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

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**

Patricia M. Inacker, LCSW, MBA

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

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Dedication

This dissertation has been dedicated to my mother, Anne M. Inacker. A strong, compassionate, faith filled, and dedicated woman who continually focuses on assuring her children's success. Her strength and grit continue to inspire and sustain me. She guides me in a love for faith, people and life. I also dedicate this accomplishment to my father Fred Inacker, who has guided me in a steadfast work ethic and makes me proud to be his daughter.

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To Laura Pritchard, my family, friends, and colleagues, I say thank you for your unwavering love, support, and encouragement. To THE BEST COHORT EVER (BCE)- There is no other group I would rather be on this journey with. We are Changing the World.

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Keywords: Patient aggression, Workplace violence, Violence prevention, De-escalation, Rapid Response Teams

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Chapter 1: Introduction and Background

Introduction to Curriculum Development

Healthcare providers are expected to continue lifelong learning in dynamic, ever-changing environments, such as hospitals and other clinical settings. One significant problem that impacts healthcare workers in these environments is violence in the workplace. Development of standardized strategies to enhance the professional advancement and safety of healthcare workers is paramount. This curriculum design for aggression management 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 (US) alone (Holloman & Zeller, 2011). The Occupational Safety and Health Administration (OSHA) estimates that each year, more than 1.5 million service workers are injured nationally. The majority of healthcare workers are injured by patients, family members and co-workers (Sorensen & Wilder, 2001). Hader (2008) conducted a large survey of nurses (N=1,377) on nursing and workplace violence. An overwhelming majority of

respondents (80% percent) from various regions, including the US, Afghanistan, Taiwan, and Saudi Arabia, reported that they had experienced some form of violence in the workplace (Hader, 2008).

Although one might assume that 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 that is 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, minimal research has been focused on how to best prepare frontline healthcare staff to proactively address patient aggression in the non-psychiatric, acute medical unit. This curriculum addresses the gap of healthcare workers' inadequate preparation for recognizing and managing aggression, with the goal of thwarting aggressive behaviors before they progress to violence.

In the acute care setting, aggressive and violent patient and family behavior that is directed toward healthcare personnel, called *type II workplace violence*, is a significant problem worldwide (Arnetz JE et al., 2015). Type II workplace violence 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, and biting). A

recent study of US hospitals reported an overall 12-month 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 for verbal and physical violence (Kynoch K. et al., 2010), suffering from twice as many violent workplace 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. Aggression 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 who has aggressive behavior, the most important actions are to ensure the 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 of time, until the physical examination and clinical assessment have been completed (Lane, 2011). Medical and behavioral health causes of aggression must be

differentiated, so that patients can receive appropriate and timely treatment (Holloman & Zeller, 2011). Additionally, hospitals have a responsibility to educate and train their staff to effectively manage patient aggression, and to successfully address the safety and health needs of patients, families, and staff using best anti-aggression practices.

Many healthcare professionals are not adequately trained, or do not feel confident about how to manage challenging and erratic behaviors, despite the high incidence rate of aggression toward healthcare professionals. Agitation, which precedes patient aggression, is a leading cause of hospital staff injuries, and can cause untold physical and psychological suffering for staff and for 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 to effectively protect themselves or patients and others from harm. Providers' lack of skills to manage aggression creates an unsafe environment in which both staff and patients are at risk for emotional or physical injury.

Purpose of Curriculum Design

The primary focus of this curriculum is to deliver a viable resource for healthcare providers to effectively identify and appropriately respond to aggressive patient behaviors in the acute medical area of the hospital setting. To be useful, the development of this aggression- training curriculum for healthcare staff 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. A core concept in the curriculum that is being developed is a person-in-environment framework. Second, social workers play a significant role on the healthcare

team. They are trained to respond and communicate in effective ways that can bring teams together to coordinate and optimize care. Subsequently, the curriculum will provide staff with a safety protocol that includes a systematic response for addressing patient aggression. Although training to reduce healthcare workplace violence is generally acknowledged as important 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*. Transformational learning includes the introduction of skills to develop essential insights and critical reflections on the aggression management for individuals who are under the care of healthcare providers. Teaching healthcare providers effective reasoning and critical reflection will empower staff who work within adverse situations in the workplace. This aggression-training curriculum addresses current gaps in education for healthcare providers on how to manage aggression on acute medical units in the hospital setting. This curriculum addresses the need for healthcare employees to develop self-efficacy in their ability to manage workplace violence.

Significance

As a leader in a hospital psychiatry department, I have witnessed multiple scenarios of patient aggression in a hospital setting. A nurse providing care to a patient in a medical-surgical care unit was physically attacked by that patient, who was in an agitated state. A nutritionist was verbally abused while performing a patient assessment as part of the patient's intake evaluation for admission to 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 while interviewing a patient. Help arrived before the physician was attacked. These scenarios resulted in requests for specialized behavioral health management training and strategies.

Aggressive behaviors are far 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 initiated a call for effective interventions, and on a small scale, has resulted in the development, implementation, and evaluation of inconsistent and diverse anti-aggression training programs for healthcare workers. Little is known about the effectiveness of such programs, because published examples of system-wide performed training evaluations are relatively scarce (Farrelle & Cubit, 2005).

Workplace violence has been established as a significant problem in healthcare. Identifiable factors increase the risk of aggression in the workplace. Research has indicated that physical violence is perpetrated by 77% of patients being treated in healthcare facilities, while 50% of non-physical violence is perpetrated by employees on one another (Findorff, et al., 2007). Although each act of violence or aggression is an independent event, with its own set of variables, a comprehensive review of incidents is warranted. This anti-aggression curriculum helps identify those factors which increase the risk of violence and aggression, which may lead to deconstructing the problem and

ultimately, decreasing the incidence rate of aggression and violence in the acute hospital setting.

