

IDENTIFYING POTENTIAL FACTORS RELATED to VIOLENCE in the WORKPLACE

A RESEARCH PAPER

SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

MASTERS OF SCIENCE

BY

STEVEN KOBLINSKI

DR. NAGIA ALI-ADVISOR

BALL STATE UNIVERSITY

MUNCIE, INDIANA

JULY 2015

*Table of Contents*

Abstract.....	i
Table of Contents .....	i
Chapter I.....	1
Introduction .....	1
Background and Significance.....	1
Statement of Problem .....	2
Purpose of the Study .....	2
Research Questions/Statements.....	2
Conceptual Framework .....	3
Definition of Terms.....	3
Limitations .....	4
Assumptions .....	4
Summary .....	4
Chapter II .....	6
Literature Review .....	6
Introduction .....	6
Theoretical Framework .....	6
Studies that Examined Violence toward Nurses .....	7
Summary of Literature .....	22
Chapter III.....	24
Methods and Procedures .....	24
Introduction .....	24
Research Questions .....	24
Setting, Population, Sample .....	24
Protection of Human Rights.....	25
Procedures .....	25
Research Design.....	26
Instrumentation.....	26
Reliability and Validity .....	26
Data Analysis .....	27

Summary .....	27
References .....	29

## Chapter I

### *Introduction*

Workplace violence (WPV) is a recognized hazard in the healthcare industry and identified as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. The WPV can affect and involve workers, clients, customers, and visitors. This violence ranges from threats and verbal abuse to physical assaults and even death (Occupational Safety & Health Administration [OSHA], 2014).

### *Background and Significance*

In 2006, it was reported that 60% of workplace assaults occurred in health care with most of these assaults committed by patients. Health care support occupations had an injury rate of 20.4 per 10,000 workers due to assaults (U.S. Bureau of Labor Statistics [BLS], 2007). The Occupational Safety & Health Administration (OSHA, 2014) stated that in 2010 healthcare workers were the victims of approximately 11,370 assaults by persons which was a greater than 13% increase over the number of such assaults reported in 2009. As significant as these numbers are, the actual number of incidents is most likely much higher due to the amount underreporting that is related to the perception that assaults are part of the job (Gates, Gillespie, & Succop, 2011).

According to Waschler, Ruiz-Hernández, Llor-Esteban, and García-Izquierdo, (2013), one of every four violent occupational incidents occurs in the healthcare sector. The abuse experienced by nurses contributes to job dissatisfaction while the increase in workplace tension results in higher turnover rates, decreased productivity, higher rates of sick leave, and even earlier retirement.

When nurses are exposed to workplace violence, the quality of nursing care is also adversely affected. The result of an unhealthy working environment can increase the chance for

nursing error while promoting moral distress, burnout, frustration, and low morale (Hameric, Spross, & Hanson, 2009).

Bowers, Allan, Simpson, Jones, Van Der Merwe, and Jeffery (2009) agree that violent events can cause significant distress for staff contributing to low morale, high sickness, high staff turnover, and higher vacancy rates. This ultimately can result in decreased staffing levels and positions filled by inexperienced staff. These adverse incidents have also been linked to lower standards of care (Bowers et al., 2009).

The Joint Commission of Environment of Care Standards (2010) require health care facilities address and maintain a written plan describing how an institution provides for the security of patients, staff, and visitors. Institutions are also required to conduct risk assessments to determine the potential for violence, provide strategies for preventing instances of violence, and establish a response plan that is enacted when an incident occurs.

#### *Statement of Problem*

Many studies have looked at assessment strategies and accompanying interventions at the individual level between provider and patient. Others have looked at hospital policies and procedures in decreasing risk for violence. Few studies have looked at whether a plan of care incorporating the healthcare provider, patient, and management can reduce workplace violence.

#### *Purpose of the Study*

The purpose of this study is to identify potentially violent situations within the workplace, particularly in the mental inpatient setting, and identify successful intervention.

#### *Research Questions/Statements*

1. Tell me about the violent situation you experienced with the mental patient.
2. How did you assess that violence situation and how the assessment work?

3. What interventions have been most effective in reducing the violent behaviors?
4. What hospital/unit policies that support nurse strategies in reducing violence?
5. Elaborate on patient participation in violence prevention strategies.

### *Conceptual Framework*

Peplau (1991) developed the theory focusing on a reciprocal nurse-patient interaction. Nurses enter into a relationship with a patient when a need is recognized. Within this interaction, the two parties set a common goal to be achieved. The interpersonal relationship originally included the four phases of orientation, identification, exploitation, and resolution. These four phases are also synonymous with the nursing process (George, 2011).

Psychodynamic theorists believe people encounter psychobiological experiences, which include frustration, conflict, tension, and anxiety. When anxiety increases, the psychological defense mechanisms are triggered leading to the possibility of negative behaviors (Shattell, Starr, & Thomas, 2007). The goal of psychodynamic nursing as explained in Peplau's (1991) previous work is to help understand one's own behavior, help others identify difficulties, and apply principles of human relations as a resolution to these difficulties.

The study will look at the dependent variable of violence along with the independent variables of assessment strategies, interventions used by staff, hospital policies, and patient participation. The framework will incorporate these concepts and look at the interrelationships found between them.

