship as the basis for developmental change as a critical element in the microsystem. The experience of the individual learner is salient and it
emphasizes features of the environment to include not only physical properties, but also the way in which individuals perceive such properties (Bronfenbrenner, 1979).

Module 3

Content: Respond-Intervention and Mitigation

- Introduce skills and strategies to de-escalate a potentially aggressive event
- Educate providers on hospital resources and support when faced with an aggressive patient and when and how to utilize these resources
- Assist staff in maintaining control during the aggressive encounter (physical management of aggression)
- Manage individual fear and anxiety during and after an aggressive event (Therapeutic debriefing)
- Process, post-incident, including access to internal and external supports

Module 3 is geared towards interventions for mitigating and managing physical aggression. Module 3 is focused on responses to aggressive behavior including demonstrating empathy, creating and maintaining a calm presence, implementation of de-escalation techniques, utilization of peer and supervisory support, and use of safety plans. When aggression becomes physical, a clear structured approach is required to maintain safety of both the patient and the provider. When an individual has a complete loss of control, the healthcare team needs to take control of the situation to prevent injury and promote safety. Most healthcare institutions have policies and procedures for managing situations that result in potentially aggressive, and at times violent events. Application of this curriculum may decrease that outcome.

Building on the importance of provider/patient relationships reviewed in Module 2, Module 3 has a strong focus on the power of the relationship between patient and provider. The purpose of developing, training, and implementing a non-violent approach to managing aggression is to care for individuals in a safe, respectful, and secure manner. Module 3 focuses on teaching providers
the skills and strategies to systematically approach aggressive behaviors in a confident, collaborative, and effective manner.

Module 3 includes a comprehensive review of strategies which includes team mitigation techniques. Team mitigation techniques include the working relationships of the interdisciplinary teams. Organizing an effective de-escalating team/risk mitigation team includes providers from various disciplines that have a relationship with the patient. This can be useful when one care provider is unsuccessful in de-escalation, the other can be an intermediary for support and resolution. If situations continue to escalate, organizations will utilize more aggressive aggression management protocols.

Utilizing an interdisciplinary model with clear consistent communication is an effective strategy in mitigating aggression. Communication techniques among caregivers regarding patient center care include interdisciplinary rounding to discuss individual patient concerns, and formalized treatment planning that provides structure and content for maladaptive behaviors. The plans must also be established in writing to enhance interventions across all shifts in the patient care continuum. The goal is to decrease maladaptive behaviors while securing the safety of team members in a collaborative, structured manner.

In all safety care events, attention needs to be focused on the physical environment. The physical environments need to be conducive to safety. When engaging in an aggressive event, safety risks can be an inherent danger. For example, objects that can be used as weapons must be removed from the immediate patient environment. Other measures that improve comfort need to be employed. This includes having individual patient needs met including, but not limited to comfort, warmth, hunger, and personal items that can assist in
providing them care. Effectively managing the medical, physical, and psychological needs of the patient may reduce the incidents of aggressive events.

Providers must be able to realize, recognize, and respond to levels of behaviors that patients may experience during an aggressive event and to use parallel approaches to de-escalate these behaviors. This is particularly challenging when a patient is medically compromised and acting out in an aggressive manner. Once a healthcare worker identifies a medical based cause for agitation, a medical intervention is warranted. Healthcare providers must stabilize the patient’s medical condition while managing the aggressive event. Medical interventions for substance use are targeted for the withdrawal symptoms the patient is experiencing. Other medical interventions include the use of medications that are effective in decreasing anxiety, such as benzodiazepines. One significant action that must be included in the assessment process includes a respiratory assessment and neurological assessment to rule out contraindications prior to the use of medications as a targeted intervention. Other interventions include the use of mechanical restraints which is a last resort intervention and is only to be used when the highest risk has been identified. Restraints, seclusion, medication, and verbal de-escalation are all options for managing aggression on an acute medical unit in a general hospital. Once a medical intervention is required for patient management, a follow-up with a behavioral specialist or provider should occur for continued management. Medical management should be one of the last resorts in managing aggression, however, if you have tried to engage the patient using an empathic, non-confrontational approach and calming tone, and the patient continues to exhibit aggressive behaviors, then alternate interventions may be indicated.
A significant, but often neglected intervention in the aggression continuum, is the follow-up once the patient has decreased anxiety and gained control over maladaptive behavior. With all aggressive episodes, the therapeutic relationship and comfort is enhanced when a review of the incident is conducted between the patient and healthcare worker. Social work can be instrumental in facilitating this interaction. The social worker is the lead for reconnecting the staff and the patient. Social workers can use holistic approaches that can help name behaviors that the healthcare provider identified, responded to, and acted upon to address the aggressive behaviors as well as social antecedents to the event. In addition, social workers can integrate the healthcare provider’s response to the de-escalation method used by the healthcare team. It is beneficial for the healthcare team to recognize and validate the behaviors that precipitated the need for intervention. Social workers can often anticipate behaviors, specifically behaviors that are inconsistent with the patient’s baseline presentation and provide a holistic approach. Social workers will use skills that develop therapeutic alliance by utilizing empathy, nonjudgmental, and active listening. Using those skills, social workers can be a leader within the healthcare team by re-examining the aggressive event through the social work lens. An essential intervention post-event is for the caregivers and patients to re-establish communication. Social work can guide healthcare providers through a process of re-establishing a therapeutic relationship with their patients after an aggressive event, as well as support the healthcare team.