For many institutions, workplace violence also causes an important financial disadvantage, prompting increased absenteeism, early retirement, and reduced quality of care (Arnetz & Arnetz, 2011; Hoel, Sparks, & Cooper, 2000). Workplace violence can cause considerable psychological distress for healthcare workers. Posttraumatic stress and decreased job motivation are two examples of how psychological distress can negatively impact employees (Arnetz & Arnetz, 2011; Morrison & Love, 2003).

In general, managing sensitive situations in a healthcare setting can be challenging, confusing and concerning. Dealing with additional patient-provider situations can be extremely unsettling, especially while care is needed and is still being provided. Nearly two-thirds of all victims of nonfatal violence are healthcare workers, which places them at five times greater risk than the entire work force in the US (NIOSH, 2013a). There is also evidence that the impact of violence in the workplace has adverse effects for workers 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 inadequately prepared to respond and manage these situations. Research identifies violence in healthcare settings as commonplace, with half of all workers reporting exposure (Findorff, McGovern, Wall, & Gerberich, 2005; Winstanley & Whittington, 2004). Evidence suggests that healthcare staff lack training and education for effectively managing violence in the workplace, which 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 healthcare 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 of agitation and aggression, to determine whether a medical etiology is likely. Mandatory training is necessary for healthcare providers to learn these basic skills, especially considering the high incidence rate of violence in the hospital setting.

Another significant issue in managing violence in hospitals 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 identifying the characteristics of aggressive patients, and the factors that predict aggression (Peek-Asa, et al., 2009). Although risks may be identified, the current training programs do not include management techniques such as adding resources or personnel to effectively handle the crisis. It is virtually impossible to examine the effectiveness of aggression management programs in healthcare since no standardized curriculum or intervention that currently exists has proven effective across institutions (Peek-Asa et al., 2009). This lack of consistency across institutions supports the need to standardize procedures for aggression management training and to evaluate outcomes after aggression management training.

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 psychiatrically-trained personnel to meet the needs of people with or without mental illness, so the patients receive appropriate therapeutic care in a non-psychiatric setting (Loucks, Rutledge, Hatch & Morrison, 2010). Targeted issues for behavioral health response teams to manage 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 who already manage full caseloads (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, which would 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. To inform the curriculum, a detailed exploration of the current literature regarding the impact, etiology and risk factors of aggression is included below. This review of literature is 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, as evidenced by the US Department of Labor, through the Occupational Safety and Health Administration's (OSHA) introduction *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (Occupational Safety and Health Administration [OSHA], 2002). These guidelines were 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 a significant way to address and reduce workplace aggression and violence. 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, a systematic review of existing guidelines and policies regarding patient aggression was undertaken. Further, the literature was reviewed for the prevalence of patient aggression, the identification of key healthcare personnel impacted by patient aggression, psycho-education regarding aggression management, clinical assessment strategies, and effective techniques to de-escalate aggression and violence.

Current State of Aggression in Hospital Settings

Literature on aggressive behavior and violence in the healthcare setting is quite extensive and has been published across a number of different disciplines, including medicine, nursing, psychology/psychiatry, and healthcare safety and social work. However, literature specifically focused on non-pharmacological strategies for managing aggressive and violent patient behavior that is directed toward healthcare workers is limited. Healthcare worker training in aggression and violence prevention and management should be a required activity, with training on an annual basis, which is the most commonly recommended timeframe (Trustees of the University of Pennsylvania, 2017).

Evidence-based research shows that younger and less experienced nurses, those who work the night shift, and weekend staff are more at risk for aggression and violence in the workplace, and that male nurses are more likely to experience physical aggression than female nurses (Trustees of the University of Pennsylvania, 2017). Research also shows that nurses' knowledge and confidence increase 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 techniques for protection.

One aggression management strategy was to raise awareness of violence on individual medical units through quality improvement checks, initially this reduced the rate of violence, but this was not sustained in the longer term (Trustees of the University of Pennsylvania, 2017). Implementation of rapid response/behavioral emergency response teams was associated with decreases in the number of reports of hospital

violence (Trustees of the University of Pennsylvania, 2017). These data show 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 rather than quelling it. A comprehensive assessment of all patients can assist providers to proactively determine patients' health needs. Another proactive approach is to train all staff to recognize early signs or cues of aggression, 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 partly due to lack of recognition and training. 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 has indicated that incident-based observation of aggression and self-reporting of violence is inconsistent (Nijman et al., 2005). One study examined verbal abuse in the field of nursing and identified that within the institutions where research was conducted, there were no methods of reporting verbal abuse, and no procedures for the management of verbal abuse (Oztung, 2006).

The prevalence of violence in the workplace is believed to be underreported by nurses. If staff members incur an injury, they are more likely to report. Conversely, when an aggressive act occurs 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, McGovern, & Sinclair, 2005). Frequency and severity of aggression is supposed to be reported. Perhaps nurses consider aggression and violence to be “part of the job” (Findorff et al., 2004). In the same study, 86% of the reports of violence were completely verbal reports rather than reports in writing (Findorff et al., 2004).