### *Definition of Terms*

#### *Workplace Violence: Conceptual*

Workplace violence is violence or the threat of violence against workers. It can occur at or outside the workplace and range from threats and verbal abuse to physical assaults and

homicide. Workplace violence is a growing concern for employers and employees nationwide (OSHA, 2014).

#### *Workplace Violence: Operational*

Workplace violence will be assessed by the five open-ended research questions.

#### *Limitations*

The limitations for this study are the small group of participants who will be interviewed and may have limited experience in violent situations. Data collected is self-reported and it is likely not all situations have been documented making verification of data difficult.

#### *Assumptions*

1. Surveys and interview methods will reveal violent situations experienced by participants.
2. Participants will truthfully respond to questions/statements asked.
3. Surveys will be used for information gathering.
4. Results will be shared among participants and hospital administrators to educate and in the hopes of decreasing violence in the workplace.

#### *Summary*

Workplace violence is a hazard in the healthcare affecting workers, clients, customers and visitors. Workplace violence can range from threats, assaults and even death. It is estimated that 60% of workplace assaults are committed in healthcare with most of these coming from patients (BLS, 2007). Violence in the workplace can cause significant distress for staff resulting in decreased standards of care. Joint Commission even requires that health care facilities address and maintain a plan on how an institution provides security for patients, staff and visitors. By utilizing Peplau's as Theory of Interpersonal Relations, (1991) this study will look at whether or

not a plan of care involving the patient, provider, and management is being utilized, and if so, do these contributing factors result in a reduction of violence in the workplace.

## Chapter II

### *Literature Review*

#### *Introduction*

Violence toward nurses in the workplace is an endemic, worldwide problem and can have a detrimental effect on nurses' psychological, cognitive, emotional, behavioral, and spiritual well-being. The impact can have a negative effect on public healthcare costs and is an escalating problem in all areas of practice.

#### *Theoretical Framework*

The first number of studies reviewed included initial assessments of nurses, the environments, and cues to notice in potentially violent situations. Subsequent studies have indicated the need for experienced and educated nurses and the importance of facility support. Few studies, on the other hand, include the patient as a participant in harm reduction techniques.

Peplau (1991) viewed the nurse-patient relationship as one of building trust and assisting persons to begin to identify problems, working with them on the problems, and supporting persons/individuals to achieve a mutual goal. This common goal provides the incentive in which the nurse and patient respect each other as individuals, both learning and growing as a result of the interaction (George, 2011).

Peplau (1991) also noted nursing is one of many functions of a professional health team in which professional workers collaborate to bring about health improvement. As studies have shown, a team effort is encouraged to increase safety in the workplace. Given the severity of workplace violence found within nursing, it is important to take every precaution and utilize all resources to reduce this trend.

### *Studies that Examined Violence toward Nurses*

In a study performed by Luck, Jackson, and Usher (2007), it was stated there is evidence of an increase in frequency and severity of violence toward nurses within high risk areas. The aim of the study was to explain the components of observable behavior that indicate a potential for violence in patients, their family and friends, when presenting at an emergency department (ED).

Luck et al. (2007) noted there is no agreed upon set of methods for case studies, and methods are consequently chosen based on the capacity to address the research aims. In this study, methods that enabled a focus on a violent situation while providing care were sought. A mixed method case study design and data were collected by means of 290 hours of participant observation, 16 semi-structured interviews, and 13 informal field interviews over a 5-month period in 2005. Thematic analysis of textual data was undertaken using NVivo2, a software package to assist in the management and analysis of qualitative data (Lakeman, 2008). Frequency counts of violence were developed from the numerical data (Luck et al., 2007).

The case study took place in a 33-bed ED located in Australia that serviced a large rural, remote and metropolitan community. The local community is multi-cultural serving a high number of tourists and seasonal workers. Convenience non-probability sampling was used to recruit Registered Nurses permanently employed either full- or part-time in the ED. The five distinctive elements of observable behavior that indicate potential for violence in patients and accompanying persons were identified.

The findings of the study revealed that staring was as an important early indicator of a potential for violence and was observed in nine of the 16 observed violent events. Thirteen of the 16 observed violent events featured in tone and volume of voice. Anxiety appeared in 13 of the

16 observed events of violence. Eleven of the 16 violent occasions included mumbling; having slurred, incoherent speech or repetitive questions or statements. Additionally, pacing was observed in nine of the 16 actions that escalated to violence (Luck et al., 2007).

The five components included staring and eye contact, tone and volume of voice, anxiety, mumbling, and pacing were given the acronym STAMP (Luck et al., 2007). The components reflected in the acronym STAMP cover a number of the multiple variables that influence, decrease, vary or exacerbate the potential for violence toward nurses in EDs. The STAMP has the potential to offer a practical, evidence based assessment framework for violence toward ED nurses. The use of the framework may also facilitate early recognition of risk situations and thereby enable earlier intervention of de-escalation skills.

Limitations of this study according to Luck et al. (2007) suggested that further research into STAMP is needed to establish validity and reliability of its components. Also, additional research that explores the generalizability of the STAMP nursing violence assessment framework across specialties and cultures is recommended.

Chapman, Perry, Styles, and Combs (2009) agreed that violence at work has become an alarming phenomenon worldwide. Although workplace violence (WPV) occurs in all work environments, the health industry is particularly prone to it. The aim of the study performed by Chapman et al. (2009) was to describe factors that nurses identify as alerting them to the possibility that WPV might occur.