**Process**

Participants begin the session with introductions again, but for Module 3, participants describe interventions that they have previously utilized that were successful or unsuccessful. This will promote a discussion for transformational learning. Next, the instructor facilitates a discussion on effective strategies that mitigate maladaptive behavior at the bedside. A
presentation on effective evidenced-based interventions is presented via PowerPoint. The participants have the opportunity to discuss how these strategies can be incorporated into their current work environment.

Next, the group has a discussion around the availability of hospital-based resources, and how to access these resources in when responding to an aggressive event. Next, the facilitator presents pertinent information on activating psychiatric codes and effectively managing aggression. The facilitator leads a discussion on the importance of the therapeutic relationship as a means of responding to aggression. A video from the Cleveland Clinic is shown to demonstrate best practices. After, participants are asked one last time to reflect on their personal work situation, and think about their responses to the incident. Were there things they could have or would do differently now? Were there resources available that they were unaware of? Were there personnel available? Is there anything they would change regarding their own approach to the event? Last, the facilitator provides a summary of Module 3’s strategies in responding to aggression, and participants are asked to complete the Confidence in Coping with Patient Aggression Instrument.

Relevance

The approach of transformational learning in Module 3 is based on what is known as other ways of knowing. Module 3 connects the learner through relationships, with other staff and the organization. Transformational learning describes building trusting relationships that learners develop the necessary confidence to deal with learning at an affective level which is needed to manage emotionally charged concepts that are experienced during transformation (Taylor, 1998). The interdisciplinary approach, assists the learning with viewing aggression in a larger
contextual model, with reflective partners experiencing the same feeling and perceptions. This can provide a systematic view for the learning.

Inherent in systematic learning is the macrosystem described by Bronfenbrenner. Module 3 approaches the culture and the underlying belief system of the organization (Bronfenbrenner, 1979). From a macrosystem perspective, members of a given culture, in this case a healthcare organization, can find support for their behavior and values and thus work together in a cylindrical pattern for change.

**Chapter 5: Implications**

The significance of aggression for healthcare professionals cannot be minimized. The incidence of aggression is increasing in general medical hospitals (Wei et al., 2016). Aggression links person, environment, health/illness, and health outcomes. For every 1% of aggressive violent acts perpetrated in society, the cost to the country was estimated in 1993 at $1.5 billion (Resis & Roth, 1993) and is clearly greater today. This represents money that could be better spent on increasing healthcare to underserved populations (Liu, 2004). Within the healthcare setting, evaluation and management of aggression must focus on discovering what environmental, biological, psychological, and social factors influence aggressive behaviors and how to effectively manage them. Hospital employees working with potentially violent patients require the knowledge, skills, and attitudes to manage aggression in the workplace. The Aggression Management in Acute Medical Units curriculum introduced in this project is one way to disseminate these skills and therefore improve aggression evaluation and management.

Aggression and violence in the acute medical setting has far-reaching negative implications on the patient and family level, staff level, and hospital level. Overall, providing education and training will increase safety, promote health and wellness, and reduce costs.
standardized training curriculum adds to the field of social work by providing education and training to staff, by increasing staff efficacy and autonomy in managing challenging situations, and by promoting the health and safety of some of our most vulnerable patients. The intended goal is to standardized curricula across medical settings with the aim to affect policy. Hospitals as organizations have the responsibility to protect both their staff and patients and this curriculum can facilitate that responsibility.