Research suggests that certain employee and staff member profiles are at increased risk for assault by patients. Characteristics such as young age (less than thirty years old), and being male place an employee at increased risk for violence in healthcare settings (Estryn-Behar et al., 2008; Soares, Lawoko, & Nolan, 2000). The likelihood that nursing experience and training has some impact on decreasing violence is implied (Johnson, 2004). Another identified risk factor that 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 a higher risk for aggressive and violent behaviors compared to psychiatrists working in the in-patient hospital setting (Lawoko, Soares, & Nolan, 2004). Evidence also suggests that a nurse’s interpersonal communication and attitude when working with patients is a potential risk factor. A hostile, provocative staff member, or one who is fearful, has been associated with an increased risk for violence (Quintal, 2002). Individual risk factors are often combined with environmental factors, which points out the complexity in this understanding patient aggression.

The lack of institutional definition for *verbal abuse* is another factor which is related 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/>).

Providers' lack of interpersonal skills lends itself to more deeply-rooted problems, such as substance abuse or depression, and is related 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).

Evidence on the prevalence of workplace violence has been variable for several possible reasons. The first reason may be the evidence itself. Currently, no uniform reporting system exists for workplace violence (Trustees of the University of Pennsylvania, 2017). 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, which results in lack of randomization and generalizability across the nursing population. In addition, the literature notes that there is clear 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 (UK) has established guidelines rooted in the Health and Safety at Work Act of 1974, 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” (Chojnacka, 2005, p.3). 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 team and that action is taken” (Diamond, 2002, p.12). 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 for conflict management. Strategies include developing successful communication styles, and strengthening confidence and self-esteem by practicing the philosophies embedded in eastern martial arts, such as Aikido. These philosophies involve 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 a better understanding of trigger factors, teaching better communication skills, and applying alternative approaches and principles may improve outcomes for successfully tackling aggression and violence 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 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). Nurses' perceptions about the aftermath of violence included blame and punishment, fear, poor morale, vigilance, and distrust within the organization (Kindy, Peterson, & Parkhurst, August 2005). This perceived aftermath is likely to be factored into an employee's lack of motivation to report this type of adverse event.

Aggression and violence against healthcare workers cannot be disputed. The prevalence and incidence, although varied, represents a significant problem for healthcare providers. It may be implied that nurses, as a “class of individuals within a social organization,” represent the elements of social injustice as described through social theory (Ahmedani, 2011, p.8). Social injustice exists when there is known exploitation or oppression, which continues through a hierarchy — in this case, through an organizational or institutional structure. The existence of violence can only be diminished through identification of factors correlated to the problem. The scope of violence in healthcare can be addressed further by examining the risk factors for patient aggression and the impact of violence, so that social change can occur.

Consequences of Patient Aggression

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

Although PTSD is associated with workplace assault, other consequences must be noted. Those who were assaulted physically (20%) and those who were assaulted non-

physically (25%) also experienced symptoms of PTSD, including anger, irritation, sadness, and depression (Findorff, MCGovern, & Sinclair, 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. Nurses exposed to verbal abuse reported anger, frustration and anxiety (Ozge, 2003). Emotional responses after aggression and violence also effects workplace functioning, by contributing to low morale, decreased productivity, and increased errors, which can lead to a compromise in job-related duties (Ozge, 2003).

When individual employees are affected and job-related duties are compromised, the organizational operations within healthcare settings are impacted. One study identified that, after an aggressive incident in the workplace, behavioral reactions occur, such as staff sick leave (20%) and employee use of alcohol or drugs (20%) (O'Connell 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, 1992).

Exploring the organizational impact of workplace violence in healthcare requires a review of institutional cost. The cost of interpersonal violence is absenteeism, related medical care expenses, and productivity losses, which is a 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 et al., 2005). Colonel John S. Murray, President of the Federal Nurses Association, presented the cost of violence in the workplace as an estimated at \$4.3 million annually, or approximately

\$250,000 per incident, excluding hidden expenses experienced by victims 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 & Scalora, 2002). Understanding the causes and risk factors of violence is as important as understanding the impact of violence. Embedded in this anti-aggression training curriculum is an understanding of the risk factors for aggression and violence in the workplace.

Risk Factors

Workplace violence has been established as a significant problem in health care. Researchers have identified factors that increase the risk of aggression in the workplace. For example, research studies have found that the most common perpetrators of physical violence are patients (77%), while non-physical violence is often perpetrated by employees (50%) (Findorff et al., 2007). Another study by O'Connell et al. (2000) identified patients as the most frequent source of physical and verbal aggression, per staff reports. A large portion of staff reported that they had also experienced incidents involving patients' relatives being 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 found that patients are the main aggressors, followed by relatives, nursing peers, and physicians. Although each violent or aggressive event is independent and has its own set of precipitating factors, evaluation of prevalence is warranted. Identifying those factors which increase the risk of aggression and violence may ultimately lead to decreasing the incidence or solving the problem of workplace violence.

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 and autonomy that results from hospitalization. Anxiety, fear, and loneliness can cause a patient, family member, or visitor to become aggressive. Reactions to medications or withdrawal from drugs and/or alcohol can result in aggressive behaviors, too. Patients and/or family members may become aggressive when they receive a new diagnosis, or if they misinterpret or question the course of treatment (Heckemann, 2015). Regardless of the reasons for patients' expression of aggressive behavior, 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. Understanding these causes is necessary to inform best practices for managing patient aggression. A need to examine the perception of the "aggressor" is critical if we are to understand the causes of aggression and the best methodology to effectively deal with it. Understanding the etiology will inform the development of anti-aggression strategies, but not all staff are responsible for diagnosing these issues. Medical staff are primarily responsible for assessment and management of aggression. The origin of aggression towards healthcare workers can be characterized by three distinct variables: internal, external, and situational/interactional (Duxbury & Whittington, 2005). The internal, external, and situational factors that lead to aggression

are explored below. These factors informed 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 & Whittington, 2005). A recent study found that 80% of violent patients admitted to an acute psychiatric hospital could be classified under the following eight risk factors: diagnosis of a psychotic or bipolar disorder; younger than 35 years of age; male; estimated intelligence estimated to be below average; psychiatric history; no history of employment; homelessness; and aggressive/agitated behavior (Newtown et al., 2012).