The explorative study collected qualitative and quantitative data through a survey and subsequent interviews. The survey was distributed to determine nurses' experiences of aggressive and violent incidents occurring within the previous 12 months. Two open-ended questions in the larger questionnaire requested the participants to identify, from their perspective,

the behaviors of the perpetrator that led up to an event of WPV and to list the factors that precipitated the event. The instrument was reviewed by 12 nurse researchers in academics to check face validity, and modifications were made according to nurse researchers' feedback (Chapman et al., 2009).

One hundred and thirteen questionnaires were completed. Interviews were conducted in a setting convenient to the participant, semi-structured, and lasted for approximately 30 minutes. Theoretical saturation was reached after 20 interviews. According to Chapman et al. (2009), saturation occurred when all categories and themes appeared to be complete.

The software package SPSS version 15 was used to summarize participants' demographic data. Respondents in this study were mainly female, in early 40s, had been registered in the profession between six months and 40 years (Chapman et al., 2009).

Nine distinct components of predicting violence and aggression emerged from the data. These components included staring, tone of voice, anxiety, mumbling, pacing, emotions, disease process, assertive/non-assertive, and resources/organization. The acronym STAMPEDAR was used to classify these nine components. While a previous study by Luck et al. (2007) had already explained STAMP, Chapman et al. (2009) stated this article focused only on four additional components including emotions, disease process, assertive/non-assertive, and resources/organization (EDAR).

With emotions considered, participants in the study reported participants were more alert to the possibility of violence when patients or patient's relatives were demonstrating a heightened emotional state, such as fear or frustration. The disease processes of confusion, intoxication, mental illness, dual diagnosis, and organic disorders resulted in a higher likelihood a patient would become aggressive or violent. The observation of someone either lacking

assertion or being overly assertive was noted as a precursor to potential violence. Furthermore, respondents believed that the time it took waiting for resources as seen in the triage process, placed patients at a higher risk for violence (Chapman et al., 2009).

Respondents identified in some cases awareness of staff actions that could escalate an episode of WPV. Improper behavior by nurses and other staff were thought to escalate incidents, especially if staff were condescending toward patients or visitors. The skill and education level of the other nurses on the ward also correlated with the risk of WPV. Nurses in this study reported staff not experienced at diffusion skills were at greater risk of experiencing violence. A nurse's attitude and behavior were identified as being responsible for violent incidents of WPV (Chapman et al., 2009).

Although much of the study showed promise towards the implementation of STAMPDAR (Chapman et al., 2009) the researchers concluded by admitting further research is needed to establish the validity and reliability of the STAMPEDAR framework. The usefulness of this instrument as a tool for predicting episodes of WPV still requires more evaluation.

Patient violence has already been shown to be prevalent in all healthcare settings. Patient violence against nurses can range from verbal abuse, threats, harassment, and physical assaults that could result in psychological or physical harm. For nurses working on psychiatric units, many tools have already been developed to assess patients who are at a higher risk for violence.

Kim, Ideker, and Todicheeney-Mannes (2012) declared a risk assessment for nurses in specialty areas is not always available. For this reason Kim et al. (2012) suggest a brief, easy-to-use risk assessment tool for nurses is needed for early identification of potentially violent patients. The primary purpose for the study was to evaluate the usefulness of the Aggressive

Behavior Risk Assessment (ABRAT) for predicting potentially violent patients admitted to medical-surgical units.

A prospective cohort study design was used to collect the data from patients admitted to six different medical-surgical units in southern California hospitals from August 2009 to December 2009. The inclusion criteria for the study were adult patients older than 18 years of age. Patients admitted to emergency department, maternal child health unit or intensive care units were excluded from the study (Kim et al., 2012).

Descriptive statistics were computed to summarize the demographic characteristics and the incidence of violent events. A 17-item checklist was assembled by combining items from the 11-item M55 tool and the five-item STAMP concept. Bivariate correlations using Kendall's tau test were generated among the dichotomous dependent variables and the dichotomous independent predictor variables from the 17-item checklist (Kim et al., 2012). Kim et al. (2012) note the following:

The independent variables with significant correlation with the dependent variables were entered into the multivariate logistic regression model with backward elimination to select a set of parsimonious items that best predict the violent events. The resulting set of parsimonious items was named Aggressive Behaviour Risk Assessment Tool (ABRAT).

(p. 352)

An initial assessment of the patients by the primary nurse was made using the aggressive behavior risk checklist within 24 hours of admission. The patients were re-assessed by another nurse using a second identical 17-item checklist to assess the inter-rater reliability. A violent event outcome section was completed following any violent episodes or prior to discharge (Kim et al., 2012).

Of the 2726 patients admitted to six medical-surgical units, fifty-six patients had one or more violent events, including 35 episodes of verbal abuse, 26 physical attacks, 15 threats of physical attack, and three sexual harassments. Fifty percent of the patients were over 70 years of age and the majority of patients were men and Caucasian. Ten items from the 17-item checklist were seen as potential positive predictor variables of violent events (Kim et al., 2012).

Kim et al. (2012) concluded with the belief that the ABRAT is a simple, easy-to-use assessment tool with promising sensitivity and specificity. The ABRAT may be useful for identifying potentially violent patients in medical-surgical units. Although the results still need to be confirmed, the ability to prospectively alert hospital workers of patients at medium or high risks of violence could help nurses in the reduction of possible violent events on medical-surgical units.