Currently, there are limited tools and resources for healthcare workers employed in medical surgical settings to manage aggressive patients. Clinician competence and confidence in effectively managing aggressive patients is without question essential for compassionate care with the patient. Confidence and competence empowers the clinician to utilize internal resources in the management of aggression. This comprehensive curriculum provides employees with appropriate tools to identify, manage, and utilize resources to mitigate threats of violence in the workplace and therefore can impact clinician confidence and competence with engagement.

The complexity of treating both medical issues and behavioral/psychiatric problems will continue to be a significant issue. It is critical for healthcare providers to have knowledge and skills to distinguish and manage medical conditions that present as behaviors and psychiatric issues that impede care (Holloman & Zeller, 2011). A comprehensive curriculum that encompasses an adult learner approach from a lived experience perspective will prepare healthcare providers to meet this challenge and build confidence in their skill set when working with complex patients. Evidence indicates that the staff can be prepared to manage patients’ aggressive behavior through increasing knowledge, skills, attitude and confidence (Arntez & Arntez, 2000; Dean, 2003; Greyner et al., 2004).
Although the evidence has indicated a significant need for healthcare providers to have the skill to manage violence and aggression, research has indicated there is no standard training that encompasses all aspects of aggression in the workplace and not proven successful curriculum across institutions (Peek-ASA et al., 2009). Evidence has suggested that an effective way to manage aggressive patients in an acute medical setting would be to systematically educate and train all healthcare staff to manage aggressive patients (Conrad, 2007). This curriculum answers that call, and asks social work practitioners to use skills that translate across disciplines to drive holistic interventions to decrease the incidence and impact of workplace violence. This curriculum is a needed resource for all healthcare teams.

The curriculum includes strategies to de-escalate a patient when early warning signs of aggression are identified. De-escalation of these factors is a multi-tiered event. In verbal de-escalation, participants are taught to identify and mitigate the underlying stressor associated with the maladaptive behavior. The healthcare provider identifies and learns to utilize tone of voice, tense, physical stance in a supportive nature. Cognitive approaches in this curriculum include positive self-talk, realistic expectations, decreased stimulation are provided by the healthcare providers. Effective management of aggression can keep agitation from moving to aggression, resulting in better outcomes for all involved.

The effectiveness of this curriculum can be quantified by minimizing the impact that workplace violence has on its employees. Benefits to an organization can be measured through less sick time use by employees in high-risk areas, decreased turnover in staff and increased staff satisfaction. The well-being of employees is closely tied to an organization’s productivity and overall cost (Hatch-Maillette, M.A., & Scalora, M.J., 2002).
**Benefits:**

| Human Resources | 1. Improved Communication  
|                 | 2. Establish a safe working environment  
|                 | 3. Reduced risk of injury to patient and staff  
|                 | 4. Reduced stigma associated with behavioral health issues through the common definition/understanding of aggression  
| Organizational  | 1. Reduce risk – litigation  
|                 | 2. Create and maintain a culture of safety  
|                 | 3. Improved staff retention  
|                 | 4. Improved patient/family satisfaction, may increase engagement in their healthcare, and overall experience and relationships with healthcare providers |

The primary focus of this curriculum is to provide a resource for healthcare providers who encounter aggression within the workplace and who want to better manage these situations. As demonstrated throughout this curriculum, the key to realizing, recognizing, and responding to aggression within an acute medical setting is to be prepared. This curriculum presents a multidisciplinary approach to managing aggression. A comprehensive curriculum that seeks to improve confidence, knowledge and skill of any multidisciplinary team can foster positive results in collaboration in an organization. The effectiveness of the Aggression Management in Acute Medical Units curriculum can, at minimum, enhance and strengthen collaboration within a team; and at its best decrease workplace violence and increase morale.

Social workers play key roles on hospital teams. This curriculum is aligned with social work values and therefore has implications for the profession of social work at large, and specifically hospital-based social workers. The relationship skills and power dynamics that are explored during the curriculum are tenets of social work practice. The attention to group dynamics and the experience of patients provide social workers opportunities for leadership roles.
in hospital-based violence and aggression prevention. Social workers navigate within the multidisciplinary hospital setting to provide services to patients, and are well positioned to advocate for implementation of this training and to facilitate the implementation.

As with most curricula, a major limitation of the Aggression Management Curriculum is that its effectiveness has not been subject to rigorous research validation. A pre- and post-test, the Confidence in Coping with Patient Aggression Instrument, is suggested as one method to collect quantitative data. Other steps include piloting this curriculum and gathering quantitative and qualitative data regarding evaluation, training facilitation and implementation as well as short and long-term impact of the curriculum on the healthcare setting.