The literature presents a concerning picture on the prevalence and distribution of workplace violence. Several forms of violence are 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 (Hacker, 2018). *Verbal abuse* is considered: intimidation; extreme criticism; bullying behavior and harassment; threatening behavior; cursing; demeaning and shouting; screaming; and using vulgarity directed at others (Hacker, 2018). *Horizontal violence* is aggression perpetrated by peers (Hacker, 2018). The majority of research on the prevalence of aggression assigns and groups violent behaviors into one category and does not differentiate type (Australian Nursing Journal, 2008).

Jaber et al. (2005) conducted a prospective study that evaluated 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, pp. 2750).

Agitation (differing from delirium) developed in 95 of 182 patients (52%) that enrolled in the study. Agitation typically started 4.4 days after admission to the 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 ICU admission; history of alcohol abuse; hyper/hypo-anthemia; fever; use of sedatives in the ICU; and sepsis. Agitation in the ICU is associated with increased morbidity (as opposed to increased mortality), due to prolonged ICU stay, infections, unplanned removal of a ventilator, and central venous catheter. Increased knowledge about agitation will facilitate identification of patients at risk and decrease the adverse outcomes that occur when agitated patients escalate and become aggressive or violent.

Data from both human and non-human studies reveal 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 & Rhoades, 2010). In addition to internal factors, external factors also exist that may increase the risk for violence. External factors, which are salient to understanding the ways that healthcare staff can respond effectively to mitigate patient aggression, are reviewed below.

External

Tishler et al. (2013) conducted a systemic review that focused 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 who 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. This research asserts that environmental factors contribute to the incidence of aggression.

Clinicians should also 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 a 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%, it is essential for clinicians to be educated by knowledge of common risk factors associated with patient violence (Lamberg, 2007). This highlights the need for clinicians and staff to learn effective interpersonal strategies, such as good listening skills and empathy, in order to build rapport with patients.

Aggression is not limited to the ED. Two articles focused on patient agitation and difficult behavioral situations in an ICU. Maunder (1997) discussed the principles and practice of managing difficult behavioral situations (mainly aggression and manipulation)

demonstrated by patients' relatives, explaining that nurses working in ICUs may be vulnerable to such situations. The author believes that within a clinical area, the causes of aggression may be from a patient or relative, staff, or the environment. Maunder (1997) asserts that the quality of communication is critical to avoid or manage difficult behaviors. A communication style of "adult-adult type transaction" that focuses on tones of voice, gestures and postures, and words, is the most productive (Maunder, 1997). 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. A useful technique to establish boundaries for acceptable/unacceptable behavior is limit setting, whether it is explicit (verbal) or implicit (non-verbal). On one hand, the many internal and external factors that affect ICU visitors, such as uncertainty and receiving bad news, should be recognized. Yet, on the other hand, understanding that aggressive or manipulative behaviors is an atypical response to these stressors is equally important. Balancing these two perspectives helps to avoid labeling patients' relatives as "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, 2005; Johnson, 2004). Effective management of difficult behaviors can reduce stress in

an already stressful environment, and can support relatives, visitors, and staff to maintain healthy boundaries.

Working conditions and organizational structure can contribute to increased violence in psychiatric mental health nursing. Performing shift work and working full-time, as opposed to part time, has been associated with an increased risk for violence (Estryn-Behar et al., 2008). This increased risk for violence may be partly due to increased exposure to the patient population. The physical environment has also been identified as a risk factor for increased violence. Poor lighting, poor ventilation, and overcrowding, which are environmental stressors for both patients and staff, are cited as potential risks for increased violence (Lawoko, Soares, & Nolan, 2004). Working conditions and the strain under which nurses function are considered high risk factors for increased violence. The nature of nursing duties, including lifting or holding patients, may also be a threat. Inadequate staffing and increased patient workload has also been implicated in violence in the workplace (Lawoko, Soares, & Nolan, 2000; Oztung, G., 2006; Soares, Lawoko, & Nolan, 2004). Lastly, inadequate staff supervision, dissatisfaction with salary, lack of organizational enhancements, and inadequate numbers of staff to accomplish job duties has consistently been noted throughout the literature as contributory to patient aggression. (Johnson, 2004; Lawoko, Soares, & Nolan, 2000; Oztung, 2006; Soares, Lawoko, & Nolan, 2004). Now that risk factors for patient aggression have been examined, the current knowledge of how to best assess patient aggression and understand the context for the aggression will be explored.

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 systematic reviews. One review focused on identifying measures to assess severity of agitation in order to predict patient aggression and violence, and/or the need for medication. The other review focused on finding clinical trials of pharmacological agents for agitation. Among 13 scales identified to assess agitation and aggression across multiple treatment settings, three were found to be applicable in predicting aggression and violence in patients with agitation: (1) the Broset Violence Checklist (BVC); (2) the Violence Risk Assessment Scheme; and (3) the McNeil-Binder Violence Screening Checklist. Only one scale, was found to be useful in assessing the need for medication. The 31 clinical trials that were reviewed 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 the ED. Among two 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. The BVC, which includes six items to assess confusion, irritability, boisterousness, physical threat, verbal threat, and attack on objects, was the most prevalent violence risk assessment tool used. The BVC had the best validity and reliability for use in inpatient settings, such as psychiatric

and medical-surgical units. Evidence from this study supports the use of a standardized violence risk assessment for early identification of aggressive behavior, coupled with early de-escalation interventions and/or patient seclusion, and could potentially reduce the risk of injury to healthcare workers.