The risk of violence does not have to occur within the hospital setting. Remote area nursing practice is characterized by providing care in isolated communities to those who require health needs. Remote area nurses (RANs) are mostly women often working alone during after-hours consults and home visits. According to McCullough, Lenthall, Williams, and Andrew (2012), violence toward RANs has been increasing over the past 13 years.

The purpose of the study performed by McCullough et al. (2012) was to report on the second part of a study that used a risk management approach to investigate violence toward RANs and to develop possible ways of minimizing the risk of occupational violence toward these nurses. The study included a panel of 10 expert RANs with an average length of service in remote health of 16.7 years (range 4–30 years). Selection was based on extended length of practice as a RAN and involvement in the RAN community.

“Questionnaires were conducted via email and Internet survey and followed a three-round Delphi process. Content analysis of data from the first round, open-ended questionnaire, and subsequent literature search, yielded a survey which assessed agreement among the panel” (McCullough et al., 2012, p. 329). A Likert scale was used in the survey to assess the level of consensus and to indicate potential usefulness of each of the control measures. The control measures identified in the study were reported using a ‘toolbox’ analogy in recognition of the complex nature of occupational violence and the need for a range of strategies to reduce the risk of violence toward RANs (McCullough et al., 2012).

Four themes emerged from the data which provided suggestions for improving the safety of RANs. The four themes included education and training, professional support, organizational measures, and community collaboration.

The panel agreed education and training for RANs should include de-escalation techniques, self-defense techniques, recognition of symptoms of posttraumatic stress disorder and knowledge of how to assess work environment hazards. RANs should be experienced in clinical skills including how to conduct mental health assessments and create management plans in consultation with the family (McCullough et al., 2012). Employers should have a responsibility to take action when the risk of violence is increased for RANs including the tending of intoxicated patients and a 24-hour telephone help line was identified as a significant avenue for support. Community collaboration included procedures for obtaining help by listing reliable contacts, identifying safe areas within the clinic, and having a plan for evacuation of staff in extreme circumstances (McCullough et al., 2012).

The study concludes by stating a ‘toolbox’ of strategies includes: education, professional support, and organizational and community responsibilities for RANs. Further development and

assessment of this 'toolbox' of strategies is recommended to address the high incidence of violence toward remote health professionals. The author surmises that reducing the risk of occupational violence might reduce staff turnover and shortages of skilled nurses in remote areas (McCullough et al., 2012).

Short-term structured risk assessment is presumed to reduce incidents of aggression and seclusion on acute psychiatric wards (Van de Sande et al., 2011). Despite the negative impact seclusion may have on patients, a Cochrane review covering 2155 citations found no randomized controlled study investigating the effects of interventions aiming at reducing seclusion. The goal of the study performed by Van de Sande et al., (2011) was to evaluate the effect of risk assessment of aggression and seclusion incidents for patients admitted to acute psychiatric wards.

A cluster randomized controlled trial was conducted over 40 weeks on four acute psychiatric wards. Two experimental and control wards consisted of 36 beds in total with 20 beds on the experimental wards and 16 beds on the control wards. They were located in the Dutch city of Rotterdam and its suburbs. All patients admitted during the study averaged a length of stay of approximately three weeks. Most of the admissions (62%) were involuntary and diagnosed with a psychotic disorder (Van de Sande et al., 2011).

Patients were monitored daily by psychiatric nurses by means of risk assessment scales from the first day of admission until discharge or transfer to another ward. The five scales covered a variety of common risk factors within the acute psychiatric wards. Daily assessments utilized the Kennedy Axis V (short version) and the Brøset Violence Checklist while weekly assessments included the Kennedy Axis V (full version), Brief Psychiatric Rating Scale (BPRS)

and the Social Dysfunction and Aggression Scale. The five scales were referred to as the Crisis Monitor.

Seclusion episodes were recorded using the Argus scale which enables detailed collection and analysis of seclusion rates. The Argus scale included both incidence and duration of the seclusion. All findings were discussed by the multidisciplinary team on a daily basis and in more detail in the weekly treatment planning meetings. Differences in patient characteristics during the baseline and intervention periods were tested by chi-squared and t-tests. The significance level for all statistical tests was set at  $P < 0.05$ , two-tailed (Van de Sande et al., 2011).

The findings of the study showed the number of incidents of aggression and the number of hours spent in seclusion decreased significantly after the introduction of the Crisis Monitor. The findings suggest that patients benefit from the frequent use of short-term structured risk assessments on psychiatric admission wards. Also, without the use of structured risk assessments on a daily basis, it may take longer than necessary before ward staff become aware of improvement in the behavior of secluded patients or act upon it (Van de Sande et al., 2011).

One limitation of the study was that it took place on only four wards of a single hospital, and the total numbers of aggression and seclusion incidents observed were low. Another limitation of the study was that participating staff could not be kept unaware of the condition they were participating in and may have reduced the occurrences of seclusion because staff members expected that escalation risks would be reduced by the use of the Crisis Monitor.

Persons working in the field of mental health are the second most violently victimized group of workers (Finfgeld-Connett, 2009). Some of the issues faced by healthcare providers include providing care for acutely disturbed or violent individuals, mentally-ill patients that

return for care after being discharged due to inadequate follow-up, and an increased presence of drug and alcohol abusers.