Chapter 6: Conclusion

In this paper I have outlined the issue of workplace violence in medical settings and its various implications regarding worker safety, productivity, functionality and satisfaction. I have further outlined the associated stigmata related to these events, wherein psychiatric diagnoses are regularly assumed as culprit without substantiation. It is my belief that with education and experience, prevention of violent episodes becomes much more viable and thus avoid the need for chemical or physical restraint. This belief is supported by the research on prevalence of violence, de-escalation, and understanding of the clinical applications of learning theory, systems, and trauma informed care that is reviewed in this paper. Such an approach speaks to the full spectrum of care perspective embraced by the field of social work as it attends to the dignity and worth of all people involved and also the importance of relationships.

A deep look at literature on aggression and hospital settings, as well as the conceptual understanding of transformational learning and ecological theory informed the development of the Aggression Management in Acute Medical Units curriculum and of the CAMPS model. Each
of these tools helps deliver information, awareness and skills to empower the workforce to more effectively manage aggression. Additionally, the program uses evidence-based, trauma informed skill development with goals of building confidence, team cohesion and increased effectiveness within multidisciplinary teams. CAMPS was developed to be highly rational and easily replicated to allow for widespread implementation. Although the results of implementation are currently unknown, the Aggression Management in Acute Medical Units and CAMPS are invaluable additions to an area that has historically been more focused on the problem of aggression rather than on prevention or management strategies.

This project is the first structured and research-informed curriculum designed to decrease aggression on acute medical units in order to inform patient and worker safety. The need for this type of curriculum is demonstrated in the data that shows the impact of workplace aggression on patients and workers. Increased knowledge and comfort around this difficult topic of hospital-based aggression can only help in our efforts toward mitigation and increased safety and security in the hospital for workers, patients and families.
<table>
<thead>
<tr>
<th><strong>Table 2: CAMPS</strong></th>
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| **Cognitions**    | ▶ Trouble concentrating  
|                   | ‣ Easily distracted  
|                   | ‣ Racing thoughts  
|                   | ‣ Forgetfulness  
|                   | ‣ Ruminating  
|                   | ‣ Minimizing  
| **Actions**       | ▶ Rocking  
|                   | ▶ Rapid, loud of excessive talking  
|                   | ▶ Clenching fists  
|                   | ▶ Rapid breathing  
|                   | ▶ Tension in the shoulders  
|                   | ▶ Restlessness  
|                   | ▶ Repetitive movements  
|                   | ▶ Lowering of body, dropping of eyebrows  
|                   | ▶ Excessive staring at targets  
|                   | ▶ Direct/indirect threats  
|                   | ▶ Refusal of food  
|                   | ▶ Pulling out tubes  
|                   | ▶ Wandering from treatment areas  
| **Medical**       | ▶ Withdrawal from drugs and alcohol  
|                   | ▶ Medications (steroids, stimulants)  
|                   | ▶ Constipation  
|                   | ▶ Pain  
|                   | ▶ Poor oxygenation  
|                   | ▶ Delirium  
|                   | ▶ Endocrine imbalances  
|                   | ▶ Dementia  
|                   | ▶ Electrolyte Imbalance  
|                   | ▶ Other infections  
| **Psychological** | ▶ Sudden changes in mood  
|                   | ▶ Easily agitated  
|                   | ▶ Changes in affect  
|                   | ▶ Sadness  
|                   | ▶ Anger  
|                   | ▶ Frustration  
|                   | ▶ Loss of control  
|                   | ▶ Fear  
<p>|</p>
<table>
<thead>
<tr>
<th>Stressors (Patient)</th>
<th>Stressors (Staff)</th>
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</thead>
<tbody>
<tr>
<td>▶ Trauma</td>
<td>▶ Personality Style</td>
</tr>
<tr>
<td>▶ Lack of social support</td>
<td>▶ Staff frustration with work</td>
</tr>
<tr>
<td>▶ Excessive crying or laughter</td>
<td>▶ Outside lives affecting work</td>
</tr>
<tr>
<td></td>
<td>▶ Poor communication with patient</td>
</tr>
<tr>
<td></td>
<td>▶ Inability to deal with aggression effectively</td>
</tr>
<tr>
<td></td>
<td>▶ Fear of physical injury</td>
</tr>
<tr>
<td></td>
<td>▶ Understaffing</td>
</tr>
<tr>
<td></td>
<td>▶ Compassion fatigue – always giving to others</td>
</tr>
<tr>
<td></td>
<td>▶ Family interactions</td>
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</tbody>
</table>
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