Current Interventions – Literature Review

Current interventions will be examined to explore their efficacy in decreasing patient aggression in hospital settings. The use of psychopharmacology and restraints, as well as education and training, will be reviewed. A strong understanding of evidence-based practices that work effectively to reduce aggression within certain patient populations informs this anti-aggression training curriculum. Benefits and risks of each intervention will be analyzed.

Psychopharmacology /Chemical Restraints

Kynoch et al.'s (2011) review included six studies (five in the US and one in Australia) that examined the effectiveness of pharmacological agents for managing patients' aggressive behaviors in acute hospital settings. Results from these studies suggested that Droperidol and Midazolam both have a more rapid and stronger sedation effect compared to Lorazepam and Haloperidol. However, Midazolam causes a 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).

Results indicate that the following pharmacological agents were effective for the treatment of patient agitation: 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 (Zeller & Rhoades, 2010). However, it was also reported that the more rapid onset of pharmacologic action is through the intramuscular route compared with the oral route for medications such as Olanzapine. The authors concluded that the most effective actions that healthcare professionals can take to reduce violence are to: (1) develop an easy-to-administer instrument to predict the risk of aggression and violence in agitated patients; (2) select pharmacological agents that are well-accepted by healthcare professionals; and (3) train staff to facilitate the management of agitated patients in the emergency care setting.

Alam (2007) discussed the effective management of patient behavioral disturbances in general hospital settings in the UK by highlighting the importance of accurately identifying specific problems, such as comorbid medical or mental illnesses. Delirium accounts for the majority of patients with behavioral disturbances in general hospitals). Management of patient aggression should be focused primarily on prevention and use of non-pharmacological approaches to modify contributing factors, followed by medication with Haloperidol as the first line of treatment. Detecting patients who have alcohol problems in the medically ill population is extremely important, since alcohol withdrawal accounts for a significant number of patients presenting with challenging behaviors, including delirium tremors, which are a severe complication of alcohol withdrawal. A successful four-part strategy for hospital staff to manage patient aggression includes: (1) a screening tool for early detection; (2) brief intervention for co-incident hazardous drinkers; (3) widely available protocols for pharmacological detoxification; and (4) reputable referrals to specialized services (Alam, 2007).

Additionally, patients admitted to a general hospital due to deliberate self-harm, who have the capacity to consent or refuse medical treatment, may also present potential behavioral disturbances. A patient's behavioral difficulties, particularly aggression, could be effectively managed in a general hospital setting by using pharmacological agents such as Lorazepam and Haloperidol, if the patient's history, assessment, medical condition, drug interactions, side effects, and safety precautions allow use of these medications (Trustees of the University of Pennsylvania, 2017).

Holloman and Zeller (2012) led efforts to develop best practices for the evaluation and treatment of patient agitation. Known as *Project BETA*, their objective was to address the major concern of aggression in emergency settings. Five workgroups who followed a patient through an intervention were established to address five 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; and (5) use and avoidance, of seclusion, and restraint. The algorithms within each topic provided guidance for non-coercive evaluation and management of the agitated patient. The goal was to assist clinicians in recognizing that agitated patients do not necessarily need to go directly into restraints. Instead, benign collaborative treatments can be applied to reduce injury, establish therapeutic alliance, and improve long-term patient outcomes.

Restraints

In our society, restraints have unfortunately been overused as a means to control aggression. One prospective observational study, conducted over a one-year period, examined the effects of mechanical restraints on consecutive patients who presented to an

inner-city ED in a US hospital. The reasons given to justify the use of restraints included patient agitation, violence, disruptive behavior, confusion, dementia, and alcohol/drug intoxication (Zun, 2003). The authors concluded that there is limited evidence to support the use of chemical and mechanical restraints in managing patient aggression in acute care settings. However, high-quality training in this area could possibly decrease incidents of aggression and improve patient outcomes. Findings in the Zun (2003) study support the development of an aggression management curriculum.

Current Training/Education Practices

Healthcare providers must recognize the signs and symptoms of patient aggression, and must also be educated on potential causes of aggression. Individuals respond differently to interventions, depending on the context and cause of their aggression. Evidence that supports the value of aggression management education and training for healthcare staff will be reviewed.

Kynoch et al. (2011) performed a systematic review of interventions for preventing and managing aggressive patients admitted to acute care hospitals. The authors analyzed quantitative research studies from 1990 to 2007. Criteria for inclusion were adult patients over the age of 18, admitted to the hospital, who exhibited aggressive behaviors that consisted of verbal abuse, nonverbal abuse, physical violence, threatening behaviors, and assaults. Three studies (two conducted in Australia and one in Sweden) were found that investigated the use of staff training programs to reduce the incidence of patients' aggressive behaviors in acute care settings, such as geriatric wards and emergency departments. The overall results from these studies indicate that staff can be

prepared to manage patients' aggressive behaviors through increased 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 that serves 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. The first BERT trial was held in a medical pulmonary unit, and was then expanded to the entire hospital, over a two-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 patient care process; and (5) to measure BERT's effectiveness. BERT has prompted 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, data on cost and patient outcomes are still not available in the literature.