The primary purpose of the study performed by Finfgeld-Connett (2009) was to uncover a framework of therapeutic nursing management of patient aggression in psychiatric settings; qualitative meta-synthesis methods were used to conduct this investigation. The framework is intended to guide practice and intervention research relating to the management of aggression toward health care personnel (Finfgeld-Connett, 2009).

The studies looked at qualitative research articles and were retrieved using the electronic version of the Cumulative Index to Nursing and Allied Health Literature (CINAHL). The search was limited to nursing literature based on the assumption that nurse-patient relationships are unique and distinctly different than other provider-patient relationships.

The following key terms were included in the search: nurse-patient relations, workplace violence, patient assault, verbal abuse, and aggression. Thirty-six qualitative were obtained with the final sample consisting of 15 English-language articles published between 1990 and 2006 and relating to nursing management of physical and verbal aggression among mental health patients. Findings from the 15 qualitative research reports were placed into an electronic matrix, analyzed, and interpreted using content analysis, memoing, and diagramming (Finfgeld-Connett, 2009). Quality of the sample was evaluated throughout the analysis process based on the credibility, depth, and breadth of the data supplied by the authors of the original study (Finfgeld-Connett, 2009).

Finding showed that nurses therapeutically react to escalating situations using one of two response styles. The first response was the intuitive response where a skilled psychiatric nurse intuitively understands a patient's situation and immediately and automatically matches the

intervention needed. Alternatively, the nurse may act in an emergent style were she may feel threatened but still act in a careful, calculated way (Finfgeld-Connett, 2009).

Finfgeld-Connett (2009) goes on to state that regardless of the therapeutic response style used; authentic engagement is the core component of any de-escalation response. Authentic engagement involves the nurse staying sincerely connected to the patient. The nurse assumes responsibility, stays in control, and calmly creates an atmosphere of security.

Non-therapeutic responses included nurses who use rigid rules and physical methods to control patients, and they are rewarded when they become part of the tough milieu. Non-therapeutic responses to patient aggression appear to lead to negative consequences for both patients and nursing staff. Inadequate management of violent episodes may result in burnout, absenteeism, reassignment, or resignation (Finfgeld-Connett, 2009).

The findings show that authentic engagement demonstrates to the patient that nurses have their best interests in mind. Patients develop a sense of security, hope, and self-acceptance. Finfgeld-Connett (2009) recommends that in the future nurse educators focus more on authentic engagement in clinical and academic learning environments.

An important factor to include while studying workplace violence within nursing is the attitudes nurses have toward patient restraint. Gelkopf, et al. (2009) suggest that restraining patients stimulates difficult dilemmas and conflicts for caregivers. The level of knowledge about restraints along with the attitudes of staff can directly and indirectly affect workplace violence.

The study performed by Gelkopf et al. (2009) examined nurses' attitudes regarding the goals of restraint, the environmental conditions influencing restraint, the emotional aspects of restraint, and their beliefs about whether other staff members should participate in restraint procedures.

The study utilized a survey conducted in the Lev Hasharon Mental Health Center. The facility is in the center of Israel, is a government, and serves the area of 400,000 residents. It is a 350-bed facility with four acute inpatient and four chronic units, each with approximately 40 patients. Of the 130 staff nurses who were offered questionnaires, 111 nurses (85.4%) participated and completed the surveys; completion of the questionnaires was voluntary and anonymous (Gelkopf et al., 2009).

A 52-item questionnaire was created to assess staff attitudes, opinions, behaviors, and emotions concerning patient restraint. The questionnaire was formulated by review of the restraint literature and consultations with clinicians in the public and private healthcare systems, as well as with allied health academics. A two-week test-retest of the final questionnaire showed correlations of .89–.95 for all items within the seven sections of the questionnaire. Findings were analyzed using chi square test for dichotomous variables and t-test for sequential variables (Gelkopf et al., 2009).

Nurses with higher levels of qualifications considered restraint a therapeutic instrument while less qualified nurses considered annoying activities as adequate cause for restraint. Gelkopf et al. (2009) hypothesizes the reasons for this stem from a lack of tools for coping with these types of behaviors. The lack of tools by these nurses can lead to loss of patience, and an inability to cope with the situation without physical restraints. Gelkopf et al. (2009) concluded by questioning whether the system invests enough in skills training for staff in general to cope with violence.

While restraints can be used as an intervention to protect psychiatric inpatients from self-harm or harm to others they can also cause dilemmas and conflicts for caregivers. The study found that early identification of potential violence is an important factor for reducing the rate of

patient restraint. Nursing staff believed overall that if they could identify predictors of patients' violent outbursts, and give more adequate attention to patients, they could avoid violent incidences and the subsequent use of physical restraints.

Great strides have been made in achieving a more humanistic and compassionate approach to the care of the mentally ill. According to Moylan and Cullinan (2011), acceptable level of care for psychiatric patients has moved from prison like conditions to the recognition of patients' civil and human rights. Current laws also help protect the rights of this population and ensure that patients are being treated using the least restrictive interventions possible. Although eliminating the use of restraint is ideal, a failure to restrain when potential danger exists can cause the nurse injury (Moylan & Cullinan, 2011).

The study performed by Moylan and Cullinan (2011) provides current, in depth information about the nature, frequency and severity of assaults and injuries of psychiatric nurses. The study also examined assault and injury in relation to the nurse's decision to restrain.

The study included a sample of 110 nurses from five institutions, 80% of the nurses were assaulted, 65% had been injured and 26% had been seriously injured. Injuries included fractures, eye injuries and permanent disability. A mixed methods design was used with the quantitative segment encompassing descriptive, descriptive-comparative and correlational elements. The qualitative data were gathered from written accounts of assault experiences and interviews with the study respondents.

A convenience sample of 110 nurses was selected to participate in the study. Twelve nurses did not meet the inclusion criteria of having 1 year psychiatric experience. The nurses who participated were informed that the study would take approximately 1.5 hours during which time they would be required to watch a 5-min video and then enter data on a form related

to the video (Moylan & Cullinan, 2011). The Moylan Assessment of Progressive Aggression Tool (MAPAT) is an instrument that allows the nurse to select the time, in seconds, at which she or he believes restraint is the only safe option in the advancement of aggression.

The survey section for nurses consisted of a demographic segment followed by a history of assault segment. In the history of assault segment, nurses were asked if they had ever been assaulted by a patient in the course of their duties. Of the 110 respondents, 80% had been assaulted. All of those reporting serious injury reported substantial loss of work time. Thirteen respondents lost more than 1 month of work days. Four lost more than 6 months of work days (Moylan & Cullinan, 2011). In the quantitative segment of the study it was noted by Moylan and Cullinan (2011) that female nurses underreport injuries.

Moylan and Cullinan (2011) conclude by indicating that the rate and nature of injuries to nurses is alarming and needs to be addressed by the health care system. Nurses may feel pressured to avoid restraints in order to comply with the restrictive policies or fear negative sanctions from administration. Places of employment must begin to take responsibility for improving the risky conditions of nurses employed in acute care psychiatry.

Recommendations by Moylan and Cullinan (2011) suggested that education relating to the progression of aggression, prediction of violence and appropriate intervention in the different phases needs to be taught to all nurses. There is also a need for educating nurses during early phases of the progression towards aggression to use the least restrictive therapeutic intervention appropriate.

A number of studies report higher rates of violence for nurses working in acute psychiatric treatment units placing them at increased risk (Lanza, et al., 2009). These high rates of violence threaten the physical and psychological well-being of nurses, place uncertainty for

potential nurses from entering the field and discourage current nurses from staying in nursing. The potential for violence while at the same time can disrupt patient care. The purpose of the study performed by (Lanza et al., 2009) was to implement and validate violence prevention interventions that are appropriate for patients in inpatient psychiatric settings.

According to Lanza et al. (2009), there are three classes of interventions designed to prevent patient violence against nurses. Patient-focused interventions included the flagging of charts for patients with a history of violence, nurse-focused interventions such as training in nonviolent methods of de-escalation, and institution-focused such as zero tolerance regarding violence against staff.

Each of the classes has their drawbacks. A number of assaults are committed by patients who have no previous history of assaultive behavior, assessment of the potential for violence by nursing personnel is not fully reliable, and hospital wide policies are not always acceptable for patients who are unable or unmotivated to comply (Lanza et al., 2009).

According to Lanza et al. (2009), the Violence Prevention Community Meeting (VPCM) views violence in an interpersonal or cultural context rather than focusing on patients or nurses or broad institutional policies. The VPCM does this by addressing verbal as well as physical violence through community meetings to provide reflection on the issue of violence.

Participants included patients admitted over a 20-week period to an acute psychiatric inpatient unit at a Veterans Affairs hospital. Participating nursing staff included 13 females and 8 males; (9) RNs, (3) LPNs, and (9) psychiatric nursing assistants (Lanza et al., 2009). The VPCM protocol was formed using a Delphi Approach to reach consensus from a panel of experts on violence and group treatment. Content included purpose of the meeting, staff and patient roles in the meeting, criteria for leader and leadership style, frequency and duration of the meeting,

essential content phases of the meeting, limit setting and alliance building, and monitoring of violence (Lanza et al., 2009).

The Overt Aggression Scale (OAS) was used by staff nurses to record instances of violence and categorized these into three subscales to include Verbal Aggression, Physical Aggression against Objects, and Physical Aggression against Others. The Wald chi-square test was used to test for differences in weekly violence incidents. The finding for all shifts combined showed that rates of violent incidents decreased significantly with the introduction of the VPCM. Post-treatment violence rates were reduced 41% relative to Pre-treatment weeks (Lanza et al., 2009).

In conclusion, Lanza et al. (2009) notes the VPCM shows evidence of significantly reducing patient violence. The treatment is both cost-effective and can be effectively implemented by nursing staff. Future research should demonstrate inter-rater reliability for reporting aggression and improve the single-key recording instrument used in this pilot study so verbal and physical violence can be recorded independently in real-time.

### *Summary of Literature*

The articles reviewed encompassed the strategies for assessing and identifying individuals for potential violence in the hopes of minimizing the risk of occupational violence towards nurses. The articles included a variety of nurse disciplines including but not limited to emergency room, medical-surgical, visiting nursing, and acute inpatient psychiatric nursing.

The majority of studies used the dependent variable of violence toward a nurse and the independent variables of the existing disease process, previous emotional trauma, the presence of anxiety, and personality characteristics such as lack of assertiveness or excessive assertiveness. Studies included both quantitative and qualitative results. None of the articles stated an explicit

framework. The implied conceptual framework incorporates the concepts of nursing, violence, workplace, and the interrelationships found between these.