Quite a few studies are primarily focused 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 with the use of restraints and the delivery of PRN medication on an acute 20-bed inpatient brain injury unit. The specific training utilized was the NCI Certified Instructor Training Program (Crisis Prevention Institute, 2007), with the goal of training staff on how to identify each level of escalating aggression, and how to intervene appropriately at each level. The results showed that the use of physical restraints initially declined and

then increased after the behavior management training. Similarly, the delivery of PRN-selected medications 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. Based on results of this study, the researchers 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 that was designed to reduce the experience of aggression in community healthcare workers in New Zealand. The interactive, multimedia communication skills training package included workbooks, academic 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 in perceived aggression was achieved for one and two months after baseline measures, as was the reduction in distress, and increase in general mental wellbeing. Additionally, the majority of participants rated the training program as excellent or good. The study enriched the growing body of research on the effectiveness and the different types of delivery of aggression education intervention, and calls for a randomized controlled trial with longer term follow-up in the future.

An escalation of any imminent signs of violence, a.k.a. *warning signs*, should alert clinicians to the need for immediate intervention. These signs include loud talking, inappropriate language (profanity, intimidation, overly sexual), the demand for unnecessary care, accusations of clinicians 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 the 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 and violent patients effectively and safely (Trustees of the University of Pennsylvania, 2017).

Further aggression management training for clinicians will help staff build a “toolbox” of interventions with verbal, physical/environmental, and restraint (physical and pharmacological) strategies that will allow flexibility in responding to specific situations of aggressive behavior, and provide alternative actions should one intervention fail. Different pharmacological agents including antipsychotics, benzodiazepines, and anticholinergics are discussed in detail in the literature. Their use may be justified, given that the benefits of use clearly outweigh the risks. Additional investigation on the best practices to train healthcare providers to assess the risk of patient violence and to effectively intervene is imperative for acute medical units within a general hospital setting. Such training should occur early in the careers of hospital personnel.

Heckemann et al. (2015) systemically reviewed current research on the effects of aggression management training programs for nursing staff and students working in acute hospital settings. The review examined the effect of aggression management training on:

(1) nurses' and students' attitudes; (2) nurses' and students' confidence; (3) nurses' and students' knowledge and skills about risk factors for aggression; and (4) incidence rates of patient or visitor aggression (PVA). In nine studies, only one was found that had a 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," or changes in culture across all hierarchical levels within an organization, as part of an overall strategy to reduce 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. *Workplace violence* is defined as "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, p.10). Despite a wide range of sociocultural and economic conditions, the characteristics of WPV are similar in different parts of the world, including Australia, Canada, Italy, Norway, Pakistan, the UK, the US, and many more. The untoward effects of WPV on the mental and physical health of staff are serious. The most common psychological effects of WPV are fear and reduced job satisfaction. Factors that underpin WPV include lack of preventative policies, inadequate education, unwillingness to report assaults due to staffs' view of 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, to

prevent staff from assaults, and to encourage ED staff to report every WPV 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. Reports suggest that healthcare workers who have had appropriate self-defense training are attacked less often, and those workers incur less serious injuries when they are attacked (Infatino & Musingo, 1985). Nurses in the US 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 the four stages of aggression: 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). Healthcare workers are at an 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 that employees are equipped to protect themselves when faced with a violent patient event or episode.

The literature suggests that there is not an effective multi-disciplinary framework for addressing aggression and violence in the workplace. Although several variables exist, there is no algorithm for frontline healthcare staff to readily use to diffuse potentially threatening events or to manage workplace violence. 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. Therefore, a training curriculum based on identifying the cues that lead to patients' aggressive and violent behaviors is indicated.

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 tested his theory scientifically, by 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 the social, historical context of human growth and development into account (Bronfenbrenner, 1994).

There are two general underlying propositions that define Bronfenbrenner's model. The first proposition is that human development takes place through progressively 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, since 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. Bronfenbrenner's model also 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 of nesting structures from innermost to outermost levels 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. The micro-system consists 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.

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 components 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 of 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).

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 chronosystem (Bronfenbrenner, 1994). This concept extends to the passage of time, not in respect to 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.

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 to make sure that employees have the appropriate knowledge and training to address victims of violence and to support professions who work with those victims. This curriculum 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, the quality of hospitals, the training of staff, and the 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 Developing a 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, multiple variables must 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 is particularly important in this training curriculum as it is aimed at changing the behavioral responses of adult learners.

Because the effect of workplace violence on healthcare staff is intolerable 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, 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, must assist the learner with acquisition of skills, sensitivities, and understandings that are essential for the learner to become more reflective about 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 for whom they care. 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, the aggression management training system 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 creates a diverse and holistic approach to patient aggression, and utilizes best practices to make sure providers can learn the strategies and apply them in practice.

Definitions of Terms for Curriculum

The concepts used in this curriculum design are informed by the definitions from peer-reviewed literature. However, definitions may vary across healthcare settings, so the curriculum could be amended to reflect organizational language. A review of definitions follows.

Aggression

Aggression is defined as hostile or violent behaviors or attitudes toward another; readiness to attack or confront (Hacker, 2018). Aggression encompasses both verbal abuse (yelling, name calling, swearing), and physical assaults (hitting, punching, grabbing, kicking, biting, scratching). Aggression is a common healthcare emergency, and poses a great risk to patients, healthcare professionals, and others in the treatment area, if intervention is not immediate. Aggression, though not the core feature of agitation, is frequently associated with psychiatric conditions, and can also be associated with CNS disease (e.g., dementia); medical conditions (e.g., thyrotoxicosis); and substance abuse (Zeller & Rhoades, 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 perform within the scope of their practice, as defined by State law (UC Regents, 2017). Social workers are an integral part of this curriculum development and implementation. Social workers are often the first to respond to patients' psychosocial presentations, and are an excellent resource to coordinate care. For this curriculum design, healthcare providers are those individuals who provide 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. Within hospital settings, there is an inherent hierarchy among healthcare providers.