Data were mostly from obtained through surveys or questionnaires in both qualitative and quantitative information gathering. The Overt Aggression Scale and the Moylan Assessment of Progressive Aggression Tool were used by nurse participants to rate patient's levels of aggression.

The articles all recognized the severity of violence in the workplace. Many of the studies looked at techniques nurses can use for assessing potentially violent patients. The articles also emphasized the need for experienced nurses, education in violence prevention, and the importance of having the institution involved in the process. Only one study involved the patient as being an active participant in the efforts at reducing violence.

## Chapter III

### *Methods and Procedures*

#### *Introduction*

Past research for violence in the workplace in nursing has concentrated on the circumstances and frequency of aggressive behaviors, risk assessment and prediction, effects on staff, and staff training. There has been a considerable investment in the training of psychiatric/mental health nurses along with their assistants in assessment and de-escalation techniques. Even with this preparation violence and potential harm still exists.

The purpose of this study is to identify potentially violent situations and identify which current assessment and intervention strategies would reduce violent behaviors in the inpatient psychiatric settings.

#### *Research Questions/Statements*

1. Tell me about the violent situation you experienced with the mental patient.
2. How did you assess that violence situation and how the assessment work?
3. What interventions have been most effective in reducing the violent behaviors?
4. What hospital/unit policies that support nurse strategies in reducing violence?
5. Elaborate on patient participation in violence prevention strategies.

#### *Setting, Population, Sample*

The desired sample size will be 10 nurses who are currently employed on acute inpatient psychiatric units located at the U.S. Department of Veteran Affairs (VA) located in Leeds, MA. Patients admitted here are primarily admitted with psychiatric diagnoses often including detoxification from drugs and or alcohol, mental illnesses, dual diagnosis, and organic disorders, such as dementia.

There are approximately 20 registered nurses working various shifts located on two acute psychiatric units at the VA. All nurses will be asked if they would like to participate. All those who agree to participate will have their names placed in a hat and the first 10 pulled will be chosen. If out of the 20 who are asked the size fails to reach 10 nurses then nurses from the long-term care psychiatric unit located at the VA will be asked at random if they'd be willing to participate. Interviews will be performed on the units in which participants are currently employed.

### *Protection of Human Rights*

Prior to conducting the research, a proposal of the study will be submitted to the Institutional Review Board (IRB) of the Ball State University and the VA hospital. Participants will be given an informed consent letter prior to the interview. The letter will notify participants of the intended study and their role within it. The letter will be detailed enough so the participant will understand the nature of the study and how long it will take. Participants will be allowed to follow up with any questions or concerns they may have and will be made aware that they are free to opt out of the study at any time. Participant's interview data will remain anonymous and participants will be made aware the results of this study, if they requested. No risks have been identified with this study.

### *Procedures*

The participants will be interviewed by a single researcher and interviews will be conducted on the unit where the participant is employed. Interviews will be audiotaped to assure that answers are recorded accurately. Participants will be made aware that the recording is for this purpose only and will not be used outside of this study. Once all interviews have been completed, answers will be reviewed and categorized for data analysis.

Participants will only be asked of their experiences within this particular facility. The open-ended questions previously listed will be used to collect data such as “tell me about the violent situation you experienced and which factors (if any) precipitated the event”, “how do you feel about your assessment of the situation and intervention to stop a potentially violent event”, “what about the unit or the hospital policies that support you and if they have changed as a result of workplace violence?”

### *Research Design*

This study uses descriptive, qualitative design, with structured interview questions. Descriptive qualitative research is used to obtain information concerning the current status of the phenomena and to describe "what exists" with respect to variables or conditions in a situation (Roberts, Priest, & Traynor, 2006). The study will describe the phenomenon of violence in work place from the perspectives of experienced nurses.

### *Instrumentation*

Data will be collected through the five open-ended questions of this study. In addition, demographic and characteristics of the nurse participants will be gathered. These include age, sex, ethnicity, educational level, years of experience, years in current institution, status (full-time, part-time, or contingent), and type of position.

### *Reliability and Validity*

In qualitative research, reliability can be thought of as the trustworthiness of the procedures and data generated. According to Roberts et al. (2006) qualitative content analysis is a particularly reliable approach to handling data. Specific codes are created to describe the data. Using computerized data analysis packages, such as NVivo (QSR), can enhance reliability

(Roberts et al. 2006). Other methods for increasing reliability include tape-recording and correct interview transcripts.

Validity is assessed in terms of how well the research tools measure the phenomena under investigation. A potential difficulty in achieving validity in qualitative research according to Roberts et al. (2006) is researcher bias. To alleviate researcher bias regular supervision and peer review by other researchers will be utilized.

### *Data Analysis*

Descriptive results of the demographic and personal characteristics of the nurse participants will be computed. Computer assisted qualitative data analysis software program will be used to code data. These programs can take qualitative data analysis much further compared to conducting the analysis manually. They can assist in recording, storing, indexing, sorting, and coding data. According to Leech and Onwuegbuzie (2011), these programs are capable of assisting the qualitative researcher with multiple types of analyses in which underlying theories and relationships can emerge.