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 (Hacker, 2018).

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 (Hacker, 2018).

Social Worker: a person who carries out any of various professional activities or methods concretely concerned with providing social services and especially with the investigation, treatment, and material aid of the economically, physically, mentally, or socially disadvantaged (Hacker, 2018).

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 to in-patients and retail areas. Is responsible for carrying 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 was 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 for patient aggression and violence, and their efficacy, guided the development of this curriculum. The goal of the curriculum is to (1) standardize the response to patient aggression by all hospital staff, and (2) to educate staff regarding the underlying causes of aggression.

The identification and management of aggression is a complex, multifactorial event requiring the integration and application of theory into curriculum development. Although evidence has suggested that a multimedia approach has shown some effect (Swain & Gale, 2014), the sample size was small and not implemented in a strictly medical-surgical hospital setting. To promote the change needed in an organizational culture, the targeted audience must be multidisciplinary workers across the healthcare organization. A patient aggression curriculum has not yet been applied, across the healthcare environment. Bronfenbrenner's theory has identified reciprocal interactions between the human organism and the environment as proximal processes that can promote development and organizational change. According to Bronfenbrenner, the macro-systems are the characteristics of a given system, so 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 tenets of the curriculum for the integrated event of aggression will be based on the ecological model. The ecological model identifies individual patient biological makeup, medical condition, personality, and coping style. The curriculum addresses 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 effective aggression management. Delivery of educational content includes small interdisciplinary groups, shared experiences, and interactive learning through experiential videos. Evidence-based research has demonstrated that a better understanding of aggression, and the causal factors underlying aggression, are essential for learning how to manage and prevent the negative impact of aggression and violence.

Curriculum development included two phases, the *Planning Phase* and the *Curriculum Development Phase*. The planning phase was primarily based on the literature review. Current research on the prevalence of workplace violence, and strategies to decrease incidents of aggression, demonstrated the need for a curriculum steeped in best practices discovered in research. 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 construct addresses the learning style of proposed participants (adult learners),

and how to best present the information to increase learning. Operational definitions are included in the review.

The second phase was the *Curriculum Development Phase*. The curriculum is made up of three modules. Module 1 – *Realize: Understand aggression in the workplace*; Module 2 – *Recognize: Identify signs and symptoms of aggression*; and Module 3 – *Respond: Learn skills and strategies on how to address aggression effectively and appropriately, and improve relationships between patients and providers*. For each module, there is a reflective process to enhance and optimize the learning capacity for participants. All elements of the instruction are informed by the literature review. In addition to the content of the curriculum, implementation guidelines for best practice are included.

Chapter 4: The Curriculum

Workplace violence in acute hospitals is a significant problem for organizations and for the personal well-being of employees in high-risk settings. Requests for behavioral health management training and strategies to manage aggression and violence is critical. The call for training to address agitated, aggressive, and violent patients and inform safety for staff and patients across hospital settings is being addressed by the aggression management curriculum.

Potential threats of aggression and violence are acknowledged in research, but there is limited understanding of the management of aggression in acute medical units, nursing staff, physicians, social workers, and ancillary staff are ill-equipped to de-escalate an agitated, aggressive or violent patient, and/or effectively protect themselves

and others from harm. Hospital organizations must incorporate effective educational strategies that prepare employees to manage the increasing epidemic of violence in the workplace. A comprehensive curriculum can meet the need of healthcare employees practicing in acute hospital settings. Focusing on prevention, this curriculum will equip hospital staff with strategies to identify, manage, and safely diffuse aggressive behavior. An education and training curriculum for the management of aggression in the workplace requires a dynamic approach. The curriculum incorporates developmental models that encompass ecological development, social ecology, and transformational learning. The interconnectedness and collaboration of these models will provide a holistic approach for a diverse work force learn how to manage aggression and violence in the workplace. This chapter includes an overview of the education and training curriculum for aggression management in an acute hospital setting. Detailed slide decks presenting the curriculum, including definitions, module flow, and reflective prompts are in Appendix A, titled *Curriculum Slide Deck*.

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 the significant influence of context, the varying nature of the catalyst of the learning process, the minimization of the role of reflection, and an increased role in knowing 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 education and training curriculum will be hospital staff who have 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 value and belief system, 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 small group of hospital workers, limited to 10 participants. 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, the first cohort of learners will be from one identified, selected medical unit from the same institution. The self-selected cohort will meet 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 (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 worldview 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). Each participant must recognize the impact of aggression and how it manifests differently in each of the participants. A time will be set for reflection after each module. Intentional reflection will allow each of the participants to identify the impact that aggression has on them, and the importance and responsibility of managing aggression effectively and responsibly.

Identified Setting

To best integrate the education and training experience of the curriculum 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 micro-systems, meso-systems, exo-systems, macro-systems and chrono-systems (Lau & Ng, 2014).

Micro-systems 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. Micro-systems are affected by their individual roles, their relationships, and their social supports. Each member's experiences will be used as part of the curriculum, to include diverse perspectives and group discussions. These discussions will also provide 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 include objective experiences as well as a way for each person in the environment to perceive the experiences 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 B Confidence in coping with Patient Aggression Instrument (Thackrey 1987).

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

Objectives	Goals:
Realize- Understand Aggression in the workplace	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. To increase early identification of signs and symptoms of patient aggression
Respond- Learn skills and strategies on how to address aggression appropriately and improve relationships between patients and providers	<ol style="list-style-type: none"> 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 begin by introducing themselves, including their role in the organization. A Confidence in Coping with Patient Aggression Instrument is distributed

and completed. The instructor provides 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 - Identifying 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.