### *Summary*

This chapter describes the purpose of this study along with the setting, population, and sample. The protection of human rights, procedures, methods of the study, and how the data will be analyzed are also included. The study will look at how experienced psychiatric nurses formally assess for potential violence in the workplace and will seek out interventions which have been supported effective in the reduction of harm. At the facility level, the study will show if hospital policies are current in aiding nurses in the protection from violence. At the individual level, this study will identify any interventions proven helpful to the safety of nurses.

The study will show whether patient participation in violence prevention has an impact on safety within the workplace. The findings of this study will then be compared to the study performed by Lanza et al. (2009) where patients were part of the solution in which verbal and physical violence was addressed through community meetings.

## References

- Bowers, L., Allan, T., Simpson, A., Jones, J., Van Der Merwe, M., & Jeffery, D. (2009). Identifying key factors associated with aggression on acute inpatient psychiatric wards. *Issues in Mental Health Nursing, 30*(4), 260-271.
- Chapman, R., Perry, L., Styles, I., & Combs, S. (2009). Predicting patient aggression against nurses in all hospital areas. *British Journal of Nursing, 18*(8), 476.
- Hamric, A.B., Spross, J.A., & Hanson, C.M. (2009). *Advanced practice nursing: An integrative approach* (5 ed.). St. Louis: Elsevier Saunders
- Finfgeld-Connett, D. (2009). Model of therapeutic and non-therapeutic responses to patient aggression. *Issues in Mental Health Nursing, 30*(9), 530-537.
- Gates, D. M., Gillespie, G. L., & Succop, P. (2011). Violence against nurses and its impact on stress and productivity. *Nursing Economics, 29*(2), 59-66. Retrieved from <http://search.proquest.com/docview/861741906?accountid=8483>
- Gelkopf, M., Roffe, Z., Behrbalk, P., Melamed, Y., Werbloff, N., & Bleich, A. (2009). Attitudes, opinions, behaviors, and emotions of the nursing staff toward patient restraint. *Issues in Mental Health Nursing, 30*(12), 758-763.
- George, J. B. (2011). *Nursing Theories: The base for professional nursing practice* (6<sup>th</sup> ed.) Upper Saddle River, NJ: Pearson.
- Joint Commission of Environment of Care Standard. (2101). Preventing violence in the health care setting. Retrieved from [http://www.jointcommission.org/assets/1/18/sea\\_45.pdf](http://www.jointcommission.org/assets/1/18/sea_45.pdf)
- Kim, S., Ideker, K., & Todicheeney-Mannes, D. (2012). Usefulness of aggressive behaviour Risk assessment tool for prospectively identifying violent patients in medical and surgical units. *Journal of Advanced Nursing, 68*(2), 349-357.
- Lakeman, R. (2008). Qualitative data analysis with NVivo. *Journal of Psychiatric & Mental Health Nursing, 15*(10), 868.
- Lanza, M., Rierdan, J., Forester, L., & Zeiss, R. (2009). Reducing violence against nurses: The violence prevention community meeting. *Issues in Mental Health Nursing, 30* (12), 745-750.
- Leech, N. L., & Onwuegbuzie, A. J. (2011). Beyond constant comparison qualitative data analysis: Using NVivo. *School Psychology Quarterly, 26*(1), 70-84.
- Luck, L., Jackson, D., & Usher, K. (2007). STAMP: Components of observable behaviour that indicate potential for patient violence in emergency departments. *Journal of Advanced Nursing, 59*(1), 11-19.

- McCullough, K., Lenthall, S., Williams, A., & Andrew, L. (2012). Reducing the risk of violence towards remote area nurses: A violence management toolbox. *The Australian Journal of Rural Health, 20*(6), 329–333.
- Moylan, L. B., & Cullinan, M. M. (2011). Frequency of assault and severity of injury of psychiatric nurses in relation to the nurses' decision to restrain. *Journal of Psychiatric & Mental Health Nursing, 18*(6), 526-534.
- Occupational Safety & Health Administration [OSHA]. (2014). Workplace violence. Retrieved from <https://www.osha.gov/SLTC/healthcarefacilities/violence.html>
- Peplau, H. E. (1991). *Interpersonal relations in nursing. A conceptual frame of reference for psychodynamic nursing*. New York, NY: Springer. Retrieved from <http://site.ebrary.com.ezgc.ez.cwmars.org:3800/lib/greendfieldcc/docDetail.action docID=10265396>
- Roberts, P., Priest, H., & Traynor, M. (2006). Reliability and validity in research. *Nursing Standard, 20*(44), 41-45.
- Shattell, M. M., Starr, S. S., & Thomas, S. P. (2007). Take my hand, help me out: Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing, 16*(4), 274-284.
- United States Department of Labor. Bureau of Labor Statistics (BLS). (2007). *Press release: Nonfatal occupational injuries and illnesses requiring days away from work*. Retrieved from <http://www.bls.gov/news.release/osh2.nr0.Htm>
- van de Sande, R., Nijman, H., Noorthoorn, E., Wierdsma, A., Hellendoorn, E., van der Staak, C., & Mulder, C. (2011). Aggression and seclusion on acute psychiatric wards: effect of short-term risk assessment. *The British Journal of Psychiatry: The Journal of Mental Science, 199*(6), 473-478.
- Waschler, K., Ruiz-Hernández, A., Llor-Esteban, B., & García-Izquierdo, M. (2013). Patients' aggressive behaviours towards nurses: development and psychometric properties of the hospital aggressive behaviour scale-users. *Journal of Advanced Nursing, 69*(6), 1418-1427.