Please refer to Appendix A for Module 2 slide deck.

Process

First, the facilitator presents a brief review of Module 1. Next, the facilitator introduces the CAMPS Aggression Management Tool (See Appendix C). 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 an 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 newly 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. Please refer to Appendix A for Module 3 slide deck.

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. A 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 an essential 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	<ol style="list-style-type: none">1. Improved Communication2. Establish a safe working environment3. Reduced risk of injury to patient and staff4. Reduced stigma associated with behavioral health issues through the common definition/understanding of aggression
Organizational	<ol style="list-style-type: none">1. Reduced risk – litigation2. Create and maintain a culture of safety3. Improved staff retention4. 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 avoids 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.

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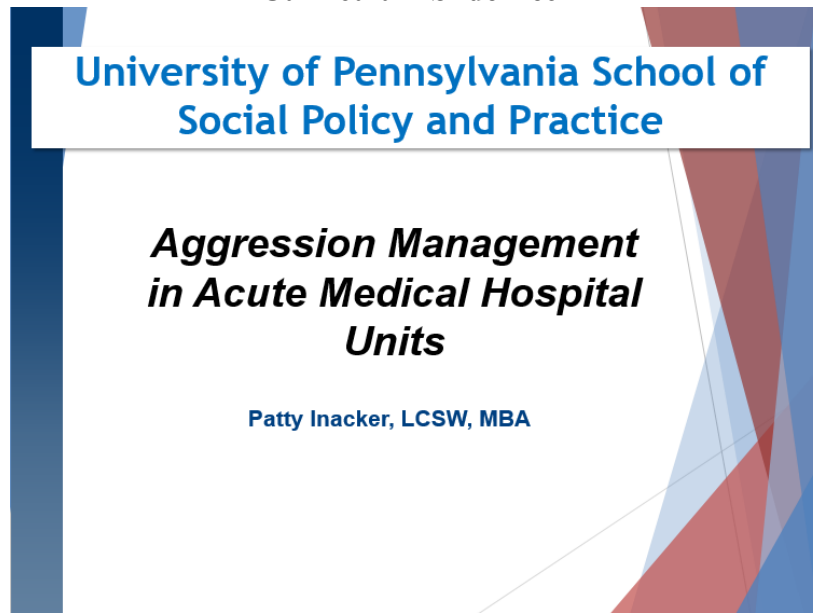
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APPENDICES

Appendix A

Curriculum Slide Deck



<https://drive.google.com/open?id=11ZWdermJCzwpP8sK7e6BLpMDpxmwVDOT>

Appendix B
Confidence in Coping with Patient Aggression Instrument (Thackrey 1987)

Below is a list of questions on dealing with patient aggression. Please read each question carefully and respond by circling a number on the scale.

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

Very Uncomfortable 0 1 2 3 4 5 6 7 8 9 10 **Very Comfortable**

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

Very Poor 0 1 2 3 4 5 6 7 8 9 10 **Very Good**

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

Very Unable 0 1 2 3 4 5 6 7 8 9 10 **Very Able**

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

Not Very Self-Assured 0 1 2 3 4 5 6 7 8 9 10 **Very Self-Assured**

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

Very Unable 0 1 2 3 4 5 6 7 8 9 10 **Very Able**

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

Very Poor 0 1 2 3 4 5 6 7 8 9 10 **Very Good**

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

Very Unsafe 0 1 2 3 4 5 6 7 8 9 10 **Very Safe**

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

Very Ineffective 0 1 2 3 4 5 6 7 8 9 10 **Very Effective**

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

Very Unable 0 1 2 3 4 5 6 7 8 9 10 **Very Able**

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

Very Unable 0 1 2 3 4 5 6 7 8 9 10 **Very Able**

Appendix C

CAMPS Aggression Management Tool

CAMPS

<u>C</u> ognitions	<ul style="list-style-type: none"> ▶ Trouble concentrating ▶ Easily distracted ▶ Racing thoughts ▶ Forgetfulness ▶ Ruminating ▶ Minimizing
<u>A</u> ctions	<ul style="list-style-type: none"> ▶ Rocking ▶ Rapid, loud or 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
<u>M</u> edical	<ul style="list-style-type: none"> ▶ Withdrawal from drugs and alcohol ▶ Medications (steroids, stimulants) ▶ Constipation ▶ Pain ▶ Poor oxygenation ▶ Delirium ▶ Endocrine imbalances ▶ Dementia ▶ Electrolyte Imbalance ▶ Other infections
<u>P</u> sychological	<ul style="list-style-type: none"> ▶ Sudden changes in mood ▶ Easily agitated ▶ Changes in affect ▶ Sadness ▶ Anger ▶ Frustration ▶ Loss of control ▶ Fear ▶ Trauma ▶ Lack of social support ▶ Excessive crying or laughter

Stressors

- ▶ (Patient)
- ▶ Lack of privacy and control
- ▶ Hunger
- ▶ Boredom
- ▶ Being in the hospital, medical procedures, tests
- ▶ Inability to smoke
- ▶ Fatigue
- ▶ Pain
- ▶ Unit noise
- ▶ Inability to smoke
- ▶ Must adapt to hospital schedule for meals, sleep, etc.
- ▶ Other patients or visitors
- ▶ Long waiting times
- ▶ Family interactions
- ▶ (Staff)
- ▶ Personality Style
- ▶ Staff frustration with work
- ▶ Outside lives affecting work
- ▶ Poor communication with patient
- ▶ Inability to deal with aggression effectively
- ▶ Fear of physical injury
- ▶ Understaffing
- ▶ Compassion fatigue – always giving to others